HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, December 13, 2017

Legislative Chamber

Physician Recruitment and Retention

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Public Accounts Committee

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[Mr. Brendan Maguire was replaced by Mr. Bill Horne.]

[Hon. David Wilson was replaced by Ms. Claudia Chender.]

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Mr. Michael Pickup,
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Mr. Andrew Atherton,
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WITNESSES

Department of Health and Wellness

Ms. Denise Perret,
Deputy Minister

Ms. Jeannine Lagassé,
Associate Deputy Minister

Nova Scotia Health Authority

Ms. Janet Knox,
President and CEO

Dr. Lynne Harrigan,
Vice President - Medicine

Dr. Richard Gibson,
Medical Director -
Primary Health Care and
Department of Family Practice

Nova Scotia College of Physicians and Surgeons

Dr. D.A. Grant,
Registrar and CEO

Dr. Graham Bullock,
Deputy Registrar, Physician Performance

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, DECEMBER 13, 2017

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Gordon Wilson

MR. CHAIRMAN: Good morning everyone. I call this meeting of the Public Accounts Committee to order. This morning we are discussing physician recruitment and retention.

We'll remind everyone to put their phones on silent, so we don't have interruptions. We'll begin with introductions.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Thank you. Ms. Perret, would you like to proceed and lead us off this morning?

MS. DENISE PERRET: Good morning, and thank you very much for the invitation to be here to speak on the topic of physician recruitment and retention.

Our priority in the Department of Health and Wellness is to connect Nova Scotians to the primary health care providers and services that they need. The recruitment and retention of physicians is central to this priority. This initiative involves many organizations and partnerships reflected here today. Three are in attendance.

We have the College of Physicians and Surgeons, the regulating body. It ensures that physicians are qualified to practise in Nova Scotia. It is the authority that registers and licenses physicians. The Health Authority, as you know, has overall responsibility for the delivery of health services in the province and the Health Authority plays a lead role in the physician recruitment effort. The Department of Health and Wellness is the policy arm of the system; we're responsible for physician compensation. In this regard, we provide incentive programs that assist the recruitment effort.

Not in attendance here but an integral part of the system is the province's Medical School at Dalhousie. The existence of a first-class medical school is an important feature for both recruitment and retention. Dalhousie is responsible for training physicians but in addition, the school plays a significant role in helping to organize and structure the family and specialist residency programs, the new clerkship program that's going to put third-year residents in various parts of the province for training. Dalhousie is also a partner in the design and implementation of a new practice readiness assessment program that will enable the recruitment and retention of international medical practitioners. This initiative includes all the partners here today as well.

Another feature of physician recruitment and retention is the important contribution made by communities and municipalities. The factors that go into attracting physicians to the province and keeping them here go beyond training incentives and compensation. Like other professionals, physicians are looking at what the community offers them - whether it supports their lifestyle, whether it provides opportunities for their spouse, what the educational, recreational, artistic opportunities are for their children.

As you can see, this is not a topic that falls to one organization to address. Just as health care touches every person in the province, we all can play a positive role in the recruitment and retention of physicians.

Finally, an important factor in recruitment and retention is also about the opportunity to work with good people. In this regard, Nova Scotia has a wonderful health care community. It is inspiring to meet the health care professionals on the front line. We are all grateful for the work they do each and every day caring for the people of this province.

I want to add and acknowledge the work of employees in the department and in the Health Authority behind the front lines. We have asked a lot of them - to be nimble, to respond to a changing landscape - and we are really pleased by how they have stepped up to that challenge.

Again, I appreciate the opportunity to be here. This is an important discussion and I look forward to your questions this morning. Thank you.

MR. CHAIRMAN: Thank you. Ms. Knox.

MS. JANET KNOX: Thank you and good morning. I, too, welcome the opportunity to be here to talk with you with my colleagues, Dr. Lynne Harrigan and Dr. Rick Gibson, as well as our colleagues from the Department of Health and Wellness and the College of Physicians and Surgeons.

Too many Nova Scotians do not have a primary care provider or can't access the one that they have. We're working hard to recruit more family doctors, but the solution to improving access to care is more than that. The Nova Scotia Health Authority's plan for improving access has always been about building and strengthening family practice teams through the recruitment and retention of valued family doctors, specialists, and other care providers such as social workers, dieticians, and mental health professionals.

It's important to have the right mix and distribution of resources in each of our communities across this province so that all Nova Scotians can get the care that they need by the right provider in the right place at the right time.

We know that fundamentally most people agree with a direction towards comprehensive primary health care, but we have been challenged in the expectations of how long it takes to make these changes, and the complexity of this work that we need to do together, and in finding an adequate plan for the people who need to see a doctor today. We are working hard with the Department of Health and Wellness for options for those patients who need access now and hope to provide an update on that soon.

We understand the desire of Nova Scotians to see rapid change and improvement, and we need to balance that with decisions that are thoughtful and well planned. We have learned that we need to be more responsive, we need to be more nimble, and we have made much progress since our last appearance here in March.

We've enhanced 14 family practices this past year with the addition of 22 nurse practitioners and family practice nurses, and just last week we issued an expression of interest inviting groups of family doctors and existing family practice teams to identify their interest in working with us to expand.

Our goal this year is to enhance 21 additional teams. We are hearing positive feedback as we travel throughout the province. People are becoming involved in moving this forward. This provides opportunity for improved access, recruitment, and retention. We value the tireless dedication of doctors across the province who work to support patients at all stages of their lives, and we know many care providers now want to work in these teams, so we have to be flexible to ensure that the health system and the providers can find a place.

Stakeholder feedback has lead to changes in our process to replace ongoing physicians. We now have a more flexible provincial model to welcome new doctors and their families to communities they want to practise in.

We know that the discontinuation of the clinical assessment for practice program in 2015 had an impact, and we're very pleased to be working, as the deputy said, with our partners to develop a replacement for that program. Recruiting physicians is high on our agenda. We have been learning about the challenges and barriers, and we've learned that we need to highlight Nova Scotia as a destination to work and live.

We've recently launched a new recruitment marketing strategy that is called More Than Medicine, and it showcases Nova Scotia as a place to practise great medicine and live a great life. It features our ocean lifestyle, the depth and scope of practice opportunities we have to offer, and the connection to community. These are things that Nova Scotia physicians have told us are important to them.

We've made significant investments in international recruitment; for the first time, this year we sent recruitment teams to England and Scotland. At the British Medical Journal Careers Fair in October, we collaborated with the Nova Scotia College of Physicians and Surgeons and the Department of Immigration, and the response has been very positive.

Recruitment requires many stakeholders. We have recently established a provincial recruitment advisory group to bring these stakeholders together on this high-priority work. In that group, we'll be working with the Department of Health and Wellness, the College of Physicians and Surgeons, our medical school, Doctors Nova Scotia, local communities, members of the public, and most importantly, the physicians themselves to make sure we are maximizing opportunities to bring doctors to our province.

Quality recruitment takes time. The investments we are making today will show results further down the road and the progress we see today is coming from efforts that took place in previous years as well. Since April of this year, we've recruited 92 doctors who are now in the province, or soon will be, and we have accepted offers from 44 more. We are competing across Canada for this very important resource. In fact, we're competing in the world. However, the environment we are recruiting into is challenging. There are things outside of the Nova Scotia Health Authority that directly impact our ability to recruit and retain physicians. This public discourse is critical and crucial in building understanding of our shared problems, and I look forward to continuing this work together. Thank you very much.

MR. CHAIRMAN: Thank you. Dr. Grant.

DR. D.A. GRANT: Mr. Chairman, I very much appreciate the opportunity to appear before this committee. On behalf of Dr. Bullock and the college, we share your concerns. This is an important issue and the college is attuned to it.

In lieu of an opening statement, I provided some written submissions to you which I hope weren't too overly-dense going. With the combination of those submissions and the conversation this morning, I hope we can strengthen the understanding of all as to how we

make these difficult and important decisions about who should receive a medical licence and who shouldn't. I hope I can keep my ears open to ideas as to how we might do it better. I look forward to this morning.

MR. CHAIRMAN: Thank you very much. We'll start with Mr. Houston of the PC caucus for 20 minutes.

MR. TIM HOUSTON: Thank you for the opening comments. Deputy, you mentioned that the Health Authority is the lead on recruiting. The Health Authority is actually responsible for recruiting - like, who is responsible for recruiting doctors?

MS. PERRET: The Health Authority leads our recruitment effort and in the context of your question, would be responsible for recruiting doctors. As I said in my opening remarks, it's not a straight line to just a role played by one organization, there are many factors that go into recruitment so it does require a coordinating effort. I think that all of our organizations play a role.

MR. HOUSTON: Inside the Health Authority is there somebody who has the job title that would ultimately be responsible for recruiting doctors? Or would that be yourself, Ms. Knox?

MS. KNOX: Thank you for the question. We have developed a recruitment strategy that has people with very defined roles. I could ask Dr. Harrigan to outline that for you, if you are interested in that.

MR. HOUSTON: Is that the More Than Medicine strategy?

MS. KNOX: That's one part of it. We have a comprehensive strategy and we have a structure in place to support that strategy.

MR. HOUSTON: When was the comprehensive strategy kind of developed and implemented?

MS. KNOX: Over the past year we became responsible for recruitment of physicians, April 1, 2016. At that point in time, one individual who was recruited from the Department of Health and Wellness moved into the Nova Scotia Health Authority and we began the development of a strategy.

MR. HOUSTON: Okay, and then the strategy actually came to life some time after April 1, 2016, I guess?

MS. KNOX: The first thing you need to do is understand what the issues are and what resources you need to put in place. We had parts of the province that had no support at all in terms of recruitment people, so we had to look at across the province what resources

were needed. We did put those in place and together they work with local physicians and community leaders to develop local strategies that would support an overall provincial . . .

MR. HOUSTON: During that time, and I don't know how long - just roughly, how long was that, from April 1, 2016, to the time when somebody said ah ha, we have a strategy, let's go with this? Was it months?

MS. KNOX: We didn't wait to start recruiting until we had an overall strategy. I'm going to ask Dr. Harrigan to talk to you about the work that we've done over time, including the development of our strategy.

MR. HOUSTON: I'm more so interested in when that strategy, for right now - when somebody said there, we have a strategy, let's run with this. When would that have been? It wasn't April 1, 2016, it was some time after that, I guess.

[9:15 a.m.]

DR. LYNNE HARRIGAN: Sure. I think that some context is important. There was a provincial recruiter situated at the Department of Health and Wellness who had a strategy. She would move over to the Health Authority, so the same strategy that was present with the Department of Health and Wellness continued. We then did . . .

MR. HOUSTON: Is that person still an employee of the Health Authority?

DR. HARRIGAN: That is correct. Joanne MacKinnon is our chief recruiting officer.

MR. HOUSTON: She's not here today?

DR. HARRIGAN: No. She reports to me, so I would respond to that.

Then we did an environmental scan to see, from nine district health authorities, what was present. Much to our shock, there was no recruiter in Capital Health Central Zone. We said, well that can't happen. One of our greatest needs is family physicians in Central Zone. We immediately put in place recruiters in each zone, set out a job description, did appropriate training for them, and got them on the ground as quickly as possible. We continued our other strategies, which requires . . .

MR. HOUSTON: For my purposes now, I'm just interested in the timeline. Immediately . . .

DR. HARRIGAN: We had a strategy from the get-go. After I think about six months, we sat down. We said, we have our people in place, and we have our previous strategies in place. What in addition do we need to do? What do we need to amplify? That's

when we brought a strategy to our board to say that we needed, number one, to enhance our presence around the world, so we went the international route. We have also enhanced our presence in Ontario and Newfoundland . . .

MR. HOUSTON: On April 1st, the recruiter comes over from the Department of Health and Wellness to the Health Authority, some realizations are made about some weaknesses, and some people are put in place. I heard immediately, and then I heard as soon as possible. Are we talking still April 2016?

DR. HARRIGAN: As you know, to actually hire people takes time, so we put a proposal forward and put those people in as soon as possible. They hit the ground running, but all the time . . .

MR. HOUSTON: But that has already happened. I don't want to try to go around in circles here. It has already happened, so at some point they were hired. I'm just asking when that was.

DR. HARRIGAN: I would have to get back to you. I don't know the exact dates.

MR. HOUSTON: Was it a matter of months?

DR. HARRIGAN: It was a matter of months, yes.

MR. HOUSTON: So sometime probably in the summer of 2016, the people got in place. You mentioned that in the past year there have been 92 physicians recruited . . .

DR. HARRIGAN: That's 92 physicians who are working in Nova Scotia this year, starting from April 1st of this year. There has been so much confusion over the numbers. We also have had people signed to come, but we will only report people who are feet on ground, who are actually seeing patients and billing because it creates too much confusion.

MR. HOUSTON: They're all family practices?

DR. HARRIGAN: No, 26 are family doctors and 66 are specialists.

MR. HOUSTON: So, 26 family and 66 specialists, and there's 44 offers.

DR. HARRIGAN: That is correct.

MR. HOUSTON: How long would those generally take to get from an offer to a person?

DR. HARRIGAN: The entire recruitment process for something can take three years. These offers are pending. We would expect them to come within the year.

MR. HOUSTON: How many of those are family doctors?

DR. HARRIGAN: Eleven.

MR. HOUSTON: The rest are specialists?

DR. HARRIGAN: Yes.

MR. HOUSTON: What would you say is the success rate in recruiting going from an offer to a person ultimately turning up here to practise?

DR. HARRIGAN: It can vary. These are accepted offers. They're accepted, so they are coming. They're just not here yet. That 11 . . .

MR. HOUSTON: The answer would be 100 per cent?

DR. HARRIGAN: Those are accepted offers. Pending offers are not all accepted offers. I would say probably about 60 per cent of our offers are accepted. These ones have been accepted, so these people are coming.

MR. HOUSTON: When?

DR. HARRIGAN: I don't have the exact date. They all start at different times, and until they're feet on the ground and actually working, they will not appear in our overall stats so as to not create any confusion.

MR. HOUSTON: Accepted offer means no more hurdles.

DR. HARRIGAN: That's correct.

MR. HOUSTON: Not with the registrar, nothing. They're coming. Those have all been cleared. That could take months? It could take years? How long could that take?

DR. HARRIGAN: It really depends where they come from. If you're talking to someone from Great Britain, for instance, we have immigration hurdles, and we have licensing hurdles. Those would take longer as . . .

MR. HOUSTON: So there are hurdles, then?

DR. HARRIGAN: Not after they're accepted, but to get them accepted.

MR. HOUSTON: But from the accepted offer. I want to come back to the 26, and I want to come back to the 11. For now, the 11 family doctors - accepted offers - do you

have a note as to when they're coming? Don't tell me their names, but if you could just list off some . . .

DR. HARRIGAN: I don't have that data. I could get it for you. Most of them are in residency right now. My presumption is they're going to be starting in the summer. These are finishing residents.

MR. HOUSTON: Okay. How do you measure whether the recruitment strategy is successful? Do you have a benchmark? It's 92 this year, and I'll put that down into two buckets, one being specialists and one being family practice . . .

DR. HARRIGAN: That's 92 to date. That's not to the end of the fiscal year.

MR. HOUSTON: What's your goal for the fiscal year?

DR. HARRIGAN: Our goal is 100 doctors. We are just about to exceed that goal, but I would say that from a primary care perspective, we don't say, oh we've got 50 family doctors and now we're stopping. In other words, our intent is to bring as many people to work in Nova Scotia as we can.

MR. HOUSTON: Of the 100, how many are family doctors of your goal?

DR. HARRIGAN: Fifty.

MR. HOUSTON: So you have a goal of 50 family doctors and 50 specialists - that's your goal for the year.

DR. HARRIGAN: Yes.

MR. HOUSTON: And you have 26 so far and 66 specialists.

DR. HARRIGAN: Right.

MR. HOUSTON: How do you determine the goal of 50 for family doctors? Do you have a spreadsheet?

DR. HARRIGAN: Yes, a lot of it is based on physician resource planning, which is quite a complex tool, but it's based on when physicians are retiring, the age of practice, male versus female type of practice, and it predicts based on that and based on the type of practice that's being done that you would need approximately 50 family doctors. So we use that as a point of data, but again we also use our data of where people need family doctors and continue to recruit there. It's a target, but it's not an end point.

MR. HOUSTON: How many people in Nova Scotia need a family doctor right now?

DR. HARRIGAN: Right now on our list, approximately 42,000.

MR. HOUSTON: And the numbers that are out there - 80,000 and 100,000 - those aren't numbers you agree with?

DR. HARRIGAN: Those numbers come from the Canadian Community Health Survey, and the first question on the survey is, "Do you have a family doctor?", and they respond. So on that, approximately 100,000 people in Nova Scotia - and it's statistical so it's an adjustment. So 100,000 people would say, "I don't have a family doctor." The next question on the survey is, "Why don't you have a family doctor?" and 50 per cent said because they don't want one.

So nationally when we use these numbers, you usually cut it in half to say, the ones who don't want one are your 22-year-old healthy males who don't really see a need for that at the time. The ones that really need family doctors are probably half that. So our 42,000 is probably pretty close to the people who are looking for family doctors. The value of that database is that those are real people with postal codes. They're people we can pick up the phone and say, hey, we found a doctor for you. Whereas the national number is a statistic and so you can't really find those people so it's a value for us.

For instance, Halifax has approximately 20,000 people on that list. That is very unusual. In the past, doctors flocked to the city. So we will change our recruitment strategies. We will change our incentive programs based on the information that we receive from this database, which we would not have known otherwise.

MR. HOUSTON: So would it be your position - and I guess maybe the department's position - that there are 100,000 people in Nova Scotia that need a doctor, but only half of that number that wants one? That's an important distinction for me.

MS. PERRET: We monitor the statistics so I think the important point that Dr. Harrigan made is that there is a comprehensive effort that goes into physician resource planning. So both Statistics Canada, the Canadian Institute of Health Information and the community survey have all for a number of years indicated - for Canada - that only 85 per cent of Canadians have a family physician. I think the question has changed to primary health care provider now, and Nova Scotia has been above that at around 90 per cent. So it's a number to track.

I agree with Dr. Harrigan - its meaning is limited in how it helps us plan. So physician resource planning effort, which is underway, we expect the new edition of the Physician Resource Plan out early in the new year will tell us more specifically about what

the landscape looks like in Nova Scotia, and there is no question that having the 811 list and the data that list provides is a real boon to planning on the recruitment front.

MR. HOUSTON: So it's kind of important - this is the first time I've heard this distinction that there are really 100,000 Nova Scotians without a doctor, but the number of 42,000 is - I'd say those are probably people who are actually actively seeking a doctor - like a real sense of urgency to find a doctor. That's the problem, is it not? It's not as simple as saying, well there are 100,000 people that don't have a doctor, but half of them don't care, because tomorrow they might care and they don't have a doctor tomorrow.

I would be more comfortable trying to work to address the issue of 100,000 people not having a doctor than say, well, it's really 42,000. Do you see what I mean? I might not be articulating the importance of this point, but I don't want anybody to minimize the importance of the point that there are 100,000 people without a doctor.

MS. PERRET: An important question and I am appreciative of the opportunity to clarify. We know that there are 42,000 people actively seeking a physician, according to the 811 data. We care deeply about that number. We are focused on that number, it's job one for us.

MR. HOUSTON: How many doctors are currently practising in Nova Scotia - family doctors actually seeing patients?

MS. PERRET: If the question is coming to me, I'm going to refer to the college's data that they have provided. Your question is more complicated than it appears on the surface because actually practising is a bit of a dynamic circumstance.

MR. HOUSTON: Seeing patients - does that help?

MS. PERRET: We know that registered in the province that we have I believe over 2,600, almost 2,700 physicians. Of those, GPs that are fully registered, there are 1,139.

MR. HOUSTON: Seeing patients, with active billing codes, I guess. Maybe the college?

DR. GRANT: We can only provide you with head count numbers. The head count is approximately 1,300 family physicians are licensed to see patients but I do not have the ability to tell you who is billing and who is seeing patients.

MR. HOUSTON: Some of them might have retired or something, I guess.

DR. GRANT: It's not uncommon for physicians to keep their licence active as they contemplate retirement or keep their licence active when they're doing other things.

MR. HOUSTON: Okay, so 1,300 - 1,139 was kind of the active, was it?

MS. PERRET: Our active number of actively billing on a full-time basis, so this doesn't account for those who may be working part-time - the full number is 2,562.

MR. HOUSTON: No, but that's specialists and stuff, correct?

MS. PERRET: It includes the whole physician complement.

MR. HOUSTON: Do have the number for families?

MS. PERRET: We don't have it broken out at this point.

MR. HOUSTON: Okay. Do you know how many vacancies there are for family physicians?

MS. PERRET: I believe the number is approximately 60 vacancies.

MR. HOUSTON: There's 60 vacancies, the goal for this year is to fill 50 of those. Is that a fair summary?

MS. PERRET: Based on physician resource planning - again, we're updating the plan early in the new year - the goal has been 100 physician recruitment, approximately a 50-50 split. But as the Health Authority has commented, a dynamic landscape and we're trying to be nimble here, so we've done a couple of things. We have a long-standing replacement committee that looks at those 60 vacancies. We've made that committee a much more flexible committee. It used to look at replacement in the location where the vacancy arose. In order to accommodate physician preference and to be as competitive as possible, we're now looking at vacancies province-wide and moving as nimbly as possible to allot them province-wide.

We have also added a new committee to add positions to the mix, so we're not restricted to the 60 vacancies. We have a new MD committee, it has representatives who are sitting here. It includes Doctors Nova Scotia, they have a priority setting committee and a funding committee. The work of that committee has just gotten under way.

MR. HOUSTON: The number is 60 family physician vacancies, though?

MS. PERRET: Plus any that are determined by the priority committee in the new MD process.

MR. HOUSTON: So, 60-plus. The target for this year was 50.

[9:30 a.m.]

DR. HARRIGAN: That's why I hate using numbers. We will get as many doctors as we can. I will take 100 family doctors. We're saying 50 is a reasonable target, based on the physician resource plan, but that is not going to stop us. We are not going to sit back and say oh, we have 50, let's pat ourselves on the back and move on.

We are aware of these vacancy numbers. We are working hard to get as many physicians as we can in this province. What we know also is pending vacancies, so we're not only tracking current vacancies, and some of these are many years old, we're tracking the people who are retiring. That is so helpful to us because we can plan and we know that a substantial number of doctors are coming down the pipe. This number will remain between 55 and 60 for some time, as more people retire and we bring more people in, so we're trying to gain traction. But 60, 70, we will take as many doctors as we can.

MR. HOUSTON: Yes, but there are 60 vacancies right now.

DR. HARRIGAN: Some of those vacancies are years and years old.

MR. HOUSTON: And some of those - you said there's a committee that's not looking necessarily at where the vacancy was generated. So a community loses a doctor - it's a factor in where the doctor comes from because you mentioned province-wide. When I heard that - so community one loses a doctor, they're not necessarily getting it back because you are looking at it province-wide. I took that from what you said, maybe I shouldn't have.

MR. CHAIRMAN: Ms. Perret.

MS. PERRET: I appreciate the opportunity to clarify. So that community that needs one doctor or more than one doctor is still on the books as having that shift in resource load. What I am emphasizing, and this was an important issue a couple of months ago, we want to make sure that we are competitive in the recruitment sphere. We want to accommodate the location decisions of doctors. We want to ensure that they are practising where and how they want to practise, to the maximum extent. So having flexibility on the recruitment process was a key part of enabling that to happen.

MR. HOUSTON: Okay, so just as I wrap up my section here, there are currently 60 vacancies, 26 have been filled - or no, I guess the 60 are still vacant, even though the 26 came, right?

DR. HARRIGAN: This is a moving number, it changes every month. As someone comes in, the vacancy number goes down, as people retire the vacancy number goes up.

MR. HOUSTON: We're going to get to that, but I want to know where we're at right now. So there's 60 vacancies today and the 26 that we talked about in the 92, they're already here so the 60 vacancies still exist . . .

DR. HARRIGAN: That is correct.

MR. HOUSTON: … and we have 11 that might come and fill them.

DR. HARRIGAN: Eleven will be coming to fill those.

MR. HOUSTON: Okay, so there's 49 other vacancies to be dealt with, as we sit here today. Okay.

MR. CHAIRMAN: Order, time has expired. We'll move to the NDP caucus and Ms. Roberts.

MS. LISA ROBERTS: Thank you to all for your presentations. I was very interested to find on the NSHA website yesterday a list of - I think I counted 49 collaborative practice teams that are in existence in some form. I would like to clarify with you because we've been hearing about these collaborative practices now called, I think, collaborative family practices, which is a slight shift in language. How many of these teams are in full existence and operation?

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: Thank you for that question. What we would say, I'll just say a couple of things before I ask Dr. Gibson to talk about their work with the teams. You are absolutely correct, we have about 50 teams across the province and they are in varying stages of development. Some would be groups of physicians working in the same facility, but not necessarily a full collaboration of different members of the team. I'll ask Dr. Gibson to talk about their work with the teams across the province.

MR. CHAIRMAN: Dr. Gibson.

DR. RICHARD GIBSON: So exactly that, the teams, as we envision them, would include physicians, nurse practitioners, nurses, other team members, according to the needs of the communities. That's a target that we're working towards over time but you don't sort of realize that on day one. So the list of teams that you've got are teams that are up, they exist, they have the mix of providers that are on the list but they're not what we had envisioned in the future, in term of the fully-formed list.

We're continuing to work with those teams to sort of build their collaborative work to add team members over time as the teams evolve so that they become more fully functioning teams over time. As we're enhancing the teams that already exist, then we are starting new teams and those teams will grow over time.

We started new teams last year, we're starting new teams again this year and we've just put out the expression of interest for new teams to start building next year. We realize

that this is a sort of multi-year process, that some teams have to think about it a bit before they are ready and other teams were ready yesterday, so they've already started. Sometimes it's a conversation and sometimes it's like yes, we're up, we're ready to go, we just need to hire the nurse and we will get right on with it. It's an evolutionary process.

MS. ROBERTS: I'm sorry - I'm going to try to adopt some of my colleague from Pictou East's ability to interrupt on occasion. Of that list that is currently on the website, are they all seeing patients right now?

DR. GIBSON: Yes.

MS. ROBERTS: They are, okay. How many additional teams do we - what is the goal in terms of additional teams for next year, for example?

DR. GIBSON: I have to refer back to Ms. Knox's opening remarks. Last year the Premier announced funding in November 2016 of $3.6 million annualized. We have been working to build teams based upon those numbers so we enhanced 14 last year based on the $3.6 million. This year there was an addition of $6 million. We are currently working with 21 teams in this year to add and we're expecting that there will be additional monies next year. In preparation for that, so that we're ready to hit the ground running on April 1st, we put out the expression of interest partly to help with spending the $6 million, which was just in the budget, which was only recently approved and partly so that we're ready for next year so that we can continue to build.

We worked with 14 last year. We're working with at least 21 additional to the 14 right now, and we're anticipating adding more next year.

MS. ROBERTS: I recognize some of the teams that are on the list and a number of them have been in operation as collaborative practices for more than five years, so this does not necessarily reflect new investment or new work, but are you enhancing the existing teams as well?

DR. GIBSON: Yes, we are.

MS. ROBERTS: I had the opportunity on my way into the meeting to speak with a manager of the Clare health centre in Meteghan Centre, and one thing that I learned from that conversation is that the Municipality of Clare - I think I'm getting the name of the municipality right. I don't believe it's the Municipality of Meteghan, I think it's Clare - underwrites that clinic to the tune of $150,000 a year to cover administration and building, and all those elements that make it an attractive, easy-to-work-in collaborative practice - it currently sounds like an excellent provision of service to patients.

Just really quickly in a phone call, six doctors, some of them on alternative payment plans, some of them on fee for service, rotating on-call duty, including Saturdays, providing

walk-in clinics for patients who are orphaned, awesome service, $150,000 underwritten by the municipality - is that what the province is prepared to do with existing collaborative teams and existing community health centres, in particular?

DR. GIBSON: I can make a start on that and then if you're asking what the province intends to do, that would be somebody else. There are a wide range of funding models for family practices and collaborative teams across the province, so that you've got situations in which the physicians are paid fee for service, own and operate or rent and operate the facility, hire the staff, pay for the phones, et cetera. They're financed by the physicians from their fee-for-service billings.

We have other situations in which the Health Authority runs the clinic and the physicians pay overhead to the clinic. We have other situations in which there is maybe a not-for-profit entity that runs the clinic with funding from the Department of Health and Wellness and/or the Health Authority. The North End Community Health Centre would be an example.

We have examples of clinics around the province where a community owns and operates the facility and may have chosen to subsidize the operations or the construction or something else in some measure. There's nothing wrong with any of those models. Each of those models works well in the particular context. We're welcome to any or all models that work. Going forward, we're open to conversations with communities and others about, what's the model that works and how do we go ahead?

MS. ROBERTS: Maybe I'll ask Ms. Perret if she could comment a bit on this because I have heard some concerning stories about Nova Scotians who have been prevented from contributing to the work of community health centres by the department, two cases in particular.

The Rawdon Hills Community Health Centre - here's a community that fundraised for a decade, organized, and moved into a community health centre that they built. Then the department moved the physician to another location, and the whole thing was shut down and lost additional services that were associated with that.

My understanding is that a citizen-led initiative to bring a community health centre to the Dartmouth North community is being told that a community health centre is not one of the options that they may consider - a collaborative health team, yes. But a community health centre with a board where the board actually has some role in determining what the provision of services would be is not something that the department would support.

Can I get some comment from you? I was very interested to hear in your opening comments some acknowledgement of the massive contribution that Nova Scotian communities have made to the development of some community practices.

MS. PERRET: Thank you for the question. I think this is an important discussion, important to understand.

I would start by saying that the department doesn't make the decisions that you're referring to. We don't relocate a physician. We're very interested in community health centres and how they can grow. We wouldn't shut one down. What you're seeing is some of the effort to stand up centres or to support centres and just some of the issues that become very specific in particular to the circumstances of a case. Sometimes you have to go much farther down in the weeds to understand what's going on. But just as you stated the question, those aren't decisions the department makes.

I do want to add that I think it would be wrong, and I'm very pleased that it's not the case in this province, for the approach to be one size fits all. Communities know their communities best. Communities are interested in playing a role in health care. They're interested in this recruitment. We see a lot of appetite. I know that the organization of municipalities is really stepping up with some positive questions on that front as to how they can play that role.

I do want to reinforce the message that it's a team sport. We're very interested in ideas and ways we can help. If we hit bumps, we want to understand what the bump is. Our commitment is to move as flexibly as possible to overcome those things.

MS. ROBERTS: Well, I'm going to give myself a bit of a break for not always understanding what is the department and what is the Nova Scotia Health Authority. From my conversations with people in the system, often they are confused as well.

Specifically, when you talk about being nimble, does that nimbleness include the ability - for example, we have these vacancies. Those vacancies are anticipated to be for doctors who would bill the province through fee-for-service. If we're not able to - Lynne Harrigan is shaking her head at me. I'm going to rephrase my question.

We have a vacancy, and we would hope that someone would come and see patients and bill. Is there money left over in the budget if those vacancies are not filled? That's question one. If that money is left over, is there the ability to shift that money from fee-for-service physician funding to, for example, alternative payment plan or looking at a nurse practitioner in a community where there is no ability or there hasn't been success at recruitment?

MS. PERRET: The short answer is quite simply yes, absolutely. The nimbleness includes that.

MS. ROBERTS: Of the 90 physicians who have been recruited successfully this year, does that number include locums?

DR. HARRIGAN: No.

MS. ROBERTS: It does not, okay. I would like to ask a few questions to Dr. Grant.

Thank you for your written submission. In that, you discussed concern on the part of the College of Physicians and Surgeons for some doctors who came through the cap program and who remain provisionally licensed in the province. Can you just speak a little bit more to what the concern or the risk is there both for those individuals and for the patients they serve and also maybe what the opportunity is if the parties come together to support them to secure full licensure.

[9:45 a.m.]

MR. CHAIRMAN: Dr. Grant.

DR. GRANT: I'm happy to discuss CAPP. I'm not sure that's a fair characterization of my concern. The CAPP was a cutting edge program for its day that the college developed on its own to try and identify international medical graduates who might be appropriate for licensure. As I say, it was cutting edge for its day.

We're proud of the work that CAPP did but while we were running CAPP, this college was at national tables trying to figure out how best to identify international medical graduates whose training might be different than Canadians' and who could meet the standard of care we want.

We arrived at a national standard which was developed through the Medical Council of Canada. We then looked at CAPP and said, is it meeting the national standard? We realized it really wasn't in many regards. It was falling short of the standard that we had endorsed and developed so at that point in time we really had no choice, we felt, but to close it down.

We spoke to our counsel, we spoke to Health and Wellness, we spoke to the Health Authority about the closure of it. The concerns I expressed were not about the people we selected because I think we did a pretty good job. The success rate of those physicians in attaining national licensure was very high. My concern was about our confidence that CAPP, as it was constructed, could continue to select appropriate international medical graduates, particularly given that we saw where it was falling short of national standards. That was the concern, it wasn't about the selected physicians.

MS. ROBERTS: So for the 16 - I was trying to follow the numbers as you wrote them down - there are 16 as I understand it. I don't know if they would be called graduates of CAPP, but 16 doctors seeing patients currently who continue to have a defined licence. Is there a clock ticking for them to achieve full licensure? I think right now in Nova Scotia 16 doctors are a significant resource, 16 doctors in hand and in place and already seeing

patients are a whole lot more valuable than 16 even accepted offers out there in the world where you're not sure when they're going to be realized. What do we need to do and how confident are you that they will be able to continue seeing patients?

DR. GRANT: I'm confident that everybody in the room shares the college's belief that job No. 1 is to make sure we select appropriate and competent, safe physicians. Physicians who have conditional licences, which is what the defined licence is, have conditions they must meet. So of the group you described, that cohort in CAPP, who went through CAPP and still have conditions to meet, the time is ticking, there is a deadline to meet these conditions. I hope they will.

There are many conditionally-licensed physicians in Nova Scotia, I think in the order of 120 or something like that. I know there's lots of numbers being thrown at everybody but there's a significant number of conditionally-licenced physicians who have conditions to meet and we established those conditions with a view of what is the acceptable standard? What is the patient safety requirement that they must meet?

The point I was trying to make in the submissions is, I think one of the important opportunities that all of us on this side of the table might look to focus on is how can we set conditionally-licensed physicians up to succeed? How to identify the resources to help them attain the level of training, competence and knowledge to be fully and independently licensed? It's extraordinarily tough if you are an international medical graduate coming from a different part of the world to come to an underserviced area, work very hard, it's hard to find that extra time to study.

MS. ROBERTS: Thank you. I am aware of the clock ticking down on my own time and I wanted to ask another question. I'm not sure to which of you this is best addressed.

I am aware of multiple clinics that serve a great number of patients in my constituency, which are clinics where multiple doctors share administrative staff where they lease space together, but they don't fit in the model. They are not by their nature collaborative clinics, but perhaps they could become them, again, with investment from the department, for example, with a family practice nurse or another health professional paid for by the department, instead of having that burden on the doctors needing to bill more when they're already going very hard.

Are we looking at that as we move to increase this list of collaborative clinics and also work with what we've got to get where we want to go?

MS. KNOX: Absolutely, yes. As Dr. Gibson has described, our focus is on enhancing the current teams that we have, developing new teams and staying focused on areas of the province where we know patients do not have access - so absolutely.

MS. ROBERTS: I guess my last question as my seconds tick down is, I hope that message can get across effectively to the doctors of Nova Scotia, because certainly I've had a number of conversations over the past year where there is not a sense that their current work in an old model is valued and that they are seen as being valuable as we move to shift to a new model. I think there has been great evidence of a lack of trust and a sense that they are invited truly to collaborate where there are multiple parties bringing value to that conversation.

MR. CHAIRMAN: Your time is just about to expire. We'll move to Mr. Wilson of the Liberal Party.

MR. GORDON WILSON: Just to start, I would like to thank all of our witnesses for being here. This is an opportunity I think from my perspective. That's what I love about the Public Accounts Committee, it's a place to learn. It's a place to get facts out. Truly in a very complicated world that we live in in doctor recruitment, this is a real opportunity and I thank you all for being here. I would be remiss if I didn't also take this opportunity to thank all of our front-line workers as was mentioned in health care. We do have a lot of extremely good people out there every day working for Nova Scotians.

I'd like to thank my colleagues for the questions to date. I think you can easily see that each and every one of us in this room wants the same thing, and that's more access to doctors. In a complicated landscape that's changed dramatically in the last four years, I think it's just an opportunity to learn what those challenges are.

To start off with, I think just in saying that we have three different entities here and we've also noted Dalhousie University, that it takes a lot when we try to ask who is responsible for recruiting, I think it was one of the first questions. It's very easy to see that it takes an awful lot. I think that's my experience that I've seen.

I cannot underestimate or understate the importance of the communities, and that's what I truly would like to ask. How can we better engage? How can we better message? How can we better bring everybody together? We have a beautiful province. It's encouraging to see the launch of your site More Than Medicine because this is more than medicine.

We're only talking about recruiting here - and I've heard most of the questions around that - but retention is extremely important. My community has no problem recruiting doctors. We've seen 10 doctors come and 10 doctors go. So let's ask those questions. That is the foundation of truly getting us out of the cycle.

To that, I would like to ask - I'm not sure who would like to answer it - how do we better engage our communities and work with them?

MS. KNOX: I am going to start. Thank you for your comments. You have really hit home in terms of what this is all about. This is about Nova Scotia welcoming new practitioners to our province and welcoming them in a way they can become part of our province. What we have learned in the past 10 years is the importance of really creating that focus on multi stakeholders coming together to help newcomers understand all that our province has to offer. So we are making a very distinct effort in our zones to have our leaders talk with municipal leaders.

As I travel around the province I always make sure I step in and talk to mayors and wardens and leaders in local communities and talk about our priorities together, but hear what is important to them in terms of what their participation can be and bringing together - Dr. Harrigan will talk about our recruitment strategy in which the real importance is at the local level, that the recruitment team is reflective of the community - the practitioners, the patients, the leaders in the community and really be talking about how we together can create the place where that new practitioner wants to be and wants to stay. If I could, I would ask Dr. Harrigan to talk about some of our specific strategies and where we've seen some success.

MR. GORDON WILSON: Actually, I did have questions and I know that you didn't get a chance to finish all your answers on strategy. That does feed in perfectly to my second question around strategy and how does the strategy tie into that?

DR. HARRIGAN: As you recall, what we found from our marketing firm is that the east coast lifestyle is important but community connectedness is as important, and working with a community of physicians is equally as important. That's what differentiates Nova Scotia from everybody else, and so that is what we have to push forward.

We've had small examples of where really hard work with us and the community has worked well, and I would use Digby as an example, where we had every member of the community sitting at a table with physicians, the Health Authority and really making a difference for that community.

We've looked across the country as to what has been successful, and what we found, through Health Match BC is something called red carpet communities. They have been extraordinarily successful with red carpet communities actually developing a program to welcome, mentor, and support physicians in their community. So at our multi-stakeholder physician recruitment advisory committee, this is something we want to investigate and make more formal. So we have it informally on the ground, but I think it's something to make formal on the ground because I think that they have been extraordinarily successful in British Columbia with that. Some of those physicians have gone only because of the welcoming community, and that's something we want to look into.

MR. GORDON WILSON: Interesting that you do mention other provinces. I know - we all know - we're competing right across Canada for doctors, and we're not alone. I

tell my colleagues within other communities in Nova Scotia, you're not alone. This isn't a new problem for Nova Scotia. I think what we're seeing are some new solutions.

In saying that - I'm not sure whether it would be the deputy or who - can you give us an idea of what that competition is across Canada in relation to - we're not the only province facing this problem, and can you give us some idea of how we're positioning ourselves in that landscape?

MS. PERRET: You're absolutely correct. The landscape across the country reflects much the same story as Nova Scotia, with some exceptions, because there are certain advantages that this province has that other provinces don't have. One of those was mentioned in an earlier question. In noting that the collaborative care team initiative actually got underway quite a long time ago, and that is a building block that this province has that other provinces simply don't have. So there is a foundational element. There is an understanding of collaborative care to really build upon, and that has been strong. There are other elements here that are attractive. It is an advantage to have a provincial platform in one Health Authority.

[10:00 a.m.]

Those are aspects that help us be more nimble so that we can keep an eye on the competition across the province and we can respond to it as quickly as possible. I think that further to your question, I would ask the Health Authority to comment.

DR. HARRIGAN: I didn't answer the second part of your initial question - what are we doing from a recruitment strategy perspective. The first thing is we did have to build the bricks and mortar. We had to have people who are in position, well trained and ready to hit the ground running, which we did.

The second thing was we said, where do we go for recruitment? We go to a lot of local recruitment fairs. We go out to Quebec. We have expanded that. We're now going to Ontario. We're going to all the medical schools in Ontario and in Newfoundland because traditionally a lot of those doctors come to Nova Scotia, so we're going to actively go to those medical campuses to say come work in Nova Scotia because it's a lovely place to live. We added the British Medical Journal Careers Fair because we think that will be a high yield for us. It has been a high yield. That's part of it, and we are looking at our return on investment. We have made these decisions. We think they will work, but we're going to monitor to make sure that they work and rethink if they don't.

The third thing is how we support physicians that we bring into place and who come into place. That's about community mentorship. That's about physician mentorship. That's about building a relationship within the community. Those are our three pillars that we're promoting for that.

From the rest of the country, I think we're all competitive. I do have to compliment the College of Physicians and Surgeons because at the British Medical Journal Careers Fair, we had an advantage over our western colleagues in that the college made a decision that if you're a family practitioner who has five years of experience and your family practice training is recognized in Canada, you don't have to write any additional examinations. You can come and start work in Nova Scotia. We were the only province that had that, and we had a lineup. That actually made a huge difference. It was our leg up on the three other provinces that were there. I want to thank the college for that ability. We think we'll see some results from that as well.

MR. GORDON WILSON: My colleague had mentioned - I love it when my colleagues bring up communities of mine, Clare for example. Interestingly enough, I think it had built the model a long time ago, and maybe or maybe not because we had nine different silos working in this province, that message didn't get out enough, I don't know. But I'm very proud of what they're doing down there and do have to compliment them on that. That's a community that has stepped up and continues to show us - but more importantly what wasn't mentioned is their approach to recruiting. When I talk about retention and how we have to have a community involved to retain, it's equally important to have a community involved in recruiting. Do you have any plans within your strategy on involving the community within the recruiting aspect?

DR. HARRIGAN: Yes, and as I said, we're going to formalize that because I think that's really important. Traditionally, it has been the local physicians and community that have recruited. That's why who's ultimately responsible - I said it takes a village to recruit, so we need the physicians of the communities, the communities themselves, and the Health Authority to work together to attract people. Most people who come to work in Nova Scotia are from Nova Scotia. We need to be very aggressive in our residency programs and talk to people.

If I can give you an anecdote, I recently talked to a physician who has been recruiting a physician in a residency program for a year. Then when someone interviewed the resident, he said he had never been recruited. This guy was appalled, and he called up, listen, I have been. And he said, I didn't realize that was what recruitment was all about. We actually need to be even bolder and say, I am now having a conversation about recruitment with you. I want you to come work in Nova Scotia, to be that forward in our conversations with residents.

MR. GORDON WILSON: Can you expand on this provincial advisory group, exactly what their role is? I don't think you completely gave a good description from my understanding.

DR. HARRIGAN: It's multiple stakeholders. The college is there, Doctors Nova Scotia is there, the municipalities are there, the foundations, members of the public, physicians. It's to look across the country and the world at what is being done and to look

at how each one of us can play a role in enhancing recruitment. We're just getting off the starting blocks now, but I think that we're looking for innovative ideas that we can all work together on to help.

For instance, when you look at our recruitment for specialists, we have trouble outside the Central Zone in recruiting and retaining specialists, so Dalhousie University is at the table. We're going to say to Dal, what can you do to help us with that? Do we create mandatory rotations in the periphery to help do this? All the players who are involved in ultimately bringing doctors to this province are at that table and participating in the conversation.

MR. GORDON WILSON: This is my last question before I turn it over to my colleagues here. Nobody has really talked an awful lot about money. They always say it's always about money. I don't necessarily always believe that. But in respect to that, is compensation the only factor when it comes to recruiting and retaining doctors and physicians? I'd like to hear an answer from both the Health Authority and the Department of Health and Wellness.

DR. HARRIGAN: When they've done national surveys, the first thing that comes up on the survey is the quality of the place where you're living and the second thing that comes up is the community of physicians that you're working with. Compensation is way down on the list so in spite of it always being focused upon from physicians themselves, it is not the primary thing. But compensation is a Department of Health and Wellness thing, so I will turn it over to the deputy.

MR. GORDON WILSON: If I just might, so this is direct information that we're hearing directly from doctors in exit interviews?

DR. HARRIGAN: Yes, there have been national surveys and that is, in fact, what we found with our marketing firm when they spoke to our own physicians.

MS. PERRET: So that said, compensation is still an important factor, and what we're seeing in the discussions we have on compensation in Nova Scotia and their discussions again across the country is people are looking for different structures to the compensation system. We know as practices change, we need to respond to that change with a different compensation structure, and it needs to balance the interest of the provider, and it needs to also have assurances that individuals, communities, families will get the services they want. So it's always a two-sided coin about what is attractive, what works for the provider, what will assure the community that they're going to get the services that they need. There are a number of innovations in compensation - I'll use that word - that we're interested in exploring.

MR. GORDON WILSON: I will probably have more questions in the next round, but I'll turn it over now to my colleagues.

MR. CHAIRMAN: Mr. Jessome.

MR. BEN JESSOME: Thank you all for your time and effort. You talked a little bit about the relationships that exist and different stakeholders that are involved in the recruitment process. Just right out of the gate, I just wanted to ask how frequently you all interact with one another generally.

MR. CHAIRMAN: Who would you like to answer this question?

MR. JESSOME: A, B, C.

MR. CHAIRMAN: Why don't we start out with Ms. Perret.

MS. PERRET: So we have multiple interactions certainly between the department and the Health Authority. They are daily, and not restricted to the hours of 8:00 a.m. and 4:30 p.m. By daily I mean 24 hours a day, seven days a week, quite literally.

With the college and the department, we certainly - Dr. Grant and I have regular meetings to explore issues. Of course all the parties interact on various committees that they serve on. These interactions permeate throughout our organizations at many levels.

MR. JESSOME: I think I can take the deputy's comments as consistent. I guess there were comments made with respect to enabling flexibility to open up different communities versus - there was a point in time where I think we were fairly prescriptive on replacing a physician as prescriptively as at a certain civic address. I'm just wondering if you can elaborate on that barrier being removed or just your comments with respect to that.

MS. PERRET: I spoke to it a bit earlier, but it's an important point, certainly any of what we would now call artificial restrictions in programs, restrictions that don't need to be there and that get in the way. They're tripping points in the recruitment process. The Health Authority knows and our staff know to look at it carefully. So "no" is never the first answer. The fact that a program may have been structured in a certain way and operated in a certain way doesn't mean that it should still be structured and operated that way.

In my opening remarks I talked about the request we made of staff to be very nimble - to look at the bigger picture, to take chances - that's risk-taking for them - to work very closely in the partnership that we have and we're solidifying on the recruitment front with the Health Authority and our other partners, so they're stepping up to that. We have quite a flexible and dynamic landscape both with respect to the positions and how they're recruited and also to how we will provide our incentive programs.

One quick example is that the incentive programs traditionally were rural programs, and again you would see this across the country. They were designed for rural and remote

recruitment, hard-to-place places. When we see the 811 list and we see the statistics in the greater Halifax metropolitan area, we have to remove that barrier. But when you remove that barrier, then you still have hard-to-place locations.

Then we ask, how can we adapt the other parts of the incentive program? We can still up the ante and have a greater incentive in some of the hard-to-locate places. That's what I mean by dynamic, flexible, having the highest degree of agility that is possible.

MR. JESSOME: How do you see the private sector playing a role in establishing clinics? You referenced different funding models to set up practices in community X. How does the private sector play a role in development of a practice?

MS. PERRET: That's an interesting question, and I'll give it a try. There's sort of two parts to it. One, in large part, physicians are the private sector, so our locational decisions to maximize their ability to locate where they want to and accommodate their interest is part of what we have tried to reinforce in flexibility. There are . . .

MR. CHAIRMAN: Order. I'm sorry. Time has expired. We'll move back to the PC caucus, Mr. Houston, for 14 minutes.

MR. HOUSTON: I do want to talk about retention to start off. We try to talk about how many actually billing family doctors there are in the province. I think it was 1,139, but we're going to get the actual number. You didn't have the actual number here today, right? But we're going to get it. Okay, what is that number?

MS. PERRET: I gave you the number of actual billing full-time physicians at 2,562. Of those, 1,092 are billing family practitioners.

MR. HOUSTON: Of the 1,092, do you have an average age? Would you know the average age of those 1,092?

MS. PERRET: I don't have a specific answer on that for you today. My understanding, and we can follow up with you on that, is that the work being done in the physician resource planning process which is under way under Dr. Wilson has the demographic breakdown. It looks at what the retiring physician population is and when we can expect physicians to be exiting the system for retirement.

MR. HOUSTON: Thank you. It's an important piece of information in this whole thing around retention, the anticipated retirements. That's a number that you don't have but somebody else has - anticipated retirements?

MS. PERRET: I don't have it here today. The physician resource planning group will have that number and will be looking at those demographics.

MR. HOUSTON: Do you happen to know - is it your sense that we have kind of an older physician population than other areas of Canada or not older? Do you have any sense as to whether we're going to get hit with a disproportionate number of retirements?

MS. PERRET: My sense, without looking at the statistics, to be honest, is anecdotal, so thin ice. Some of the statistics I have seen about the aging physician population and retirement aren't that different than some of the stats across the country. I think there's an article in the Globe and Mail on B.C. today, and I was surprised at the size of their aging physician population, which seemed higher than stats I have seen. But I am speaking anecdotally.

[10:15 a.m.]

MR. HOUSTON: Would it be fair to say that older physicians have more patients than younger physicians?

MS. PERRET: It would be fair to say that the practice, particularly in family medicine, is changing. That's a good thing in many respects, because we know from population statistics that we haven't been getting the best outcomes entirely in our health care system. We want to improve health outcomes. Collaborative care practices are evidence-based shown to improve population health outcomes. As the physician population changes in age, in the manner that they want to practise, including collaborative practices and sometimes by not having a single focus on practice - they might not want to be a family practitioner full time. They might want to vary that with other parts of practice.

MR. HOUSTON: That's certainly something that's on people's minds. I know in my community, there's quite a few doctors that are nearing retirement age. I'm worried about how they're going to get replaced. I don't want to put words in your mouth, but it did sound like the older physicians may have more patients, but the outcomes might not be that good.

MS. PERRET: Thank you for letting me clarify. I think generally speaking, and it's a generalization, family practitioners carried larger patient loads traditionally than they do now. But qualification, that's when you look at it from a family physician perspective; when you add the collaborative team to the mix, you increase the patient load that's carried by the clinic. The evidence would say that the care and attention given to the management of chronic diseases, for example, actually improves health outcomes. Generally speaking, we're moving in the right direction.

MR. HOUSTON: Is Nova Scotia a happy place to be a doctor? Where would you put Nova Scotia on the happy scale? Is it is a happy place to be a doctor?

MS. PERRET: To my knowledge, I haven't seen a happy scale. The discussions that I have had . . .

MR. HOUSTON: I'll tell you to my knowledge if you want. I don't think it's a happy place to be a doctor. I think there are a lot of things that frustrate doctors. I think Dr. Harrigan's comment about the two realities - I don't know that there are two realities. I think it's a difficult place to be a doctor right now. We have lawsuits going against doctors. We have all kinds of things going on, and that cannot help with the recruitment of doctors. All of these things must kind of chip away. I don't think it's the media that's saying this is a negative place for doctors. I think it's the reality.

Do you think there's two realities? Is the media wrong, and this is a happy place to be a doctor?

MS. PERRET: I hesitate on my answer because I haven't said the media is right or wrong. I can only speak personally and from my personal experience in the interactions that I have with the physician community. I think that they are passionate. I think they're energetic. Most importantly, I think they really care.

I don't know that it's so much a question of happiness. I see a commitment to respond to the changes that are happening in the system, the transitions that are happening. They have great ideas, and they are engaging in the best ways that they know how. They bring forward really good ideas. I think there's a dynamic going on that, generally speaking, is really positive and has a really good energy to it. We're paying attention to the discussion publicly.

Any transition is difficult. Any transition requires a high degree of change management and can be bumpy. Loud voices don't necessarily mean that there's a problem that can't be fixed. Loud voices sometimes really focus you on where you need to change something, and they help us. They're actually inspiring us to be nimble, to be more agile, to take risks. In doing that, we know we won't always get it right, and we're going to have to course correct. I think there's a real spirit of support to be doing that.

MR. HOUSTON: There are always loud voices. There are a great number of quiet voices on this situation. One doctor said to me that the extent of the retention exercise from their perspective was that they get a new contract put in front of them once in a while and are told, sign this. I'll leave that with you to consider - unless you want to expand on the retention efforts. Communities are a part of it, sure. That's nice to say communities should be a part of it. Government is also a part of it.

We're here today, and if I wanted to leave here today with a good grasp that the need is understood and that there's a plan to address the need, I don't have that just yet. I don't know that the need is properly understood.

There are 100,000 people who don't have a doctor. Okay, maybe half of them said they're not even looking for one, but they might be tomorrow. That need has the potential to go up very, very quickly. I don't think we're ready for that when we have 49 vacancies

of family doctors and our target for the rest of the year is only another whatever it was, 14 or 24. I don't have a great comfort that the need is understood, so therefore I don't have a great comfort that the need will be addressed. But I do have a very specific question - and it might be for the college, I'm not sure - is there any circumstance where a fully qualified licensed doctor would be denied a billing number in this province?

MS. PERRET: Not to my knowledge at this point.

MR. HOUSTON: What about the Health Authority? Is there any circumstance where a fully qualified licensed doctor would be denied a billing number?

MS. KNOX: Not that I understand.

MR. HOUSTON: From the college perspective?

DR. GRANT: Not our territory - we do the licensing.

MR. HOUSTON: Could their billing number, they could get it - I'm hearing they could get a billing number, but could it be severely restricted?

MS. PERRET: Not to my knowledge.

MS. KNOX: No.

MR. HOUSTON: Okay, no restrictions on billing numbers in the province?

MS. PERRET: Not to my knowledge, no.

MS. KNOX: No.

MR. HOUSTON: Is there any circumstance where a fully qualified licensed doctor would be denied privileges at an area hospital?

MS. PERRET: I'm going to ask the Health Authority to jump in. The concept of privileging, which I think was put in place in 2012 or so, or earlier than that, is one of those areas where we're also being responsive to how it's applied and how it works. To my knowledge, we are not using that to determine locations or other . . .

DR. HARRIGAN: There is a proviso, though. For instance, I'm an internist and if I just want to go work in a hospital and say, hi, I'm here, I'm working, the hospital has to have the appropriate facilities to support me. As a specialist requiring hospital work - and that goes for surgeons, pathologists, et cetera - they can't just come in and say, you have to give me privileges and I'm going to come work here.

For community-based physicians it's a different story, but for hospital-based physicians it was ever thus, so nothing has changed in the last few years. That has been present for the last 50 years in Nova Scotia.

MR. HOUSTON: The Auditor General's Report raised issues around communications with Nova Scotians. I think the issues that were raised were accepted by the department and by the Health Authority. I'm thinking specifically about the 811 number. Who is responsible for the 811 number? Is it the Health Authority?

MS. KNOX: Yes.

MR. HOUSTON: The Health Authority is administering the 811 - a listing of people who have called and said, we want a family doctor?

MS. KNOX: That is correct, yes.

MR. HOUSTON: That's the 42,000.

MS. KNOX: The 811 is an opportunity for Nova Scotians to tell us that they are in need of a family physician.

MR. HOUSTON: There has been some back and forth on the 811. Sometimes it's not always what you say, but how you say it. There have been some calls placed to people - basically, are they still looking for a family doctor. That's something that was done under the Health Authority's direction, I guess?

MS. KNOX: Absolutely. Yes, that's correct.

MR. HOUSTON: I did have a call recently, and I kind of transcribed it. I have some copies here for the House. It was a very robotic call. Are you familiar with it?

DR. HARRIGAN: I'm on the list so I got a call. It was very robotic.

MR. HOUSTON: It was very robotic. It was insultingly robotic, to me. Are you okay with the way that call went out?

DR. HARRIGAN: No. There was a news release that went out saying that calls would be coming. Those calls were extraordinarily important. You need to verify that the people on the list still needed to have a family practice. There may have been some confusion, but basically unless you said "I no longer need a family doctor," you were kept on the list.

There was a lot of miscommunication about that, and we would probably do it differently in the future, but you have to verify that the people who are on the list still require a family practice.

MR. HOUSTON: I do want to pass out the transcript, if I may. I think it's important for people to hear how the call went out. If we had it here, maybe we could play it. We couldn't get a person to make that call? It was like a speech-to-text recognition system. It was strange that a person couldn't record that. Are you familiar with the call, Ms. Knox?

MS. KNOX: I am, but I don't work with the team directly in terms of planning that. I can say that system is one that we used to remind people also of their appointments, so it's not just the 811 call. This is not the first time that we've checked the list. It's part of our process to making sure that we know who is on the list and really trying to keep track of people.

MR. HOUSTON: I guess it's just giving people the comfort. I'm getting a lot of calls from constituents that got this robotic call. I was going to try to play it, but I had a technology failure, because it really took a lot of people back. It doesn't give them comfort that somebody is concerned that they need a doctor. I think the AG's recommendations around communication were well-placed specifically there.

MR. CHAIRMAN: Order, the time has expired. We'll move back to the NDP caucus, and Ms. Chender.

MS. CLAUDIA CHENDER: Thank you to the panel for being here. We wear several hats on this side, as I'm sure all of you do. We are legislators, we hold legislators to account, and we also work in our constituencies. I have the privilege of working in a constituency that is home to now the third largest hospital in the province in the form of the Dartmouth General with a catchment area of a little over 116,000 people. In my short tenure in this role, I see people on a daily basis who ask about physicians and family doctors and hospitalists. It's far and away the number one issue in my riding.

I'll apologize in advance if some of my questions might be a bit more specific and a bit more patient focused, but I'm sure we can extrapolate from those. I want to start with picking up this question of succession planning.

We know - and I've spoken to some of you about this - that we're losing over 40 per cent of our family doctors in Dartmouth inside of less than five years, which is a chilling statistic. Dr. Harrigan mentioned in her opening comments that the Central Zone had no formal strategy until 2017, I believe. (Interruption) No recruiter.

On the one hand, it's sort of shocking and chilling, as I say, and on the other hand it's completely common sense. It's simple demographics. We have older physicians who want to retire and, in fact, I know anecdotally that many wanted to retire five, six, or 10

years ago and are not retiring because they know what the impact will be. With Dr. Gregus' recent retirement - with whom some of you will be familiar - we now have 1,000-plus more people, many of whom are reflected on the most recent stats of the list and who have been into my office.

I guess I'm wondering if you could speak a little bit more about what, if any, succession planning has happened in the last five or 10 years. How did we get to this place where we have 40 per cent of doctors retiring in a single community and as far as I can tell - hopefully you can correct me - no real hope in sight for rapid replacement of those folks? Why didn't we recognize this earlier? I guess that's my first question. I'm not sure who it should be directed to - whether it's the Health Authority or the department or Dr. Gibson.

MS. KNOX: I think what you're talking about is, we've come to a point in time with the health system of Nova Scotia that we have years and years of challenges behind us and we're coming to the realization that we need to do things differently. I can't answer why 10 years ago we weren't planning succession, but we had a very different system then. Many family practitioners were very independent of the rest of the system. It just was what it was.

[10:30 a.m.]

Where we are now is at a pivotal time in our history where we are trying to understand the needs of Nova Scotians, the areas where we need to focus, how we work with our physician colleagues in planning for their future together. They are in the driver's seat on that, but to be talking about what that looks like and how we need to work with you to plan for your succession.

I would like, if you would indulge me, to ask Dr. Gibson to talk about his work around Nova Scotia.

MS. CHENDER: It's his community too, so I'm always happy to hear from Dr. Gibson.

DR. GIBSON: Yes, it's a really interesting question and why was it the way it was five or 10 years ago. This actually highlights the importance of having a single Health Authority and the work that we're doing. Five years ago I was the Chief of Family Practice for Capital Health. At the time, physicians in the community, in their offices, did not have to be credentialed so we actually didn't know how many family doctors were out there in the community because they were independent business people, practising in offices that they were responsible for creating and operating, and they came and went as they chose to.

When it came down to matters of recruitment, it was entirely their responsibility as independent business people to do that and, as a Health Authority, we had no responsibility over them and no ability to help them or to ask them to do anything. On the occasions when

I went to people and said, would you like some help with recruiting for your practice, the almost universal answer from the doctors five years ago would have been no, that's our business, stay out of it.

Now we're in a much better position because they are credentialed so, to Mr. Houston's earlier question, yes, I do know the age of the doctors in all the communities in Nova Scotia because they put their birth date on their credentialing form. We do know their birth dates, their ages and we do know which communities face larger numbers of people that are approaching retirement but you cannot assume with physicians that they're going to retire at the age of 50 or 65 or any other age, they just retire when they want to. A lot of them work until they are 70 or 75, by choice.

Now we're in a situation where - and we've gone through this process of approving vacancies - so now when they're going to depart they tell us that they're going to depart. The good news is that now they're telling me they're going to depart in 2019, so we're getting ahead in the sense that I know somebody is going to leave or planning to leave or thinking about it.

MS. CHENDER: Well that's a whole practice that's going to close in 2019, is my understanding.

DR. GIBSON: Then we're into the question of okay, we know there's a practice, and we are helping with the recruitment - then you get into the question of what are the practices in the community and what happens when you take a candidate out to a given practice to have a look at that practice and what's the messaging they get when they are in that practice. Sometimes that's quite interesting, either the messaging from the community or the messaging from the colleagues in the practice or the messaging from the management of the practice.

It speaks to this earlier conversation about it takes a community to recruit a doctor. Sometimes as a Health Authority we're saying, we welcome you with open arms in this community. It's quite interesting the message that the doctors get when they actually go and look at a practice, what their colleagues in the practice would tell them, to explain some of the challenges.

MS. CHENDER: I appreciate that and I'm moving along only because I have a limited period of time and there are a few other questions I want to get to. I'm going to leave that question for moment but looking forward, I'll just flag that - as my colleague brought up - in many cases these practices are the old model. I recognize that there are going to be big issues with recruiting there and I'm hopeful that there are some innovative strategies at play and maybe we'll be able to come back to that.

In the meantime, I think this is connected to the physician resource plan that was brought up recently, in terms of identifying needs. My question is whether that plan and/or

the triage for the 811 line - Ms. Knox, you made a kind of interesting comment that we'd hear something soon about this - does it take into account the needs of the folks on that line or the needs of the folks in a community? I'm asking two questions, but they are mirror questions.

For Dartmouth South, for instance, for many of us we have a lot of seniors in our community, and we recently had a situation where we found out about a new doctor who was accepting patients. We keep a list and we called every single person on the list in our office and said, this doctor is taking patients. He didn't accept many of the people who had been in our office because the people who come to us are the people who have really hit the end of the road and are looking for any resource, and their health needs were too complex.

I'm asking about seniors with complex health needs. I'm talking about people living in extreme poverty who may have multiple other challenges. I'm talking about pregnant women and women who are in need of prenatal care. Are we triaging those folks either at a community level or at kind of that 42,000 need-a-physician level? I would love any answers to those questions.

MS. PERRET: There were several questions there, and I'll just start with your question specifically about the physician resource plan and whether it takes that information into account. The answer is yes. It looks at population health. We have very good information about population health status throughout the province, and that's absolutely taken into account.

MS. KNOX: To your question about the people on the list, they are of great concern to us. The list, as we have it, is just that they need a physician, and we don't know who they are. We are working with the department to see what our options are in terms of what we can do there. We are both very concerned about that.

That's the transition of getting to where we have access in local communities for Nova Scotians. We have to deal with this population now, and we need to look at different strategies - innovative, creative, different strategies that will get to those needs.

MS. CHENDER: I also want to ask about what those 100,000 people, or 42,000 people, or in my case several thousand people and growing are meant to do when they require the services of a family doctor and they don't have one. I'm not talking about having a kid with strep throat, which I have a lot, because there are ways to triage those things. I'm talking about when the Dartmouth General pain clinic closed.

I have an elderly constituent who had been a patient at the pain clinic. When someone finally returned her phone call after she saw on the news that it had been closed, she was told that she needed to go back to her family doctor to get a referral to the QEII pain clinic. Luckily she had one, but if she didn't, what would she have done?

Because I have limited time, I will also just mention the other things that have come through all of our offices - people who are applying for income assistance or disability support, people who are applying for CPP database. The list goes on and on of tasks that I know are challenging for family doctors at the best of times to be able to complete. Nonetheless, these are still things that we require of our family doctors. Are there provisions being made for patients so that they can find those services in another way until we fix the situation?

DR. GIBSON: Those are very important issues. You raised a couple of different issues in there.

One is the issue of medical care. You have quite properly said that when people have acute issues, there are options for them to get their acute care. It's important that people who have chronic issues get their chronic issues looked after, and that's the conversation that we're having with the Department of Health and Wellness around what the options are for those people.

Interestingly, on the forms issues, you have actually raised a question of uninsured medical services because filling out forms for Canada Pension Plan or something else is an uninsured medical service. I don't know that it's actually the responsibility of the Health Authority or the Department of Health and Wellness to ensure that people have access to doctors for uninsured medical services. It is tangentially related because if you are disabled because of a condition and then have to get the form filled out for Canada Pension Plan, it's connected, and it's not something that can be done by a doctor who doesn't know you. But it's not what the Department of Health and Wellness is paying doctors to do. It's a related but uninsured service.

MS. CHENDER: That's very interesting. Maybe there's some other department we'll ask that question of in the future.

I have only a few seconds left but, Dr. Gibson, maybe you could speak to how we're going to fill those 50-odd vacancies in Dartmouth. I would love to hear your thoughts.

DR. GIBSON: We have the recruiter on the ground, and she is actively interviewing or meeting with candidates and touring them around and showing them the vacant practices where we have good information about the practices and what those opportunities look like. As alluded to, we need to find a way to work more closely with the community to present Dartmouth as an attractive place to practise.

Dartmouth, in particular, is kind of the demographic thing. It just happens, because of a variety of circumstances, that a large number of doctors are hitting retirement age at the same time, so we are faced with that. It is generally an attractive place to practise. I have been doing it for 35 years myself.

We should be able to fill the vacancies. We are having success filling vacancies in a variety of locations in Central Zone . . .

MR. CHAIRMAN: Order, please. I'm sorry, time has expired. We'll move back to the Liberal caucus. Mr. MacKay.

MR. HUGH MACKAY: A question to the Health Authority - perhaps Ms. Knox, you can designate. My colleague earlier mentioned that he can't overstate the importance of engaging the communities in recruitment of doctors. You've spoken to that on the More Than Medicine and so forth.

Certainly what we clearly see is a transitional time in health care across Canada - not just here in Nova Scotia, but across Canada. I think that speaks to the importance of having a single Health Authority so that we don't have multiple provincial authorities trying to work on what is really a national transitional time.

On the local level, which we as MLAs operate at - and we are amongst the boots on the ground in the local areas, I'm wondering what advice you could give us as MLAs to help work with the Health Authority and our local communities to ensure that our communities' voices are being heard and reciprocally that the Health Authority is being heard in the communities. If you could speak to that, I'd appreciate it.

MS. KNOX: Thank you very much for that. I truly believe that's really very important. In fact, after the last election we wrote to every single newly elected MLA in Nova Scotia to invite them individually to have a conversation with us. One of the things I think is really important is to have a dialogue about what you see as important in the areas of the province that you represent, and also to have the knowledge about what we're seeing and what we're trying to do. So I think that ongoing dialogue - I would encourage MLAs to work with the Health Authority in that way. I did get response from two MLAs on that one and I did meet with them, so I'm really open to that.

The other thing in terms of working with local communities is to really be encouraging them to communicate with our local leaders in the area. We're working with our site leaders and our zone leaders to really help them create communication lines with local communities, and where opportunities exist, to encourage citizens to participate on advisory groups. Where that has happened it has been really successful.

Everything that we can do together to encourage citizens to be fully participating and voicing - we need to hear the voice of the citizen. I offer to all MLAs, we want to hear from you and we're willing to spend time with you to talk about what we're seeing and what we're trying to accomplish together.

MR. CHAIRMAN: Mr. Jessome.

MR. JESSOME: I'd just like to start by trying to finish off the question I started around the private sector playing a role in the development of practices and communities - more specifically, I guess, getting away from individual practitioners as the private sector I'm referring to and kind of the relationship that physicians might have with a landlord to set up a new practice.

[10:45 a.m.]

MS. KNOX: I'm not sure what your question is.

MR. JESSOME: If a developer wanted to come in and set up a building or take on the overhead to allow physicians to practice within their building.

MS. KNOX: I apologize for not quite getting that. As our deputy has said, we believe that we need to have flexible models. In looking at how collaborative practices could be set up in this province, we said there could be several different models. We are open to having that conversation - the government and us - and looking at what might be the options. Around this province there are different options already, and so we do not need, as Deputy Perret said, a "one size fits all".

What I would like to say is that what we do need is a commitment to what Nova Scotians should expect from their health system. Nova Scotia Health Authority is an amalgamation of nine previous organizations, and what we have found - and it has taken us some time to learn - is that we had multiple approaches to multiple strategies to provide services across this province. That in itself is taking us some time to get to the place where you say it doesn't matter where you live in Nova Scotia, your geography should not determine access to service.

Access to service has to take into account your geography but as my colleagues are saying here, the standard of service has to be the right standard for all Nova Scotians so we can have multiple players. What we need to agree to is that Nova Scotians deserve the very best system that they can have and we have to find ways to bring that system to them.

MR. JESSOME: Thank you for that response. How do walk-in hours play a role in the system now? I've heard several examples of communities that have existing practices who would like to open up opportunities for I guess physicians from outside the community or who are practising elsewhere, to come in and fill a gap or fill a need for service, perhaps in the evenings. Can you comment on whether that's okay or not?

MS. KNOX: I'm going to ask Dr. Harrigan to talk to that.

DR. HARRIGAN: There are as many definitions of walk-ins as there are walk-ins, I think. So there are walk-in clinics that are affiliated with family practices. In some communities they have evening hours that service not only their own practice but the

community in which they live. We are highly supportive of that and any of those models we're highly supportive of.

The fundamental issue really from a walk-in perspective is, we need some place for people who have chronic diseases and illnesses to go to have blood work done that someone will review and to have their chronic diseases assessed and consultations made. We don't really have that at the time. There are some walk-ins that do but we don't have any standardization of our walk-ins. But certainly anything that enhances the care for the practice in the community we would be fully supportive of.

MR. JESSOME: Thank you and I would make a comment to say that the sooner we get the one patient/one record system online, the more accommodating I believe walk-in clinics perhaps can fill a gap.

I think this question is probably best directed at the college. My colleague referenced a group of Nova Scotians out there who have higher need, have chronic conditions, pregnant women. There has been an acknowledgement that we have to find a way to better understand the intimate needs of the patient who is on the 811 list.

My colleague made a comment - and I think I would say that it's consistent with some of the things that I've heard as well - with respect to physicians kind of triaging in deciding to accept or not patients who are perhaps of higher demand. What obligations do physicians have or what responsibility do physicians have, based on the college's standards, to accept patients when they are dealing with someone of high need?

MR. CHAIRMAN: Dr. Grant.

DR. GRANT: The college has a standard. A standard is a mandatory document for physicians which outlines the process for accepting new patients and it can't be done on a discriminatory basis, so it aligns with things in the Human Rights Act. As well, the standard outlines that the default process is first come, first served. We frown on meet-and-greet processes whereby a physician might cherry-pick. The unfortunate reality is that we probably aren't aware of when this is happening, most of the time.

The standard, preferred method is first come, first served - avoid meet and greet, no discrimination of accepting new patients on a number of bases; again, aligned with the Human Rights Act. Also, I would say that unless there's extraordinary medical conditions that are really outside the scope of practice, then I would say first come, first served.

It's available on our website, we have a standard that . . .

MR. JESSOME: Okay, and just around my line of questions briefly, what consequences are there for physicians who don't follow that practice?

DR. GRANT: Well there's formal and there's informal. The formal process of the college is one of the core responsibilities we have, which is to investigate complaints and discipline accordingly. More often than not, on occasion when I do hear of this, I'm able to reach out to the doctor, give the doctor a copy of the standard, and have the doctor aware of his or her responsibilities.

Most often, I don't hear of this by way of a complaint. I hear of it in a coffee shop or in the grocery store, that type of thing. Our standard is very clear, and our standard is in keeping with standards across the country. I think Ms. Chender saw me breaking out in a non-specific rash when she described it. That meet-and-greet process is delicate.

MR. JESSOME: Thank you. My colleague from Clare-Digby, please.

MR. CHAIRMAN: Mr. Wilson.

MR. GORDON WILSON: Mr. Chairman, I believe I have about three minutes?

MR. CHAIRMAN: Yes. You have until 10:54.

MR. GORDON WILSON: In summary, we have heard a lot of information on recruiting - about who recruits, roles and responsibilities. Could I ask each one of you just within a 20- or 30-second blurb each to tell me what your role and responsibility is in a nutshell? I'll start with the Department of Health and Wellness.

MS. PERRET: As I said in my opening remarks, the department is the policy arm of the system and the funding arm of the system, specifically responsible for compensation. In this context, it's our obligation to look at compensation systems that are competitive and that work for both providers and, importantly, for the public. As the policy arm, we want to set strategic direction. We want to remind people that this is an all-in effort.

MS. KNOX: We are the operational arm of the health system. In that instance, that means we need to understand what the population needs from us and how we need to provide those services. That includes the right practitioner in the right place at the right time. In this instance, discussing physician recruitment, we have a leadership role working with our stakeholders in bringing the right physicians to our province.

DR. GRANT: Our role is anchored in patient safety. Our primary responsibility is to license only competent and qualified physicians. Our secondary role is to do that licensing in a way that supports and enables those on the recruiting front end and create a welcoming process for potential candidates. The decision as to license or not to license, which is ours alone, is rooted in patient safety.

MR. GORDON WILSON: Just quickly in closing, and I hope I can get a comment from somebody on that - I believe Nova Scotia is a happy place for doctors, to answer my

colleague's questions. I say that because I just recently had our three new doctors at my house for tea and coffee the other evening. We had a very good conversation. They were excited to be here. They saw a lot of tremendous opportunities in this province, mainly because of the changes that we're seeing in the flexibility.

I would ask if there is any kind of understanding of that to be taken into hand. It isn't all what we read in the paper. It isn't all what we hear in the news. There are some excellent stories out there.

I would like to thank Crystal Todd and Jo-Anne Wentzell, the hard-working people of my community stakeholder group, for the work that they have done. I didn't get a question out of that, but I do want to thank you again.

MR. CHAIRMAN: Order. Time has expired. We have about 60 seconds for each to provide a closing comment. Ms. Perret, we'll start with you.

MS. PERRET: Again, I thank you very much for the invitation to be here. We can't stress enough that this is an important discussion. It's a discussion that needs to continue beyond this Chamber, and we're happy to be part of it.

MR. CHAIRMAN: Ms. Knox.

MS. KNOX: Thank you very much for the opportunity. I want to say to all of you that I feel very encouraged that we were having this conversation today. This is a very, very important issue for all Nova Scotians. To your very intuitive and interesting and thoughtful questions - we need to have this conversation. I can't thank you enough.

MR. CHAIRMAN: Dr. Grant.

DR. GRANT: I consider the college to be a public-facing organization. I welcome members of all Parties in my office at any time. The only thing I want to avoid is that people misunderstand our processes. If you leave here unsatisfied with what you have learned from me today, please reach out to me directly. I'll buy the coffee.

MR. CHAIRMAN: Thank you. The only committee business we have relates to our next meeting, which is on January 10th. That meeting will be with the Department of Business and the Department of Labour and Advanced Education to discuss funding the Ocean Innovation Centre, (COVE), Centre for Ocean Ventures and Entrepreneurship.

With the upcoming retirement of Deputy Minister Murray Coolican, we do not have a deputy to come in for that meeting. It has been recommended by the department that Ms. Una Hassenstein, who is the executive director, appear as a witness. Would members be agreeable to her coming in instead of a deputy minister?

Would all those in favour please say Aye. Contrary minded, Nay.

The motion is carried.

Our clerk will make note of that. Our next meeting is January 10, 2018. Is there any further business to come before the committee?

Hearing none, this meeting is adjourned.

[The committee adjourned at 10:56 a.m.]