House of Assembly
Nova Scotia

HALIFAX, FRIDAY, MARCH 24, 2023

COMMITTEE OF THE WHOLE ON SUPPLY

12:39 P.M.

CHAIR
Angela Simmonds

THE CHAIR: The Committee of the Whole House on Supply will come to order.

The honourable Government House Leader.

HON. KIM MASLAND: Would you please call the Estimates for the Department of Health and Wellness.

Resolution E11 - Resolved, that a sum not exceeding $4,854,073,000 be granted to the Lieutenant Governor to defray expenses in respect of the Department of Health and Wellness, pursuant to the Estimate.

THE CHAIR: I will now invite the Minister of Health and Wellness to make opening comments.

HON. MICHELLE THOMPSON: Good afternoon, everyone. It is my privilege and my pleasure to introduce Estimates for the Department of Health and Wellness for the 2023-24 fiscal year. To do this, I am joined by two very important people, Associate Deputy Minister of Health and Wellness, Craig Beaton, and also Chief Financial Officer for the department, Shelley Bonang. We will work together to answer your questions and I am sure you will have plenty.

As you know, Budget 2023 invests in moving our province forward, and nothing is as important to Nova Scotians right now as fixing health care. When our government came to power, health care was suffering from decades of neglect. Previous governments of all stripes failed to do the work required to have a modern health care system. They let short-term thinking, political games, ideology, and turf wars eat away at our health care system until we ended up in the situation we are in today.

I worked in that system, I saw the short-term thinking and turf wars, I saw the health care system die by 1,000 cuts. As a nurse and a long-term care administrator, I also saw the impact it had on patients and their families, and it is why I ran for office and why I am here today.

Our government has a real plan to fix health care, it's called Action for Health. We launched it last Spring. It includes six solutions and measurable actions that touch on every aspect of health care. We report on our progress regularly online, and we report on it whether it is good news or bad. It is not a plan that sits on a shelf; it drives our work every day. We are talking to Canadian and international experts to ensure we avoid the mistakes that other jurisdictions have made.

We encourage Nova Scotians to read the plan and to hold us to it. We are taking action and we are making progress. We are making the kind of reforms that other governments wouldn't take on, the kind that will expand the role of all our health care professionals, embrace technology, and support new ways of working. We will deliver better health care that Nova Scotians deserve. We will do more, and go faster, and we'll do whatever it takes. This Budget will help us move forward.

Across the health system, including the Department of Health and Wellness, Seniors and Long-term Care, and the Office of Addictions and Mental Health, we are investing $6.5 billion this year. That's $1.2 billion more than two years ago, a 21.2 per cent increase. The Department of Health and Wellness itself has an increase of $587.7 million, or about 14 per cent.

Of course it's not just about dollars and cents; it's about what those dollars will do for people, people who need care in this province, and the staff who have been struggling to provide it in a broken system for years. We have heard time and time again from health care workers and from others about long waits in our emergency departments, our surgical wait-lists, and our EHS wait times. They've told us all these things are happening because we don't have patients moving through the system the way we need them to.

Some people are staying in hospitals because they can't live independently anymore, even with support, and there isn't a space in long-term care for them. Others could be discharged sooner, but nurses are overrun with patients requiring complex care and with administrative paperwork, and they don't have time to help them get up and moving and ready to go home.

This Budget includes a $34 million investment in access and flow initiatives. That's health care speak for getting hospital patients to where they need to be, getting them the care they need and getting them home as soon as it is safe. We will hire more health care staff to provide care, physiotherapists, occupational therapists, recreation therapy associates, and rehab assistants who will help people get up and moving earlier, so their muscles don't deteriorate while they are in hospital.

[12:45 p.m.]

Dietitians can now prescribe nutrition for people requiring feeding tubes and central lines for their nutrition, as well as changing a patient's diet without getting a doctor to order this change. That helps take the load off physicians and nurses and expands access to the care that people need.

Social workers will help connect patients to the supports they need in their communities. That may sound like a lot but, in fact, it's everything. Some patients need income, housing, or help navigating the programs they're eligible for. Others need meals. Still others need social interaction and to be connected to their communities. That's all crucial to independent living. If you don't have those things, you are more likely to end up back in hospital.

More ward clerks will help take the administrative load off nurses. Any nurse will tell you that cuts over the years to crucial support staff in years past means nurses are picking up a lot of administrative work that they shouldn't be doing. It's taking away from patient care, and we need to fix that.

There is also funding in this budget for nurse mentors. We are short on mid-career nurses. Again, short-sighted budget cuts decades ago meant we weren't training or hiring enough new nurses. I know, because I was one of them.

Now we're offering a job to every new Nova Scotia nursing graduate and the Office of Healthcare Professionals Recruitment and the Nova Scotia Health Authority are working hard to recruit new nurses and doctors and continuing care assistants, as well as other health care workers, not just from across the country, but from around the world.

In 2022, we saw our best year for recruiting international nurses; 237 more registered nurses, 264 more licensed practical nurses, and 47 more nurse practitioners moved to our province last year. Recently, the Nova Scotia College of Nursing announced that Nova Scotia will be the first in Canada to shorten the licensing process for nurses from the Philippines, India, Nigeria, the U.S., the U.K., Australia, and New Zealand, reducing the licensing process from over a year to a few weeks.

Nurses from other parts of Canada can now get a Nova Scotia licence within 24 hours. This is beyond exciting. It will help our recruiting staff, who are travelling the world and telling the story of what it's like to live and work in Nova Scotia.

Now when a new graduate arrives on the hospital floor, or when an international nurse starts working in Nova Scotia, they may need help getting used to our processes and the way we work. Their colleagues on the floor are busy caring for patients and it takes time and energy to mentor and support a novice nurse. It's important, but we've heard from working nurses that they just don't have the time.

This budget includes $1.4 million for more nurse mentors. That may be a nurse who might otherwise leave the system altogether, but they can see that this is a way to keep supporting their colleagues while slowing down a bit. It may be a retired nurse who wants to help.

We will also create a new graduate program so that graduates can contribute to and experience future workplaces while they wait to write their licensing exam. Again, it may not seem like a huge thing on its own, but it's just one of the many steps we are taking to support our hard-working staff so that they can focus on caring for patients.

I want to take a moment to talk about recruitment and retention. We are doing the work required to reform health care so that Nova Scotians have a sustainable health care system for the future. It will be one where health care workers have access to cutting-edge technology, one where they can sign into one digital system rather than five, to get the information they need to help their patients, one where there is less administrative burden on doctors, particularly family doctors.

We are creating a health care system that allows every member to work to their full scope of practice, where there are many ways to deliver care in the places where Nova Scotians need it. In short, we are building a health care system where people can do their best work.

Right now, we know that our staff are tired and burned out. We can't reform health care without staff, and we need our existing staff to stay. We know they are in demand, and we want them to know that they are valued and appreciated by this province.

Earlier this week, we offered bonuses to 55,000 health care workers in our publicly funded system. That's 11,000 nurses and 44,000 key health care staff - paramedics, physician assistants, respiratory therapists, disability support staff, physical rehab staff, housekeeping and food service staff, and so many more.

You will likely know someone who is getting a thank-you bonus and I hope you'll also hear of the nurses planning to return to the publicly funded health care system and sign a two-year return of service agreement. We're doing this outside of the regular collective

bargaining process which, of course, we will continue, but this is extra. We want to thank our hard-working health care staff and to encourage them to stay or come back to the publicly funded health care system. We need them and all Nova Scotians need them, too.

All these health care workers would, no doubt, agree with me when I say that primary health care is the foundation of good health. I think all Nova Scotians know that the number of patients looking for a family practice is high and going up every month. We have family doctors retiring and population growth; it has created the perfect storm.

I'll get technical for a moment and talk about how we need both access and attachment. Access is where you have the ability to get an appointment with a health care professional for the care that you require; attachment is when you have someone who regularly follows your care. Some Nova Scotians have a family doctor, but can't get an appointment quickly because the doctor is so busy, so they have attachment but not access. It's the access that they need most. We are working on both fronts.

Over the past year we have expanded options for primary health care for those who don't have a family practice. This includes the mobile primary health care clinic that travels across the province and offers appointments on weekends. These are clinics for unattached newborns, pop-up respiratory clinics, VirtualCareNS, and our Community Pharmacy Primary Care Clinics program pilot, and 12 pharmacies already up and running across the province, offering testing and treatment for a variety of conditions, and there will be more to come. Obviously that is no substitute for having your own family doctor or nurse practitioner, better yet a team of health care providers. We know that's how we offer better care for patients and that's the way in which our new physicians would like to work.

We have 96 collaborative family practice teams across the province, and we need more. This budget includes a $31.3 million investment in primary health care. This means more practices across the province. We'll expand team-based care, including family doctors, but also nurse practitioners, social workers, and dietitians as examples.

There's another $1.7 million to put physicians' assistants in 10 primary care sites. Research shows us that collaborative teams offer patients better care, and these practices can take on more patients. We'll expand our virtual care services, both VirtualCareNS and virtual consultation options in emergency departments, and for mental health and addictions. We'll open more urgent treatment centres that will help people with the kind of care you can't plan for, and we'll help existing family practices take on more patients with the help of a rapid onboarding team that does the administrative work and meets new patients' short-term health care needs.

The Need a Family Practice Registry is useful in letting us know how many people aren't attached to a practice and in what areas of the province. But it is simply a number. It doesn't tell us how many of these people have chronic illnesses that need regular follow-up compared to others who may only need to visit a practice once a year; it doesn't allow

patients to update their condition and be moved up the queue if they need to be; and it doesn't help us link them to care in the meantime while they wait. That will be part of the work we're doing in primary health care this year. There's $11.5 million in the budget to help improve the registry, and we'll also use new technology to help people find the care they need and where they need it - at an urgent treatment centre, a primary care clinic, a pharmacy, or mobile primary health care clinic.

I'd like to take a minute to speak about something that everyone here and, in fact, across the province has been touched by, which is cancer. There are families in every area of the province who are dealing with a cancer diagnosis and we're working to help them fight this disease. Last year the Nova Scotia Health Authority introduced a new system called Ethos designed to better pinpoint tumours and focus radiation, cutting down the number of radiation treatments a patient must endure. We're the first province in Canada to use it, with clinical trials starting last Fall.

Earlier this year I was so pleased to take part in announcing a new Oncology Transformation Project to help connect cancer teams across the province and provide more information to patients. Budget 2023-24 includes $8.7 million more for cancer care improvements. Lung cancer in particular is our leading cause of death in this province. This year we will offer early screening and detection for those most at risk of developing lung cancer, so we can catch it early, treat it, and save lives. I look forward to telling you more about that this Spring.

Many Nova Scotians, particularly those living outside of Halifax and Cape Breton, face the additional struggle of having to travel for care. We are increasing access to chemotherapy and drug treatments at the two main cancer centres and nine community oncology clinics, so more people can get the life-saving care they require close to home.

As MLAs, we all know the importance of our emergency departments. There is immense comfort in knowing that emergency care is available close to home. None of us wants to see an overcrowded emergency department or to see people leave without getting care. After the two tragic deaths in our province earlier this year involving long emergency department waits, we needed to take action.

This Budget contains a $22.6 million investment in the emergency department initiatives we announced in January. Patient advocates are already in place in every emergency department in the province. Waiting room providers are working at the Dartmouth General Hospital and the QEII, and similar staff are in place at the Valley Regional Hospital and the Colchester East Hants Health Centre. Physician assistants have been hired at the Dartmouth General Hospital and hiring is under way in Bridgewater.

We need more paramedics, so we're offering an $11,500 rebate toward the cost of tuition for everyone who wants to take on this exciting and rewarding career and is willing to sign a return of service agreement. About 50 people are expected to start training this

Spring and we'll be offering training at two new campuses, in Yarmouth and Stellarton, in May and June.

We've added a new EHS air ambulance, an airplane that will be in service by this Summer. It will be able to transport patients from Sydney and Yarmouth, saving them up to a five-hour trip and keeping ground ambulances in their communities. The work we are announcing in this year's Budget to increase primary health care, to offer more services at pharmacies and through mobile primary health care clinics, and to free up beds by getting patients home or into long-term care sooner, all of this will help our overcrowded emergency rooms.

The last item I'd like to highlight from this year's Budget is very important to me but, more so, it's important to Nova Scotia communities that don't often see themselves reflected in health care - African Nova Scotians and Indigenous communities and the 2SLGBTQIA+ community in particular. I could tell you very upsetting stories about what happens when we don't have a diverse workforce and I'm sure I can't imagine the worst of it. There are patients who simply don't feel safe coming to our health care system for the care they need, patients who travel for hours to other communities to make sure they have a welcoming and supportive provider, and patients who don't seek out care at all because they or their loved ones have experienced racism and discrimination in the health system.

This Budget includes some very important investments in health equity. We're expanding prideHealth across the province. It's an important primary health care support service for members of the 2SLGBTQIA+ community and it provides resources to the Nova Scotia Health Authority and IWK Health Centre staff.

We will also be investing in more gender assignment surgeries to help with the increased need. This Summer we will launch a health equity framework so that we can better address the differences in health of our equity-seeking populations. We'll start an Indigenous patient navigation program, something First Nations communities have told us they need, and we'll create a new Summer internship program for high school students from equity-seeking communities to encourage them to consider careers in health care. We are doing this because we need them and their talents and their insights and their lived experience in our clinics and hospitals across the province. We want them to know that this is a safe and rewarding environment for them to work in.

This Budget doesn't tell the entire story of what we've done so far to fix health care: we have worked to expand scope of practice for all health care workers; to recruit internationally and help those international workers find jobs and pathways to qualifications when they get here; to create new facilities like transitional care facilities that will help free up desperately needed beds in hospitals; to start building new long-term care rooms so our seniors will have a place to go when they can no longer live independently at home.

We've brought cutting-edge technology, like CAR T-cell cancer therapy to Nova Scotia. We've invested in a much-delayed and much-needed One Person One Record system that will modernize health care, reduce repeat tests and, most important, free up health care workers to do their very best and provide exceptional patient care.

[1:00 p.m.]

Everyone has a story to tell about health care, but this one is mine. I got into politics, not because I ever imagined running for office, believe me, but because I worked in a system that was broken and one that I felt desperately needed change. I put my name on the ballot. I couldn't bear to sit on the sidelines and watch others make mistakes or avoid making changes and investments that we needed. When the time came, I put my hand up.

When the Premier asked me to do this job, I did not hesitate, although many people think I should have. This is actually a job that I take great privilege in having. I feel the responsibility on me from Nova Scotians, but also from my former colleagues.

We are working hard to correct the mistakes of the past, to change the things that should have been done and changed decades ago, to reverse decades of budget cuts, failed plans, of delaying tough changes that are politically difficult but absolutely necessary.

We are building for the future - building more, faster - new hospitals, new primary health care clinics, new technologies, new ways of delivering care. We've always said that it will be expensive and it will take time. We are making progress and there is still much to do, but we won't stop until the work is done and Nova Scotians can feel the difference. We will do whatever it takes and invest whatever it takes to fix health care because that's what Nova Scotians need and it's what they deserve.

With that, I'll take my seat and will be happy to answer your questions.

THE CHAIR: The honourable member for Halifax Atlantic.

HON. BRENDAN MAGUIRE: Speaking of health care professionals, I'd like to read a few things to the minister.

Tif Nebul says,

> Dear Mr. Houston, As the Premier of Nova Scotia I think there are some important things of which I'd like you to be reminded. Today my office looked a bit like this: beautiful rural Nova Scotia. I am still a registered nurse.
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> My days are sometimes long. In the last several months, I have driven over 8,000 kilometres to meet people where they are in

> their homes. I am still a registered nurse. My employers are not publicly funded, but I am still a registered nurse. My clients are fortunate enough because of a dedicated team like mine in collaboration with other care providers and community supports, they are at home rather than in-patients in an overwhelmed publicly funded system. I am still a registered nurse.
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> In my time off, I work extra shifts casually in a privately funded LTC facility for no reason other than the fact that I care deeply for the residents that call that facility their home. I am still a registered nurse. I pay the same amount, $600 a year, for registration. I self-regulate. I continue to seek education. I practise accountability. I am empathetic. I make a difference. I follow best practice in my delivery of holistic care. I am still a registered nurse.
>
> I've lived in rural Nova Scotia my whole life and worked here my whole career with no intention of ever leaving. I am still a registered nurse. Because of people like me, beds get emptied in publicly funded hospitals, relieving some strain from the health care system. I provide life-saving quality of life, maintaining palliative support to my clients in the community. I am still a registered nurse.
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> Although I'm not considered worthy of $10,000 to $20,000 bonus, I answer the call of duty five to six days a week. I am still a registered nurse. I assure you, though, I do not always feel seen or recognized within this health care system, but I am still a registered nurse.

Why does Tif not get that $10,000 to $20,000 bonus?

MICHELLE THOMPSON: I want to thank the person for the letter. We have seen a number of folks who've reached out to us.

I think I heard you say that the person works casual? (Interruption) Full-time in private care. We have agreed to provide publicly funded folks with the $10,000 bonus. If her employer wants to match that, that would be up to her employer. She works in private care.

There are also opportunities for her to come into the publicly funded system. If she works in rural Nova Scotia, there may be a sign-on bonus in those areas. We are providing that bonus to all publicly funded nurses in the province.

BRENDAN MAGUIRE: Just to be clear, these bonuses are not going to privately funded health care facilities, even though this government is spending $45 million on 100 nurses from out of province?

MICHELLE THOMPSON: There are private facilities that are publicly funded, but we are not giving the private companies the bonus. If there is somebody who works at a private company who wants to come into the publicly funded system and return to work, then there is a bonus available.

BRENDAN MAGUIRE: Just let me be a little clearer on that. I apologize. For long-term care, there are 100 travel nurses in this province right now at a cost of $45 million. That's what we heard in Public Accounts Committee from the Department of Health and Wellness. That equates to about $450,000 a nurse, is what we're paying. I know they're not getting that $450,000; I know it's a whole assortment of things. Are you telling me that for travel nurses we're willing to spend $450,000 a nurse, but the nurses like Tif, they're not going to get any type of bonus to stay in this province, even though they are contributing to the health care system?

MICHELLE THOMPSON: We've said before, we do really appreciate the work of travel nurses. We know we need them, but we need them because there are so many vacancies in our system. Much of the point of the incentive, number one, is a thank you for the people who have been working in the system. It is really important that we fill our vacancies. What we hoped is that this incentive would bring people back into the public system. That is the big driver of that.

Our hope is that as we continue to recruit and our nursing vacancies go down, we won't need to spend that money on travel nursing. I don't want to be disrespectful in any way. Those travel nurses provide care in our province, they keep staffing levels safe, in some cases they keep facilities open, and we appreciate that. However, ideally, we want to grow and immigrate our own workforce so that we are not dependent, and that money can be used directly in the publicly funded health care system.

BRENDAN MAGUIRE: I'd like to read another email, from Cynthia.

> I took a day to sit on it before sending an email to see if the upset and hurt would be better, but it's not. As a paramedic with over 20 years' experience, the $5,000 bonus is nice, but it's a bit of a slap in the face to be grouped in with support staff. Even though I don't begrudge the nurses' bonus, they do deserve it, the Nurses' Union says they're short-staffed. Staff are getting overtime, et cetera, as well as the paramedics, but we are also providing patient care for our counterparts in hospital hallways. While the nurses are busy with offload delay, the paramedics deal with the patients.

> We also have a huge problem with paramedic retention, as do the nurses. Again, I'll take the $5,000 bonus, but it still feels like a slap in the face.

My question to the minister is: Do you think paramedics are worth the $5,000 or $10,000? How did you come up with the number? Let's be honest, paramedics are first on the scene in accidents. I talked to the head of the paramedics' union. They were extremely upset with only being given $5,000 while nurses are getting $10,000 and $20,000. We all can agree that the nurses deserve that, but where did you come up with the number of $5,000 for paramedics, who are doing some of the same work as nurses, especially when there are off-load delays?

MICHELLE THOMPSON: Thank you for the question. When we looked jurisdictionally, certainly in terms of the bonus that was provided, that was an amount that we felt was meaningful and signalled a thank you.

I believe that we are probably one of the only provinces, if not the only, that have extended the bonus program to all health care workers. There are a few things that are happening. We want to be profession-specific in some cases.

I do want to acknowledge that we have made some significant investments for paramedics. We've been working with the paramedics since we first formed government. We have invested, as an example, because of the injury rates, $3.5 million in specialized equipment for them. We've also implemented double overtime, because we know that shift overruns are something that's been difficult for them. We did offer the $5,000 bonus.

We also, in December, had heard from paramedics that there was an issue with a short-term illness benefit that they felt was very expensive for them. We worked through the department to cover that bonus, which is around $2,500 per year for paramedics, which is a benefit that is not always covered in other professions. We have workforce planning. We've also signalled that we know there are issues around pay that the paramedics have brought to our attention, and we've signalled that we want to go back to the table to support them.

There are also some employer incentives. There is an employee referral program that offers incentives of up to $1,000 for new paramedics who are hired. We have a moving allowance as well, offered to paramedics, and there is a signing bonus in some areas. We've been looking at that profession. That $5,000 bonus, we were happy to offer it to 44,000 health care workers in the province, but we have been working around some of the particular issues specific to paramedics.

BRENDAN MAGUIRE: I'm glad the minister actually mentioned pay, because this government has shown a willingness to increase the pay of other employees outside the collective bargaining agreement, which they did with CCAs. And yet when we ask about

the paramedics, who are some of the lowest-paid in the country, they continue to say that we're in negotiations.

The minister just talked about a program - you just spoke about a program where you're bringing in 50 paramedics, but this year, as per the paramedics' union, they're going to lose 160 paramedics not due to retirement - so not counting retirement. A workforce of 900, which lost 133 last year - these numbers are not made up, they're coming straight from the union, so if there's any disagreement, I would advise people to talk to the union leadership.

So why is there a willingness for the government to go around the collective bargaining agreement and give CCAs a raise, and yet there is no need, no urgency, to do that with paramedics? Will the minister commit to an increase in pay for the paramedics and do it outside the collective bargaining agreement, as was done for the CCAs? We've seen this government do it. I guess what I'm trying to get at is, why would you do it for one side and then say on the other, well, we have to go through contract negotiations?

Will the minister commit here today to giving the paramedics the much-needed resources and raises they need and deserve and increasing their bonuses from $5,000 to $10,000? We're seeing that when it comes to keeping our paramedics here on the job there are very few professions in the health care system where we're losing quicker.

Will the minister commit to increasing that bonus from $5,000 to $10,000, and will she commit to pay raises outside the collective bargaining agreement, as they did with CCAs?

MICHELLE THOMPSON: What we've done is ask to go back to the table early. We've heard from paramedics loud and clear that there are a number of issues. We know pay is one of those, but we also have to look at work-life balance and we need to understand what other things we need to negotiate.

We want to get back to the table. There have been early discussions. The contract isn't up until October 2023, but I anticipate that we will be back at the table very soon talking about and addressing those things right away.

BRENDAN MAGUIRE: So the question is, why the urgency to wait - why the urgency for CCAs and not the urgency for paramedics, when we're hearing there's close to 300 of them leaving over the next two years and they are screaming for this to be done? I guess the answer I want to find isn't that we're waiting for collective bargaining, no, we're going early - it really isn't that early, I mean this is usually around the time you strike collective bargaining.

I've been on both sides. I've been in union negotiations; I've been one of the leads, one of the helps in union negotiations in the past. It usually starts eight months to a year

before the contract expires, so this isn't early. Maybe for the government it's early. But what I'm trying to get at is why the urgency for the CCAs, and why won't the minister stand here today and say, you know what, we did it for the CCAs, we're going to do it for the paramedics because every paycheque, every day, every week, every month counts when it comes to pay and morale.

[1:15 p.m.]

MICHELLE THOMPSON: What I will say again is it is not early. Our collective agreements generally are elapsed for a long period of time. This one is not ending until October. We have a working committee where we sit with the paramedic union, the paramedic college, the Department of Health and Wellness, and Nova Scotia Health, in order to hear routinely about how we can support paramedic practice. Like I said, we've covered a benefit that we knew was difficult outside of the collective agreement. We've given them a bonus, we've added double overtime to them which, again, is outside of collective agreements, so we are responding.

I really do believe that the things that paramedics want to see are best handled at the table. There are a number of issues. I don't think it's as simple as just pay, I think there are a variety of issues in my preferences. We've done some of those short-term investments. We want to get back to the table and make sure that we have meaningful negotiations.

BRENDAN MAGUIRE: It may not be as simple as just pay, but when you are some of the lowest paid in the country, it really goes a far way to retention. We've seen this government act on this with other professions. I guess I'm just looking for a yes or no. Will the minister today commit to a pay increase outside of the collective bargaining agreement? Will she commit to advocating for the paramedics outside of the collective bargaining agreement to get a pay raise - yes, or no?

MICHELLE THOMPSON: We will adjust pay, based on the collective bargaining process.

BRENDAN MAGUIRE: That's a good way to say no, I guess.

We do know, speaking of agreements and processes and timelines, we do know that the Master Agreement is up for the family doctors; I think it's up this month. Is there an update on that - where are we on that?

MICHELLE THOMPSON: We are currently at the table with Doctors Nova Scotia. We are doing interest-based negotiations and they are going well. They will continue for a period of time, but yes, we are at the table with them now.

BRENDAN MAGUIRE: I just want to get back to paramedics for one second. You did say there are 50 new paramedics coming onboard this year or taking the course, and we

do know that 160 are leaving - that's not retirement, that's just people leaving the profession, due to burnout, stress, everything like that. So you are down negative 110, without taking into consideration retirements.

This government has said they have plans. I've read the plan. There is no actual structure to the plan, it's just a lot of words that don't have a lot of meat behind them. What is the actual plan to pick up that net deficit of paramedics?

The minister made a great point about it is not just about pay - a large part of it is about pay but a large part is about working conditions. When we have 160 paramedics leaving, 50 coming onboard, not including retirement, what is the short-term plan, i.e., over the next couple of months, to replace those paramedics so that they are not working mandatory overtime, so they are not burnt out, so they actually have a life and they are able to go home and spend time with their family?

MICHELLE THOMPSON: In terms of that number, about 160, we would have to verify that. We haven't really heard that number before. But we have expanded - well, a couple of things that we've done to support paramedic programs. We have expanded. We've added two more courses, one in Yarmouth, which has 80-plus applicants within, I think, a week, which is very, very encouraging. We also have about 40 applicants in Stellarton, which is the second new program in addition to the Cape Breton and the Sydney program.

Also, we've created tuition relief so that those students will each receive $11,500 in tuition relief for a return of service agreement. And since 2021, we've brought in over 100 paramedics, so our recruitment efforts are working. We do know that there are folks leaving. Not all are leaving - they may be leaving the trucks, but they actually are transitioning, in many cases, to our partners at the Nova Scotia Health Authority, so they are still remaining in the system.

We are very focused on the recruitment, retention, and training of paramedics, and also looking outside of the province and outside of the country at who the paramedics are who are most aligned with us in order to recruit internationally.

BRENDAN MAGUIRE: What is the total health care spend from budget 2022/23 and this budget, 2023/24? So, what is the total health care spend from the Department of Health and Wellness - your budget, obviously - and also, the health care infrastructure spend? I'm looking for a total from 2022 to 2024. So, that includes health care infrastructure and all budgetary items in the Department of Health and Wellness and NSHA.

MICHELLE THOMPSON: Department of Health and Wellness in 2022/23 was $4.266 billion. This year, $4.854 billion. If you look at all departments together - that would include Seniors and Long-term Care, Office of Addictions and Mental Health,

Office of Healthcare Professionals Recruitment - $5.750 billion in 2022/23, $6.5 billion this year. We'll get you the capital in a second.

BRENDAN MAGUIRE: Is it safe to say - I mean, it's hard to wrap your head around those kinds of numbers, right? Is it safe to say that this is the largest health care spend in the last - in a two-year period, would you say - is this the largest health care spend this province has ever seen?

MICHELLE THOMPSON: Yes, I would say that it is. I only have a few recent memories here, but I can't imagine they would spend more than that. I would say it's historical.

BRENDAN MAGUIRE: So, in your first two years as government, you've spent more money on health care than any government before you, and yet - can you give me the numbers from last year at this time to current day, on the Need a Family Practice wait-list? So, what was it last year when you presented your budget and what is it this year currently?

MICHELLE THOMPSON: We'll double-check on the number from this time last year, but certainly, the number this year is 137,000 and we do know that it's up. What I think, again, is important to understand about that list is that if we believe that's the only metric around how health care is in the province, I think we really need to talk about the metrics and I'm sure we'll have lots of time to do that.

That list does need to be modernized and we've talked about it before. We've committed to $11.5 million to invest in that list because we want it to be more functional. We need people to be able to update their health care status. We need to understand how to triage folks.

What is important is that we've invested a significant amount of money so that people on that list have access to care. That's a list about attachment, it does not reflect access.

BRENDAN MAGUIRE: We know that it's up substantially. We're talking 20, 30, 40, 50 per cent since last year. That's what it's up to. Where does the province of Nova Scotia rank when it comes to walk-in clinics? There was a recent report that ranked Nova Scotia on access and wait times to walk-in clinics. Where does Nova Scotia rank over the last 12 months and $11 billion. Where do we rank on walk-in clinics?

MICHELLE THOMPSON: There are national benchmarks for a number of different metrics across the country, but walk-in clinics are not a benchmark that we would see from any of the health organizations, like the Canadian Institute for Health Information, as an example, that we use as benchmarks, to my knowledge.

BRENDAN MAGUIRE: We are last in the country on access to walk-in clinics - last. It has been tabled in this House a few times, as the Department of Health and Wellness should know, do know and are aware of this. If you don't know, we have issues. In fact, I will say to the minister that when the minister comes down the elevator, walks across Scotia Square, walks past the walk-in clinic in Scotia Square, take a look to your left. Almost every single day there's a sign on that door that says that walk-in clinic is closed and no longer taking patients. I actually tabled that a couple of days ago. I went down, took a picture, put the sign up. It's the same with the one in Spryfield, it's the same with the one in Fairview. We are ranking last in the country in access to walk-in clinics.

The last time in Public Accounts Committee when we had the Department of Health and Wellness there, one of the questions I asked, and we never got an answer to, was, what is the average wait time for a Nova Scotian in the emergency room?

If you go to the emergency room in Nova Scotia - we'll use the QEII - what is the average wait time?

[1:30 p.m.]

MICHELLE THOMPSON: We don't have that right in front of us, but we'll get it to you.

BRENDAN MAGUIRE: Madam Chair, to the minister, I really do hope that that comes to me during this Estimate, because, again, this is several times I've asked for this number, and we've been unable to get it.

We do know that wait times are not good. If I call virtual care, what is the average wait time to get through to virtual care?

MICHELLE THOMPSON: We will get that number. It will fluctuate, obviously, on demand. So we'll figure out what the average is. And we'll also - virtual care is also available in the emergency room, so we'll also get that number for you. I think it's around 75 minutes for virtual care in emergency rooms.

BRENDAN MAGUIRE: So the reason I'm asking these questions - and the minister probably knows where I'm going with this - is that the Premier of Nova Scotia stood in this House time and time again, and said that every Nova Scotian has access to primary health care, be it virtual care, walk-in clinics. The minister said that you don't get those numbers and you're not measuring those, and the Premier Nova Scotia has touted walk-in clinics over and over. I suspect the Premier of Nova Scotia has never been in a walk-in clinic.

They've also touted emergency care service. So the next question is: What is the average wait time for a paramedic to show up if I call for a paramedic?

MICHELLE THOMPSON: This is one of those questions that is not quite as straightforward. There is, based on the level of the call, so there's Code 1, Code 2, as an example. Depending on the call, there would be an average.

Also now with the doctor and the comms., sometimes that patient can be triaged and, in fact, the ambulance is delayed and there is a plan that is put in place with the family or with the patient and the patient is put in a queue, so there is quite a delayed response time working with the health care provider to ensure that folks are getting access to the care they require.

We can get a table, but it is a bit of a moving target in terms of why the person called. We also have response time standards that are different in urban areas versus rural areas, so it's not as simple as a singular number all the time, which is what I think the member would be looking for.

BRENDAN MAGUIRE: I guess we have a government that spent $12 billion on health care, is willing to spend whatever they can on health care, they've said. They're spending record amounts of money on health care and some of the basic questions around health care cannot be answered by the Department of Health and Wellness - paramedic times, wait times in emergency rooms, walk-in clinics, they are confused about the Need a Family Practice list.

What I will say about the Need a Family Practice list is this, everybody on that list needs a doctor, that's why they're on the list. Some may need it more than others but they're on the list because they need a doctor. We can rearrange the chairs on the deck of the *Titanic* any way we want but we're still on the *Titanic*.

We know this - all the numbers in primary health are going down, they are getting worse. We now have the worst walk-in clinic access in the country - and I'm going to table that again for the minister. We know that this list has grown faster than it ever has, in fact; it's more than doubled under this current government.

The Premier of Nova Scotia was calling it a crisis when there's 30,000 Nova Scotians on that list. I will remind the minister there were months before COVID-19 that that list was actually going down. In two years, this government hasn't had a decrease in the list once, and we're not even talking about COVID-19 numbers. This government went from the best COVID-19 response in the world, where Nova Scotia was the face of the COVID-19 response, to the absolute worst, one of the worst responses. We are now one of the worst in Canada. If you look online at all the metrics, we are consistently a hotspot for COVID-19 over and over.

I'm trying to figure out where this $12 billion went. People don't have doctors anymore. Our nurses are leaving in record numbers, from full time to part time. Our paramedics, last year we lost 15 per cent of the workforce, with another 15 to 20 per cent

leaving this year, not including retirement. So just for access to primary health - access to primary health, that's it, we're not talking about wait times, we're not talking about surgeries, I am just talking about access to primary health.

Can you name a program, an initiative, that this government has done with that $12 billion - and you cannot include virtual care, because virtual care was here before you started. The Premier at the time, who was in Opposition, bashed virtual care, said it was a terrible idea and it was not access to primary health. That's what the Premier said.

I'm trying to figure out what program has been created with that $12 billion, from scratch, that has had a tangible impact on people accessing primary health care.

MICHELLE THOMPSON: I just want to let the member know, the average wait time in our emergency rooms across the province, from triage to provider, is 1.9 hours. That's the data. And the average response time for ambulances all together, 25 minutes.

I just want to talk a little bit, actually, about the health transformation that's happened in primary care. We have introduced a number of new or expanded options. To the member's point, virtual care did exist prior to us forming government, but we have certainly expanded it over the last number of months, 18 months.

We also have - and what's really important about that virtual care, the expansion of that, is actually the primary care clinics that sit in behind. If you are someone who goes to access virtual care and the primary care provider who assesses you feels that you need to be seen in person, you will actually be triaged to a primary care clinic. There are a number of those across the province that actually will connect, particularly people who have chronic illness.

I visited a couple where people are seen on a regular basis in these primary care clinics and their care needs are met. Then when a regular primary care provider becomes available in the community, they are then transitioned. We do have mobile primary health care clinics, which have been very, very successful across the province. These clinics are able to move around, built on the success of the mobile clinics that were implemented during COVID-19.

The pharmacy walk-in clinics that have pharmacists and nurse practitioners, those have been very, very successful as well. Our Community Pharmacy Primary Care Clinics have, in fact, seen 5,800 people within a month, to support their care needs. We also have a primary care clinic to attach babies who are unattached.

There are also pop-up clinics. Where we can work with a clinic that can expand their hours based on their staffing, we've been able to pop up clinics around a variety of different places, particularly in HRM. So, there are a number of ways to access.

Part of the investments we that we talk about in the budget, is how do we create the technology, so that a person with that technology can look at the primary care needs that they have after hours and on weekends, and that technology will support them and direct them to the available primary care sites.

What we do hear a lot from people is that they don't know where to go. It's not very easy for them always to navigate and find out where the opportunities are, so one of the investments that we make in the technology will be to support Nova Scotians in talking about their location, talking about what their care needs are, and actually supporting them and finding the most appropriate care.

BRENDAN MAGUIRE: The question wasn't, what are you expanding; the question was, what new initiatives or programs have been put in place over the last two budgets, brand new programs, with that $12 billion you've spent on health care, that has helped reduce any of these lists. And the answer is none. There are no new programs. It's all expansion of the former government's program. And none of the metrics have decreased. They've all increased.

My question to the minister is: If more people are waiting for a family doctor, if it's longer wait times in emergency rooms, if it's longer wait times for paramedics, 15 per cent to 20 per cent of paramedics are quitting every single year, more nurses are going part-time and leaving the profession, what is the plan? Because right now the only plan I see is to throw out large numbers.

In the minister's opening speech - I wasn't going to talk about it, but I take some exception to some of the stuff that was said about the previous governments. Because the previous two governments opened collaborative cares. This government hasn't opened a single one yet, have they? I don't think so. And that's the model we're hearing from doctors coming out of school. They want collaborative care. This government hasn't opened up a single one. Not that I know of.

They tout expansion of the scope of practice for pharmacists. That was started under the previous government. If she denies that, all you have to do is go back and look at COVID-19. I got my COVID-19 vaccine from a pharmacist. I didn't get it from a doctor; I got it from a pharmacist. Our pharmacists took on a massive amount of work during COVID-19. The scope of practice was expanded under the previous government.

Yes, this government did more, but this constant politicization of the health care system, where people say the previous governments did nothing, that they didn't do anything - the previous budget, your very first health care budget, was a 1 per cent or 2 per cent increase on the health care budget. That's what the increase was. Then the numbers got worse. I think we need to be honest here. There's nothing wrong with saying the previous government did good things because it's clear that this government agrees because there's no new program. It's all expansion. What really gets my goat is that we had

a Premier in Opposition who bashed every single one of those programs, and now he's touting them. He's saying how great they are.

[1:45 p.m.]

Virtual care is good, but it's not the answer. Walk-in clinics are essentially a thing of the past. I am going to table this. This is the information on walk-in clinics. I would advise everybody in this room to read this because these are the things that this Premier is saying to do: call virtual care - wait an hour and a half to get through if you're lucky; go to a walk-in clinic - can't get to one; go to the emergency room, where the minister just said the average wait time is 1.9 hours.

I have been in the emergency room twice in the last 12 months - twice. Once I was there for 20 hours with broken ribs and was not looked at. I left. The second time, I was there for 18 hours with a broken fibula. I'm a very social person, so I was talking to people who were there. Everybody in that room was there for over 10 hours. I had a buddy actually come in out of the blue - had his finger cut off, the tip of his finger from the knuckle up was gone. It was a 14-hour wait. That has nothing to do with the health care professionals. It's the stress that's on the system.

But I think there's a lack of understanding if they can sit here today and say it was only 1.9 hours. I just don't know what world we're living in if we think that's how long people are waiting. And in 25 minutes I can give you a whole list of people who have called for a paramedic, who have waited hours and they haven't even shown up,

I asked a question of the minister the other day about heart attacks in Nova Scotia and the response from paramedics who said to get a machine in your house because if you have a heart attack in Nova Scotia there's a good chance you're going to die - it was 80 per cent, is what they told us - or get someone to drive you.

My next question is around family doctors. How many family doctors are retiring or leaving their practice - they could be leaving for other positions - in the next fiscal year?

MICHELLE THOMPSON: There are a few things I would like to respond to in that preamble.

What I would like to say is there have been a number of things that have happened to support primary care across the province. Virtual care has absolutely been expanded throughout the province, and it certainly has had a very positive effect. mobile primary health care clinics have been launched. They see an average of 75 to 100 people at any given time. We have mobile respiratory clinics. I have also talked a little bit about the pharmacy work that has happened. There have been a number of expansions in urgent treatment centres as well.

The average wait time is based on the entire province, which is what you asked for. There's a lot of variability around that. The other issue is we know that primary care is so essential because 50 per cent of the people who present to an emergency room in the province are a triage score of 4 and 5. We know that those folks automatically will have expanded time to wait because it is an emergency room. It really is essential that we continue to have primary care access.

One of the things that's been very effective are the virtual emergency rooms, which came from a health care worker, Dr. Sommers, in Truro. It allows people who require primary care to go to a virtual care person and be able to be triaged in and out in roughly, I believe, around 75 minutes.

I think it's really important to look, too, at the expansion of primary health care. There's been implementation of 14 new collaborative care clinics and there are at least 37 more that will be expanded. While this is our second budget, this is a forecast. Things that are noted here today are things that are forward-looking and transformational.

There is also a Virtual Hallway project, which I think is very important to talk about. What it allows is primary care providers to reach out to specialists with their patients and allow specialists to speak directly to a primary care provider. It's been very effective in supporting people not having to leave their community in order to get specialty care and have a treatment plan in place. Those would be some of the things.

In terms of family physicians, it really has been difficult. We look predominantly at the age of physicians. We know that there are about 20 per cent of physicians who are 65 years of age and older. We often see that physicians actually work past the age of 65, as well. These physicians are independent business owners and there is no requirement for any of us to report when we are going to retire. We don't have a line of sight on that.

Dr. Nicole Boutilier recently reached out to physicians in the province. They were very grateful to hear from her. She wants to know how best to support them. If we can start that retirement transition process early, it would be very helpful. There's now a hotline that's available to physicians to reach out to support. Those calls will be answered in a timely fashion.

That is part of the work that we're doing. We're also looking at physicians not just fully retiring. My understanding is that in times prior to the former government, if you wanted to leave your practice, you had to fully retire. There was no transfer into practice or transfer out. That was only just starting.

I know that there are physicians who maybe don't want to have their full practice but can still contribute and still want to contribute, whether it be through virtual care or mobile units or perhaps hospitalist care. There are a variety of ways for our physicians to

transition out of a full practice, work partially, and then also to contribute to the system in a different way.

There will be more to say on that as time goes on. We are working with physicians to understand.

BRENDAN MAGUIRE: I just want to break this down into zones for a second.

In Central Zone, we've seen some areas like Bedford see an increase on the wait-list of 600 per cent. Doctors are saying that one of the reasons is that this government removed the incentive for family doctors in HRM for the Central Zone.

I understand that rural Nova Scotia needs doctors, but this is an us-versus-them. This is what's happening here. We're pitting rural Nova Scotia against HRM. This is what's happening. We're saying that you'll be given a bonus to go to rural Nova Scotia, even though it's hurting HRM.

The cold, hard facts have shown that since that incentive was removed from HRM - and we're one of the very few urban cores in Canada that does not have a family doctor incentive - in fact, I think it's the only one. Does the minister not see the correlation between removing that incentive and the Need a Family Practice Registry list skyrocketing in HRM?

Will the minister commit to returning that incentive to HRM so that both HRM and rural Nova Scotia have a doctor incentive? If the minister wants to have one side get more doctors than the other, maybe the minister can just have a higher incentive in rural Nova Scotia. The cold, hard fact of the matter is that not having one in HRM has had a negative impact here in HRM.

Will the minister return that incentive to HRM and listen to the graduating doctors who said that they want it?

MICHELLE THOMPSON: As I've said before, we know that - I think it was 60 per cent of physicians did settle in the HRM, which did leave our rural communities without physicians.

We also know, as well, that the Office of Healthcare Professionals Recruitment is always changing and looking at ways in which we can support. Rural parts of Central Zone in fact do qualify for the incentive program. We will continue to look at that. We are at the table with Doctors Nova Scotia, and we're looking at jurisdictional scans to understand best practices.

We're also working with physicians who want to work in the city and looking at a variety of practice environments for them. As an example, the incubator clinics have been

very supportive. We're also looking at practice supports, creating team-based environments. There's a lot more work to do; we're happy to do it.

This is going to change. This is a fluid situation. We had a significant issue in rural, we now have to look at that list and understand the distribution of primary health care teams and understand how best to move forward. We are very open to looking at different opportunities moving forward.

BRENDAN MAGUIRE: The incentive is working. We know it worked; we know that is a fact. The minister just said that she is open to ideas. I've got an idea for her to recruit doctors to the HRM: it's called a Central Zone incentive for family doctors. It worked for years. The worst HRM has been is over the last two years under the guidance of this government, which just so happens to be a majority-rural-MLA government. It actually does feel political.

We know it works. We know it works in HRM. I have a yes or no question for the minister - I have two yes or no questions: Did that incentive work in HRM to help attract doctors, yes or no? And will the minister bring that incentive, which has years and years of data to show that it worked, will the minister bring that incentive back to HRM to ensure that we get the family doctors we need? Because we're seeing a decrease in family doctors and an increase in the list larger than anywhere else in this province. Yes or no on those two questions, please.

MICHELLE THOMPSON: Well, they're not really yes and no answers. The incentives have changed over time. Prior to 2018, there were rural incentives and there were central incentives and now we've gone back to rural incentives.

Again, this is a fluid situation. We need to continue to look at what's ahead of us. We're very open to hearing from physicians about what it is they want in order to practise in a variety of environments. Some people really like a rural practice lifestyle, it gives them more opportunities. Others would prefer to practise in a Central Zone environment. We will continue to work with physicians to understand what their needs are, as well as primary care practice teams in order to support their practice.

BRENDAN MAGUIRE: The question was, did this incentive that was in HRM work to help attract doctors to come to HRM, yes or no?

MICHELLE THOMPSON: Again, there was a variety of incentives that were a bit different prior to us forming government. Similarly, again, we wanted to look at how we support rural communities. I can't tell you exactly that incentive program because there were a number of different ones. These incentives are different from the previous ones.

Certainly, this was the recommendation of a physician himself, who was the CEO of the Office of Healthcare Professionals Recruitment at the time, and felt that this was in the best interests moving forward and we would re-evaluate, so here we are.

Again, I am not saying no, I'm just saying that right now these are the incentives we have and we'll continue to look forward and understand how best to support Nova Scotians equitably across the province.

[2:00 p.m.]

BRENDAN MAGUIRE: I am actually glad they used the word equitably because it's not, it really isn't. Dartmouth, Bedford, Halifax, Spryfield are now some of - if not the - worst places for doctor attachment in Nova Scotia. There was an incentive that worked. A government that was elected on rural seats came in here, removed it, and gave the money to rural Nova Scotia instead of doing something that was fair across the board. If she didn't think it was fair, you could have done something that was fair across the board.

Instead, you're penalizing HRM. Doctors are telling you it needs to come back. The numbers on the ground are showing you it needs to come back and yet you won't do it. This is a government that likes to tout science and data and facts, but only when it helps them. Everyone in the Department of Health and Wellness knows it works. Everybody knows it works. What worries me, Mr. Chair, is that the person at the top of NSHA who's making the actual decision has no health care experience.

Before, we had a board that was diverse. Now we have one individual whose real background is as former chief of staff and fundraiser for the PC party, who's now making the decisions. One of the first things they did was remove a doctor incentive in a place that is predominantly Liberal and NDP. They know it's not working, they know people are suffering, and they're choosing politics over health care.

THE CHAIR: Order. The time allotted for Liberal questioning in this round has elapsed. We will now move on to one hour of questioning from the NDP.

The honourable member for Dartmouth North.

SUSAN LEBLANC: Does the minister need a break of any kind? Okay. Well, I'd like to start by thanking all of the staff in the department and the hard-working health care workers on the front lines. They are true heroes in Nova Scotia and against all odds are working to serve Nova Scotians. And so, deeply grateful to our frontline health care workers.

I just wanted to make a couple of quick opening comments based on the minister's comments, and I'll get more into these things later. I just wanted to talk really quickly

about the access versus attachment issue. I'm glad to hear the minister talk about those things as different things.

I am one of those people who is lucky enough to have a physician, and it's important to me to have a physician who can follow me, especially as I hit this amazing period of life called perimenopause. It's nice to have someone who knows the history and, hopefully, can guide one into the future. That kind of attachment is essential, but it is hard to see my doctor. It's hard to get an appointment. It can be three months, two months for a - yes, it's a long time.

That's fine when it's not an acute issue, obviously. It's great that if I have a strep throat, I can call Virtual Care Nova Scotia. I get that. I think that those things are good, but attachment and accessibility to the attachment is, to me, the most important thing, and that is obviously what we need to strive for in Nova Scotia, because that is what will create the healthiest situation for us.

I also want to just quickly say - and I will say this at other times during the Budget process, but I think about the folks who live in my community and the folks who are facing renoviction and housing insecurity, the people who are living in tents near where my office is. And I just think we need to remember that housing is health care. And income is health care, and there's lots more to health care.

The Overlook in Dartmouth North is a perfect example of this. People are being housed at The Overlook who are chronically hard to house, and there are support health services right in their building. There's a pharmacy right in their building. This is starting to fill up with folks and by all accounts it's successful so far. I just encourage the government to invest in more places like The Overlook and in people in deep housing insecurity. Not just deep housing insecurity, but housing insecurity. We will have a healthier population if we have a housed population.

I'm just going to start with emergency care. My first question, I would like to start by asking about the series of promises that were made earlier in the year in the wake of the deaths of Allison Holthoff and Charlene Snow. We all remember, the minister remembers the response from the government with a number of promises, but the announcements were criticized by doctors and nurses as not going far enough, and also that they didn't have timelines attached.

Our caucus attempted to obtain information around those announcements through a Freedom of Information and Protection of Privacy request, but we were told it was too many records. We'd like to try to get some updates on some of those announcements. My first one is the promise of having teams led by doctors focused on getting patients out of ambulances and into emergency departments faster. These will be similar questions for each one of these things, but how many ERs have that now in place in the province? Which

are the ERs that have that in place in the province? By what date will every ER in the province have that plan in place?

MICHELLE THOMPSON: I'll start. We're going to get some information to supplement as we go through. The Flow Lead and Offload Assessment Teams, acronym FLOAT, they're being implemented, consisting of doctor-led teams. I believe there are five out of nine in our emergency rooms. What that means is that incremental hours are provided to the emergency department, and the emergency department, actually based on their utilization, uses those extra hours of care with the FLOAT.

They actually have a lot of autonomy over when they utilize that. The FLOAT would be there during those - we can predict in the emergency rooms high times of usage. Those are coming along very well. They require emergency room physicians, so there's some recruitment and reallocation of work that's happening, but they have been going very well.

Also, just trying to look at emergency rooms in general, we did hire two physician assistants in Dartmouth, and they're actually hiring some in Bridgewater, so that's been very helpful as well, as well as the - there are patient advocates in all of the emergency rooms across the province. Those are implemented. Again, I would say they may not be 24/7 depending on usage in the department. A regional hospital may require more support than perhaps another, smaller emergency room that may have some quiet times, as an example, where they would be seen more quickly and the waits would not be as long.

We're also adding the clinical care provider as well, and those are implemented in Dartmouth General Hospital and a couple of other spots in order to support the care. Which EDs and where, we'll let you know.

SUSAN LEBLANC: For the FLOAT, you're saying there are five teams in place out of nine, or five ERs have teams in place out of nine ERs, I think that's what you said. For all of these things I'm going to ask about, we want to know which are the EDs that have them and what is the target date of having every ED have all of these things in place.

The next promise was assigning physician assistants and nurse practitioners to provide care in emergency departments. The minister mentioned the Dartmouth General Hospital and Bridgewater, that's two out of nine. I'm wondering if there are any more and by which date physician assistants or nurse practitioners in emergencies will be in place throughout the province.

THE CHAIR: If I could just gently remind the member for Dartmouth North to go through the Chair and not use "you" - please and thank you. (Interruption) I offered gentleness.

MICHELLE THOMPSON: We will get the breakdown of where the nurse practitioners are. I know for sure there is one in Amherst, as an example, and also to let you know that the five out of the nine - we'll give you the places where they are but the other four will be implemented by the end of this quarter - the next quarter.

THE CHAIR: I suppose I should also gently remind the minister to go through the Chair as well - gently.

SUSAN LEBLANC: But to clarify, Mr. Chair, we can look at each other, correct? We just need to refer to people in the third person, correct?

THE CHAIR: Please and thank you.

SUSAN LEBLANC: That's a relief. The next one is the promise of adding care providers and patient advocates to support patients in waiting rooms. The first question on this one - are patient advocates and care providers two different positions; are they nurses or some other health professional; and are they paid or are they volunteers?

So clinical care providers, nurses, paid, volunteer and then of course the usual question - how many ERs have these folks in place? Which ones and by which date will all of the ERs have them?

MICHELLE THOMPSON: The care advocates - this is how I understand them, and this is what helps me - when I think about an advocate in a waiting room, that person does not necessarily need to have a clinical background. They would be somebody who is there to support and provide comfort. It could be a continuing care assistant. It could be a variety of different folks.

There is some volunteer work that is happening. We know there are some students, as an example, who were doing some waiting room support earlier in the year and we had an opportunity to speak to a couple of them. Those advocates are there to really respond in terms of comfort, if somebody is able to eat or drink, as an example, if they need anything they would be able to offer them support - warm blankets, if somebody is sick, giving them the supplies they need or showing them to the bathroom, just really around comfort.

In fact, I get a variety of emails in my constituency office related to health, as you can imagine. I've actually received a lot of good feedback about the care and the support, any accompaniment is what I would say, through that emergency room experience with the patient advocates. They do a very good job.

There certainly is a learning curve in terms of who can get what, so there are patients who are in a waiting room who really, because of their presenting complaints, should not eat or drink, types of things like that, so they are growing, and they are maturing in their roles.

The patient care provider is, in fact, a clinician. It would be somebody who would provide care. There's a great video of a nurse from the Dartmouth General Hospital, I'm not sure if the member has seen it, it really defines and describes the role. It has been out on social media. We interviewed her. She is a registered nurse in the video. She talks about doing assessments, making sure triage is done. If there is somebody who needs to come into the - just behind triage pre-treatment, they are able to initiate or run tests, do types of things like that. It actually is an additional resource, a clinical resource who can assess and initiate treatment in the waiting room or just behind the waiting room, actioning tests, things like that, to support the person, so yes, they are clinical. They are different.

SUSAN LEBLANC: Well, Mr. Chair, I'd like to thank the minister for that clarification but, also I just want to clarify that we will receive the nuts and bolts answers to all of these, like the numbers and locations for each of these questions.

[2:15 p.m.]

My next one is the promise of making virtual care available to more patients with less urgent needs, and the minister actually talked about this today in the House. How many ERs have virtual care in place, which ones, and by which date will virtual care be available in all ERs?

MICHELLE THOMPSON: In terms of the Flow Lead and Offload Assessment Teams, they are currently implemented in Cape Breton Regional Hospital, Aberdeen Hospital, Valley Regional Hospital, the QEII Health Sciences Centre, Colchester East Hants Health Centre. And by the end of June, it will be at St. Martha's Regional Hospital, Cumberland Regional Health Care Centre, Yarmouth Regional Hospital, South Shore Regional Hospital, Cobequid Community Health Centre, and Dartmouth General Hospital. So, that's for FLOAT.

Waiting room providers are now in Colchester, Valley Regional, the QEII, and Dartmouth, and the rest will be implemented by the end of Quarter 1.

In terms of the virtual care emergency rooms, their pilots are happening now at Yarmouth, Strait Richmond Hospital, and in Colchester.

SUSAN LEBLANC: The minister mentioned pilots, but it was a promise making virtual care available to more patients with less urgent needs. I suppose that's not a commitment to all ERs, but wondering if, when that pilot ends, there is a plan to be expanding virtual care in emergency rooms.

MICHELLE THOMPSON: The places we have NPs in emergency rooms are Digby General Hospital, Yarmouth, QEII, IWK Health Centre, and Amherst. It really is a test and try, is what I would say, in terms of those in emergency, rather than a pilot. These

virtual care emergency rooms - it's far easier to work the kinks out in three sites and then scale it once we know what the kinks are.

I don't have a commitment. I can get back to you about it, but it certainly has proven to be very effective, especially if it's running at a time where there's less access to primary care in the community, like an evening or (Inaudible) et cetera. It has been very successful. It's got a pretty much shortened wait time as a result and it gets people in and out very quickly. It is going well, but the test and try will have results, and then we'll scale it from there, but I don't have a date.

SUSAN LEBLANC: Another of the promises was providing health care teams with real time data on where beds are available across the system, and what tests or other actions are needed to get patients well and home quickly, which will free up beds for others. The question on that promise is how many ERs have this in place now, which ones, and by which date will it be in place for all ERs?

MICHELLE THOMPSON: The member has probably heard us talk about the Care Coordination Centre or C3. That is currently in Halifax. This is an advanced technology that provides real-time data that allows people - there are a number of different tiles, just like the television that we're all on. It shows exactly what's happening in each of the units in the hospital. It's amazing, in fact. It shows what's happening in Central Zone. The beauty of it is we are actually going to expand it across the entire province. It will go tile by tile. It's completely done. I think all the tiles are up now - most. I think there's one left. What it will allow us to see is bed capacity throughout the whole province. It allows us to have real-time data in terms of acuity of patients, where the beds are available, where some of the difficulties are or where some of the clogs are, et cetera. This is amazing.

People are watching this project very closely. It generally is in one hospital, but we're actually going to scale it across the province. That will happen this year, particularly around bed managers so that we can see where capacity is in the system and when we can repatriate patients back to their home facility, if that's appropriate.

It's excellent. It's staffed by clinicians. I visited it not all that long ago. It's amazing. They all have headsets on and they're moving around and talking all the time and getting people into surgery and getting people out of surgery and into beds. It's amazing. It looks like a very high-pressure environment, so I'm very grateful that there are people who have that skill to be logistically smart. It is wonderful, and certainly it will be a huge improvement to support the flow of patients.

It also says when people are ready to go from a particular unit. If you're ready to be discharged from an intensive care unit, it actually tells where you could go and how long you have been ready to go. It's a lot more accountability. It's very objective data that allows us to move people based on the clinical nature of their condition versus perhaps other things.

SUSAN LEBLANC: I just want to pick up on that system for a second because it just triggered a question of mine that I wasn't planning on asking at this point. Speaking of moving patients and discharging patients and that kind of thing, if you're looking at that flow, and you can see, oh, this person is okay to go home - we've heard a number of concerning stories lately in my constituency office, where people who are ready to go home, the families or caregivers of those people are being sort of pressured to - sorry, back it up. Not family, but a caregiver or someone who just happens to be their closest contact but doesn't live with the person - they're being pressured to take the person, to bring them home to their home and care for them with home care or without home care - who knows? - in situations where they are not able to do it.

I heard from one person who, in their words, the hospital wouldn't let up even though they informed the hospital that they did not have the capacity to care for this person who was undergoing cancer treatments. I just wanted to know the minister's thoughts on that. Is that a thing that happens? If someone says, I don't have the capacity to take care of this - even if it is a loved one or someone like one's partner, but maybe the other person at home is physically unable to or for whatever reason - what happens then? What supports are put in place for a family or a person to be able to be released from the hospital safely?

MICHELLE THOMPSON: First of all, we want to make sure that patients are ready to go home. We want to make sure that people are ready to take them home. There may be some questions on that for the Minister of Seniors and Long-term Care when that time comes. I think it speaks to the necessity of discharge planning, making sure that we have discharge planning immediately when people are admitted to hospital. The day you're admitted to hospital is the day that we should start looking at how we can transition you out.

A lot of the things, as you know, that happen in the emergency room are in fact - if we just look at the process and not the individuals, it's an outflow problem. It's often not an inflow problem. It's an inflow problem in terms of people and the long waits. That is why the transition-to-care facilities are so necessary for us. We do have individuals who cannot go home, who don't require active medical treatment, who are deemed to be alternate level of care, and those folks are living in hospital right now. We want to reduce those numbers and, again, the Minister of Seniors and Long-term Care will be able to discuss the initiatives that she has.

Those transition-to-care facilities are so necessary for us in order to create a care environment where individuals who are medically stable but still have some issues are able to be cared for, but also mobilized.

You'll notice in the speech that I gave, we talked a lot about our mobility teams. Often if you come in and you have a complex illness, you come in, the nurses are busy, it's a very different environment, and people are not getting up and moving and they

decondition over their time in hospital. So these mobility teams, in fact, will solely be focused on keeping people active as they get better, as they start moving towards home.

Getting them moving, making sure they do not decondition - looking - occupational therapy. What are the things that it takes for you to go home? Do you need to cook a meal, do your laundry, and something else - so working with that occupational therapy role, physio role, and supportive people to make sure they recondition. We don't want that.

There is some work happening around how we support people in community to better give them the care they need in the community, if they want it, but also to transition them in a more meaningful way. So that's a huge priority. That is the issue, is outflow. But it needs to be safe outflow or we're going to end up with re-admissions.

So re-admission rates, I don't have them, but that would be an indicator. Certainly when I worked in acute care, we would look at re-admission rates at a time interval, to see how discharge planning went or the care, et cetera. So, that's actually a quality indicator that the Nova Scotia Health Authority would be keeping an eye on, in terms of their quality program.

SUSAN LEBLANC: That was just a bit of an aside, but going back to that amazing sounding system, I just missed the actual answer. Does every ER have that system set up now? Is it fully functioning or are we waiting on parts of the system to be ready?

MICHELLE THOMPSON: The Care Coordination Centre will have a provincial roll-out. It will be the tiles - there will be tiles available in all the regionals. But a lot of the other things will happen - there will be some central work that happens.

The real-time data that it allows - so as an example, if there are people waiting to be discharged, they're able to see right to the detail of, somebody needs bloodwork. They can see who ordered it; they can see how long that bloodwork is going to take. They can constantly see and move people around - understand where things are jammed up, where people can maybe, if they're waiting for something that's not critical, maybe you can actually go home.

The real-time data is very, very deep. It allows people to support clinicians. If you're in a busy emergency room, if they're not your patients, you may not actually know what's going on with them. So there's actually somebody helping the frontline staff coordinate.

The regionals will have certain tiles that will allow them to do that. And it will support the movement of people. Seeing where people can be discharged to, what the bed capacity is in other hospitals. Sometimes we're not always as upfront about the number of beds that we have sometimes, certainly over the years. Once someone's discharged, we'll immediately know that that bed is available.

Instead, I would say we now have a push system. So people are coming in and they're pushing forward trying to get into the system. Where this will help us create - we immediately see the capacity and it becomes a pull system. So everybody can see what's happening and have these care providers and this coordination centre see, and they better help pull people from the emergency rooms into the appropriate service.

SUSAN LEBLANC: But is it all up and running, that's my question. And if not, when?

[2:30 p.m.]

MICHELLE THOMPSON: Just in terms of the project itself, typically a project like this in a single facility would take about three years. We've compressed that, so it is almost fully functional here in 18 months. It has only ever been used in one facility. Humber Hospital uses it, Jewish General Hospital uses it. We actually are the first province that's going to roll it out. Those new tiles were in that process stage. We want to get it up and running. It's very functional and being used right now at the QEII every day.

The expansion is now going to start to the regional sites. It's not a lag thing, we want to go. It's been very helpful. There's been a lot of learning. We will roll out very quickly to the regional sites over the next six to eight months. That is the hope, that we will have it up and running provincially and it will really be first in class because it hasn't been utilized in that way.

The team is really engaged and it has been a tremendous effort for them to get to where we are in that short period of time.

SUSAN LEBLANC: Great, I thank the minister for that.

My next one on this, and of course this is the topic of the hour, but we do know, Mr. Chair, that if we had more access to primary care, we'd have less need for emergency care. One of the promises by the government was support for new and existing collaborative family medicine practices so that they can see more patients.

My question is: How many new collaborative clinics have opened since this government has formed and what is the plan for collaborative clinics for this coming fiscal year?

MICHELLE THOMPSON: We've been working with clinics now and, again, we go back to Dalhousie Family Medicine because it really taught us a great deal as we worked with them around practice optimization, the rapid onboarding team, and also the development of that incubator clinic, which has been very, very successful.

We expect to expand into 14 different communities, new clinics, and also expand 37 other practices to support them in the upcoming years. We expect significant attachment as a result of that.

I also want to talk about the success that we've had with the Community Pharmacy Primary Care Clinics and the nurse practitioner and pharmacist working together. That new clinic, the new clinics that we talked about that we opened in collaboration with the Pharmacy Association of Nova Scotia, those pharmacy clinics have seen 5,800 people in a month, a significant impact in terms of people's ability to access primary care. Fourteen new communities will get health homes and 37 more will be getting expanded.

SUSAN LEBLANC: Just to clarify before I dig into this a little more, in this budget that we're debating, there is money and there is a plan to open 14 new collaborative health homes in communities across Nova Scotia, and to expand the scope or expand the capacity of 37 others. Is that correct?

MICHELLE THOMPSON: The planning - if there is a community - I don't know how to - it's like charades. There will be some places - as an example, we have new collaborative care clinics, new health homes - it may actually be a combination of a number of practices coming together. So, it may be physicians who are currently working in a physician-only environment who want to come together and work in a practice.

The number is a little bit - there may already be physicians working, but when we put them all together in a team and we add additional resources, that's a new health home for folks. It is a bit of a moving target. There will be communities that will have a number of people working individually in their communities, but we will bring them under a health home environment to support one another, and then we'll be strengthening other practices.

There's a variety of different things. Again, to the point that different communities have different needs, different practice environments have different needs, whether there's physicians and nurse practitioners, et cetera. And then different communities have different capacity based on the care providers that they have in the community. There may be a community that already has a pre-existing clinic that we can expand, that maybe have dieticians, as an example. Maybe someone else needs a social worker.

What I would say is, it's really important that we're agile, that we expand those clinics, but we work with the health care providers that are currently providing care, (1) to understand what they're doing, and (2) to see where their gaps are.

SUSAN LEBLANC: I get that. We know that more and more physicians want to practise in collaborative settings, and to have the supports of allied health professionals like nurse practitioners and nurses, and if the NSHA is going to come in and support some of those positions, then that's awesome.

But we also know that we need net new clinics and net new teams. Are there any of those 14 that are brand-new teams that are getting put together, that are not coming from existing clinics? Like, with new grads or whatever, even if there's no physician? Are there any net new teams in any communities that are not what the minister has just described? And where are they, if there are? I mean, if the minister can speak to that.

MICHELLE THOMPSON: That is the point of a collaborative team. If I have a couple of physicians' offices and I bring them together, their patients would come. If I add additional resources to them, there is increased attachment as a result of that. If I add a family practice nurse, if I add a nurse practitioner, if I add a social worker, then the team is able to care for more people.

When you use people to their scope currently, we can give this much care, but when we create a team and they work together and they understand each other's scopes and they see the clientele and the patients they work with, we can actually increase it by this, so it is kind of difficult.

I can't tell you the places right now. We are working with several teams and communities, but we are looking across the province, across communities to better understand how to deliver that. There will be some new ones, absolutely, where we bring folks in, but you're going to see a mix of late career physicians, early career physicians, nurse practitioners, family practice nurses, et cetera.

Looking at the resources to try and understand what folks have and where they're going is the work that's under way now.

SUSAN LEBLANC: Can the minister say how many are brand-new teams and if there are any of those brand-new teams in the Central Zone?

MICHELLE THOMPSON: We're going to have eight new clinics in the province, 13 primary care clinics in addition, five of which are new, and there will be a couple of those in the Central Zone. There will be 21 collaborative care clinics strengthened. There's going to be a significant investment in primary care. It's the answer. We need these teams; we need to find the practices that are most ready.

We're not going to fix primary health care this year. This is the investment that we have this year, so we're going to invest in the most-ready practices and move them forward. There will be a definite commitment that there will be an increase in Central Zone. It will depend a bit on practice readiness, but we need to work across the province.

I can confirm the numbers. There's a lot of numbers flying around about what is being strengthened and what's new and primary clinics and those types of things. We can kind of get that more concise and I'll give that to you. They are probably not exactly where

they are because the investment is there, but the locations may change, based on practice readiness.

SUSAN LEBLANC: I guess I understand. I've been working with folks in the NSHA on collaborative care for a long time and I understand, sort of, a lot of how the thinking goes and about the value of a collaborative care centre and all that stuff. I think it's great.

[2:45 p.m.]

When we talk about the clinic in Spryfield and we talk about the clinic in South End Halifax, it seems to me that those two clinics would have been perfect examples of adding folks to support the positions that were already there and turning them into a collaborative care practice. But it sounds like the strings that the minister talked about in Question Period a couple of days ago - you know, it comes with strings attached, i.e. take more patients on - that negotiation on that couldn't be met.

Is that an accurate picture of that? And does the minister have kind of a metric? So, if you add a nurse practitioner, how many more patients have to be taken on, when you're talking about already overworked and exhausted physicians? Where is the sweet spot where you add this many people and you can afford to take more people on because the work is spread out? That's a complicated question, but is there a metric that looks at that?

MICHELLE THOMPSON: We go back to Dalhousie Family Medicine again. We had a practice at Dalhousie Family Medicine that felt that they had reached capacity and, in fact, maybe would have to decant patients, right? So, what happened was that practice optimization team can go in, worked with Dal over the course of four days, looked at the processes that were in place, looked at the workforce, looked at the number of primary care providers and support staff and allied health care professionals.

And as a result of that work, that team, with some tweaks that were specific to that team, were actually able to take on 3,500 more patients. That is a team of individuals, staffed by industrial engineers, available to any practice free of charge in the province.

The other thing that happened is those 3,500 patients - we heard from physicians that it takes so long to onboard a new patient, so there actually was a rapid onboarding team that came in and supported and settled those individuals into the practice in order to make the time frame shorter, in order for the physicians to care for them. These are the supports that we're looking at and offering to clinics across the province.

Sometimes it's: I have a practice and I'm going to retire and I need a replacement physician. But other times it may be difficult to recruit to a certain practice because it's not the type of practice environment that somebody wants to work in. What we need to do is

understand when people are getting ready to leave practice, so that we can work with them. It does help to have a longer runway.

We need to look at recruitment for replacement, but is there an opportunity to optimize? So, a nurse practitioner would have an expected panel that she does not need to work with a physician. They're an autonomous health care provider who can take on their own panel of individuals, but can also support with access.

To your point, when you have a health home, the clinicians can change but your health care stays there, which is really essential, too, for people who have locum physicians. So, you come into your health home; the folks who work there know you, maybe it's the nurse practitioner, the family practice nurse, the admin staff, whoever. But if you have locum physicians, your information is there and the people around there know, so you may see the nurse practitioner today, you may see the physician another day.

So, that's the deal. When we add those resources, it's to increase attachment because they're capable to do it, but other health care professionals are actually extenders. What a family practice nurse can offer in terms of chronic disease management, well-baby visits, those types of things, that person takes some care away from the physician and actually increases their capacity to see episodic complaints or people who have more complex care.

That's how we work, but we need to know in a timely way, which is why we've set up that practice support team, and why we've created that hotline to work with physicians so that we know when they're retiring, because there really is no requirement for them to tell us when they go.

SUSAN LEBLANC: I've always found that really kind of amazing, that if physicians are on their own there's no way to track. Maybe now there is a better way of tracking but I know that when I was first elected there was talk of Dartmouth being a place where there was going to be a ton of doctor retirements, but we couldn't get any solid numbers because there was no requirement to collect those numbers. Lo and behold, lots of doctors have retired in Dartmouth, or are trying to retire.

Just in general, everything we've been speaking about, in terms of the 37/14/21/5, do we have or does the department have a sense of with that investment - this year's investment - how many people get new access to primary care? How many people will come off the list, as it were?

MICHELLE THOMPSON: Again, it's a bit of a complicated answer because it's going to depend on - so, we have an expected panel, as an example, for a physician that has to be adjusted as well for what we would call a weighted case, so the more complex patient. Very different from a 17-year-old who comes once a year, every second year. That

attachment, we will monitor it but it will depend on the type of clinician who goes into those practices and the efficiencies that are found through that optimization team.

There may be folks now who feel they have reached capacity but when we get in there to support, when the team gets in there to support, they recognize that maybe they have a variety of processes that will improve. Part of it will not only be attachment but also looking at what is our opportunity, as an example, for same day or next day appointments, which would fix that whole thing about people who are already attached but can't access for, like, eight weeks, 10 weeks.

When I see someone like that, I know that's a big practice, but I also wonder, is there technology that can support? Is there an additional resource that can support that practice in order to maybe change the way they've been working for however many years?

It is difficult. We do expect the attachment to be significant, but I can't give you the exact number until we see the combination or the compilation of the team.

SUSAN LEBLANC: I appreciate that. I'm wondering if there's a target, though, if the minister could speak to any kind of target. Do they have a target?

MICHELLE THOMPSON: I wonder what the timeline is for More, Faster, is what I would say. As we are able, these things are happening. We want to go as fast as we can. We have the money; we're recruiting. We have a lot of good work that is happening, in terms of bringing - like, we're recruiting nurses. That change that the Nova Scotia College of Nursing made is significant in terms of bringing people into Nova Scotia.

The same with the physicians. When the College of Physicians and Surgeons of Nova Scotia opened the door to American-trained physicians, we have so many people who want to return home, so as soon as we can stand these teams up, we will. We have no intention of lying. Some will require different infrastructures, some practices may need to move, et cetera. Again, it speaks to that practice readiness, like, if you're ready, let's go, let's go. It's imminent right now, as best and as fast as we can - more, faster.

SUSAN LEBLANC: I remembered my other question, Mr. Chair. It was: Was that optimization team offered to the clinics in South End Halifax and Spryfield that are closing their doors?

MICHELLE THOMPSON: I'm not going to talk about any individual practices here. I've never really spoken to those folks. I know that the department has. I don't think there's anything to be gained or lost in terms of talking about it on the Legislature floor or in the media. We want to be supportive of any practice that's here in the province. Certainly, there is a willingness to work and understand what supports are needed.

I think that out of respect I really don't want to discuss that on the floor.

SUSAN LEBLANC: While I appreciate the minister's candour or honesty on that, I will say that when the government is talking about the optimization team as a real important tool and the team of engineers that go in and sort of help and support, and then all of a sudden, a clinic can bring on 3,500 patients, it seems to me that it's a good idea. I understand that the minister won't speak about it here, but it seems to me an important question.

Is it a policy of the department that any clinic that says they need you to take a look here is offered this optimization team? If they weren't offered an optimization team, then there's an issue. If they were, that's a whole other story. If they were and they didn't like what the team said, then that's a different story. I get that we don't want to talk about it any more on the floor, but I think that is an important piece of the conversation.

I will move on. This is the last part of my Question No. 1, Mr. Chair. This is still all on emergency care. The last promise that was made following the deaths at the ERs around the New Year was making available a new phone app known as a digital front door that will help people find the right services for their needs and where they are offered.

Can the minister explain a little bit more about this? When will it be available? Is there a budget line attached to this project? What is that budget line?

THE CHAIR: While we wait for the minister, I'll share with the group that at the conclusion of the NDP questioning this hour, we're going to take a six-minute break prior to returning to the Liberal caucus.

MICHELLE THOMPSON: The digital front door has an estimated budget allocation of $3.9 million. That will be happening - again, all of these initiatives, as soon as we can implement them. Work is under way and we will implement as quickly as possible.

SUSAN LEBLANC: Question No. 2: I understand that nurse prescribing is being piloted in some hospital ERs for prescription renewals. I'm wondering if the minister can talk about that. Is that looking at being expanded? What needs to be learned before it become a permanent change?

MICHELLE THOMPSON: There is a cohort and I have a number in my head, but I don't want to say it because I don't know if it's accurate or not. It's a number of individuals.

There is training associated with that, as well as a competency. There's an education component and a competency component. The first cohort has gone through and it's been quite successful, so there will be an expansion of that - absolutely. It's been a great program.

[3:00 p.m.]

SUSAN LEBLANC: Somewhat like the sick note policy that's coming, does the minister have a sense of how many physician hours it might save to have nurses be able to do that prescribing?

MICHELLE THOMPSON: No. I don't know how I would figure that out, but I can ask. I think it would take a lot of math. I think what it will do is it will be, again, efficiency, but it will also be an extension as well of primary care providers that the nurse works with. I think that would be hard to boil to a simple number, but I think it will have a significant impact.

SUSAN LEBLANC: Probably the last question I'll get in this round. The government has closed a number of collaborative emergency centres - my first question is: Why? Are there others that are slated for closure or transition to urgent treatment centres - which ones?

MICHELLE THOMPSON: We'll get that information for hopefully the next hour but, if not, we'll get it to you.

SUSAN LEBLANC: I guess I have to use my time, otherwise it gets forfeited. I could also talk about another question I'm going to ask, in case the minister wants to prepare for the next round, which is: The minister has already talked about the importance of having those transition care centres. Could the minister explain the reasoning behind the purchase of . . .

THE CHAIR: Order. The time for NDP questioning in this round is over. We will offer our minister and her team a six-minute break. You get priority access to the restrooms, because you're the only ones we need for the next start-up again. A six-minute pause, starting now.

[3:02 p.m. The committee recessed.]

[3:08 p.m. The committee reconvened.]

THE CHAIR: Order. I reconvene the Committee on Supply. We are beginning another hour of questioning with the Liberal caucus.

The honourable member for Timberlea-Prospect.

HON. IAIN RANKIN: I was actually going to ask about the Bayers Lake Community Outpatient Centre, which I will, but the discussion around collaborative care interests me, so I just want to maybe ask a few questions on that to start off. Thank you for

all the work that you're doing on behalf of Nova Scotians, and of course the hard-working staff in the largest department that continues to grow.

On collaborative care teams, I wonder if the minister could provide a number of how many collaborative care teams are operating now versus how many were operating when they took over government.

MICHELLE THOMPSON: We'll get that. I don't have that right in front of me in the materials.

IAIN RANKIN: I find that a bit odd. That was something that we were tracking closely when in government. We had targets on how many collaborative care centres we wanted to provide for Nova Scotians. It was definitely a paradigm shift that we needed to embark on because doctors who we were recruiting, especially those newly graduated doctors, wanted to practise in teams. I know the minister is aware of that.

It was a way that we were going to be able to attach more patients to physicians and allied health professionals, and it's in fact how we reduced the list before COVID-19 hit, bringing more nurse practitioners into team-based care, such as the two major clinics near me. In Timberlea we had a nurse practitioner, and in Hatchet Lake we had a nurse practitioner, and they've taken on lots of patients in those clinics. I wonder if there is a target, how many new - I'll ask again - actually I'll start with the question that my colleague asked: How many new collaborative care teams are in place now since they've taken over government? Forget about the baseline, we'll get that at a later date, I guess - how many new ones have come in in the 18 months?

THE CHAIR: Order.

IAIN RANKIN: I'll wait for the number that we can get. It's probably the most important thing to know about when we're looking at trying to attach - if the idea is to continue to grow our primary health care teams and ensure that we have more teams, given that the wait-list continues to climb in unprecedented numbers.

I want to ask: With this budget, how many people do we see are projected to come off the 811 list? What are the projections of actually seeing that list start to go down?

MICHELLE THOMPSON: We do know that there are 137,000 people on the list. What we know is the primary drivers for the registration pretty much consistent across the zone. About 36 per cent of individuals are new to the area; 25 per cent had a provider who moved or closed their practice; 31 per cent had a provider who retired or who has actually given notice, so they continue to have a family practice, but they expect their primary care provider will retire; and 8 per cent of people did not need a provider until now.

Again, to the previous point, it will depend in terms of the clinicians. Each clinician would have a certain number of people they would be able to attach. A physician attaches so many nurse practitioners, and then what the clinic looks like as they extend their practice, so whether they have a family practice nurse or a social worker.

I don't have a number to offer today, but certainly as these practices evolve you will see that the list comes down.

IAIN RANKIN: Will the list decrease in this mandate?

MICHELLE THOMPSON: Yes.

IAIN RANKIN: When will the list decrease beyond where they started from the baseline of 69,000?

MICHELLE THOMPSON: It's a similar question to the one just before the last one. We really do have to look at the teams that we have in place. We also have to look at our physician retirement and our nurse practitioner retirement. Those projections, the work is happening around that right now, but I believe that these teams, these health homes, will be a recruitment effort and also will support in the expansion of practices.

I don't really have a way to project that right now, but I'm very confident that the number will start to come down.

IAIN RANKIN: Will there be fewer Nova Scotians on the 811 list in this mandate in order for them to fix health care?

MICHELLE THOMPSON: I believe that the list will be less, but I also want to talk a little bit about the functionality of the list. I think it's really important that the money that we're investing in that list will be significant for people. There will be individuals who currently need a family practice perhaps or are anticipating a retirement who actually don't have regular needs in terms of being able to access their physician.

What it will help us do is actually triage people so more complex people get care quicker, get the right care from the right provider in the right place, so I think the functionality of that list is significant.

The other thing is when we look at the access, the digital front door that we talk about, it will also allow people to move into the care that they require. Even though I have a family physician for however much longer I will have that person, this opportunity will allow me to know if I can't get an appointment with him that I can go to a pharmacy for my episodic concerns, or I can go to a mobile unit, or I can go to a variety of different areas.

[3:15 p.m.]

Attachment is one thing but it's really essential that we also improve access throughout the province because access is what gets people to present late, et cetera. They are not the same thing - equally as important but access is really essential as well.

IAIN RANKIN: I picked up on two numbers that were given previously - 14 new collaborative care centres and 37 expanded centres are expected. Maybe you could clarify if that's not correct. Would that be in this fiscal year that we expect to have 14 new health homes and 37 expanded? Do we have an estimate of how many Nova Scotians can be attached to primary care through those investments in new or expanded collaborative care centres in the province?

MICHELLE THOMPSON: We expect there will be three new clinics open by the end of this first quarter. The clinics that are open are primary care clinics and they are collaborative family clinics, so we have five new primary care clinics. Primary care clinics are those clinics where individuals who are on the list are referred to primary care clinics to have their care needs met until they are attached permanently to a provider.

There will also be three new collaborative family practice teams. Then we're looking at strengthening the other 37. That strengthening - we'll look at adding resources, working with potentially the optimization team, looking at what capacity those individuals have. Then of course we also have to recruit for individuals who are retiring as well.

It's a bit of a moving target but we certainly are very focused on it. We expect to have three clinics open by the end of the first quarter.

IAIN RANKIN: So just to clarify, three new ones in the first quarter. Is that three out of the 14 projected for the fiscal year? I just heard the 14. That's correct. Okay.

Is one of those primary care clinics set to open as part of - and this is my original thought of asking questions about Bayers Lake, because part of the scope of that project was a collaborative family practice team. I'm wondering if that collaborative family practice team will be opened around the same time that the facility is projected to be open, which is August 2023. Correct me if I'm wrong on that.

MICHELLE THOMPSON: We can confirm the details, but it won't be the first three, because the time of that Bayers Lake completion is on schedule, but it's not going to be open in the first quarter.

IAIN RANKIN: I would appreciate in writing if I could get the numbers between the collaborative care teams, the baseline when the current government took over to what it is today.

Relative to the Bayers Lake Community Outpatient Centre that we announced in 2017, this was a project that was opposed by both the party that's now in power and the NDP, but we're thankful that it continues to go forward. The construction was past the halfway point when the new government came in, so that's good, and they're actually expanding with the transition community building, which is great to see.

The timeline is for August. Things happen fast. It's now mid-March, so we're months away from the projected opening of the Bayers Lake Community Outpatient Centre. There was a wide-ranging scope of practice that was there, lots of visits that had to do with anything, basically, that's considered routine, not urgent care. I just want to take this opportunity to confirm that that scope is still in place, and if it has changed, maybe there's some new additions to the different scopes of practice there, that in fact, a family practice team is still part of the project. Of course, the challenges with the list growing in Central Zone more than any other region, I think, is a good opportunity for a really great location to have a large family practice team that includes nurses and doctors and other allied professionals.

To get to the question, are we still on track with the same scope in this project with the family practice team? I think we should be ready for August, and that's why it's important to get in these questions in the Spring, because we won't be back in the Legislature until the Fall. I would just like the minister to tell me what she can about planning for this facility to open in August and have an operating family practice team so that more Nova Scotians will access - not only in Timberlea-Prospect but all over HRM and perhaps beyond HRM - can come in to a convenient location off Highway No. 102 and Highway No. 103 and access a family practice team.

MICHELLE THOMPSON: The facility, in terms of the information I have, is on track. The substantial completion date is August, with an opening in the Fall. In terms of the services provided, similar: hemodialysis, eye care, diagnostic imaging, medical/surgical clinics, and certainly the primary care clinic is listed there as well. The scope hasn't changed.

IAIN RANKIN: I'm wondering if there's anything that can be shared in terms of recruitment. This is a massive health care facility, over 100,000 square feet. Presumably, you can't just plop in people to start Day 1, on opening day in the Fall. I would think many of these health professionals would be in training or operating in a different facility. I am just concerned that we are making sure we're prepared to open with as many health care professionals as we can, given the challenges around recruitment. We know that this project has been planned since 2017 - six years of construction and then planning, and lots of patients going on to the 811 list, from the South End clinic especially.

I get calls all the time from people, and I'm doing my best to direct them to the successful clinics in Timberlea and other areas, but we need this clinic to be ready. If there's anything that the minister can share in terms of recruitment efforts, I think this is

going to be a state-of-the-art modern facility that we can all celebrate, but we need to staff it. The question is, how are recruitment efforts going at the Bayers Lake Community Outpatient Centre?

MICHELLE THOMPSON: As part of the planning, as the member mentioned, there has been extensive workforce planning, not just for nurses, physicians, et cetera, but also for the support staff that would be working in the facility. I would have to get an update in terms of what is a reallocation in terms of staff.

To your point, it will be a recruitment tool, right? It will be a new, modernized facility, and so it will, without question, draw people to that. I think it speaks to the recruitment overall that we need in the province, so that if there are people who reallocate to that space, which inevitably there will be, that we have the staff coming in behind them to support that.

IAIN RANKIN: Those are all the questions I have. I just want to implore the department and the minister to get ready for that facility. It's going to be, I think, a gem of the whole QEII New Generation project - and to get ready to get the staff moving and take thousands of patients off the list in Central Zone. I look forward to my invite on opening day.

THE SPEAKER: The honourable member for Halifax Atlantic.

BRENDAN MAGUIRE: I want to thank the Minister. We've got a good 40 minutes left, so let's jump right into it. How much will private health care and access to private health care play into this government's health care solutions?

THE CHAIR: The honourable Minister of Health and Wellness.

MICHELLE THOMPSON: We are fully committed to a publicly funded health care system. We are not investing in private health - we don't - I don't know what the question is really. We don't have private - this is all publicly funded that we're talking about today.

BRENDAN MAGUIRE: So, zero dollars from the health care budget will go toward private health care, or private health care procedures, or access to private health care nurses or physicians? We already know that we're paying nurses. So, zero dollars is going to go toward private health care, or any type of private health care, or for-profit procedures, processes, surgeries, operations, staff, blood work - anything like that?

MICHELLE THOMPSON: Anything that we fund is actually through a public-private partnership. As an example, if there are contracts with the Nova Scotia Health Authority or the IWK Health Centre to deliver services that would be through the operating budgets of those facilities.

[3:30 p.m.]

Certainly there will be some support with public-private partnerships, with pharmacies as an example. This is an opportunity to make sure that Nova Scotians have access to the care but there will be no cost at all to individuals who receive these services.

BRENDAN MAGUIRE: Respectfully, that wasn't the question. There is a cost to individuals because the money that is in the budget for health care is actually tax dollars.

The question wasn't will it cost me or individuals, the question is will there be more public-private partnerships within the health care and the Department of Health and Wellness and the Nova Scotia Health Authority to meet some of these benchmarks and some of these mandates that were given to the Minister of Health and Wellness.

I'll give you an example, we just saw the 18-month mark pass and in the minister's mandate letter there were benchmarks that were around surgeries and wait times that were supposed to be achieved. Those were not achieved.

We heard from Karen Oldfield from the NSHA in the Public Accounts Committee that those benchmarks have now been pushed out two more years.

Is there going to be any money - more money - in this current fiscal year and going forward to 2025 on public-private partnerships to reduce wait-lists, to reduce wait times, to provide surgeries, to provide procedures and to provide treatment to Nova Scotians? The question isn't is it going to cost Nova Scotians money out of their pockets, it is: Are Nova Scotia tax dollars going to be used to pay private industries and for-profit organizations?

MICHELLE THOMPSON: What I would say is that the taxpayers' money, in order to deliver health, has been involved in public-private partnerships for a number of years. Certainly we won't leave any stone unturned. If we can provide care faster and use public-private partnerships to deliver care while we optimize and continue to optimize our publicly funded system, we will do that.

We want to make sure that we get people the care they require, and we will leverage the relationships that have been in place for a number of years such as Scotia Surgery. Those contracts have been in place for 10 years or more.

We will utilize every available asset in the province using publicly funded money to support people in getting the care they require.

BRENDAN MAGUIRE: Does the minister foresee more publicly funded money being spent in the next two to three years under her government - more money going to public-private partnerships and going to for-profit health care providers?

Is the money that is being spent today, will that increase, decrease, or stay the same, in her opinion?

MICHELLE THOMPSON: Again, I would say that we will utilize and leverage the assets that we have. We need to maximize our publicly funded system and it will take us some time to do that. I anticipate that there will be waxing and waning of the services that we require, based on the demand of the services that we need.

As an example, there will probably be less money in terms of our public-private partnership related to vaccination, given the place where we are in terms of this mass vaccination process that we had over the past two years. That public-private partnership may look different this year than it did in the previous two years.

We may need to leverage some of our surgical private partnerships in order to make sure that people have access to things like cataract surgeries and arthroscopic knee surgeries, et cetera. We're going to look at all the different assets in the province. We're going to leverage that asset and that capability where we can, and make sure that Nova Scotians get the care they need when they need it.

BRENDAN MAGUIRE: I'll take that as yes, so we'll move on.

First of all, has there been any preliminary discussion within her department on increasing access to public-private, for-profit procedures? Is there any ongoing discussion about strategy or short-term, long-term, medium-term planning that includes for-profit organizations, and has there been any contact, any discussion, or any preliminary feelers put out to anyone within this jurisdiction or outside this jurisdiction that are for-profit health care providers?

MICHELLE THOMPSON: We want to leverage, again, every asset that we have. Similarly, if there is a treatment or a procedure that's not available here but medically insurable and we need to go outside the province, then we would consider that in special instances. Again, we fully expect to leverage every asset in the province. We want to use our own assets first, and if we can have public-private partnerships that shorten the wait times and provide better access to care, then we are willing to do that. That will be ongoing work that happens, yes.

BRENDAN MAGUIRE: Something that's come up over and over during the last 18 months to two years with the skyrocketing of the Need a Family Practice Registry is storage of medical records. People are being charged $200, $300, $400 to store their medical records. This is the charge they're being handed over by the doctors. My question is: If the government that was elected on health care cannot provide access to a family doctor to those 140,000 Nova Scotians, and climbing, can they at least cover the cost to store the medical records?

Does the minister think it's fair that one day you get a call that you no longer have your family doctor, and then within 24 hours you get a bill for $300? Will the minister advocate for those 140,000-and-climbing Nova Scotians who are being charged $300-plus to store their records, and will she assure them that that money will be covered by the Department of Health and Wellness, the Nova Scotia Health Authority, until they receive a family doctor or access to primary care?

MICHELLE THOMPSON: In hospital, those are stored - they are owned, I guess, by the hospital. The issue is with physicians' offices. Many of them are independent practitioners, and how they manage the storage of records is actually part of their standard of practice code of ethics through the College of Physicians and Surgeons of Nova Scotia. That's one of the things that's really important, as we try to attract new physicians, is that we move to electronic medical records so that we don't have these charts locked away in place anywhere.

I think if people know that their physicians are leaving, they should be able to ask for their charts in order to have them, because it is their medical information. There are standards of practice and a code of ethics that govern how records are stored in private offices. I will check on what happens with electronic medical records in terms of how people have access to that.

BRENDAN MAGUIRE: I'm just trying to get an answer to this specific question because it's costing people a lot of money. When my doctor left, I was charged a fee to get my records by the medical clinic. They gave me a USB stick with my medical records on it, or I could choose to store my medical records for $300. One was $80, and one was $300. That's the cost. I think one of the primary responsibilities of government is to provide health care to Nova Scotians. We can all agree to that, obviously - not the easiest thing to do. I understand that these are independent contractors - and I understand that doctors store their records in all different ways, but Nova Scotians should not be faced with a bill at one of the worst health care moments of their life, when they lose their family doctor.

Will the minister work with Nova Scotians and cover the cost of getting their medical records - which can be upwards to $80 to $100 - or storing their medical records, which is over $300? One of the ideas that you could do is - obviously doctors bill the medical system - could they not create a billing ID where they charge Nova Scotia Health Authority or the Department of Health and Wellness the amount for storage? I don't think it's fair that 137,000, and climbing, Nova Scotians now just had to pay money for their health care records. Will the minister commit today to looking into it and finding a solution so it doesn't cost Nova Scotians money out of their own pocket?

MICHELLE THOMPSON: Again, I certainly don't mind looking into it. It does sit with the College of Physicians and Surgeons. That's the first part. We need to speak with the college and understand what the rules are for physicians and what some of the solutions

may be for them. It's another opportunity for us to discuss with Doctors Nova Scotia, so I certainly will look into it.

BRENDAN MAGUIRE: One of the things that the minister had mentioned earlier was about inclusion and diversity in the health care system. We all can agree that that's extremely important. We have a very diverse population, obviously. Does the minister agree, or does she think that that diversity is reflected in our current health care system?

MICHELLE THOMPSON: We have heard again and again that we need to increase representation from equity seeking individuals and communities throughout the province. Certainly we want to be able to do that. We had a community conversation in Cherry Brook, and we were able to speak with a number of individuals in the community who had some ideas around increasing representation. We also have a very good relationship with Tajikeimɨk, which is First Nations health, working with the health directors and the executive director in terms of supporting designated spaces in university. Certainly the Health Association of African Canadians has been excellent. I know that there's a cohort going through Dalhousie University right now of social workers of African descent.

[3:45 p.m.]

There are a couple of things. We need to increase representation. Certainly through the work that's happening with immigration, I think that we will succeed. We also need to work with our historic communities to understand how best to create pathways across government to ensure that there are opportunities, and also that their communities are reflected in the health care system. It really is around building relationships, seeking opportunities, and working with HAAC, who have been wonderful partners, as well as Tajikeimɨk. We are also working with the Immigrant Services Association of Nova Scotia to better understand the individuals who have come through their offices who have a medical background. And we'll continue to hear from, not just our newcomer communities, but also historic communities about how we can do better.

BRENDAN MAGUIRE: I would argue that we had a lot of diversity on the board. We had representation from the African Nova Scotian community, we had representation from the Indigenous community. We had some world-renowned individuals who, when fired, were immediately picked up throughout different jurisdictions.

And that board was replaced - the very first action of this government was to fire the individuals on the Nova Scotia Health Authority board, who had just received recognition across Canada for their response to the COVID-19 pandemic. Why did this government, why did this minister think it was appropriate to fire African Nova Scotian representation, Indigenous representation, and replace it with a single person who had no health care expertise at all and no relationships in those communities, as we heard?

MICHELLE THOMPSON: The entire board absolutely was dismissed when we came in. We have a health leadership team that consists of four individuals: the Deputy Minister Lagassé, Dr. Kevin Orrell, CEO Karen Oldfield, and Janet Davidson, who was appointed as administrator. We did that because we felt that we needed a very agile decision-making team. We felt that we needed to move quickly.

We continue to work in community. There is some very meaningful work happening with the Department of Health and Wellness, as well as the Nova Scotia Health Authority, doing community engagement sessions throughout the province, speaking with communities, working with associations that represent equity-seeking communities around health care.

We very much value our relationship with HAAC. We certainly hear directly from the health directors and meet with them regularly to understand the needs of those communities. We continue to do that work. We know that at some point a new governing structure will need to go into place and we are looking at the options for that now, but we will continue with this health leadership team for the foreseeable future.

BRENDAN MAGUIRE: What I heard was the individuals you replaced - African Nova Scotians and Indigenous individuals - who were well-respected in their communities, who were already in their communities doing work with COVID-19 and building trust in those communities, and you replaced them with a white person, white person, white person, white person - people with no connections to those communities.

I just would like to know, because we never got a firm answer on why those individuals - what was the reasoning behind those individuals being let go? When we know that they had just received credit right across this country, and through the United States, for their work on COVID-19.

Two questions: Why were they fired? And who ultimately decided they were fired? Did you come into that position and say they have to go? Was that decision made at the Premier's office? Was it a collaborative decision? Who made the decision, and what reason were they given for being let go?

MICHELLE THOMPSON: When we formed government, as I said just briefly before, we needed a new decision-making team. We needed to be agile. I spoke with every one of the board members and told them what was happening and explained that we would be seeking a different government structure at a later time.

We continue to have the health leadership team in place. It's no disrespect. We very much value the work of the board. This was really to allow us to make decisions in a quicker fashion in order to move more quickly - no disrespect to any of the individuals who were on that board. We know they contributed, and we will continue to look at the governing structure moving forward.

BRENDAN MAGUIRE: I guess I'm a little confused because we had the best roll-out, the quickest roll-out, the most efficient roll-out when it came to COVID-19, which was the predominant health care issue for the last government. And yet the minister is now saying that these individuals were not agile enough? That they didn't react quick enough?

I'm a little confused because everybody inside the province and everybody outside of the province celebrated how great of a job these individuals did. And yet within a week of being hired, the minister saw fit and said that they weren't working fast enough.

So, again, there were a few questions that were not answered there. One, I guess what we can tell them is that you're not agile enough. Two, you did not answer who ultimately made the decision to let the board go. Was it you? Was it the Premier? Or at the time, the individual working with the Premier was Karen Oldfield, to roll out how all this stuff looked.

So, was Ms. Oldfield involved in that decision-making process? Did you make that decision? Did the Premier make that decision? And was the job for CEO, was it advertised? How did Ms. Oldfield fall into that position?

THE SPEAKER: Before I recognize the minister, I'd like to advise the member for Halifax Atlantic that that's the third time you've asked a very, very similar question. And I'd like you to not dispute or interrupt the Chair. The rules clearly state that irrelevance and repetition is not accepted. I'd also like to remind the member not to interrupt the Chair. And now it pleases me - order. That is a warning, Mr. Maguire.

The honourable Minister of Health and Wellness.

MICHELLE THOMPSON: Again, the decision was made after we formed government that we would dismiss the entire board, and that we would have an agile decision-making team. We thanked the individuals who were on the board for their service. We talked to them - I talked to them directly. That decision was made once we formed government, and we have committed to re-evaluating the structure of the board at a later date.

BRENDAN MAGUIRE: Who was involved? Which individuals were involved in that decision-making process to remove and dismiss those board members? Which individuals? Who was part of that decision-making process? That's what I'm trying to ask.

Were you involved in that? Was the Premier involved in that? Was staff involved in that? Was Ms. Oldfield involved in that? Which group made that decision? We know that it has to be something you would know because it directly impacted your department. It is the most senior management in your department. Who exactly was involved in that decision? Who made that decision? Who first approached you about this decision?

MICHELLE THOMPSON: I would say to the member that all new governments make decisions when they come into government to - and that's the decision that was made as we transitioned to government. We needed to be nimble, and we felt that with health care as one of the most pressing issues, if not the most pressing issue for Nova Scotians, that this was a decision that we would undertake as government.

BRENDAN MAGUIRE: Again, I will ask - and you're going to give me the same answer, which is a non-answer - were you directly involved in that decision-making? Was Karen Oldfield involved in that decision-making? Were there any conversations between yourself and Karen Oldfield? Were there any conversations between Karen Oldfield, yourself, and the Premier, or any of the Premier's staff, that you had around this? - a simple question.

MICHELLE THOMPSON: And the simple answer is that all new governments make decisions when they come in. We transition in as government. We make decisions as government and, again, we were committed to looking at what the future of a board governance structure would look like. At the time this - and continues this health leadership team will be in place for the foreseeable future.

BRENDAN MAGUIRE: Does the minister not see the conflict of interest here, where the individual in charge, or helping to make these decisions, appointed themselves to this position? The individual who was responsible - and part of the transition team for the Premier of Nova Scotia at the time - helped dissolve a board that was world-class, had diversity and was nimble - even though the minister wants to claim that they were not - and replace the board with herself. Does the minister not see that?

There is a non-answer coming here, so we're going to assume that someone who was part of the transition team was part of those discussions. I'm trying to figure out, to your knowledge, was Ms. Oldfield part of the decision to dissolve the Nova Scotia Health Authority board, yes or no?

MICHELLE THOMPSON: The current board administrator is, in fact, Janet Davidson. She would be familiar because she was actually a former CEO of the Nova Scotia Health Authority, and because of Janet's long-standing experience - she is a thought leader not only nationally but internationally. Janet is actually the administrator and serves as the board, in place of the board of directors, for the Nova Scotia Health Authority.

BRENDAN MAGUIRE: Again, Mr. Chair, the question is not being answered. The question was, and I repeat - I don't know how to say it any easier - was Ms. Oldfield involved with the dismissal of and the decision-making process around the dismissal of the Nova Scotia Health Authority board? Not anyone else, that one individual, Karen Oldfield - did she have any discussions with you, with the Premier, to your knowledge? Any discussions that you were involved with? Was she involved with the dismissal of the Nova Scotia Health Authority?

MICHELLE THOMPSON: Again, I will simply say that when we transitioned in as government, in my role, discussions were had that are private. We made the decision that we would dismiss the board and that we would appoint an administrator to serve as the function of the board for the immediate future. We, again, are committed to looking at board structure but we haven't landed on what that looks like yet.

BRENDAN MAGUIRE: The minister said that these discussions are private. Does she not think that an individual in charge of hiring and dismissing the board and then replacing them with herself - does she think that should be privately kept from the public? That somebody who helped get the Premier elected, who is a known political operative, advised the Minister of Health and Wellness to dismiss the board and replace the non-partisan, non-political board with somebody who is partisan and political? Does she think that information - if it happened - should be kept private and away from the public eye?

[4:00 p.m.]

MICHELLE THOMPSON: As a new government transitioned in, a health care leadership team was appointed. It consisted of the deputy minister, the CEO of the Nova Scotia Health Authority, a board administrator, and the CEO of the Office of Healthcare Professionals Recruitment. That was the decision that was made.

BRENDAN MAGUIRE: I'm almost done with this line of questioning. Sorry, I didn't hear - my hearing is actually not the best, so I apologize. Did you say that the transition team - the current CEO of the Nova Scotia Health Authority was on the transition team? Was she on the transition team? The minister doesn't know who was part of the transition team and who helped make the decisions to appoint senior management in the department that she runs?

MICHELLE THOMPSON: I can't speak to any of the discussions of the transition team. What I can say, for the innumerable number of times I have said it, is that when government transitioned in, a health leadership team was appointed, and it consisted of the CEO of the Nova Scotia Health Authority and a board administrator. It consisted of the CEO of the Office of Health Professionals Recruitment, and it consisted of the deputy minister. Those appointments were made and, again, we are very grateful for the work of the board. I was able to have the opportunity to speak to each of the individual board members and let them know that we appreciated their work and that we were moving forward with a different leadership structure.

BRENDAN MAGUIRE: I will have this printed off, and I will table it, just so you know. The transition team chair - we don't need to go through every single member - Karen Oldfield was part of the transition team who appointed herself to the head of the Nova Scotia Health Authority, and this was a news release on August 18, 2021, labelled "Incoming Premier Tim Houston Names Transition Team." Karen Oldfield was part of the

transition team, a transition team that appointed and fired - first they dismissed the Nova Scotia Health Authority, and then they appointed a new head of the Nova Scotia Health Authority. Does the minister not see that as a conflict of interest?

MICHELLE THOMPSON: The interim CEO was appointed, as was the current board chair. The board chair was appointed as the interim CEO by the former government. Janet Davidson served as the interim CEO of Nova Scotia Health for a period of time, is my understanding. These decisions are made all the time. Again, we have a health leadership team that is stewarding our health care system, and we will continue with this model for the foreseeable future.

BRENDAN MAGUIRE: The minister keeps saying the foreseeable future. When Ms. Oldfield first appointed herself as head of the Nova Scotia Health Authority, it was under a temporary position, right? This was a transitional period for the government. They had just fired some of the most qualified health officials in the world and replaced them with a singular person. My question to the minister is - she keeps saying for the foreseeable future. The future has now been two years, so that's the past. When will there be a new board that is reflective of the diversity and culture of Nova Scotia?

MICHELLE THOMPSON: Just to be clear, the board was replaced with the board administrator, who is Janet Davidson. Janet Davidson acts as the board administrator, which is a representation of the board - one person.

We are currently looking at a variety of different models to best understand what the governance structure - we absolutely want to make sure it's representative. We want to make sure that it's meaningful. That's not to say that work has not been happening around the health equity framework. There have been a number of different consultations. The health equity framework will be tabled this Summer. There has been a lot of work strengthening our relationships in equity-seeking communities across the province. We are very committed to that. We speak with HAAC on a regular basis. We meet with Tajikeimik on a regular basis. We are working with ISANS to better understand the newcomer population and expanding health care services to them. We continue to work, and we will continue to work because we want representation not only in our system of health care providers but also to make sure that the services we provide are safe and culturally appropriate.

BRENDAN MAGUIRE: We're almost off this topic. To your knowledge, has Ms. Oldfield ever attended a partisan PC political function like an AGM or any type of partisan function to do with the Nova Scotia Progressive Conservative Party?

THE CHAIR: Order. On the advice of the Clerk, that line of questioning does fall beyond the scope of things that are within Minister Thompson's purview in her capacity as Minister of Health and Wellness.

BRENDAN MAGUIRE: When will Ms. Oldfield be replaced with a permanent position, an individual? We know that this is a temporary assignment for Ms. Oldfield. She's been in it for two years now. Can you tell us when that position will be filled, and what is the current salary for Ms. Oldfield annually?

MICHELLE THOMPSON: So, I would say that the current health leadership team will be in place for the foreseeable future up to and including until the end of this mandate.

BRENDAN MAGUIRE: What's the salary?

MICHELLE THOMPSON: I don't know, I'll have to check.

BRENDAN MAGUIRE: If the minister could table the salary, the annual salary, and if there's been any salary increases, that would be great. I wish I could get a temporary position that lasts for the foreseeable future, but here we are.

So again, we're going to look at facts. Facts are, at one point, we had the most diverse health board and leadership in the country that gave the best response to COVID-19. Before COVID-19, no matter what the government wants to say, there were months where the Need a Family Practice Registry was decreasing. There were massive structural investments, which this government has patted themselves on the back for, which is that they're up there putting hard hats on in Cape Breton, they're in Bayers Lake. We see the QEII redevelopment.

All these things were happening, and the health care outcomes were moving in a positive direction. This government got in, within a week threw a grenade in it, blew it all up, had somebody self-appoint themselves as the head of the Nova Scotia Health Authority, refuses to keep numbers and facts. And every single statistic, and every single number in the health care system has gotten worse. The wait-list has gotten worse. The wait-list for family doctors has gotten worse. Surgeon wait times have gotten worse. Offload times are horrendous. There are more ER closures than ever before. There's a correlation.

THE CHAIR: The time for that round of Liberal questioning has expired. We'll turn now to the NDP. I believe there is 37 minutes on the clock.

The honourable member for Dartmouth North.

SUSAN LEBLANC: Well, thank you, I've been upgraded to an honourable member so that's good. So, where we left off, Mr. New Chair, is that I had asked the minister about the closure of a number of collaborative emergency centres. I'm wondering why they were closed, are there others slated for closure, are there others slated for transitioning to urgent treatment centres, and which ones?

MICHELLE THOMPSON: Welcome. Just to the member's question, we haven't closed any CECs. New Waterford was closed for renovations. But, Pugwash, Parrsboro, Tatamagouche, and Annapolis Royal, have moved to urgent treatment centres. So, the care it provided continues there. North Sydney, when it's built, will also function as an urgent treatment centre.

SUSAN LEBLANC: Thanks. Sorry. I hit the wrong response there. My question is - oh yes. Forgive my ignorance, but are there any other centres that still exist as CECs that are going to be transitioned, or has the minister named them all now?

MICHELLE THOMPSON: There are two CECs, Twin Oaks and Middle Musquodoboit and they're just in early days of community conversations to understand the model of care. Whether it would be continued as that or urgent treatment centres.

SUSAN LEBLANC: The minister just mentioned that care continues, but my understanding is that the care is actually quite different in the model of a CEC to an urgent treatment centre. Could the minister explain what level - so the ones that the minister mentioned, Pugwash, Parrsboro, what kind of care is available to those communities at those centres?

MICHELLE THOMPSON: The CECs would be partially staffed by physicians, but there would be periods of time where they would be staffed by nurses and advanced care paramedics. The urgent treatment centres are staffed by physicians as well as nursing staff to support them.

So, urgent treatment centres are not life-threatening conditions but unexpected. So, a variety of different things. This model is based on, when we look at the data, what generally people present to emergency rooms with that are low acuity. So, a lot of episodic complaints, mild abdominal pain, things like that. So that they can be worked up by a primary care provider, a physician, and then referred on to other sources of care if required, or treated and released.

SUSAN LEBLANC: Are there differences in the operating hours? In general. I know that there are times when centres have to close because of staffing shortages or whatever, but in a perfect world, what are the differences in the way that they are open?

MICHELLE THOMPSON: Staffing models dictate the amount of time that the facilities are open, and also staff availability. So, urgent treatment centres generally have predictable and stable hours. That varies, depending on the community. CECs, when there are staff available, would be open 24/7.

SUSAN LEBLANC: Okay, but someone in an emergency situation can present at a CEC and get treated with emergency medicine. I want to make sure I'm understanding this. But at an urgent treatment centre, if someone is in an emergency, can they go to the urgent

treatment centre and get care, or do they need to call 911 and go to a regional emergency department, or a bigger emergency department?

So, I guess I just want to understand that difference. That's my first question.

MICHELLE THOMPSON: Not a short answer, so, a couple of things. Urgent treatment centres would be staffed by a physician, and they would be for unexpected, probably in some ways, episodic care, like something that people were not predicting, so abdominal pain, as an example, would be something.

[4:15 p.m.]

People are taken now, because of our emergency room system, because of the care that we provide and the varying levels of emergency room care, as well as the varying levels of physicians, we actually have protocols that dictate where people go and when. I use the example all the time of a stroke. If people are experiencing symptoms of a stroke, they will absolutely bypass every emergency room until they get to a regional site where they can have a diagnostic CT scan. So the CT scan decides whether or not you get medication to dissolve a clot or whether or not you come to Halifax because you have a bleed because there's two reasons that you can have a stroke.

In fact, regardless of how many were open, health services would bypass every hospital in order to get to a CT scan because there's a very defined window of time. It's a little bit dependent on why people call. Similarly with trauma, if we have somebody who is experiencing significant trauma, there are trauma designations throughout our emergency rooms.

At a CEC if they were to come and get care, they would receive stabilizing emergency care, sometimes from a physician but depending on the hours of the day, they would actually see a nurse and an advanced care paramedic. In our system now, our Emergency Health Services, an advanced care paramedic and primary care paramedic in the back of an ambulance now have access to a physician in the EHS Medical Communications Centre 24 hours a day, seven days a week. Based on that team, there's actually a trifecta - there's a registered nurse, there's a critical care paramedic, and there's a physician. When 911 is called, this trifecta supports the reason the person has called and they actually help decide where that person goes.

It's really about a status plan, that is what we're working towards all the time. We have the medical coms, these are emergency room physicians who work in the communications centre, who support paramedics and actually will support patients in the field as well, depending on what's happening, in order to divert folks to the type of care they require, so urgent treatment centres in some places.

We are understanding what the services are. There may be people who have low acuity who are able to present there. I think about some communities as an example that maybe you and I couldn't go with a low acuity issue from an ambulance but people living in long-term care could, as an example.

We are working out the model in terms of the support. Urgent treatment centres are working very well. People are very pleased with the service, it's meeting the needs of the communities they are in but I think there is an opportunity to understand how to better serve the communities. So for low acuity, EHS transfers potentially but not all right now.

SUSAN LEBLANC: I'd like to move on to the purchase of the Cresco hotel. I alluded to this at the end of the last session, too. I understand the need and usefulness of stepdown housing, as it were. We discussed that in the last session but I'm wondering about this particular purchase, especially given the report that it wasn't really appropriate, according to the experts, for the use that the government wanted to buy it for.

I'm wondering if the minister can explain the reasoning behind the purchase and is there a cost estimate to renovate it into what is actually needed?

MICHELLE THOMPSON: This is a complex file. I can speak to the model of care and the expectation of the opportunity that helps us in terms of outflow and the service provision and things like that. In terms of the actual structure itself, those are questions that would be better left for Public Works.

SUSAN LEBLANC: Okay, in case the minister thought I had already asked my primary care questions, now I am going to ask my primary care questions. Some of them may be repeats but I don't think so.

Family health teams: other provinces have announced plans and are in various stages of rolling out family health team models. Can the minister tell us exactly what is in the budget for the expansion of collaborative models - not just what's in the budget for primary care but in the expansion of the collaborative models?

MICHELLE THOMPSON: In the bundle of the primary health care money, I would say $18 million, $20 million of the $31 million would be directed to them.

SUSAN LEBLANC: British Columbia has overhauled its fee-for-service system in order to incentivize collaborative primary care models. I'm wondering if we are looking at an overhaul of ours.

MICHELLE THOMPSON: Again, there's never a straightforward answer. What I will say is B.C. had predominantly a fee-for-service environment, and actually the model that they've implemented is an APP, alternative payment plan environment. In Nova Scotia we have three models: we have fee-for-service, we have a portion of our physicians

who work there, in terms of primary care, who work in that model; we have alternative payment plans, these are our salaried physicians who work throughout the province; and we also have a new and emerging model called blended capitation, which is actually a blend of the both of those. We also have our C/AFP physicians, who are academic physicians as well.

We continue to look at the models. There are a number of models. We just assume that there's a certain age range of individuals, that newer physicians like APPs, and for the most part they do, but I know that there are a number of more junior or mid-career physicians who continue with fee-for-service. I think what's really unique about us in Nova Scotia is that in fact we offer choice, which I think is one of the reasons why we've been successful with recruitment and retention of physicians.

We hear people say, get rid of fee-for-service altogether, but in fact, there are a number of physicians who quite like fee-for-service. It fits with the way they work, it fits with their value system, they like it, they can anticipate, things like that. What we hear is that we really do need to be very flexible with physicians, so these options are very important. I think the other piece is too, fee-for-service, looking at as we move into these models, really understanding accountability, understanding when we have salaried physicians, supporting them, understanding what it is that they want, making sure that there are accountability structures in place for them.

The work with Doctors Nova Scotia is ongoing. We're in negotiations now, and certainly family practice folks have been very helpful at the table. We're interested in hearing more from them as the negotiations continue.

SUSAN LEBLANC: Okay, a couple of things from that. I guess I wonder where the government sits - I understand that flexibility is important. We don't want to - especially with our existing physicians - we don't want to alienate them and say now you have to change after doing something 30 years one way and five years the next way or whatever. I get that, but I also understand that we have a value and we're investing heavily in the collaborative model, which would suggest, I think, in a true collaborative model, definitely an APP works better than a fee-for-service model, if we're talking about a newly set-up practice. I can't really kind of square that circle. The other thing is that we don't seem to be doing a great job of retaining our new physicians, at least of late - the new recruits. There has been a number who have come and left again, and of recruiting new ones. I just want to know, where is this model or the change of model in the conversation when it comes to retention and recruitment?

MICHELLE THOMPSON: We actually are retaining roughly around 70 per cent of the residents who are in the province. I think that speaks to the model of the residence. That's across a variety of different things, which I think is important, and it's up significantly. I don't have a baseline year-over-year, but it is up significantly. I think the model of payment is really an essential part of that.

I also will say that in the last number of months, through the Welcome Collaborative, which is predominantly run by the College of Physicians and Surgeons of Nova Scotia, it's actually looking at a different way. Physicians who came from outside of the country, internationally educated graduates - our system is very different. Every system has its own uniqueness, and I think some of them particularly who were coming into communities felt overwhelmed. There is a new program that has started with the Nova Scotia Health Authority, the Department of Health and Wellness, a variety of people under the umbrella of the college, to do orientation with these new physicians to help support them and also kind of connect them, show them the different connections. If they are billing, wondering how to navigate the system, we really do need to mentor and support them.

[4:30 p.m.]

There has been a lot of work done. So retention of our residents is significant, much higher than it has been in the past but also just the work and talking to physicians and understanding why they're leaving. Some people will come for a period of time, knowing full well that they're going to go. I also think that that's why the Atlantic licence is such a great tool for us in the province. It provides economic mobility, and if there are physicians - because some physicians do simply want to practise. I met one physician who works in a primary care clinic, an internationally educated graduate, licensed in Nova Scotia, who does not want to take on a practice but is willing to work in a primary care clinic, which is a very similar environment but not with the same responsibilities because that physician does want to be able to experience different places, although that physician has been here for an extended period of time. The economic mobility that that Atlantic licence will give us will allow physicians to move around if locums are of interest to them. I also think it's going to help us share the talent as well. It's going to allow more mobility and competency throughout the Atlantic region.

You know, those are some of the things that we've done to try and make this practice environment more appealing to individuals and feeling that we've had success. And doing exit interviews. Understanding when people leave, why, and how we can improve for individuals. We would prefer to catch them before they go. But certainly there's been a lot of work around understanding, if physicians only stay for a period of time, why they're leaving.

SUSAN LEBLANC: So, 70 per cent of residents are being retained, can the minister tell us how many primary care residents are being retained each year and the percentage of the primary care residents that are being retained. Because presumably 70 per cent of residents, that's across all of the residencies. So, it might not have any real bearing on how many primary care physicians are staying.

MICHELLE THOMPSON: So, I'd have to check that specific sub-specialty to understand that. I just wanted to say that this week we actually had the Canadian Resident

Matching Service match. So, we have introduced 10 new residency seats for Nova Scotians who were internationally educated medical graduates. That CaRMS match happened on Wednesday, so we'll have 10 additional folks with connections or from Nova Scotia who will have matched into that program which is really exciting.

SUSAN LEBLANC: There's been a lot of different information from government about what the approach is to doctors who are looking to transition their practice, either because of retirement or because they're burnt out and cannot practise family medicine any longer.

The Premier says that all doctors will be supported but multiple doctors have gone public saying that when they ask for help, they can't reach an agreement with the Nova Scotia Health Authority. Either they can't find a doctor to replace them, or they cannot have a nurse funded to work in their clinic unless they agree to increase their patient roster.

We've talked a little bit about this already, but I'm wondering if the minister can speak any more to this. The question has been asked several times this week already, which is, why not help the clinics that are open and the doctors who are practising to stay practising so we don't lose those doctors and add more people to the wait-list, and keep patients attached no matter the cost.

We've heard from this government that at all costs, or no matter the cost, so again I'm trying to square the circle. No matter the cost, whatever the cost, but how come four doctors can't get a nurse and still not have to take on patients? You know what I mean?

MICHELLE THOMPSON: We do want to be supportive of practices, and so recently there was a hotline set up so that physicians can phone in. When we add additional resources, we do need to look at attachment, right? Sometimes it's a replacement physician, and so if there's an opportunity - we need to look at a number of reasons.

If there's a practice and we need replacement physicians - so if somebody is transitioning out and we need a new person to come in, we really need to try and match that person with the practice. So, some practices that perhaps were in existence for extended periods of time, they aren't always - they may not be as attractive to a new graduate, as an example.

So, perhaps there are still people - and I have no idea about their practices, so this isn't specific - perhaps there is no collaborative team there, or perhaps they still have paper charts, there's a variety of different reasons. For that reason, sometimes it's hard to recruit into an existing practice, as an example. That's why we have the practice optimization team. That's why we want to offer support.

It is really important that we know somebody is transitioning out of their practice but it also is important that if we can't add resources to see the same amount of people - so

there is an expectation if we're going to add resources that we're going to do optimization of that practice. We're going to look at the practice that's in front of us. Where are the opportunities for efficiencies, what are the things we can do to support the practice and care for the patients who are there? If we add a nurse practitioner to that practice, as an example, the expectation is that that nurse practitioner would take on an extra panel.

If we have a family practice nurse who is going to look after a certain variety of things, that should in fact open the opportunity for people to have access to care. Those are things we have to work out with those practices, which is why the discussion is so important in advance.

SUSAN LEBLANC: There's a couple of things there. First of all, I know that when a Nova Scotia Health Authority new family practice opens, or I'll use the example of the North Preston community health and wellness centre, that's a turnkey Nova Scotia Health Authority home, right? That is the definition of what that is, in my understanding. When those physicians were recruited there, presumably, they weren't asked to take on 4,000 people in their panel, or 3,500 people in their panel. My understanding is that those salaried positions, the panels are less because it doesn't make any sense to be working 18 hours a day treating patients or seeing patients for only five minutes at a time. The care is not going to be as good, generally - a large generalization there. If doctors can spend more time with people, then presumably the care is going to be effective, at least.

If a clinic has had historically like 70-year-old doctors who have had 3,500 patients for their whole life, doesn't it make sense that if you are replacing that doctor, if that doctor wants to retire and you are bringing on a new doctor, to actually change the model so that the new doctor is not saddled with the same stress and difficulties that the retiring doctors are facing? I just don't understand it.

We know that it's not good to work 18 hours a day or to work seven days a week or to feel like I can't go on vacation because everyone is going to fall apart around me. That's not a good way to live; it's unhealthy.

Getting back to this whole thing about bringing on new patients, my understanding is also bringing in the other part of this, which is that since people have a very hard time accessing specialists now, we're hearing from family physicians or primary care providers that they are having to do a lot more. Their patients are sicker because they are not able to see the specialist. There's a whole bunch of stuff going on there, so does it not make sense to stop, to be flexible - we've heard the word flexible several times - why can we not be flexible with either spreading out a whole bunch of patients over five people so that everyone is working a little bit less, rather than adding more people and then bringing someone in? It's a zero-sum game, as far as I can tell, which doesn't help alleviate any stress or difficulty on behalf of the providers.

THE CHAIR: Before I recognize the minister, I just want to clarify the clinic that the member referenced, I believe it's the North Preston Community Centre. I just wanted to make sure that it was properly named here in the House.

MICHELLE THOMPSON: There's a lot in there. As an example, if we have a family practice that we are not able to recruit to, so to get the actual replacement physician, to some degree we need to work with the outgoing physician to understand what role they want to play transferring out of practice. If that is not an appealing practice to a new individual, we may actually want to look at the practice environment for the new physician and then attach patients to them - see what I mean? We may just simply find a practice environment where that person wants to work and shift the patients as opposed to trying to pound a round peg into a square hole, or whatever that saying is, right? There is a variety of different things. We have 137,000 people on the list, so we have to be very focused on investments that are going to add to attachment and to access.

Currently the physician line in the budget is significant. It is roughly around $1 billion so if we triple the number of physicians in this province and never actually triple the amount of attachment or access that we try to do, it would be $3 billion for exactly the same amount of care. We have to be really mindful and innovative which is why those health homes are such an important part for us. We need to expand the scope making sure that we are utilizing individuals to the best of their ability and build those teams.

It is going to take a while and that is why we are saying if physicians could let us know through that hotline to give us a couple of years to look at what the practice environment is, look at what perhaps we can set up, look at residents, look at return to service and try and match them. It is not as easy as it sounds. It really is important that we - while we want to support the people in practice and the people who are already attached, we also have to be mindful that every investment has to lead to either more access or more attachment and we can do that in really innovative ways and particularly in team-based care.

SUSAN LEBLANC: Just for the record, it doesn't sound easy. The minister said it is not as easy as it sounds. It doesn't actually sound easy; it sounds very complicated.

I know that my colleague from the Liberal party asked this question but I didn't get to hear the answer. So, the government cancelled the family doctor incentive for the Central Zone. My first question is why and is there a plan to reinstate it?

MICHELLE THOMPSON: The answer is the same - oh, you didn't hear it? Okay. When we formed government what we realized is that anyone who received the incentive - 60 per cent of people who received the incentives settled in HRM and as a result we had a significant gap in terms of our rural access to care - rural settlement. In the Office of Healthcare Professionals Recruitment, the suggestion from them - from the CEO at the time - was that we should reconsider and make sure that there was a rural incentive to

support access throughout the province which is what we did. Here we are. We continue to look.

There has been population growth and there have also been a number of retirements. As I've said before, we are at the table with Doctors Nova Scotia. We are constantly reviewing ways in which we can support our workforce as recently as - not just physicians but nurses and all of the other health care professionals that we need because we are so - you know, nobody prepared for a day that we all knew was coming. We are open to it. We did need to spread that around. Sixty per cent of recruits coming into one area - we had to spread that around. We are very committed to making sure that everyone has access to primary care and so we will continue to re-evaluate those as we move forward.

SUSAN LEBLANC: It makes sense. Sixty per cent versus fifty. There are a lot of people in Central Zone. At this point, more than half of the population of the province so it makes sense that that many people were - I mean, even I know that - as my son would say. No offence, but I have my neighbour in middle Dartmouth - their family doctor was in Mineville. No offence, Mr. Chair. You represent Mineville don't you? Oh. Sorry. In any case, they were right in the middle of the city but were travelling quite a distance. Listen, I'm just going to babble for a second here.

[4:45 p.m.]

I want to ask about the mobile clinics that are operated by a private company - as a private company. Is it being considered by the department that the model of the mobile clinic could be a publicly run entity?

MICHELLE THOMPSON: I'll probably have to continue this but - it's a public-private partnership so they are publicly funded. There's no cost. Again, they have capacity in order to deliver that care which has been very successful. Until the system has its own capacity, we will continue that public-private partnership.

SUSAN LEBLANC: Can the minister tell me what the number budgeted for mobile primary care is for this coming year?

THE CHAIR: Order. The time allotted for consideration of Estimates on Supply has elapsed for the day. I would like to take a moment to thank the minister and her team for the wonderful four hours that we've just spent together. I will note that the NDP has 23 minutes remaining on this hour of questioning.

The honourable Government House Leader.

HON. KIM MASLAND: Mr. Chair, I move that the committee do now rise and report progress and beg leave to sit again on a future date.

THE CHAIR: The motion is carried.

The committee will now rise and report its business to the House.

[The committee adjourned at 4:46 p.m.]