HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, April 26, 2017

Legislative Chamber

Doctors Nova Scotia
Funding and 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. Terry Farrell replaced Mr. Brendan Maguire]

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

Doctors Nova Scotia

Ms. Nancy MacCready-Williams, CEO
Dr. André Bernard, Chair, Board of Directors
Dr. Heather Johnson, Member, Board of Directors/Chair of Audit Committee
Ms. Alana Patterson, Director, Compensation and Practice Support
Mr. Kevin Chapman, Director, Finance and Partnerships

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, APRIL 26, 2017

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Good morning, everyone. I call this meeting of the Public Accounts Committee to order. This morning, we have with us Doctors Nova Scotia. We will be discussing funding and physician services.

I would like to remind everyone to place their phones on silent. We'll start with introductions, beginning with Mr. Farrell.

[Committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you for being with us. Ms. McCready-Williams, we'll now allow you to provide some opening comments.

MS. NANCY MACREADY-WILLIAMS: Thank you very much. As I said, my name is Nancy MacCready-Williams, CEO of Doctors Nova Scotia, the provincial medical association and collective voice of physicians across the province. Thank you very much for this opportunity to have a chat with you this morning. I also want to share that our President, Dr. Michelle Dow, is unfortunately out of the country and sends her regrets this morning.

As CEO, I am the sole employee of our Board of Directors of Doctors Nova Scotia, which is made up of physicians from across the province elected in a democratic process. Our association is made up of 3,924 physicians here in Nova Scotia. I will ask my colleagues, Dr. Johnson and Dr. Bernard, to introduce themselves and present their opening statements.

MR. CHAIRMAN: Dr. Johnson.

DR. HEATHER JOHNSON: Thank you, Nancy. We need look no further than the news to see ongoing discussion about physicians in Nova Scotia. Collaborative care, recruitment and retention, the shortage of family doctors, and gaps in service are just a few of the issues making headlines in our province today.

Doctors Nova Scotia has a role to play in resolving each of these issues. In fact, the association has a legislative mandate that requires it to do much more than just negotiate contracts for physicians. We also work with our partners to promote health, prevent disease, and improve services for Nova Scotians. Doctors have solutions, and we welcome the opportunity to improve the system for our patients.

Engaging individual physicians is important, and there is great value in engaging the profession as a whole through Doctors Nova Scotia. Long ago, physicians decided that the organization should be much more than just a union. Physicians see Doctors Nova Scotia's role as a means to influence policy, advocate on behalf of patients, and contribute to health system decision-making in a way that reflects the diversity of physicians' experiences and perspectives in the province. Individual physicians represent their unique and specialized interests and needs, but Doctors Nova Scotia understands the broader context in which health system change will take place. Doctors Nova Scotia can help decision makers by providing perspectives from all physicians. Both of these engagement methods are important.

Over the years, Doctors Nova Scotia has worked closely with provincial governments and health authorities to improve care for Nova Scotians. We value this collaborative relationship; it was the envy of other provincial and territorial medical associations. This collaboration was beneficial for patients, for physicians, for government, and for the health care system overall. For example, Doctors Nova Scotia worked with partners to develop the province's 2012 Physician Resource Plan. We helped reduce medical seats in some specialties in order to increase seats in family medicine to allow more family doctors to be trained in Nova Scotia. We continue to be a part of the working group which considers a regularly updated Physician Resource Plan - and its implications - for Nova Scotia.

Based on recommendations from John Ross in 2012, we supported the move to Collaborative Emergency Centres. Today, services are offered more consistently in communities that previously suffered closures. Doctors Nova Scotia worked with

government on MyHealthNS, the personal health record. We see tremendous value in technology allowing patients timely access to safe, coordinated care.

MR. CHAIRMAN: Dr. Bernard.

DR. ANDRÉ BERNARD: In 2011 we extended the 2008 Master Agreement contract by two years, when our province faced a significant fiscal challenge - a context that we know now as well. Extending the contract with smaller increases at that time saved the then NDP Government $45 million.

Over the years we have worked with the government and the Nova Scotia Health Authority to use physician contracts as a means to help incent the kind of services that Nova Scotians need and deserve. We have worked closely with the government and partners on a naloxone demonstration project to save the lives of people suffering from opioid overdose. In collaboration with the Nova Scotia College of Pharmacists, we developed a demonstration project on which physicians and pharmacists will collaborate to support the needs of patients with complex care needs. We championed health promotion policy by advocating for banning tanning beds and energy drinks for youth, supporting anti-smoking legislation, and supporting the Health Minister's legislation on e-cigarettes.

I'll say that some of our decisions and positions have made us unpopular with our members, but we persisted and we persist because they were the right decisions for our patients then and now, for our profession as a whole, and for our province.

Today our health system is experiencing challenges and doctors have solutions and wish to contribute. We recently released two position papers. One outlines 11 recommendations for primary health care renewal to ensure that Nova Scotians have better access to family doctors. The other paper offers recommendations for government, the Nova Scotia Health Authority, and the IWK to ensure that physicians individually and collectively, through Doctors Nova Scotia are involved in health system change.

Nova Scotia is a small province, but together we can do great things. Working with Doctors Nova Scotia will yield the best outcome for the system and, above all, for our patients. We welcome any questions you may have.

MR. CHAIRMAN: Thank you, Dr. Bernard. Mr. Houston, with the PC caucus, you have 20 minutes.

MR. TIM HOUSTON: Thank you for the thoughtful opening comments. It seems to me that there are government policies that are impacting the ability to recruit doctors to the province. It also seems to me that there are policies that are impacting retention and that are causing doctors to want to leave. It appears that there's a vicious circle happening here.

In both their opening comments, Dr. Johnson and Dr. Bernard stressed that doctors have solutions, through working with Doctors Nova Scotia.

I'll just ask kind of a short question to begin with: is anybody listening? Does Doctors Nova Scotia feel like anyone is listening to the solutions that doctors are tabling?

MS. MACCREADY-WILLIAMS: Yes, I think people are listening. We value our relationship with our colleagues at the Nova Scotia Health Authority, the IWK, and the Department of Health and Wellness. But we are going through a significant period of change in this province, with standing up one health authority, and with the Health Authority moving forward with a new primary care model.

We thought it was important to make sure that the physician voice and the various perspectives around the implications of moving forward are heard. We put it in the form of a position paper so that we could share that perspective easily with our partners.

I'd like to turn to my colleagues because they can provide some first-hand experience in terms of what practising in Nova Scotia has been like for the past couple of years.

MR. HOUSTON: I do have some questions about that, but as a relatively new politician, I've been at Public Accounts Committee and we have had the Department of Health and Wellness and the new Health Authority here numerous times. I'm always taken aback because it seems there's a clear line of accountability that's missing. Oftentimes witnesses come here and they seem to have little understanding of the businesses they're trying to run. It just makes me wonder how these people are managing a massive thing like the health care system. It kind of makes me nervous because there is a relationship over time, no question, of political meddling in the system. Past and present governments have contributed to that, for sure, but we have to get past that.

In terms of experiences in the system today, I'd like to ask a question of Dr. Johnson. What's the sense, in the profession, of the impact on the mental health of the people working in the system? It's a heavy burden that's being carried by the people working in the system. As you said, you don't have to look past the news. Some of these terribly depressing situations that we're hearing about - I'm just trying to put myself in the stressful situations of the doctors, whether it's pressure to take more patients or whether it's pressure to provide treatment in an environment where we have a Code Census every day. Do you have concerns about the mental health of your colleagues?

DR. JOHNSON: We always have trouble when the work situation is challenging, and there are challenges. They're written in the paper. Most physicians in Nova Scotia cope as best as they can and work as hard as they can to advocate for their patients. It is challenging. Mental health-wise, I don't have concerns, but I think that people get frustrated when they feel like they advocate over and over. It's difficult to make change in a system that's this big.

MR. HOUSTON: So the burnout factor must be - do you have any stats on the burnout factor? Are doctors lasting as long? I don't know what the proper way to phrase it is, but are they practising as long as they would have traditionally? Is Doctors Nova Scotia sensing any change in the burnout rate of doctors?

MS. MACCREADY-WILLIAMS: I think that there are a number of stressors in the system right now. We have actually worked with Acadia University and our GP council to do a burnout survey, to gather data on that. When that's complete we'll be analyzing that and understanding how we, through our professional support program - which is a program that we offer to physicians to provide supports - mental, physical, et cetera - what programs we need to put in place to help support physicians through this time.

I'm sure my colleagues could speak to their own personal experiences working in the system.

MR. SPEAKER: Dr. Bernard.

DR. ANDRÉ BERNARD: As an anesthesiologist working at the QEII Health Sciences Centre - we're a massive institution that provides exemplary care in spite of huge pressures - we're hearing about that on the news nearly every day - in the face of those pressures.

I'm an anesthesiologist; I work in the OR. I have one patient at a time. My job is to provide life-saving care while they're having their procedures done, and to deliver them through to their families at the end of it.

In those moments of the day that I'm sitting in the coffee room and listening to my colleagues in anesthesia speaking, what we recognize is that we see around us, within the system - it's like a pressure cooker. We are working harder than ever with limited resources, and doing the best we can.

One of the heartening things is that, outside of the news headlines, I see that we are providing exemplary care in spite of those circumstances. I think part of what we have to offer - and I think part of the reason, through you, Mr. Chairman, to Mr. Houston - is that there's a resilience being trained among doctors today. I think it has always been there, but there has been a clear focus. I'm an early-career physician, and resilience and mental health have been focused for me, but there's an implication for that, and that implication is that new entering physicians - and I think Dr. Johnson could speak to this as well - are expecting practice changes. They perhaps aren't willing to work the incredible hours that were expected of - I grew up in Mabou, and doctors worked all the time in Inverness County, as our chairman will know. That context is changing in response to the need to adapt, to be a practice that is resilient and yet works that quickly for the health of Nova Scotians.

I think we are more attuned to that. That is why I would argue and put forward that we are here to engage the system as Doctors Nova Scotia, as the collective of physicians

in Nova Scotia, to build a system that is more robust for patients and is more sensitive not only to doctors but to nurses and pharmacists and allied health care professionals who make up the health care team. It's not just singly us. It's all of us trying to work together to make the system as effective as possible in spite of the stressors. This fiscal context, we hear again, is not just in Nova Scotia. We hear about it in every province. There are no signals that it's going to get better, so we need to find ways of creating institutional resilience despite that.

[9:15 a.m.]

MR. HOUSTON: That's helpful, actually. Doctors are doing all they can. They're speaking out about issues and asking for help.

Then we have situations like the $6 million that was withheld from doctors. I heard there were payments due to doctors under their contract. They were normally paid in January, and I heard from doctors in March and April who said they still had not been paid. Do you know if those payments have been made yet? I'm sure when you're working hard, and your boss gives you a chintzy paycheque, it's not a great feeling. Do you know if they've been paid now?

MS. MACCREADY-WILLIAMS: Yes, they have, and we really appreciate the deputy minister becoming involved in the issue and seeing that those payments were made very quickly.

MR. HOUSTON: It's very kind of her to fulfill the government's contractual obligations. But they fulfilled them in the next fiscal year, did they not? The payments went out in April, not January, as they were due, right? Not February, not March.

MS. MACCREADY-WILLIAMS: The payments were late, yes.

MR. HOUSTON: But you believe they've been made as we sit here today?

MS. MACCREADY-WILLIAMS: Yes, we have been told they have been made.

MR. HOUSTON: I do want to hear some of the solutions that you might have. We have a doctor shortage here, that's for sure. We have a number of Canadians studying abroad - I've heard over 3,000. They could probably be part of the solution to the crisis we're feeling here, but there are probably some obstacles to those Canadians returning and practising here. Are those obstacles something that we can overcome with good policy and good leadership?

MS. MACCREADY-WILLIAMS: Yes, there are challenges in terms of recruitment and retention, and there are opportunities. To set the landscape, the physician resource plan that we've developed with government states that we will, over the next 10 years, require approximately 1,000 physicians to be recruited. That's 100 per year: half

specialists, half family physicians. Just like in every other industry, we have an aging workforce of physicians in this province. Over 1,300 of our practising members are over the age of 50, and over 630 are over the age of 60. So we know, based on the aging demographics and, I think most importantly, the population health needs of Nova Scotians, that we need to recruit. That's why our shared plan calls for 100 per year for the next 10 years. There are opportunities to help with that. For example, a program called the Clinician Assessment for Practice Program that was run by the College of Physicians and Surgeons has been discontinued. Right now, it's very challenging for international medical graduates to become and to be recruited to the province.

MR. HOUSTON: When was that program discontinued?

MS. MACCREADY-WILLIAMS: I believe it was discontinued last year. I know there are conversations happening between the college and the Health Authority . . .

MR. HOUSTON: Were you surprised when it was discontinued?

MS. MACCREADY-WILLIAMS: No, they served notice that it was going to be discontinued, but it needed to be replaced with something else. The something else is in development. In the meantime, there isn't a way to make sure that international medical graduates are ready to practice.

MR. HOUSTON: What was that program called?

MS. MACCREADY-WILLIAMS: The Clinician Assessment for Practice Program.

MR. HOUSTON: Is it a mentor program?

MS. MACCREADY-WILLIAMS: It is partially a mentor program, and it's a program to ensure that those who are trained abroad meet the standards in Nova Scotia and are integrated and welcomed into the province.

MR. HOUSTON: Was that program in existence for a long time?

MS. MACCREADY-WILLIAMS: For a number of years, through the College of Physicians and Surgeons.

MR. HOUSTON: Was it effective? Could it have been more effective? What was the issue with it?

MS. MACCREADY-WILLIAMS: My understanding is that the college didn't see this as their mandate any longer and that the Medical Council of Canada was going to show some leadership by working with the provinces to help find a replacement program. As I

understand it, that's in the works. But nonetheless, there's an opportunity, from recruitment and retention, to put something in place to ensure practice readiness.

Also, opening up residency spots in our clerkship program. We have a family medicine residency program, we have three sites. That's very effective in training family medicine residents in rural areas. We know that when family medicine residents train in rural areas they are likely to stay in rural areas. Perhaps consideration of adding seats to the existing three sites, or even adding a new site in Nova Scotia to meet the need, but we do need to grow our own family physicians.

MR. HOUSTON: You've been asking for that - you've been asking for them to open up seats?

MS. MACCREADY-WILLIAMS: Yes, we would. We've been asking to create a warm and welcoming environment in this province for physicians generally. Part of our primary care position statement is to let us work collaboratively with our partners to put in place a comprehensive recruitment and retention strategy for Nova Scotia – and this would be an element of that, certainly.

MR. HOUSTON: So how long have you been asking for them to open up more residency spots - has that been a Doctors Nova Scotia position for awhile?

MS. MACCREADY-WILLIAMS: This has been a position that we've advocated in our position paper on primary care. We've been involved in many conversations because we are part of the physician resource plan working group. We put the plan in place and we're part of understanding the implications of the data when it's refreshed on a regular basis. So moving residency spots around is something we are part of. For example, we were supportive of moving a couple of residency spots out of urology and plastic surgery to the new family medicine residency program in Yarmouth, to ensure that that met the need for an increased number of family physicians trained in this province. We're part of that conversation now, so we've put that forward as an opportunity for the province.

MR. HOUSTON: That working group you referenced, is that an active working group?

MS. MACCREADY-WILLIAMS: Yes, it is.

MR. HOUSTON: And who is in that working group?

MS. MACCREADY-WILLIAMS: It would be senior leader decision-makers, so it would be representatives from the Health Authority, the IWK, Physician Services, other areas within the Department of Health and Wellness - and the medical school, of course.

MR. HOUSTON: In terms of applications for credentialing, are you aware of - does the province get many applications for credentialing a year, would you have a ballpark number? I'm trying to find out how many are getting rejected and what the reasons are they might be getting rejected.

MS. MACCREADY-WILLIAMS: I do not have that data; that's not data that we would be privy to at Doctors Nova Scotia. I could ask my colleague whether you would have that data. We don't.

MR. HOUSTON: Do you have a sense of whether there are – there are doctors who would come to Nova Scotia and live and work here but there are obstacles to bringing them here. I think you mentioned something about the international thing. With that having stopped last year, are we kind of just on hold right now?

MS. MACCREADY-WILLIAMS: That is on hold, but I don't think that's the full story. I think there's a piece of this that talks about creating a climate that is warm and welcoming for physicians. I'd like it if you could turn it to my colleague to speak to that.

DR. ANDRÉ BERNARD: In medical training we start at the beginning of a journey that lasts between six and sometimes 15 years of formal medical training, let alone undergrad training. I think it's important to understand that part of that story of what it means to be a medical student, into a resident, into an early-career physician, into a full practising physician in this province is that we have choice at every step along the way.

To become a specialist in Canada, in any province, you need to do residency. It's usually typically favoured to do residency in a place other than where you did your initial training, although that's not required. There's kind of a tacit understanding that that would be an asset if you were to return to your home, if you will.

As you move along the system you have opportunities. For example, to become a specialist academic in Halifax within any of the specialties, including family medicine, there's expected possibly to do something that brings added value - go away, come back. I think at these sort of nexus points that's a challenge for recruitment and, to go back to what Nancy MacCready-Williams mentioned, creating this welcoming environment and an infrastructure that is attractive.

I'll tell you a story. It's a story from my best friend who is a Prince Edward Islander, not a Nova Scotian. He and his family have decided not to come back to this region because it's more attractive for them to raise their family in another place in this country. The remuneration profile is better and the work/life balance is better.

I think that's the reality we see, that people are having to make choices, that you get swept up. If I were to go to British Columbia to do a fellowship in something within anaesthesia, opportunities come before people like me who have choices. Some of us - the Field of Dreams phenomena is something that I cite. Nova Scotia, it's a wonderful place to

live. I don't deny that, I grew up here, but we can't just sit on our hands and assume that people will come just because it's a nice place to live. Within the context that we have, pressures that you alluded to before, through you, Mr. Chairman, as well as remuneration context that makes us less favourable across the country. Those are sheer realities of what it means.

From a policy perspective - I'm thinking about the remuneration framework within this province - that enables recruitment and retention is important. I would say the solution that has been put forward at the international medical graduate is one component of a very complex scene. We are training physicians for Nova Scotia and for Canada within our 17 medical schools across the country. Again, to go back to the beginning, there is mobility and choice when you are done at any point in time.

MR. HOUSTON: Yes, and in the face of the competing factors and jurisdictions and maybe better pay and all these types of issues that go into deciding where a person lives and works, my sense is that doctors, quite frankly, just don't feel respected in this province at the moment, on a lot of different levels - whether it's the pay, whether it's the pressure cooker that's constant every single day due to staffing issues. I guess I'm running out of time.

MR. CHAIRMAN: You have 30 seconds remaining.

MR. HOUSTON: Okay, well I'll defer my 30 seconds and maybe I'll come back to Ms. Patterson in the second round and ask what she is hearing from the practices that she is supporting but we'll save that one.

MR. CHAIRMAN: Thank you. We'll move to Mr. Wilson of the NDP caucus.

HON. DAVID WILSON: Thank you again for coming and accepting the invitation. I know we were not scheduled to have a meeting today and I know especially this issue is extremely important to Nova Scotians. It's no secret, we're on the eve of an election and health care, in my opinion, is still the number one issue that Nova Scotians face and are concerned with. Thank you for accepting on short notice and for coming here today.

There has been a lot of talk around physician resources, recruitment. How are Nova Scotians gaining access to care in our province? One of the things I know over the last number of years and as a former paramedic I understand completely that yes, we need to be ready for those emergency cases when trauma and accidents happen. I have to say that when Nova Scotians are deathly sick or ill or injured they get amazing care here in our province.

When we go down the level, I guess, of urgency and not that it's less urgent to be able to get in to see your doctor, but, it has a domino effect. I know how important it is for access to primary care, access to a family doctor that can alleviate visits to ERs, use of the 911 system or the EHS system.

Engaging with your organization is so important. You indicated that you represent just over 3,900 physicians. Could you just give us a quick snapshot of the types of physicians that are there? I know a physician is a physician. Some people get all upset when you say a nurse is a nurse, a physician is a physician, a paramedic, an ambulance driver. We get upset with terms. Could you quickly tell us the demographic of the physicians you represent?

MS. MACCREADY-WILLIAMS: Of the roughly 3,900 members, 2,400 are practising members in this province. Almost 400 of our members are retired but still actively involved in the association. We have almost 350 students and we have almost 600 residents. All of those make up our membership.

MR. DAVID WILSON: Just quickly, when a medical student becomes a resident, is that what you mean by residency?

MS. MACCREADY-WILLIAMS: Yes, they are still in their formal training, exactly.

[9:30 a.m.]

MR. DAVID WILSON: So I see that as an important resource. I know in my time behind the big table I guess, if you want to call it, I engaged in dialogue with Doctors Nova Scotia. I believe my colleague before me, Maureen MacDonald, ensured that I recognize the importance to engaging with Doctors Nova Scotia, meeting regularly - I think it was monthly, how we set it up - is that continuing with the current government? Are you engaging with the department, the deputy minister, so that those discussions can happen?

MS. MACCREADY-WILLIAMS: Yes, certainly the president and I, Dr. Michelle Dow and I, meet monthly with the minister, and I meet monthly as well with the deputy minister. We don't have as much communication with our colleagues in Physician Services and with the NSHA, as much as we used to, but we're working on that and we're open to collaboration and continuing to work - together we can do more than we can working in isolation.

MR. DAVID WILSON: And that's part of the area of concern that I've seen over the last little while. Is it the fact that some of those in charge of Physician Services have left the Department of Health and Wellness? I know they - well in my word "gutted" many of the higher senior positions there, and they are somewhere out there in the new Health Authority. So, did you find a difference when those positions were eliminated in the Department of Health and Wellness, the ability to engage and bring concerns to the forefront to people who can maybe address those issues?

MS. MACCREADY-WILLIAMS: So, certainly, some people left, but others came. So I don't think that's the issue. I think quite frankly that - and this is not something that is surprising because we've had open discussions with the Department of Health and

Wellness and Physician Services specifically about this - the negotiation process was a long and difficult one, and when you work collaboratively with people and then you're across the table from one another, it's not easy - and it's not easy on relationships. So we're in the rebuilding process and we're looking to get back to sort of a mutual collaborative framework - and I'm hopeful that we will find ourselves there. So that's essentially the situation.

MR. DAVID WILSON: So is that a result of the way the government approached those negotiations? Because it's not a secret, the government has taken a hard line from day one with unions and with groups that they've been negotiating with. I know that Doctors Nova Scotia signed the agreement - was there at any time any indication what would happen if you didn't sign it? Did you feel pressured to sign it? Did your members feel any pressure that they needed to agree to the master agreement and move on?

MS. MACCREADY-WILLIAMS: It was a difficult situation all around. Negotiations are not pretty, and we worked very closely with our members, with our negotiating teams, and with government and their negotiating team, and we believe that in the current fiscal climate we got the best possible deal for our members. We endorsed it; our board endorsed it; and we went to our membership and recommended it. It was the absolute best possible outcome in the fiscal environment. That's not surprising to anyone. That doesn't mean that our members are happy with it, but they understood, I believe, and they had confidence in us when we told them this is what it is and we believe that, you know, it's time to move on, time to work to improve the system, the health system for everyone. Time to go back to doing what we do best - that's caring for Nova Scotians.

MR. DAVID WILSON: Thank you for that, and I understand the difficult position you were in. We understand the current government and their appetite to move forward with the amalgamation of the Health Authority. That has been their flagship commitment that they made to Nova Scotians, amongst some others like a doctor for every Nova Scotian - and I'll get to that in a few minutes. But with the amalgamated Health Authority, I know that some of the concerns are the loss of the ability to make sure that in certain communities and areas of the province that their voices aren't being heard and when I read through your recent position paper, Physicians' Recommendations to Improve Primary Care in Nova Scotia, it seemed to me that physicians - primary care physicians, family physicians, maybe Doctors Nova Scotia - are not feeling part of the discussion about the new approach or model that the government continues to beat the drum on, the collaborative clinic model. We know that they've made a number of decisions; some of them I think prematurely.

When I look through your recommendations, you address some of them. Do you think that is the feeling out there? Do you think that the government hasn't done a good enough job engaging with Doctors Nova Scotia and front-line family physicians to move towards changing the model of primary care delivery in the province?

MS. MACCREADY-WILLIAMS: Government, and the Health Authority in particular, has admitted that the engagement of physicians through the creation of the new

Health Authority and the development of a new primary care framework was not as high as it should have been. We have talked about that publicly, and I am hopeful that the Health Authority in particular sees the importance of it. Last week, I spoke at a panel discussion with senior physician leaders about physician engagement, hosted by the Health Authority. I was very hopeful about what I heard regarding the need for the Health Authority, and about the senior leadership of the Health Authority stating that it's time to further engage the physician community. That's what our members want. They want to be part of the solution. There has been huge change in this province in the health care system. It's Change Management 101 to engage those impacted by the change to understand how it impacts them and to give them a voice to help shape it. Physician engagement and the engagement of Doctors Nova Scotia - because we can bring the collective perspective - is critically important moving forward.

MR. DAVID WILSON: Have they responded yet to that discussion paper? I think there are 11 recommendations in it. When we asked the deputy minister, the day before or the day of the release, I was okay with, "we're going to look at it". But that was about three weeks ago. Have you had any response from the government on your position paper, specifically regarding the recommendations? There are some good ones there that I think will assist with moving the province forward.

MS. MACCREADY-WILLIAMS: Yes. I got a got a call that day from Dr. Lynne Harrigan, who is VP of Medicine for the Health Authority, congratulating us on the paper and stating that it aligned with the Health Authority's vision of primary care moving forward.

We have also been asked to co-chair a working group for a new primary care payment model. We have put that suggestion forward. Let's get at that now before we get to the next negotiation table. Let's be thoughtful and take the time needed to do what's best for Nova Scotia. I am hopeful that we've prompted some stimulating discussion and that we'll move things forward.

MR. DAVID WILSON: It's unfortunate, in my opinion, that it took Doctors Nova Scotia to release a position paper to have the new super board or Health Authority ask you to be on a working group to hopefully improve access to family physicians and primary care. It's extremely frustrating to see the timeline that has passed without the engagement of Doctors Nova Scotia.

Of course, one of the other commitments that the government made in health care was a doctor for every Nova Scotian. For years, that was a rural issue. I have to admit, as an MLA from the suburbs, I didn't receive many calls from people without access to a family physician. But over the last two or three years, I've definitely been called. It's not just a rural issue. It's across the province.

One of the things we have seen is a recent decision to change the policy around credentialling. I call it "access to licensing", but they say it's credentialling or privileges that they're limiting.

Are physicians being asked or forced into buying into the collaborative clinic model, or having to move to that type of a model here in the province - are you hearing from members that that's the process that's being unfolded now or taking place?

MS. MACCREADY-WILLIAMS: I think the privilege in question and the collaborative care question are two different ones. If I could just answer them separately. The privileging process is new to the province, since the new Health Authority was stood up and the question we would have a concern with is how it's being done, not necessarily that it's being done.

In fairness, Doctors Nova Scotia participated in helping to shape the bylaws. Government put forward that in fact this was going to be a requirement of receiving lab and DI results. If a physician wasn't privileged and they wanted that kind of access to test results they would need to be privileged, so we helped to shape the bylaws.

Sometimes we're concerned and we hear from our members that how those decisions are made is not clear and that there isn't as much flexibility in the privileging discussion with physicians as we would like there to be. That would be sort of a separate topic.

MR. DAVID WILSON: We know in recent past history, I guess - recent maybe - places like British Columbia, government tried to, in my view, impose restrictions on physicians and their ability to move about the province. They were taken to court; the government lost it. Is that an avenue, or are you familiar with that? The deputy wasn't familiar with the court case even though she came from Alberta, the province right next door. Are you familiar with that court case and the decision? Are your members concerned that potentially the government is doing something they really don't have the authority to do, and that's restrict physicians' ability to work in the province in the communities that they choose to work in?

MS. MACCREADY-WILLIAMS: Yes, I'm absolutely familiar with the B.C. situation. Doctors Nova Scotia took a position that in terms of restricting billing numbers, we would be absolutely opposed to that. However, we did help to shape the privileging process but how that's done is what has been at issue. For example, most physicians in Nova Scotia who worked outside of HRM, of the urban core, were already privileged. They were seeing patients in hospitals.

Many family physicians in the Halifax-Dartmouth area, Bedford-Fall River, were not privileged, so when the new Health Authority was stood up there was a transition to bring those physicians in. The privileging discussion also comes up vis-à-vis recruitment retention because in the recruitment for new physicians the Health Authority appears to be

fairly rigid in applying whatever guidelines it has around making decisions about who can practise where and how physicians would spend their time, and so that has created a challenge in terms of recruiting for some really key positions.

Right now we have 118 positions on the NSHA website, physician vacancies that need to be filled. As my colleague Dr. Bernard said, the younger demographic coming in doesn't want to take over a patient load of 3,000, 4,000 cases. It's impossible for them to deliver good patient care in that environment as a young career physician. For an example of flexibility, what I'm talking about is it's not a one-for-one situation that one physician leaves and another physician replaces them, particularly if the demographics are different.

What we would love to explore is what they've done in the province in the surgical area where there's a program where physicians who are nearing retirement, surgical specialists, particularly in rural communities, will start to sort of wean off their caseload and bring new surgeons on, and there will be sort of a weaning-off and a ramping-up at the same time.

What's most important is a mentorship opportunity so that young early career physicians or surgeons, family, whatever specialty, has an opportunity to become familiar with the caseload and, most importantly, have a mentorship opportunity with that retiring physician.

[9:45 a.m.]

So if you are just looking at sheer numbers of how many physicians can be privileged, that kind of flexibility, we would suggest would go a long way to creating that warm and welcoming environment in the province. It shouldn't be a burden, in terms of the sheer dollars. Really you are creating an opportunity for sort of a handoff and a growing and a mentoring opportunity.

MR. DAVID WILSON: Would you agree that that burden is in place now? That's what I'm hearing from physicians in my area who are looking at trying to retire, for one, but trying to recruit physicians to come in and support them in their practice, especially when their practices are growing and they are getting calls every day from patients who don't have a family physician. Is there a burden now and is that what I read from your position paper, that the government has made decisions like what you just spoke about, prematurely, before physicians transition?

I know I have only a minute - are you aware of any of your members being forced to move into these new collaborative clinics, are they being told that they will no longer have a license unless they practice here? Are you aware of any of those cases happening to your members here in Nova Scotia?

MS. MACCREADY-WILLIAMS: I'm going to turn that over to my colleague Alana Patterson, if I may, through the Chair, to answer that question.

MR. CHAIRMAN: Ms. Patterson.

MS. ALANA PATTERSON: I'm going to look to Kevin as well in case he has insights here. I don't think we're aware of any current members who are being given that stark a choice. I think for incoming potential new recruits to the province, the situation is a little bit different and I think that their choices might be a little more limited than we would like to see. I can't sit here and give you a specific example of that, I think that's our sense.

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

MR. IAIN RANKIN: I want to thank you for coming in today on such short notice, for an important topic today. Maybe we'll start with articulating the mandate of Doctors Nova Scotia. I know you mentioned it's more than just negotiating for your members, but it is an important part of your mandate to look after the economic interests of the members.

Maybe talking about recruitment, because that's the topic today and trying to work together co-operatively to attract doctors to the province. Obviously there's some negativity in the media from Opposition members about compensation and other things. I know, compensation seems to be dominating the discussion today but I think it's also good to talk about a patient-centred model.

I guess a couple of questions, if you want to articulate within your mandate, what have you been doing to recruit doctors to Nova Scotia, or to help government recruit doctors to Nova Scotia?

MR. CHAIRMAN: Ms. MacCready Williams.

MS. MACCREADY-WILLIAMS: Certainly what we've said to government is let's develop together a comprehensive recruitment and retention strategy because there's things we can do, as an association. We have a robust benefit plan as part of our master agreement that's an attractor to Nova Scotia for physicians. For example, there's things we can do, there's things the Health Authority can do, there's things that the Department of Health and Wellness can do.

Our offer is let's work together. For example, last week I know my colleague Kevin Chapman met at the invitation of the Health Authority, which was great, with all the physician recruiters in the province. They asked the question, what is it that Doctors Nova Scotia can do and what services do you offer that will attract physicians to this province? So we had that conversation. Again, together I think we can create that warm and welcoming environment.

MR. RANKIN: So you do see that as within your mandate to work together to recruit doctors to Nova Scotia?

MS. MACCREADY-WILLIAMS: Yes, we would welcome that.

MR. RANKIN: Okay. So let's talk about the master agreement that you cited there, 80 per cent of your members accepted that less than a year ago and 87 per cent of your members accepted the AFP contract, so there was support there.

When I read through the physician papers that you recently released it seemed to me that you took exception to some of the things in that contract. When you're talking about the transition to collaborative care, and there's also more accountability measures in that contract, there's also the requirement to focus on the patient. Weren't these issues discussed during the negotiations when this agreement was decided upon?

I notice that compensation was mentioned quite a bit in the position paper. So was it the compensation that you had the biggest disagreement with, in terms of that agreement?

MS. MACCREADY-WILLIAMS: I would say that for our members, it wasn't really about compensation, because I think they appreciate the challenging fiscal realities of this province. Regardless of which test you use under CIHI data - there are four different methodologies - physicians in Nova Scotia are the lowest or near the lowest paid in Canada. That's a fact. It's in the data that you shared with us in your opening materials. To increase that is expensive, and our members appreciate the challenging fiscal realities of this province.

So, it was not the money, per se. There were some physicians, family physicians in general, who weren't happy - I'm not going to say that they were happy - but they appreciated that it was the best that was on offer. I think what physicians were most disappointed about when we went around the province were the challenges and lack of opportunity regarding some of the innovation we had hoped to see in this contract. I think it just wasn't the right time. Things like a new payment model that would support a collaborative practice: that was something that we had hoped to see. But it wasn't good timing. I'm really pleased that we're able to have those conversations outside of a negotiation context with our partners and now that the NSHA's vision for collaborative care in the province is clear, I think those conversations will happen.

For other innovations such as non-face-to-face care, we didn't get as far as we would have liked in terms of the opportunity brought by MyHealthNS, the personal health record. But, again, those are conversations for a future time, and we're hopeful about that moving forward.

MR. RANKIN: Okay, so, you represent around 3,900 physicians, and I see the breakdown in terms of different cohorts. But, what is the breakdown on full time and part time within that 3,900?

MS. MACCREADY-WILLIAMS: We do not track the part-time numbers.

MR. RANKIN: Okay. In terms of physicians per capita, which is probably a good measure relative to the other, bigger provinces, where do we stand, per 100,000? Do you have those metrics?

MS. MACCREADY-WILLIAMS: Yes. There has been a lot of press around numbers of physicians. How many do we need? How many do we have? What we know from CIHI data, is that we have a very high number of physicians per capita. There are lots of physicians in the province. So, how do you square the circle? Why are there waits-lists? Why can't people find a family doctor? I think the number of physicians is a bit of a red herring, because we would expect there to be more physicians in Nova Scotia than in other jurisdictions, certainly in Atlantic Canada, because first, we're a teaching province. We have a medical school here. Our physicians not only deliver care, but also train the next generation of physicians. Because of the QEII Health Sciences Centre, we also have a research arm, so our physicians are doing research as well as delivering clinical service.

I think the most important thing to remember is that our physicians, certainly those at the QEII Health Sciences Centre and the IWK, serve all of Atlantic Canada. Their patients are not just Nova Scotians. But regardless of how many physicians are in the province, that's already factored into the Physician Resource Plan. We know those numbers. And still, with those numbers, given the demographic changes in the physician community that I shared with you, we need 1,000 more physicians in Nova Scotia over the next 10 years. So, recruitment retention . . .

MR. RANKIN: So, what does that look like fiscally for the province to try take in 1,000 more physicians?

MS. MACCREADY-WILLIAMS: So, remember, many of those are just replacements for this aging demographic we have. Thirteen hundred of our 2,400 practising physicians are over the age of 50. We need to replace those who are practising now and who are set to retire. There's a small number in the Physician Resource Plan that is there to deal with what we and the governments believe is going to cause an increase in burden of illness, because we have an aging demographic in this province.

MR. RANKIN: Yes, and that's an important point, the aging demographic. So, do you have a role on promoting health wellness?

MS. MACCREADY-WILLIAMS: Absolutely.

MR. RANKIN: What is Doctors Nova Scotia doing? Did you put anything into the Choosing Wisely Canada campaign, and can you articulate what you submitted to that campaign? We do have to focus on a healthy society, not just treating sick patients. I would think that's within your mandate, and maybe you can articulate how you helped us with that.

MS. MACCREADY-WILLIAMS: Absolutely, we have a health promotion mandate. I think my colleagues, in opening comments, talked about some of those initiatives. Just before I turn it over to my colleague, Kevin Chapman, who's been very involved in the Choosing Wisely initiative, I just want to remind everyone here that we have embraced the Kids Run Club for over 10 years now. As a result of a program that we have in the school system in Nova Scotia, we have over 17,000 young children running every year in over 300 schools in this province. Physicians are very, very proud of that program, and they firmly believe that being leaders in health promotion will address some of the issues that they see in their patients on an ongoing basis. Health promotion is very much part of our mandate.

To the chairman: If I can turn it to my colleague . . .

MR. RANKIN: Okay, no, that's okay. I just want to go back to the paper.

You're pretty clear that you want doctors to be able to determine where and how they want to work - can you articulate how that benefits patients? It's basically one of the only professions where the government would step back and say you're using taxpayer money, you choose wherever you want to go, regardless of demographics. Do you believe that there should be an incentive for doctors to go into rural communities?

MS. MACCREADY-WILLIAMS: I just want to clarify. I didn't actually say what you summarized me to have said. We didn't say that physicians should be able to practise wherever they want to. We helped to shape the bylaws that govern the privileging process. We appreciate that there should be a population-based need for physicians to be practising in any particular area.

It's how it's being done that we're suggesting should be more flexible. Physicians are business owners; they're small business owners for the most part. They're pretty savvy about where they can set up a practice in order to be able to pay the bills; they are pretty savvy that way. Supply and demand will eventually be a deterrent if there are too many physicians in one particular area.

We appreciate the privileging process, and we appreciate the need for that from a patient care perspective, making sure that physicians are located where there are patient care needs. What we're suggesting is that the Health Authority and the government need to respect that physicians are small business owners, and work with them with some flexibility in the recruitment and retention process.

MR. RANKIN: In terms of the international program, you think that's a good program if someone has signed and gone to a different country that they're going to an underserviced area - you think that's a positive thing that they will be placed in an underserviced area in rural Nova Scotia rather than if they wanted to choose HRM?

MS. MACCREADY-WILLIAMS: We have no problem with the IMG program.

MR. RANKIN: Also in your paper, you suggested doctors should roster their patients - does that mean having a certain number of patients to clarify per physician?

MS. MACCREADY-WILLIAMS: Yes. We believe that every Nova Scotian should have access to a family physician as part of a primary care team. There would be a rostering of patients to that team, and the blended payment model would support how that care is delivered and who delivers what kind of care between the various specialties.

MR. RANKIN: Have you calculated exactly how many physicians we would require for a population of one million to meet that need?

MS. MACCREADY-WILLIAMS: That's already factored into the Physician Resource Plan. There's a proxy there for collaborative care. Even with collaborative care baked into the plan, we need to replace those who are going to retire over the coming years to the tune of 100 a year for the next 10 years.

MR. RANKIN: That challenge is across the country, replacing doctors - right?

MS. MACCREADY-WILLIAMS: Yes.

MR. RANKIN: Basically, all provinces have this challenge of recruitment in the country.

Can you explain in your document when you say the pressure is on the physicians in Nova Scotia from being an Atlantic centre. I don't quite understand how that's congruent with general physicians because they are typically based within a community, and do they not see, by and large, just people who are from the community, and very limited people from outside the province? I'm not talking about the hospitals; I'm talking about family physicians.

[10:00 a.m.]

MS. MACCREADY-WILLIAMS: The numbers in the Physician Resource Plan would reflect community-based family physicians and specialists, as well as our clinical academic physicians based at the IWK and the QEII Health Sciences Centre. It's those specialists, and there are about 630 of them in our active membership who serve not only Nova Scotians but some . . .

MR. RANKIN: So that's the acute care system that Atlantic Canadians use at the IWK and stuff like that, but in terms of the family physicians, there isn't a drain from Atlantic Canadian people coming to use our family physicians - right?

MS. MACCREADY-WILLIAMS: Correct.

MR. RANKIN: Okay. I just wanted to clarify that.

The concern in the media about Northside being impacted by the signed agreement - the deputy minister and the CEO of the NSHA were saying that as a result of the negotiations to remove inconsistency in how physicians are paid throughout the province - this is an agreement, again, that you've agreed to. The consultations took place over five months, involving the NSHA and the Department of Health and Wellness. The total volume of patients seen at the effective sites is comparable, ranging from 25 to 27 patients per 10-hour shift. The Department of Health and Wellness has discussed with Northside General physician-led ways to manage the implementation of changes to minimize the negative impact.

So I'm not understanding. The agreement was made, so how come there is such negative feedback on that?

MS. MACCREADY-WILLIAMS: I'm just going to introduce the topic and then, through the Chairman, if you don't mind, I'll turn it over to my colleague Alana.

We were brought in once the agreement had been reached with the chiefs of emergency departments across the province and with the NSHA. We all understood a certain set of facts. They brought us in. Terrific. We signed off on it, absolutely, and then, as I understand the facts, there was a misunderstanding about a particular assumption around those facts that might have had an unintended impact.

I'm going to turn it over to my colleague Alana to speak to that, through the Chairman.

MR. CHAIRMAN: Ms. Patterson.

MS. PATTERSON: As Nancy said, the Department of Health and Wellness and the Health Authority worked, as we understand it, with emergency department chiefs across the province in an effort to look to standardizing emergency department hourly rates, across the province, for emergency departments of comparable patient volumes and patient acuity levels - or patient complexity, if you will.

The exercise was intended to reduce the occurrence of ED closures by creating consistency across like facilities. In principle, of course, we would support that.

We were brought in as that analysis had been concluded. We reviewed the data. We gave some consideration to the physicians who had been consulted, and we were comfortable that the principles were sound, the analysis looked sound, and appropriate physicians had been engaged. We brought that to our board of directors and they did indeed approve, as you've suggested, the approach that was recommended.

What's come to light since, and I think it's news not just to DNS but to the Department of Health and Wellness and the Health Authority as well, is that the implications for Northside might not be quite what was intended. As I said, the exercise as

we understand it was intended to reduce the occurrence of ED closures, and the risk now, as we're hearing it from Northside, is that in the case of Northside they may be far more challenged in trying to fill shifts in that emergency department than previous to the change.

With that in mind, we believe the Health Authority was fairly responsive and indicated that they would delay the intended rate reduction for Northside in order to give this some further consideration. We have been watching the committee's deliberations in recent weeks, so we were pleased a few weeks ago to hear Deputy Minister Denise Perret from the Department of Health and Wellness indicate that she was prepared to revisit the implications for Northside. We look forward to being engaged in those discussions in order to ensure that the objectives are in fact met by the final decisions.

MR. RANKIN: I'd just like to end with - to try to get some of your thoughts around alternate care - nurse practitioners come to mind as the top of the list, but there are obviously others.

So you're supportive of collaborative care; that's your official statement. Do you have any issues with nurse practitioners getting more involved at the hospital level or other types of work, signing off on when patients can be released from hospitals - any of those? I recognize that you represent doctors and that there's an economic component to that, but can you say that you support alternate system delivery?

MS. MACCREADY-WILLIAMS: Certainly. We support, and our members support, working with allied health professionals, including nurse practitioners. In fact, we hosted a webinar last month for physicians who are working with nurse practitioners - who have had a wonderful working experience with them in collaborative practices - because collaborative practices have been around for a long time in Nova Scotia. There are great examples, in Clare for example, of collaborative practices in which health professionals such as nurse practitioners and family practice nurses have been part of that team. So we hosted a webinar to give physicians who have not worked with a nurse practitioner an opportunity to sit down with their partner and have a conversation about what works well and what the challenges are, in anticipation that more of these practices will be supported moving forward.

MR. RANKIN: And in that same vein if I may, Mr. Chairman: Do you think that it's a positive thing that we are moving towards a lower percentage of the fee-for-service model? I think Nova Scotia is the lowest, other than Ontario and Alberta, that we have been able to decrease the fee-for-service payment model - do you think that's a positive trend?

MS. MACCREADY-WILLIAMS: Payment models are a policy tool, because how one pays physicians can have an impact on that physician's behavior and the type of care that is delivered to a patient. So that's why we are recommending a collaborative practice model, that there be a blended tool, part to have both a fee for service to ensure appropriate volumes, and part to recognize that as patients have more complex needs they need to spend more time with physicians. That is not taken care of in a fee-for-service model, but we have

great examples of alternate payment mechanisms such as our academic funding plans that compensate physicians for not only clinical care, but also time spent teaching other physicians at the medical school and for doing research.

MR. CHAIRMAN: We will now move back to Mr. Houston of the Progressive Conservative caucus for 14 minutes.

MR. HOUSTON: Thank you, Mr. Chairman. I had indicated that I was going to start with Ms. Patterson, but I think I will start with Mr. Chapman after listening to the discussion.

I have a question about the federal transfer payments. Canadians across the country are reading about the tragic situation of Mr. Webb and his stay in hospital. The Nova Scotia Health Authority officials are continuing to reassure us that very sick people are getting the care they need, but clearly that is not always the case. We have heard about the pressure-cooker environment in some of this hospitals with the Code Census, but we need more resources to solve shortages in long term care, in mental health and, of course, in primary care. With the new federal transfer agreement, we are going to get less money. Are you concerned about how we are going to provide the services that we need under the new agreement?

MR. CHAIRMAN: Mr. Chapman.

MR. KEVIN CHAPMAN: Thanks for the question. We are going to get less money than we would have, but we will still get more funding. And targeted funding for mental health and for home care are areas of need. Certainly Dr. Johnson, I think, would see that. The situation with Mr. Webb that you talked about was incredibly tragic and unfortunate. But, I think it speaks to the kind of things that Dr. Bernard talked about, in terms of the stressors on the system.

We need to be able to do things to relieve some of stressors, certainly alternative levels of care, having patients who do not need to be in the hospital. CAEP, the Canadian Association of Emergency Physicians, has released a position paper on ED blocking and one of the big things that have talked about is alternative level of care patients and having those patients out of the hospital. Focus on home care is key. One of the things CAEP has talked about is a robust primary care strategy; reducing those kinds of pressures on the acute care system by having individuals treated in the most appropriate places. So if somebody does need to get to the hospital, such as a level 1 or 2 CTAS patient - I believe it was said that Mr. Webb was the sickest person that they had seen that evening - they can get care they need in a timely manner.

I think having some directed and focused funding around mental health would help family physicians. For example, we had practice support program that allowed family physicians to improve their skills in managing patients with mental health and addictions. So if we can look at those kinds of things and improve our primary care framework and

our sort of secondary care, I think there's a great opportunity for reducing or removing some of the stress in the acute care system.

MR. HOUSTON: Yes, so is there is a plan to how we're going to pay for the things that we need because certainly on Christmas Eve, or whenever it was when the government announced the new funding arrangement, it was heralded as a big success particularly around mental health. Now my colleague and I, Mr. Wilson, have been asking questions in here about what that actually means. And the details aren't worked out - nobody actually knows what it means. It doesn't sound like it's much in the grand scheme of things.

So when I know that the province, I am going to say, kind of catered on the negotiations with the federal government and walked away with less and tried to make it sound like they got more. Once we started asking: Did we get more? There's not much substance to the answers. So, I'm deeply concerned about how we're going to pay for the things that we need.

In your role with Doctors Nova Scotia, do you have any more comfort than I do? Is the department sitting down with you and saying well here are our needs and here's our plan and here's how it's going to work? Did those discussions happen? Maybe it's part of one of the working groups or something.

MR. CHAPMAN: A couple of things. We've worked with the Canadian Medical Association who has been speaking with the federal government, because these are federal funds, around what parameters, if any, the federal government might place on the use of those funds. So, we're working through the Canadian Medical Association on that perspective.

One of the benefits I think that we have in Nova Scotia, particularly with the mental health, is we have the Together We Can Strategy which was developed and provides a guideline for investments in mental health and addictions services. And, again, one of the programs that is near and dear to us is the B.C. Practice Support Mental Health Program. So, while we don't know for certain how the funding will be spent and what those, as you've mentioned, what those constraints might be …

MR. HOUSTON: Or how much it is.

MR. CHAPMAN: Or how much it is.

MR. HOUSTON: I think you kind of answered my question when you said you're trying to work with the Canadian federation as opposed - because our own minister signed it and I guess there's nothing coming your way from the Department of Health and Wellness as to what might have been signed because they don't probably know what they signed. You're having to go to somebody else to try and find out what your government agreed to - is that the long and short of it?

MR. CHAPMAN: What the parameters might be from the federal perspective on what the targeted funding of the CHT is and then what opportunities that then might present to us.

MR. HOUSTON: So, the deal has been signed; maybe it's been signed - I don't know if they even know. First they said it was an agreement, and then they said it's maybe not an agreement, it's going to be legislation or something, but anyways okay. So, I'm concerned about how we're going to pay for what we need - everyone here probably shares that same concern.

I do want to talk about the reference to the 118 vacancies. I'm not sure who is the best person to answer, but we heard here this morning about new doctors are being kind of pushed into collaborative centres. Maybe that's a good thing, maybe it's not. It's certainly a restriction though on new doctors. Also the discussion about no mentoring system in place for doctors that might be wanting to retire or slow down or whatever the case may be. Those are two things that kind of make me feel that those are difficult situations to recruit under, anytime you have restrictions like that.

In terms of the 118 vacancies on the Nova Scotia Health Authority website, we hear the statistic that we need 100 doctors a year, for ten years. What is the number? How many doctors do we need in Nova Scotia to fill the void that's there right now, to kind of release the pressure from the pressure cooker and kind of make the system function more smoothly? It's not functioning smoothly right now - do we have a number as to how many doctors we would need right now?

MR. CHAIRMAN: Ms. MacCready-Williams.

MS. MACCREADY-WILLIAMS: Thank you for the question. We can just go to the data sources we have access to to be able to answer that question. We know, again our shared plan would suggest we need 100 a year. There are 118 vacancies according to the NSHA's own site, and they're a combination of full-time, part-time locum and academic positions. So, there's a variety there of ....

MR. HOUSTON: Is 118 the 100? Are they the same thing, or is it really 118 plus 100? Do you have any sense?

MS. MACCREADY-WILLIAMS: No, I don't have a sense of that. André, do you?

MR. CHAIRMAN: Dr. Bernard.

[10:15 a.m.]

DR. ANDRÉ BERNARD: I think we're talking - my understanding is the Physician Resource Plan is a planning tool looking at a broader context over time, year on, year on. That's a snapshot of trends over time, based on all the factors that are components of it.

I think that needs to be set as something to use on the medium to long-term time horizon. In the context of what I would say we're speaking of now are current needs that we know of specifically right now.

To return to Ms. MacCready-Williams' notes, there is a composite need of family doctors, specialists, academic physicians, to meet those current needs within the new Nova Scotia Health Authority to address current vacancies. Which is to say that as we plan for tomorrow, next year and the year after, we should expect that that number will sustain as approximately 100 per year as the Physician Resource Plan is populated with new data that influence those trends.

Nothing is static and I accept the challenge of the context we're working in. We're trying to use as clear an opaque crystal ball as we may have to predict what we may need, but we know certain truisms, which are that complex care is becoming more and more clear. Doctors want to give the best care they can to their patients. Early career physicians want to practice collaboratively, by and large. We can't say that all individuals would, but that's a trend we are seeing and we need to find a way.

We're running a relay race but it's not just simply passing the baton from one physician to the next. As we continue, the system is being rebuilt around us as we're running the race. I think what we need to understand is how to create the preconditions to allow people to enter practices that address the health needs of Nova Scotia in a way that patients - I'm a patient, too - expect and deserve within their places.

I think we have our finger on how we can be collaborators with the Nova Scotia Health Authority, and with government, on how to do that. Certainly, if we take the snapshot of today we see 118 vacancies. Well regardless of the innovative strategies to address the broader concerns, we need to address those gaps.

MR. HOUSTON: Got to fix that. In terms of the Canadians studying abroad - and I do want to go back to that - is there anything that we could be doing as a province right now to help bring some of those back? Is there any obvious policy changes we could make that would help entice them back? Would that fall under the clinical assessment for practice program, if we had a functioning clinical assessment for practice program, would that help?

DR. ANDRÉ BERNARD: The issue of international medical graduates or Canadians studying abroad, is a complex issue in that they are at a different stage of training. Canadians studying abroad at medical schools in the Caribbean, in Ireland and Australia, among other countries, still need further training before they are practice-eligible, period. Part of that is about residency, training both in family medicine and for speciality training.

In having this conversation I think we have to be sensitive to the fact that there's that population of people, also there are physicians who are trained Canadians, Nova Scotians, who wish to enter the physician workforce. That's where the cap really comes

into play, so that's slightly different, whereas the international medical graduates are presenting themselves as they move through their training at a point at which they are practice- ready. I might turn to my colleagues for further comment.

MR. HOUSTON: I have only a couple of minutes, and I do want to ask about the Doctor Matheson arbitration. Are you familiar with the Dr. Matheson arbitration? It seems like maybe that arbitration identified a system-wide billing issue and the Health Authority or the department is trying to say well no, that actually only impacted one physician and not the broader group. I don't know if Doctors Nova Scotia has looked at that arbitration decision. Is the Health Authority being kind of heavy-handed on this - am I missing something here?

MR. CHAIRMAN: Ms. Patterson.

MS. PATTERSON: I am familiar with Dr. Matheson's arbitration. Any arbitration on a billing matter does, in fact, technically legally affect one physician, but of course we can draw some conclusions more broadly since other physicians are presumably billing similar codes in similar circumstances. That would be the case with Dr. Matheson's arbitration, I would say.

Dr. Matheson's arbitration involved a billing rule that's quite complex and I'm happy to explain it, but I don't want to eat into your time either. It involved a very complex billing rule which has been improved a bit through better technology at MSI. It's not a Health Authority issue, I should say it's really a MSI and Department of Health and Wellness issue

I would say some of what affected Dr. Matheson's billings and the arbitrator's ruling has been addressed through better technology, so that physicians submitting their billings are now in a better position to comply with the rules as written than they were at the time of Dr. Matheson's arbitration. That's not a full and complete answer to all that the arbitrator discovered, but . . .

MR. HOUSTON: No, it's helpful, actually; it is helpful.

MS. PATTERSON: Okay.

MR. HOUSTON: I think my colleague touched on the mobility of doctors even with the province and the ability of a doctor to bring another doctor in to practise with him. I think that's all being limited by the strategic plan of where doctors are needed. There is some kind of strategic plan that the department has or the Health Authority has, of where doctors are needed. Is that a strategic plan that you would have had input into as Doctors Nova Scotia? Are you hearing frustration from doctors about wanting to bring somebody into their practice, but aren't able to - it's a real issue, eh?

MR. CHAIRMAN: Ms. Patterson, you just have about 20 seconds.

MS. PATTERSON: Thank you, Mr. Chairman. The short answer would be yes, we certainly hear those frustrations increasingly since the stand-up of the new Health Authority which, in part I suspect, is about trying to develop processes on the fly on their part, and in part is a reflection of their privileging process and procedures. But there's no question - I think it's fair to say we hear from physicians often who are interested in beginning to think about retirement, or in fact quite retirement-ready, and are struggling to bring in new physicians or to get approval to bring in new physicians and worry about the gap in patient care if they in fact follow through on their retirement plans. So yes, that's a very real concern.

MR. HOUSTON: Okay. Thank you.

MR. CHAIRMAN: Thank you. We'll move to Mr. Wilson of the NDP caucus.

MR. DAVID WILSON: Thank you, Mr. Chairman. I know Stephen McNeil and the Liberals promised a doctor for every Nova Scotian. That was in their platform; that's what they've been saying for the last three-and-a-half years, and we know they've backed away from that. They haven't fulfilled that promise to Nova Scotians. We know that collaborative centres, the centre model is what they're talking about. So, will the collaborative centres model meet the needs of Nova Scotians entirely and their access to a family physician and primary-care clinicians?

DR. JOHNSON: It will meet the needs as it evolves, but it's a beginning strategy. This has to be a long-term implementation. There has to be a plan for now, a plan for 15 years from now, and some vision of how to get us there that takes into account the needs of patients and their communities and the physicians that are providing the care. Then that brings in all of the questions like: How are you going to recruit people to this spot; how are you going to let them retire; and how are you going to organize this care appropriately? So it could and it should, but it requires long-term strategy and planning.

MR. DAVID WILSON: Long-term strategy and I think that's the transition I think the Premier is trying to make now in their commitment. They committed to a doctor for every Nova Scotian a year after they formed government, and here we are almost four years into their mandate. We've heard this from not only members of the government caucus but the government and other organizations that this is a long-term goal. To make that type of commitment really is, I think, an irresponsible way to try to get yourself elected.

You mentioned the need to attract 100 a year for the next ten years - is there a plan in place to do that today?

MS. MACCREADY-WILLIAMS: I'm not sure if there is right now. What we know is that there are a number of vacancies. So physician recruiters are working very hard, and I know the Health Authority is working very hard to recruit physicians. I have no question about that.

I think, because of the need that if we have more of a more integrated strategy and we do it together, we might have a better outcome. That's what we are recommending as part of our primary-care paper, let's do this together, because we know what the need is, it's staring us in the face, and together I think we could accomplish much.

MR. DAVID WILSON: I appreciate that direct answer that there's no plan in place. Now I would assume that's on top of - that's not even addressing the 118 vacancies that we have now.

There was a commitment from the government to fund, I believe, 25 medical students per year. We're pushing into the fourth year now, so we're looking at potentially 100 physicians. Are you aware of that? Were they able to meet that, and I know it would take a number of years before the province would benefit from that. Are you aware if that commitment was achieved over the last three and a half years, going into the fourth year now?

MR. CHAPMAN: We've heard anecdotally - because the program isn't run through us - that there have been a number of physicians who have taken advantage of the program but that the full program has not been exercised.

MR. DAVID WILSON: From what I heard, they do become members of Doctors Nova Scotia, right?

MR. CHAPMAN: They do.

MR. DAVID WILSON: So there is another example of a commitment from the government that really hasn't transitioned into reality and that concerns me. I know we heard earlier about some of the successes we've seen over the last number of years. I'm very proud to be part of a government to increase the residency seats for the rural residency program. Down in the Valley there was mention of Dr. Ross and his report, there was mention of the Collaborative Emergency Centres being opened. There was mention of the mental health strategy, the first in our province. All those were introduced prior to this government.

Could anybody on the panel direct me to a new initiative the current government has implemented that has made an important improvement to access of care here in Nova Scotia? I'm open to any suggestions.

MS. MACCREADY-WILLIAMS: Certainly MyHealthNS, the personal health record, is an innovative tool, the first of its kind in Canada. We were part of the steering committee that put that in place; it's only in place in a limited form right now. There's 177 physicians who have signed up for that.

We think the opportunity presented by MyHealthNS is huge, in terms of access, increasing access for patients and for patients being able to take control of their own health,

having their own health information and playing a more proactive role in that, so I would point to MyHealthNS.

MR. DAVID WILSON: I thank you for that and I know that's important, but that is a long-term process. I believe you said 177 physicians - you represent over 3,000 physicians alone. I'm concerned that the priority for the government has been the amalgamation of the district health authorities.

We've seen Dr. Ross' report, the Collaborative Emergency Centres, the mental health strategy implemented all within four years and having a direct, positive impact on the lives of Nova Scotians. Here we have a government trying to go back to the polls to say don't worry, we have health care in control. I have to say their major plan to amalgamate the district health authorities - because it's going to solve all the problems in health - actually has created more problems.

I know my colleague talked about this a little bit, around the federal transfers health agreement that is not an agreement, we heard last week in Public Accounts Committee - it was signed in December. In 2015 the Premier said that Nova Scotia has to sign a new agreement that included recognizing the aging demographics in our province. We know now that that did not happen. I think that was a huge mistake on our government's part to sign early, without having that implemented.

Are you hearing from your members, from family physicians, the challenges of having a practice dealing with that aging demographic? Are they finding challenges finding long-term care placements, for example? We know the current government hasn't opened one long-term care bed in three and a half years.

Are your members or the family physicians that you represent challenged when they are dealing with providing care to our aging population?

MS. MACCREADY-WILLIAMS: Mr. Chairman, perhaps I could ask my colleague Dr. Johnson, a family physician, to answer that question.

MR. CHAIRMAN: Dr. Johnson.

DR. JOHNSON: That's a daily challenge. The patients are complex. They require more time. There are in-patients currently in acute care institutions waiting to go to long-term care beds until we have a space open for them. It provides increasing complexity every day, trying to figure out how to meet those needs appropriately, and it's frustrating. Then you have the patients within your practice who also need access to other allied health care professionals - diabetes educators, asthma educators. All of those things help us deliver care more effectively, and that's that team-based approach that we keep talking about when we talk about collaborative centres. Those things continue to be a challenge every day in every practice across the province.

MR. DAVID WILSON: Would anybody agree that the number of long-term care beds in our province is a concern? We know the domino effect when we have patients who are in our hospitals who need long-term care. I know there's an emphasis on home care. I'm fully supportive of that. But the decision to not implement and go forward with any new long-term care beds in this province has a devastating effect. We know Dr. Campbell at the QEII ER talked about patients in ER and patients in the hospital not being able to be placed in the appropriate place. Would you agree that that is a huge challenge and it was a mistake by the government not to look at increasing the number of long-term care beds in the province?

[10:30 a.m.]

DR. ANDRÉ BERNARD: I will speak from my perspective as someone who listens to the PA system at the QEII every single day, and we heard the numbers. It's in the 20s, the number of times you hear Code Census overhead. That issue is felt every single day - how we provide care in the bottlenecks that exist in the midst of the system, of which comprehensive long-term care and home care need to be part of the solution. I won't speak to the government's choices right now, but I would say that's an enduring problem.

My father-in-law cut his finger two weeks ago on a table saw, and he wondered what the crisis was when he heard Code Census overhead. I said it's a crisis that happens nearly every single day. We're seeing that in the news. You are hearing about that from your constituents. Part of that solution is addressing inefficiencies within the system and addressing bottlenecks that don't allow us to provide long-term care spaces and comprehensive community-based home care.

MR. DAVID WILSON: Are some of those deficiencies being addressed? Do you feel that there are people listening, especially at the top level of the government and the Nova Scotia Health Authority? You work daily in what we would call the trenches. Often those who are making the decisions are not in the trenches. Are you feeling that those concerns are being addressed as quickly as possible?

DR. ANDRÉ BERNARD: I think the answer to that question will always be no. But I say that in jest a bit because we're not seeing it reduce in numbers. We're seeing it as a recurring theme. I would say from the perspective of me looking after the patients I have to look after - I don't just care about them or care for them when they're in my operating room where I work collaboratively with my colleagues. We care about where they end up, where they get the best care possible, and how they recover. Absolutely, we think solutions - I'm speaking on behalf of Doctors Nova Scotia. We want the best for our patients. We need to see a care continuum that's sensitive to the needs that we have right now. Yesterday was too late.

MR. DAVID WILSON: I know I have only a couple of minutes, so I'll hopefully try to get a couple of quick questions in here. I know in your discussion paper, one of the recommendations was to continue with the walk-in clinics. I know that continuity of care

is maybe compromised or not there when patients use walk-in clinics, but there's a need, a great need, in our province. Has the government acknowledged or backed away from this notion that we need to close the walk-in clinics or change them into a different type of service delivery.

MS. MACCREADY-WILLIAMS: Certainly in the conversations I've been part of, they recognize that they fill a need while we're in transition to a new primary care model that will have greater access to care in communities as part of these collaborative care teams. But in the meantime, until we have that in place, they fill a need for non-emergency conditions, and they prevent those patients who are unable to get to see a family physician or a nurse practitioner from going to an ER if that's not necessary. To me, it's a transition piece and that in a perfect world, the walk-in clinics would be aligned with the collaborative care centres and able to help with that provision of care after hours and on weekends.

MR. DAVID WILSON: You mentioned Collaborative Emergency Centres, that you supported them. Do you feel there should be more in the province?

MS. MACCREADY-WILLIAMS: Yes, at the time we were supportive. We helped to roll those out and they certainly brought stability to those communities where there were ER closures happening on a regular basis.

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

MR. RANKIN: Just a couple of quick questions. You mentioned the 118 vacancies were planned retirements so it's important that people understand they are not vacant today. So of those 118 vacancies, how many of them are practising doctors today?

MS. MACCREADY-WILLIAMS: I don't think I understand the question. Could you please repeat the preamble.

MR. RANKIN: You said there's 118 vacancies?

MS. MACCREADY-WILLIAMS: I'm just looking at what's on the NSHA's website, yes.

MR. RANKIN: Okay, but some of those vacancies are practising doctors today.

MS. MACCREADY-WILLIAMS: Yes, according to the website, there are 52 GPs and 23 specialists who are full-time, nine GPs and one specialist who are required on a part-time basis, 25 GPs and one specialist required on a locum basis and seven specialists in the academic centre.

MR. RANKIN: So planned retirements, not retired today.

MS. MACCREADY-WILLIAMS: I don't know that you could make that assumption.

MR. RANKIN: Maybe you could clarify then if there's any of those vacancies that are practising today.

MS. PATTERSON: Again, we're pulling this information from the Health Authority website. I think you may have misunderstood if you thought that Nancy had said earlier that we believe some or many of those are planned retirements - we have no such knowledge. So we believe those to be primarily vacancies, actually - meaning practitioners who have left the province or retired and there are vacancies left behind. We have no data to support that either. That would be our best guess, but not that they would be planned retirements as in anticipated retirements.

MR. RANKIN: Okay, because I know some in my community that are planned retirements but they are labelled as vacancies. I would just like to flesh out a true, normalized number.

Again I'll ask specifically, what is Doctors Nova Scotia doing to help recruit? What specific suggestions would you make to NSHA to help with recruitment? The studies have shown that it's not just about compensation so maybe you could just tell NSHA what you would like to suggest to help with recruitment for doctors in Nova Scotia.

MR. CHAPMAN: A couple of things. First off and back to an earlier question, there are two ways we get physicians, we either train them through our medical school, so one of the things would be to continue the work with Dalhousie, and particularly as Nancy said earlier, open up a new family medicine residency program. We actually need more anesthetists. While we can currently recruit individual physicians, we need to train them as well because those are basically the two paths in.

It would be the long-term goal of training our workforce but also recruiting from other areas. In terms of recruiting from other areas, you are absolutely right, the payment model is whatever the payment model is today. We will negotiate in two years or whatever that works out, so the payments are whatever the payments are.

What we need to do and it's what Dr. Bernard said, we need to make a climate here that individuals want to come to, and there are a lot of things. If you are going to go practise as a radiation oncologist in Sydney, you need a support system there so that you are not the only radiation oncologist and you are going to work 24/7/365. You need supports through, in this case, the QEII Radiation Oncology Department and perhaps colleagues. Supporting physicians, particularly in rural areas, is incredibly important.

Mentorship programs are incredibly important. You mentioned you have physicians who are planning to retire. I'll use Dr. Frances Moriarty who is a lovely family physician in Dartmouth who wants to retire. It would be wonderful to have a family

physician come in and work with Frances, where Dr. Moriarty would start to wind down and a family physician or two with Frances would start to take over that practice. They would learn not only managing patients, they would learn how to run that practice, the business side of it. Those are the intangibles that I think are really critically important.

We met with the Health Authority last week, as Nancy talked about, to fill them in on our health and dental plan and our maternity/paternity program. We were the first in the country to have a maternity/paternity program for physicians. Those are important recruitment tools.

Then we're working actively with the Health Authority and with others to - I don't want to say "resurrect," but to create robust medical staff associations. I think communities of physicians, whether you are at the QEII or whether you are at Bridgewater, need support from their community and their colleagues, so that if you're a family physician on Main Street in Springhill, you are not in a solo, you are not out there by yourself, and you have a population of colleagues and physicians you can turn to.

Creating that medical staff association and creating that environment where a physician can come in with his or her family and be comfortable, accepted in the community, have supports, have colleagues - those are the kinds of things I think we're looking to try and move forward.

MR. RANKIN: I would agree that a support system is important. I was happy to see the mayor come out in Digby and have all kinds of support systems in place for the new doctors placed there.

You mentioned the mentorship idea, which sounds great, like a lot of ideas do, but there's obviously a fiscal component that really needs to be looked at. Have you costed this out? What will the impact be financially, and how will it get paid out? Do all doctors require this?

MR. CHAPMAN: Great questions. We haven't costed it out specifically, but what we have looked at is that new physicians do not come in and bill the same way that a physician like Dr. Johnson might bill, who has practised for four or five years or perhaps longer. There is not necessarily a linear or even an exponential growth.

A physician who's winding down will start to wind down their practice, and a new physician coming in - we've looked at billing patterns - does not hit the start mark on day one. There is that natural transition in and transition out. If you have two physicians in a practice, clearly there is going to be an incremental cost, but it isn't an exponential or a linear increase. But you're paying for that, in the guise of getting better access, because now you have two or three individuals in a practice seeing those patients. You are improving access and you are making an investment in the long-term sustainability of the system.

MR. RANKIN: I agree with the qualitative part. I was just wondering if you had measured costs.

MR. CHAPMAN: There is very good empirical data to suggest that new physicians don't bill at 100 per cent on day one, and physicians who are going to retire can wind down. There is a curve where they kind of match each other.

MR. RANKIN: Okay, thank you.

MR. CHAIRMAN: Thank you, Mr. Rankin.

We'll now move to Mr. Porter. You have until 10:50 a.m.

MR. CHUCK PORTER: I've got a few questions. I probably won't get them all in, but I'll go through them quickly.

Ms. MacCready-Williams, there has been discussion around how you supported and were part of the collaborative rollout. In your opinion, is the collaborative model a good model?

MS. MACCREADY-WILLIAMS: Collaborative care, generally speaking? Yes, we support it. It's foundational in our position paper on primary care.

MR. PORTER: To your knowledge, is this used in other parts of the country?

MS. MACCREADY-WILLIAMS: Yes, it is.

MR. PORTER: Would you deem it to be successful?

MS. MACCREADY-WILLIAMS: There's great evidence out there that it delivers really good patient outcomes. It's why we're endorsing it.

MR. PORTER: The patient outcomes are the part I wanted to get to. Obviously you would see that there are improved outcomes, benefits.

Also, to your knowledge, when did Nova Scotia start having a problem with doctor shortages? Do you know what actions were taken to address it when the issue started? How long ago? This didn't start yesterday or last year or two years ago.

MS. MACCREADY-WILLIAMS: Certainly this has been an issue we see more of a discussion of in the last couple of years.

MR. PORTER: My question was, just to be clear, when did it start? When did the issue of doctors and shortages start in Nova Scotia? This was not an issue that just started

and came to light in the last couple of years. I'm just trying for some clarity here, if you can tell me, from the perspective of Doctors Nova Scotia, when that may have occurred.

MR. CHAIRMAN: Ms. Patterson.

MS. PATTERSON: I think others might have some insights on this, so feel free to jump in.

What I would say is that this is an issue that ebbs and flows. In the past couple of years we are experiencing a more pronounced issue around physician shortages than we had seen in the preceding period. In the early- or mid-1990s we know it was quite prevalent as well. I think there are various ebbs and flows that people could point to.

I think the experience of physicians in the province right now would be that we are currently experiencing a more pronounced physician shortage than at other times in history.

MR. CHAIRMAN: Dr. Bernard.

DR. ANDRÉ BERNARD: I think any health system needs a tightly-coupled health human resources planning mechanism to address the changing context. The context isn't just the underlying population health parameters. It's everything. It's people moving in and out of the province, it's how we practice, it's advances in medical care. I almost chuckled to myself when you asked the question because I would ask myself whether it has always been this way, from the very beginning, because this is not a static system. How we practised in the 1980s is very different from how we practise today. The care we provide our patients is constantly changing. We need an efficient planning tool that couples the needs in a way that addresses - it's not just about the numbers of doctors, although that is often used as the composite for the underlying health needs. And, we've been talking about our support for collaborative care. It's about providing the best care possible for our patients, collectively as Nova Scotians. In terms of the mechanisms to do that, we have data points or markers in the channel that help us get where we want to go. We would appreciate being faster and more attentive to the needs as they present themselves.

So, regarding the question, "do we believe in comprehensive, collaborative care?" Absolutely. But, as we've said in our paper, it's not a one-size-fits-all solution. If you put in a one-size-fits-all solution, you won't address the variances that exist across this province. I think most of us would agree on that.

[10:45 a.m.]

MR. PORTER: Thank you. I want to ask a couple of questions about MyHealthNS. Technology has changed so much over the years, especially in health care, from advances in medicine to how we do business every day. I always find the technological piece interesting because we're living on the edge of change. It's so quick. It's about always being on the leading edge and not the bleeding edge of the sword. Where do we go? How

do we go? But - and I'll use myself as an example - you can take my social insurance number anywhere in this country and learn everything you want to know about Chuck. When will we be at the point where I can type Chuck's health card number in no matter where I am in this province? This seems rather simple to me. I should be able to type it in in Yarmouth or Glace Bay and you should be able to see everything about me. Why is that taking so long? It was mentioned that this is a long term? Technology is everywhere.

MR. CHAIRMAN: Ms. MacCready-Williams.

MS. MACCREADY-WILLIAMS: Thank you. The one patient/one record initiative is incredibly important moving forward, so that health care providers, physicians, nurse practitioners and others can work together, virtually sharing patient files. We're delighted that although it was on again and then off again, it has now been resurrected by government. A platform in our primary care strategy is that using the technologies that are available to us - including one patient/one record and MyHealthNS - is critical moving forward.

MR. PORTER: Thank you. I agree. There's a huge benefit to that, and I think it has a lot of other benefits as well, with regard to technology and treatments and so on.

The other piece you mentioned was around physicians. My own physician, I've had her for years. Yes, it's a small business. It's exactly that. They are running their own businesses. Many may see it as a very good business. My physician probably has 2,500 or 3,000 patients, and I'm guessing that she has been there for many years. Some might think, wow, there's a chance to step right in and take over a business and be quite successful from a financial perspective. But, I don't get the impression that that's assessed. Is that assessed along the way when we're in the recruiting mode? Maybe one of the physicians would like to speak about that - someone who does it every day. It does seem like something that would be attractive - or maybe enticing would be a better word - to get the opportunity to set right up in business even with the mentorship piece, whatever that might be. Could we get your thoughts on that in my last 30 seconds?

MR. CHAIRMAN: Dr. Johnson.

DR. JOHNSON: It is. It sounds true. In theory, that would be great.

MR. PORTER: Okay.

DR. JOHNSON: I would argue that most new physicians who are currently being trained in residency programs are not being trained in a system where they're seeing that many patients. A practice that has 3,000 patients probably needs to generate 40 to 45 visits a day, which is very daunting to a new grad who is used to spending 15 minutes with each patient and having time to address all of their complex issues. As we age, physicians' practices age with them, so their patients become more complex. And, while I may know

the in and out of the last 20 years of my patient, somebody who's new has all of that history to acquire; so, it's very daunting and not very efficient.

MR. CHUCK PORTER: How many patients a day would you . . .

MR. CHAIRMAN: Order. I do apologize, but the time for questions has expired. Ms. MacCready-Williams, we'll give you an opportunity to provide some closing comments.

MS. MACCREADY-WILLIAMS: I certainly want to thank the members of the committee for the invitation to appear today and to say that physicians have some great ideas in terms of how to improve the system. They are key members of any collaborative care teams moving forward. In fact, they, you know, in terms of just their practice, the tests that they send patients for, the prescriptions that they write - they, in fact, control a lot of the costs in the system. So, having them involved to help shape the future of the health care system in Nova Scotia is critically important. They, as members of the association, come to the association and say, you know, can you please champion these causes on our collective behalf; and that's certainly our role. So, they have some great ideas, they want to be part of the solution and they welcome an opportunity to work collaboratively both with the Health Authority, with the IWK, and with the Department of Health and Wellness. So,thank you for the opportunity to speak with you today.

MR. CHAIRMAN: Thank you for being with us. We appreciate your time in answering all of our questions.

We do have some committee business. We received some correspondence from the Department of Municipal Affairs that was requested from the March 22nd meeting. Are there any questions on that correspondence? Hearing none, we did have some outstanding communication between the committee and the Department of Transportation and Infrastructure Renewal about the Cobequid Pass. Mr. Houston, I believe you had something that you wanted to provide in terms of clarifying the question asked for the Department of Transportation and Infrastructure Renewal.

MR. HOUSTON: Well, in fact, I think, Mr. Chairman, we might have raised enough attention to the tolls on the Cobequid Pass that I think the minister just now said he's actually going to come clean and take them off. So maybe we'll close that one for now.

MR. CHAIRMAN: Okay. Thank you, Mr. Houston.

Our next meeting is scheduled for May 3rd, and the topic will be on school capital planning which was Chapter 2 in the November 2016 Report of the Auditor General.

We have a briefing that morning from 8:30 a.m. to 9:00 a.m. and the full meeting from 9:00 a.m. to 11:00 a.m

There is a possibility - there's election talk in the air – that this could be our last meeting; it may not be but given there is some uncertainty around that, I just thought I would take the opportunity on behalf of the committee to thank those who provide us with support here for our committee business. I want to thank Legislative TV for the services they are providing. I want to thank our Committees Office, Kim Langille and Kim Leadley. I want to thank Hansard, Colleen Denomme. I want to thank our Legislative Counsel, Nicole Arsenault and Gordon Hebb, and also the Auditor General's Office, Mr. Terry Spicer. Thank you, everyone, for your support.

Again, our next meeting may be May 3rd. We will now adjourn this meeting and we will wait to see if there will be any more. Thank you.

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