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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, September 28, 2016

Legislative Chamber

Department of Health and Wellness/Nova Scotia Health Authority
Management of Nova Scotia's Hospital System Capacity

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Public Accounts Committee

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Ms. Kim Langille
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Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Nicole Arsenault
Assistant Clerk, Office of the Speaker

Mr. Michael Pickup
Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Department of Health and Wellness

Dr. Peter Vaughan, Deputy Minister
Mr. Kevin Elliott, CFO, Finance & Treasury Board, Advisory Services
Ms. Ruby Knowles, Sr. Executive Director, System Strategy & Performance

Nova Scotia Health Authority

Ms. Janet Knox, President & CEO
Mr. Allan Horsburgh, VP, Stewardship & Accountability & CFO
Ms. Paula Bond, VP, Integrated Health Services Program Care

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, SEPTEMBER 28, 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 of the Public Accounts Committee to order. This morning we have with us the Department of Health and Wellness and the Nova Scotia Health Authority. They are here to discuss with us the June 2016 Report of the Auditor General where they were featured in Chapter 2 of that report, which was: Management of Nova Scotia's Hospital System Capacity.

I'd like to start with introductions.

[The committee members and staff introduced themselves.]

MR. MICHAEL PICKUP: Maybe I could just publicly congratulate Evangeline Colman-Sadd on her appointment as the Halifax Auditor General, effective in October, so a thank you to Evangeline Colman-Sadd and all the best. (Applause)

MR. CHAIRMAN: Thank you and congratulations, Ms. Colman-Sadd.

Just a quick reminder so that people ensure their phones are on silent so we don't have interruptions. We'll have our guests introduce themselves.

[The committee witnesses introduced themselves.]

MR. CHAIRMAN: Now we'll begin with opening comments, Dr. Vaughan.

DR. PETER VAUGHAN: Bonjour tout le monde. Good morning, Mr. Chairman and distinguished members of the committee, and thank you for your introductions as well. It is a pleasure to be with you today to speak about the capacity of our health system and the other important questions identified earlier this year by the Auditor General.

First I would like to introduce my colleagues - once again, as you know, Ruby Knowles and Kevin Elliott. With their able assistance I will endeavour to answer your questions and provide information you need. The questions raised in the Auditor General's June report are both timely and relevant. At the time the Auditor General's Office was completing its review, the consolidation of the former Nova Scotia district health authorities was less than one year old. The Nova Scotia Health Authority has since submitted its first annual report. In that report it lays out in detail the success of CEO Janet Knox and her excellent executive team; the board of directors, under the leadership of Mr. Steve Parker; and of every staff member, physician, and volunteer in achieving the significant objectives established for them.

When the Nova Scotia Health Authority was created, the goal of government was set forth: to make the health system more effective and as efficient as possible, and to deliver safe, quality care and services while improving the health status of Nova Scotians.

With the consolidation of the authorities we are working to improve access to services, enhance the quality of care, increase innovation, and use our resources wisely. This year for the first time our Health Authority has presented fully balanced budgets, even as they improved service delivery - a significant achievement.

In April we redesigned the Department of Health and Wellness to direct more services to the front line and reduce administration, and for the second year in a row we held the line on health care spending.

Mr. Chairman, we accepted all the Auditor General's recommendations and we are working hard to implement them. The report's findings highlight some of the challenges facing the health care system. I believe they validate the work we have already undertaken with the Nova Scotia Health Authority and the IWK Health Centre to better plan, coordinate, and deliver health services to Nova Scotians.

The Auditor General has told us that the old ways of providing health care to Nova Scotians are not sustainable. We agree. Together with the two Health Authorities, the Department of Health and Wellness is planning for a health care system that will serve Nova Scotia for the next 50 years. We are already working hand in hand with the Nova Scotia Health Authority and the IWK to build a system that is both sustainable and responsive to the future health care needs of our province.

An example of this is the plan to redevelop the region's premier research and teaching hospital, the QEII Health Sciences Centre, which we announced in April. This comprehensive plan incorporating facilities in Halifax, Dartmouth, and Hants County will ensure our health care infrastructure and services are better connected to improve service for Nova Scotians for another generation. The province and the Health Authority are at the planning and design stages for most aspects of the redevelopment, and we continue to update Nova Scotians regularly about our progress.

Among the recommendations in his report the Auditor General also asserted that Nova Scotians deserve to know what is expected from their health care system. We endorse this recommendation.

As planning for health services moves forward, we are absolutely committed that Nova Scotians receive clear and timely communication. The users of our health system must be fully engaged in helping build the health care facilities of our future. That is why the Health Authority has embarked on a robust program of engagement and consultation with patients, physicians, communities, and other important stakeholders to ensure their needs and their expectations are heard and reflected in both short-term and long-term planning.

The department has accepted all of the Auditor General's recommendations and is working hard to address them. In many cases the work has been completed or is nearly complete. I look forward to answering your questions to the best of my ability. At this time I will turn things over to Ms. Knox for her comments. Thank you - merci beaucoup.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Thank you and good morning everyone. We, too, at the Nova Scotia Health Authority agree with the Auditor General and are working to address the issues that have been identified in his report. I welcome the opportunity to be here today with my colleagues, Paula Bond and Allan Horsburgh, to share our update on our efforts to plan, manage, and deliver health services more efficiently and effectively within our province.

Our first 18 months have shown promising results. Nova Scotians are seeing shorter wait times and improved access in a number of key areas, including home care and long-term care, as well as some diagnostic and surgical services.

As our deputy minister mentioned, there have also been financial gains. Along with the ongoing savings from our one streamlined organization, we are finding efficiencies and putting our money where it's needed most. We balanced our budget in our first year despite a $70 million challenge in cost pressures. We know there are more opportunities.

We are working with the IWK Health Centre and the Department of Health and Wellness to develop and implement a multi-year plan that will result in new provincial

approaches to a range of health services. We are focused on creating an accessible health system that offers the right care in the right place at the right time based on evidence and the needs of the population. This is what the Auditor General has asked us to do in his report and, in fact, that's what Nova Scotians we talked to are asking of us.

Creating that system involves listening to what Nova Scotians tell us is important to them. Their voices are reflected in many ways: through surveys and consultation sessions on health system initiatives, in our work with our community health boards and the development of our community health plans, and through our Talk About Health public engagement strategy.

Here is some of what we heard so far. Nova Scotians want access to care as close to home as possible. They want timely access to doctors, nurse practitioners, and other primary care providers. That's no surprise to anybody here. There are inequities in services across our province, and certain population groups and communities have unique needs that have to be considered. It should also be easier for patients to move from one service to another. We also heard from the people we are speaking with that we need to live well as a province. We need to build supportive systems, and we need to encourage a healthy population.

All of this is informing our planning for the future, and we intend to keep listening. Engaging with citizens is a key strategic priority for our organization and is increasingly built into how we make decisions. We are now in the process of recruiting a patient, family, and public advisory council, which will help bring a public lens to our work as one strategy.

While this process is still evolving, we know for certain that we need to do things differently if we want different results. I think we can all agree, we want and we need different results in Nova Scotia. Nova Scotia has an aging population with high rates of chronic disease. Despite spending more and more on health care over many years, we aren't getting any healthier. We know that as Nova Scotians, we live an average of one year less, and two years less of good health than Canadians.

Growing demands related to the health needs of our population, inflationary costs, and aging buildings and equipment continue to drive up our costs. Continuing to invest more in the same way is not the answer.

The planned approach to the redevelopment of our QEII Health Sciences Centre is a good example of rethinking how we can deliver safe, quality, and appropriate care in a more efficient and effective way. There has been progress made in all aspects of this project with some key milestones over the past few months.

What I really want to make some points about is the approach we're taking. This isn't and cannot be simply about replacing an outdated facility. It's about understanding the health needs of our population and what programs and services are required to meet those needs now and into the future. From that, we can plan what type of spaces are needed

and where they are best located. While we have a plan to address the challenges with the VG site of our QEII Health Sciences Centre, there are aging buildings and equipment across this province. We are taking a similar approach to addressing those needs, prioritizing our investments based on the evolving needs of the population.

Nova Scotians expect and deserve a high-quality, sustainable, and effective health system, one that supports them in being well and provides timely access to care when it's needed. By planning and acting as one system for the benefit of all Nova Scotians, by using evidence and best practice to make the best use of our financial, people, and infrastructure resources, and by engaging the public in creating a healthier future together, we are working hard to ensure that that's what we get. Thank you.

MR. CHAIRMAN: Thank you, Ms. Knox. We'll begin with Mr. Houston, of the PC caucus, for 20 minutes.

MR. TIM HOUSTON: Thank you for the opening comments. Many people talk about a crisis in health care - a crisis in mental health care, a crisis in health care. When I hear from a lot of people who work in the system, they talk about a lack of accountability across the whole system. That's the common theme that I hear at the moment that's causing problems.

In fact, Ms. Knox, you were with me in Pictou on the weekend. There was a public meeting for people to gather to talk about their concerns about health care. Dr. Vaughan was there as well. There was a doctor who stood up and said he has known Ms. Knox for quite some time - decades, I think it might have been - and that he has a tremendous amount of respect for her professionally, but he can only describe your performance in this role with the Health Authority as you being under a gag order. Then I've heard from another person in the health care profession who has known you for quite some time and also has respect for you, but said it looks like you are trying to fly an airplane as you're building it. The point is, the common theme I'm hearing is that people in the system and the users of the system are not impressed by what's happening. The general consensus is somebody is giving you marching orders that are failing Nova Scotians.

We know where those marching orders come from, and I'm sure you don't want to speak to them. But I'd like to ask you, what is the number one priority you've been given? What has the government asked you to fix? What's the number one priority they've asked you to address?

MS. KNOX: I think there's a lot of questions there. For me, when I was asked to take on this role, it was to bring together the health system of Nova Scotia in a way that would pay attention to what the population needed now and into the future, to be healthy and stay healthy.

I can tell you I took great effort to make sure I understood that, so our legislation that brought together the Nova Scotia Health Authority is what directs the work that I do

in terms of maximizing our resources, planning for the population of Nova Scotia, and implementing at the local level based on what the needs are. I think understanding the total population is very important, but understanding the lived experience in a community is really where the final decision must be made. That's how I see what we are challenged to do as an organization.

MR. HOUSTON: I thank you. I've heard the word "efficiency" used a couple of times. I think the goal is to make the system more efficient, but I don't know if it's being made more efficient. We'll talk about some of the things like the doctor shortages and the access to care.

Would you say there's a crisis in mental health care or a crisis in health care? Is there a crisis in the system right now?

MS. KNOX: How I would characterize our system is that we have a major challenge in terms of our health status. Whether you want to call that a crisis or not, but we are living in a province where people are less healthy than everybody else in the country, basically, from a provincial perspective. I know our northern communities have different realities as well. I think that is something very important that we pay attention to.

In terms of the health system and efficiency and effectiveness, when we came together as the Nova Scotia Health Authority we had nine previous organizations, and as Dr. Vaughan has said, many of those organizations did not balance their resources so had lots and lots of challenges. When you come together you can't make assumptions about what that means, you need to take the time to really understand that. We have learned that when we can develop a strategy, we now can move it across the system very quickly and that's how we dealt with, for instance, the home support . . .

MR. HOUSTON: Thank you for that. So if we say that the system is under stress or it's in crisis, however we want to describe it, I think - did you attribute the main cause of that crisis to the fact that Nova Scotians are more unhealthy than others, is that the root cause of the problem?

MS. KNOX: That's what I would suggest, yes.

MR. HOUSTON: So what's the first real step that the Health Authority is taking to address the root cause of the problem which, in your mind, is unhealthy Nova Scotians?

MS. KNOX: When we begin our planning for services across Nova Scotia we have developed a framework for planning that takes into account population needs, as opposed to planning purely for a diabetes program or people who have diabetes, but to consider what supports we need in planning for service delivery. Mental health would be a good example, what's the health promotion side of that service that we really need to pay attention to?

It will take time to change this because Nova Scotia is not greatly different than the rest of Canada. We have developed our health system based on a hospital system which is when people become ill, we look after them. So our resources have been put into when people are ill, we look after them.

In our planning we need to understand the needs of the population, work with our partners. It doesn't mean the health system has to do it all but we are charging all of our folks to truly understand the population and understand the community so that we bring partners together and some of that up-front work that's focused on the health of the population, we will do part of it but we need to be good partners with other assets in the community to do that. That will take us some time to change, it's changing the focus of our system while we still will care for the people who are ill.

MR. HOUSTON: It must be frustrating then if the root cause is unhealthy Nova Scotians, but do you have any jurisdiction to make Nova Scotians more healthy to begin with? Your mandate is to treat them when they have an illness, is there a frustration there?

MS. KNOX: I think my mandate is to focus on the population and what their needs are. I would say that we have not spent enough time in the past really focusing on the broad needs of the population. I spent 10 years in a district health authority where that board made the decision at the beginning that everything we do would be focused on population health, so that's the background I come with and really reorienting your services to more community-based services to support young families who need support. It can be done. It takes time though.

MR. HOUSTON: I'm sure it can be done, but I think the sense is that we're always playing catch-up in this province. We're always behind the eight ball. We're always playing catch-up, and now we're talking about changing mindsets to make people healthier. It will take decades, but as we sit here today there are real issues in the health care system that aren't being addressed to the satisfaction of the consumers of that system. One area is obviously doctor shortages. Is there a doctor shortage in Nova Scotia?

MS. KNOX: We have lots of vacancies in Nova Scotia for doctors across all disciplines of medicine. When we look back over the last 10 years, we have had a constant challenge in recruiting physicians to this province.

MR. HOUSTON: How many vacancies? I use the term "doctor shortage" but how many vacancies do you have across the province?

MS. KNOX: I haven't got the exact number with me right now.

MR. HOUSTON: What percentage would you say?

MS. KNOX: That's a hard thing. I'll tell you why it's a hard thing. All of the previous areas did not account for doctor vacancies. Some areas of the province, family

physicians manage that themselves so we don't have a constant piece of data that I can tell you, but I can tell you that since July to September, 39 new physicians started in this province. In the previous 10 months about 80 new physicians started in this province.

MR. HOUSTON: But without perspective, that's just a number.

MS. KNOX: That's what I'm telling you.

MR. HOUSTON: I would have hoped that with the stress that the doctor shortage is putting on Nova Scotians, a year into the Health Authority they would at least know, are we 10 per cent short or 15 per cent, but we're not there yet.

MS. KNOX: We're working on a tracking system. All of our zones track it differently. The previous 10 organizations tracked the vacancies differently. In some instances, physicians managed it and would not have told the district health authority about it at all.

MR. HOUSTON: But that's all yesterday. We had a year of the Health Authority - if the goal is to make the system more efficient, I don't see the efficiency in a Nova Scotian going to a specialist and the first question is, who is your family doctor? I don't have one. I don't see the efficiency in a Nova Scotian taking their child to an emergency room for an X-ray for a broken arm and the first question is, who is your family doctor? I don't have one. I don't see the efficiency in a system where somebody is going to a specialist to test for cancer, who is your family doctor that we can send the test to? I don't have one. I don't see how that type of system is serving Nova Scotians. I'm taken aback that we're sitting here today and the Health Authority doesn't seem to know how widespread that is, because you don't know how many Nova Scotians are without a doctor. How many doctors do we need in this province?

To me, that should be an area. That's front-line care. We can talk about saving millions of dollars, and we'll talk about that, but we're always going to ask, what's the cost to the system? There's a tremendous cost to the system when you don't have enough family doctors. I was hoping when I came here today that we would say the number one priority of the Health Authority is to make sure that people have access to care through a family doctor. I'm not hearing that.

MS. KNOX: The number one priority for the Health Authority is access to primary health care in your local community. I would not suggest that is only access to a family physician. Our goal is to move to family health teams, so access to the full range of primary health care that is needed to help people be healthy and stay healthy.

I do have a list of what vacancies we have. I told you, I can't bring it up in my head. We are working on a tracking system to make sure that we can follow that. We have met with 67 per cent of all family physicians face to face in this province to talk to them about

what their plans are, what their needs are, what they want to be involved in. Those are the kinds of things you have to do.

We have a recruitment strategy in place that is ongoing every day and have put a team in place to do that while we are waiting for family physicians. For instance, in the group that we talked to on Sunday, we know there are 981 patients who have signed up with our line to find a physician in Pictou County because their family physician died. We are working with other physicians, with interim strategies, to take on some of those patients while we are recruiting a family physician to replace that. In that county, we actually are recruiting two family physicians.

We are not just stopping in the area of the province in Digby where we've had retention issues for a decade. What we have organized is what we will need to care for those local people in that community. We have brought in two nurse practitioners; they started about four weeks ago. In the interim we have worked with the surrounding area family physicians who will come in and provide service. We know we have two physicians signed up who will start a year from now - they are in their final year - and we are working to get two more colleagues with them. We are doing interim strategies while we are recruiting. It is not easy to recruit any physician, you need several months to do that.

MR. HOUSTON: Thank you for that and I do want to pick up on something there - a couple of things. The first thing was that somebody working in the system told me that the doctor shortage in Pictou County is 4.1. So there are 4.1 vacancies, I guess you would use for Pictou County. You just mentioned that you are recruiting two physicians for that area, there's a disconnect between those two numbers. Is one of those numbers right? Do we need four and we are recruiting two, or what? Where are we on that?

MS. KNOX: Our evaluation of what we need to do at this point in time is two. I don't know who you were talking to or what . . .

MR. HOUSTON: So you're not familiar with the 4.1 number?

MS. KNOX: No.

MR. HOUSTON: Okay, so I guess maybe, Mr. Chairman, what we do is ask for the list of vacancies across the province. Maybe that's something that can be provided to the committee.

Now in terms of the collaborative model, you referenced the teams of physicians. In my understanding, in the collaborative model, that is the focus that we're moving to, the doctors are basically on salary. It's something called alternative fee arrangements, but it's a salary.

Now the Auditor General did a report where they looked at the number of physicians in the province on salary. They found a shockingly long list of physicians who

weren't meeting the terms of their contract - they weren't seeing enough patients. I'd like to ask Ms. Knox, are you familiar with the AG's Report on that? What steps has the Health Authority taken, because it speaks to the whole lack of accountability that has people in the system so frustrated. Have you taken concrete steps to oversee physicians on those arrangements?

MS. KNOX: First, I'd like to correct - the collaborative care teams do not require that the physician be on salary. The physician can be fee-for-service or on salary - that's a negotiation with the physician. Secondly, we are able to monitor the physician's - we'll get reports around what their billing looks like so their activity is monitored. If they don't meet their criteria in terms of what they should be for the salary they're getting, there is a strategy. They are met with, they discuss the strategy, and they have so much time to meet the goal.

It does require management of all professionals, including the physicians, so it's good information for the physicians as well. So yes, we do have an approach.

MR. HOUSTON: Before I go with that, you say you have the ability to do it, but presumably somebody is doing it. Can you give the committee an idea of over the last six months how many such physician meetings there have been?

MS. KNOX: No, I cannot tell you that. I don't know that.

MR. HOUSTON: Okay, because that's the point the Auditor General was making - nobody was checking or following up, there was no accountability on it.

MS. KNOX: The whole process is through the family practice department head in the zone.

MR. HOUSTON: Okay, maybe we'll come back to that, thank you. Before I leave the first round - Dr. Vaughan, you look lonely there, I did want to ask you about the code census at the IWK. There is a code census right now; when is the last time there was a code census at the IWK?

DR. VAUGHAN: We'd have to ask the IWK that; I don't have that.

MR. HOUSTON: It was in April. April is what I heard. It wasn't something that was made public at the time. Would it be? Should it be practice to make it public when there's a code census? Obviously this one was made public. The last one wasn't. What is the best practice there?

DR. VAUGHAN: The code census is a management approach to alerting staff to the issues around overcrowding in the emergency room. It's a management tactic to rally resources within the hospital, in this case the IWK, to look at all areas of care, what can be done to improve the flow through the hospital. Perhaps it's about discharging patients that

can perhaps be discharged that day to try to speed up the process. It's a management technique.

MR. HOUSTON: So you would think that it shouldn't be made public or it should be?

DR. VAUGHAN: I have no objection to this information being made public, but again, it's a management technique. The purpose of it is to allow the hospital itself to rally the appropriate resources to address the situation in the emergency . . .

MR. HOUSTON: Do you know how long that April code census lasted?

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

MR. HOUSTON: Three months it lasted. What percentage of the year is that unit under code census? Half the time? A quarter of the time?

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

MR. HOUSTON: That's something that I think is critical because when that unit is in code census, it's putting additional pressures on hospitals around the province. Are there any additional resources that go to hospitals or units around the province to help them cope with the fact that they've lost a resource to them, which is the IWK? Are there any additional resources right now being sent to a hospital like the Aberdeen?

DR. VAUGHAN: Let me be very clear if I haven't already been clear. This is a management technique to manage the flow through the hospital. Hospitals - no matter where they are, whether it's the IWK or any regional hospital - when they have an issue of crowding in the emergency room, as we often have at the different parts of the year with flu season et cetera, the hospital rallies its resources. I've been in those situations to do that personally in the emergency rooms, working with staff to try to improve the flow through the emergency room.

That is the signal. It's not the end of the story. It's only an alerting system. As a traffic light system allows you to stop and go, this allows staff to look at how we can better deploy through the flow discharges in the hospital.

MR. HOUSTON: But that traffic light is stopping people from access to care that they need. I guess my question is, if the people are being stopped at that traffic light, and they're being rerouted somewhere else, the rerouting is back to a unit that's understaffed to begin with. It's not a management technique; it's a people problem. It's a resource problem. I guess what I'm asking is how often do we have this resource problem, this people problem, and what steps do we take to fix it?

MR. CHAIRMAN: Order. I do apologize. Time has expired. We'll move to the NDP caucus and Mr. Wilson.

HON. DAVID WILSON: Thank you for coming today on quite an important component to providing care for Nova Scotians, I think, and that's the hospital system.

Of course, the AG's Report focused on the system capacity. I'm going to start off a little bit about that. Knowing what Ms. Knox had indicated, that Nova Scotians really want access close to home as much as possible, there is a reality that that doesn't always happen. There is, I think, an understanding with Nova Scotians that if the acuity level of their illness or injury or whatever they're dealing with is more serious, then they know the resources are here in Halifax through the IWK or through the QEII or the VG site.

I want to start with that need and the ability of our system to ensure that the capacity is there. I know through the audit, it was indicated that there are serious repairs needed, infrastructure funding and repairs to hospitals all across the province. I believe the figure was about $114 million was needed to maybe get our hospital system up to where it should be with all the repair, and there was about $29 million indicated that was available. So there is a huge gap, I think it was indicated through that audit.

Does the government have an inventory of the needs of the hospitals throughout Nova Scotia? If you do, is that something that is public? What are you doing to try to address those infrastructure needs? I know a lot of the attention is the QEII and the Centennial Building, but there are many smaller hospitals that need some support. So I'm wondering if you have an inventory and what you are doing to address the gaps that are seen with the funding envelope that's available on a yearly basis to the sheer magnitude of maybe $114 million, and that's not even addressing replacing the Centennial Building.

DR. VAUGHAN: It's an important question and let me start by saying that we are where we are with our infrastructure challenges in Nova Scotia today because over decades we have known that we've had challenges with the infrastructure needs of all of our communities and hospitals throughout the province. So there is nothing new that's happened over the past recent years - this is an issue that has been building over decades.

What we are doing today though is looking at all of the hospital needs across the province. We prioritize those needs and those needs are really built on the people who are working in those facilities, drawing to our attention what those needs are. So they prioritize those needs through the capital planning process. We prioritize those needs and the most urgent needs are dealt with first. Just like you would in prioritizing renovations in your home - you have to look at what you have to do today versus what you can do down the road.

Let's be clear, any emergency issues are dealt with right away. Our most important priority is safety - both safety of our clients and patients, as well as staff. So any safety

issues are dealt with immediately. The prioritization of what we can do over time is looked at on an annual basis, but as I said, any emergency issues are dealt with acutely.

MR. DAVID WILSON: I know through the audit and through the Auditor General, the indication and the statement - things need to be done differently. People can interpret that whatever way they want. The elephant in the room is that there is a possibility that maybe we don't need as many hospitals, maybe we don't need as many ERs. Maybe we should be looking at consolidation or divesting of our interest in infrastructure.

Has a decision like that been made through the government? Have you been given any directive yourself, deputy or Ms. Knox, from the government that we need to look at this and potentially there could be divesting of infrastructure - meaning closures of hospitals, reduction of services in communities across the province? Have you had that discussion and could you maybe give us an indication on where you're at with that?

DR. VAUGHAN: It's an important question for us to clarify. There are no plans to close hospitals. We need to plan for the future. We need to look at the needs for the next 50 years and everyone knows that health care is rapidly changing. Medicine is rapidly changing. What used to be done a number of years ago - even 10, 15, 20 years ago - with gall bladder surgery you were in hospital for seven to 10 days. That's a day procedure most of the time today.

There are many, many procedures that can be done on an outpatient ambulatory basis today. That is increasing in many, many areas of medicine. So as we look at our infrastructure needs across the province - and we thank the Auditor General for his comprehensive report - we will plan with Nova Scotians, as Ms. Knox has said, and look at what the needs are going to be for the communities going forward.

Minister Glavine has said that smaller facilities may be repurposed, but there is no one talking about closing, let's be very clear about that. Repurposing is really about better meeting the needs of the future. What was needed 50 years ago, frankly, isn't what's going to be needed today, let alone tomorrow. We have gotten to the situation we are today because we have not addressed the issues over the past 20 years, let's be frank about that.

MR. DAVID WILSON: Thank you for that and I think that we need to be frank when we talk about this so I'm glad you answered that question in the way you did.

When we hear terminology like "repurposing," does that mean reduction of services? As we know, Nova Scotians want to try to get services close to home. I understand fully the evolution of health care and how things are done differently now than 10 years ago, 15 years ago. Are you then looking at all the services in these hospitals and potentially moving them out of these smaller facilities, to maybe the regional hospitals or centralizing that to Halifax? Is that where your energy is right now? Is this repurposing goal to look at what services are where? Should we be moving those services to other locations?

DR. VAUGHAN: Thank you for the question; it's a very important question. The foundation of our future changes in health care really started with the consolidation of the Health Authority; the redesign of the department is really part of that, all founded in legislation. That is the foundation for the future direction of the delivery of health services.

There's great opportunity to enhance the services in regional hospitals in particular. In the smaller hospitals there's a great opportunity to now look at the needs of communities today and into tomorrow, based on evidence that we now have going forward, evidence of population need. So it's not just pulling ideas out of a hat, it's about evidence of population need. We know that many of our rural communities, and with aging populations, require different kinds of services than they did in the past.

In addition to that, quality of medical care is of utmost importance in our strategy. We all know there are services that are better done in tertiary care facilities with incredibly better outcomes. We also know and you know we have fabulous emergency health services. When my father died in Amherst in 1969 it was a funeral home ambulance that came to see him. He didn't survive. Today clot-busting drugs are delivered by advanced paramedics to your door.

The health care system is changing. We have not kept pace over the past 20 years in the design and delivery of the health care system. Now we have the foundation, we have to build it with Nova Scotians, based on evidence of need.

MR. DAVID WILSON: I would agree with some of what you said but I think we have kept pace in certain areas. We now have paramedics giving clot-busting drugs in homes. That's a change from 20 years ago. We have seen changes in health care that I think lead to better care for Nova Scotians.

I don't think that just because of an amalgamation of a district health authority that that's the start of this evolution. It has been happening and I've been part of that, fortunately, over a number of years.

The key when these changes happen is trying to ensure that Nova Scotians know what's going on. If they don't understand and they don't buy into these changes, government is going to run into roadblock after roadblock. I give an example of Collaborative Emergency Centres, when they were first brought to the communities there were those roadblocks. What I think helped take those down was the fact that the department and those involved in it went to those communities, engaged with community members, with leaders in the community - municipal, provincial, even federal - and engaged with people who use the system to try to educate them, to try to have that discussion.

To what level is the public engaged now with these changes we're seeing? I give an example of just recently we heard that in Glace Bay people will no longer be able to deliver there, have babies there, they're going to move them to the regional hospital. What

kind of engagement happened or discussion happened with the community so they could understand it? If you don't have that avenue we're going to continue to see people very angry, very upset, and picketing outside the Legislature. So what engagement component with the community are you putting in place so that people understand where we need to go in the next 10 or 15 years in health care delivery?

DR. VAUGHAN: Over the past 14 years in Glace Bay, for example, staff, doctors, and nurses were saying things need to change, there just isn't the sustainability. That's an evolutionary process. It didn't happen overnight. I think there were a lot of conversations over a number of years.

We are looking to engage Nova Scotians in a new and different way. I know the Health Authority has been out talking to many people across the province. They've had a lot of online feedback - Facebook and other mechanisms - to try to engage Nova Scotians in the conversation around where health services need to go.

Our overarching driving force is quality of health care and that means focusing on outcomes; that means focusing on services that deliver better value to citizens of Nova Scotia. That means we have to do things differently. Yes, change is difficult, but if we're going to expect to get different outcomes, we have to do things differently.

Again, the data speaks for itself. We spent among the highest in the province, and we have the most doctors and the worst outcomes. We have to do things differently - working with our clinician partners, working with Nova Scotians to plan for services in a rational way with a vision for Nova Scotia that has not been done before. The CEC work was excellent work, but its primary purpose was around addressing the needs of primary care, which we laud and continue to support, and that is exactly what we are doing and building, by the way, in a One Nova Scotia approach and not an ad hoc, isolated district health authority silo approach.

MR. DAVID WILSON: All I have to say on that is that, yes it's good, this online stuff and engagement in that way, but there's nothing more intimate than when you are face to face with people - when they have the ability to look you in the eye or the minister in the eye and say, I'm concerned for my family. Going online and engaging people would never have worked in Parrsboro when we decided we were going to put a CEC there. It really took that personal connection.

All I'm going to say is that I think the government needs to do a better job at ensuring that happens. You would be surprised at the buy-in you'll get if you can really have that connection with community members.

I want to go a little bit to the need here in Halifax, and that's the announcement back in April around the redesign of the QEII and the system of hospitals that we have, and the Centennial Building is part of that. It's great to hear the announcement, but there was

no real budgetary allotment in this year's current budget to facilitate putting it in high gear and moving forward. We know that is needed. We need to address that.

Are you concerned that was not part of the package in the budget? My concern along with that is the fact that we've heard from the federal government that they're not really in the game of funding hospitals like the replacement of the Centennial Building. I received a letter from the minister indicating that. So that really means that we need to step up our game in the province.

Has there been a request for this year - for the upcoming budget? I'm sure you're preparing the budgets now. Mr. Elliott is keeping busy, I'm sure, trying to get all the figures that are needed. Are you anticipating or is there a request that we need significant funding in this year's budget coming up to look at moving that project forward and putting it in high gear so that we can finally address the needs in the QEII system of facilities that we have?

DR. VAUGHAN: That is an important question to highlight the fact that we are doing things differently. In the past, people might have thought that the solution to the Centennial Building problem was to build another Centennial Building. For all the reasons I've talked about, how health care is rapidly changing - knowledge and medicine is doubling every 12 to 14 months today. That is a huge driving force. We are doing things differently, we need different kinds of facilities. That means the facilities of the past aren't what we need going forward necessarily.

As we look at the distributive model at the QEII site, the Dartmouth General which is under development right now is part of that; it's an important part of that. So when you look at the next piece of that puzzle, the Halifax Infirmary, the redevelopment of that is in process.

The importance of planning, as you know, and having built hospitals and other facilities, it's very important to know you do the planning first before you start projecting costs because that's the world we live in. We need to get very good at that. We have learned a lot from mistakes of the past in this province around just throwing out budget numbers without good planning, so we are doing the good planning.

Other pieces of the QEII also include distributive ambulatory care sites, other places outside of the metro core, again because of access to the patients who may be coming from other parts of the province. So it's not about a simple, monolithic approach, it's about a distributive approach. That is the modern way of planning for health care and we need to make sure we get the right amount of information to design and understand what the costs are at every stage. So it's not one big number, it's a staged approach.

MR. DAVID WILSON: It does take funding to do that. Can you give some kind of ballpark figure on a timeline on when we will see maybe upgrading of other facilities, for

example? I know that's in the mix here. Nobody is questioning the fact that we don't need to build another Centennial Building, I'm 100 per cent on board with that.

Really it comes down to bricks and mortar at times or renovation - I know the Dartmouth General is happening - but when would you see the next kind of big announcement or movement on improving the access to those services here in the Halifax area?

DR. VAUGHAN: As I said earlier, we plan on an annual basis, as you know. We look at the requirements, we have capital budgets and we are looking at what we need to do this year and we do that every single year.

MR. DAVID WILSON: I know I have one minute. I asked you about closing hospitals - what about closing Collaborative Emergency Centres? I know there has been some talk and rumours out there, so a very clear question, are you looking at closing Collaborative Emergency Centres after hours in the province?

DR. VAUGHAN: Thank you for the question. No, we are not looking to close Collaborative Emergency Centres for the reasons I talked about earlier. They were designed to do just primary care and that's important. We need to look at efficiencies perhaps, in terms of how they are being run, but that's an evolutionary process that we'll be having in conversations with communities going forward.

MR. CHAIRMAN: Thank you. We'll now move to Mr. Rankin of the Liberal caucus.

MR. IAIN RANKIN: I'm interested in the outcomes and the facts, not as much as the anecdotal statements about a supposed crisis because when I'm talking to health care providers in my area and throughout, they don't talk about a crisis. What they do talk about are challenges that have been there for decades. We do have a system, as was mentioned, that basically catered to institutions and to treat acute care. We have more and more chronic care because of our aging population. Because of that, I want to talk a little bit about home care and the direction the government is going in home care, what types of investments have been made.

It is important, not only financially, because of the cost of having someone in a hospital bed, but tying up that bed for someone who needs it in a hospital emergency room. Also, that's what the patient needs and is looking for. This has been talked about for at least 20 to 30 years. Governments were told back in the 1990s that we need investment in home care and that investment wasn't there; there was a financial hardship for the government. What kind of investments have been made in home care recently? Again, I'm looking for the outcomes, the performance indicators in this regard. What does the wait-list look like for home care and what has happened over the last year?

DR. VAUGHAN: I'll start and then I'll ask my colleague, Ruby Knowles, to give you the details of the home care wait-list. Let me first say that home care is an important part of our strategy for health care now and into the future. Government has invested, over the past two years, over $50 million in home care - over the past year alone over $14 million in additional home care resources. We are looking to enhance home care. We have worked diligently with home care providers to look at areas where efficiencies can be brought in to improve service so there isn't duplication, so there aren't multiple people coming into the home. These are all very important elements that are of concern to our individual clients.

I'll ask Ruby Knowles to address the question around wait time numbers.

MS. RUBY KNOWLES: The wait-list for home care is also related to the wait-list for long-term care. Maybe I can answer by just making the connection between those.

The last couple of years, we have spent a lot of time on trying to understand the pressure in hospitals. The AG Report that we're here talking about today talked about the pressure in hospital of people in hospitals waiting for nursing homes, for example. It used to be, 18 to 24 months ago, most people who entered long-term care came directly from hospital: over 50 per cent of the placements. Today, it's about one-quarter.

People are going home from hospital with home care services that they didn't have before. If they require nursing home care, then they are admitted to a nursing home from home. It's much better for the individual and for the family. That has resulted in less pressure in the hospitals.

What that has done is create significant pressure on home care. We did have a wait-list for home care that was significant in some areas of the province. For about the last 12 months or so, really through a combination of working with the service providers - we have about 25 home care service providers in Nova Scotia - the Nova Scotia Health Authority, ourselves, the staff who work in those organizations and their unions, we have been working on various strategies to reduce the wait-list for home support services. It's substantially reduced in many parts of the province; for example, in the northern part of the province, there's absolutely no wait-list for home support services. We get weekly reports on home care wait-lists, and in the last report from last week, there are 168 clients in Nova Scotia who are waiting for some home support services. I do make a distinction between home support and nursing in the home. There is no wait-list for home care nursing.

The link between home care and long-term care is this: when we support people at home, and you've already heard that's where people want to be supported and that's what they tell us, that actually reduces the demand for long-term care. The wait-list for long-term care, meaning nursing home level care in most regards, has decreased almost 50 per cent in the last 18 months.

MR. RANKIN: Thank you, that's a very thorough response. So both home care and long-term care wait-lists have gone down. What about wait-lists for surgeries in terms of the major surgeries that you hear people are waiting a significant time for? I'm just wondering about the progress on things like knees and hips and those types of day-to-day surgeries?

DR. VAUGHAN: Surgeries, in 2016-17 we have increased our activity in those areas. For hips and knees, the current reduction is 195 for hips, 640 for knees. For others there are virtually no challenges there.

We have been able to move patients around in some cases. I know that patients from the Valley have sometimes chosen, for surgery that doesn't necessarily have to be done in the Valley, like an orthopaedic case, but maybe a general surgery case, they may choose to go to Amherst, for example, to have their surgery faster. Patients are now choosing to go to different parts of the province, and so we're working on improving that as well.

MR. RANKIN: So it sounds like there is more coordination to achieve some of these outcomes. What about community-based care? I've heard earlier that was a strategy and not so much focusing on one doctor per one person, but access to a team of health care providers, whether it be nurse practitioners. Is this strategy translating into more collaborative care in communities? Can you actually pinpoint when this sort of pivot in terms of the strategy - when that strategy really started to take some fruition in terms of the funding and the implementation?

DR. VAUGHAN: The collaborative care approach started back in the early 1970s. We have the North End Community Health Centre, which is a fabulous example of collaborative care. Sometimes people forget about that, but that facility was started in the early 1970s.

We didn't really progress in Nova Scotia through the 1990s. Some previous governments did support various ad hoc approaches to the establishment of collaborative care. Many of those were driven by physicians themselves who saw that this is where care needs to go. Many would be familiar in the physician community of at least four randomized control trials - the gold standard of science, of outcome measurement in medicine, that show the outcome in quality care - better results, if you will - through collaborative practice. Physicians themselves have been championing the movement to quality care over several decades.

What we've had is very much a silo approach over the past 20-odd years with some districts. While I was at the South Shore district, every single community when I left had a collaborative care facility - whether it was Lunenburg, Bridgewater, Liverpool, Caledonia, et cetera. Chester is in development now as well. Almost every community has a collaborative practice. In other areas - the Valley, similarly - you had many collaborative practices. In other parts of the province, you didn't have any at all.

So now with a One Nova Scotia approach, we are rolling out more collaborative care across the province in a planned, rational way. You saw the announcement in Sydney. There are nurse practitioners in Digby. I met with them a couple of weeks ago - two young excellent nurse practitioners working with physicians. We will have announcements shortly, perhaps even as soon as today, in terms of further expansion of collaborative care.

MR. RANKIN: The audit actually did source that the hospital base care is not sustainable and services should be moved into community, so it is good to hear that progress. Are there any other thoughts on that in terms of what you attribute that success to? Does the amalgamation of the district health authorities showing the results that we're looking for?

DR. VAUGHAN: The consolidation is just a foundation. As important as that is, it's the enabler. We have to then put the walls up and the roof on and plumbing and wiring and all those other features that will develop a modern health care system. All the pieces that we've been talking about are important ingredients to that.

What Ms. Knox and her colleagues are doing - and our colleagues at the IWK are doing - are working together to consult Nova Scotians to develop a plan for the next 50 years that will include a foundation in primary health care. Access to primary health care is our most important objective going forward. It's about having the right resources available in communities so that people can access those resources when and where they need them. There is a lot of opportunity that we can learn from other jurisdictions, but we can also develop a made-in-Nova Scotia approach that other jurisdictions are looking at. We are seen across the country as one of the leaders in the country in the evolution of the health care system.

MR. RANKIN: That kind of strategy, is that part of the QEII development plan - instead of rebuilding everything downtown, bringing it further out into the community? I represent an area that is kind of the suburban part of HRM where there is no outpatient clinic nearby. Is that part of that strategy? Are we looking at areas where we can kind of bring the services out further into the community as part of that?

DR. VAUGHAN: Absolutely. We have seen many changes around us. We all have these little devices today. I remember when I went to university, we had super computers lined up with punch cards to do simple tasks. Now we have many advances around us. The health care system needs to advance as well, and we are planning for that advancement.

The distribution that we've talked about with the QEII redevelopment is very much a foundational piece. It is our specialty centre not only for Nova Scotia but for the Maritimes and in some cases Atlantic Canada. We need to have the specialized resources and the tools they need in the right place, to do the kinds of very intensive work that is not only being done today but is increasingly going to become more high-tech over the next number of years.

MR. RANKIN: Thank you very much.

MR. CHAIRMAN: Thank you, Mr. Rankin. We'll move to Mr. Stroink.

MR. JOACHIM STROINK: Thank you very much for your presentation and coming here today. I guess I kind of want to go - you mentioned that collaborative care kind of started back in the 1970s. I'm fast forwarding to where we are today. There has to be an unbelievable amount of research being done on collaborative care, because we wouldn't be investing millions of dollars into collaborative care if we didn't think it would work. Based on that research and scientific research, can you share some of that with us so people can understand that there is science behind this?

DR. VAUGHAN: Sure, thank you for the question. As I think I mentioned earlier, there are at least four randomized control trials - the gold standard research methodology that allows us to then generalize from that research in broad ways and with confidence know that that kind of planning will also occur in other settings. That means that when we're looking at that rapid pace of knowledge growth in medicine and health care, that we have the advantages of bringing a number of different kinds of practitioners into that one stop, if you will.

There are many cases and many examples where many people don't always need to see a family doctor for that particular appointment. They may be able to see a family practice nurse or maybe they want to see a dietitian, because those are real challenges we face in Nova Scotia. They may need to see a social worker for their immediate mental health needs. Over and over again, the research tells us that mental health resources available in the primary care setting is what we need to be doing to have better outcomes, rather than perhaps waiting to see a specialist.

Specialists are important, obviously, but they might not necessarily be the answer to every single person who has mild to moderate anxiety or depression, for example. There is good research evidence around the tools that we can use. I'm talking about these tools that we have around us today to improve access to services. Sometimes it's a prescription renewal. Nova Scotia is the first jurisdiction in Canada now that has negotiated non face-to-face payments for physicians, which allow us to start to modernize the health care system to access care in a way that people need it and when they need it.

We have a fabulous mental health program for children and adolescents, called Stronger Families, the rest of the country looks to us as the leader in this regard. That's again about access. So families and patients can access information through that 19th Century technology called the telephone, who can use that resource to actually improve access to care when and where they need it. These are the kinds of things we are doing and will continue to do to improve the quality of care and access to care in the province.

MR. STROINK: Great, thank you. I guess we often hear so much negativity on that and partly it's that members are fighting for their constituents and they have every right to

do that and I commend them for doing. But also there's a lot of good news out there and there is a lot of good stuff happening in Pictou, as an example. Maybe if you could share some of the reduced home care times in Pictou, what else is happening in Pictou that shows that community is getting the support they need?

DR. VAUGHAN: Thank you for the question. I was there on Sunday in the fabulous County of Pictou, in New Glasgow. I know the work that many of the clinicians do there is excellent work, they work very hard. We're developing a $32 million new emergency room in New Glasgow. That is an important commitment to improve emergency services. Remember that emergency services are a network, as we talked about, building on the foundations of the integration of the ambulance service 20 years ago. We now have the ability to lay on top of that an integrated acute care, an integrated primary care, an integrated long-term care sector. These are the goals. These are what we are working on.

The home care wait-list in Pictou had been eliminated. These are important milestones that are tangible and meaningful for people. Do we have more to do? Absolutely. Will it ever be done? Never, because that is the nature of health care, talking about the needs of people, talking about the rapid evolution of technological change in health care. We have to continue to improve. That is what has been our driving force in all of our efforts for consolidation and redesign of the Department of Health and Wellness. We've taken close to $49 million, or a little bit more than that actually, from the department to put it into the Health Authority to improve front-line care. That's our commitment: to improve resources to the front line.

MR. STROINK: I guess part of that commitment, and you spoke to it earlier today, is on the preventive health care system. We do have a major issue, and I think the collaborative care model will help with the education of teaching people how to eat properly, that pop is not the go-to drink; it's water. Those are things that need to be discussed within Nova Scotia to help with diabetes and stuff like that. I guess my understanding with the collaborative care model, with the nutritionists in there and social workers, is that that pressure is not going to go on to the family doctor. I think that's so key for Nova Scotians to understand that.

DR. VAUGHAN: Thank you for that; I'm hearing a question in there. I think it's important for everyone to understand that in the past there was only the family doctor. As important as family doctors are, believe me, today we have many more resources, everything from nurse practitioners to social workers and dietitians and others in between. These are the issues that people need to have access to and have the appropriate care at that right time in those facilities. It's about how we change the delivery of health care. It doesn't happen overnight. We're in that period of change in many, many aspects of our modern lives, and health care needs to change. We haven't changed fast enough, in my view, in the past. We are now making significant change. You know what? I'm glad people are talking about health care.

[10:12 a.m. Mr. Iain Rankin took the Chair.]

MR. STROINK: I guess that's what I also wanted to touch on. We went through this with emergency medicine numerous years ago, and now we have one of the best emergency medicine programs in Canada because of the hard work and dedication from departments like yours and the hard decisions that were made - seeing that hard work works, that this collaborative care model is going to work, and we're going to get there, and we're going to build a great Nova Scotia on this model.

I just want to go back to the preventive health care because I think that's also key. It's not just in the Department of Health and Wellness, and it's not just in emergency rooms or Collaborative Emergency Centres. It's in other places, education and stuff like that. I guess I want to understand where the Department of Health and Wellness and the Department of Education and Early Childhood Development are working in those areas to work on preventive health.

DR. VAUGHAN: We have a SchoolsPlus program . . .

MR. CHAIRMAN: Order. Time has elapsed for the Liberal caucus. We'll move back to the PC caucus for 12 minutes. Mr. Houston.

MR. HOUSTON: I just want to come back to the code census at the IWK. This week the minister attributed the need for that code census to back-to-school pressure. Is that the official position of the department, that that code was necessitated by back-to-school stress?

DR. VAUGHAN: It's possible. That code census lasted less than 24 hours at the IWK. I've been in this business a long time, and we do see seasonal stress and strains. It's not uncommon, when school starts, that there are increased challenges, and as I said, in flu seasons. It's not uncommon to have those kinds of things. Can I say definitively? No. There are probably a number of variables, but that's probably one of them.

MR. HOUSTON: It struck me as a little insensitive to kind of try to boil it down to something simple like that. I guess we can leave that.

In the interest of time, I do want to go to Ms. Knox. Ms. Knox, you referred to the budgeting process for the new Health Authority as recouping, I guess, $70 million of what was forecasted shortcomings. Is that $70 million of savings that you found in this budget? Is that the way you would describe it?

MS. KNOX: Thank you for that question. When we began as the Nova Scotia Health Authority we had $70 million worth of challenges so perhaps cost pressures that were not funded, and the previous 9 health authorities contributed a $29 million deficit. So as we roll over the next day to the new Health Authority, they had spent $29 million that they didn't have in their budget. We had to find a way to continue with services and not

spend $29 million-plus, the additional $41 million was the cost of oil and all those kinds of things.

I can honestly say that our process really was, in terms of how you look at efficient use of your resources, best practices in terms of management of resources. That was the combination - new pressures and a rollover of a deficit from the previous . . .

MR. HOUSTON: So the $29 million, $41 million, $70 million - I think one of the things I find frustrating is, the shells are moving around a lot. I think it was last week that there was a budget update and the minister said that there was $1.9 million in the Department of Health and Wellness because that was transferred to the Health Authority. The Health Authority is part of the department. There's so many numbers moved around and it's not productive.

I'll ask you again very clearly, did the new Health Authority save $70 million?

MS. KNOX: Yes, we did. I guess that's the way to say it, yes we did. If we had not changed our strategy, we would have spent $70 million more.

MR. HOUSTON: Okay, the not changing of the strategy is kind of where I want to focus because when many people thought about the amalgamation of the health authorities, they thought about a consolidation of administrative services. I think what has taken many Nova Scotians aback - they have been surprised by the speed of the consolidation, not just of administrative services but of medical services. Like they're not going to sterilize surgical instruments at the Aberdeen any more, they're going to move that to Truro. There's talk of moving weekend surgeries there and this is happening all across the province.

On this $70 million of savings that you've identified, do you have any sense as to how that - how much of that was true inefficiency and how much of that is from structural change to how health care is delivered?

MS. KNOX: Thank you for the question and I'd like to clarify a couple of things as well in what you said. The MDR in the Aberdeen Hospital needed to be moved because of issues with the facility, so we had to move the processing of equipment. That was an unplanned event. What we will commit to the people of this province is, we have to have quality and safety of services. We could not guarantee that we could safely sterilize equipment in that facility, so we had to find a place and the nearest place we could move quickly was to Truro.

All the same surgeries are happening at the Aberdeen. I think that's significant, to make sure the people understand that. We're able to support the program. It's scary for people when we see changes because they make assumptions but that's the cold, hard truth on that one.

For several years the previous 10 authorities - that includes the IWK - were working with the Department of Health and Wellness. We had been working for several years on what we called merged services, in terms of our corporate services. As we entered into the Nova Scotia Health Authority last year, we already had the plans for what would human resource support look like to support the nine organizations, what would a financial department look like . . .

MR. HOUSTON: Those are administrative services.

MS. KNOX: Yes.

MR. HOUSTON: But I guess the question was, what are the savings from administrative services? Much of the other savings, or cost avoidances, are coming from changes to medical services.

I'll ask a specific question just in the interest of time. How much in administrative savings have you realized from your consolidation of HR and finance or those types of administrative services, do you have a number for savings from the consolidation of administrative services?

MS. KNOX: We do have a breakdown of the different areas where we found savings so we can provide that for you. That would have been our budget plan that we had for the first year . . .

MR. HOUSTON: Is it a number you can share with us today?

MS. KNOX: I might give you the wrong number; it's divided out over about six areas . . .

MR. HOUSTON: Is it in the tens of millions?

MS. KNOX: In terms of administrative savings? Yes, the majority would be administrative savings . . .

MR. HOUSTON: It's over $10 million in administrative savings . . .

MS. KNOX: For instance, we had a 17 per cent reduction in overtime. When we pay people overtime, we pay them double. How did we do that? We worked with our managers to help them understand how best to bring staff to work and plan for the workforce. We didn't reduce services. Our reduction in the cost of the expenditure was not to reduce services. Our board chair describes it as hygiene measures from a management perspective . . .

MR. HOUSTON: I think that will be perceived as a greying of things because there's certainly lots of people who think there are services that were reduced with those

types of things. Certainly the nurses probably feel that those types of scheduling things may have saved you money but have been a reduction of services.

There's no real number today - it will be provided in the future, I guess - for savings from administrative purposes, purely administrative, finance, HR, these types of things. That's not a number that you have top of hand today?

MS. KNOX: We absolutely can provide that number.

MR. HOUSTON: But not today.

MS. KNOX: I came today to talk about different things, but yes, we can.

MR. HOUSTON: I do want to talk about the concept of savings in health care. The thing that's difficult for me to get my head around is the $70 million savings but changes to services, huge infrastructure spending deficiencies. I think, by the numbers that were presented, there was $85 million in infrastructure spending deficiencies for this year. That doesn't even speak to the types of infrastructure maintenance and things going forward. So it's hard for me to get my head around the fact that there has been $70 million in savings but there's all of these things that are just - I'm going to say being ignored. I'm going to use the word "ignored."

Do you see the disconnect that Nova Scotians feel when they hear those types of numbers? They hear the $70 million of savings, but they know that they're trying to access a health care system - whether it's mental health or whether it's a family doctor - that's not available to meet their needs. Do you feel that sense of frustration that they have when they hear on the news that there's $70 million of savings? Do you understand how that would frustrate Nova Scotians?

MS. KNOX: I think you're asking me if I know how Nova Scotians feel. I won't speak for them on that note at all. But I can say what I do hear from Nova Scotians is that they want access to services in their local community, and they want support to have a different outcome for their health and their families. That's what I hear from them. What we're trying to do here is to use our resources in a way that we can focus on outcomes for the community.

Part of our work in coming together as the Nova Scotia Health Authority was to grapple with the challenges of different ways of managing a system around the province. Our work in the first year was to bring together the nine organizations and put some rigour around how we use resources. In that course, we have had some great experiences with some of our folks in terms of really understanding one organization, one huge facility, really talking about paying attention to who came through their doors and how they really needed to look at the work they were doing and reorient it over the course of several months, reorient how we receive Nova Scotians in that facility . . .

MR. HOUSTON: So time is passing by; it has been a year, I think, now. When can Nova Scotians expect to see some real - if everything is happening behind the scenes, consolidations, these things are not in the view of the public. What's in the view of the public is a system that's not meeting their needs. When can they expect to see real changes to the system that will meet their needs?

MS. KNOX: In this current year, we are enhancing collaborative care. The deputy mentioned that we will be having a focus in the very near future in terms of more collaborative care. That will be very visible to the people of this province. We know the areas in the four zones that are of the greatest need because we have done all the background work in terms of who the people are, what access to services they currently have. In each of the zones, what the hot spots are or the areas where we need to focus collaborative care on. The next steps we'll be working with the practitioners in those areas. Nova Scotians will see that.

I would just remind you respectfully that this is not a new issue that we have. This did not just happen April 1, 2015. All of these issues for the health system of Nova Scotia have been growing over time.

MR. CHAIRMAN: Order, the time has elapsed and we have to move over to the NDP caucus - Ms. Zann.

MS LENORE ZANN: Thank you, and I'm going to try to move pretty quickly through this and if I could get some shorter answers it would be great because I have a number of questions and I only have 12 minutes.

I noticed that there seems to be a significant gap in infrastructure spending when it's concerned about safety, but the government has really underspent the hospital infrastructure budget by $27 million and in this year the budget for hospital infrastructure was actually cut by $8 million. So across the government's last three budgets there has been approximately $146 million budgeted for hospital infrastructure, but only $72.6 million spent. So if urgent infrastructure repairs are required, could one of you please answer why haven't we seen attempts to actually address that funding gap?

DR. VAUGHAN: I'll take that. As I said earlier, we look at an annual list of capital requirements that are driven really from folks who are on the ground and see what those issues are. I think the Auditor General has pointed out rightly that we need to plan for going forward. We do look at every issue that comes forward, we prioritize those, and any emergency issues that need to be addressed immediately are addressed immediately.

I think the Auditor General very articulately outlined that it doesn't make a lot of sense just to spend a lot of money to deal with those challenges all at once when we really need to be planning for the future of the delivery system for the next 50 years, not the last 50 years. That is exactly what we are doing. When we plan our capital projects you can't spend all the money all at once, as I said earlier. You need to do the appropriate design so

we know the exact costing of facilities, and that's exactly what we're doing. So sometimes you don't spend all that money in that year because you're in development of design.

MS. ZANN: I also noticed that the presentation included in our research in the briefing says that P3 funding will be considered as an option for the QEII development. A recent report, as you may know, by the Canadian Centre for Policy Alternatives Nova Scotia concluded that the P3 schools program in Nova Scotia was a failure and P3s haven't fulfilled the promise of reduced costs. In fact, we've seen companies reap significant benefits. In one instance, two developers I believe in Cape Breton saw a profit of $52 million over the length of the lease for property management services there.

Then I noticed in September 2014 there was a report about P3s prepared for the Premier's Office - actually by you, Dr. Vaughan. That report states that private financiers provided only $66 million for the Cobequid Pass, which was a P3 project, while highway users have paid more than $300 million in tolls. So given that experience and the experience we've had with P3s here in the province, why would the government still be considering this as an option?

DR. VAUGHAN: It's a great question actually. P3s are a methodology of funding. That's all that is. I can't speak to the schools or other initiatives of the past, but it very much depends on how they're structured. It is a methodology that is used right across the country in many places very successfully. So that's the background to the P3 - it's used in many places.

The lessons that we've learned - not only in Nova Scotia, but in other jurisdictions - it is incumbent upon us to at least consider what those costs might be, what that methodology might look like.

It in no way implies at all that any decisions have been made around incorporating or using that methodology in the QEII redevelopment. However, as I said, it would be remiss of us not to even look at or consider that possibility.

MS. ZANN: So are you saying then that that is definitely one of the major ideas that you are considering for that particular project?

DR. VAUGHAN: Let me make it clear - it is not the prime methodology that is being considered, frankly because the QEII redevelopment is a hybrid; you have a facility and you have an expansion of a facility. That may or may not be the right approach, given that scenario. We wouldn't probably put a lot of weight on that analysis but I think it's incumbent on us to look at all options, but it is not the driving motivation.

MS. ZANN: Thank you. The AG's Report recommends that the department and the Health Authority communicate with Nova Scotians about what level of service to expect in communities across the province. Access to health services often relies on a patient's ability to move from one end of the province to the other. We've seen this already with

mental health patients being forced to drive from New Glasgow to Yarmouth for treatment and so forth. We've seen it also in the recent decision to stop providing labour and delivery service in Glace Bay.

The system will have serious impacts on rural Nova Scotians and I represent a lot of rural Nova Scotians - even though we're close to Halifax, still a lot of us are rural and many of these people are actually struggling to make ends meet. What is the department's or the Health Authority's plan to support patients who will experience increased transportation costs to access health services in Nova Scotia?

DR. VAUGHAN: It's important for us to understand that all the changes we are looking at, in consultation with Nova Scotians going forward - let me make it very clear, there isn't some secret plan that people haven't seen. It's about where do we want to go.

In the past we have, as George Harrison said, if you don't know where you're going, any road will take you there. We are looking to have a destination and that destination is about quality of medical services.

MS. ZANN: Thank you, but I don't understand the answer there. Are you going to pay for it to get these people back and forth to the different medical appointments they need to get to? I'm hearing from people they are struggling.

DR. VAUGHAN: I'm coming to that. So that's our overarching approach. When we look at where facilities are located, we need to focus on the quality of the services that are available and not all services - specialty services, people understand that, need to be clustered in areas where you have expertise.

The issue of transportation in rural Nova Scotia is an issue that is similar around the world and it is not just a health issue, it impacts many other areas of government. Government is looking at those challenges around transportation, but it's not just a health issue.

MS. ZANN: Okay, thank you. One of the other findings from the Auditor General's Report is that overcrowding in the emergency department often results from issues elsewhere. Issues such as a lack of access to family doctors and inability to move patients quickly from the emergency room to appropriate levels of care.

Over the past two years the government has cut $7 million from long-term care facilities and has not opened up a single new nursing home bed. Since the government has come into office we have seen wait-lists for nursing home placements rise by over 23 per cent. I'm hearing from many constituents with great concerns about their loved ones, their parents, husbands and wives, who are on two- or three-year waiting lists and many who are being sent far away from where they live and they are finding it very difficult to go visit them every day.

How is this crisis in long-term care affecting our ability to effectively manage capacity within the hospital system?

DR. VAUGHAN: First of all, our home care wait-list is down by almost 50 per cent since March 2015.

MS. ZANN: I said long-term care, sorry.

DR. VAUGHAN: In the long-term care.

MS. ZANN: Okay, I thought you said home care.

DR. VAUGHAN: Long-term care. We have increased capacity in home care. It requires investment, as we are, in primary health care and that's exactly what we're doing - when we're talking about collaborative health care, it's to build that capacity which didn't exist and hasn't existed, except for sporadic ad hoc ways across the province. We're building on that in a One Nova Scotia approach. That will be part of the solution to the emergency room, as the Auditor General was alluding to.

MS. ZANN: Thank you very much. Also, when it comes to home care, which I know that Ms. Knowles, I believe, mentioned earlier, I have to say there is a problem there with home care because many people are finding they are not qualifying for it and they are saying it is almost impossible to qualify for it.

So you have people who have dementia, for instance, but can still dress themselves and they are being turned down. You have people who can feed themselves but they are having problems, they can't move, they can't get around and their husband or wife is not able to access any money from the department. That actually is a growing concern and I would suggest that's an area that really needs to be looked into.

In 2013, I know the Liberals said they would ensure a doctor for every Nova Scotian. Obviously we all know the doctor shortage has worsened. It's more than three years later now and the cover story in New Glasgow on Monday said that doctor shortages topped the list of health care concerns.

The AG Report is clear that this has an impact across the health care system. I also noticed that there is a funding cut to the department that does research on influenzas and different types of diseases, infectious diseases, so how are you dealing with that particular issue as well?

MR. CHAIRMAN: Dr. Vaughan, you have 30 seconds.

DR. VAUGHAN: We've allocated resources to the front line of the Nova Scotia Health Authority and they are the ones who are doing that work where it actually has an impact.

MS. ZANN: And what about the infectious diseases?

DR. VAUGHAN: That's what I'm talking about.

MS. ZANN: So you cut funding to the specialists?

DR. VAUGHAN: We haven't cut funding at all. We transferred resources to the appropriate place, which is the Health Authority.

MS. ZANN: Also, when do you expect to have met the goal of ensuring that there is a doctor for every Nova Scotian?

MR. CHAIRMAN: Order, time has elapsed for the NDP caucus. We will now move back to the Liberal caucus for 12 minutes. Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Dr. Vaughan, would you like to continue what you were saying about the Department of Health and Wellness and Education and Early Childhood Development working co-operatively together for healthier Nova Scotians?

DR. VAUGHAN: Yes, thank you for that question. So I think the SchoolsPlus program is probably the flagship program across many schools across the province. That allows young people to access where they are, when they need the important health care resources and often there are mental health resources that they are coming forward with. That allows them to get access right away - they don't have to wait, they don't have to go and see somebody else. Those resources are a great success to improve access to health services for young people.

MS. LOHNES-CROFT: Access to primary care is an issue in Nova Scotia. Was there ever a study done in Nova Scotia to look into the doctor shortage?

DR. VAUGHAN: Nova Scotia was, I think, one of the first jurisdictions if not the first jurisdiction in Canada to do a physician resource plan, that is looking at the needs of Nova Scotians in a number of specialties, not just family medicine - a number of health specialties, medical specialties going forward. That database is constantly updated and it gives us projections around the needs going forward.

Some of the planning that was done, the early planning that was done for the health workforce, was done in 2005 and 2006. At that time there was no action in terms of the needs that were coming down the road. We knew at that time, 10 years ago or more, that a number of physicians were going to be retiring because of the age of the physician workforce. It is only recently that we actually implemented in a province-wide, One Nova Scotia way, the collaborative practice approach, which is actually what was recommended over a decade ago.

MS. LOHNES-CROFT: What is the current situation with recruitment for primary care doctors here in Nova Scotia?

DR. VAUGHAN: Recruitment of physicians is a complex community event. I've been dealing with physician recruitment for close to 30 years. We're always going to be recruiting physicians. There's never going to be a day when we're not recruiting physicians. People are always deciding to leave for family or professional reasons. They're always moving around. They're always deciding to go back to school and do other things. We're always recruiting physicians.

One of the things that we strongly recommend is that communities be involved in the recruitment of physicians because it's not just a physician that you're recruiting. You have to recruit the partners. You have to appeal to students and children. It's a complex multi-pronged approach. It's not just about money. Money will get them; it won't keep them. We've seen that many, many times across the province. People will come on board for a certain period of time, and they'll leave three years later. When we ask people why they're leaving, in many cases it's because they have family elsewhere, or they are seeking other professional opportunities in other provinces sometimes. But often it's because their families are looking to have different lifestyle experiences.

So it's very important not just that we have a doctor in the community but also that we have the right kind of physician in the community who meets the needs and who wants to stay in those communities. To be honest, we live in a very mobile world. People do move around, and we're always going to have the influx. It's very rare for people now to take a job for 30 years, and physicians are no different in that regard. Young people today go into health careers because they do have mobility. They want different kinds of experiences.

We want physicians to come to Nova Scotia. We know that what attracts physicians to practice is collaborative practice. That's how they're trained. That's the kind of practice they want. When I was on the South Shore, I couldn't get a doctor for eight years in solo practice at all, which is the reason we developed the collaborative practice in Bridgewater. We have physicians who want to work there today.

MS. LOHNES-CROFT: I've heard from some groups who have been hopeful to get a doctor, and the wait has been so long they've gone somewhere else or they got picked up by another practice. Can you address that? There seems to be a long wait to get approval from the Health Authority to hire physicians.

DR. VAUGHAN: I can recall under the previous health authority structure, it took me nine months to get a doctor approved. We have not changed the notion that the department approves the appointment or recruitment of physicians. What we have changed, though, is the process. We've streamlined that process so now the Health Authority does that work. It doesn't have to be approved by the deputy minister, which is how it used to be under the previous health authorities.

This is not a new phenomenon. What we have done is streamline it under the new structure so that now it should take around two to three weeks in that process. We're constantly trying to make that better. We're not happy with three weeks, and we're constantly trying to make it better. Janet Knox and her team are doing that.

MS. LOHNES-CROFT: Is having more collaborative practices available helping with recruiting?

DR. VAUGHAN: Absolutely, because as I said, younger doctors who are coming out, that's how they've been trained, that's what they know, and that's how they want to practise. They're not interested, by and large, in going and setting up a solo practice. As I said, I couldn't get one doctor in eight years to do that. They want collaborative practice. They'll come and say, we love the area. Show me your collaborative practice, and then I'll come. That's what we're doing across the province in a systematic way because we know where we need to go. Thank you to the Auditor General for laying out that very important analysis. We now have a vision, and we're developing a plan.

MS. LOHNES-CROFT: I'd like to move on to long-term care. Has our government invested any money into long-term care? I get the sense that there haven't been any investments? Have there been?

DR. VAUGHAN: We invest over $500 million in long-term care facilities. We continually have invested over and over again, year by year but we know that people want to stay in their homes. We know that actually people do better when they stay in their homes, for a whole lot of reasons. So like many other provinces, we are investing in home care, which is the appropriate place to put the resource going forward.

MS. LOHNES-CROFT: The 811 service is fairly new. I've used it as a resource, especially when I'm here in the city because I don't always know what's available for health care. Has that helped with lessening the numbers in emergency rooms or is it working?

DR. VAUGHAN: Thank you for the question. The 811 service is a resource - I think it's an early resource, in my view. It's a telephone kind of resource and I think we will look at evolving that to other platforms and technology because it's really about people having access to good information about their condition.

Many people will use 811 to make a decision about well, do I really need to go to an emergency room? They get good advice. They sometimes get advice that says, do you know what, we need to transfer you to 911 and get directly to the hospital. So it's kind of a nurse triage tool - they get really good information. It's hard to say that it saves money by not having people go to emergency rooms. I think that's really not the metric that we would argue is the benefit of 811. It is really about having good information, having access to a nurse.

Often it's young mothers with sick children when they get home and giving them some good information that may include going to see the family doctor the next day, or into a collaborative practice, see a nurse practitioner. There are many options and many resources. The key with 811 is they have all that information at their fingertips and they can directly triage people appropriately.

MS. LOHNES-CROFT: I'm going to pass it on to my colleague.

MR. CHAIRMAN: Mr. Maguire.

MR. BRENDAN MAGUIRE: A minute and 30 seconds, let's do this. I just want to quickly ask you about investments in home care - how much has been invested, why this is important, and how are the wait times now when it comes to home care?

DR. VAUGHAN: Thank you for the question. We have invested over $14 million last year alone, over $50 million over the past two years in home care. This is an area of priority for government and will continue to be a priority, I am sure.

MR. MAGUIRE: Can you just quickly let me know about the foot and ankle surgeries and where we are at shortening the wait-lists?

DR. VAUGHAN: We recently have recruited another ankle surgeon, I believe started in July. Janet Knox, my colleague, may know exactly when that occurred. We are doing very well in our hip and ankle surgery wait times. We've done an additional 675 cases of so-called long-waiters in 2015-16 and we have completed many cases at the end of the second quarter of the last year.

MR. MAGUIRE: We continuously hear the Opposition say that health care funding has been slashed. We heard the number $70 million, yet you are here telling us that wait times are going down. How is this happening? What kind of impact is the savings within the Health Authority having on front-line services?

DR. VAUGHAN: We are directing all those resources, including the over-$40 million from the redesign of the Health Authority.

MR. CHAIRMAN: Order, questioning time has elapsed for the Liberal caucus. You could actually continue on, if you'd like, to provide your closing remarks.

DR. VAUGHAN: Thank you, Mr. Chairman. I want to thank the committee for the opportunity to be with you today and to address some of the important questions that face us as a province. We spoke to you today of some of the successful outcomes we have achieved in nearly 18 months since the establishment of the Nova Scotia Health Authority.

While we celebrate our progress, I can assure you that we are all well aware that a great deal remains to be done. We are doing things differently to ensure Nova Scotians are

better connected to the care they need. That means putting more resources into health program services even as we realize efficiencies and savings. The decisions we make are not always easy. They involve changing a system that needs to be changed and institutions people are familiar with. That is often very difficult.

The Auditor General has challenged us to recognize that the old ways of doing things are no longer sustainable, and we agree. He expects us to make tough decisions and tough choices, and we are committed to doing so based on sound evidence and supported by open communication. We are working responsibly to make the needed investments within a sound fiscal framework to protect the health and safety of Nova Scotians and to better connect them to the care they need.

In conclusion, and on behalf of Minister Glavine and everyone at the Department of Health and Wellness, I want to say to you that those who work tirelessly to protect the health and well-being of Nova Scotians are committed to change. Thousands of physicians, clinicians, administrators, staff members, and volunteers serve patients every day. It is for them that we do what we do. Merci beaucoup. Thank you.

MR. CHAIRMAN: Thank you, Dr. Vaughan. Do any other witnesses want to say anything? Okay, thank you very much.

We're going to move on to committee business. We just have one item, the endorsement of the Auditor General recommendations from the June 2016 Report. The committee has a practice of formally accepting and endorsing the Auditor General recommendations that departments have accepted. The recommendations contained in the June 2016 Auditor General Report were provided to the members for review. So I'd like to ask for a motion in this regard with respect to the recommendations in the report.

Ms. Lohnes-Croft.

MS. LOHNES-CROFT: I move that the Public Accounts Committee formally accept and endorse the recommendations contained in the 2016 Auditor General's Report and ask that the departments and agencies commit and take responsibility for full and timely implementation of those recommendations that they have accepted.

MR. CHAIRMAN: There is a motion on the floor. Any comments? Mr. Houston.

MR. HOUSTON: With respect to the Auditor General's Office, I would say that 99.9 per cent of the time, I would have no issue endorsing his recommendations. But in this case there is a recommendation in there that I have a little reservation with. It's Recommendation 2.2, "The Department of Health and Wellness and the Nova Scotia Health Authority should review hospitals located close to each other to assess whether this is the most efficient and effective approach to providing health care for Nova Scotians."

To me, that speaks directly to the number of hospitals we have, and I do think that is an area where the government should be making the decisions. While members of the committee might be in favour of closing hospitals, I'm not so certain today that I would sit here and say that this committee should be making that recommendation to the department. I would say that personally, I have a reservation with that specific recommendation. I do think that that is a decision that should be in the hands of the government as opposed to this committee or even the Auditor General's Office, with respect. That would be my comments on that.

MR. CHAIRMAN: Thank you for your comments. Mr. Porter.

MR. CHUCK PORTER: Let me be clear on behalf of this caucus, let me be very clear. I don't know where Mr. Houston reaches into that report and talks about closing hospitals, but let me be clear: this caucus does not support the closure of any hospitals. We do support, however, the Auditor General's work in this province, as he has done and works with each and every government department as we have all the way along and will continue to do going forward.

Playing politics in this committee is something I thought we put aside a long time ago, given that I've sat on it for more than eight years now. This is about the people of Nova Scotia doing the right things. That's why we have an Auditor General in this province, to look back and make these recommendations.

We put a lot of support and faith in what the Auditor General does and brings forward to this committee - not 99 per cent of the time, but 100 per cent of the time. Hence the reason we've made the motion this morning to move forward with those recommendations and accept them in full.

Again, for the record and for Hansard, I'm going to be clear, this caucus does not favour closing hospitals.

MR. CHAIRMAN: Thank you for the comments. Any other members before we have the vote? Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

The next meeting date is October 5th and it's the Department of Seniors regarding senior safety grants. If there is no other business, the meeting is adjourned. Thank you.

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