HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, January 27, 2016

LEGISLATIVE CHAMBER

Department of Health and Wellness
Nova Scotia Health Authority

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WITNESSES

Nova Scotia Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Mr. Kevin Elliott, Chief Financial Officer

Nova Scotia Health Authority

Ms. Janet Knox, President and CEO
Mr. Allan Horsburgh, Vice-President, Stewardship and Accountability

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, JANUARY 27, 2016

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Good morning, everyone. I call this meeting to order. Today we have with us the Nova Scotia Department of Health and Wellness and the Nova Scotia Health Authority with respect to Chapter 3 of the November 2015 Financial Report by the Auditor General, and the Nova Scotia Health Authority Business Plan.

We'll begin with introductions, starting with Mr. Maguire.

[The committee members introduced themselves.]

MR. CHAIRMAN: Just a reminder for everyone to make sure their phones are on silent so we don't have interruptions, and a request as well from the services here at the Legislature for people not to move their microphones around too much because it can impact the ability of our systems to pick up what you're saying for the record.

Dr. Vaughan, would you like to begin with introducing yourself, along with members of your team?

DR. PETER VAUGHAN: My name is Dr. Peter Vaughan, and I'm Deputy Minister of Health and Wellness. To my left I have Kevin Elliott, Chief Financial Officer for the Department of Health and Wellness.

To my right is Janet Knox, CEO of the Nova Scotia Health Authority. With her is Chief Financial Officer and Vice-President Allan Horsburgh.

Thank you very much, and thank you for inviting us here today to talk to you. Having an accountable, evidence-based approach to delivering quality patient care is one of our main goals. Being able to evaluate and monitor health outcomes and use valid and reliable information to make decisions is the foundation to building a modern, high-performing health care system.

Nova Scotia is faced with an increasingly-aging population with high levels of chronic disease. The old ways of delivering health care were not only expensive but inefficient and, quite frankly, unsustainable. Nine independent health authorities plus the IWK meant care was being done in nine different ways sometimes. Services were not necessarily aligned provincially, and the delivery models were often acting independently of each other.

Today, Nova Scotians are already seeing the benefits of a One Nova Scotia approach to delivering health care. The Nova Scotia Health Authority and the IWK are now planning care services and delivering them locally. Duplication has been reduced. The artificial barriers of nine organizations have been brought down, and Nova Scotians now have one provincial health authority focusing on delivering efficient, innovative, quality health care. The audit highlighted some of the real challenges of the old system, and many of those recommendations have been implemented or have been remedied through the creation of the NSHA. Having a modern, innovative One Nova Scotia system is what the province needs now to make sure that every Nova Scotian has access to the care they need.

I would like to share some of my time now and pass it over to Ms. Knox for some comments.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Thank you, Deputy Vaughan, and good morning, members of the committee. The Nova Scotia Health Authority welcomes the opportunity to talk with you this morning about our work. We're a very large organization, as you know, with a budget of $1.8 billion, but we're also a new organization, and in the first year of this start-up. Several of us in leadership positions at NSHA came from the previous district health authorities, but the external analysis and recommendations, such as those provided by the Auditor General in his Fall report, have been invaluable to us as we work to establish the policies and practices of a new organization.

This first year, really, is about maximizing the opportunities of amalgamating in the way we structure our organization, and identifying and implementing the most effective processes across Nova Scotia. We have seen some successes already. Along with the ongoing savings from a streamlined administrative structure, more than $6 million

annually, we found efficiencies through consistent policies on vacation spending and bookkeeping, among other areas.

As an example, by adjusting our MRI staffing and scheduling around the province, in Cape Breton alone we've been able to see 100 additional patients each month, 40 additional patients each month in St. Martha's and another 50 additional patients each month in Kentville. Those are just some examples.

There have been some unpredictable challenges along the way and there always will be in a health system. But we've been able to deal with them and remain on track to balance our budget at the end of this year.

In large part, we believe our ability to meet these challenges and implement best practices comes from our provincial mandate. Clinic and administrative leaders come to the table with the authority and, indeed, the expectation to make decisions across the organization that will be in the best interest of all Nova Scotians. In the past, efforts to improve quality and effectiveness throughout Nova Scotia required discussion and negotiation across nine different organizations. That provincial mandate and the approach also sets us up well for year two of Nova Scotia Health Authority and beyond, when together with our partners and Nova Scotians, we can focus on the whole system change.

The relationship between a single health authority and government allows for a proactive and streamlined business planning and approval process so that we can truly align resources and strategic goals with a shared vision for creating a healthier Nova Scotia. Reaching those goals does not necessarily mean adding more and more to the health system which already accounts for nearly half of the province's spending.

Since the Fall, I've been hosting Talk About Health conversations around Nova Scotia. We begin with some of the data about the current health status of our population: 6 per cent of Nova Scotians report having been diagnosed with a heart disease; 5 per cent nationally. For those making the lowest incomes in our province, this rate increases to 10 per cent. Our rates of cancer are significantly higher than the national average of 423 cases per 100,000, nationally it's 391; 23 per cent of our adult population report having arthritis, nationally that's 16 per cent and if you are living on a low income in this province that percentage jumps to almost one-third. Our life expectancy in Nova Scotia, perhaps one of the things that touches everybody the most, is a year lower than the national average and even more, the number of years we can expect to live in full health is indeed two years less than the national average.

The fact that Nova Scotians are spending more and more money on health care but aren't getting any healthier shows that our dollars alone are not the answer. We need to talk about health, what it means to us and how we each can contribute to a different and better story of health and prosperity in Nova Scotia. There has never been a better opportunity. I look forward to your questions.

MR. CHAIRMAN: Thank you, Ms. Knox. We'll begin with questions from Mr. Houston for 20 minutes.

MR. TIM HOUSTON: Thank you for the introductory comments. I'd like to start making sure I understand the budget available to the Nova Scotia Health Authority. I'm looking at the budget approved by the Legislature, within the Department of Health and Wellness budget, and maybe I'll ask that of Dr. Vaughan.

There was at that time a budget for the health authority of basically $1.5 billion. Then I think it was June, the new Nova Scotia Health Authority came out with their budget which covered the same time frame but which budgeted expenditures of $1.8 billion. So the health authority is budgeting $300 million more in expenditures than the Legislature approved and I wonder if Mr. Vaughan can reconcile those numbers for me.

DR. VAUGHAN: I think I'll ask Mr. Elliott actually to answer that question - he has those numbers before him.

MR. CHAIRMAN: Mr. Elliott.

MR. KEVIN ELLIOTT: Thank you for that question; it's quite a straightforward answer. The health authority's budget is found in many places in the budget of Health and Wellness so what you've seen in the Estimates Book under NSHA and IWK was just one piece, there's another $155 million throughout the rest of the department. Some of that is out-of-hospital provincial payments, drugs, physician services and continuing care. Then about another $140 million that the health authority has for other revenue that's not from the Department of Health and Wellness. So between those two big amounts of money, accounts for the $300 million difference.

MR. HOUSTON: Okay. It seems peculiar that they would be spread around like that when you have a page that says, here's the budget for the health authority, and then well we have little bits and pieces over here. I guess in many ways, it unfortunately fits the way things operate where something is announced and it's really meant to be something else. I thought the lowest common denominator would be the budget for a health authority and I thought it should be in one place but that's a clarification that maybe next year you can look at making it more straightforward for Nova Scotians to understand, I guess, what the budget is.

I want to talk about the Seniors' Pharmacare Program. I wonder if you can tell me, how much does it cost per year to run the Pharmacare Program - what's the cost per year?

DR. VAUGHAN: Around $166 million.

MR. HOUSTON: That's the total cost of the program so that's funded through contributions from seniors, through their premiums and through the department. I wonder

if you can tell me, without the changes, how much of that came from premiums from seniors?

DR. VAUGHAN: First of all let me say thank you for the question, that the Seniors' Pharmacare Program is optional, seniors are not required to join that program. It is a program that has benefited from our ability to lower generic drug prices and negotiate those prices. We are now losing the ability, going forward, to have that benefit so we've had to look at the sustainability of the program. Drug costs, as you know, are the second highest costs going forward in our entire budget, after hospitals and before physicians. We have a large aging population, we need to ensure sustainability, so we've had to introduce new elements, new ways to ensure sustainability of Seniors' Pharmacare going forward.

In the past it was not, if I could say, considered from a sustainability perspective; it was a budget line that every year was considered whether they were going to add resources to it or not. But now, as I said, indicators have changed and we need to look at it differently.

MR. HOUSTON: How much came from the seniors towards the cost of $166 million?

DR. VAUGHAN: Going forward, only 7 per cent of seniors will pay the new premium; that's about $100 a month.

MR. HOUSTON: I'm sorry, I'm probably not being clear on my question. If it costs $166 million to pay for the program, a portion of that came from seniors. However, many seniors contributed that side thing, and a portion of that came from the province, I guess, to cover. So how much came from seniors last year?

DR. VAUGHAN: To answer your question directly, $53 million.

MR. HOUSTON: Okay, so a $166 million program and $53 million came from seniors. Now some changes were introduced recently, how much now is the government expecting to recover from seniors? It won't be $53 million, it will be something else. How much will it be under your models with the changes?

DR. VAUGHAN: Thank you for the question. It's difficult to answer that question directly because we don't know what the enrolment will be, we don't know what the drug costs will be and the overall use of the program. We're not trying to avoid your question but it's very difficult at this stage to be able to answer it at this point, this year.

MR. HOUSTON: I would hope that before changes were made and premiums were changed there would have been some estimates so there surely must be a piece of paper somewhere that somebody wrote some numbers and said if this happens and this happens, and ultimately that led to a premium increase, so how much?

Seniors are going to pay more, I assume, otherwise why would you make a change? How much more are they going to pay, I guess, is the direct question?

DR. VAUGHAN: So 66 per cent of seniors will pay the same or less, only about one-third of seniors will pay more and that will be very much a variable of each individual. It doesn't mean that they will all be paying more.

MR. HOUSTON: In aggregate; if the province is expecting to not recover $53 million, they're expecting to recover something else. How much is the province expecting to recover from seniors?

DR. VAUGHAN: Let me just say it won't be the entire amount of the amount necessary to fund the program, which is why we're looking to have as many seniors as possible join the Seniors' Pharmacare Program. It is a shared risk pool so the more seniors we have join the program, the more sustainable and the more we'll know.

MR. HOUSTON: So the cost is $166 million, last year seniors contributed $53 million, and next year they're not going to contribute $53 million. Do you have an estimate of how much seniors will contribute towards the $166 million next year?

DR. VAUGHAN: At this time, it's difficult to know the exact amount of what that will look like.

MR. HOUSTON: Okay. I have far less information than you have. I only have what I've picked up from various news releases. I only know what the department wants me to know, and I have to sort through it to find out. I was able to come up with my own estimate. I estimated that the department's going to recover almost $100 million more. Do you have an estimate, or did somebody just pick a number out of the air and say, "Let's charge this and see what happens"? Surely to goodness the department doesn't work like that.

DR. VAUGHAN: When you're planning for any increase in any service, there are various models and various projections. There isn't one . . .

MR. HOUSTON: Just share one of them with me.

DR. VAUGHAN: And there's a wide variability depending on the number of people who enroll in this.

MR. HOUSTON: So the department is very reluctant to tell Nova Scotians how much more seniors are going to pay. I think that's unfortunate. I think it's the least the department could do, to say, "This is what's going to happen here, in our estimation." Why won't the department? If the department can't give us a number, it looks very poorly because it either means you really don't have it, which would be very sad, or you just don't want to tell us, which is even worse.

I'm just asking, how much does the department expect to recover from seniors this year?

DR. VAUGHAN: Again, it is difficult to land on a particular number because there are different scenarios.

If we knew exactly the number of seniors who were going to enroll . . .

MR. HOUSTON: But you must have made an estimate. Or do you expect everyone's going to leave because the premium is too high?

DR. VAUGHAN: We don't know the answer to that question. We do know that 66 per cent . . .

MR. HOUSTON: But you must have made an informed guess.

DR. VAUGHAN: We know 66 per cent of seniors will pay the same or less.

MR. HOUSTON: That's a made-up number. By virtue of you telling me that you have no idea how much more you expect to recover from seniors, every other number you put out in that conversation has to be made up because every number would lead to an end point, a bottom line on a spreadsheet. If you want to pick out numbers from various points on that spreadsheet and throw them out there and make it sound like you've done some big analysis, then show us the analysis. If you won't tell us a number, there's no bottom line; there's no end date. It doesn't make sense. I'm sorry to be so blunt, but I think Nova Scotians deserve to know how much more this government expects to recover from seniors. I'm surprised you won't tell us.

DR. VAUGHAN: Again, if we knew that exact number, we would be happy to share that with you. There are scenarios. There are a variety of scenarios depending on a variety of factors. At the end of the year, we will have that clarity for you.

MR. HOUSTON: Okay, we're going in circles here, but I would say in my own experience - I worked in venture capital for eight years and we were always analyzing things. We would do various models: low-case scenario, high-case scenario, best-case scenario. There would be a serious range of outcomes on every situation. I'm led to believe that you have those various models and various outcomes, and I'm just asking you to tell me, what's your best guess?

DR. VAUGHAN: We can get you the various information around the models at a future point. I do not have all the model numbers at my fingertips today.

MR. HOUSTON: Okay, through the Chair, I'd ask if a spreadsheet or some analysis of those models could be provided to the committee, I would appreciate that.

I think any way you look at it, seniors are going to pay more, in aggregate. There might be a few seniors who pay less, but I'm certainly hearing from a lot of seniors who have received letters that say they're going to pay more. They're looking at your options. I think your concern about attrition, people leaving the program, is a real concern because the department may have pushed the envelope too far on this one. There could be a lot of people who will leave this program, to the detriment of the overall program. It would surprise me if a decision was made like that with those possible ramifications without a good solid analysis.

DR. VAUGHAN: If I could respond, Mr. Chairman, 66 per cent of seniors will have the same payment or less. That's a significant benefit to the vast majority of seniors. Individual seniors will have to do a calculation based on their own particular circumstances. We're looking to put a calculator on the website as soon as possible, to allow individuals to actually know what they are going to pay.

MR. HOUSTON: I'll leave this with one more question. So if the cost is roughly $166 million, last year seniors paid $53 million, next year they're going to pay something else, did the department have a target of how much of the $166 million they want to recover? Is it, let's try and set a premium that we recover 90 per cent, or is it that we try and set a premium that we recover 100 per cent or did the department look at it from that perspective?

DR. VAUGHAN: We looked at a variety of models and looked at what's being done across the country. Every jurisdiction in the country is struggling with rising drug costs. We needed to look at a model that was fair and equitable, at the same time benefiting the vast majority of Nova Scotia seniors who were not going to pay any more; in fact many would be paying less. The co-payment has gone down, which means real money in individuals' pockets on a day-to-day basis when they go to the drug store.

MR. HOUSTON: I think most seniors exceed the co-pay. They're going to pay anyway, it's just a question of when they pay. I think that's a red herring. The answer to the question of, did the department look at this as how much we want to recover from seniors, is yes or no.

DR. VAUGHAN: It's a cost-sharing model, as you know, it's an insurance-based model so the more people we have in the system the more sustainable it is at the end of the day.

MR. HOUSTON: Okay, let's move on to another topic in the last five minutes, I think, Mr. Chairman.

There was an announcement yesterday, I believe, about the reorganization and some staff moving. I think there's 100 positions going from the departments; some of those are going to the new health authority and then there's also going to be some new positions

created. When all the dust settles, less employees overall between the department and the health authority? More employees overall, or the same amount of employees overall?

DR. VAUGHAN: Thank you for that question. We've reduced the number of positions within the department by 100. Some of those will go to the health authority or the IWK. Some of those positions will transfer to Communities, Culture and Heritage, and 20 layoffs have been notified.

We need to be able to bring on some positions that allow us to build the appropriate skill sets that we need for a high-performing health care system going forward.

MR. HOUSTON: Maybe this question will be for Ms. Knox. For the new positions at the health authority, including the people coming over plus the new positions that might be created - who creates the job descriptions for all those people, including the people who came over? Does that health authority create those job descriptions?

DR. VAUGHAN: I'll answer that question first and then I'll feed some input from Ms. Knox. We worked collaboratively with the Nova Scotia Health Authority and the IWK over these many months, remembering that the restructuring or redesign of the Department of Health and Wellness is really the second phase of consolidation. We consolidated health authorities, we need to have the right structure that links up with the consolidated health authorities. So those job descriptions were done and are being done in conjunction with the health authority.

MR. HOUSTON: I believe the release said that this would improve front-line care, is that . . .

DR. VAUGHAN: That's our goal. Our goal in all of these changes is to improve front-line care so the resource that we'll save $3.5 million annually going forward is what we will need to put towards front-line care.

MR. HOUSTON: So if it's improving front-line care. then is it safe to assume that the 62 positions transferred from the department to the health authority - let's talk about those ones specifically - those are people who work on the front lines?

DR. VAUGHAN: Absolutely not. People who work in the Department of Health and Wellness are working in policy and planning and analytical kinds of jobs in many cases; they are not front-line health care workers. That's why we're transferring a significant number of people to work with the health authority who are delivering front-line health care, and the savings from the department redesign can then be allocated to front-line care. Those staff are not front-line health care workers in the Department of Health and Wellness.

MR. HOUSTON: Okay, so those are people who are going to transfer from the department to the new health authority. They were working on policy at the department; they're going to work on policy at the health authority?

DR. VAUGHAN: Some of those people are involved in planning for primary care which is really the work of the health authority. Some of those program people who were working from the department, things like Cancer Care Nova Scotia, the renal care, those kinds of programs, were really built into the department in an era to get around the structure, frankly. So now that we have a new structure, they need to be incorporated to deliver better, efficient care within the health care system, which is the health authority.

The role of the department needs different kinds of skill sets and that's what we have to build within the department if we're going to really achieve our role of planning, monitoring and achieving better health care for Nova Scotians.

MR. HOUSTON: Okay. So the staff levels at the department are decreasing because there's a better home for some of those roles at the health authority.

DR. VAUGHAN: The roles have changed. One of the lessons we learned from provinces across the country that have consolidated is don't miss the opportunity to realign your department because what you have in many cases is a ministry or a department doing many of its old roles while you have a new health authority and they butt against each other. We have to change that.

MR. HOUSTON: Okay. I have one minute left but I might as well get the ball rolling on the VG. Does the department have a plan to replace the VG? I know that at one time the minister said the public would hear before the end of January, which I guess we can expect to hear from the minister today or tomorrow. Is there a plan to replace the VG that you're aware of?

DR. VAUGHAN: As you know, there has been planning over successive governments to look at the role and the future state of the VG. The Dartmouth General, as a significant expansion of Dartmouth General's capacity is an important step in that evolution of acute and tertiary care services really for the entire Province of Nova Scotia. The VG is a site that's also a resource to the Maritime and Atlantic Provinces.

If you're referring to the Centennial Building issue, the Centennial Building is really one part of that equation, and it's really looking at what we want the health care system of the future to look like. There's no sense in building another structure that's going to be outdated as soon as we open it, which has happened in some places.

MR. CHAIRMAN: Order, I do apologize, but we have to stop there. We'll move to the NDP caucus and Ms. MacDonald.

HON. MAUREEN MACDONALD: I want to ask you a few questions about your opening statement. In your opening statement, deputy, you indicated that the old way of delivering health care was expensive - is expensive, I would say; delivering health care is expensive. You're saying the old way of delivering health care was expensive, to whom was it expensive?

DR. VAUGHAN: I would say to Nova Scotians it's expensive when we spend the highest per capita in the country, as a percentage of budget, on the CIHI data and have the worst outcomes in the country. We can say that the old ways of doing things weren't achieving the goals of the health care system, which is to improve the health of Nova Scotians.

MS. MACDONALD: So how does it become less expensive to increase Pharmacare premiums for 34 per cent of the seniors who are enrolled in the plan?

DR. VAUGHAN: The Pharmacare, those individuals, those seniors who could potentially be impacted by an increase in their premium to a maximum of $1,200 a year or $100 a month, have access to the best drugs on the formularies in the province. They have access to all those services for a very reasonable cost, a cost you could not get in a private plan.

MS. MACDONALD: But it doesn't make it less expensive for them. In fact, perhaps the new model you're talking about just transfers the cost of an expensive program on to 34 per cent of the people enrolled in the plan.

DR. VAUGHAN: The previous Seniors' Pharmacare Program was not sustainable. That is our challenge. We need to make the program sustainable into the future to allow us to be able to add new drugs that are coming on all the time. The only way to do that is if there's cost sharing and cost sharing that includes an income element to that which allows us to be able to deliver those new drugs.

MS. MACDONALD: Let's talk about the plan and how it was set up and the promise that was made to seniors at the time. When the Savage Government set the plan up in the mid-1990s, there was a commitment made to seniors that the government would pay for 75 per cent of the cost of the plan, and seniors, through premiums and co-pay, would pay for 25 per cent. We know that that commitment was put into regulation in 2008, and then last year that regulation was eliminated by the government, which opened the door to changing a commitment to seniors but also the ratio by which government funds the plan, and seniors through their contributions fund the plan.

This morning we've heard that the plan this year is $166 million. Seniors contribute, through premiums, $52.886 million, rounded off to $53 million. Government is putting in $113 million. Next year, with these changes, we don't know, because the information has not been provided, the estimate of how much seniors will be contributing to the plan.

But we're two months away from a provincial budget. There's no way that the Departments of Finance and Treasury Board, and Health and Wellness, in preparation for that budget, don't have an estimate for what the government's share of that plan will be next year. I would like to know - the government's share this year is $113 million - what will the government's share be next year?

DR. VAUGHAN: Through you, Mr. Chairman, it is difficult to know the exact answer . . .

MS. MACDONALD: I didn't ask for the exact; I asked for the estimate.

DR. VAUGHAN: As I said . . .

MS. MACDONALD: I know you don't have an exact answer . . .

DR. VAUGHAN: There are various models based on enrolment and drug cost, to put it simply.

MS. MACDONALD: Well, give us an estimate. Tell us the range.

DR. VAUGHAN: Well, if we look at annual rates of increases of drugs, it's somewhere around 4.5 per cent to 6 per cent per year. That's a driving force, plus the aging population utilization. Even with the measures in place, we will not see the coverage coming from government entirely or from seniors being able to co-pay entirely. There has to be a balance to achieve sustainability.

MS. MACDONALD: I'm trying, on behalf of the people of the province, to understand what that balance is. There was a commitment made to seniors: 75/25. That has been a little bit fluid over the last number of years; we know that.

But because I've sat in the chair of the Minister of Health, I know the process of looking at what the Pharmacare premiums are going to be in a coming year. People don't sit around in a boardroom and pick the numbers out of the air. There is very detailed work done on what the trends are, what the trends have been, and going forward, what the possibilities are and what the options are. And with all due respect, the Premier's Office and the Minister of Health and Wellness have refused to release that information. We're here at the Public Accounts Committee today, and that's the role of this committee, to get that information.

Have you been told not to provide that information to this committee?

DR. VAUGHAN: Mr. Chairman, through you, again, we have agreed to provide that in models to the committee at a future time. I don't have that information before me today.

MS. MACDONALD: Why do you not have it today? Why, coming to the Public Accounts Committee to discuss the finances of the department, and this being a very current topic - was there no discussion about this topic coming up today, in preparation for this committee?

DR. VAUGHAN: Through you again, Mr. Chairman, we were here originally to talk about the Auditor General's Report of the challenges related to the budget of the previous health authorities.

MS. MACDONALD: That's not my question. My question was, was there any discussion about coming to this committee today, and the possibility that the Pharmacare premiums and the changes would come up? Was that discussed in preparation for this committee?

DR. VAUGHAN: Thank you for the question. As you know, whenever we come to Public Accounts Committee, we're prepared for a variety of questions, and Pharmacare is one of those questions.

MS. MACDONALD: Yes, so this was discussed. And then my next question is, what information were you advised to present to the committee, or to not present to the committee?

DR. VAUGHAN: We are presenting information that is publicly available - the real facts around the number of seniors who actually benefit from the Pharmacare changes, and the lower co-pays, in particular.

MS. MACDONALD: Were you advised not to provide this committee with the estimates of what the changes would mean in terms of the contributions of seniors to the Pharmacare Program and the contributions that would come from government to the Pharmacare Program?

DR. VAUGHAN: No, we were not advised that, because the information is based on models, and as I said, at the end of the year we will give you those exact numbers.

MS. MACDONALD: We all know we'll get that at the end of the year. It's kind of a standard thing that happens when the budget is presented, and then next year we will get the exact amount.

We're looking for estimates. We're looking for the financial information that was done prior to the decisions to change the premiums in the Seniors' Pharmacare Program. Why are we not being given that information? What is the government hiding? Is there something in that information that is so objectionable and will create such problems for the government that they don't want the public to know what the estimated impact of these changes will be? That's all I can conclude.

DR. VAUGHAN: Through you, Mr. Chairman, to answer that, the answer is no. We are, as you know, in a budget-building process. That's part of that budget process until that budget is approved. There are no finalities around that.

MS. MACDONALD: Can you tell me what the savings have been as a result of the changes that were made with respect to the price of generic drugs? How many millions of dollars of savings has that resulted in? Why do you say that those savings no longer accrue to the plan?

DR. VAUGHAN: I don't have the figure, we can get you that exact figure but I don't have that before me today.

Right across the country we have benefited from a pan-Canadian approach in negotiating generic drugs. There are fewer and fewer coming on-board these days and so that's the reason. There's very little wiggle room anymore, we're sort of done that work. It's still in the budget but we're not getting any additional benefit.

MS. MACDONALD: And you can't tell me how many millions, not even a general?

DR. VAUGHAN: We can get it while we're speaking here.

MS. MACDONALD: Thank you. Seniors received a letter from the Pharmacare Program in the last number of days. Who prepared this letter that went out and what was the approval process for this?

DR. VAUGHAN: That was approved through the department.

MS. MACDONALD: Was the minister aware of the letter?

DR. VAUGHAN: The minister would have seen the letter before.

MS. MACDONALD: Was the Premier's Office aware of the letter?

DR. VAUGHAN: I couldn't say off the top of my head whether they had any involvement.

MS. MACDONALD: You can appreciate that as representatives, we're getting a lot of calls from people in our constituencies, and I'm hearing from people outside of my constituency as well. One of the concerns that has been raised with me is the legality of telling seniors that if they don't sign the waiver, the CRA consent form, that their premium will be calculated at the maximum amount of $1,200 per year. Did you have any legal advice on that, on the legality of that aspect of this letter?

DR. VAUGHAN: I'd have to check on that, I don't have that off the top of my head.

MS. MACDONALD: Was the Department of Finance and Treasury Board involved in the preparation of this letter?

DR. VAUGHAN: The Department of Finance and Treasury Board has been involved in the determination of the content.

MS. MACDONALD: So you don't know if there was a legal opinion or not?

DR. VAUGHAN: I'd have to check the specifics of that.

MS. MACDONALD: One of the other things - many aspects of this are troubling, but one of the things that certainly troubles me, I had a gentleman in my constituency last night, he and his wife are both members of the plan. They're looking at their premiums going from $424 each, last year, to the full $1,200 amount - so from $848 to $2,400 in an increase, and they are going to leave the plan. They've made the decision that they're going to leave the plan.

What modelling has the department done with respect to people who are eligible for the plan who are already, first of all, not in the plan and secondly, the impact of these changes on others leaving the plan? What's the tipping point and what analysis have you done with respect to that?

DR. VAUGHAN: The challenge is that we don't know what those people will do, which is why we have scenarios, as I said earlier. The reality is that it's a very good plan, it's a very cost-effective plan for members of that plan. To go outside that plan, anyone who has pre-existing conditions looking for a private plan will undoubtedly pay much more.

MS. MACDONALD: So 34 per cent are going to see increases in their premiums, 34 per cent of the people enrolled in the plan - seniors - what percentage of people have you estimated, if they left the plan, would significantly harm the plan? You must have some idea of what percentage of that 34 per cent you could afford to lose, but then after that, it would have a serious and detrimental effect on the plan.

DR. VAUGHAN: Just to be clear, it's not a black and white - 33 per cent of people who may pay more may only pay $1 more. Not all of those people are going to pay the maximum amount. I think we need to be very clear that it's not everyone paying the maximum amount, which, again, makes it difficult to project how many people will leave the plan.

It's better for everyone if more people join the plan than leave the plan, obviously. The sustainability of the plan, because we provide very good drug coverage and bring on

new drugs every year, requires that we have more people in the plan. This allows 66 per cent of people - the poorest people in Nova Scotia - to get a break on this, 66 per cent.

MS. MACDONALD: I'd like to take you up on that question as well. My assessment of the information that the department has provided would indicate that, in fact, you could have two seniors both in receipt of the Guaranteed Income Supplement, or the federal supplement, who last year paid no premium and this year they will. What do your models tell you about that?

DR. VAUGHAN: Our models tell us about the total income on line 150. If there's income-splitting and all of those other individual items, those have to be looked at. But the models are looking at those individuals who make above $70,000 to $75,000 a year. That's the cumulative amount of money that they have.

MS. MACDONALD: So in making these changes, you didn't take into consideration that people getting the Guaranteed Income Supplement - who are the lowest-income seniors in the province – who, under the old way of delivering health care never had to pay a premium, are now going to have to pay a premium?

DR. VAUGHAN: Any individual who is feeling that their determination of how much they're going to pay is problematic should call the department. Again, very soon we will have a calculator for individuals to look at what the real cost to them is. If they have questions, they can call staff about the determination of what their individual cases are.

MS. MACDONALD: Well, that's fine, but with all due respect, most seniors don't need a calculator from the department to figure out what their income is, what they've been paying, and what they're going to have to pay in the future . . .

MR. CHAIRMAN: Order. I do apologize. We do have to move to the Liberal caucus. Mr. Irving.

MR. KEITH IRVING: First of all, I would like to thank Dr. Vaughan and Ms. Knox for taking on one of the biggest challenges for our province, and I appreciate your work in transforming the health system here in this province.

Obviously discussions around Pharmacare pointed to this issue of sustainability. I think that's what this transformation in health care is really all about, getting to a more sustainable system both in terms of its cost to Nova Scotians and in terms of its health outcomes for Nova Scotians.

We're 10 months now into a new health authority, that new structure. I'm wondering if you could give some examples of how that is working now for Nova Scotians. What have been some of the significant improvements - and challenges if you want to touch on that as well - under the new health authority?

DR. VAUGHAN: I think we have seen significant improvements. I'll let my colleague Ms. Knox talk about some of the front-line improvements that she and her folks have made.

We've had a very fragmented approach in the past, which has cost us significantly, annual deficits of the rolled-up amalgamated health authority costs running annually about $25 million to $30 million a year. These folks to my right have addressed that and I'll let them talk about those benefits going forward. We've seen some of those situations with floods at the VG, sterilizers breaking down, where we've had the ability to think and act as one province. That's a huge benefit going forward. We will continue to see benefits over time and I'll let Ms. Knox talk about the benefits that we're seeing today.

MS. KNOX: Thank you very much for that question. I would start out by saying that for us the biggest benefit, challenge and opportunity is the requirement under this new approach to see the entire province in every decision we make. Our goal is really to use our resources in the very best way we can to have an impact for the people we serve. That being said, we are in a start-up organization so a lot of our early months were really to amalgamate nine organizations that had minimally nine different ways to do any one thing and we learned that very quickly.

That being said, the biggest benefit we've seen is being able to deal with challenges before us, from a provincial perspective, and bring all of our resources together for solutions. So we now have 23,000-plus people who know that the expectation is to look after the entire province. Some examples would be, in terms of that, when things happen that we didn't plan like the flood happens at the VG or the sterilizers go down, within hours we have the people who lead those services around the province coming together and saying, how are we going to deal with this issue?

We've also seen that in the early days of just saying we will have one approach to how we determine our resource need and how we deploy our resources that very quickly - I'll let my colleague here talk about the financial perspective in a minute, but I always like to start to talk with what the benefits are.

I told you earlier where we had an opportunity to use our resources differently. As we began April 1st, MRI services in this province were at wait times that were a challenge for us. That was one of the areas we were asked to look at. We have been able to, in our diagnostic imaging service from a provincial perspective, focus on the MRI services. As I said earlier in my opening comments, not using more resources, in fact we are spending hundreds of thousands of dollars less in that service this year because we are thinking differently and deploying our services differently and creating access for people around this province to that service. So as I said, 100 more in the Cape Breton area and those other numbers.

The other area that was a real problem for us in the past few years was the issue of access to hip and knee surgery. So working together with all our service providers, coming

together as a provincial service, we have had an ability to bring the four key players into the room and say how are we going to have increased access for Nova Scotians. Together they are focusing on the wait-lists, together they're looking at who is on the wait-list, who needs to be. We're cleaning that up and taking a very important focus on who are the longest waiters but probably more significantly, to help you understand the challenge and the opportunity, by the end of March we will have had 637 additional surgeries in this province. Areas like the Aberdeen Hospital where we were having a challenge to do enough, we will have done 167 more.

We are looking at what resources are needed, and we have four key areas that see themselves equally responding together. As you know, we've had challenges around emergency services in this province, we now provincially can bring the service together and say, can we send a physician from here to there. So it's about learning how to work differently and holding us all accountable. We see this total resource, the Nova Scotia Health Authority, for all Nova Scotians. So it's bringing down the barriers and taking away the silos. In 10 months we've seen that has been a real benefit for us.

As you know, we entered April 1st with a challenge. Some of the previous district health authorities had longstanding challenges with meeting budget requirements and so we did enter with a clean slate, in terms of we didn't enter having to pay back a balance but we entered with all of the strategies that created that improper balance. So we had some real challenges before us, adding then on inflation.

I'll ask my colleague here to talk from the perspective of thinking as one province, and really learning about strategies has helped us very quickly deal with some of those financial challenges.

MR. IRVING: If I may, that was leading to my next question. There were two concerns about the amalgamation that came up when we debated this in the last election, so I wanted to ask two questions, if I can sneak them in here.

One was on finances, and this was going to cost more. Coming back to our question of sustainability, for many years health care was just expanding at a rate of 6 per cent, and as you suggested, outcomes were no better. Our last budget was about a 1 per cent increase. How has the amalgamation of the health authority helped us use our dollars more wisely and efficiently, and in getting more bang for our buck? If you could answer that.

MS. KNOX: Thank you very much for that question. I will start by saying that having the ability to see the challenge from a whole provincial perspective and having the ability to see where we have best practices and quickly turn them into reality - we have some wonderful examples of that. I'll ask Allan Horsburgh to address some of those issues, please.

MR. CHAIRMAN: Mr. Horsburgh.

MR. ALLAN HORSBURGH: One of the benefits, in addition to the examples that our CEO has noted in the improved care and access that we've worked hard for this year - we also started out with a focus on the finances to be able to deliver better care in an affordable, sustainable way. Both Janet and I come from organizations where we did balance our budgets, so as leaders, we take that role very seriously; we're taxpayers as well. We worked with our organization and our leadership, and the ability to have decisions without nine borders has enabled a lot of process and policy improvements, which has allowed better financial management decisions, in addition to better care.

Just some context on numbers: the $29 million cumulative deficits that the previous DHAs would have ended with, which we inherited as the new Nova Scotia Health Authority - that carried forward. Although we didn't have to pay it back, it did carry forward - there were contracts and staff and real work happening. So we had to address the $29 million on day one as well.

For the past several years, on average, health authorities experienced inflation that totalled around $40 million every year - again, you have to have contractual increases and things like that that you're obligated to deal with. We started the beginning of our new journey with a $70 million challenge in front of us. That's actually larger than one of the smallest old health authorities. We are projecting to be balanced in dealing with that $70 million through the benefits of this merger, or this amalgamation. Not only through the streamlined administration - and we have streamlined administration significantly - and not just fewer CEOs and VPs, but we've also been working significantly on the corporate services, the back office, where we have streamlined significantly.

A lot of these smaller health authorities were small teams doing a lot of work, and now we have the benefits of critical mass, where we don't have to pay expensive consulting and legal fees. We can have in-house counsel full time, without the benefits of having to pay outside legal counsel, and that saves us money. There are also fewer memberships - memberships of nine organizations, we have membership for one. So significant streamlined administration has contributed to this.

The ability of decision making around things like procurement - before, there were procurement initiatives. Some health authorities participated at various levels, and others didn't. We now have the ability to put procurement forward with the benefits of the new structure for government's Internal Services Department role in that, where we partner and we leverage greater procurement opportunities with those borders down.

Our ability to leverage best practices - looking at the best of what has happened, both on the care envelope and the corporate side - the best practices that have been with the old nine entities, we have been able to make decisions and employ and roll out throughout the organization. That has both improved service and been more efficient financially.

Part of the equation that my counterpart, Kevin, referred to in the difference in the budget numbers, part of that is related to revenues on our side. We do bill for out-of-province and out-of-country coming to our organization. We're able to do that much more consistently. Our collections are able to be improved, because now - some old health authorities used to go to Service Nova Scotia to help with collections, and some did not. Now we have all of our organization going through Service Nova Scotia, which helps with our collection rate. The ability through policy, process, borders-down, and the decision-making process - which are all benefits of the amalgamation - has allowed us to deal with the $70 million in one year where we are projecting to be balanced.

MR. IRVING: It sounds like you could talk for a while on that issue. Just quickly, before I turn it over to my colleague, the other concern about the amalgamation was loss of community input. I'm wondering, Ms. Knox, what have you seen on the ground at the community level with the amalgamation?

MS. KNOX: Our approach as a provincial resource is to plan provincially, implement locally. That's a very important nuance because we really need what happens locally to be accessible to our local people and to be relevant. So where we have new programming and need to think about how we do things differently, we need to be very close to the community and interact with them. We have built-in processes - we call it the community engagement strategy, to make sure that that is part of what we do, how we understand the community.

That's right with citizens or local leaders. Very, very importantly, as we step forward with the Nova Scotia Health Authority, our 37 community health boards have remained intact. We are working with them to really understand together how we best engage our community.

One of our strategies as we step out and talk about the need for change is this talk about a health strategy that I have initiated last fall. Our community health boards co-host those activities with us. We'll have a variety of decisions that need to be made over time which require a variety of strategies to engage our residents and our leaders in communities, and indeed, the people who provide the service. It's very much part of what we do and needs to be part always as we go forward in terms of creating a climate of change.

MR. CHAIRMAN: Mr. Stroink.

MR. JOACHIM STROINK: Thank you very much for coming today and sharing your thoughts on these issues. I guess I just kind of want to go back a bit to the Seniors' Pharmacare Program. That seems to be taking a lot of this time today, and it's a very important issue. My understanding is that the premiums have remained the same since 2007, and income levels used to calculate premiums have been the same since 2002. With that, can you tell me roughly how much drug costs have gone up in this province from that time period to now?

DR. VAUGHAN: On an annual basis, as I said, it's anywhere from 4 per cent to 6 per cent.

MR. STROINK: With that, I guess a big discussion too, is if seniors' groups were talked to during the process of developing this new program.

DR. VAUGHAN: Yes, a number of seniors. We have a seniors' advisory council to the Department of Seniors, as you may know, affectionately known as the Group of IX. They represent various organizations. Groups like Community Links were involved. They're very concerned about protecting low-income seniors in particular. They were supportive of this.

MR. STROINK: So being supportive, maybe you can kind of run down what the new premiums look like based on income, so that people understand exactly who's being affected here.

DR. VAUGHAN: There's a maximum premium; it was $482 a year. Now 33 per cent of seniors will pay a little bit more. We want to be clear - it's not that everyone's going to be paying the maximum amount.

MR. STROINK: What salary range is that?

DR. VAUGHAN: I don't have that with me, right in front of me. We can get that information.

MR. STROINK: My other question - generic drugs are a big part of the calculation here. However, there are some changes happening, I guess in Canada, with generic drugs and initiatives that have been put federally and provincially, can you just explain to us what is occurring with the generic drug programs here in Canada?

DR. VAUGHAN: Well the pan-Canadian Pharmaceutical Alliance - which is all the provinces and territories, and now the federal government as of last week - has come on board which allows us to use the resources of all the provinces and the leverage of all the provinces to better negotiate a price point for new drugs as they come on board. As part of that we negotiate generic drugs as they come on board.

As I said, there are fewer and fewer generic drugs coming on board at the present time. The whole environment around pharmaceuticals globally is changing. The feeling across the country was that we can't rely on expecting to get the big savings that we have gotten over the years by utilizing generic drugs, by negotiating better agreements on generic drugs, and we have to look at trying to make the program sustainable.

It was not sustainable before, let's be very clear about that. There was increased need to add government revenues into the program over those years, to the point where it's

clearly not sustainable. The only way to make it sustainable is a cost sharing between the participants and the insurance program, and government.

MR. STROINK: Great, thank you. I'm going to change quickly before I turn it over to my colleagues. With the new health board system, I guess there's greater opportunity to do more to help Nova Scotians. Some of those abilities that we can look at now is nurse practitioners across the province, midwifery across the province. Those are key components of health care for Nova Scotia and the future of Nova Scotia. These solutions are great in rural parts of Nova Scotia. Can you kind of explain to us where that sits, what your thoughts are on that? I see that's a big part of the future of the new board.

DR. VAUGHAN: Thank you for your question. As you well know, health care is rapidly changing. There was a time when nothing changed in health care for 50 years, back in the early parts of the last century. We've seen tremendous change in health care since the Second World War, since the 1960s, and increasingly health care is changing - the knowledge is growing every 12 to 14 months in health care. That's a dramatically changing industry. That means there are more services available, more things that one can do, and more treatments available. It means it's very difficult for one person to keep up on that growth and explosion of knowledge, so teams are necessary.

The collaborative team approach in Nova Scotia, which is very much a leader across the country, is really the way to go so that people are actually seeing the right provider, whether they be midwives or nurse practitioners, social workers, nutritionists, et cetera.

MR. CHAIRMAN: Order, thank you. We have to move back to the PC caucus. Mr. Houston for 14 minutes.

MR. HOUSTON: A $4 billion budget, I almost wish we could have you guys here every couple of weeks, there are so many topics to talk about certainly. Obviously mental health is a big topic, and you'll be back to talk about that for a session in a couple of weeks. Obviously I should acknowledge Bell Let's Talk Day, I hope they raise lots of money today for that for mental health, it's a very important issue.

A couple of things; I do want to talk about the VG but I just wanted to kind of wrap up from my perspective the Pharmacare discussion because I'm going to have to go and refine my own analysis since one wasn't here. The Department of Finance and Treasury Board says there are about 120,000 seniors enrolled in the Seniors' Pharmacare Program. Is that a number you agree with, 120,000 seniors in Pharmacare?

DR. VAUGHAN: That's an approximate number, realizing that in real time it's fluctuating day to day.

MR. HOUSTON: Okay, so that's a reasonable number. Now during the technical briefing on the changes to Pharmacare, I think a representative from the department

indicated that the cost of the Pharmacare Program is about $122 million, and today we had a number of $166 million. I wonder if you can give us some clarity, what is the full cost of the Pharmacare Program, is it $120-ish million or $160-ish million?

DR. VAUGHAN: The $166 million figure we gave you is from the Estimates Book.

MR. HOUSTON: Okay. And is it still reasonable? Okay. The $120 million was kind of just a wrong number, I guess, that somebody said at the technical briefing, or a different context, maybe.

DR. VAUGHAN: It could have been a different context.

MR. HOUSTON: Okay, fair enough. I had another question on that, but it has escaped me for the moment.

In terms of the VG, in the capital plan this year, there was a line item for Centennial Building relocation of services design. I guess that was the way it was described in last year's capital plan, "Centennial Building relocation of services design". Was that a project that happened? Was there money spent on that project last year or not?

DR. VAUGHAN: There are some planning dollars that were spent. We're just trying to find those exact numbers.

MR. HOUSTON: Okay, because the reason I ask is this year there was a line item for Centennial Building infrastructure. Last year we had Centennial Building relocation of services design, and this year we had Centennial Building infrastructure, and I'm wondering if it's really the same project.

DR. VAUGHAN: Yes, because it's all the same project, the VG.

MR. HOUSTON: It's the same project, okay. So there is a budgeted amount, I think it was $1.5 million, and it's really to do with relocation of services design; that's what's happening there. Does that mean moving patients to other hospitals? Is that what relocation of services means?

DR. VAUGHAN: Great question, and thank you for that. The dollars are for planning for the future of the entire QEII site including the Centennial Building and the VG. There are many services at that campus, if I could use that language. Those dollars are really looking at what we need to do to modernize the entire campus model, and I would include Dartmouth General as a part of that, and then looking to what services are appropriate for that acute and tertiary Atlantic One Nova Scotia site and what services can be distributed to other regional hospitals. I think we've had some discussion around that.

MR. HOUSTON: Those types of relocation of services, presumably that would be a combination of a temporary relocation of some services versus a permanent of other? Or is it that when something's relocated, it's permanent?

DR. VAUGHAN: Let's be clear that in terms of the Centennial Building, that building's life expectancy is over. It has been for some time and recognized to be for some time. The planning is really what to do and to cluster those services in a more appropriate place. I don't know if Ms. Knox wants to comment on that . . .

MR. HOUSTON: That's good on that, but one of the CBC articles talked about possibly repurposing the Centennial Building. I don't know if you . . .

DR. VAUGHAN: I'm not familiar with the feasibility of that. As far as I know, it's not feasible. I think that was one of the challenges from the previous plan that was developed.

MR. HOUSTON: The Centennial Building is done? It needs to be demolished?

DR. VAUGHAN: It needs to be retired.

MR. HOUSTON: Retired is one word. Would demolished be the same thing?

DR. VAUGHAN: Yes, the services certainly need to come out of there. I think everyone recognizes that.

MR. HOUSTON: Has there been any work done yet on what it might cost to build a new hospital?

DR. VAUGHAN: The short answer is no, there is not an accurate number. There were numbers bandied about in previous years; those are not valid or reliable numbers. The most important point is that we don't want to develop something that is instantly going to be outdated. That's one of the risks of developing a new hospital.

As I said earlier in my comments, health care is dramatically changing. More and more services are done on an outpatient basis. There are always going to be some highly centralized services that are acute and tertiary in the Halifax Infirmary. Clustering those in that site makes a lot of sense from a human resources and from an efficiency perspective, patient convenience, outcomes, all of those things - but not necessarily building a monolithic hospital.

MR. HOUSTON: Okay, fair enough. I want to come back to that, but do you have any sense of the accounting book value of the VG? What is it carried out on the books?

DR. VAUGHAN: That can be gotten from these folks but I don't have that today, the book value.

MR. HOUSTON: I'd ask maybe, Mr. Chairman, if we can get that. By the same token, I'm wondering if there would be any kind of an estimate of the fair value of the land that the complex sits on?

DR. VAUGHAN: That would be through Transportation and Infrastructure Renewal, they would have that information, we wouldn't have that.

MR. HOUSTON: Maybe we can get that in the same document as to some estimate of that.

The capital budget for this year, the $1.5 million for a study on relocating services, infrastructure or whatever it is, the $1.5 million, is it your expectation that at the end of that project there would be a comprehensive plan announced for how we move forward?

DR. VAUGHAN: Very soon we hope to be able to sketch out not only the vision but the plan for that site. We need to do that, it has been too long in the waiting, as people might say, and we understand that. It has been known for a long time that the Centennial Building . . .

MR. HOUSTON: So mindful of the fact that the minister at one point said we'd hear something about this before the end of January, you just said very soon we hope to be able to sketch it out. Does that imply that the $1.5 million project is pretty much complete, or is it separate things?

DR. VAUGHAN: I think we need to look at it as monies that have been committed to do the planning. As anyone who has built large facilities like this knows, it involves significant planning resources and time. Likely beyond that, as you get down into the details of the puzzle, it's important to understand that those monies are well spent. Large projects of any kind that don't have good planning associated with them are at risk of both delivering on time and on budget.

MR. HOUSTON: Are you aware of any discussions? I think the Health and Wellness Minister was just at some meetings - are you aware of any discussion with the federal government on funding towards a replacement or a new facility or whatever the case may be? Do you have any indication that the feds are going to come to the plate with dollars for this project?

DR. VAUGHAN: I wish I could say yes. At this point I do not have any information. I know there have been many discussions in various sectors with the federal government, various ministers responsible for capital infrastructure, for example. There have been no messages at this point, yes or no, either way. I think the federal government is also looking at its own financial challenges.

I think we're well positioned with what Nova Scotia is doing with the consolidation of health authorities. I think it positions us well in the federal mindset to be a leader in the integration of services.

MR. HOUSTON: So we have 11 federal Liberal MPs in this province and we have a majority Liberal Government. You referenced a number of people with competing interests wanting money. Have you been in any discussions where we're trying to prioritize things across the province? Presumably this would be your number one priority and somebody else may have a different priority. Sometimes too many cooks can spoil the thing we make. We could get shut out because we aren't organized. Are you aware of any organized plan from the provincial government to approach the feds for a cohesive ask?

DR. VAUGHAN: Certainly it's top of the list for our business planning process; it's top of the list. I know the Premier has spoken to the Prime Minister, I know the Health and Wellness Minister has spoken to the federal Health Minister, and I know there have been other conversations with other federal departments. To highlight it, I think it's pretty solidly demonstrated as a priority.

MR. HOUSTON: I think I have a couple of minutes left. I'd like to ask about the testing that has been outsourced to the Mayo Clinic. It was reported that up to November it was $1 million Canadian that had been spent on testing down there. That was to November. Is it still happening? Is the Mayo Clinic still doing tests as we sit here today? What's the tab at now?

DR. VAUGHAN: I will hand that over to the health authority folks specifically, but let me just say that we have put offers forward for two physicians to take up spots in hematopathology, and we're just waiting to sign the dotted lines, as they say. So that will help to significantly reduce some of the outsourcing. We were very concerned about it, particularly in terms of the declining Canadian dollar. There are some times when outsourcing makes sense for a variety of reasons, and there are lots of tests that get sent out.

MR. HOUSTON: Well, maybe on that, I might have gotten my answer. But the two positions, would they absorb that whole workload? How many tests would have been done? Of the $1 million, how many tests did we get? Is that a number we could get?

MS. KNOX: I'm going to ask Allan Horsburgh to give you some specifics on the financing, but what I would like to say - and thank you very much for this question - is that we offer tertiary, quaternary services to the people of Nova Scotia and to the Maritimes. There will always be some tests where it's one of, or a few of, or maybe even 30 or 40, and it would be inappropriate for us to try to have here in Nova Scotia. It would be very expensive in such a small number, and we probably wouldn't maintain the expertise. So we will always seek for Nova Scotians where we can get appropriate support in the world.

MR. HOUSTON: But probably not $1 million worth, so I'm wondering how many tests we have done.

MS. KNOX: That $1 million is a longstanding issue that we inherited. We've done some work, and we're very appreciative of having the two positions, because that will go a long way to help us with this. I'll ask Allan Horsburgh to tell you what we've done in the meantime.

MR. HOUSTON: Just the number of tests, because I'm going to run out of time. I was just wondering how many tests you had done for $1 million.

MR. CHAIRMAN: Just seconds, Mr. Horsburgh.

MR. HORSBURGH: We are projecting about $1.1 million this year, and we've just negotiated a 16 per cent savings on the billing from the Mayo Clinic to help us with that for next year.

MR. HOUSTON: How many tests did we get for $1.1 million?

MR. HORSBURGH: I don't have the test numbers.

MR. CHAIRMAN: Order. We'll now move to the NDP caucus and Ms. MacDonald.

MS. MACDONALD: Deputy, you indicated that the Group of IX, a group that I have a great deal of respect for, were supportive of the changes to the Seniors' Pharmacare Program. I would like to know, what information were they given from the department with respect to the changes?

DR. VAUGHAN: That was information that was what we're talking about today - would this be acceptable, the changes that we've been talking about?

MS. MACDONALD: Were they ever told how much more seniors would be contributing to the overall cost of the program, in terms of the millions of dollars that the changes would realize? Were they ever given those estimated numbers?

DR. VAUGHAN: The conversations were around the challenges with sustainability of the program as it currently exists, and the need for contribution on the part of those who can afford to pay to pay some. It doesn't pay all of the cost, by any means. They were supportive of that, though.

MS. MACDONALD: So the answer is no, they were never given any of the financial details of how much more revenue would be generated from the change in premiums.

DR. VAUGHAN: The context was more in terms of, would this change be acceptable to seniors? They were very supportive of the 66 per cent who probably would be benefiting from it.

MS. MACDONALD: Well, certainly. I'd be supportive as well if the department came and presented to me a rosy picture for people on the lower end, who we all agree have a difficult time affording drugs. If somebody came and said, "Look, we're going to make these changes and all these lower-income folks are going to benefit, would you agree with that?", I would agree with that.

But my question is not about the people who are going to benefit. My question was about whether or not they knew how many millions of dollars would be extracted from the 34 per cent of people who are going to see increases in their premiums, and I think the answer I've received is no, they weren't given that information.

Are the Group of IX still supportive of these changes now that the details are coming out?

DR. VAUGHAN: In my conversation with the Department of Seniors who have a good relationship with the Group of IX, my understanding is yes, they support the transition to a model where those who can afford to contribute do contribute to the cost, or the program is at risk going forward, it is not sustainable.

MS. MACDONALD: That wasn't my question, but I haven't gotten many answers to my questions this morning about these changes.

My final question on this is a very direct "yes or no" question. Will your department provide by the end of today, all of the financial modelling that has been done with respect to these changes? Will that be provided by the end of today? Yes or no.

DR. VAUGHAN: We will provide you with the model that has been produced.

MS. MACDONALD: By the end of today?

DR. VAUGHAN: By the end of today.

MS. MACDONALD: Thank you very much. I will turn my remaining time to my colleague.

MR. CHAIRMAN: Thank you, Ms. MacDonald. Mr. Wilson.

HON. DAVID WILSON: I know we have a short time. I have a couple of different areas but I do want to continue on with the Seniors' Pharmacare Program for a few minutes and then get into the other ones.

Of course with the lack of information that has gone out since the announcement - I know myself my office has been contacted by a number of seniors concerned because they often want to plan - they budget and they stick to that budget - and there's a lot of missing components to this.

If I could give you an example and maybe you can clarify it, you have someone who is turning 65 who is going to want to enter the Seniors' Pharmacare Program. They now, from my understanding, their spouse's income will be looked at to determine where they fall on how much they pay. If their spouse is under that age - their spouse is 60, for example - is that still the case? Do you just look at the income of the senior who is 65 and over and determine their co-pay or what they are being charged, or do you look at the younger spouse's income also?

DR. VAUGHAN: That's a good question. I believe when they are doing the calculation it's done on an aggregate basis so they would have to determine that specifically. If I was in that situation I'd call the department and find out specifically.

MR. DAVID WILSON: If that's the case, then will that younger spouse be offered the ability to join the program early, if you are looking at both incomes and they are close to that age? I mean, is that something you are aware of? Can you answer that, or is that a question they would have to ask.

DR. VAUGHAN: They would have to ask that and I would have to get back to you on that good question.

MR. DAVID WILSON: Thank you for that. The other area of course - we've talked for a few minutes about the pathology tests being sent out of the province, and that $1.1 million or just over $1 million that has been spent so far in the last year. I believe there was a proposal in front of the department asking to increase the capacity of doing those tests here, so increase the number of pathologists, for example. Why was that option not looked at? Did you do the analysis on if it's cheaper to send them out of the province, out of the country, than to beef up the capacity within our province?

DR. VAUGHAN: Thank you, that's a great question. This dates back - there were requests in 2008 and 2010 for additional resource and they were turned down at those times. When we faced the declining Canadian dollar and increasing costs, it became apparent that it was an issue that we needed to look at again and in fact we did that and, as I have said, have recommended two additional staff.

MR. DAVID WILSON: When you talked about the changes to the department staff just recently, is it 25 new staff members within the Department of Health and Wellness where you are going to look at certain skill sets that may have been missing, is that correct?

DR. VAUGHAN: Yes, that's right.

MR. DAVID WILSON: So when do you anticipate that happening? When are the hires? Is it after the end of the fiscal year, will be in the new year coming?

DR. VAUGHAN: We are significantly reducing the management costs. The department had a management expense ratio of around 30 per cent, which is significantly out of line with best practice, so we'll have a much smaller senior team. Next week, those postings will go out. Once we have those folks in place, then we'll be starting to work with them to look at recruitment of others in those areas that you talked about. We would obviously like to have them in place by April 1st.

MR. DAVID WILSON: With all the changes, mental health has been an area of concern for me. Are there any changes there? Did you reduce the number of staff in mental health? Did you move those staff out? Maybe a quick comment on that.

DR. VAUGHAN: Mental health is one of the areas that often intersect with the service delivery side, the real folks who are on the front line delivering care. Those folks would be integrated within the operational units within the health authorities.

MR. DAVID WILSON: Being a former Minister of Communities, Culture and Heritage and Minister of Health and Wellness, I'm trying to understand the relationship between staff at the Department of Health and Wellness and staff going to Communities, Culture and Heritage. Can you indicate the details of that transfer?

DR. VAUGHAN: Sure, the majority of those would be going from the Active Living group. That seemed to nest well with community development. Activity is obviously an important element of health care, but it really fit with that sort of community development project.

MR. DAVID WILSON: There are always a lot of questions when there are few details released when you see something like this happening - the transformation of a department.

I know Mr. Horsburgh mentioned that you're going to close maybe a $70 million gap in the budget. I know the minister has indicated that, and the health authority is looking at ways of closing that gap. Are parking fees amongst those? I know that over the years, it's an issue that concerns many. Are parking fees around the province at our health authorities going to be increasing in the near future?

DR. VAUGHAN: I'll pass that along to my associate. Perhaps, Allan, you could answer that.

MR. HORSBURGH: We're still in the process of looking at all of our retail pricing and strategies right now. We're assessing what things look like and whether it will be an impact negatively or positively. We're working on all revenue strategies as we speak.

MR. DAVID WILSON: I would say that is a yes, parking fees are involved in that. I would say yes, you may not have made a determination yet, but you are looking at it. Okay.

That definitely concerns a lot of Nova Scotians, especially people in my community. The only spot you pay for parking in my community is at the Cobequid Health Centre, which is concerning.

I know some of that funding goes towards the foundation. Are you looking at diverting those funds from going to the foundation, potentially? I believe there's a number of facilities where the parking fees go towards the foundation goals. Are you looking at changing that model?

MR. HORSBURGH: Part of the parking fees are actually to help pay for the parking facility itself, so to make sure that that's at least self-funding, and as well to contribute resources that go back into helping out with care. Foundations that receive parking revenues actually contribute those monies back into helping us purchase medical equipment and things like that. All these monies go right back into the care of our patients and our communities.

MR. DAVID WILSON: I know I only have a few minutes, but I do want to get a couple of questions in. In Paragraph 3.37 from the Auditor General's Report, it indicated, "2014-15 budgets in two health authorities did not represent expected activity." If you go on, it also says: ". . . these expense projections had been reduced during the 2014-15 budget process to amounts well below the anticipated expenditures for the year in order to submit a balanced budget to the province, because the province does not accept deficit budgets. The auditors reported that the budgeted cost savings had not been realized and resulted in significant variances between actual and budget amount . . ."

That's a significant finding. Can you explain the concerns not only in Paragraph 3.37 but Paragraphs 3.38, 3.39, and 3.40 on the findings from the Auditor General's Office?

DR. VAUGHAN: Well, that's the reason we consolidated the health authorities. I'll just hand it over to Allan and Janet.

MR. CHAIRMAN: Mr. Horsburgh.

MR. HORSBURGH: Since becoming the new Nova Scotia Health Authority, these are some of the areas that we did look at to see what was happening from previous decisions. We have actually spent time in those areas trying to understand the issues. Part of the $70 million I referred to earlier was the ability to do some policy, process, and service streamlining to help manage those budget issues differently. They are contributing to the ability to balance now.

MR. DAVID WILSON: From my understanding, the reason they consolidated the health authority is to try to reduce health administration costs. This budget came after this review - the audit came after that, so it's interesting. You can link it to that; that's fine. But ultimately the government's indication was to try to tackle health administration. We know in the first year that health administration costs have actually increased, and there have been significant costs factored to that. I know my time is up now . . .

MR. CHAIRMAN: You have 30 seconds.

MR. DAVID WILSON: I'm good with that. Thank you.

MR. CHAIRMAN: We'll now move to the Liberal caucus. Ms. Arab.

MS. PATRICIA ARAB: I'm new to this committee; I'm a guest today. I'm very thankful for the opportunity to be here.

I'm not sure, Mr. Chairman, if you're aware of my constituency or if our guests are, but I represent an area that has the largest public housing development in the province. I service a very large number of low-income seniors. I'm sitting here listening to this debate today, and I'm listening to the conversation over the last couple of days, and I feel that those low-income seniors who will benefit from these changes are sort of being dismissed. I know individuals who take half of their dosage of medication because it allows them to make it last longer.

For my questioning, and I am aware of the fact that I have other colleagues who would like to question as well, I would like to ask our guests, through you, to possibly elaborate on the actual benefits to low-income seniors, some of whom make $5,000 a year, what these changes are going to do for them specifically, how it is going to impact their ability to afford the medication that they desperately need.

DR. VAUGHAN: Single seniors with income below $22,986 will not pay any premium whatsoever - there's a significant number of Nova Scotians in that area - earning between $22,900 and $35,000, less than $40 a month; earning $35,000 to $75,000, somewhere between $40 to $100 a month based on their income, as we've heard a lot about; earnings more than $75,000 a year is $100 a month, which is just over $3 a day, $3.33 a day.

MS. ARAB: You mentioned, and I guess that explains this, the income element to cost. Can you further explain that?

DR. VAUGHAN: You're talking about the income element in particular?

MS. ARAB: Yes.

DR. VAUGHAN: That's based on your income tax form, the Canada Revenue Agency form, line 150, where you have your income total. That's where that is determined. We require individuals to release that information to us to be able to make the appropriate determination for where they sit.

MS. ARAB: Just one final question from me before I pass it on to my colleague, through you, Mr. Chairman. Understanding that the numbers are in flux, and we can't really have a concrete percentage of individuals who will fall under this program, based on your understanding, is it possible to get a percentage of seniors who will have no co-pay on this new program?

DR. VAUGHAN: Let me be very clear on that. About 12,000 seniors who paid a premium in 2015 will not pay any premium in 2016. That's 12,000 seniors. An estimated 47,500 seniors will be exempt from premiums - 47,500 exempt from premiums. And about 29,000 will qualify for reduced annual premiums. So you can do the math, I think, and calculate the totals.

MS. ARAB: Thank you very much.

MR. CHAIRMAN: Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Thank you all for being here. Ms. Knox, I'd like to ask a question of you. I've heard you use a term in the media and whatnot of a One Nova Scotia approach to health delivery. Being an MLA from rural Nova Scotia, I'm really concerned how is this going to look in rural Nova Scotia? What benefit will this be for my constituents when getting health care delivered?

MS. KNOX: Thank you very much for that question. Our approach in looking at and every decision we make in terms of how we use our resources, how we plan to meet the needs starts with understanding the people of Nova Scotia and what their needs are. We have done some work already and have descriptions of the population as a whole and we have also done some work that brought it down to local communities so we can know what the needs are of those folks in local communities.

As we plan provincially it gives us the opportunity for no barriers, to really say what the needs are but what is our basket of resources and how might we bring that around all Nova Scotians, and to really be focused then on what kind of services we need, what are the standards of service delivery. Then where it becomes local is that while we may say that we are generally the same population in Nova Scotia, there are nuances of differences. Our deputy has talked briefly about interdisciplinary collaborative care teams and how we focus on the care of people where they live. As we develop standards for what that might look like in Nova Scotia, when we implement it locally it can be based on what the needs of that population are.

Where I came from, there were seven major communities that we focus services around. Western Annapolis County had a very big burden of chronic obstructive pulmonary disease. They really needed respiratory therapy support, that kind of support. That's an example of when you put a team together of professionals and supports for that community, you can cater it to the needs of that community.

The other part is that you really need to engage the community as part of what it is that's happening in the community because there's a big sector of how we support people in the broad context of health that is volunteer - how we live in our community, how we support each other. That's what's happening in our schools, what's happening with our employers, what the community looks like. So we need to engage the members of that community so that we then together say this is what it can look like here. It is a process that we call community-based planning but with a provincial lens.

So to conclude, I would just say the advantage of having the two approaches is that we understand who the people are, where they live and how they need to be supported as individuals in their families in the context of their community but we can bring around the resource of Nova Scotia and say maybe we need to look at access to a particular resource in a different way and bring that to bear on a local community.

MS. LOHNES-CROFT: Dr. Vaughan, you recently were in Vancouver for a conference of Health Ministers - where does Nova Scotia play? Where do we stand in what other provinces are delivering for health care? Are we on the scale there? Are we on the bottom, top, middle?

DR. VAUGHAN: Nova Scotia received a lot of recognition for the work that Nova Scotia has done with consolidation of health authorities, looking at the redesign of the department to fit in, many provinces said you have got it right, you have to stay the course, you are doing the right things to achieve sustainability of health care for the population. They are looking to us so there were lots of conversations around the kinds of things that Nova Scotia is looking at. From a technological perspective Nova Scotia led in fact the conversation around innovation for the Health Accord. Nova Scotia is recognized as a leader in innovation, not just in technology but in service delivery.

MS. LOHNES-CROFT: Would that be in home care delivery, too? We're trying to keep more people in their home. How is Nova Scotia faring that way?

DR. VAUGHAN: Nova Scotia again is seen as doing the right thing, as a leader. Many, many jurisdictions have lagged behind but look to Nova Scotia. They are doing that same thing. Quebec, for example, and other provinces as well, looking to deliver care. Saskatchewan and others looking to deliver care in the home. Technology allows us to deliver more care - and better care in many cases - in the home. So Nova Scotia is looked at as being a jurisdiction that has all those foundational pieces in place - an integrated ambulance system, a consolidated health authority, a department that's focusing on the future and understanding trends and analytics. All of these pieces put Nova Scotia on the

forefront of the national stage, and ready for the next level of investment when the federal government finally decides to do that and when they're ready to do that.

MR. CHAIRMAN: Mr. Maguire.

MR. BRENDAN MAGUIRE: Thank you for coming here today. I appreciate your answers. I want to go back to Pharmacare for one second here. Your explanation today is basically that the Pharmacare system is now income tested, so anyone making over $75,000 per year - and correct me if I'm wrong - will now be paying essentially $3 per day, which is about the price of a cup of coffee. Is there anything privately that compares to this?

Also, what are the benefits to the low-income and the middle-income seniors, who will be paying considerably less to the entire health system? What kind of benefits are we going to see with 66 per cent receiving a benefit? I go with the member for Fairview-Clayton Park here. This is going to have a wide-ranging positive impact on the people in my community, so I'm wondering, what is the impact overall on the health care system?

DR. VAUGHAN: Thank you for that very important question. At the end of the day, this is about individuals who need to take medication. Medication is one of the major therapeutic options we have in health care today. Those individuals who are on the lower socio-economic scale who can't afford to take their medications end up in hospital at the end of the day because they're sicker, and end up having to receive more expensive care at that point of care.

The more people can be treated at home - including medications as part of that - the more access they have to medication, and the more medications that they're taking appropriately - it's not about more medications but about appropriate use of medications to keep them as fit as possible and out of hospital, which has a significantly higher cost per day, as most people recognize - then it's better for all Nova Scotians, at the end of the day. The sustainability of that program was top of mind, and to be able to sustain that program into the future, we needed to introduce those changes.

Those making more than $75,000 do have to potentially pay $1,200 per year. That's a small price to pay, at the end of the day, for access to very expensive drugs. These drugs are not free. Health care is not free. There's a significant cost to health care, and that's why we, in this province, have to look at our contribution to health care expenditures, as a percentage of budget, and look at the outcomes that we've been getting from that. We have not been doing well on the national stage in that regard.

Change is inevitable. I think people understand that they have to pay something. I appreciate that some people don't want to pay anything, but the reality is that to sustain the program, and for all the reasons we've talked about, people are going to have to pay a little bit if it's appropriate. But again, 66 per cent of people, they're not going to change. A lot of people are going to pay less, or nothing.

MR. MAGUIRE: We've had many people come into my office, seniors in particular, who were looking for all different services. More than one time myself or my assistant have given money out of our pockets to some low-income seniors who could not afford medicine. Are you saying this is going to have a direct, positive impact on those individuals?

DR. VAUGHAN: In two ways to answer your question. One is, as I said, those earning less than $22,900 will not pay any premium at all, and they will benefit directly from the changes to the co-pay, directly in their pocket.

MR. MAGUIRE: So it's money saved.

DR. VAUGHAN: Money saved.

MR. MAGUIRE: The other issue I wanted to touch on quickly - we have some time, do we, Mr. Chairman?

MR. CHAIRMAN: You have about 30 seconds.

MR. MAGUIRE: The other issue is the VG. We keep hearing from the previous government that there was a plan put in place, after five years of being in power, what happened to that plan?

DR. VAUGHAN: The plan that was produced previously still had some services being retained in that VG and, as you heard me say earlier, that building is not sustainable going forward so right there that was problematic. It did not have support of the medical staff who were going to have to work there.

Because of that, when the new health authority came in, they rightly looked at that plan and the challenges associated with that plan and made the decision - and I think it's the right decision - to say where's the future of health care going? We need to have our medical staff and nursing side onside, we need to look at what the appropriate care will be like in the future. We know that is increasingly ambulatory with some high specialist areas.

MR. CHAIRMAN: Order, the time for questions has expired. I did let it go a little longer there to allow a final answer.

Dr. Vaughan and Ms. Knox, if you have any closing comments we'd certainly be open to hearing them.

DR. VAUGHAN: Thank you, Mr. Chairman. I just want to thank the members of the committee for giving us the opportunity to answer your questions and share the vision for the future of health care, using a One Nova Scotia approach.

We are entering an important new era in our history. We've learned from the past, we are working together with the Nova Scotia Health Authority to make sure this next chapter of health care is right for Nova Scotians. Nova Scotia now has a health care system that is building a modern, innovative and efficient system that will make sure they have access to the quality health care they need now and into the future. Thank you very much.

MR. CHAIRMAN: Thank you, Dr. Vaughan. With that, we do have some business before the committee. Our clerk has made note of some requests for information. They will be getting in contact with you, Dr. Vaughan or Ms. Knox, as appropriate, to get that information. Ms. MacDonald.

MS. MACDONALD: Actually perhaps before our witnesses leave because this does correspond to the witnesses who were here today, I want to start by saying that I asked no questions today and our caucus asked no questions about the Nova Scotia Health Association. I want the record to reflect that at 9:00 p.m. last night, our office received a response to a Freedom of Information and Protection of Privacy request for budget information from the Nova Scotia Health Authority. This is information we asked for back in December. We were most surprised that it came in at that late hour last night - some poor soul was tasked with being on the job at that time.

I want to indicate that this is not acceptable, in my view. In preparation for this meeting today, that information should have been provided during work hours when staff in my office would have had an opportunity to look at that information and assist me in preparing for today.

Mr. Chairman, I am growing increasingly concerned by the number of departments and witnesses that are coming before this committee and refusing to provide information in advance, which is a requirement in order for us to be able to do the job we are tasked to do in this Legislature. I hope it is not an expression of disrespect for this committee and its members, and the work we have been tasked with, but I can't help but feel somewhat disrespected and a little infuriated, frankly.

I want to say, Mr. Chairman, that I think it's time that we as a committee get a little tougher. Perhaps we could speak with Legislative Counsel with respect to the powers of the committee regarding the power of not only subpoenaing witnesses but subpoenaing documents that we are required to have in advance of these committee meetings, so that we can do a thorough and professional job. As my colleague indicated earlier, the department and officials in the department have more information than we have.

We can only do our jobs if we have access to that information. We attempt to follow the rules as best we can. To have roadblocks put up, and what have you, is just not acceptable. It's not acceptable.

It's 2016. We live in a democracy. We have a government that said it was going to be the most open and transparent that the province has ever seen, and we're not seeing that, Mr. Chairman.

I want to raise this issue as a concern. I think we as a committee need to take a much more aggressive, assertive stance with respect to the role of this committee and the power we have to get information.

MR. CHAIRMAN: Thank you, Ms. MacDonald. You've put an issue before the committee. Mr. Houston.

MR. HOUSTON: I thank my colleague for raising this issue. It often happens that witnesses come before the committee and have to go away and get documents to send to us. We all accept that that's a reality. There's a lot of information in departments, and certainly they can't come prepared with all of it.

But at the same time, I think today does kind of highlight the issue. I have a concern about Pharmacare in particular. I have curiosity as to how much the Liberal Government - and let's be honest about it, that's what's happening - is looking to recover from seniors. In the case of today, I have 20 minutes in the first round of questioning, and I have a lot of questions on a lot of different issues that I'd like to get to. I think I invested 15 or 16 of those 20 minutes trying to get an answer to that question, of which there was none. I got no answer on that today.

Ultimately, I think in the second round of questioning to my colleagues, the department offered to provide a document before the end of the day. To me, Mr. Chairman, that suggests that either somebody is going to go and work pretty hard in the next couple of hours to prepare a document and backfill, or it exists. I don't want to give my opinion on which one of those answers I think is correct. I think I was pretty clear in my line of questioning what I think the case is on that.

But that was a clear unfortunate effort to frustrate the committee. I sympathize with the witnesses because I know they come before this committee in a position of not wanting to jeopardize their own careers by maybe embarrassing somebody up the stream. Oftentimes politicians say things, and staff have to try to work around it. We know that's the case, particularly with this government. It tends to say a lot of things that are unsupportable that need to be supported later.

I don't know if the way forward for this committee involves us not just scheduling witnesses but also includes asking for certain information to come, but it's hard for us to do that, Mr. Chairman, because we don't know. As I said during the committee, we have a lot less information than the 9,000 bureaucrats in the province.

The purpose of this committee is for us to get that information so Nova Scotians can have a better understanding of how government money is being spent and what's

happening with their tax dollars, which includes how much they're expected to pay towards it, which is I think the case in the Pharmacare thing. I don't know the way forward, but I certainly share my colleague's concerns, and I look forward to the comments from the government members on this committee and how they feel.

In particular, let's talk about the Pharmacare situation as a symptom of what I think is a bigger problem. A document will now be provided before the end of the day that this committee spent, between myself and my colleague, probably a half-hour trying to get an answer that we didn't get, and that's not fair.

MR. CHAIRMAN: Order. Is there agreement by the committee to go beyond 11:00 a.m.? Okay, there is agreement.

Mr. Houston, I believe you were finishing off. I do have a comment from Mr. Stroink. Did you get a chance to say everything you wanted to say?

MR. HOUSTON: Yes, I did. Thank you.

MR. CHAIRMAN: Mr. Stroink.

MR. STROINK: In fairness to the Department of Health and Wellness, they came prepped to talk about Chapter 3. They didn't come prepped to talk about Pharmacare. So the questions that they have agreed to answer at a later date, I think it's very fair for them in this situation. They have a lot of information; there's a lot of data out there just on Chapter 3 on its own.

I guess this is my concern that I've brought up on numerous occasions with the chairman - when we come to this committee, we talk about the issue at hand, not around other things directly in that department. I guess, Mr. Chairman, I'm asking, if we're going to do this right, and the Opposition here can't get their answers, then I think we need to decide as a committee, are we going to allow for a free flow of questions? If that's the case, then they're not going to be able to answer all this, and their frustration is going to be felt more and more.

I guess, I'm asking if we're going to have these kind of questions on Pharmacare, and we're here to talk about Chapter 3, then I feel it's your job to curtail the questions. "Sorry. At this time, that question should not be asked because we're here to talk about Chapter 3. If you want to talk about Pharmacare, maybe that can be talked about later on as a committee." That's all I wanted to say on that comment.

MR. CHAIRMAN: To respond to that, I think that's an important point that you're raising. Typically in the Public Accounts Committee - and in this case today, we are talking about Chapter 3 of the Auditor General's Report - this committee looks at past expenditures. We have witnesses who come in to talk about a subject, specifically this

Chapter 3. As chairman, I hear questions from all caucuses at meetings every day that are often not connected specifically with the issue at hand.

There has also been a legal opinion given by our legal counsel that states that each caucus is given an allotted amount of time. They're also given freedom to use that time to ask questions as they see fit.

You're right that it is my job as the chairman. It is different, this committee, than, say, a typical sitting of the Legislature, where the Speaker keeps people on topic. If there's a bill being discussed, they have to stay on the topic of the bill. This committee operates with different rules than that and that needs to be stated because, as chairman, I have to respect the freedom of members, and it has certainly been the practice. In fact, if you speak with some of your colleagues who have been on the committee before, they can tell you that there are times when the questioning is pretty free-flowing. That has been the practice of the committee. That's something that is difficult for me to change. It's certainly something that our committee could discuss further.

To comment on the issue of members not feeling questions are answered, we do have the ability - and I as chairman have the ability - to compel witnesses to answer questions. I think that is important because answers do have to come forward to the committee, or we could have a situation where people just don't give answers any longer.

I don't want to comment too much on what has happened today, but I do know that there were questions asked about Pharmacare, which is not directly connected to the Auditor General's chapter. But it is, once again, something that falls within the issue of free-flowing questions. The department was not able to provide a direct answer to that question, however, they did state that they would provide, I believe, modelling for the new Pharmacare premiums later today. That may help to answer the question that was asked.

I would say this: if members ever feel, during questioning, that their question is not being answered, they certainly have full right to call upon me to compel witnesses to answer the question, and witnesses, of course, do have to answer questions. If they don't have the information to answer it, I don't have the ability to evaluate that. But I can certainly press witnesses to answer questions, within reason.

I don't know if my comments are helping to make people feel better about the process. But as chairman, I would say we need members to have freedom to ask questions that they wish to ask. They should try to link them to the subject of the day, and if they don't feel that they're getting an answer, I am certainly here to be assertive in getting the answer for them, as chairman.

Mr. Irving, did you have a comment?

MR. IRVING: I think your comments are to the point. I do want to point out, as chairman of one of the other standing committees, this challenge of staying within the

mandate of the committee and again, I think this brings up the question, particularly with the Department of Health and Wellness, which is 41 per cent of our budget, that we have no standing committee giving the opportunity for legislators to learn about health, except through this committee. So again I think that's a discussion that we should pursue in terms of more opportunities to delve into the issues with the Health and Wellness Department.

I will speak briefly to the two interventions about today. I think it's difficult to comment on a freedom of information request that we have no idea whether it's on this subject or not, I do think it's fair, in terms of the hour, something is being received and I'm sure the department can make corrective measures to that.

I understand my colleagues' frustration with their seeking an answer. I took from that response that the department didn't have an answer for this, and I took from that that the realignment of Pharmacare has been driven by sustainability and balance and fairness, and has not been driven by budget. For me, that is the reason they didn't have those numbers here off the tip of their tongue. I think it's a bit of an issue of perspective and I somewhat respectfully disagree with my colleagues.

Again, back to the topic of what this committee should be doing, we have spent two hours not talking about the work of the Auditor General, for the most part, and I think we're perhaps doing a disservice to the Auditor General and his work by not ensuring that at least part of our discussions really focus on that report. Thank you.

MR. CHAIMAN: Ms. Arab.

MS. ARAB: Mr. Chairman, I was actually going to move that we adjourn our meeting. If my colleagues want to continue further, I would ask that maybe we could excuse our witnesses and continue the conversation, if our Opposition members would like to continue it.

MR. CHAIRMAN: Are there further comments on this matter? We do have a couple of other items of committee business. If there are no further comments, I think it's important that our witnesses do hear these discussions - perhaps you can pass to your colleagues what you've heard today because it is important for witnesses to understand, I guess, how committee members look at their role here in this committee. Certainly taking your point, Ms. Arab, our witnesses . . .

MS. MACDONALD: I want to ask one question and that's whether or not we could get a legal opinion from Legislative Counsel with respect to the powers of the committee around the subpoenaing of documents.

MR. CHAIRMAN: Okay, thank you, Ms. MacDonald. I'm seeing agreement from our legal counsel that that can be provided to the committee. Mr. Maguire.

MR. MAGUIRE: I'd also like to have our legal expert give an opinion on whether a topic that's being discussed that's not on the paper, to have the information given by the end of the day, if that's appropriate or if that's too long a process. The witnesses here said today that the information that the Opposition was seeking they'd have by the end of the business day, which I'm assuming is 4:00 p.m. or 5:00 p.m., so about five to six hours. I just want to know if that's an appropriate time frame.

MR. CHAIRMAN: Generally we would leave that up to the department. Certainly members could request a time by which information be provided and if a department can comply but there's no hard and fast rule that I've seen to that. I don't know if I'm answering your question.

MR. MAGUIRE: What's the normal practice in the past of the committee for retrieving information? Is it five to six hours?

MR. CHAIRMAN: Yes, just while we're (Interruption) I was getting word from our clerk that generally the department agrees to a time by which they would provide information. If a committee member didn't feel that was timely enough, they would certainly have the right to state that and to request it earlier. The department, in this case, has offered to provide the information you've just spoken of by the end of the day, and that was of their own volition.

Mr. Houston.

MR. HOUSTON: Thank you, Mr. Chairman. I just think really what we're getting to is the heart of the matter here, and that is that I'm trying to ask questions about things that are timely and relevant, to make sure that this committee is important. We've now heard from two government members trying to find ways to make this committee less relevant, to try to find ways so that witnesses don't have to answer questions. First they'll talk about, don't make the witness answer, because it's not relevant . . .

MR. CHAIRMAN: Order. I think we've made some progress on the issue, and we do have a couple of other items before us on the agenda. It is now 11:11 a.m. I know there's a function that some of us are going to across the hall. Is there agreement that we've made some progress?

I don't want to stifle debate, Mr. Houston, but I'm also wary of moving this along indefinitely, and we do need to proceed. Are you okay if we proceed to other items on the agenda? Thank you.

Our witnesses are free to leave now - thank you for being with us.

We have a meeting update from the Department of Finance and Treasury Board. They're coming to appear on February 24th to discuss Chapters 2 and 4 of the November 2015 Auditor General's Financial Report. The deputy minister is coming on that day.

We have one item that we need approval of from the whole committee, and that is that our Subcommittee on Agenda and Procedures met on January 20th to come up with a list of topics for future meetings. I believe all of you have that before you. Would somebody on this committee make a motion that those topics be accepted?

MS. MACDONALD: So moved.

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

The motion is carried. Our clerk will make record of that decision by the full committee.

The last item is that our next meeting is February 3rd. That will be the Executive Council Office, and it's on ministerial travel. We will have the Executive Council Office as the witness.

If there's no further business before the committee - seeing none, this meeting is adjourned.

[The committee adjourned at 11:13 a.m.]