HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, March 8, 2017

Legislative Chamber

Department of Health and Wellness/Nova Scotia Health Authority
Physician Services

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Public Accounts Committee

Mr. Allan MacMaster, Chairman
Mr. Iain Rankin, Vice-Chairman
Mr. Chuck Porter
Ms. Suzanne Lohnes-Croft
Mr. Brendan Maguire
Mr. Joachim Stroink
Mr. Tim Houston
Hon. David Wilson
Ms. Lenore Zann

[Mr. Bill Horne replaced Mr. Chuck Porter]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Nicole Arsenault
Assistant Clerk, Office of the Speaker

Mr. Terry Spicer
Deputy Auditor General

WITNESSES

Department of Health and Wellness

Ms. Denise Perret, Deputy Minister
Mr. David Bartol, Senior Executive Director, Corporate Services & Asset Management
Ms. Victoria Goldring, Executive Director, Health Human Resources & Supply Management
Mr. Kevin Elliott, Chief Financial Officer, Finance and Treasury Board/ Health and Wellness

Nova Scotia Health Authority

Ms. Janet Knox, President and CEO
Ms. Tricia Cochrane, VP, Integrated Health Services, Primary Care & Population Health
Dr. Lynne Harrigan, VP, Medicine & Integrated Health Services

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, MARCH 8, 2017

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Good morning, I call this meeting of the Public Accounts Committee to order. This morning we'll be talking about physician services. We have with us the Department of Health and Wellness and also the Nova Scotia Health Authority. Just a reminder to everyone to ensure that your phones are on silent so we don't have interruptions.

We'll start with introductions, beginning with Ms. Lohnes-Croft.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: We have lots of people here today. We have two offices with us and I'm not sure who wishes to go first but there's an opportunity for opening comments.

We'll start with the Deputy Minister of Health and Wellness, Ms. Perret.

MS. DENISE PERRET: Thank you very much for the invitation to be here. I think the topic of physician services, and more specifically access to physician services, is an important one so we really appreciate this forum and the opportunity to address the questions you might have.

I'd like to make a few comments sort of touching on three things. I want to talk a bit about the context that we understand this issue plays in, talk a bit about numbers - because there have been lots of numbers reported by the media in the last couple of weeks - and a bit about the initiatives underway to address supply issues.

Let's talk context. Access to physician services isn't really a Nova Scotia issue, it's a Canadian issue. Every province and territory in this country is wrestling with how to improve access to physician services, and they are doing it in a context where health systems across the country are in transition. The factors that are pushing us into transition are economic, demographic, changing expectations of the public, demands for greater accountability, and importantly, emerging and established health research that tells us we need to focus on how to improve health outcomes. We need to focus on how better to serve the population of our provinces.

You are probably all familiar with the general statistics that have been quite topical over the last couple of years: Canadian health systems are costly, we spend more per capita and we do not get equivalent results. We do not get the results you'd expect from that investment, compared to other countries that have publicly-funded health systems comparable to ours. So in response we have health systems across the country under pressure to transition. That transition in its simplest form is moving from acute care to community, from a focus on system needs and interest to the interests of individuals, families and communities, and from a system that is highly fragmented and disjointed.

We have a lot of independent providers that operate on their own to a system that is integrated and coordinated because we know the evidence tells us this is how we'll improve health outcomes.

Very briefly, and it's important because the shift goes beyond just physician services, we have a system of Medicare in the country that has served us well, that we are proud of and we should be proud of, but it is a very deep and narrow system. You get universal coverage if you are in a hospital or if you see a physician.

When we say we don't compare well on health outcomes to other countries, their systems are comprehensive and you know the gaps in our system. We don't cover dental care, we don't have universal drug programs, we don't cover a lot of mental health providers or physiotherapy or the like. We need to shift the system in this country from not just the focus on acute and medical but into a comprehensive, well-organized system.

There are numerous studies that show a growing consensus that individuals experience better health outcomes and they receive better care. They are happier when care is provided through a collaborative team environment that uses a range of qualified health practitioners working in the partnership.

The beauty of this is not only do health outcomes improve, but health system providers are better supported, and they're happier. What you will hear if we're talking

about physician services is that we have a new generation of physicians that are graduating and they don't want to practise in solo practices. They are trained in collaborative practice, and they want to practise in team environments. We need to utilize all of our qualified resources if we're going to talk about access.

There are some stunning statistics. Dr. David Naylor did a really important report in 2015 to the federal Minister of Health that if you haven't seen, I would refer you to. One of the comments he makes in the report is that we have known - there have been well-established studies - since the early 1970s that qualified nurse practitioners, working in collaboration with family physicians, could do up to 70 per cent of what the physician can do without a difference in patient health outcomes or satisfaction. That's important. It's important for Nova Scotia because you have a very vibrant and dynamic nurse practitioner population.

You also have a wonderful emergency health system, and it has a role to play in primary care. You have led the country in EHS, and you are the envy of many provinces in what you're doing in community paramedicine. That supports care most recently by supporting the care for seniors in long-term care or patients who are in palliative care. These are important valuable resources that are a wonderful foundation in this province.

All of us - the department and the Health Authority - are focused on physician services and how to improve them but in a context where we take advantage of all our affected resources.

Very briefly on numbers: there have been a lot of news reports lately - I seem to read them every day - with a lot of numbers in those reports. I want to just say a few things about our reference point, which would be primarily the Canadian Institute of Health Information. There's some important stats that I think we should be aware of. The Canadian Institute of Health Information - or CIHI, as we refer to it - monitors physician services for a number of years. They have a trend analysis.

In their 2015 report, they noted that Nova Scotia had one of the highest physician-to-population ratios in the country. Between 2010 and 2015 in this province, the growth in family physicians was over 15 per cent, specialists were a bit higher than that, and the population growth was just under 1 per cent. CIHI noted that MD graduates across the country are strong, and that there should be a supply of physicians throughout the country for the next couple of years, so we do not have a supply issue in that regard. Just yesterday, the report that I read in the media referred to Stats Canada information based in 2014 that said 89 per cent of Nova Scotians had access to family physicians. That compares relatively favourably to Canadian averages which usually peg access at 85 per cent.

I know, and we all know, that if you are in the 10 per cent or so who don't have access, if you're an individual or a family seeking a family physician right now, statistics are cold comfort. I can talk about positive supply statistics, or I could talk about evidence on collaborative care, but that doesn't address your problem.

What we have done and what we have under way are a number of initiatives to address the problem. They range from the major initiative of consolidating the health region, and the Health Authority will speak to the advantage that that gives this province - simple things, even removing the competition between nine competing resources that would try to outbid each other.

We have in this province, and we led the country on this - in 2012 a physician services resource plan was put into place, a 10-year plan, and it's updated every two years. That was a significant leadership component of how health provider resource planning is under way. We offer incentive programs to move physicians into communities of highest needs. We have a medical school in this province that's on the job on this front, that's training physicians in collaborative care and encouraging us to place residents and third-year students in communities of high need because the evidence is so compelling that if you train there, you stay there. We also have an initiative coming out of November on the 811 line that gives us real-time data on who's looking for a physician.

I will end there. I appreciate the ability to make opening comments. I will say this - there is a lot to be proud of in this province, there are some really good foundational elements. On a personal note, it's one of the reasons that I was convinced that I should come here. I think there is good work to do. Thank you.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Thank you for the opportunity to be here this morning and to be here with my colleagues from the Nova Scotia Health Authority and the Department of Health and Wellness.

Nova Scotia is in the midst of a province-wide health transformation and this work really is about ensuring each person in our province has access to appropriate care in the right place by the right provider at the right time. Doctors are an essential and a valued part of our health system, and I want to echo the comments of our deputy - we are competing nationally and internationally for this valued resource.

We know, having been here for some time, that these issues that we have are a couple of decades old. Addressing our issues now require new and different strategies to get different results. That is what we need for the people of our province - different health outcomes. So we are planning for the future and a new model, but at the same time we need to pay attention to the access issues that exist today.

As our deputy has said, the future is improved access to primary collaborative care in local communities, and she has well described that. I would like to echo that we believe that outcomes for our population do matter. Evidence does matter; it's very important. We have been steadily putting more and more resources into health care for decades without changing the health status of Nova Scotians. Removing the silos of the former districts, consolidating data from a provincial perspective so we can see where the hot spots are for

our province, and creating province-wide processes are how we're going to get to a better place.

So we are doing this work as a province and the literature tells us and the evidence of our colleagues internationally show us that this can result in improved care and improved outcomes. It also can result in improved recruitment and retention of physicians and team members that we require to support our population.

We know now more about our health system than ever before. Nova Scotia was the first province to do this comprehensive physician resource strategy and how we use that is as a planning tool to help us forecast where physicians are needed to ensure the right number, the right mix and the right distribution to support our population needs.

Our deputy has talked about where we sit in the country in terms of how many physicians per capita that we have. I would also like to say that since the beginning of the Nova Scotia Health Authority, we have welcomed more than 170 doctors into this province.

We have been collecting our data to help us understand the vacancies in our province as part of a targeted provincial recruitment strategy. We are no longer competing as nine districts with our IWK colleagues for these resources, and we are now able to match doctors to communities in need in a way that will improve the retention of those physicians in that community. We know that the key element of success for recruitment is the practice model. Our doctors are telling us that and new graduating doctors want a team-based support. They need, want and describe the need for mentorship and they like this team environment.

We take advantage of the provincial incentives that are available to us to recruit doctors to areas where they are needed; this is very helpful. We also work closely with the Dalhousie Family Residency Program and 90 per cent of our residents who train in local communities stay there. We know from them that community support is crucial, and I want to say a word about that.

We have learned over our years that the most successful activities in terms of recruitment of physicians - and an example of where we have done some focus work would be the Town of Middleton. We partnered with the town to create a tone of optimism and welcoming, and paired the jobs that we had with a place that a new doctor would like to come with their family to build their lives together. The doctors told us that they were attracted to the collaborative practice, to the mentorship opportunities, and the support and engagement of the local community was a crucial element to that success.

These recruitment challenges are not unique to health care. We do need to promote Nova Scotia communities as destinations of choice for our young and our older professionals. We need the entire community working together to create the winning

conditions for successful recruitment and, most important, for retention of our practitioners.

We will continue to recruit doctors and build interdisciplinary teams that improve care and access for Nova Scotia. We know that more than 25,000 Nova Scotians have enrolled in our Need a Family Practice registry and we are very focused on that. We acknowledge that some of those people have complex conditions that need continuity of care now and we must do something about that now. So, knowing this group, our focus is on an interim strategy that will help us ensure that these high-needs patients receive the care they need while we're helping them find continuing care with a local practice.

The issues are complex. Some of our citizens have a doctor but wait too long for an appointment. Improved access to primary care means building teams that provide coordinated care across the individual's lifespan.

Last Fall we were very pleased to receive a $3.6 million investment in primary health care from our Department of Health and Wellness to add more than 20 new nurse practitioners and family practice nurses. In this process we've identified priority communities based on the need and readiness of those for these positions, and we worked with our physician community to identify those who are interested. We had 45 practices respond, and we are now working with the selected practices to finalize arrangements and are hiring new staff members. Integrating these resources into community practice will increase access to care by offering same-day, next-day access, as well as evening and weekend options, in addition to offering comprehensive care for patients. We expect that this change alone will open up more than 14,000 spaces in areas of the province that we've identified that most need them.

As we work to transform how Nova Scotians access health care, we know that community-based collaborative models are the foundation for our system as we go forward. We know that we have to change the way we provide in-patient hospital coverage in smaller centres through a coordinated provincial hospital strategy. We also have to work with communities and acknowledge that recruitment of a professional into a community requires a partnership with the health system and the community.

There are challenges and there always will be in this very complex system. We need the courage to make the changes that will improve the health outcomes for our population and we remain focused on making sure our resources go where they are most needed, to enhance the care and health of Nova Scotians. Thank you.

MR. CHAIRMAN: Thank you. We'll begin with Mr. Houston for 20 minutes.

MR. TIM HOUSTON: Thank you for the opening comments. I do want to start with the report that the Health Authority commissioned on mental health and addiction services. It was received by the Health Authority in October 2016. It recommended the

closure of inpatient detox units in Pictou, Springhill, Strait Region and some of the Cape Breton beds.

I would like to ask Ms. Knox, is the Health Authority going to act on those recommendations?

MS. KNOX: Thank you for that question. You probably heard some of our conversations this morning with our Senior Director of Mental Health and Addictions. As we became the Nova Scotia Health Authority, our challenge and our mission is to provide the best access to service to all Nova Scotians. As we go forward, we have to remind ourselves we need to use the best evidence that's available to us but we need to make a made-in-Nova Scotia solution.

When we make decisions as we go forward for mental health and addictions, they need to be tied to what the resources for primary health care in the local community are, and what the access is to the other services that promote and support some of the work in mental health and addictions.

What I would say to you is this is a piece of the evidence that our team, with local citizens, will use to make decisions together. That is how we use the data.

MR. HOUSTON: You had that report since October 2016. Do you know how much that report cost?

MS. KNOX: I believe that that work cost $185,000, of which $115,000 was funded through a national project that Nova Scotia was part of.

MR. HOUSTON: Was it sole-sourced or was it put out for tender?

MS. KNOX: I'll have to get back to you on that one.

MR. HOUSTON: So you've had the report since October, and you haven't decided whether or not you are going to act on it yet. Is that a fair summary?

MS. KNOX: The ongoing work that we need to do has to be in combination. So no, you are asking me have we decided, are we responding to all the recommendations . . .

MR. HOUSTON: So you are still thinking about closing those units, you haven't decided whether you'll close those units or not?

MS. KNOX: We have to look at the whole picture to decide what the comprehensive plan is. Yes, it can't be a decision on one piece of the program.

MR. HOUSTON: So the consultant wasn't asked to provide a plan, they were asked to provide just something in isolation? That's just one piece of information, I guess?

MS. KNOX: That would be one piece of the information that the consultant was asked to look at. That consultant helped us do literature reviews, bring together a meta analysis with the best evidence around the country and the world.

MR. HOUSTON: So that consultant looked at whatever they looked at and then they made the recommendation that these units should be closed and then when that's received you say, well that's interesting, but there's also these other factors that we need to consider that the consultant wasn't asked to consider?

MS. KNOX: Absolutely. There are more pieces of action that we need to take care of and I would . . .

MR. HOUSTON: How soon would you think you would decide what you are going to do with those units? Would that be a budget item for this year?

MS. KNOX: Our approach in supporting and going forward is to really look at community-based services and pay attention, as our deputy has described, to what we've learned from others across the country and, in fact, internationally. We need to look at what services are available in local communities and moving to community-based services and really helping people have access to those in their local community is the first step. Then you layer on what we traditionally would have described as the hospital system that we currently have.

MR. HOUSTON: Based on that, I'd say you are not going to follow the recommendations. Community-based services - to me that doesn't imply taking services out of the community, which is basically what the consultant recommended, is it not?

MS. KNOX: I think, with respect . . .

MR. HOUSTON: To close the detox units in Pictou and Springhill and the Strait and stuff.

MS. KNOX: But that doesn't mean that the service wouldn't be provided on a community-based service in the local community.

MR. HOUSTON: It would be a different service in the community?

MS. KNOX: Yes. I come from a long background in the health system and I'll give you an example. I began my work as a paediatric nurse, where we would have a 300-bed hospital, now we have a 100-bed children's hospital. When I began three decades ago, nobody came to the ambulatory clinics in a children's hospital in this country and we probably have between 500 and 1,000 visits a day, so it's a very different way of providing services.

MR. HOUSTON: Sure, and sometimes change is good but my only example is the short-stay unit in Pictou County which was closed for 90 days back in August 2015. I know that the department and the Health Authority would say that things are better right now in Pictou County. They are not better in Pictou County. So when I hear about these types of transitions and stuff, I refer to that example.

I'll leave it at that for now, you are thinking about what to do with that consultant's report, based on other factors.

I do want to switch to - maybe we'll ask the deputy. I did hear some statistics in there in your opening remarks but I didn't hear some of the statistics that I was looking for so I'd like to ask if those are available now.

How many practising family doctors do we have in the Province of Nova Scotia? You might call them primary health care professionals or whatever. I want to get away from the term "physician" because it's too misleading. There are too many specialists and academics and stuff. I want to focus on practising family doctors and I'll use that term if that's okay - how many of those do we have in Nova Scotia today?

MR. CHAIRMAN: Ms. Goldring.

MS. VICTORIA GOLDRING: Our latest numbers for family physicians in 2015 is 1,241.

MR. HOUSTON: So 1,241, and that was in 2015. Do you know how that would compare to 2014?

MS. GOLDRING: I can tell you how it compares to 2010. In 2010 we had 1,077, so it's an increase of 15 per cent.

MR. HOUSTON: That's over a five-year increment, so is that only looked at every five years?

MS. GOLDRING: Well it's based on CIHI data so we look at it yearly, we update it yearly. We provide the information yearly to CIHI.

MR. HOUSTON: But the department is paying the doctors in the province, are they not?

MS. GOLDRING: Of course.

MR. HOUSTON: How many practising family physicians is the department paying right now?

MS. GOLDRING: If you want a valid statistical number, that's the number that I gave you . . .

MR. HOUSTON: But that's - I'm just curious about right now. Now we're in 2017. What's the date today - I don't know if they get paid every two weeks or whatever. I don't know how often they get paid, but they recently got paid. I'm just wondering how many we paid.

MS. GOLDRING: We often talk about the full number of physicians, so including specialists. The number that we use is 2,602 physicians that we are paying in Nova Scotia.

MR. HOUSTON: Many of those are not practising family doctors, so it's not a number you have to hand.

MS. GOLDRING: Those are practising family physicians and specialists. It does not include residents, who we also pay.

MR. HOUSTON: You can't split that between specialists and practising family physicians?

MS. GOLDRING: I can tell you the 2015 number. It's 1,241.

MR. HOUSTON: I guess no real answer to that one. The second question I was going to ask - what I need to know is, I believe there's a shortage of family doctors in the province, and I believe that based on the number of people that I know in my constituency office, in my circle of friends, and in my family who don't have a family doctor and don't have any prospects of getting a family doctor. I'm just trying to figure out how many more family doctors we need in the province. But I guess if you can't tell me how many we have, you probably can't tell me how many more we need, right?

MS. GOLDRING: With respect, I did tell you how many we have. You asked how many we paid, and I answered that as well. We have, as our deputy minister explained . . .

MR. HOUSTON: Sorry, Mr. Chairman, I would like to clarify.

MR. CHAIRMAN: Order. Mr. Houston did ask for a specific answer. This is the Public Accounts Committee of the Legislature. This is the only place where Nova Scotians can hear answers about past expenditure of government. Mr. Houston has asked a question. There has been an answer provided. It hasn't been exactly what he has asked for. Can the witness work to provide an answer to the committee at a date in the near future? Ms. Goldring.

MS. GOLDRING: Is it possible to get the question in writing?

MR. CHAIRMAN: We can pull the transcript or, Mr. Houston, you can rephrase the question now. We can have the clerk send it in writing to the department.

MS. GOLDRING: Thank you.

MR. CHAIRMAN: Mr. Houston.

MR. HOUSTON: I would just like to ask a very specific question - practising family doctors in the Province of Nova Scotia, not specialists, not academics, practising family doctors, people who are actively seeing patients in a clinic somewhere. How many practising family doctors do we have in the Province of Nova Scotia? If it's a number we don't know today, then I'll take that as an answer.

MS. GOLDRING: I will turn it over to my colleague from the Nova Scotia Health Authority.

MR. CHAIRMAN: Dr. Harrigan.

DR. LYNNE HARRIGAN: These numbers are very hard to track, and I think part of the reason that they're hard to track is the diversity of family practice. Twenty years ago, if you trained as a family doctor, you opened a practice, and you set up shop. You may have done other things, but your primary base was the office. That has changed dramatically, so you may now actually be exclusively an emergency room physician, or you may be a sports medicine physician, or you actually may work as a hospitalist.

When you actually look at the numbers - you're right - it's very difficult to say if that's someone working in their office. Through the physician resource planning document, we actually have an estimate of that, physicians working in offices. In 2012, that was 780 physicians working in practices. At that time, we knew that there was an incorrect ratio between primary care and specialists, and other specialists were hired . . .

MR. HOUSTON: Okay. Mr. Chairman . . .

DR. HARRIGAN: But I'll tell you the value this year. The value this year is 808 family physicians working in practices. That's an absolute increase, and based on our physician resource planning document tool, it shows that we have now levelled that playing field. The number of family doctors that we have working in offices in Nova Scotia actually is at the number that we predicted it should be.

The question then to ask - I don't want to usurp your questions - is, then why are there people without family doctors? We have adequate numbers. So that's a question we have to answer. The answer is not necessarily more. It's maybe changing the way we provide care so that people can get access.

MR. HOUSTON: Okay. I think it's overly complicated for a simple question. Maybe it's because I'm an accountant, but people say follow the money. You know how many doctors are being paid fee-for-service; that's obvious. You know how many doctors might be in a collaborative practice on an alternative payment plan or whatever that arrangement is. I'm quite surprised that it just took up most of my time to figure out how many doctors there are in the province. Surprised is the word I'll use, but I have other ones.

We have too many people in the province who don't have a doctor. That's the simple reality of life. In Pictou County, I listened to some members of the department and the Health Authority present to Pictou County Council on Monday night. They were asked how many in the County of Pictou were without a doctor, and they were told 1,600. It's way more than that, and everyone in Pictou County knows it's way more than that. They were asked where they got the number of 1,600? They said that's the number of people that called the 811 number and registered. That's not a good way to determine the need in the province.

I'm probably going to move in to my questions, but I'll leave you with this thought. If you don't actually know just like that how many doctors are seeing patients in the province today, and you don't have an accurate number of how many people need a doctor, you're never going to solve the problem. I was hoping that we would come here today, and we would hear that we're ready to talk about this, and we're ready to figure out how we're going to address it. But we just used all this time to try to figure out how many doctors are in the province, and to me that's pretty unacceptable.

My understanding of a collaborative practice - and it sounds like a great theory, the collaborative practice. The doctors seem to like it. The patients seem to like it for the most part. But my understanding of that was when you're a patient of a collaborative practice, you're a patient of that team. When a doctor is out or whatever the case may be, the team kind of picks up. Sometimes the team has a full complement. Sometimes the team doesn't have a full complement, but that's the value of a team.

In Pictou County at the clinic on the west side, you're probably aware that they're down a doctor. Patients are being discharged from that clinic because their doctor is no longer there. That was contrary to my understanding. My understanding was that you had a team of physicians, but now that one specific doctor is out, you're gone.

Again, at county council they asked if people were being discharged, and the answer was not to the knowledge of the Health Authority or the department. I forget who actually said it. I guess I would ask, Ms. Knox, did you know that patients are being discharged from that west side clinic because of the doctor shortage?

MS. KNOX: We are very much aware of the situation in that clinic. I think I will ask Tricia Cochrane to talk a bit about that clinic. You're asking, are we aware? We are aware that there are challenges there. Did you want us to talk about the . . .

MR. HOUSTON: Are you aware that people are being discharged from that clinic? They're being told they don't have a doctor anymore.

MR. CHAIRMAN: Ms. Cochrane.

MS. TRICIA COCHRANE: I am hesitant to get into a particular situation. It's delicate, the work that is being done to try to address the patient needs in that community. Our staff are working with the physician to try to address that issue.

MR. HOUSTON: I guess what I am getting to is, there is a policy issue here. My understanding of the policy issue was that once you are a patient of a collaborative practice, you're a patient of that collaborative practice. Is that not the case?

MS. COCHRANE: That is our vision for where primary health care teams are going to be into the future. What we're dealing with now is a history of 10 years of evolution in nine different districts that approached what the requirements and accountabilities are for that primary care team.

We are now in a position where, as one province, we can be working not on nine different ways but one way. When you sign up to be part of a collaborative team - an example of that would be the new providers that are coming in, the practice nurses and nurse practitioners - as they're joining teams, one of the deliverables will be access. That team will be owning the practice population, but that has not been so in the past everywhere.

MR. HOUSTON: When doctors sign a contract with the province, was there nothing in those agreements? Is there anything in the agreements for - let's call them salaried doctors or alternative fee arrangement doctors. Something fell through the gaps there where the people were informed that you're part of a collaborative team but they really weren't, they just happened to be in the same building is what it seems like to me.

The Auditor General did a report in May 2014 so it's three years old now. He raised a lot of concerns with doctors on alternative funding arrangements, not being policed, let's say, for lack of a better word. He had pages and pages at the time of doctors on alternative funding arrangements who weren't seeing the number of patients that their contract said they should.

To me this is almost the same thing just on a different level, with the collaborative. I guess I'm surprised that three years after the Auditor General raised these types of concerns that this is happening in real time and everyone is taken aback that they're calling for an appointment and saying you don't have a doctor.

I understand the pressure that the doctors in that specific - and this is a significant policy issue, there's a problem here with the way this is being constructed and there are

many collaborative practices around the province. They all have the same problem if this is a symptom of it.

I see the deputy wants to chime in, I'd be happy and willing to let her speak.

MS. PERRET: I'm going to thank you for the question, not in a superficial way. I do thank you for the question and I'm quite sincere. That's why I made the comments I did at the beginning about context because it is a policy issue and we are in transition. Transitions are not always easy because they require structural changes and cultural changes. I think that having a forum like this that points those out, that holds our feet to the fire, is critically important.

I want to say two things. One of the changes, the structural changes - and there's an excellent article in *The Globe and Mail* quoting Professor Colleen Flood, February 17th of this year, who talks about the challenge of family practitioners, physicians, who have largely practised autonomously. They determine when and where to work, how to work. To make that shift, even to the APP environment, is a significant shift, it's a cultural shift, and it's not going to happen overnight.

I agree it's a policy change and one that we have to be resolved about, but it's not necessarily going to be an easy change and it requires a lot of transition.

My second point is, and I am not diminishing the fact that people are looking for a family physician, and I know that's an important issue so I know it's cold comfort. Nova Scotia has less of a problem on that front than the other provinces, for the most part, and has foundational pieces in place that really give us encouragement that we are going to move the marker on this one, and forums like this are going to help us.

MR. CHAIRMAN: Mr. Houston, you have just five seconds left so we will have to move on to the NDP caucus. Mr. Wilson, 20 minutes.

HON. DAVID WILSON: Thank you for being here today. I want to welcome the new deputy minister to the Public Accounts Committee. I'm glad that the initiatives of the former NDP Government convinced you to come to Nova Scotia. We worked hard on ensuring that paramedics work extremely hard in this province in a number of capacities. We worked hard on ensuring the rural residency program is successful and was initiated in this province. We worked hard on ensuring a collaborative approach to health care, like the CECs that were initiated in the province, and I look forward to working with you over the next number of years.

Of course, we're here on the topic of physician services. To get right into it, how many new - and it's really around family physicians that have been kind of getting the news media lately, especially with the current government's commitment to have a family doctor for every Nova Scotian - so how many new family physicians have we attracted to the province in the last year? I would hope we could have that data. I don't know who amongst

you all may have that. How many new family physicians have we attracted to the province in the last year?

DR. HARRIGAN: Since July 2015 it is 71, and for this past year it is 36.

MR. DAVID WILSON: So since 2015, 71 and this year 36. How many physicians have left - have retired, have taken leave, have passed away, have closed their practice, since 2015?

DR. HARRIGAN: That is a number that has not always been tracked but we now have vacancy numbers and so if I can just pull my binder I can add it up quickly. I know there are 27 in Central Zone.

MR. DAVID WILSON: That's just in the last year?

DR. HARRIGAN: No, that's since we started to record it so that would be since April 2015. Those are current vacancies that haven't been filled. We've actually filled a fair number of those - so those are the current vacancies that have not yet been filled.

MR. DAVID WILSON: But you couldn't tell us how many physicians retired, are ill, have passed away, because I've experienced that in my own community where we've unfortunately lost a physician.

DR. HARRIGAN: I can get that number for you, but I don't have it on my fingertips.

MR. DAVID WILSON: I would like to officially request that: a list of new physicians that came to the province since 2015 hopefully; a list of physicians that have left or retired or who no longer practice. That would be very helpful because often when we are engaging government, especially elected officials, they're very quick to give us the number of new doctors, especially in Cape Breton where there has been a significant loss of a number of physicians and the caseload of those physicians are just staggering. We know that the net gain is not in a positive number, so I would appreciate those numbers. I look forward to seeing those.

One of the areas, of course, of concern to many of us is of course access to care. We've heard from the government, from the Department of Health and Wellness, around the collaborative practice and how we need to move towards a collaborative approach to delivering primary health care. I couldn't agree more, but there are a lot of steps that need to take place in order to have that be successful. I look at the experience of Collaborative Emergency Centres. There are a number of things that need to happen in order to be successful. I still commit and say that they're very successful in the communities that they are currently running in.

A number of things need to happen. First of all, there's a negotiation with physicians in that area - try to get them on board to understand the new model of care that is being presented. The other one is consultation with the health care providers in that community so that they understand this new model of care and how this is going to be transformed into improving care.

I think the most important thing that we learned about in initiating the Collaborative Emergency Centre model was community engagement, community consultation. You had to go into those communities to explain the new model, explain how things are going to work, explain how you'll receive better health care.

So with this collaborative practice model that we've heard about that the government has been saying for three years now that we're going to see here in the province, we understand the negotiations with the doctors to a certain extent have been finalized. There is a contract with them. So a couple of questions on that.

Interesting to find out that the negotiations for that happened not within the Department of Health and Wellness, but through a third party, through hiring a consulting firm - McInnes Cooper. Could you provide me the cost of utilizing? I know the deputy is new, but there is other support staff from the department - how much did that cost the department to go outside, and maybe why the government chose to go outside to negotiate with the doctors when that has been happening within government for as long as I can remember? So the cost of that consultation or how much that cost, and why did we go outside externally to negotiate with Doctors Nova Scotia, for example?

MS. PERRET: If you don't mind, I'll get you that information in writing.

MR. DAVID WILSON: I appreciate that. The next step is of course the consultation with health care workers - that happened with the Collaborative Emergency Centres. Has that happened with nurses and those who might come together and work in a collaborative approach. If that has happened, who have you been discussing that with and what has been the result of that?

MS. PERRET: I'm going to respond just briefly on a more general level and then ask the Health Authority to respond more specifically because it's an important question, and it's one that is quite exciting, frankly.

We're talking about transition. We're talking about moving to collaborative care. We're talking about structural and cultural change. What is so reinforcing is, if you talk to health professionals, and you would know this based on your work in the paramedic community, but if you work in the pharmacy community or if you work in the nurse practitioner community, the level of excitement, the level of progressive ideas, and the energy in those communities are amazing.

There is a huge policy shift taking place across the country, but there are professions stepping up and saying not to look at this issue narrowly. That's part of my submission here. It is not simply a physician supply issue. It is how we make the shift to collaborative care, how we do it with community support, and how we build on a tremendous momentum that exists.

I've seen it in this province. I had a nurse practitioner sit beside me at a talk that I was attending, and you had to contain her in her seat when you asked her what her ideas were. That's a general comment. You wanted more specifics, and I'll ask the authority to address that.

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: For us at the Nova Scotia Health Authority, it is about really saying we need to take the time to do that well. As you describe, that was the change in terms of the development of the CECs, the team engagement in planning what the service might be and engaging with the community about what they wanted and what their experience needed to be.

I'll ask Tricia Cochrane to talk to you about what our engagement is about.

MR. CHAIRMAN: Ms. Cochrane.

MS. COCHRANE: I would say that we are pretty pumped and enthusiastic about the support that has been provided by providers around the province. This is not a matter of convincing people, our providers, that they should, and the population needs us to, work in a collaborative team-based approach in the community. They've embraced that.

In the first couple of years that we've been an organization - I'm going to start there - we needed to look at where our physician leadership is because physicians want to talk to physicians. Right? The rest of us are interesting for them, but really they want to talk to other physicians. So we took some time to begin to put a structure in place where we've got physician leadership in the Nova Scotia Health Authority from a physician perspective.

In our four zones, the new geography for the Nova Scotia Health Authority, there are four physician leaders. They are practising family physicians, so it's not as if they are not aware of the practical issues in a practice. It has taken some time to get them in place.

I'll really focus on the last six to nine months. After some initial evidence-gathering and planning happened, the chiefs, along with our primary care directors - we have a co-leadership model in our organization - we can say they have met formally with well over half of our family physicians across the province. In an informal way, they're talking to physicians day in and day out. That's their day job, so that is occurring.

In a formal way, there have been forums to talk about collaborative teams and what we're calling a health home model, what the difference is between the team and the model around health homes. We're discussing with family physicians what their questions are, what their concerns are, and what their advice is. That has been happening in these geographies.

Just last Fall, 14 or 15 sessions happened. That is in combination with some forums or focus groups, one hosted by Doctors Nova Scotia, which was a webinar format. Sixty family physicians - that's not small - attended that partnership with Doctors Nova Scotia. Again, we're committed to working with Doctors Nova Scotia on this and with our primary care leaders. Lynne and I have met with them, and we're now at the stage where we're thinking through about what our joint role is. So that has happened.

There is a newsletter that has been initiated - and good response to a newsletter . . .

MR. DAVID WILSON: Okay, I appreciate that. We do have limited time. There is some consultation with doctors. I think you mentioned time, that time is needed to make sure we move forward. I can agree with that, but with all due respect, the issue in front of us is that there are Nova Scotians without a family doctor. There are Nova Scotians without access to primary health care. There are Nova Scotians who are falling through the cracks every single day.

There comes a time when the government needs to make a decision. I haven't seen any timelines from this current government. We hear from them every now and then in the media - it could be five years away. We don't have five years. I don't believe that it would take five years to get these up and running.

We have an example just down the street here, the North End Community Health Centre. They have been running since the 1970s if I'm not mistaken - maybe the 1980s, but I think the 1970s. It's very, very successful. I don't buy the idea that the government's going to take five years, because Nova Scotians don't have time.

It takes a government to make a decision saying, this is how we're going to go about it. There have been countless studies and information on how collaborative clinics are the way that we should be going, not only in our country but across the globe. It's going to take commitment. Where are those timelines?

I have to say, in our mandate of four years, within three years, we only did the consultations with doctors, consultations with health care workers, and consultations with the communities, and then opened eight Collaborative Emergency Centres in three years. It's three years now, and we're still talking about talking with physicians.

I respect physicians immensely. They're a key component to delivering primary health care, but if we're going to approach it in a collaborative way, there needs to be a timeline to say, okay, we've collaborated with the physicians, and we've collaborated with

nurses and pharmacists and other people who are going to be involved in this. We need to consult with the community.

When is that going to happen? Is that going to be five years from now? It's very frustrating to be on this end and continue to hear that this is what we're going to go to, to solve the problem around access to physicians and access to primary care. Nova Scotians don't have the time.

Maybe I'll ask the deputy. Is there a hard set timeline when we're going to see the first new collaborative community clinic or whatever the term is going to be? I'm sure there's going to be consultation on what the right name is for these clinics. When are Nova Scotians going to see the first clinic in Nova Scotia so that we can get on with ensuring that Nova Scotians have access to primary care? Can you give me that timeline, or is that premature?

MS. PERRET: No, I can't give you the timeline that you're requesting, but I do appreciate your comments around the need for that. There has been a lot of change just in the move to one Health Authority but also in the role of the department. That is up there in job one of the type of managers we need to put in place.

I do want to say this, and I'll ask the authority to correct me if I've misunderstood. I do want you to understand the progress that's under way. When I say there's foundational elements, I'm not speaking lightly. There is a lot of planning for where community collaborative care clinics need to go. There's a tremendous amount of data and information that we've never had being put into play to plan for those clinics.

My understanding is we need roughly 78 clinics in the province today. We have 42 under way that are in various stages of standing up. I say that because I want you to understand that in this shift - and it's a structural cultural shift - there is momentum, and we have some traction. So there is positive movement forward.

MR. DAVID WILSON: I would say that especially in front-line health care delivery, professionals who work in the community, there is buy-in. There has been buy-in for a collaborative approach to health care delivery for 25 years in this province. I don't think we need to waste a lot of time on that aspect. I think physicians right down to pharmacists are more than willing to step up to the plate and ensure that this new approach is going to happen in the province.

You talked about where these might be. We heard in the Fall that the community of Weymouth, for example, had a retiring physician. There was a plan to replace that physician, but the authority had advised them that there would be no billing code given to the community of Weymouth. I still don't understand why that has taken place.

I have a number of questions. I know we're limited on time. Have there been other communities like Weymouth identified that will no longer be issued billing codes? I know

that the Central Zone has restricted family physician licences to try to address the collaborative clinic - I see the physician shaking her head, but I read the policy. There was a restriction there.

I ask the deputy, are there other communities identified like Weymouth that will no longer be given a billing code or restricted? Maybe down the road they'll be given it. I don't know if that's the intention. Are there a number of communities that have been restricted like Weymouth and can you provide that list to us?

MS. PERRET: The Health Authority is leading the recruitment effort, so I'm going to turn this question over to them so you can have a specific answer.

MS. KNOX: I am going to ask Dr. Harrigan to address this.

DR. HARRIGAN: Thank you for the opportunity to correct a lot of misinformation that's out there. There are no restrictions of billing numbers in Nova Scotia, period. But every physician who comes to work in Nova Scotia must be privileged.

So instead of actually planning for what providers want, we're actually planning for what the people want, and so we have to turn the system on its head and we're using a lot of information. We know the clusters. We know the community status of where our places should be.

We know that physicians don't want to work in solo practice. If you want to speak specifically to the Weymouth area, they tried to recruit there for two years because no one wants to work as a solo practitioner.

Our goal is to build with communities a plan for the future, and so we actually have built with communities. We actually have a group - Digby, Weymouth, Clare - where we're all working with community members, the wardens, the government, and the Health Authority to plan what we need for the future to serve all those citizens, and everyone is in agreement.

So what we're trying to say is, we want to avoid one-offs, popping someone in and in two years we have the same problem. We're building a specific foundation for primary care that's sustainable into the future.

MR. DAVID WILSON: But wouldn't that help the thousands of people currently without a doctor until the system is ready to accept that? I must have dreamt Dr. Saad coming to my office looking for another billing code to expand his practice and was denied - and I brought it to the floor of the Legislature and then he was given a licence. I must have dreamt that.

DR. HARRIGAN: It's a terminology thing and I think it's important to correct because no licences are restricted in Nova Scotia, no billing numbers are restricted. He was asking for a new position.

From an accountability perspective, what we have said as the Health Authority and as a government - every position that's currently here will be replaced, but remember, our current system isn't planned. There is no planning in our current system, but we need to maintain it.

MR. DAVID WILSON: We're not doing a great job if we only brought 36 in and we have 27 vacancies in Halifax or Central Zone alone. That's not a great record and I can't understand why Weymouth - if they were able to find a physician tomorrow, would the government approve that? Would the Health Authority approve the ability for a physician to go to Weymouth just in the interim?

DR. HARRIGAN: What we would approve . . .

MR. CHAIRMAN: Order, please. I do apologize, but we have to move on to the next round. We'll go to the Liberal caucus. We're going to go to Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Would you like to finish that comment, Dr. Harrigan?

DR. HARRIGAN: Yes, I would. We have been working with the three communities and we have a plan to create a collaborative base in Digby, and those physicians in that practice will service the Weymouth area and will actually be present in the community. That is something we've worked together on. It's a group of physicians as part of a collaboration that we think is sustainable into the future, and we think it's something we should actually celebrate.

MS. LOHNES-CROFT: So we've heard lots of questioning about doctor shortage. Is it a crisis here in Nova Scotia? Who wants to answer that?

MS. PERRET: I would say no, it's not a crisis. That's why I laid the context about giving you a national perspective in which you'll always have some gap in who wants a family physician because, quite frankly, not everyone wants one. There are some people that are quite happy to have walk-in clinics and have the convenience of that type of service. But there is, based on every study we've seen, a steady supply of physicians across the country and in this province.

The shift that has taken place on how we use that resource and how many we need when we move into a collaborative care environment is the central discussion. If we just say, let's keep doing what we've always done, let's just replace the model that we've had, then I have to circle back to say that when Canada is compared internationally or when Nova Scotia is compared internationally, we don't have the health outcomes that other

countries have. Just doing the same isn't giving us better health outcomes for our population. That's the motivating factor behind reorganizing how and where we provide care. That's a huge effort.

As you've heard in the comments, we have a system now across Canada that is largely unplanned. Physicians have been independent providers. They are private practitioners. They set up businesses. They decide where and when to work. It has been in an unplanned context, and we're coaching that system into a planned context, into a much more supportive context. We're including new health practitioners in it. We're doing it in a fiscally responsible manner so that it's not just - and this has been a curse of the health care system in Canada - ad hoc incrementalism. This is a restructuring that is carefully planned and focused on improving outcomes for patients.

MS. LOHNES-CROFT: So it seems to have come to a head. It's in the news regularly, as one of you said, the shortages. This isn't a new problem, so what's changed? What has happened? How long has this been going on?

MS. PERRET: I think if you read some of the reports - I referred you to Dr. Naylor's report. He would say we have to change the way we deliver primary care. We've known that for a long time. He is the one who makes reference to the 1970s, when we knew how valuable a resource we have in nurse practitioners, but we never included that resource into our publicly-funded delivery system. So we do have a large body of research information, of evidence, of established practice that tells us that collaborative care is the way to go.

As I said, in this province, there is very good planning under way. There is a realization that we need around 78 collaborative practices, and 42 are in process. That's over a relatively short period of time. If you compared that to some of the other provinces in Canada, I think Nova Scotia would compare very positively. You would see momentum here to a greater degree than you would see elsewhere.

MS. LOHNES-CROFT: As other members have mentioned, I regularly get calls at my office. Someone's physician is moving or retiring or some people, I'm amazed, just don't have a family practitioner, and they never have. It's not until they have a health issue that they say, oh my gosh, I guess I need a doctor. I'm finding that a frequent response I get when I ask, what happened to your doctor? They say they have never had one.

What do I do? What do I tell people who call my office and ask for help finding a doctor?

MS. PERRET: I'm going to refer this to the Health Authority, which is managing that initiative.

MS. KNOX: It's a real issue, isn't it? You are identifying it in terms of those people we don't necessarily know about. With the help of 811, we have developed a process where people can say they need a family physician. It's a way of getting some real information. I

can let Dr. Harrigan, who led this initiative with our primary care folks, talk to you about how people use that. We are encouraging people to use that line.

DR. HARRIGAN: I can say that I've been in this business for 10 years, and recruitment is a day-to-day job. So for me this is no different than it has ever been. The patients who don't have family doctors currently might not be the same ones that I dealt with before, but there's a constant ebb and flow. Because residents finish their training in June, largely we get our new doctors in July, August and September. So often there is a gap.

There have been numbers thrown about everywhere, and it's really important to get some accurate numbers. We compiled all the previous lists that were kept by previous health authorities. Previous health authorities kept lists of patients who did not have family doctors. We combined those, and we also created the 811 number so people could call in or go online and register as someone who needs a family practice.

That's critically important. You can look at polls, you can look at numbers, or you can say it's 100,000. But all we know is, these are real people with real postal codes. From a Health Authority perspective, this is how we plan our recruitment. We now know the areas, based on 811, that are areas of greatest need. There were no surprises there for us. It helps us focus our recruitment. For instance, there is an issue in the Central Zone that had never happened before, so we've actually hired a full-time recruitment officer for the family practice in the Central Zone.

We actually pay for site visits for people to visit other parts of the province. We have actually now included that for the Central Zone so people can come to the Central Zone and do that. So that's step one, to get the numbers.

Now are the numbers right? I suspect not everyone has phoned in. I would use this as an opportunity to encourage everyone who is seeking a family practice to please phone this number because when new physicians come into communities we will be handing them a list of people in that postal code to these doctors to take on these patients. So it's critical that people get on this list as that is the fastest way to get in.

The one part that concerns me is that there is a small portion of people who really cannot be without primary care, they just can't. These are people who have active cancer, people who are undergoing palliative care - these are the people who keep me up at night. This is a very complex process to try to filter out who actually needs a doctor right away. So we are taking this on as our personal mission, to create a bridge for those patients who really cannot be without a family doctor, until we can actually find them one. That will be one of my major missions over the next two or three months.

I have to say that I don't have a family doctor. My family doctor retired and has not yet been replaced. Now let's be honest here, I know a lot of doctors, they're out in the lobby right now, I could actually pick up the phone and get one because I know them, but

I have chosen not to do so. I have chosen not to do so for one very precise reason, and that is that I need to be sure that the system we put in place is actually working. So it is my full expectation that when a family doctor now joins the Wolfville practice in the area where I reside, that I will be receiving a phone call that I am now part of a practice. It's one way of making sure that the system is working because I'm going to go through it as all our patients are going through it to get a family doctor.

It's a huge commitment for us. We're finally on the path with having numbers that are important for us.

MS. LOHNES-CROFT: So do you go to a walk-in clinic or do you see one of your friends?

DR. HARRIGAN: I go to a walk-in clinic and I go to emergency and I wait my turn.

MS. LOHNES-CROFT: That's another question I have, when people say my child has an ear infection, I need a doctor to look after her, what is the advice you give people waiting for a primary caregiver? What do they do when they need to access - get prescriptions filled, for example?

DR. HARRIGAN: First, you can call 811 because in addition to taking names for people for family doctors, there are nurses on the line who can actually provide you with advice. We do advise people to use walk-in clinics or community clinics or emergency rooms, as necessary. It's not ideal but they can refill prescriptions, they can provide advice, but unfortunately will not provide you with continuing care, which is the beauty of primary care, but it can be a bridging measure until such time as you have a primary caregiver.

MS. LOHNES-CROFT: So someone who has a chronic illness or is a cancer survivor but needs regular checkups, would they also go to an emergency room?

DR. HARRIGAN: That's the group I talked to you about that is of concern. We need to find a solution for those people. When many family physicians retire they identify these groups. I was talking to a family physician recently, she had 1,500 patients but she identified 100 who really could not be without a family doctor. She arranged for another doctor in the community to take those ones on.

In the circumstances where that does not happen, we have to have some kind of process to triage those patients and support them until we can get them into primary care.

MS. LOHNES-CROFT: OBs must be a concern, too, or will the IWK look after those people?

DR. HARRIGAN: Pregnant women are generally cared for, not necessarily by the IWK but by obstetricians throughout the province.

MS. LOHNES-CROFT: Thank you. I did want to go back to the comment about the study that included the nurse practitioners. I see them as the saviours of the health care system. I, myself, see one on a regular basis and I'm very satisfied with the health care I've received.

I hear from people all the time, oh I know someone who's a nurse practitioner and she'd love to come to Lunenburg or Mahone Bay or whatnot. So why does it take so long to fill these positions? Why are we waiting a month, months, or maybe a year for a position to be filled?

MS. KNOX: That's a wonderful question, and it's about how we hire folks. Tricia Cochrane is leading that process for us. I'll ask her to respond.

MS. COCHRANE: We appreciate very much the new investment in the last number of months to hire up to 22 nurse practitioners and registered practice nurses for teams. There has been a great deal of effort that went into how we decide where we most need them. We've looked at the criteria that's required. It's a combination of access, so where we are hearing the biggest gaps are the demographics of a community and the age of a community. It's looking at a number of factors that help us determine where we should put that investment.

After the criteria were developed, there was a team of folks - including family physicians, a practice nurse, a nurse practitioner, and members of the public - who sat on the selection panel and determined where those physicians would go. That finished, and when those decisions were made - we had 45 applications or expressions of interest from practices. That's something to celebrate. There is real interest among physicians to do this. The selection process determined which were the practices that we were going into further discussions with on those positions. That has taken some time.

Then once we nailed down the practices where the new providers will go, the positions will go, then we have to work with those physicians and determine practical things. Is there space for those new providers? What is the collaborative care arrangement going to be? It takes time.

We're in the stage now where the physicians have signed off on an agreement to say, yes, we're in. There are a couple that we're still working on. We're solid. We know those practices are going to be welcoming environments. The positions have been posted. We've posted them province-wide so that instead of hiring in one location and then one person saying, oh, I would rather go to the posting in the next location, we're hiring them all at once. It's complex to do that, but that's where we are. The positions have been posted. The screening has happened across all these positions. Now we will be into the interviewing.

MS. LOHNES-CROFT: How many nurse practitioners are we graduating a year here? Is it just Dal that does the nurse practitioners program?

MS. COCHRANE: Yes.

MS. LOHNES-CROFT: How many are we graduating a year?

MS. COCHRANE: I don't know the answer to that. We have had interest. That hasn't been an issue.

MS. LOHNES-CROFT: But to me an easy solution would be to open up the program to take in more people interested in being nurse practitioners. I know we've talked about helping doctors with their tuition fees and whatnot. To me it seems only logical that we would open up more placements for nurse practitioners in their school.

MS. COCHRANE: We'll have to look at the supply versus the demand for nurse practitioners. They don't only work in primary care.

I would also not want us to forget the practice nurse positions. Those are very, very critical positions. Chronic disease management requires a lot of attention. We need to manage our disease with the help of a health system. So there's a lot of work to get us there and to manage it well.

Vehicles like group education sessions for blood pressure - we need some new ways, some more efficient and effective ways in our primary care system to deliver care and support. That's built in. The teams need to think about roles and skills, and what our population need is and how we best meet that.

That team of people needs to sit down and figure it out. This is our population. What's the nurse's role? What's the nurse practitioner's role? What's the physician's role? They do it as a team. Guidance, yes, but it's a team. They will be developing an accountability document with us on that, how they're going to serve the population. But it's the whole team that is the magic.

MS. LOHNES-CROFT: I spoke a little bit about incentives with the medical school. What tools are you using for recruitment and retention of doctors to get them here to Nova Scotia?

MS. GOLDRING: At the Department of Health and Wellness we have a number of programs. We have return of service agreements and the communities of need are identified in the province, so we have those. We have a family medicine bursary. We have debt assistance and we have tuition relief.

MS. LOHNES-CROFT: So those are being well taken up in Nova Scotia, currently?

MS. GOLDRING: Yes. As an example, last year we had 18 communities across Nova Scotia where those programs put physicians into those communities on return of service agreements.

MS. LOHNES-CROFT: Return of service means?

MS. GOLDRING: Return of service means the physician signs a contract and they provide service to that community for a number of years.

MS. LOHNES-CROFT: When you are recruiting, I know there are a lot of communities - I know I have one - that have their own recruitment group trying to find a primary care giver. Dr. Harrigan, is there collaboration between your group and these groups? I get confused sometimes because I'm not always sure which one is doing what. Would you like to speak to that?

DR. HARRIGAN: We know, and studies will prove, that working with communities and helping to recruit people is absolutely essential. We're working very closely with communities to do that, and would encourage anyone who is looking to recruit to talk to us about it.

I think we actually know that the tendency is to provide income incentives to people, but in fact, what we found is actually much more valuable is to create a welcoming environment in your community for the people who are coming. We have spouses who frequently need to be employed. We have school systems that the children are going into. We frequently have people who may be of a different cultural or religious background. We need to welcome them with open arms, and where we've been successful is where we've mentored members of the community with the physicians coming in and making them feel part of that community.

It's absolutely essential. We're happy to work in collaboration with all communities, but that is the key - to make the physicians welcome and part of the community that they're joining.

MR. CHAIRMAN: Mr. Maguire.

MR. BRENDAN MAGUIRE: Just a quick question, back to the nurse practitioners. In December, we made an announcement of 22 nurses. When will we actually see those nurses in the communities? I don't want to talk about the whole system. I just want to know when, because one of them is going to Spryfield. When will we see that nurse in Spryfield?

MS. COCHRANE: We're in the hiring process now for all 22 positions across the province.

MR. MAGUIRE: Roundabout date - time. Are we weeks, days, months?

MS. COCHRANE: They will be hired between now and the end of April and be in place this Spring.

MR. MAGUIRE: Thank you.

MR. CHAIRMAN: Thank you. We will now move back to the PC caucus - Mr. Houston, for 11 minutes.

MR. HOUSTON: I have a limited amount of time and I have a series of questions. Hopefully we can get some brief answers.

Dr. Harrigan, you mentioned that since you don't have a family doctor you said you either go to a clinic or go to emergency. I think that a lot of emergency room physicians I know would kind of cringe to hear that, but that's what's happening. So I would like to ask the Health Authority - I've seen some statistics on the number of visits to emergency rooms. For 2015-16 I think it was about 78,000.

I'd just like to ask if the department can provide in writing - maybe even by the end of the day - the total number of emergency room visits across the province by year since 2009. So for the last seven years, how many people are going to emergency? I suspect we'll see that ramping right up, but I'd like to see that from the data if we can get that. Is that something we can get - emergency room visits by year?

MS. PERRET: We'll see what information we have and put something together.

MR. HOUSTON: Okay, thank you. In terms of the nurse practitioners and the family practice nurses, 22 of them - there was an additional budget allocation of $3.6 million. Was that $3.6 million for this fiscal year that's ending in a few weeks?

MR. KEVIN ELLIOTT: That's the annual total cost, but that won't be spent this fiscal year because as Ms. Cochrane indicated they're not all going to be filled this year. That will be the annual cost once those positions are all in place.

MR. HOUSTON: Has any of that been spent? Did we tap into any of it?

MR. ELLIOTT: I'll have to ask Ms. Cochrane if any of those positions are filled.

MR. CHAIRMAN: Ms. Cochrane.

MS. COCHRANE: No, we haven't filled - I explained earlier that we're doing this as one fell swoop, posting across the province, doing the selection across the province, doing the interviewing . . .

MR. HOUSTON: Okay, I just wanted clarification on that. So the minister made the announcement, it was a well-received announcement, there was a lot of fanfare around it but not a penny has gone out the door yet since then. That was quite some time ago. Okay.

In the interest of time I'll leave that. It does seem bizarre - if you get one you should put them into play, I would have thought. But if you are waiting for them all at once, I guess that's a decision for a higher pay grade than me.

In Ontario they're talking about allowing registered nurses and nurse practitioners to prescribe certain medications. Is that something we're looking at doing here?

MR. CHAIRMAN: Ms. Goldring.

MS. GOLDRING: It is something that is being examined right now, but it's under active discussion in our department.

MR. HOUSTON: Okay, so it's being looked at but there's no decision. Are you aware of any other provinces that are doing it?

MS. GOLDRING: I am not. It doesn't mean that they aren't, I am just not aware at this point.

MR. HOUSTON: It seems like there might be a role for that but it's being looked at, okay.

We talked about transitioning the system - turning it on its head, I think I heard was one thing and all kinds of different things. In terms of community-based health care and people taking more responsibility for their own health care - physicians play a role in that, but I often hear from physicians that they just don't have time to try and work with people as to how they can be healthier. They've just got to get them in and out and try to see the next person.

Is there any kind of a billing code a doctor could use if they were to see a patient and try to work with them on a healthier lifestyle? Is there a billing code they could use for that?

MS. GOLDRING: Are you talking about a code just for a physician to talk about a healthy lifestyle?

MR. HOUSTON: Yes, to work with somebody to improve their own health outcomes.

MS. GOLDRING: We have a number of codes that would cover that. A specific one just to discuss a healthy lifestyle - we have complex care codes. I think in a general office visit code that we have with the physicians, they can have that discussion with the patient. A code exactly like that, I'll have to check for sure for a well-being code but . . .

MR. HOUSTON: They could maybe work it into a code, I guess. I wonder if maybe you should have a specific code, then you guys could track that. If you're trying to move

the system to people taking more responsibility - I don't know if that's the way to describe it, but people being healthier. A doctor did tell me, he said Tim, as a politician, you have way more influence on a person's health than I do as a doctor, because I have to deal with what's there but I don't have much time to invest in prevention, so if you had a code like that.

I know there was a code review that was started a few years ago under the NDP. Is that review still happening?

MS. GOLDRING: Yes, it is. It's the Physician's Manual Modernization Project - PMMP - and that is still under way. Physicians are actively engaged in that project with us and are . . .

MR. HOUSTON: Do you have a timeline for that?

MS. GOLDRING: Yes, November of this year we expect to have . . .

MR. HOUSTON: So in November 2017 the report would come out, okay.

MS. GOLDRING: Well, not just a report. We expect to have the new manual available in Nova Scotia for physicians to use.

MR. HOUSTON: New billing codes?

MS. GOLDRING: Well it's looking at relative values. We're trying to get away from that terminology of billing codes. What the manual will look at is the real way the physicians practice now, so exactly what you're talking about - being able to provide payment to physicians for taking the time to have those discussions with the patient on their well-being and their care and what they can do on their own. The manual will recognize those types of care and it will be in the manual.

MR. HOUSTON: Okay, so November 2017.

MS. GOLDRING: Yes.

MR. HOUSTON: I often hear from people who say they had to go out of province to see a specialist or to have a surgery, they couldn't get one here in an amount of time. They could get one in New Brunswick or somewhere else in a much shorter amount of time. I guess I would ask the deputy, is that just anecdotal or is that happening? Are Nova Scotians going to other provinces to get care quicker?

MS. PERRET: I'm going to give you a general answer and I'm taking a bit of a leap . . .

MR. HOUSTON: Maybe could we be as specific as yes or no? (Laughter) Are they going to other areas to get care?

MS. PERRET: I was going to say that all provinces have arrangements where members of the population can go to other provinces to receive various services. I don't know the number in Nova Scotia. Certainly I do know there is a number that come into Nova Scotia to get services as well.

MR. HOUSTON: Maybe I could ask for those numbers - maybe we have it at hand - how much has the province paid to other jurisdictions in transfer payments to cover the cost of Nova Scotians going to other areas to get treatment? That would be one part of that. The other part of that would be, how much has Nova Scotia received from other provinces? Then we'd have a net amount. Is that a number we could get? Do we have it at hand?

MR. ELLIOTT: I don't have it right now, but I can tell you that Nova Scotia has for a long time been a net recipient. We receive a lot more than we actually pay out. So that number is a significant number - in the millions - more that we receive than we pay out because of our Atlantic presence.

MR. HOUSTON: I imagine, yes. So if we could get that - maybe it could provide some level of detail on what services people are leaving the province for, and coming in. Could we break it down like that by service?

MR. ELLIOTT: I don't know if I'll know why they left. I'll see what we can get.

MR. HOUSTON: I wonder if we can ask about the VG. What is happening with the VG replacement? Where are we with that? We've seen monies announced and pictures taken and stuff, but what can Nova Scotians expect to happen with that?

MS. KNOX: It is an important question for Nova Scotians because our QEII Health Sciences Centre is a Nova Scotia resource and, in fact, a resource for Maritime Canada. So we have a very aggressive strategy. As you know, we need to decant the VG site - those two wings of that VG site. We have gone through a process and we are now at the process of design of the space that needs to replace those two buildings.

MR. HOUSTON: So the design is done?

MS. KNOX: No, it's not done. We're in the process and that will take about a year.

MR. HOUSTON: So another year for a design.

MS. KNOX: Yes, but in the meantime, as you know, we have created a solution to the services that we provide there by enhancing services at other sites, and it is our approach to not be centralizing all services in one place, but put them in the place where Nova Scotians can access them.

The Dartmouth General Hospital is a very important part of the work that we're doing and enhancing - adding 44 new beds there and new surgery suite. That work is well in development. We're in the process of finishing the design for the work that will be done at Hants Community Hospital and we'll have that work done in the next months, and so that's really important.

MR. CHAIRMAN: We will now move to the NDP caucus - Mr. Wilson.

MR. DAVID WILSON: I just want to quickly return - my time was cut off and Dr. Harrigan was answering a question around Weymouth, so I just want to be clear. Dr. Harrigan indicated there was no restriction on billing numbers, but I believe I heard if the community found a physician they would not be granted a billing code. Did I hear that correctly? If the community of Weymouth found a physician tomorrow to fill the gap until we have a collaborative model in that region, would they be allowed to practice in Weymouth?

DR. HARRIGAN: It's just the billing number thing - everyone says "billing number" and it's always wrong. What we have said as part of the Nova Scotia Health Authority, is that all physicians are in. So if you want to work in Nova Scotia you need to be privileged in the Nova Scotia Health Authority - if you want to utilize the resources of the Health Authority, which are lab and DI, you must be privileged.

MR. DAVID WILSON: Completely understand that.

DR. HARRIGAN: So what we would say because of our planning - and we are planning with the community of Weymouth, I know not everyone in Weymouth is happy, but we are working with the community of Weymouth. We have the warden of Weymouth on our committee, and our plan is to put a collaborative practice in Digby with satellites to Weymouth. We would not grant privileges to someone to work in Weymouth.

MR. DAVID WILSON: So it doesn't matter if it's a billing code - it's not my term - a physician, a doctor, a medical person, I understand that no, they would not be allowed.

DR. HARRIGAN: We would encourage them to come and work in our collaborative, which they would want to do.

MR. DAVID WILSON: You would encourage them to go to Digby, once a clinic is open, when we don't even know that - there are no timelines. That's the frustrating part, not only for us but for people in communities like Weymouth.

The deputy mentioned there were about 42 possible clinic sites. None are open right now, and we can't get when they are going to be open. Could you provide the list of the potential 42 sites in the province? Is that something you could share with Nova Scotians?

MS. PERRET: So there are 42 that are in play, either stood up or in the process of being stood up, but the Health Authority will have more specific information for you.

MR. CHAIRMAN: Ms. Cochrane.

MS. COCHRANE: It's not one size fits all. Over the last 10 years, the funding that has been available to enhance and begin to build collaborative teams has been one position at a time. We have part-clinics or part-teams that have formed and so part of our work is going to be to build the new collaborative team members to those 42 teams, continue to work with them on what we call quality improvement, looking at their patient population and figuring out with them and with their teams how to best serve that population.

Those teams are, in one way or another, already in shape. We have about eight that we would consider - pretty much the team is there. Now we'll continue to work on how we offer quality care for the population.

MR. DAVID WILSON: That didn't answer the question. Are you able to provide us where those teams will be working?

MS. COCHRANE: Yes, we can give you the list.

MR. DAVID WILSON: Excellent. You indicated there are eight already there, or the team is together. I couldn't agree more that not one size fits all; that was the key to implementing the Collaborative Emergency Centres. Each one was different because the community needs were different. So this is not a new concept, that's the frustrating part about this - that happened six or seven years ago. We understand that. Communities are in need.

I would say that because of the amalgamation of the district health authorities, maybe the delay is because each community's voice is lessened because of the amalgamation. Maybe there will be a difference of opinion, but I truly believe the reason we don't have hard dates on when these collaborative centres - clinics, models, whatever you want to call them - aren't open is because of the loss of that community input.

I'd like to go quickly to the VG replacement - I know my colleague mentioned it. Just a quick question - is the Cobequid Centre in Lower Sackville being considered for expansion to offer some of the services that will be displaced from the closure of the Centennial and the VG site?

MS. KNOX: Thank you for that question. It will definitely be one of the areas that we would be looking at, yes.

MR. DAVID WILSON: Okay, great, thank you. I know I don't have much time. I want to go quickly to the recent follow-up from the Auditor General's Report. I know there's a number of recommendations that had not been completed in the report. They

identified those and I know there was a response from the department and from the Health Authority.

One area that I know was a bit frustrating for the Auditor General was around even just trying to find out if the department, if the Health Authority, if the government is committed to meeting the national benchmark for hip and knee replacement? How come the Auditor General couldn't get a response to that? I'll ask that now, is the government committed to meeting those benchmarks for knee and hip replacement surgery wait times?

MS. KNOX: I'll speak on behalf of the Health Authority and I can say the answer is yes.

MR. DAVID WILSON: So is that a commitment? The province has agreed to meet that? Is there a plan in place to reach those goals?

MS. KNOX: Would you like to hear our strategy?

MR. DAVID WILSON: No, I'd just like a timeline, really. The strategy is fine. I mean the strategy of trying to do more surgery is ultimately what the goal is. Is there a timeline on meeting the national benchmark? That's the most important thing really. Is there a timeline?

MS. KNOX: We have a three-year strategic plan and it's part of that. That strategic plan would be starting in 2016. We would see over a three-year time frame that that's our goal.

Our challenge from the Auditor General's Report is that we had to look at hips and knees in particular. We had an extraordinarily long wait. A number of people who were very exceptional long waiters and when we looked at our population who's on our waiting list, we decided that our best approach for the sake of the people who are on the waiting list was to focus on the long waiters. That's not how the recommendations would have been - they weren't direct to that.

We put in a target for the first year of Nova Scotia Health Authority to do 600-plus new hip and knee surgeries. We did 675. We put a target for more than 800 in the second year, which we're finishing. We're in our 24th month of Nova Scotia Health Authority, and we will have achieved 875 to date. For the first time ever in the second year, we have put fewer people on the wait-list for hip and knee surgery in this province than have had their surgery, then have come off.

So our wait times look worse because the people who weren't waiting as long are waiting a little bit longer while the people who are the longest on the wait-list were having their surgery done, but that process will take us two years to really then be constantly reducing our wait list. It's a very complicated strategy, but thank you very much for giving me the opportunity - it is a major focus for us.

MR. CHAIRMAN: Ms. Zann.

MS. LENORE ZANN: I'm glad to hear that it's starting to move along because I have a number of constituents in the Truro area who are waiting for hip and knee replacements as well - some that are very complicated. They've been waiting for three years in agonizing pain and they're really, really frustrated. So I hope that does move along.

MS. KNOX: One of our contributors to getting our wait-list reduced is being able to do orthopaedic surgery now in Truro.

MS. ZANN: Right. That would be very handy.

Despite commissioning a report that showed Collaborative Emergency Centres were working, the McNeil Government hasn't opened any more CECs and I don't really understand why. They obviously work and they were the first of their kind. The whole country was talking about it. I noticed that in the 2013 platform the now-government said that they would ensure a doctor for every Nova Scotian within their first year and at the cost of $3 million. I noticed that you said you just got $3.5 million from the Department of Health and Wellness recently. Again, I'm not quite sure why more CECs aren't being opened.

Also on Thursday, October 2, 2014, the Minister of Health and Wellness stated that the CEC in Lunenburg would have a definite date very shortly. In a June 2015 article in *Cape Breton Post*, the minister said he confirmed that CECs would be coming to North Sydney, Lunenburg, Glace Bay and New Waterford and a type of emergency room community health centre would go to Shelburne. During Question Period on Friday, May 20, 2016 the Minister of Health and Wellness said, "During the health services review, the current clinics and future CECs are part of that review, and I am looking forward to a final determination on the communities that are on the list as to what will happen in those areas."

I'm confused because we are almost four years into the government's mandate and yet are you telling me that they're now just compiling a centralized waiting list for the thousands of people who don't have a family doctor?

When are we going to have the timeline that's going to fulfill (a) the election promise, and (b) when more of these Collaborative Emergency Centres are actually going to be opened across the province?

MS. PERRET: I think a point of clarity because you talked about Collaborative Emergency Centres and we would distinguish those from collaborative care centres. So most of the conversation has been focused on the collaborative care centres and standing them up. I just don't want to confuse the two. As I mentioned earlier, the use of community paramedicine and the support that that's providing in communities to enhance primary care responses has been fabulous. Nova Scotians should be proud . . .

MR. CHAIRMAN: Order. Time has expired. We'll now move back to the Liberal caucus and Mr. Rankin.

MR. IAIN RANKIN: It's a very interesting discussion today on a no-doubt challenging issue for the province.

I guess I'll just start by asking a question on the VG replacement as well. Given the fact that there is significant growth outside of HRM, I'm just wondering, is there any discussion on looking to decentralize - another outpatient clinic or something in that realm? My interest is particularly the Halifax West region, not specific to my constituency, but that's where the growth is happening. I'm just wondering if there's consideration given to locating some of the infrastructure outside of the city core peninsula, and my question would be specific to that region.

MS. KNOX: The answer is yes, looking at how we maximize all the resources that we have. I would say the VG replacement is a good example of how we're trying to do business. Let's not be creating new structures if we don't need to. Let's maximize the structures that we have.

The VG replacement particularly requires special attention because in it resides our tertiary and quaternary acute care service, so the highest level of sickness care for the people of Atlantic Canada. Not all services are easily moved to another location, but some have.

We are looking at those services that do not need to be all together in the downtown core of our city. They need to go elsewhere, and that is part of our planning.

MR. RANKIN: I appreciate that answer. Just going back into the physician recruitment plan, given that HRM has some vacancies and others that are imminent - the last I looked, it said 30 vacancies and 22 coming up - what is the transition plan on a broad level for those FTE allotments? Are we speaking directly to those people who are considering retirement or have already confirmed retirement? I think of the clinics that have team-based approaches - not necessarily official collaborative practices. I would hope that we are working with them to see if they will stay longer, because that would reduce the burden on the recruitment for new FTEs. Do we fully understand what they're looking for in order to stay in the system to help us transition through to that collaborative practice?

MS. KNOX: I would ask Dr. Harrigan to respond.

DR. HARRIGAN: April of last year, we got a provincial recruiter transferred from the Department of Health and Wellness to us. That has been a tremendous benefit to us. We realized immediately that we had no recruitment officer for the Central Zone. There never had been. We totally recognize the concerns that you're raising. We also had no idea, because physicians are independent practitioners, so they didn't have to tell us that they

were retiring and moving on. So we are now working together. We have a recruitment officer. She is visiting all the offices of people who are actually intending on retiring.

We have one website with every single position that's available in the province on a website. We make sure they're aware of all the incentives that are available. Also, we talk to all the residents. We make sure the residents know what the positions are.

But it's bigger than that because we know what the new graduates want. Part of the planning is that we have to create an environment that will be attractive for new residents to come and work in. That's one of the reasons to move toward team-based care. We have many balls in the air looking at this at this time, but we have better data now than we ever had before, and we actually have a direct connection with our doctors as well.

MR. RANKIN: When you say you know what the new graduates want, I just want to understand if that goes beyond just the model of practice and if we're actually looking at the methods if it's not. I understand some of them aren't as interested in the fee-for-service model. Is there flexibility for a clinic that is looking to sustain itself and is used to having a certain complement of staff, is there flexibility to say look, we know in order to keep you open, in order to keep thousands of people having access to primary care, is there an ability to say yes, we'll approve someone at, say, a salary level or something along those lines?

DR. HARRIGAN: We have multiple vacancies in the Central Zone so we have plenty of positions available. There's a great deal of interest on the part of doctors to look towards moving towards group contracts or looking toward alternative payments. We're working together with the government, with Doctors Nova Scotia, and ourselves to make that a reality. I think that will help.

We have some very innovative practices in the province that have themselves developed group practices and collaborative practices but are struggling because the costs of doing so almost make it not viable for them. We are in active conversations with them to try to - the way we pay them, the way we support them is different, so that we can continue those practices. Those are happening all over the Central Zone.

MR. RANKIN: And what about the doctors who are on a return of service contract? Some of their contracts are coming up for expiration. What's the plan to ensure that the Nova Scotians who have that person as their doctor continue to have a doctor?

DR. HARRIGAN: I'll take a step back to say that our hope is when we have people who come to a community as return of service that they stay there forever. Currently it's a three-year commitment. It has been our experience that many of those physicians leave so it becomes a little bit of a revolving door.

Again, our answer is the same. If we create a work environment for them that is something that provides appropriate work/life balance, it is one part of it, so looking at the

environment where they're working, but the bigger environment is looking at the community where they're living. The work we have to do is make sure that those people who are in return of service positions are welcomed into the community and feel part of the community and, therefore, want to stay. That's actually critical to us.

MR. RANKIN: Right, I understand that's the hope but it's not always the case and when you have a culmination of maybe an FTE that has a return of service expiration and then another FTE that is looking to retire, there's obviously a challenge there with trying to keep a clinic moving. When some of these clinics have thousands of patients relying on it, how can we ensure that they continue to be sustained?

I ask that because I understand the direction of collaborative practices. I'm aware of a clinic that uses a team-based approach and has applied and although it was admitted they had a strong case, they weren't approved for a collaborative practice model. How do we explain that to that clinic when our answer is that we're going towards a collaborative practice model? They're willing to play by those guidelines, how do we ensure that they have the opportunity to sustain themselves and keep their patients at that clinic?

DR. HARRIGAN: It's a really good question. As we build the system, on the one hand it's a wonderful problem to have, that everyone wants to be part of a collaborative, but we have to be methodical about the way we do it, to make sure that the appropriate accountability is in place.

For those practices, and I've talked to several of those practices, I think we're suffering a bit from our inability - we used to have international medical graduates, usually 12 to 14 per year, who could come and help fill spots in our province. That program is gone and it has not yet been replaced.

One of the ways we can work with that is to work very hard with our colleagues at Dalhousie family practice to build a practice for the assessment so we can bring more doctors into Nova Scotia who are international medical graduates.

The other issue is to open up to the U.K. We now have the ability, through the College of Physicians and Surgeons, to bring in physicians from the U.K. and to use those as mechanisms to bring people in to help those practices until such time as we can build.

MR. RANKIN: So what's the biggest challenge? I've heard it's not a supply issue so you are talking about bringing in more supply, so what is the challenge? Is it trying to find the funding, because I've seen FTEs approved but no ability to fill that position so I'm not getting the supply/demand dynamic.

DR. HARRIGAN: I think the largest challenge that we have right now is attracting people to team-based care - no, it's not attracting people to team-based care, it's attracting people to replace an older model that people are no longer attracted to. Our challenge is to build the team so that people will come and work in those environments.

MR. RANKIN: So you articulated your plan for Weymouth, can you say what your plan is for the Prospect-Hatchet Lake area?

DR. HARRIGAN: I don't know the specific plan for Hatchet Lake. I've been to Hatchet Lake, I've spoken to all those physicians, a wonderful environment. We need to assist them with recruitment and, in fact, we are doing that.

MR. RANKIN: The number was 1,241 doctors in 2015; how many doctors have been hired in the last two years since that number was provided?

DR. HARRIGAN: The problem is 71 physicians, family practitioners have come but some of those are replacements and some are new, so I can't actually tell you how the total will change.

MR. RANKIN: So we don't have a net total in the last two years to see if we have more doctors today than we had in 2015 - do we have that?

DR. HARRIGAN: We do. We do have more but I don't have the actual number for you right now.

MR. RANKIN: We do have more. So given that number, I would just expect that anyone who has a doctor currently today will not lose a doctor - is that a correct assumption?

DR. HARRIGAN: I think the issue is, and it's a constant dilemma, if you look at the actual numbers, which we have, why doesn't everybody have a doctor? The thing is we don't control how many people are taken into a practice, we don't control how many patients physicians see so this dilemma will continue until we establish a system where we actually say, this is your panel size, here's how many people are taken into your practice. That is where we are headed but that is not where we are now.

MR. CHAIRMAN: Order, time has expired. I'd like to give both the Nova Scotia Health Authority and the Department of Health and Wellness an opportunity for some very brief closing comments. We'll start with Ms. Perret.

MS. PERRET: I would just like to thank the committee again for having us here. This is an important discussion. If it does anything it enhances my resolve on some of the issues that are important to you and to your constituents that we need to be paying attention to. I've heard a lot of support for collaborative care and for the transition under way and I appreciate that support.

As you've heard, I don't know what the analogy is, but we're building the plane as we fly it, so it does take some time and care. I would reiterate that Nova Scotia is really well positioned to make the shifts that are taking place in health care systems in the country, and I'm very appreciative of the opportunity to be part of that. Thank you.

MR. CHAIRMAN: Thank you, Ms. Perret. Ms. Knox.

MS. KNOX: Thank you very much for the opportunity to talk with you today and for your very good questions to help Nova Scotians understand our issues. The Nova Scotia Health Authority is driven by a simple mission: to help Nova Scotians stay healthy and be healthy for generations. It's the foundation of our strategic plan, it's how we are making decisions, it's what drives us.

We need different health outcomes for this province and we have to have the courage to do things differently so I hope you are hearing us. We understand the needs of today, we have to focus on how we help people today, and we need to make decisions that look at all Nova Scotians into the future and that takes courage.

We are working to build a health system that collaborates with communities and care providers and one that engages people as partners in their own health. What we know is that we have worked together as a province. We have work to do to bring our best assets, and we believe we have a lot of assets in this province and resources to the challenges that we face. It really is about how we're willing to work together to find the best solutions for our people. Thank you very much.

MR. CHAIRMAN: Thank you, Ms. Knox. Thank you for all the answers you have provided today. Our clerk will be following up with any questions that remain to be answered.

We do have some committee business. We had a meeting of the subcommittee to choose topics for upcoming meetings. That is before you. Are there any questions or comments about the record of decision from the subcommittee?

Hearing none, would all those in favour of the topics put forward by the subcommittee please say Aye. Contrary minded, Nay.

Our clerk will acknowledge that that motion is passed, those topics are approved.

We had two items of correspondence, both from the Auditor General's Office. Are there any questions or comments about those letters received from the Auditor General's Office?

Hearing none, next week we do not have a meeting because of March break. The following week we will return on March 22nd. We will have the Department of Municipal Affairs as a witness, the topic will be financial oversight. Is there any further business to come before the committee?

Seeing none, this meeting is adjourned.

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