House of Assembly
Nova Scotia

HALIFAX, TUESDAY, MARCH 28, 2023

COMMITTEE OF THE WHOLE ON SUPPLY

3:40 P.M.

CHAIR
Kent Smith

THE CHAIR: Order. The honourable Government House Leader.

HON. KIM MASLAND: Mr. Chair, would you please call Resolutions E11 and E29.

THE CHAIR: The honourable member for Dartmouth North, with just over 22 minutes remaining in your hour.

SUSAN LEBLANC: Welcome back, everyone - exciting second day. As a theatre practitioner, I like to keep my questions thematic and whatnot, dramaturgically tight. I'm going to actually move to the nursing bonus and ask a bunch of questions on that, but I have other questions, obviously unrelated, as well.

We have had a lot of questions come into our caucus office and constituency offices about the nurses and their eligibility for the retention bonuses. When I say nurses, I should say health care workers who are qualifying for that bonus. My first question is, are casual nurses eligible for the bonus?

THE CHAIR: The honourable Minister of Health and Wellness.

HON. MICHELLE THOMPSON: In terms of the retention incentives, casual nurses would be paid the bonus if they have left the public system and agree and are selected to return for a two-year return of service. They would qualify for a return-to-nursing incentive of $10,000.

SUSAN LEBLANC: Okay, casual nurses who are out of the public system who return to the public system can qualify if they return. Do they have to return to a full-time position, or can they return and be casual in the public system?

MICHELLE THOMPSON: Casual nurses working in a facility but would not have a permanent full-time equivalent, whether that's 0.4 or 0.5 full-time or whatever. In order to qualify for the return-to-nursing incentive, they would have to take a position that was permanent.

[3:45 p.m.]

SUSAN LEBLANC: Recently on a town hall, the Premier suggested that nurses under a return-to-service agreement would be eligible, but we have also heard from nurses who were told differently. What about the nurses who are under return-to-service bonus agreements?

MICHELLE THOMPSON: Can you clarify?

SUSAN LEBLANC: I will just actually come back to that one because I, in fact, don't know how to clarify it. Let's pause.

My next one is: Are nurses who are on parental leave eligible for the bonus?

MICHELLE THOMPSON: Nurses on parental leave are able to receive the bonus, the thank you bonus.

SUSAN LEBLANC: Can the department provide a detailed list of how the eligibility is being determined? What are the thought processes going into that?

MICHELLE THOMPSON: The department would not be able to give you that. What we've asked - there's a bit of a war room set up to support a variety of different questions - so there is an ability for people in the Nova Scotia Health Authority to reach out to HR and have their individual questions. There's a lot of variability answered if they have any questions. I believe in the Department of Seniors and Long-term Care that those questions are being directed to Health Association Nova Scotia.

SUSAN LEBLANC: So just to clarify that, if we are contacted - we've been contacted many times - do I qualify for this or not? Of course, it's really tricky for someone like me to be able to answer. People should go to Health Association Nova Scotia for their answer?

MICHELLE THOMPSON: If an employee is with the Nova Scotia Health Authority, they can email retention@nshealth.ca, or speak with their manager. We're a week into this, so we are getting through some of the variabilities so they can do that. We

can find out the exact way to contact, but if they're working in long-term care, continuing care, they should reach out to HANS, and I don't have the contact information. Is that clarified?

SUSAN LEBLANC: Here's an example of one of the letters that was sent to us from a nurse working outside of Halifax. This is a quote:

> The different amounts of monies has caused quite the rift between classifications. The paramedics, lab, RTs, etc. are - I'm not going to say this word, but PO'd - that they are getting less than LPNs. They see themselves at the same level as RNs and are finding it very insulting. There are many casuals working full-time hours in the lab because the work is there, but there were not any postings over the last few years to apply to, and they will not be eligible.

Can the minister respond to this concern?

MICHELLE THOMPSON: We've seen and heard a lot about retention in the nursing profession, and we've also seen other jurisdictions as well provide incentives to thank nurses and to help retain them. We were certainly happy to do that, to provide retention incentives, and stay incentives for the nurses because of the number of vacancies that we have. But we have, in fact, the broadest-sweeping incentive package that we think of in the country.

We felt it was really important, in addition to acknowledging and thanking the nurses, that we include other individuals across all designations, which hasn't happened in other provinces. We felt because we wanted to thank folks, we did include 11,000 nurses, I believe, and 44,000 other employees were included in our incentive package to thank them as well.

We know that there is a significant crisis around our nursing vacancies in particular, and while other jurisdictions have chosen to only look at a couple of professions, nursing included, we have actually made the broadest swath that we can, to include 55,000 employees throughout the province.

SUSAN LEBLANC: I also continue on with the statement from the same nurse whom I was quoting from before:

> I asked one of our recent RNs, who left to go travel nursing, if this would make her come back, and she said, no, it would not match what she is making.
>
> It will not keep me from retiring as my bridging is $1,000 a month until age 65, so I would give up $24,000 to make $10,000.

Can the minister respond to those concerns?

THE CHAIR: I'll ask the member for Dartmouth North to table the document that was just cited.

MICHELLE THOMPSON: We've also heard from individuals who were very pleased to receive the bonus. We've actually heard, anecdotally, that there are people who are coming back into the system, so we appreciate that this isn't for everyone. Certainly our intention was to show our thanks and to pull as many people back into the system. It's a signal, a meaningful signal to us, that we value health care workers, and we want them in our system. The way in which we are able to reduce our reliance on travel nurses is actually to bring as many people back into the system.

We're also looking at other ways that individuals can contribute. Perhaps if the return to service is not something that interests an individual, there may be opportunities for late-career nurses to consider mentorship. You know, we did our very best. We wanted to signal to our health care workers that they're important.

We know that it's not going to capture everyone, but certainly it was a very important and meaningful gesture in order for us to signal to health care workers that we understand that they've been working under strain and we're grateful for the work that they do.

SUSAN LEBLANC: What was the amount budgeted in last year's budget for spending on travel nurses? And can the minister say what is the final amount that was spent on travel nurses for the year about to end?

MICHELLE THOMPSON: In fact, that number - for acute care - would come out of the Nova Scotia Health Authority's operational budget. It wouldn't be something that we would designate. The Department of Seniors and Long-term Care would be able to answer in terms of the impact on continuing care.

SUSAN LEBLANC: Aha. So now we get to this awkward place where some things are the Nova Scotia Health Authority and some things are the Department of Health and Wellness, but surely the minister must have an idea of how much money was spent on travel nurses this current year and how much is budgeted for next year. And if not, can the minister write to the CEO of the Nova Scotia Health Authority and get that number for us?

MICHELLE THOMPSON: We can reach out to the Nova Scotia Health Authority to get the number. We don't actually budget for a particular - we don't have a budget line or budget for travel nurses. In the operations of an organization, you would have a number of funded FTEs; that would be your budget. You would have their benefits on top of those FTEs, and so you would work within that.

Similarly, we would not have a budget, as an example, for overtime or things like that. So, it isn't a budget line where we have this amount of money. However, we do need to ensure that things are staffed. Similar to overtime, we use those things as we need them in order to make sure that we maintain staffing levels.

SUSAN LEBLANC: I understand that, but I wonder - but travel nurses who we hire to bring in from outside Nova Scotia, to fill vacancies, make more than our local nurses, correct? We pay more for the people that come in from outside, and therefore would there not be an amount that is, like, a budget for inside nurses and outside nurses?

MICHELLE THOMPSON: I'm very sorry, I'm wondering if you can repeat that question? I was trying to get your attention.

SUSAN LEBLANC: It makes sense what you're saying about how there's a budget for full-time equivalents, but if we're spending - I guess the first question is, I'm presuming we spend more on nurses coming from outside, travel nurses coming to Nova Scotia to work to fill vacancies. If we're not, then my question is moot. But if we are, then do we not have a budget line for this kind of nurse who's paid this much, and a budget line for that kind of nurse who's paid that much? Or is it just one pot of money, and you just use it until it's empty?

MICHELLE THOMPSON: From April 1st to December 31st of last year, $16.3 million was spent on travel nurses in acute care. There would be a contract with the company that employs the travel nurses. The contracts could vary on a variety of different things, so we don't have a line of sight on that. We would sit with the contract and what the nurses get or receive or what have you, based on where they go or what they do, really is not - it would be part of their contract with that company.

SUSAN LEBLANC: So there's a contract with a company, the company pays the nurses whatever, we don't know about that. That is different than the answer the minister just gave previously, which is that there's a pot of money that is full-time equivalents and you just use that to pay whoever is working when.

MICHELLE THOMPSON: What I say when I talk about FTEs is that every organization, facility, would have a staffing model and you would have so many FTEs. That's how we know how many vacancies there are in the acute care system or in your long-term care facility. You are funded for X number of FTEs. That's the money you use to pay employees their salary, and then it would include their benefits and things like that.

We're not funded for overtime, so you have to take that out of existing vacancies or you actually go over your operational funding. That is how we fund publicly funded organizations. You are given an equivalency and you hire to that, which is how we know what the vacancies are.

In order to fill these spots, we actually would need a contract, which would be very separate. There may be a reallocation of funds. If you have a lot of vacancies, you may be able to reallocate funds. It is a bit complicated, but we don't have a budget line for that; we would have to have a contract.

SUSAN LEBLANC: Does each facility have its own contract with a travel nursing company or does the department or the Nova Scotia Health Authority have the contract and then there's someone who sort of doles out nurses from the contract to the different facilities?

MICHELLE THOMPSON: I can only speak to the Nova Scotia Health Authority. I don't know what's happening in terms of the Department of Seniors and Long-term Care. The Nova Scotia Health Authority would have a company that they have a contract with and then through the workings of it all would identify areas in which they need to be used, through the site managers, through the VP of Operations, all of those types of things, but we would have a singular contract and the supply would come from a company. Then the Department of Seniors and Long-term Care, I'm not really sure how they allocate resources.

SUSAN LEBLANC: I want to go back to some primary care stuff. When we ask about the exploding number of people on the primary care wait-list, we're told about virtual care, mobile care, and pharmacy care, which are all great things in their own way. I know the minister understands the difference between these services and being attached permanently to a family health team because we talked about that the other day in Estimates.

The minister is a nurse, so she understands the incredible difference for someone with a chronic illness, with cancer or someone who is pregnant or someone who is just getting older. She understands the serious importance for people like that of being attached to a place that can follow your health. Of course, I am not saying a physician who can follow your health, but a place or a team.

I also want to say that when we talk about virtual care, the principle of virtual care, in my opinion, is a good one. I don't have virtual care with my family doctor, but I have phone care. During the pandemic that's when that started and it's great. If you just need to talk about a prescription or something, you can just have a phone call and you can get a phone call quicker than you can get an in-person appointment. It works really well, and I know that people like that.

There's a difference between that kind of thing - having a virtual appointment or a phone appointment with your own team and your own people or person - and going Maple, right? So when I'm talking about virtual care now and mobile care, I'm talking about through Maple for people who aren't attached necessarily.

[4:00 p.m.]

In these cases, virtual care and mobile care are basically Band-Aid solutions. Pardon the pun, Mr. Chair, since we are talking about health care. What is the long-term plan for people who are currently being attached at virtual care or seeing people at the mobile clinics?

MICHELLE THOMPSON: It's a good question. First of all, the folks on the Need a Family Practice Registry - there is a variety of different folks and currently that is simply a list. It really doesn't have - it has very - like, no functionality, so it's unhelpful in many, many ways, in terms of supporting people. Anybody on the Need a Family Practice Registry has access to virtual care and some people on that list, for good reasons, only need episodic care and so that is where they would access in a variety of different ways, as you said, urgent treatment, all those things.

If that virtual care provider deems that the individual seeking care has more complex needs, there are actually primary care clinics that are through a number of communities where patients can be referred to see an in-patient, in-person primary care provider. That primary care provider, based on their needs, that person may be followed by that primary care clinic during the course of their health care journey until such time as a primary care provider is found for them. There are people with more complex needs who are seen at this primary care clinic. That is the function of these clinics - which is really important because the other piece is that when somebody sets up a family practice, they are then drawing from the people in that primary care clinic because their needs would be higher than someone who just needed episodic care on the list.

Currently there are 95 collaborative practices across the province. We are increasing by 11 across the province to support that care. We are also strengthening a number, as well. To your point, it is around collaborative care. We do want to move people into teams but in the interim, there is episodic care that can be reached and there are primary care clinics that are supporting and really stabilizing people with chronic disease issues and following them. Then they can take those folks at primary care in off the list and move them to a new practice as they are established or as access improves when we strengthen. As we increase the number of providers in these collaborative centres, it's always to increase access and to use people to the fullness of their scope so that more people could come off that list.

SUSAN LEBLANC: Speaking of that list, say I'm on the list and I need to be followed for something - maybe it's a pregnancy - and I need to be followed and so I get attached to a mobile clinic or one of these family practice clinics that you're talking about for the duration of my pregnancy, and then lo and behold . . .

THE CHAIR: Order. The time for New Democratic Party questions this round has lapsed. We will now move to the Liberal caucus.

The honourable member for Halifax Atlantic.

HON. BRENDAN MAGUIRE: I will start out with some easy ones. How many family doctor and specialist openings are there in the system as of today?

MICHELLE THOMPSON: There are still 200 physician vacancies according to NSHA data: 123.3 family physicians and 76.4 specialists.

BRENDAN MAGUIRE: Sorry, did you say 76.4 for specialists? Okay.

How many new collaborative care centres have been opened in the past 18 months - brand new collaborative care centres, from start to finish?

MICHELLE THOMPSON: The collaborative family clinics are stable at 95, and there will be increases in this upcoming budget. And we'll get the number for the number of primary care clinics that have been opened across the province.

BRENDAN MAGUIRE: I'm going to ask for a little bit of clarification on what is mean by stable at 95. The question wasn't how many are currently open, the question is, how many have opened over the last 18 months, from concept, to start to finish, to the doors open? How many of those centres have opened in the last 18 months under the previous two fiscal budgets, under this one and the upcoming one?

MICHELLE THOMPSON: So under the last budget - this is our second budget - moving forward we have plans to open new ones. Under last year's budget there were no new collaborative family clinics opened, but there were five primary care clinics opened last year.

BRENDAN MAGUIRE: So we went from year after year of new collaborative care centres being opened. We've heard that this is what young health care professionals want to work in. They want to work in the collaborative care centre; they want to have the resources around them. We've heard that, personally have heard that as a Liberal caucus, from graduating students. I'm sure the NDP have heard it too. Under the previous government a record number of collaborative care centres were opened.

Can the minister explain why zero collaborative care centres have been opened over the last 12 months?

MICHELLE THOMPSON: Certainly we've been working with the collaborative family practices across the province to understand what their needs are. And the primary care clinics have actually been there to support folks on the Need a Family Practice Registry. So there have been five new practices opened, and this year we have a plan to open 11 more collaborative family practices.

BRENDAN MAGUIRE: Okay, so the question was, not what are you opening going forward, the question was, over the last 12 months, why have no collaborative care centres been opened, what has been the obstacle, and why has this government not opened up a single collaborative care over the last 12 months?

MICHELLE THOMPSON: Over the past year we've been working with practices, particularly with the optimization team. So again, we go back to Dalhousie Family Medicine, we talk about the work that's happened. Building a team of industrial engineers and people with very skilled administrative skills to look at how we can optimize practices.

So recognizing that there are a number of practices that are feeling quite overwhelmed, working with them around attachment and also access, supporting them in terms of their scheduling, making sure that they look at the processes that they have. It has taken us a little bit of time to work with folks and understand what some of the needs are, and also look at those primary care clinics as well as other points of access for people on the Need a Family Practice Registry.

We know that it's going to take some time for us to fix health care. There were some immediate things that we felt were necessary. Certainly, optimization at Dalhousie Family Medicine resulted in 3,500 people coming off the Need a Family Practice Registry in the city. Looking at that incubator model as well, helping new physicians panel up. We've had a test-and-try environment, which is really essential. The learnings from those test-and-try environments will have informed how we will move forward. This is a multi-year plan in order to get us where we need to be, so those early planning and test-and-try environments have informed the work that's coming up this year.

BRENDAN MAGUIRE: Can the minister table how many collaborative care centres have been opened, year by year, for the last five years?

MICHELLE THOMPSON: Certainly, we'll get back to the member with that.

BRENDAN MAGUIRE: Was that a yes, you will table that? Okay. What budget lines are associated with the Dalhousie incubator clinic, and is it being expanded?

MICHELLE THOMPSON: It is in the Nova Scotia Health Authority line. It's under the primary health care bundle. The proof of concept will be - there's a $3-million investment to increase to four practices over the coming year, four communities.

BRENDAN MAGUIRE: I would like to skip ahead a little bit and talk about the bonus that this government has given to some people and some people not. Some people get this amount, and some people get that amount. There's a lot of confusion around that. I have been contacted by a lot of people who are off on short- and long-term leave because of workplace injury, an injury they received while working as a nurse or a health care professional, and they have been told that they are not eligible for the bonus. Can the

minister clear this up? If they are not eligible for the bonus, can the minister explain why these individuals who were injured on the job are not eligible for that bonus?

MICHELLE THOMPSON: What I would say to anybody who is wondering about clarification, I think it's really important that they reach out to their employer. The employer is working very hard - there are several employers: the Department of Seniors and Long-term Care, Emergency Medical Care Inc., the Nova Scotia Health Authority. It's very hard to blanket it. There are a number of individual cases, and they're very committed to working with people to better understand how they qualify or if they qualify for the bonus. The best bet is really for them, if they work for the Nova Scotia Health Authority, to reach out directly to retention@nshealth.ca, and they will have their concern followed up.

[4:15 p.m.]

BRENDAN MAGUIRE: Obviously a lot of thought went into this bonus and the retention and the idea around this bonus. Can the minister give me an example of which workplace injury she thinks would qualify for a bonus and which workplace injury would not qualify for a bonus?

MICHELLE THOMPSON: I'm not able to do that. What has to happen is that employees - each are very individual situations and there's no way that we can just have a blanket approach, so it's really important that employees work with their managers and their employer to understand if they qualify.

BRENDAN MAGUIRE: Is it my understanding that some people who are injured on the job, as a health care professional, may not and will not receive the bonus, depending on the circumstances? Is that what the minister is saying, that circumstances will vary and some people will receive it and some people won't?

MICHELLE THOMPSON: What I would say is that, similar to the COVID-19 bonus that was given to health care workers a number of years ago, there are so many particularities that it's very difficult to give a blanket statement. Again, it has to go back to the employer. They are in the best position. There's a variety of different intricacies around that work and HR is really in the best position to be able to answer those questions.

BRENDAN MAGUIRE: Last week I think the minister agreed with us when we talked about women on maternity leave within the health care system who have been told they are not eligible for that bonus. This is kind of a similar situation but last week the minister said that she would look into it and make sure that those individuals would be eligible for a bonus. Can we get an update on that?

I guess the question for me is, first of all, can we get an update on it? Second, why is it that that is not a human resource issue, but this is?

MICHELLE THOMPSON: Certainly, maternity leave/paternity leave is a little bit easier to qualify. There's generally only one or two ways to be on maternity leave versus injury. Again, we can go around this tree a hundred times, it best sits with the employer, and it best sits with the HR department.

BRENDAN MAGUIRE: Certainly, there must be some kind of process - so, we'll tell the thousands of people that they're not eligible to go to HR. If they are denied, is there a process to appeal that or is it just, that's it?

MICHELLE THOMPSON: Everybody has the opportunity to go to HR. There's nobody who does not. If they are employed, their employer would have the details. There will be people who are ineligible, and I can't presuppose who those folks will be, so they should work with their employers.

We're not trying to exclude people unnecessarily. I know there is a group of individuals who are working very hard on this, they're very dedicated. This is a thank you to the people who have been working in the system for the last year. This is an opportunity to bring people back into the system. This is an opportunity for people to reach out directly to their employers to find out whether or not they're eligible.

BRENDAN MAGUIRE: I'll move on from this topic in a second, but I just want to get this right. The bonus is for individuals who have worked in the system for the last year - those are the words of the minister - not for individuals who have been working in the health care system. So, the criterion is that in order to receive a bonus you have to have been working in the system for the last year. Anyone else, for any specific reason, if there has been any interruption, it sounds to me like they wouldn't be eligible for that bonus, or not eligible for the full bonus.

The minister just said this bonus was for people working in the health care system for the last year. Is that her understanding of a bonus that was created by her department and the Nova Scotia Health Authority? Surely, she had some hands-on with this bonus.

MICHELLE THOMPSON: We will get back to the member with the exact dates.

BRENDAN MAGUIRE: I don't understand what the minister is going to get back to me about. The question was: There was a statement just made seconds ago where the minister said this bonus is for people who have worked in the health care system for the last year. Does the minister stand by the words that she just said, which are, this bonus was made for individuals who worked the last 12 months in the health care system. Does she stand by those words or is that a slip of the tongue?

MICHELLE THOMPSON: Certainly, there are complexities around this, and I want to make sure that I have all the details related to that bonus in order to offer them to the House, as well as the member. It is a good opportunity for me to talk about how

innovative we have been trying to be over the last number of years - the last 19 months - very focused on moving health care forward and this thank you bonus is really an opportunity for us to do that.

Health care is steadily improving, and I know it's going to take some time but certainly this is one of the ways that we can show our appreciation to the health care workers in the system. We heard directly from health care workers across the province, not only doctors and nurses but all of our health care workers, that they really do feel that things are improving but it is time for us to show our appreciation, which is why we implemented the bonus and why I want to make sure that I have all of the details right.

I was talking to a couple of health care workers the other day who used to work in management with me. I had a chance to see them over the weekend and they were so excited about the opportunity to actually have a budget that put money into health care, into all of the different places in which they work. I remember in years gone by where budgets would come out and there would be very short, small lines - two or three things, four things - and often if there was an addition somewhere, there was a reduction somewhere else.

It made me remember, working as a manager many, many years ago, when I managed the ER ICU and renal dialysis, and thinking about the NDP government at the time. One of the reasons I left that job, which I loved, was because as budget preparations were coming that year, we were asked to prepare business cases that would reduce our care by 3 per cent, 5 per cent, and 10 per cent in the health care system. So, here we were as middle managers trying to run a department emergency ICU and renal dialysis with really no control over the inflow of individuals and, as a result of that, having to figure out whether or not we could reduce our budgets by 3 per cent, 5 per cent, and 10 per cent in order to support health care.

It was very, very difficult and I remember waking up - obviously around this time - I took a new job with a different organization and waking up and hearing the then-finance minister on CBC Radio with Don Connolly and him saying that they never had any intention of cutting health 3 per cent, 5 per cent or 10 per cent. I remember lying in bed that morning listening and being very tearful because I didn't know that. I didn't know that that was the case when, in fact, there was a 1 per cent reduction overall. Imagine leaving a permanent full-time job in order to take a five-month temporary position with no benefits because it just was so unpalatable.

Then we went into the Liberal government years. In 2014-15 we saw Emergency Health Services and ambulance operations reduced. We saw EHS quality control reduced. In 2015 the Department of Health and Wellness spending went up by less than 1 per cent. It's hard to believe it was the smallest increase in over a decade. Then the active living budget in 2015, the same year, that was reduced. The primary care budget was reduced by over 8 per cent. Chronic disease management and injury prevention was also reduced by over 16 per cent, and this was quite a blow.

In 2016, the Department of Health and Wellness budget was further reduced. Primary care was reduced again. They announced One Person One Record, 2016, the Liberal government, and the headline was, OPOR was moving to the next phase. So, I'm assuming that phase was the bottom drawer, Mr. Chair, because it didn't surface again until we formed government in the past year.

In 2017, primary and acute care cuts again, and budget for health promotion reduced. In 2018, health promotion reduced. In 2019, the mental health budget was reduced. So, there was no plan and really waning hope among health care professionals throughout the system. It was a really hard time in health care. Decisions became centralized in local hospitals, and staff had less and less agency over what was happening in their communities and in their hospitals.

The policy, as well, in primary care was one doctor out, one doctor in. I remember my own GP; his daughter is a physician and was in residency. He had hoped that perhaps she would be able to join his practice and, of course, wouldn't that have been great? But unfortunately, due to the one out, one in policy at the time, in order for his daughter to join his practice, he would have had give his practice up.

So, as a result, for a period of time, we didn't have those physicians in our community. But when we were finally able to look at transfer into practice and transfer out of practice, that one physician brought six physicians to our community in total - five other physicians: her partner and two other couples - in order to provide care in our community. So, it really does make a difference in terms of how we recruit.

So again, at this time, throughout this, this was the acute care issue. And all the while our baby boomers were aging. All the while, innovation was changing, our pharmacology was getting more complex. Certainly, our investigative procedures were getting more complex, and here we were cutting back all throughout health care. There was no vision, there was no plan, and there was no investment.

Here we have an aging population, high rates of chronic disease. We were under-bedded and under-staffed and there was no strategic investment - none.

I'll just share my own experience. I became an administrator at a long-term care facility in January of 2016. It was the first time the small equipment budget in long-term care had been halved - completely halved - unheard of.

And as a result of that, we weren't able to invest in some of the things that are really important. So, looking at commode chairs, looking at lifts, looking at wheelchairs. All of these things that are so essential to the quality of life of long-term care residents, and only half of that was able to be invested in.

In 2016, there were no capital plan investments. Usually we would submit a number of pressing issues that we would have in order to plan. Those were not accepted in 2016. We were not able to submit any of the things that the facility needed.

And then in 2016-17, three weeks into the budget year, with absolutely no consultation with the sector, here we were with 1 per cent of our budget reduced in long-term care. And what that meant to us, in long-term care - 1 per cent of a global budget, which was $120,000 in the facility that I worked in. So, here we were. We weren't able to do a number of things and only realized through operations. So, even though 70 per cent of a budget is people, the people that work in your facility, only 1 per cent - that could only be realized at 30 per cent. So, that 30 per cent share is actually food, it's heat, it's lights, it's incontinence products. It's the things that contribute daily to the quality of life in long-term care.

What happened when long-term care raised the roof - very interesting. First of all, we were essentially ignored at the time by the Liberal government. Nobody wanted to hear about it, except for a couple of bigger facilities, really trying to advocate on behalf of the sector.

And as a result of their advocacy, auditors were sent in to look at the books of those facilities, because the former government must have felt that they weren't believable, that the money that was taken out of their budget obviously would not have a direct impact on residents. And as a result, auditors were sent in to review the books of several nursing homes.

That was a very strong signal to those of us in the industry at the time, but we certainly needed not try and regain that 1 per cent. So, this year, no vision. There was no vision - none. Couldn't get anybody to talk to us about long-term care. There was no plan and there's obviously no investment. At that time, they took the money from long-term care, and they actually put it in community, which is obviously a great investment, but why would we ever take from one to pay for the other? But, this year, we have $6.5 billion in our health care system. That's a 22 per cent increase over the last two years in order to support health care in this province. It is generational.

There is a vision. We have Action for Health. It's built on the voices of our health care workers of this province. I tell the folks across the way all the time, people were willing to help, but nobody wanted to be in the health care system that we were in. People wanted to help. They wanted to have their say, but when you spoke up, or when you tried to reach out, things like auditors showed up at your door, and there really was no opportunity for us to have the meaningful dialogue about the impact that these reductions had.

Now we have significant investment. We have political will. We have a government and a Premier that is very committed to improving health care. We have $6.5 billion, and this isn't about cobbling together, our nibbling around the edges of a system

that has been ignored for generations. This is about transformation, and transformation is going to take some time. It is going to take some investment in order for us to move all of these various initiatives forward.

[4:30 p.m.]

I would also like to note, just before I move off long-term care, that in 2016, when we did have that budget reduction, it was also the year that the long-term care program requirements were actually enhanced. We went from a reasonable number of requirements in long-term care, and those were increased quite significantly with no additional resources so that some of our most vulnerable Nova Scotians were housed and cared for in these facilities when the budgets continued to shrink, and when we tried to advocate on their behalf in order to ensure that they had adequate care, our voices were silenced.

Then, after all these years of constriction, restriction, losing money out of our budget, then we hear, in 2020, about the pandemic. I will tell you, for those of us who have worked in public health, we had been talking about pandemic preparedness for years - for years and years. I could remember sitting around the table when the Department of Health Promotion and Protection was down on Lower Water Street and talking about schools closing, talking about all the different things that would happen in the event of a pandemic. And I couldn't believe it. I just couldn't imagine a time that that would actually happen. Thankfully, I had the opportunity to plan, and to sit there amongst my public health colleagues, so that when they did talk about a global pandemic, we certainly understood what was ahead. But we were afraid.

So then came the pandemic on the shoulders of a very worried, undervalued workforce, which is why it's so essential that we gave those bonuses to those health care workers, so that they know that we value their efforts.

THE CHAIR: Order. The honourable member for Halifax Atlantic on a point of order.

BRENDAN MAGUIRE: Thank you, Mr. Chair, and I saw the wink between you two, so I'm sure this isn't going to go anywhere.

THE CHAIR: Order. That comment was unparliamentary and I'd like you to retract it, please.

BRENDAN MAGUIRE: I'll retract it, but it's not unparliamentary.

THE CHAIR: The member for Halifax Atlantic.

BRENDAN MAGUIRE: Mr. Chair, there was a very simple question put towards the Minister of Health and Wellness. What she's actually doing is filibustering and not

allowing members on this side of the house to ask questions. She spent the last twenty minutes answering none of the questions that were put to her. It's a waste of the Opposition's time. It's disgraceful and it's a waste of public funds and money. We're in here today to try to get answers and to try to get questions . . .

THE CHAIR: Order. To insinuate that the Minister of Health and Wellness is doing something disgraceful is unparliamentary and I expect an apology for that.

BRENDAN MAGUIRE: No, it's not. It's what she's doing.

THE CHAIR: I ask the member to retract that statement.

BRENDAN MAGUIRE: My perception is that what she's doing is disgraceful, and that . . .

THE CHAIR: I ask the member to retract the statement.

BRENDAN MAGUIRE: I want to remind the Chair that the Speaker of the House already ruled on perception and so did the Clerk, that perception is not unparliamentary.

THE CHAIR: Order. I understand what the member is saying, but I've asked the member to retract the statement and then rephrase it in a parliamentary way.

BRENDAN MAGUIRE: I'll retract the statement, but I stand by the fact that the minister - what's happening here today is - the Department of Health and Wellness is the most important department. My perception is that a mockery is being had here today and made. Instead of answering the questions and allowing members on this side of the House to ask questions - questions that have come from the public and, quite frankly, questions that have come from her home constituents who have emailed me and asked me to ask questions to the particular minister.

The minister has decided to not answer questions, to continue to filibuster and not allow anyone on this side of the House to ask questions. I ask that these questions can be asked, and these questions can be answered in a timely manner and that she respect this side of the House as we respected them.

THE CHAIR: I appreciate the member's comments. It's my opinion the minister has every opportunity to speak on anything under the purview of her department and she is providing you an answer . . . (interruption).

Order. (Interruption) The member for Halifax Atlantic, please don't interrupt the Chair. That is disorderly conduct. The Minister of Health and Wellness has the purview to speak to things in her department.

MICHELLE THOMPSON: I'd like to continue to talk about why these bonuses are so essential for our health care workers after the last number of years that they've put in.

Then came the pandemic, where there was really a system that had no give and no slack because of all the restrictions and cuts that had happened in the years before, all in the name of efficiency, saving money, and making sure that there was not an extra bed. We know that occupancy rates really do need to be at about 85 per cent in order to have a high-functioning acute care system, which means we needed to invest a number of years ago in long-term care, which means that we needed to invest in our health care workers in the number of seats, all of those things.

Yet health care workers at that time, knowing the pandemic was coming, really dug in. It was a time that I don't think I will ever forget. I certainly had the opportunity to give Queen Elizabeth II's Platinum Jubilee Medals on behalf of the Nova Scotia Health Authority to a number of folks who had worked during the pandemic at a time when we were all very afraid and really weren't sure about the impact, pre-vaccination in particular. How emotional and moving it was for us to be able to be together in the room, knowing that we really were the only ones who fully understood the way we lived during that time.

In 2021 we made a commitment that we were elected to fix health care. We entered some vision.

BRENDAN MAGUIRE: I'd like some clarification on time allotted for question and answer. If the minister is unable to answer a 30-second question without going on an hour - and I know they are smirking and laughing over there - am I allowed to take an hour to ask a question?

THE CHAIR: I understand in discussions with the Clerk that you are free to use your hour to ask questions and the minister is free to answer the question as it relates to her department.

BRENDAN MAGUIRE: Can I respond to that?

THE CHAIR: I have made a ruling on it, so unless it's a new point of order, I have ruled on that one.

BRENDAN MAGUIRE: Now that the Clerk is here, can we take a few minutes to discuss if, in fact - because in the last round of Estimates, I was told there were questions I wasn't allowed to ask because it wasn't on topic.

What I am asking right now is: On Friday there was a ruling that I had to stay on topic, so I'm asking the Clerk, when a question is put to a minister, does the minister have the ability to talk about whatever they want, no matter if it is on subject or not? I am asking the Clerk to specifically answer that, or help you answer it.

THE CHAIR: I will say that I have had extensive discussions with the Clerk on this topic and the reason that the member's question on Friday was disallowed was because it did not relate to the purview of the Minister of Health and Wellness. The minister right now is discussing her department in response to your question, and it is in order and allowed.

The honourable Minister of Health and Wellness . . . (interruption).

Points of order are not debatable. (Interruption)

BRENDAN MAGUIRE: My point of order is that we have a specific question that was asked. We have seen in the past where the minister has answered those questions specifically. I asked that the minister stay on topic, and if she's not going to stay on topic, at least have the decency to answer the question, which she hasn't answered in the last 30 minutes.

THE CHAIR: I would like to advise the member that insinuating that the Minister of Health and Wellness is not decently answering . . . (interruption).

I would like the member to retract that statement, please and thank you.

I would like to give the member a moment to reflect on that. I'm requesting that the member for Halifax Atlantic retract the statement.

BRENDAN MAGUIRE: Why?

THE CHAIR: It is contrary . . .

BRENDAN MAGUIRE: I would like to see the ruling, and where in the (inaudible) book, it says that I can't say my perception is she doesn't have the decency to answer the question. I would like to see . . .

THE CHAIR: The member is being disorderly right now. He has not been recognized. I'm asking the member to please retract the derogatory statement towards the Minister of Health and Wellness.

BRENDAN MAGUIRE: It's not derogatory.

THE CHAIR: I recognize the member for Halifax Atlantic to retract his statement.

BRENDAN MAGUIRE: I respectfully decline.

THE CHAIR: I would ask that the member for Halifax Atlantic be removed for the rest of the session.

Persistent disregard of the Chair's instructions is grounds for dismissal. I'm respectfully requesting the member for Halifax Atlantic to vacate the seat for the rest of the day. I will also add for the record that during the minister's speech, the member for Halifax Atlantic called the Chair disgraceful. The member for Halifax Atlantic said that the Chair was a joke . . .

BRENDAN MAGUIRE: When did I say that on record? I didn't say that on - there's no - now you're just making things up . . .

THE CHAIR: The member for Halifax Atlantic said that the Chair was a partisan hack.

BRENDAN MAGUIRE: You're just making things up now.

THE CHAIR: I would like to request assistance and have the member for Halifax Atlantic removed for the remainder of the day. Under Rule 28(1), Disorderly Conduct by Member, "the Speaker may order any member who disregards the authority of the Chair or whose conduct is otherwise disorderly to withdraw immediately from the House."

MICHELLE THOMPSON: Again, when we formed a government, we did go around, and we spoke to health care workers across this province, and we wanted to talk to them directly about the things that we felt would improve health care. Over and over again, health care workers showed up and told us about the things that they felt were relevant in order for us to improve health care. We travelled the province. It was the first time in my career that I heard emergency room physicians talking about the importance of how we addressed and supported those folks living and working in long-term care.

From the voices of those health care workers, we built Action for Health, and the voices of health care workers informed our six-pillar strategic plan. This plan is to address current strain and transform our health care system. Our health care system was built in a very, very different time, a time when many of us sought care primarily from physicians, nurses only worked in hospitals, and there was no team-based care.

We talked about a time when there would be mass retirements, which is why it's so important that those return-to-service bonuses are included, because we want to keep our late-career nurses in the system to mentor our junior nurses. We want to make sure that we are thanking those nurses who stayed in the acute care setting and long-term care, because we want to become a magnet for health care, which is the very first pillar of our Action for Health plan.

We are very committed in terms of supporting the six core solutions for health care. These are the foundation for Action for Health. Becoming a magnet for health care workers, opening the Office of Healthcare Professionals Recruitment, solely focused on recruiting a workforce and sustaining individuals. Last year, we were able to recruit 163

doctors to this province. We had 261 registered nurses, a net gain for the first time in a very long time. We had a net gain of 264 LPNs in this province, and a net gain of 47 nurse practitioners, which is a significant investment.

[4:45 p.m.]

In order to become a magnet for health care workers, we invested in more nursing seats. We committed to a medical campus at Cape Breton University. We created 10 new residency seats which were recently filled, actually, through the Canadian Resident Matching Service in the past week or so. I'm really pleased to say that we had over 100 applicants for those 10 positions.

We have an MOU with the Michener Institute of Education at UHN to train allied health care professionals and support not only our nursing staff and physician workforce, but also to look at a variety of different allied health care professionals who work in our system.

We expanded the scope of practice for nurse practitioners, and we passed regulations that were long dormant for pharmacists, so we in fact actually are the most progressive work environment for nurse practitioners and pharmacists in the country. We worked collaboratively with regulating bodies to address red tape and shorten our registration time, and we've created this really great model, tried-and-tested, proof-of-concept incubator clinic for new medical graduates.

We've covered tuition and books for continuing care assistants and we've introduced an $11,500 tuition rebate for paramedics, recognizing that we have to do things across the board to support our health care workers, as we did with that incentive, but also to look at what the profession-specific things are that we can do to make Nova Scotia an attractive place for people to come and live and work.

We've also provided $2 million in support to work with communities across the province, making sure that they have grants. We know that it's one thing to bring people here as we become a magnet for health care workers, it's one thing to bring people here, but it's really essential that we ensure that folks are settled well into their communities. Really appreciating the work that municipalities and navigators and communities do, we have this grant application.

Again, these are all signals throughout the system that we really are committed. Back to the incentive program, we really are interested in making sure that the health care workers know that this is a place where they can come and live and work.

Certainly under Pillar 2, provide care that Nova Scotians need and deserve. In order to care for people, we need people. We developed innovative primary health care models over the past year, expanded virtual care, introduced primary care mobile units. We have a

virtual care emergency room with three tried-and-tested sites across the province. We have pop-up primary care and respiratory clinics, all in an effort to make sure that health care workers have not only diverse opportunities to work in a variety of settings, but also opportunities for people to access care.

I know that the Minister of Seniors and Long-term Care will be more than happy to talk about how she and her department are supporting seniors in community through long-term care expansion, making sure that there's remodeling of existing spaces and strengthening community supports.

Further to this initiative, and some of the other things that we're doing to support our health care workers, we're expanding that successful INSPIRED COPD Outreach Program to support folks living beyond the boundaries of Halifax and HRM. We're addressing surgical wait times through the use of technology: long-overdue e-referral and single-entry programs for surgery, and eventually expanded to diagnostic imaging. It's hard to imagine that in this day and age we would have one million faxed referrals throughout this province, so reducing red tape is really another essential way that we can support our health care workers.

We're expanding OR capacity and extending hours wherever possible and leveraging public-private partnerships, looking at cataract surgeries, and outpatient arthroscopic surgeries to support people waiting for joint care. Surgical ratio has actually stayed below target and is reducing over the last number of months.

Despite the strain that our surgical teams across the province have felt over the last number of months, they actually are at or exceeding 2019 surgical levels, pre-pandemic. It is a pretty remarkable feat. Again, why that bonus was so essential in order to support our health care workers and give them a thank you for those who are currently working in the system, and really trying to entice those folks to come back. We want to make sure that people who have left see that there is a clear recognition and appreciation and a pathway back to come.

If folks will stay with us just a little longer, just a little bit longer, we anticipate investing another $110 million next year for that bonus for those folks who will sign a return-to-service agreement. That bonus, we feel, is a real meaningful signal. We did a jurisdictional scan to understand how best to ensure we were providing competitive and meaningful monetary thank yous to the folks across this province.

Looking at cultivating excellence on the front lines, it is essential that we invest in people. Investing not only in them, themselves, through wages and incentives, but also at their work environment. There are huge investments looking at infrastructure projects with a common-sense approach to making sure that we can do more faster and that we can really build and expand our health care system incrementally over the next number of years, and expand medical equipment, specifically lab and diagnostic imaging.

I know many of us as MLAs get a lot of correspondence in our offices about some of the wait times associated with diagnostic imaging and lab, and we are very, very focused on working with that workforce, making sure that we have enough people and making sure that we have the facilities in order to deliver that care.

The investing in mentorship program, again, is a really important piece. Our late-career nurses coming back and supporting our novice nurses is really essential. Those new nurses - if there is a sign-on bonus or if they qualify for this thank you bonus, we are implementing a mentorship program where we have senior nurses who are considered above core and would not have a patient assignment. They would come and mentor those younger nurses, perhaps in person and sometimes by phone, and looking at other different ways in which we may be able to invest in that workforce.

We really do feel that this bonus is essential. We know that it has caused a lot of questions throughout the province. We are committed to working with health care workers across the province to understand what it is that they need. We want to be as inclusive with that bonus as possible, so I would really encourage folks throughout the province who are wondering if they are eligible to reach out to their managers and certainly the HR department will support them in understanding the eligibility requirements.

THE CHAIR: The honourable member for Bedford Basin.

HON. KELLY REGAN: Last year the minister said we have a target of approximately 153 physicians every year, after bringing them on, to keep pace with the Need a Family Practice Registry and current specialist vacancies.

I would like to ask the Minister: Given the uptick of people on the doctor wait-list of over 137,000 people, is this the target for the year, and if not, what is the new target?

MICHELLE THOMPSON: Of course, we want to recruit as many physicians as we can and what I would say our target is really - we have 123.3 family physician vacancies and we also have 76.4 specialist vacancies. That is the current vacancy, and we are also working with that hotline to better understand how many physicians are planning to retire. Our target is 160, year over year, but we will continue to take as many physicians as we can.

THE CHAIR: Order. The proceedings of this committee are suspended momentarily while we report back to the House.

[4:55 p.m. The committee recessed.]

[5:16 p.m. The committee reconvened.]

THE SPEAKER: Order. We are reconvening the Committee on Whole House on Supply.

KELLY REGAN: The minister outlined we have 123.3 family physician positions that are currently vacant and 76.4 specialist positions that are currently vacant, correct?

If we look at the NSHA website for the month of March, there were over a thousand vacancies in a variety of different positions in the NSHA. Can - you've already provided us with a list of the vacancies of physicians in the NSHA. What about the IWK Health Centre? Can you tell us how many vacancies there are at the IWK?

MICHELLE THOMPSON: I thank the member for the question. We'll get back to you about that. It may be in here, but if not, we'll get it for you.

KELLY REGAN: How many new doctors have been recruited during this past fiscal year, the year that's just about to end. How many physicians have been recruited?

MICHELLE THOMPSON: NSHA has recruited 113 physicians so far. After considering departures, we have a gain of 41 physicians: 10 family doctors and 31 specialists. I have to find the exact dates, the range of it, but that's the information that we have.

KELLY REGAN: At this time last year, we had 189 doctors over the age of 65. Can the minister give us an update on how many there are over the age of 65 now, bearing in mind, of course, that not all doctors retire at 65. It seems awfully young to me, but do we have an idea how many are over the age of 65 now, and do we have any idea of how many are planning to retire in the coming year?

MICHELLE THOMPSON: The number that I just gave the member opposite was to December 31, 2022, those recruitment numbers that I just gave you - remember that I said I needed the date range. That was to December 31, 2022, and there are 219 physicians over the age of 65.

KELLY REGAN: We know that COVID-19 is still with us, we know it's in the Chamber, but our concern is that it's still harming some of our most vulnerable populations. For example, of the 27 deaths that were reported in January, 26 of those were people 70 years of age or older; 11, or 41 per cent, were people living in long-term care homes.

I'm wondering how many residents of long-term care homes have passed away from COVID-19 in the last 18 months.

MICHELLE THOMPSON: The information I have is by month. I don't have it broken down - it's a cumulative number - between acute care and long-term care.

KELLY REGAN: I do have some of the stats. I don't have all of the stats because they're not available online. Since May of last year, 87 people have died of COVID-19 in long-term care. That would not include the ones who were announced earlier this month but that would have been up to the end of February. That's out of a total of 199 above the age of 70 who have died during this time.

Given that we now know so much more about how this virus spreads, given that we now know so much more about how to protect people from COVID-19, given that we have vaccines, how do we square the fact that 25 per cent more residents of long-term care died in the last nine months in this province than died in the first year of COVID-19, when we didn't know what the virus was, didn't have vaccines, didn't know how it spread or anything like that? We are hearing that long-term care homes are being closed down now but people don't seem to know about this.

What we know is that the deaths are greater in the last nine months - and that's not even a full year - than it was during the first full year of COVID-19. I'm wondering if the minister can talk to us about what is happening and why it is happening.

MICHELLE THOMPSON: I thank the member for the question, and I'll answer some of it. I think some of it may be best answered by the Minister of Seniors and Long-term Care, but I know that Public Health sits under me, so there's a bit of a crossover.

In those early days of COVID-19 there really was nobody in and out of the facility whatsoever and certainly a variety of different screening and people weren't moving around their communities in the same way and vaccination really was essential for us to be able to try and return to normalcy. We know that as the variants moved along, there were significant changes in regard to the variants and their effects. I'm no expert, so I'm not able to speak about that, for sure. With immunizations, what we know, from the beginning of the pandemic, pre-vaccination and vaccination, people who live with complex illness, frail, elderly people, do have a significant risk associated with COVID-19. That's why we continue to have masking in aggregate settings, particularly in long-term care, and we continue . . .

THE CHAIR: Order. The time for Liberal questioning this hour has lapsed.

The honourable member for Cape Breton Centre-Whitney Pier.

KENDRA COOMBES: Thank you, Mr. Chair, and hello to our guests here. Last year, the minister and I discussed miscarriages, and as an individual who experienced miscarriages, when I was taken to hospital via ambulance, the paramedics could not take me to the regional hospital, where they have OB/GYN services as well as provide D&Cs, because I was under 20 weeks. Last year, the minister told me that they would work with NSHA to make sure that we have trauma-informed care, so that people can get the care that they require. I just want to know if the minister can give us an update on this policy.

MICHELLE THOMPSON: I would have to have a look to understand if the policy has changed over that time. I do know that generally people who are experiencing miscarriage do present to the emergency room, and I know that it is a very, very difficult time. I can check to see if there has been any change, particularly in terms of the approach. Having a different triage score would be outside the realm of policy related at the Nova Scotia Health Authority, but certainly I can follow up on that question.

KENDRA COOMBES: Thank you, and I very much appreciate that. I want to talk about some Cape Breton health. I'm just wondering what amount of new funding in the budget will we spend on the health care in Cape Breton? If the minister is able to provide me with those numbers.

MICHELLE THOMPSON: Typically, we would not break something down necessarily by region, other than capital. There's money that we're targeting for certain initiatives, but it would be more of an Eastern Zone approach, as opposed to a particular geographic region. It's just hard to do that, except for capital investments, which is a little bit easier number to define.

KENDRA COOMBES: Back in January there were some promises made that would - changes taking place to the Cape Breton Regional Hospital emergency room, and I'm just wondering if the minister is able provide me with some updates. I've been hearing at the Cape Breton Regional Hospital that the FLOAT physician - which is the extra physician on shift to evaluate EHS patients in the waiting room - is effective, when they have someone available, but the FLOAT doctor is only present one-third of days. I'm just wondering what is the government doing to ensure that we have FLOAT physicians available at the Cape Breton Regional more than one-third of those days?

MICHELLE THOMPSON: There absolutely are some challenges around them, the FLOAT MDs in terms of - it's an allocation of hours and each emergency room is able to utilize those hours in the way they best see fit but also in the way best that they can staff.

I expect and am assuming that they are going to look at their high demand periods of time and use those hours during that time. There are issues, we have a round recruitment, but that is implemented there. There is also some work under way so the care providers - the waiting room care providers - are in place and also looking at an expansion, based on recruitment, for physician assistance as well.

KENDRA COOMBES: It's like the minister read my mind because my next question was with regard to the Cape Breton Regional Hospital. What is the update on assigning physician assistants and nurse practitioners to provide care in the emergency room departments? Also, if the minister has any updates on the Cape Breton Regional Hospital itself, that would be great.

MICHELLE THOMPSON: I thank the member for the question. Pending recruitment possibilities and capabilities, that physician assistant position would be implemented by the end of the first quarter of the fiscal year.

[5:30 p.m.]

KENDRA COOMBES: I was wondering if the minister could provide me with an update and tell me if the space for the split flow, which I believe is supposed to be the fast track. Has there been a dedicated spot at the Regional, now that they have this fixed, dedicated spot for that fast track to occur? If they do, are there any updates that are being required for that area?

MICHELLE THOMPSON: We'll check with the operations folks at the site to see what we can find.

KENDRA COOMBES: Great, thank you, this is off to an excellent start. I'm just wondering if the minister could provide me an update of where the Department of Health and Wellness and the Nova Scotia Health Authority are at filling the approximately 63 per cent vacancies regarding full-time ER nursing staff at the Regional.

MICHELLE THOMPSON: This is a good opportunity for us to talk a little bit about the recruitment efforts. Some of them are across the province, so certainly working with Cape Breton University, looking at growing our own workforce. They've been excellent partners at CBU, lots of opportunity there for us to continue to grow that school and provide at home, people from Cape Breton specifically. You don't have to travel as far in order to get their education and work as nurses.

Certainly trying to lure back some of our recently retired or folks who were in casual positions. I'm not sure that 63 per cent vacancies is accurate, I'm going to check on that number. That's a lot, that's over half. I don't know if that's per unit, but I don't think the whole facility. (Interruption) Oh, ED. Sorry. We'll have a check on that to be sure.

I do think it's important that we look at the facilities, understand what's happening. It is a bit of a speciality to work in the emergency room; it's not for everybody. I know there is work ongoing in terms of looking at how best to support folks, what are some of the reasons why people are leaving and addressing those work-life balance issues.

I know that looking at work-life balance specifically, making sure that there's an opportunity for people to be laddered, so if they want to take the critical care nursing course that we are able to support them in doing that, and it can be quite a daunting place. I think the peer mentors will be very important. We're looking at the junior novice nursing staff and we have something called the just-in-time program. Sometimes there will be a person, like a more senior nurse, a more experienced nurse, who would be able to support in real time. There are also inter-professional practice folks, and there are also clinical leaders,

and just trying to provide opportunity. When there isn't someone there, the opportunity to reach someone by phone, so really trying to support the nursing staff because it is such a high-pressure environment.

KENDRA COOMBES: This will be my last question. I agree with you, 63 per cent vacancy was high. This was the number I received from somebody within the Cape Breton Regional Hospital.

I'm just wondering if the minister could provide an update on what they're doing at the Cape Breton Regional Hospital to make virtual care available to more patients with less urgent needs.

MICHELLE THOMPSON: We'll get back to you. We have to find it, so I'll get back to you with it.

THE SPEAKER: The honourable member for Dartmouth North.

SUSAN LEBLANC: Hello again, everyone. I'm going to ask some questions all over the place now for a while - some that were held over from our last day. So, the first question - and I think I did begin to ask this last time when we ran out of time.

I wanted to talk about the hotel purchase in Bedford, for the - I forget what it's called now (interruption) - transition, thank you. I was going to call it a step-down unit, but that's not quite the same thing. The transitional care facility. So, I'm wondering if the minister can - oh. The minister said that I needed to ask this of the other minister.

But I'm wondering if the minister knows if there is a cost associated with renovating the hotel so that it can be used for its intent, which is to house people - or to care for people while they're waiting for long-term care.

MICHELLE THOMPSON: There will be, of course, a cost associated with the renovations of the facility. We are budgeting around $14 million - yes. I mean that's the budget, and we'll see about supply chain and all of those different things, but that's the target.

SUSAN LEBLANC: Is there a timeline? Is there a date to open - a hoped-for date?

MICHELLE THOMPSON: Not to be obtuse, but my role really is around what happens inside. I think it would be - like those milestones. I will say though, they're very focused on getting that facility open because of the opportunity and the expansion of the available beds in the acute care system. We're really going to work very hard to get that open as soon as possible.

SUSAN LEBLANC: This month, Mr. Chair, is Endometriosis Month. I'm wondering if there's any money - any new money, excuse me, in the budget for endometriosis care or - well. Let's keep it with endometriosis, actually.

MICHELLE THOMPSON: So, there is $2.445 million for the IWK Health Centre gynecological and neuro-gynecological services to improve access to care and address the existing backlog and reduce wait times. There is work under way increasing operational hours achieved through after-hours clinics, bolstering emergent treatment centres, expansion of the endometriosis and chronic pelvic pain clinic, and expansion of the Maritime Centre for Pelvic Floor Health.

SUSAN LEBLANC: Great, and is there any new money for sexual and reproductive health or operational funding for Sexual Health Nova Scotia?

MICHELLE THOMPSON: Yes, there is money in the budget supporting the Halifax sexual assault centre, Ally Centre of Cape Breton, AIDS Coalition of Nova Scotia, and also doing some work expanding pride health across the province. There is funding allocated in the budget.

SUSAN LEBLANC: Is there operational funding available or in the budget for Sexual Health Nova Scotia?

MICHELLE THOMPSON: For Sexual Health Nova Scotia, there is $287,000 allocated in the budget to support them.

SUSAN LEBLANC: Again, I'm jumping around here; I apologize. We're hearing more and more reports about people being forced to pay upwards of $300 to collect their medical records when their family practice has closed. There's a company that holds the medical records and if you want to get them out, then you have to pay $300.

I'm wondering if this is allowed and also if there's a plan by the government or the department to address or to support folks with those fees?

MICHELLE THOMPSON: Medical records, if there is an actual physical paper chart, do reside at a physician's or primary care office. In fact, the way in which those are stored and provided and things like that is actually under the College of Physicians and Surgeons of Nova Scotia. They are the folks who mandate how those records need to be stored and how accessible they are to their patients.

I will check on the electronic medical record because I'm not sure about that. I'll have to check if someone has an electronic medical record in a clinic, how they would access that. That is regulated by the College of Physicians and Surgeons.

SUSAN LEBLANC: In a world where the college says that everyone has to pay $300 to get their records, I'm wondering if the government would entertain a fund so that people could recoup their money. I had to pay $300. This is my income. Kind of the way that ambulance reimbursements happen or whatever.

[5:45 p.m.]

I'm just wondering if there's a thought to entertaining a reimbursement for that money given that there are so many people whose family practices are closing or they're ending up unattached and have to hold onto those records for the day that they get reattached.

MICHELLE THOMPSON: Essentially, we would be funding things that are insured services. That would be considered an uninsured service at this time. There are no plans to address that at this current time, no.

SUSAN LEBLANC: I just want to go back on the $287,000 for Sexual Health Nova Scotia. I just wanted to clarify: is that a new $287,000 – like, an increase of, or is that the status quo?

MICHELLE THOMPSON: Yes, that is additional funding.

SUSAN LEBLANC: In the government's election platform there was a promise to increase pay for family doctors and a program that contributes to doctors' retirement funds but to date none of this has been announced. I am just wondering if there is any money budgeted for those two things in this budget.

MICHELLE THOMPSON: We are in the midst of negotiations now with Doctors Nova Scotia on behalf of the physicians in the province. I suspect inevitably there will be an increase in compensation as a result of those talks.

What was the other thing you asked? Oh, the retirement fund. Yes, sorry. It is currently being reviewed by the department but there is nothing to announce right now.

SUSAN LEBLANC: The Nova Scotia Association of Community Health Centres has a long-standing ask for a one-time stabilization fund of $4 million so they can address some key operational gaps for their members. These clinics, as we all know, are a critical part of the primary care puzzle in many communities. They are collaborative, they are community-focused, and they are sharply focused on communities' unique needs. I wonder, is there increased funding for community health centres in the budget and if so, how much is there?

MICHELLE THOMPSON: Yes, there will be an investment of $1.47 million in these organizations across the province - new.

SUSAN LEBLANC: Great. Good to hear. See? Not all negative. I am going to go back to what we were talking about in Question Period today about midwifery. Why was the midwifery education feasibility study cancelled at the last minute by the department?

MICHELLE THOMPSON: We are actually involved in an Atlantic provinces review to understand how best to offer that. Our own individual one is now going to be expanded around that Atlantic provinces review of midwifery services.

SUSAN LEBLANC: Does that include the educational feasibility study? That is different from a review of services. I just want to clarify that.

MICHELLE THOMPSON: Yes, it is a study partnership understanding and it is being led by Newfoundland for the education.

SUSAN LEBLANC: Okay. Can the department or the minister talk about why that was changed? Does that mean that if Newfoundland is leading it, then Newfoundland would take the school, if it came to that. Can you talk about that at all?

MICHELLE THOMPSON: Only one of us could ideally lead it and so it is a feasibility study that Newfoundland is leading around midwifery in the Atlantic provinces.

SUSAN LEBLANC: I can't tell if the question is being avoided or not, but anyway, okay. Be that as it may, in terms of current midwifery practice in Nova Scotia, I asked the minister today in Question Period about it and she said something along the lines of: We need to shore up the midwives and the practices that we have right now before we look at expanding and all that, because we have some retention issues. Certainly, I know we have heard from plenty of midwives who are working in a rural practice or a rural community and all of a sudden, a midwife goes on leave and then there's one midwife for the whole entire practice, and that's just unsustainable because you can't deliver babies 24 hours a day. Obviously, that makes a lot of sense.

I guess my obvious question to this is: Why not just fund more midwifery positions so that the midwives who are working have people to work with, so they don't burn out and therefore don't need to leave?

MICHELLE THOMPSON: Really, the answer is that we can't expand because we can't currently fill the vacancies that we have, so we need to stabilize the vacancies that we have throughout the province first before we are able to expand.

To your point, somebody goes away, moves, it is very difficult to fill those positions. That is the issue. There's not a ton of midwives who are available and it is a different type of practice, perhaps, in rural Nova Scotia than it would be in other places. It is really around our ability to fill the current vacancies that we have.

SUSAN LEBLANC: I guess I just have to pick at this for a minute because it doesn't make any sense to me. It's going to be harder to attract people to vacancies if the reason why there are vacancies is because midwives are working on their own or in very tiny, little practices.

I know personally several midwives who would love to come to Nova Scotia to practise but there are no jobs. It feels like it's a bit of a chicken-and-egg thing. Does it not make sense - I am honestly asking this; this is not like getting in some political jab or whatever - does it not make sense that if the reason midwives are leaving is because they can't sustain their practice because it's too much for two midwives or three midwives, that instead of saying, well, we can't expand because we can't fill those positions, rather expand in a meaningful way so that all of those midwives would not be working with just two people or three people, and rather be working with five people or six people? I'm thinking out loud here, folks.

MICHELLE THOMPSON: I think you just described it perfectly. That is the issue, that there are teams that we would maybe want four midwives in but there are only two and we can't fill the other two vacancies, so it's the same issue. If we have vacancies that we are not able to fill and, as a result, some midwives leave, that is the thing. There is no reduction. We can't pull the teams up to the FTEs that they are funded for now.

SUSAN LEBLANC: I guess what I am saying is the reason we can't fill those positions is because no one wants to work in tiny little teams where they know they are going to burn out. If we were to expand the program so the teams are bigger or there are more supports, then there would be an ethos of midwifery. People would see, oh, there are midwives here, I'm going to use them, and there would be demand for more. It would just build it instead of us trying to, sort of, fill - it's like bailing out a boat with a bunch of holes in it rather than getting a better boat - yes? Anyway, I hear the minister. I don't think we're going to get any further. We're just not going to.

It's a shame, though, because midwives are telling us that they're heartbroken about yet another missed opportunity in the budget. Is the department, is the minister working with the Association of Nova Scotia Midwives to figure this out and to see how midwives can fit into family practices, into family practice teams, into other midwife teams? What are the discussions that are going on with midwives themselves?

MICHELLE THOMPSON: We're not aware that there's a glut of midwives that are dying to come here. Certainly if you have a whole bunch, they should contact the Office of Healthcare Professionals Recruitment, because that is the issue. Like we may have five vacancies in the team, and there's three on the team, and one leaves because of work-life balance, then those two vacancies are not filled, right? So, that's the issue. We can hire up to the level the teams are funded for, but we don't actually have the applications, so there's a bit of disconnect. So, if you have 18, all of them, okay, you should absolutely get them to

call the Office of Healthcare Professionals Recruitment, but we do want to have those teams at full capacity.

SUSAN LEBLANC: The minister was talking about exit interviews the other day, with certain people who are leaving the health professions. Have you done exit interviews with midwives, and do we have an understanding of why folks are leaving?

MICHELLE THOMPSON: Anyone who would be leaving NSHA or the IWK Health Centre would be offered an exit interview, if they would choose to participate, and I don't have many results from those exit interviews as, specifically for midwives.

SUSAN LEBLANC: The government claims that it's focused on expanding scope of practice. Midwives are trained to provide a wide range of sexual and reproductive health care, but they're not used this way in our province. I'm just wondering why, and if that is a conversation that is happening in terms of increasing midwives' scope of practice.

MICHELLE THOMPSON: So, this is a little bit like a chicken and an egg, but anyway I will just say, if we had more, then absolutely we could, you know, look at what they provide in our system, but also what their capacity is. Just as an example, there are some midwives who are supporting and helping the unattached newborn program. There have been 60 unattached newborns in HRM, in this area, and midwives are supporting that program in terms of providing care. The more we get, the more we're able to look at where they would fit in teams. It just depends too in the way in which they want to practise. Some may want to do prenatal work, maybe some want to do sexual health, some maybe, people want to actually work in delivering babies, and postpartum and so, it's really to match the person with the ability. We are very open to it, to understand how we can use them, but they certainly have been very helpful with that unattached baby clinic.

SUSAN LEBLANC: For almost two years now, well since the minister has been in government, when asked about like drug coverage, or device coverage, the things that are covered in the formulary or not covered in the formulary, the minister refers to an ongoing review about drug and device coverage. I'm just wondering if the minister can comment on the scope and purpose of the review, and who is responsible for overseeing the review at this time.

MICHELLE THOMPSON: The review and the program itself, is the pharmaceutical and extended health benefits, right? They would have a senior executive director who would look at that. We've currently reviewed what's on the formulary. Also looking - you know, our formulary is pretty consistent with other provinces.

And looking at not only that but Canada's Drug and Health Technology Agency CADTH, the way things get on the formulary, CADTH and the pCPA process that does the pricing - the pan-Canadian Pharmaceutical Alliance - they help us price it and CADTH

gives us recommendations about new things. We have new devices and new - well, does CADTH do devices? Yes, devices and pharmacy - medications and things.

[6:00 p.m.]

We are consistent with other jurisdictions. I will say that certainly the demands on this program are growing, (a) because of the people who currently use it. We know that there are people living with chronic disease, but also the number of requests, because as technology and pharmaceutical advances happen, there are more and more. It is really almost always an ongoing review when there are new requests coming in.

It is very much a living file in terms of how it's managed, but it's a significant expenditure, absolutely, and we do our best to cover the things that we can.

SUSAN LEBLANC: The minister mentioned, I think, a sub-set of the department that does that reviewing. Is it just staff in that department, or is there an external panel that is looking at it on behalf of that department, or how does that work? Is it basically like there's no official review happening, but as the minister has just said, everything is just always being examined and considered? Or is there a timeline for it?

MICHELLE THOMPSON: CADTH is Canada's Drug and Health Technology Agency and those are the folks who would make recommendations around whether or not something was effective, and we would follow those recommendations. Then pCPA, the pharmaceutical folks, then kind of negotiate the pricing.

There are a number of requests that come all the time and as things are emerging, CADTH will - I'm just trying to think of an example. Trikafta is a good example. Recognizing that there was an identification that this is an emerging and effective treatment, CADTH makes a recommendation, pCPA then negotiates the price and then provinces will bring it on as part of their formulary.

That's how it's living. It has been reviewed. There may be things that become dated on the formulary over time, of course, as new things come. That review has been done, in terms of reviewing what's currently on our formulary, but there are always things coming into the line of sight for that program.

SUSAN LEBLANC: Over the last couple of years, I've asked a number of questions about specific drugs, like PrEP for folks with HIV. Birth control, obviously, which is - and I'm talking about prescription birth control. We've talked about the high-dose flu vaccine, for instance, which is now being covered. That's great.

When I've asked about these things, the minister has said there's a review going on. My question is: If what is happening is actually what the minister has just described, which is there's a panel and a new drug comes and we look at it and do we want it or not, blah blah

blah, (a) where's the accountability for that? But also, just because one province is doing something doesn't necessarily mean that we will.

For instance, I know that I have a constituent who needed injections in her eye for macular degeneration and she pays for them out of pocket because they're not covered in the formulary. She came from Alberta, where all of the eye care - the whole list of choices for the macular degeneration shots - is covered in Alberta. She was going to use her Alberta health insurance because she has private health insurance from being a teacher there or something, but it wasn't covered by the health insurance because it's not - you don't have to pay for it in Alberta.

So she was stuck between a rock and a hard place. And that's just one example of, like, Alberta covers all this stuff. We don't cover it at all. Anyway, I guess I don't know what I am really asking here except that I understand when drugs that are obsolete fall off the end and I understand when drugs that are new and exciting and helpful come in but where is the accountability? What about these ones that are more controversial like PrEP, like birth control, you know, maybe not for full portions of the population, although I would suggest that birth control is. Anyway, how does the minister or how does the pCPA decide and who do they report to when they say yes, no, yes, no, maybe?

MICHELLE THOMPSON: The line for Pharmacare, for all of this, is $381 million a year which is pretty significant. We do our very best to extend coverage, you know, to the best of our ability. Certainly every province varies, as well, in terms of their ability to provide things based on their resources. In terms of comparing Alberta to Nova Scotia is tough because their surplus is probably as big as our entire budget so the ability to list things is a little bit different. We do really try to incrementally increase access to these medications and sometimes it comes down to decisions that need to be made, but we do our very best. We look at CADTH, we look at requests, we look at all these different things. There is art and science to it as to how we list things.

SUSAN LEBLANC: Yes, I agree with that. But the reason I'm using the Alberta example is because the minister herself said we do what other provinces do, but we don't because other provinces have way different budgets. We have a bigger budget than presumably other - maybe P.E.I., I don't know who we are bigger than but - maybe not. What I am saying - this is my point. My point is we can't just judge ourselves against other provinces in terms of what we cover. One province might have a whole bunch of people with - in fact, it might be us. We have a higher percentage of people with diabetes, for instance, so glucose monitors might be a more important thing for Nova Scotia to cover.

Ultimately my question is: if this is not actually a review where there is going to be a start and a finish and results made public, then where is the accountability, who are the people who make those decisions accountable to? Is it ultimately that they answer to the minister, or they report to the minister and the minister is accountable for what we cover in

Nova Scotia as the Minister of Health and Wellness, or is there some other way for Nova Scotians to have their say about what's covered and what's not covered?

MICHELLE THOMPSON: Certainly as the Minister of Health and Wellness, ultimately I would be responsible for that work. The folks in the department do report to me. We look at all the different requests and things in front of us and we see what we are able to do year over year and incrementally increase access to a variety of different medications and technology.

SUSAN LEBLANC: Given that, I want to say we are really happy to see the coverage for the high-dose flu vaccine in the budget. Thank you very much. We will take that as a win for the NDP and for seniors everywhere, but we know that people badly need help paying for SHINGRIX, the shingles vaccine, as well. I'm wondering, is there money in the budget for the shingles vaccine? I'm also wondering if there is money in the budget to cover the cost of prescription birth control in a universal way.

MICHELLE THOMPSON: In this budget there is no publicly funded SHINGRIX this year. The access to birth control is through the Nova Scotia Family Pharmacare Program, as it was prior to, so the opportunities that exist through that program continue, but there is no expansion for universal birth control in this budget.

SUSAN LEBLANC: Well, that's too bad. Sorry to hear that. Can the minister tell us what was spent on virtual care in Nova Scotia in the year that is about to end?

MICHELLE THOMPSON: I'll get that number. I'll have to double-check it.

SUSAN LEBLANC: I'm also wondering what is budgeted for Virtual Care Nova Scotia in this budget.

MICHELLE THOMPSON: We're investing $12.5 million in 2023-2024 to expand access to virtual care, primary health care this year coming up.

SUSAN LEBLANC: The same question for mobile clinics: What was spent on the mobile clinics last year and what is budgeted this year?

MICHELLE THOMPSON: I'll go back to the other question around virtual care: $6.25 million was spent last year and we're anticipating spending that and an additional $6.25 million this year, which will make $12.5 million. We'll just find those numbers. We're probably going to be a question behind for a minute.

SUSAN LEBLANC: What is budgeted this year for pharmacy clinics - that means i.e., the primary care clinics that are connected with pharmacies - and will those be expanded beyond the initial sites that have been put in place now?

[6:15 p.m.]

MICHELLE THOMPSON: In terms of the mobile clinics under the primary care bundle, there will be money that is allocated to expand. It is also with the Dalhousie Family Medicine and mobile clinic so it's a total of $3 million and we'll move those initiatives forward as we are able. So it's $3 million for the proof of concept for Dalhousie Family Medicine, as well as the mobile clinics. It is shared in terms of that Pharmacare access. There actually will be 12 more of the primary care delivered by pharmacists opening in May of this year.

SUSAN LEBLANC: Great, thank you for that. The next one is: what was spent last year on contracts with Scotia Surgery Inc.? What is in the budget this year for contracts with Scotia Surgery?

MICHELLE THOMPSON: We'll have to get those numbers for you from the NSHA.

SUSAN LEBLANC: Great. The federal government recently announced that it would fine the provincial government under the Canada Health Act's Diagnostic Services Policy, $1.3 million because it continued to allow a private fee-for-service MRI imaging service, which was HealthView Medical Imaging, to operate and charge people for diagnostics.

My questions are about this: First of all, is HealthView Medical Imaging still operating in Nova Scotia? Is the government budgeting for fines under this policy - or for more fines under this policy?

MICHELLE THOMPSON: It is HealthView. As far as we know, they are still operating. They are predominantly used by the WCB and Veterans Affairs. We do take issue with some of the numbers that the federal government has so we are in active communication with them about that charge or clawback. We do have time, like a couple of years, and actually I believe that is from the 2020-21 year that they are referring to in terms of the usage of that. We do have some time to negotiate with them and talk to them about the usage of that clinic and make a plan, if need be, to reduce that use.

SUSAN LEBLANC: I see. So that's from a couple of years ago and the minister thinks that, or hopes that, the usage of private diagnostic imaging will lessen.

Regardless, folks in Nova Scotia have an opportunity to use a pay for private service which kind of contravenes the spirit of universal health care in Canada. I am also wondering, when we're looking at primary care solutions right now, we've got VirtualCareNS, we've got mobile clinics, and we've got pharmacy clinics. These are all private, for-profit clinics where public money is being used to pay for the services but it's going into private enterprises. I'm wondering if the minister agrees that there's value in

building capacity in the public system to provide these services. I know that there obviously is money going into public primary care, but I want to know what the minister hopes for in the future. Does the minister see a time when all of our primary care services are returned to the public sphere?

MICHELLE THOMPSON: I think there's a lot to say. Of course, ideally, we would want to make sure that we're fully staffed in our system and that we have an adequate number of beds and facilities. That's why the new build looks at new ORs, as an example, to make sure that we have the infrastructure. What we have to look at right now is every opportunity to leverage assets. I don't think public-private partnerships will ever go away. I think there will be opportunities.

I always use the example of pharmacists and pharmacies. Those are private facilities that were absolutely essential in the delivery of the vaccination process and now continue to be, not just in terms of COVID-19 but in other situations. I think there will always be technology or skill sets or a variety of things that perhaps we aren't able to build, and aren't cost effective for us to build, but we can work in partnership with other folks. Public-private partnerships have existed for a very, very long time, and I think they will continue to exist. What's important is that there are contracts in place, that people don't have to pay, and that we use expertise that's available to us to make sure people get the care they need quicker.

SUSAN LEBLANC: I want to read into the record a letter that one of my colleagues in the NDP caucus received. It says this:

> "Dear, Honourable Gary Burrill
>
> "My name is" - Mackenzie - "and I am a licensed practical nurse residing in your district . . . I am writing to you in hopes to garner your support in regards to the recent nurse 'thank you bonus' that was announced yesterday by our premier. It seems the 'no strings attached 1 time $10,000 thank you bonus' indeed has strings. I have worked since I graduated in 2017 as a full time nurse in varying part time and full time and permanent positions. During the last 3 years of the pandemic I held a permanent full time position working on the musculoskeletal unit at the Nova Scotia Rehab Center. This unit serves many different patients with varying diagnosis. Primarily Amputees doing rehab in hopes of receiving a prosthesis, patients with ALS, MS, Burn victims as well as several stroke rehab beds. As most units within the NSHA our unit became overflow and we worked tirelessly and short staffed for the better part of 3+ years providing care and health support to man[y] very ill patients outside of the physical rehab

scope. Due to the heavy nature of this unit and the physical demands on my body I knew I needed a break.

"In September I gave up my permanent full time position and chose to take a term full time position at the IWK working with adolescents in mental health and addictions. This term has been extended from 6 months originally to add another 6 months. I have continued to be committed to working full time, and would take a full time permanent position but there currently are non[e] posted for LPNs at the IWK in mental health. I had to take a term extension to be able to work full time and provide for my family. Because of this I am not entitled to the 'thank you bonus' as my title says I am considered casual while working a full time term position. I believe this to be very unfair. Despite myself holding a term position I am speaking on behalf of casual nurses who are the back bone of health care! Many casuals work full time hours above and beyond into overtime some days working 16 hrs between multiple units. Casuals are used to fill holes and gaps to cover vacation and especially with sick calls and sick restrictions during the pandemic. Also to be noted many casuals work multiple units to be able to retain full time hours as there truly is not an abundance of permanent full time 1.0 positions posted or available. Currently 1 posting for LPNs at the IWK (which is a term) and 6 with NSHA in the Halifax area (4 of which are terms). I hope you will support your nurses and advocate that the Thank you $10,000 bonus be awarded to all nurses who have worked full time regardless of if they hold a permanent or term position. Saying you don't deserve a thank you bonus because you don't hold a permanent Position, despite working full time and showing up to support our fellow Nova Scotians our healthcare system - quite frankly is the biggest slap in the face. I also urge that you support an offer of a prorated option to include casuals just as the part time permanent nurses are being awarded the bonus based off hours worked."

THE CHAIR: Order, order. I ask the member to table the document as well, please. That concludes time.

The honourable member for Bedford Basin.

KELLY REGAN: Mr. Chair, perhaps I'll go back to what we were previously speaking about - no. Last year at Estimates the minister said there would be a dashboard to report and track vacancies in the health care system. Has this been done, and will it be made public?

MICHELLE THOMPSON: We're going to check on that, but I just wanted to go back to the IWK Health Centre physician vacancies, if you want. So there's a total of eight physician vacancies at IWK.: 2.5 critical care, six pediatrics, and 0.1 of an emergency room physician.

KELLY REGAN: So, we'll find out about the vacancies. What budget lines are attached to doctor recruitment incentives and are there any new incentives in the budget now to recruit new doctors? I recognize that obviously you're in contract negotiations right now, but I'm just wondering if there's something you can point to.

MICHELLE THOMSPON: I just wanted to confirm that the previous question, the Action for Health website, it actually does post vacancies. There's a website there that you can have a look at. The other, if you look at Page 13.7 in the Budget Book, you'll see $1.47 million allocated to other services in the Physician Services section, and that would be the allocation. If we're fortune enough, we shall exceed. (Interruption) I said if we're fortunate enough we're happy to exceed it.

KELLY REGAN: So last year we asked for the minister to report back on alternative payment plan contract obligations. Are you able to do that this year - let us know where we are in terms of those obligations?

MICHELLE THOMPSON: I'm not sure if this is exactly the answer. We can go back and forth a bit, just to see. In 2023-24 we are allocating $135,991,000. Last year was $128 million for alternative payment plans. We do have conversions. Some of the increases are conversion for fee-for-service physicians who've moved to alternate payment plan, and funding of some Office of Addictions and Mental Health strengthening, and mostly just contract increases.

We'll see what the negotiations bring as well. I'm not sure if that is what you were looking for.

KELLY REGAN: We know that there have been reports around walk-in clinics and the pay models being an issue at walk-in clinics. And it seems to me - not to wax poetic, but it seems - well, it's not really poetic. It seems to me like health care is kind of like Whac-A-Mole sometimes. You whack a problem here and up pops a problem over there.

Just to go back to the Whac-A-Mole of walk-in clinics, once upon a time in my area, we didn't have walk-in clinics, but physicians banded together. It was probably over 20 physicians between Bedford and Fall River, and each doctor would provide some after-hours care in the evening or on a weekend. They didn't do it a lot because there were so many physicians involved and they had great coverage.

Then, I think it was under the NDP government, they introduced walk-in clinics. So, the walk-in clinics open, and everybody starts flocking to the walk-in clinics, and the

family doctors are saying: why would I be open? No one's coming here. I have to pay for my assistant. So they all stopped providing that particular service.

[6:30 p.m.]

Meanwhile, we all get hooked on the walk-in clinic, and the problem now is that successive governments - and I would say probably ours included - wanted people to actually be family doctors, and we weren't pushing people towards the walk-in clinics.

So, now we have this issue where walk-in clinics - physicians don't want to do it and they're tough to get into. In Bedford, I can tell you, I keep hearing stories from people about going to the walk-in clinic, which involves showing up often an hour before the clinic opens, standing in line, and you hope that you get in.

I'm just wondering, last year the minister said that they were working on the business model and the alternative payment plan contracts for physicians working at walk-in clinics. Can the minister give an update on this? Is there movement on implementing changes around payment for walk-in clinic doctors, or are we even doing that?

MICHELLE THOMPSON: A couple of things. Predominantly, my understanding is that walk-in clinics generally are a fee-for-service model. To your point, absolutely that's kind of how that shift has happened. I think that's why the collaborative care - when we look at alternative payment plans particularly, as we're strengthening these collaborative care teams, and we're currently in negotiations - really making sure that people have access after hours, evenings, and weekends. That would be part of the collaborative care model, implementing that.

To your point, when you have seven or eight physicians or seven or eight primary care providers in a clinic, they are better able to accommodate that.

I do still believe there's a spot for that non-urgent, episodic care. I think it's different based in a more densely populated area than perhaps it would be in a more rural community. I think really open to what works in a community, is what I would say, whether it's a walk-in or an urgent treatment centre or if it's extended hours in a collaborative care centre. I think all those things will be utilized by the people around who need care.

KELLY REGAN: Probably about a month ago there was a news release saying that the government was extending the hours of virtual care and it went into the evenings and I think maybe it had some weekend availability, I believe?

What I didn't see there was that there were going to be more appointments each day. I saw extended hours. My training is in what is actually said somewhere, so I'm

looking for how many more appointments are we getting per day? Can the minister please outline, as a result of that announcement, how many more appointments are available to Nova Scotians? We were originally told, I think, 150 to 200 appointments each day for virtual care across the entire province. Could the minister please indicate how many daily appointments there are now across the entire province for virtual care?

MICHELLE THOMPSON: There are 15 to 25 providers who are currently supporting Virtual Care Nova Scotia. We now have a range of appointments based on those extended hours. There are between 200 and 300 virtual care appointments per day.

KELLY REGAN: Sorry, I was busy writing there, so I didn't catch it. You said there's 15 to 25 providers online on any given day and 200 to 300 appointments per day? Okay, thank you very much.

Will the new Cape Breton University medical school increase the number of residency seats overall?

MICHELLE THOMPSON: Yes, it will. We'll bring in the first class. It will be several years before they are required but we will have - we need to match the number of residency seats with the seats that we're funding for education, so yes. There will be a particular focus at CBU around rural care.

KELLY REGAN: At this time, do we have any idea of how many residency seats will be accompanying that first class that's moving out into residency, once they finish their MD?

MICHELLE THOMPSON: I don't have an exact number for you. I think that's still under works. As an example, we've increased the number of residency seats this year for internationally educated graduates by 10 more in the province. I think it's going to be something that we move - there are always more physicians than there are residency seats across the whole country with the CaRMS match. Certainly we will have to increase the number, but I don't have the exact number today.

KELLY REGAN: I'm just going to circle back to something we were discussing earlier, which is the doctors who may be in the age range for retiring. I'm just wondering - and, again, understanding that they are in contract negotiations right now - so you may not be able to share everything with us - but what is being done in this budget to prepare for the inevitable? It's the big bulge of the tail end of the baby boomers who are getting ready to retire. What is being done to ready ourselves for that last big cohort retiring, not just in family doctors but also in a lot of the specialties, because those folks are getting ready to retire too? I was just wondering if the minister could outline some of those things.

MICHELLE THOMPSON: It's hard to draw a direct line to exactly that. The Office of Healthcare Professionals Recruitment is working at seeing our current vacancies

and then also looking at how folks are going to retire. We hear about the model of transitioning into practice and transitioning out of practice, so giving people opportunity and then trying to - some of the things - as an example, there is $5 million for physician assistants to be extenders to our physician colleagues and to support some of their work.

We are also looking at NICHE. That is Nova Scotia's International Community of Health Workers Engagement Program, NICHE. I will give you an example of how the Nova Scotia Health Authority worked with Ukrainian nationals when they came to live here. We are really looking at specific environments and that is across all designations. Certainly, we have a very good partnership now with a number of Nigerian nurses. We found a real champion in one of our community conversations and that champion has been able to connect the Nova Scotia Health Authority with a number of individuals.

Similarly, looking at those recruitment efforts, and then also giving those physicians who are leaving, and maybe don't want to carry a full practice, the opportunity to work in some of these more novel places like virtual care, like our mobile clinics, like our unattached baby clinics, all of these different things, to keep them in the system longer, and providing mentorship opportunities with them as well. And we now have that hotline, so as physicians are starting to transfer out, they can call that hotline, talk about what their plans are. The longer runway they give us, obviously, the better, so that we are able to plan.

THE CHAIR: The honourable member for Bedford South.

BRAEDON CLARK: Thank you, Chair. You have Bedford bait and switch here. I'll be here for a little bit.

I just wanted to ask the minister about something that has come up in the past, which is the incentive in the Central Zone for family doctors. As the member for Bedford Basin would have mentioned and I'm very familiar with as well, and I might not have the numbers exactly right, but my understanding is in September 2021, just after the election, we were looking at somewhere in the range of 4,500 people in the Bedford-Sackville zone without a family doctor. Now that number is about 18,000. That is a 400+ per cent increase in a year and a half. The member for Bedford Basin and I get people coming to the office all the time. I am just wondering if the minister can explain why that incentive was removed and how much it was costing on an annual basis, prior to its removal.

MICHELLE THOMPSON: When we formed government, certainly there were a number of incentives. We can look at the different ones, and these were rolled into the incentives for physicians who are willing to go to rural Nova Scotia. There is tuition relief. I can't remember. We can find that for you, what those programs were.

At that time, 60 per cent of the people who got incentives actually were settling in HRM, so we had a real big gap in our rural workforce in terms of physicians. The decision was made at that time to look at supporting rural settlement, making sure that our rural

communities - of course, we're always open to changing. Then we saw exponential population growth. We'll continue to look at that. We know that the list is growing. We want people attached, so we will look at that and see. We have to continue monitoring whether or not now it's disproportionate in terms of the number, percentagewise, in terms of how many people are off. We do know that there's a significant number of people moving. It's very fast-growing, particularly in your area. We're very open to that, very open to understanding from physicians what would attract them and again, just trying to match people.

[6:45 p.m.]

At different times we match people in a rural practice, and they would prefer an urban practice. We really have to look at that. There are areas in HRM that are eligible for the practice, in the more rural areas of HRM, because it's so big. Again, we're very open to that. We want people to be attached, and we'll continue to look at the incentives program, getting feedback from physicians as well as the Office of Healthcare Professionals Recruitment and physician services - and the recruiters. We now have nine recruiters who are physicians throughout the province who can help us understand what it is that physicians are looking for when they want to settle.

BRAEDON CLARK: I appreciate the response, actually, quite a bit because I think, as the minister noted, for most of the past decade or so, the conversation has been around shortages on the primary care side in rural areas, with reason. I think sometimes pendulums can shift quickly, much quicker than we would have anticipated. Just to clarify - and I don't expect the minister to commit to anything by any means - the minister is at least open to the possibility of future changes to the incentive programs within the Central Zone that no longer exist, in most cases.

MICHELLE THOMPSON: We certainly are open to reviewing it. What we really do want is equitable distribution of primary care services and specialty services across the province. We do know that we have a number of vacancies. We have a number of retirements. We really do need to look at the percentages. Numbers, raw numbers, don't always say. When we look at the percentages, there are actually still places in rural Nova Scotia - if you look at percentages - that have a higher degree of unattachment. That's why we really want to focus on access first, making sure people have access to care, and then work on the attachment moving forward. We're very open to understanding how best to make sure there's equitable access to care across the province, and incentives are a huge part of that.

BRAEDON CLARK: I just want to switch tack here a little bit and talk about another issue that we have talked about in the House during this session and in the past as well, related to continuous glucose monitors. I know that the minister and I have talked about it in the past. I'm just wondering if the department has done any kind of study or analysis to determine what the cost of those monitors might be if they were to be publicly

covered, as they are now in some other provinces. Not only the cost, which obviously is important, but the secondary piece would be how much money could theoretically be saved by people not having to go to ERs, not having to have amputations, any of those severe outcomes from uncontrolled diabetes. I'm just wondering if that work has been done.

MICHELLE THOMPSON: I will say I think everybody in the House can agree that CGM is an important piece of technology for people living with diabetes. There has been a review started, really looking at a jurisdictional scan, trying to understand what the program could and should be. There is ongoing conversation. It's an active file within the department and we continue to make decisions as we're able about what things we're able to add.

It is on our radar, absolutely, and we'll continue to monitor, but it is under active review.

BRAEDON CLARK: Just wondering if there is an expected timeline on when that review might be done.

MICHELLE THOMPSON: I don't have an exact end date, but I do want to assure you that it is an active file and we are reviewing it, and the jurisdictional scan, and things are happening as we move forward.

BRAEDON CLARK: I wanted to ask about doctor recruitment numbers as well. I know somewhere in the range of 130 was the overall number, the net number, obviously a little less than that. On the family doctor side, what is the net number of new family doctors that we need in the province in order to - that the department, I guess, has a goal of attracting on a yearly basis? The net number, obviously excluding retirements and people who might move out of province.

MICHELLE THOMPSON: We've recruited 113 physicians to the province in total, a net new gain of 41 physicians, 10 of whom are family doctors, and 31 specialists. I'm going to tell you that that's to the 31st of December, the last quarter.

Certainly, we have a significant number of vacancies, so if we could quadruple that or fill all our vacancies - we are working to our vacancies, is what I would say. First priority is to get us there, then looking at the number of retirements we have. We have 219 physicians over the age of 65, so we know that in the next five to seven years, we're going to need to replace them as well.

I don't know if we have a cap. We do have a target. We had 163 physicians come to the province last year. Of course, we want to exceed that. We want to beat our record every year. Certainly some of the recent changes that have happened with - the College opening their doors to the United States, as an example, will be a significant - and a lot of missions, a lot of recruitment with U.K. physicians in a variety of different places.

Really catching our stride around - not mine, I don't go anywhere - the Office of Healthcare Professionals Recruitment really catching their stride with their recruiters getting to different places and recruiting physicians to come here.

BRAEDON CLARK: I just wanted to ask about international recruitment and retention ongoing efforts. The minister mentioned health care workers from Ukraine, which seemed to be a very quick turnaround from an outsider's perspective - not knowing behind the scenes, of course - but that seemed to be quite a quick turnaround.

The minister mentioned nurses from Nigeria as well. I can think of a few whom I have spoken to who are in my riding, doctors from the U.K., doctors from Egypt, all over the world, really. Some conversations really stick in my mind from the election and just from door-knocking, talking to people who really want to work and are frustrated by their inability to work in some cases.

I wonder if the minster could give us a sense of that experience with the Ukrainian health care workers, which obviously was unexpected. Is there anything that the department took from that as a learning, going forward, to make sure that more foreign-trained health care professionals, who are coming to the province in greater numbers than we've seen in decades, can get to work as quickly as possible?

MICHELLE THOMPSON: This is a very important priority for us, for me, for the department, in terms of how we support. Nova Scotia's International Community of Health Workers Engagement Program, NICHE, really is around a settlement program, so bringing folks in.

In the instance of the people from Ukraine, we did have an opportunity to bring people in in a very quick fashion and we knew they had training. We want to use people to the best and highest use. Perhaps we weren't able to put people in their pre-displacement profession, but we did want to really welcome them into the province. We actually hired some spouses, as an example, of health care workers to be navigators so they could speak with people directly in Ukrainian and support their settlement. These are the things that we're looking at.

We're looking at MOUs with a couple of different countries around the schools so that we have a relationship with the schools, particularly in India and the Philippines. We're not doing one-offs. If they are all here from India, we don't have to do each one of them. We know that this school is accredited or credentialed, so we can always pull those graduates from those places so that it becomes a very clear pathway.

The work that happened with the Nova Scotia College of Nursing - opening up to Nigeria, the United States, the United Kingdom, Australia, New Zealand, India, the Philippines - 87 per cent of their applicants come directly from those countries. Because of their experience and seeing that they are credentialed and trained similarly to us, they were

able to now say that folks can come in and their time to licensing is shortened exponentially as a result of that ongoing relationship. So NICHE is one.

We have MOUs. Also working with the Minister of Labour, Skills and Immigration, working with community-based navigators, helping folks settle, helping communities be prepared to welcome people from different cultural and racial backgrounds, making sure that it's a safe environment and having mentors so that if things are not going well or they have questions, they have a support person.

Also looking at - for nurses - a transition to practice, taking folks in. Even though our credentials are the same, the work environment may be very different. I certainly experienced that when I moved to Scotland, trying to get in, and even though we were all speaking English and the systems are very similar, it took me a little while to get settled and I got in trouble a little bit now and then because of it.

Looking at how we transition those nurses to practice and a new orientation program for physicians. Really looking forward to working with colleges to understand, as we recruit these new health care professionals, how do we support them? I don't think it's going to be the same for everyone, so there's a lot of work that's happening in order to do that.

KELLY REGAN: We're just switching Bedfords now. I was scarfing down my burger week - burger month, whatever it is - burger and listening to this and I did hear my colleague talk to you about the Need a Family Practice Registry. I heard something which does concern me because I think there's a narrative out there that the reason we have so many people on the doctor wait-list is because people are coming here from afar and they need doctors. In fact, if we look at the last number of months, the majority of people who are joining the wait-list are not joining because they are new to the area.

If we look at the most recent one, it's 35.6 per cent of the people are actually new to the area. It could mean that they moved from Cape Breton. It could mean they moved from some place closer. It doesn't mean they are from out of province. It doesn't mean it is necessarily connected with population. I can tell you, from going door to door in this area - which has exploded since 2009 - when I knock on doors and somebody is going to vote Liberal so you want to make sure you get them out, so you get the phone number - just to talk across politics, sorry to the civil servants in the room - but they will say things like - oh, just did the 10,000 steps, there we go.

I would say, oh, is your number such and such and they would say no, that was my number in Stewiacke or Truro or wherever they moved from. They were moving to town to be closer to their grandchildren or closer to health care. I just do want to make the point that, in fact, if we look at the most recent statistics that are out from the department, "I'm new to the area," 35.6. And then if you look at who actually had a doctor and lost it, well, "My provider has moved/closed their practice," that's 25.4 per cent. "My provider has

retired," 15 per cent. "My provider is retiring," 15.9 per cent. We end up over 55 per cent are actually people who had doctors and don't now.

[7:00 p.m.]

I just want to be really clear with people because I think there is a false narrative evolving that the reason we have so many people on the doctor wait-list is because all these new people are coming in. That's not the majority, not even close. The majority is people who had doctors and who lost them.

I just want to clarify that for the minister, because I have heard that said in a number of places. I want to be really clear with people, that, no, it's not that we have come from aways coming in here and they need doctors. It's, in fact, people who had doctors and they're losing them for one reason or another - retirement or they have moved or closed their practice.

With that in mind, is there anything the minister would like to say to that particular issue?

MICHELLE THOMPSON: I thank the member for that. Similarly, 36 per cent are new to the area, and that could be, to your point, moving, which is - and then we look at 25 per cent had a provider that moved or closed their practice, 31 per cent had a provider who retired or is giving notice of retirement.

That's why really investing in the functionality of that list is so essential. There's about $2.7 million going to be allocated to the functionality of that list. There are people, as an example, who will be able to identify, yes, I'm on that list. Perhaps I did just move here from Stewiacke. I may still be attached, or I may still be attached in Cape Breton, but I do need to find a provider here. There still is some sort of a relationship, but it's not the ideal relationship.

The investment in that list really is that, for us to be able - and the other thing that - you know, I find it a little bit stressful is the fact that people aren't really able to interact with that list to tell us what's happening with themselves. Someone who's living with a chronic disease and my 20-year-old son who only needs episodic care are very different.

That's why we're investing in that list. We want to really make sure that we understand who is on the list, if they have attachment, but making sure that while they're on the list they have access. You will see that there's a number of things that are happening with that list in an effort to make it more functional, and also making sure that we can decant people off that list in a more meaningful way.

Because if you're on that list - and it's very cumbersome to call everybody, it's a lot of people power to do it - there's actually no way to come off the list unless you call and

say: Oh hey, I have a doctor and I need to come off the list. It's just not very functional, is what I would say.

Really committed to understanding who's on that list and how they're accessing care and what they need, is part of this budget.

KELLY REGAN: To that point, is there any way the government is planning to prioritize who comes off that list? For example, cancer patients who are unattached. New Nova Scotians, in that they're brand new, they just were born - they should be attached to a doctor or a family practice. People with chronic ailments who are vulnerable, any of us who have a family member who has a chronic disease, we want them to have doctors.

I'm just wondering, out of the $2.7 million, is there anything we're doing to ensure that the people who are the most vulnerable - so that your son who's 19 and super healthy, and my son who's 26 and pretty healthy, they are not the first people we worry about. In fact, it's the people who are more likely to need care.

MICHELLE THOMPSON: To the member's point, that's exactly what the retooling of that list will do. It will help us triage, for lack of a better word, or prioritize, number one, who has access while they're on the list, and what type of access that looks like.

If there is somebody who's living with chronic disease and they're not attached to a permanent practice, they may, in fact, be regularly followed by a primary care clinic that's going to take unattached patients and be that regular care provider until they can be transitioned to a permanent provider. Also to your point, we're going to triage attachment and we're going to triage access. The other thing to the point about the folks who are typically well and need episodic care, as an example - the work that's happening around digital front door will help them. If I only know one walk-in clinic or I only know one place, here I am going to that place all the time when in fact, there might be a pharmacy walk-in clinic or mobile clinic around. This digital front door is going to help people say: This is what's going on, and this is how I navigate what's closest to me for the services that I require. Technology really is a big investment this year because it is going to be such a leverage for us to support people.

KELLY REGAN: How many new residents from Dalhousie University are currently practising in Nova Scotia and is the department working with the current residents on staying here in Nova Scotia?

MICHELLE THOMPSON: I will get you the residency retention rates to let you know how we're doing in terms of retaining residents from Dalhousie, but also working with Maritime Resident Doctors and simply looking at practice environments.

We're very, very active with physician residents throughout the province. Those nine recruiters have been pretty significant in terms of their ability - also the community-based committees across the province that we offered grants to to support their work. What we find is that when we do get residents in communities, we're able to really settle them there and keep them there when the community has the means to wrap around them.

There's a lot of work trying to keep those residents here. Maybe we need a health care worker Tinder, specific to keep people as local as possible.

KELLY REGAN: I think a number of members have asked you questions about the removal of the physician incentive here in the Central Zone. It's a fact, basically, on physician retention here. I haven't quite heard an answer yet that makes sense to me.

We're going to take away an incentive that kept physicians in an area where you have a high population and a growing population of seniors. You often have a lot of people who are disabled, and they are here because they're closer to services.

I'm looking for an answer to why you would get rid of an incentive that actually kept people here. I have people calling me who were on the Need a Family Practice Registry, got a doctor, the physician incentive was gotten rid of, and they're back on that list again. For those people, their health care has been wobbly. They have not had the kind of access that we would want our fellow Nova Scotians to have.

I'd love to have an explanation of why somebody thought that was going to work or make things better. I'm not saying take it away from rural areas, but I'm saying, why it would be removed from a place where it was working? It doesn't make sense to me.

MICHELLE THOMPSON: There are a couple of things that were done. Under the advice of the CEO of the Office of Healthcare Professionals Recruitment at the time, he felt that that was something that would help us recruit to rural Nova Scotia; 60 per cent of the previous incentives had settled in the HRM area.

The other thing is that I'm not sure that if somebody was enrolled in a program, those were grandfathered in. There was no clawback of anybody enrolled in the previous program. If you came in under an incentive program in 2020 and it was a three-year thing, that will all sunset. Nobody lost an incentive. If they had an incentive, we will continue to honour those. This was a new incentive for rural.

I am just going to look at a couple of things. Our recruitment efforts - I wanted to check to see whether it was a higher demand that was resulting in the position or if it was a fewer number of people coming into the Central Zone, in terms of physicians. We're actually recruiting more in the Central Zone than in the year prior.

We do have success over success years recruiting to the Central Zone. Again, we're open to understanding what it is that physicians want. Certainly the advice at the time was to continue with the incentives that were given and to look at incenting people to move to rural Nova Scotia to have more equitable distribution of the new folks. We continue to recruit in central even though they are gone.

KELLY REGAN: When a physician is recruited into the Central Zone, are they obliged to take people off the list, or can they choose their patients how they want? How does it work?

I have to tell you that I used to routinely, before the summer of 2021, I would see notices of physicians coming in, not just to Bedford but to the metro area, right. People from Bedford are happy to go to Dartmouth for a doctor, as long as they get one. We used to routinely see notices of new doctors setting up practices and we would keep track of that. We would keep a list at my office, and we would call people when we saw a new doctor moving in.

We have not seen that. We get no notifications, there is no indication that anybody new is coming in at all. I am wondering if doctors have been told that you have to take people off the list, or how it's working. We have been unable to call the people on our list for well over a year with news about new doctors coming to, again, metro.

MICHELLE THOMPSON: In regard to whether physicians are taking people off the list, the answer is really that it depends. Sometimes physicians would come in and they would actually be a replacement physician for the practice they are currently working in. If you are already in a full panel or you take over a practice, there would not be a requirement.

If you are an additional physician - and there hasn't been a requirement in the past for people to come off the list specifically, which is why we want to retool that list - the expectation would be that people would come off the Need a Family Practice Registry with physicians as they come in. We need to understand who is on the list and then how we put them on a roster in a meaningful way.

KELLY REGAN: For the last year, can you give me the number of family physicians who have set up practice in the Central Zone? In the - I think it is called the Bedford/Sackville cluster, just to have an idea of how many doctors we have coming into these areas because I can tell you again, I think I am the only MLA in this House who, to my knowledge, has ever served three different ridings. The reason my riding kept changing is because people kept moving in. I would literally drive up Larry Uteck Boulevard every three weeks and I would be driving up, and: Where did that building come from? This was pre-COVID-19.

My riding has shrunk and shrunk, and I have two new colleagues as a result of it because these ridings were created since I was first elected in 2009. I am just trying to get a handle on how many new physicians we've had in the last year in that particular cluster.

MICHELLE THOMPSON: I'll get that from the department, I don't have that drilled-down detail, but I will get it for you. I just want to let you know, too, that in terms of resident retention from the Dalhousie program, it's at 75 per cent.

[7:15 p.m.]

KELLY REGAN: The budget says it will reduce wait times for gynecology care to improve care for urgent cases, which I do appreciate. I have spoken to the minister about this, and I appreciate her attention to this particular issue, as she indicated that this was something she was aware of before becoming elected. There's a need for more than just urgent cases. Sexual health, the ability to have children, et cetera, all of those things are important whether or not it's a life-threatening issue. We know that OB/GYNs are crucial specialists we need more of. I know they're not always easy to get, for a variety of reasons. Have there been any more new OB/GYNs in this province in the past year? Are you in talks with any more to come to the province?

MICHELLE THOMPSON: We will give you those numbers around that. I don't know - do you want simply the IWK Health Centre, or do you want across the province for the gynecology? Right across the province, okay.

KELLY REGAN: In the budget, there's $1.7 million to add physician assistants to collaborative primary care sites across the province. Is there a timeline when these positions will be filled? What sites are they being added to? Do we have any information on that?

MICHELLE THOMPSON: We are looking at increasing by 10 physician assistants. It's a bit of a stay-tuned moment in terms of where exactly they go and also the availability of that skill set because it is so new to the province. The commitment is there for 10, but it's evolving, is what I would say. There are some pilots happening now. We still have orthopaedic and Bridgewater and Dartmouth General as well under way in the hiring phase. There will be an expansion of that program. We're still working towards it, but yes, we're excited about that.

KELLY REGAN: On a number of occasions prior to 2021, my colleague for Sackville-Uniacke - I think is the name of the riding - asked the then-government about extending hours at the Cobequid Community Health Centre in Sackville. Currently it's being shut down at 11 o'clock, but patient flow starts restricting long before that. I didn't see anything in the budget about the Cobequid Centre. Are there any plans to extend the hours of the Cobequid Centre? I know that this particular member was keen for the Cobequid to be open 24/7. Are there any plans to expand the physical plant there so that if

people need to stay in overnight, they can do that kind of thing? Are there any plans for expansion to that because it is certainly - it is a well-used facility, I guess is what I would say.

MICHELLE THOMPSON: Certainly when we announced the infrastructure project in HRM, we are looking at the expansion of the Cobequid Community Health Centre, including an in-patient unit as well as a 24-hour emergency. That will not be happening in this year but there are plans to expand the services there.

KELLY REGAN: I am sorry, although I briefly worked in a hospital, it was in fundraising so, you know. When we are talking in-patient unit, we are talking about beds in the hospital that people could stay overnight in, that kind of thing. So the Cobequid would be changing from strictly an ER and outpatient to something more like a community hospital? Is that what we're looking at?

MICHELLE THOMPSON: We will get more details. I'm speaking from memory, and I am always a little timid about that and the television never forgets. I will get you some more information about that. That is my understanding, but we can confirm the services and the number of beds.

KELLY REGAN: I have a senior doctor in my district who is in his sixties and he currently pays for a nurse in his office out of his own practice. To me, that doesn't make sense. To me, if he has someone there who is helping him be more efficient, we should be paying for that nurse as a physician's assistant or something like that. It doesn't make sense to me that we are actually penalizing a doctor for being proactive - for bringing a nurse to help move his practice along. Could you speak to that? Are there plans here to help doctors who, particularly as they are getting older, may wish to remain practising but would like some help? I am wondering if you could speak to that.

MICHELLE THOMPSON: You know, many of our physicians - almost all are independent business owners essentially - and so that is obviously a business choice. Certainly we do work with physicians and that collaborative practice team is exactly that - looking at supporting physicians and attaching them to clinics where NSHA resources are provided. There are some physicians - I don't know this particular case at all but there are some physicians who prefer to work outside of NSHA. When we have NSHA employees in a facility, there are certain protocols and things that need to be followed as a result of that and some physicians choose not to do that. I can think of a couple of examples where they would prefer to remain as independent and hire their own staff. We're pretty open to the models that people have, and if that's something that physician wants to explore, that hotline number is available to see if that practice can be expanded.

KELLY REGAN: I would just say I will be looking for that hotline number so I can give it to him because he would like to be having a collaborative practice and I don't think he has been approved for it yet. I think that would possibly ensure that he might stick

around a little bit longer, which we would like him to do. He is a very knowledgeable doctor, a very good doctor. Thousands of patients in the area do rely on him.

Finally, I will just quickly say this, when the minister says that the previous government was doing nothing, I want her to know that a lot of the things I have seen from this government are continuations of what we were doing, so it was not nothing.

THE CHAIR: Order.

SUSAN LEBLANC: When I left off, I was reading a letter from a constituent of my colleague's. I'm going to recap it and pick up where I left off. (Interruption) Great. I like reading it:

> Casuals are used to fill holes and gaps to cover vacation and especially with sick calls and sick restrictions during the pandemic. Also to be noted many casuals work multiple units to be able to retail full time hours as there truly is not an abundance of permanent full-time 1.0 positions posted or available." Okay, I read all that. "I hope you will support your nurses and advocate that the Thank you $10,000 bonus be awarded to all nurses who have worked full time regardless of if they hold a permanent or term position. Saying you don't deserve a thank you bonus because you don't hold a permanent Position, despite working full time and showing up to support our fellow Nova Scotians our healthcare system - quite frankly is the biggest slap in the face. I also urge that you support an offer of a prorated option to include casuals just as the part time permanent nurses are being awarded the bonus based off hours worked. I would love your feed back and support on receipt of this email. I hope you can stand behind all nurses - who lead [sic] the way when most people were home scared, and continued to deal with the effects of the forgotten pandemic.

Mr. Chair, I tabled that letter earlier, so it has been tabled. I am just wondering if the minister can speak to that.

MICHELLE THOMPSON: Certainly the best avenue for that individual is to reach out directly to her employer, but full-time, temporary-assignment folks - if she is not casual, is actually in a temporary, full-time assignment, she would be eligible for the bonus.

Also, any casual who wants to come back into the system and hold a position is eligible for the return to nursing $10,000 incentive as well.

SUSAN LEBLANC: I just want to talk about paramedics briefly today. The targets in the Emergency Medical Care Inc. contract are routinely not met. I'm wondering if this concerns the minister.

MICHELLE THOMPSON: Of course we're concerned about the health care system in general and we're working really hard with Emergency Health Services, as the regulator, and the company EMCI, to look at how we support those services. We've done a lot to support the paramedic workforce because we know it is under such strain.

[7:30 p.m.]

Really separating the emergency response from the transfer response has been very significant and supporting medical communications; in fact, we need to look at a couple of different things. As an example, now that we have 24/7 doc in the box there are actually people who call 911 who are triaged out and actually will wait as a result of that. There are a number of things happening to support patients. They may need care but not emergency care or urgent care; they may be able to be referred to primary care.

We are really utilizing a number of different avenues to support people in the field, and the paramedics in the field. Those doctors can not only support emergency situations with the paramedics, but there's also a physician and a nurse who can work with patients in community when they call 911 to support them, create a care plan, and get them to access care in a different way. Also, around that triage is like, sending out the SPEAR unit as an example.

So we're looking at a multitude of different ways to respond to people. In community, looking at how we utilize the skill sets of the paramedics and match them with the incoming calls, so more of a triage system. Actually in-person support people in a crisis, whatever that may be; if it's EHS of course it's easy, if it's an emergency code 1 or code 2 but there are people who call who can be supported in a different way which also affects in terms of how we measure the response times.

SUSAN LEBLANC: Speaking of that, a while ago we brought the idea of a fourth aspect of the 911 system to the floor of the Legislature, which would be like a mental health component, and I know that the minister is not the Minister of Addictions and Mental Health, but I just wonder if there is discussion about that. So that there would be an expansion of, so you know, you call 911, your emergency is actually a mental health emergency, and there's an expansion, there's a fourth type of first responder who goes to a mental health emergency. Is there any progress being made in that sort of direction?

MICHELLE LEBLANC: I know there's some work under way, and I'm just going to redirect you to the minister. I don't want to one, steal his thunder, and two, underscore what he's doing, what work is happening. So there is some work around there, and around

how we support people who are living with mental illness, and how we support them in crisis.

SUSAN LEBLANC: EMCI has never paid a fine under its contract according to a Freedom of Information and Protection of Privacy request that we put in, I'm just wondering why? There are fines listed for not meeting service agreements, or expectations. I'm wondering why the department has never actually recouped any fines from EMCI.

MICHELLE LEBLANC: The issue around this is quite complex. I don't have the contract in front of me but there are times that there are outside influences, other than just the company, that result in their response times, or such as off-load, as an example. It's fairly straightforward in some ways, but there are often times that it's the system itself that is leading the inability to reach those targets.

So, we are working with EHS, EMCI around those targets, looking at the reasons, the root causes of why those things happen. So, it could be off-load times; it could be further travel related to emergency room closures. So, it isn't always solely the fault of the company, which is why we need to take a whole system approach and move forward. So, we are working with them.

We certainly have increased the staff in EHS in the department to work around solutions. We're working at a table where we have, you know, the College of Paramedics of Nova Scotia, the union, EHS, our own regulator, Department of Health and Wellness, the NSHA, looking at these really complex problems to support. Because when they do well, then we all do well, and it isn't always solely an issue with just EMCI. Sometimes it's related to the ability to off-load, things like that. So, there is a lot of work under way, and it's not a straight arrow I guess is what I would say from A to B.

SUSAN LEBLANC: Okay, I'm going to leave paramedics for now.

I forgot to ask this question earlier when we were talking about nurses. Before I hand my time off to my colleague, I just want to ask about the Nova Scotia Nurses' Union's call for a public travel nurse program within the province - a travel nurse incentive to be set up. I'm wondering if that is being looked at. Just to expand on that, the idea would be that nurses who live in Nova Scotia would be dispatched to areas that are chronically short, or not even chronically short but short for whatever reason, and they would get paid a travel bonus, per diem, blah, blah, blah. It would give nurses some flexibility, but they wouldn't actually be going out of province and living somewhere else.

MICHELLE THOMPSON: We're not currently exploring that at this time.

THE CHAIR: The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: I had the chance to spend some time with the Minister of Advanced Education in Estimates and asked some questions around the Cape Breton University medical school, and I can't remember exactly what point I was supposed to follow up on, so I'm just going to ask the questions again.

I was curious about the strategy for making the school a success. We have heard about 30 new family doctors every year in Nova Scotia - in a decade - once things get rolling. I guess I was wondering: How is that going to be accomplished? Are we going to limit people's study to not apply for specialty residency positions? There are also challenges in attracting people to family medicine, as you know. CaRMS, the Canadian Resident Matching Service, which took place on March 22nd, there were 268 family medicine vacancies across the country. This isn't just a challenge for Nova Scotia. It's a challenge for the profession, to get people there and to have them want to match with family practices. I guess I'm wondering: How are we going to get 30 grads? Are we going to tell people they can't become specialists if they go to CBU medical school?

I also wonder about how we're going to keep 30 grads in the province. The Minister of Advanced Education said there would be a five-year return of service agreement, but I'm wondering what we're giving to get that. Normally, when people get a return of service, you get a tuition rebate, or you get something for making your commitment to a province. I'm wondering if you can walk me through that whole process.

MICHELLE THOMPSON: Again, it's art and science. I'll tell you a little bit about some of the things that we think about. I will tell you that I have heard for a number of years, but really increasingly since I came into this role, that there are a number of Nova Scotians who apply to medical school and because of the competitive nature aren't able to get in. We do feel that there are a number of Nova Scotia students who aren't successful because of the current number of seats that we have, so we feel confident that there is an ability for people to have that pool expanded when we increase seats. That will certainly open opportunities for Nova Scotia students. We do know that there are a number of people who have tried repeatedly to get into medicine and, again, the competitive nature of the program - it doesn't mean the difference between 88 per cent and 92 per cent can make a big difference in terms of an application. We do feel that there's a pool of individuals.

Currently our retention rate for residents in Nova Scotia is at 75 per cent and I think, when we tailor a program specifically for rural medicine, I think it will attract a certain type of individual who wants to work in that type of a practice environment. I'll give you an example. I think it also opens a door for people who didn't maybe see themselves to have that opportunity.

When the medical school was announced there were two individuals who were just by the stage as the Premier was coming off the stage and one of them was in nursing; maybe both, but I know one for sure, and that nursing student said, I'm going to graduate from that class. I'm going to be one of the first people. That nursing student said at the time

that she didn't see herself - you know, she didn't want to leave Cape Breton. She didn't want to go away. She wanted to do all these things, but this opened a door for her that perhaps she would not have considered before.

I also think that there is an opportunity for us to look at supporting our diverse and historic communities. There is a large population of First Nations communities in Cape Breton, and we also have the school there led by a very capable dean, and I think there is also an opportunity for us to increase the potential and the opportunity for people to increase representation. I do think there is going to be very much a niche with CBU. I think they have been carving that out over the last number of years and are very committed.

In terms of the residency seats, there is also, as part of that, a huge clinic that will service up to, I think, 8,000, or 10,000 patients which will provide a really unique practice environment. It is going to happen incrementally; there is no question about it. Dalhousie University certainly has expertise in running that medical campus. This is the second campus, and they are working in lockstep and so they are going to do a lot of the nuts and bolts of that but I do think it is a really exciting initiative. I just think it is a terrific opportunity for those folks who come from rural communities across the province to have an opportunity to be educated in more of a rural environment. I do think it will be quite appealing to a number of folks and eventually maybe we will - if we max out here, I'm sure there will be folks from our Atlantic provinces that would eventually consider attending.

LISA LACHANCE: I am wondering if you could speak to how the plan is to recruit specifically Nova Scotian students. Will there be tuition waivers, a bonus, something like that and can you talk about the return of service contract that the Minister of Advanced Education discussed?

MICHELLE THOMPSON: I will just give an example. We have five additional seats funded out of CBU at Dalhousie and so those five additional seats specific to rural folks - the response was significant, so we are not overly worried about the inability to recruit. I think to a large degree that a number of those seats are subsidized already. What we find is we have a lot of Nova Scotians who train internationally because they can't get into medical school here and so this gives us an opportunity for them to be able to work and study at home.

To the level of detail around return of service, that is going to be a little bit further down the road. I don't have those, but I do really think this is a significant opportunity. We believe that we have up to 200 internationally educated Nova Scotians who are trying to get back through residency and all those things. What an opportunity if they had been able to live and train here. I do think it will be very successful and everything evolves over time. This is our focus and I expect that how Dalhousie started and how Dalhousie is today is not exactly the same. I expect that over time, once this program gets up and running, that there will be adaptations but certainly the focus right now is rural medicine and specifically with our Nova Scotia graduates.

LISA LACHANCE: In terms of the funding that has already been allocated to CBU, can you talk a bit about what that is being used for and over which fiscal years? I am wondering within the agreement what is happening with things like interest. Is the interest on that funding - because I don't think it is going to be spent in the next couple of months - is that returning to the province or is that staying with the institution?

[7:45 p.m.]

MICHELLE THOMPSON: The funding is not coming from Health, it's actually coming from Advanced Education, so we don't have that information.

LISA LACHANCE: I guess I would invite you and the Minister of Advanced Education to work out those details. I think Nova Scotians have now made a significant investment and to not know how that is being managed or for what, I think Nova Scotians will want that level of transparency around the funding.

I wanted to turn to gender-affirming care. There's $1.7 million in the budget that I think talks about increased access to gender-affirming services and I'm wondering what that is for.

MICHELLE THOMPSON: Certainly, it is an increase in utilization, so anticipating a significant increase in the number of people seeking the services that are required. It really is in an effort to ensure that we are allocating funds to ensure that we are there to meet the demand when people are looking for gender reassignment surgeries.

LISA LACHANCE: Is that $1.7 million FTEs? I'm wondering if you are anticipating an increase in gender seeking - and is it for assessments or actual surgeries? Have you seen an increased demand this year? What's the expectation of what that increased demand is, in terms of numbers for this coming year?

MICHELLE THOMPSON: It is increased utilization. It's mostly for out of province, people seeking care out of province. Generally, numbers have been about 100 individuals in past years, but we are anticipating a significant increase to around 350 to 380 this year.

LISA LACHANCE: I don't mean to belabour the point, but the $1.7 million, is that in travel funding for people who seek services? Does it involve any increased FTEs? I'll let you have a chance to respond on the microphone.

I'm also wondering if it also would include increased numbers of services to become World Professional Association for Transgender Health compliant.

MICHELLE THOMPSON: So that $1.7 million is all towards service delivery; it's actually the cost of sending people away to get what they require. In terms of WPATH

standards, the Department of Health and Wellness is very engaged with WPATH standards making sure that people are compliant, that there's more folks in the province trained, and the proposed policy is being updated. We're working with folks from the transgender community, making that sure our policies are appropriate and supporting their needs.

LISA LACHANCE: So in 2021, I think there was a FOIPOP that indicated that there were 42 folks who went to Montreal for MSI coverage surgeries under gender affirming care. So just confirming that this past year that actually increased to 100 people who went to Montreal, and so specifically those types of services that would make this province WPATH compliant, because it isn't right now. We don't fund - MSI does not currently cover boys' feminization for instance, facial feminization, or masculinization. Is there intent to cover those processes this year? And if not, when can we expect the policy?

MICHELLE THOMPSON: We will confirm the numbers. There are just a lot of numbers, so I just want to refer and make sure that we have them right. We are investing an additional $1.7 million this year in supporting folks in getting access to care outside of the province. That is the extent of the investment this year in terms of this service provision.

LISA LACHANCE: You referred to some policy work that's ongoing in terms of the review in compliance with WPATH, and I'm wondering if you can talk about that process, and when Nova Scotians can expect to hear the results.

MICHELLE THOMPSON: There was a policy from community that was submitted to Department of Health and Wellness, and I know that the Department of Health and Wellness has been working with members from the transgender community, making sure that we are compliant and making sure we meet the need of the community. So, we expect that will be released this Spring. I don't have a hard date for you, but certainly the work has been ongoing, and we expect that the policy will be soon.

LISA LACHANCE: I mean, that would be great because I think we thought it was coming last Spring, so community is definitely anxious to see that. I'm wondering if you can talk about how many FTEs from within the department are currently working on gender affirming care or 2SLGBTQ+ health issues. If you're bringing forth the policy in the Spring, are there increased FTEs to focus on that from within the department as you implement the policy?

MICHELLE THOMPSON: There are staff from the clinical services branch and equity engagement branch working on the policy at the Department of Health and Wellness. In the Department of Health and Wellness, there are no proposed new FTEs, but there is an expansion of prideHealth across the province, which will involve increased FTEs. The investment is $368,000 to support provincial . . . (Interruption)

THE CHAIR: The honourable member for Halifax Citadel-Sable Island.

LISA LACHANCE: I was going to ask about the prideHealth investment because in the budget it was bundled with a couple of other equity measures. So, $368,000 for a province-wide program - can you tell me how many new FTEs that is?

MICHELLE THOMPSON: I don't have that off the top of my head. We'll have to look and find it.

LISA LACHANCE: That would be great, to have access to that information. It's a pretty specific number, so either it was the residual from a little pot of money for equity or there were specific calculations around what that $368,000 would do. I know there was the review that has been going on and on and on and taking quite a long time, in terms of prideHealth. Again, this was something that the community expected last Spring or last Summer. It seems to take a long time. I'm wondering, will you be able to table a public document that talks about how prideHealth was evaluated and what the recommendations were?

MICHELLE THOMPSON: For us in the Department of Health and Wellness, a business case was put forward by the Nova Scotia Health Authority as a result of their own internal processes. That business case is what informed the budgetary information that we have today. It actually came from the Nova Scotia Health Authority, from the program, as a business case.

LISA LACHANCE: It would still be really interesting to be able to see that, see what questions were asked about the program, what goals the program now has. Do you have access to that sort of information? Do you know who was engaged in that business case or review? Last year it was a review, an evaluation of the services, so it sounds like it changed form a little bit over the past year. Was there engagement undertaken?

MICHELLE THOMPSON: I don't have that information. I'll have to check with NSHA and prideHealth to understand how that business case was developed.

LISA LACHANCE: Speaking of engagement, going back to the WPATH policy work that's being done through the Department of Health and Wellness, you have made reference to consultation with the transgender community, which is obviously diverse and made up of individuals and formal and informal organizations. Would you be able to provide a table of who was engaged and when, so that we can have a look at the extensive consultation that did take place?

MICHELLE THOMPSON: Certainly just in terms of the engagement, we can't get a table of who was involved but overall, internal and external partners, including community advocates, clinicians and subject matter experts across Canada - and conducted a research and cross-jurisdictional scan to inform the development of the policy. There was some consultation and development done and it has taken longer because they actually went back out and did other consultation, following the original draft of the policy.

[8:00 p.m.]

LISA LACHANCE: Again, we've been waiting a long time for this revised policy; people are anxious to see it. If the minister could provide a timeline and a list of who was engaged and when, that would certainly be helpful in terms of understanding the process that has been followed, specifically this particular delay around the draft policy.

THE CHAIR: Order, the time allotted for the consideration of Supply today has elapsed.

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.

[8:02 p.m. The committee adjourned.]