House of Assembly
Nova Scotia

HALIFAX, FRIDAY, MARCH 31, 2023

COMMITTEE OF THE WHOLE ON SUPPLY

11:44 A.M.

CHAIR
Angela Simmonds

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

The honourable Government House Leader.

HON. KIM MASLAND: Madam Chair, would you please call the Estimates of the Minister of Health and Wellness, Resolutions E11 and E29.

THE CHAIR: The honourable member for Dartmouth North.

SUSAN LEBLANC: Madam Chair, I wanted to begin with a question from yesterday. Yesterday I asked about ER deaths, and the minister said that she would get back to us. I'm just wondering if she has the information now needed to discuss this. FOIPOP documents that our office received show that 2022 had the highest number of ER deaths in the last six years. It also showed that 2022 had the highest proportion of deaths, meaning that it was not only a high number of visitors but also that there were worse outcomes. My question yesterday and today is: Can the minister explain why this is?

HON. MICHELLE THOMPSON: What I want to say first and foremost is that I want to hold this conversation with intention and compassion. It is very difficult to lose somebody in emergency. By talking about the numbers, I in no way wish to minimize the loss of any individual who has lost somebody through any sort of urgent or emergent situation.

[11:45 a.m.]

In terms of the numbers, there were 590 deaths in 2022, so we do have an increasing trend in ER deaths compared over several years, but there are a number of confounding factors, including people coming to the emergency room sicker. If we break it down by Canadian Triage and Acuity Scale score, we see that there is an increase in deaths for individuals who present to ER with a CTAS score of 1 and 2 in terms of the numbers. There have been increases in visits in both of these areas - the number of people presenting with CTAS 1 and CTAS 2 - and also in those presenting with CTAS 3 and a decrease in CTAS 4 and CTAS 5, so an increase in the number of sick people as well. There has been an actual decrease in the percentage of people who are dying who present as CTAS 1, and the percentage of people dying who have a score of CTAS 2 has been steady for the past four years. I can table that.

SUSAN LEBLANC: Yes, I appreciate the minister's approach to this discussion. Just to confirm the scores, 1 is the highest acuity and it goes down from there. Is that correct? I'm honestly trying to get my head around this. Would that then suggest that people who are coming with scores of 3 are actually the ones who are having the worst outcomes? If Level 2 is remaining steady and Level 1 has decreased, then what else do we think is going on there?

MICHELLE THOMPSON: People who present with CTAS 1 and CTAS 2 are critically unwell. The percentage has actually not significantly changed, but the numbers have changed. We see more people presenting with Level 1 and Level 2, and they are sicker as a result of perhaps late presentation or delayed diagnosis or a whole constellation of things. I would say unequivocally that period of COVID-19 has certainly impacted that on a whole variety of issues, not to mention that our population is aging, and we also have very high rates of chronic disease, as an example, in this province. The numbers are increasing, but the percentage has stayed steady.

SUSAN LEBLANC: I'm glad to hear the minister think about possible reasons. I'm hearing aging population. I'm hearing COVID-19, because people are presenting sicker because they didn't go to the doctor, perhaps, or it was harder to access care during those lockdown times. That makes sense to me. Would the minister agree that the lack of available primary care - more people unattached to primary care - could possibly contribute to sicker people arriving at the hospital? If someone doesn't have a doctor, they don't want to go and sit and wait in the ER if they have some small ailment, and then by the time they go to the ER, they're sicker. Does that sit true?

MICHELLE THOMPSON: I would say that it would be similar. It would be hard to draw a straight line to all of those things. I think it is a very complex issue in terms of late-stage disease. I also would say that the number of people - as we see high chronic disease rates - I don't have the age breakdown, of course. We would see people presenting with late-stage disease for a variety of different reasons. The people who present with a

CTAS score of 1, to me, are the ones who are full cardiac arrest or peri-arrest. There has been an event or through injury, as an example. Level 2 would be just marginally below that. People come with those illnesses, and they are critically ill. The numbers are increasing likely related to - it could also be related to our population growth. It could also be related to utilization. I just don't think we can say one, two, three. I think it's very, very complex, and all the factors would influence that number.

SUSAN LEBLANC: I just have a couple of questions about the quality review process. I, like many Nova Scotians probably, didn't even know that term until the unfortunate terrible death of Allison Holthoff. We heard that quality review process term in the news following her death. I have heard the minister say that families are provided with a copy of the final report when that is done. Is that correct?

MICHELLE THOMPSON: A quality review is part of the accreditation process. It's covered under QIIPA. I don't know if you remember QIIPA. It's the Quality-improvement Information Protection Act. The Quality-improvement Information Protection Act is actually what protects and leads to a just culture in health care. I'm not sure if you're familiar with the term just culture. A quality review brings together the people who are involved in a case where the outcome was unexpected and allows them to debrief and speak within the confines of the review.

As a result of that review, recommendations are shared - looking at recommendations for the facility, perhaps the department, maybe recommendations for the system as a whole, maybe if there's any integration between two systems, as an example. What's shared amongst the team - because it's not about blame - it's about really understanding from a quality perspective where there was a failure in the system or if there was a failure in the system. The recommendations are shared, not the information that is discussed, which leads to a just culture. Dr. Brian Goldman - he does *White Coat, Black Art* - has an excellent podcast about just culture. He talks about how important this process is. If anyone is interested, I would encourage you to listen to it. It is very helpful to contextualize it.

After a quality review is done, recommendations are created by the team, and then the health care workers and leadership sit with the family and review the recommendations with them so they understand how the system will respond in future to a similar event, what initiatives will be undertaken in order to prevent this from happening again. The system is changed as a result of the event, and that's what a quality review does. It's protected by legislation, part of the Accreditation Canada process. Recommendations are shared with family by staff directly. It's not just a simple handover of a report.

SUSAN LEBLANC: That's helpful. When the family receives information, are there restrictions on how the information can be shared by the family after it's provided? If a family goes in and sits down and understands the recommendations, is the family allowed to talk about that publicly? Is there stuff that's not shared with the family? I understand

things like protecting identities of individual health care providers and that kind of thing. Is there anything else that's just not given to the family other than the identities of people?

[12:00 p.m.]

MICHELLE THOMPSON: As the team meets, the conversations are held in confidence. Sometimes people know who was there. It depends how big the community is or how small. The conversations are held in confidence, and it really is a team discussion. In my experience, it has been a timeline of events and actions: this is what happened, this is how it happened. Really doing a root-cause analysis, essentially, is what happens. That discussion is protected. From the root-cause analysis that happens in a quality review, recommendations are then developed as a result of that. It indicates where the system could have been stronger, where as a team member - not me as an individual - how I would go forward in the future.

Those recommendations are provided to the family and to the team as well. The team needs to also understand. Sometimes there is a quality improvement project that results from these quality reviews. We recognize that there's a gap in the unit, in the hospital, or in the system, and a quality review starts as a result of that. Recommendations that are given to family can be shared. They're welcome to do with those recommendations what they want. Often, depending on the family's wishes, always, updates can be provided about how the implementation of those recommendations is going.

SUSAN LEBLANC: Is there any aggregate information at all that can be made public, from all of the reviews that have taken place? How many take place each year? What are the general findings or recommendations?

MICHELLE THOMPSON: There would be. Again, pulling back from my past experience, there would be what we would call sentinel events - unexpected or significant events with an outcome associated. We track near misses, something that happens where the systems fail, either as a result of the system or a person, and there's no harm. That would be a near miss. Those are tracked to the best of our ability. Then there would be incidents with harm. Serious reportable events are made public. The quality reviews I can check. The serious reportable events are counted and reported publicly.

SUSAN LEBLANC: I understand accreditation processes happen every however-many years, and that kind of thing. In between, is there any work done by any part of the department, where somebody's job is to take all of this stuff and produce an accountability report or whatever, the way that Nova Scotia Legal Aid has an accountability report and community colleges have an accountability report? Is anything like that worked on on a yearly basis or every three years or anything like that?

MICHELLE THOMPSON: There are actually designated staff in the Nova Scotia Health Authority and the IWK Health Centre, as well as the Department of Health and

Wellness, who look at this quality and the trends - are there more events, are there similar events? There would be a whole variety of things. Accreditation doesn't just look at your last month, your last quarter, or your last six months. That is the point of accreditation. It's totally around quality patient safety. It is a foundational piece of the work that happens around quality review, around quality in the system. We track very closely, it's monitored, and responded to. It's not annually. There would be regular reporting and response related to (a) the number and (b) if there was a trend in a particular unit or directorate or facility. There are all different ways to slice it to monitor it in a quality program.

SUSAN LEBLANC: Is that information available to the public?

MICHELLE THOMPSON: Serious reportable events are reported publicly, in terms of the trends. I'll just find out if they are on a website, whether it's the NSHA or IWK Health Centre or Department of Health and Wellness. I'll just confirm that, but they are reported publicly. Similar to handwashing, you know what I mean? There's a number of different quality indicators we would use, a variety of different indicators for people.

SUSAN LEBLANC: That series of indicators that the minister is referring to, can she speak to the trends since this government came into power, so Summer of 2021?

MICHELLE THOMPSON: I'll have to pull that. We'll have to see if we can gather that up for you.

SUSAN LEBLANC: Yes, I look forward to that.

Moving on, vaccine uptake among young children is concerningly low in Nova Scotia. Can the minister talk about this and what's being done to address it?

MICHELLE THOMPSON: Many of our public health resources were pulled for pandemic response over the last two-and-a-half years, but those services are being re-established. Our Early Years folks are back in the field again, working with families, supporting well baby work, making sure that we're screening high-risk families, talking about immunizations again. We do know that there is some catch-up that has to happen. There are some available options - obviously, primary care providers. It is a special skill set for nurses; you need to take a competency course in order to deliver immunization. They are focused in Public Health on resuming our rates, making sure that we're reaching out to communities, working with primary health care providers through the newcomer clinic, places like that.

We have an unattached baby clinic as well, which is supporting families who don't have a primary care provider that they're attached to, to give them access. There is work that's beginning, and the rates are monitored very carefully and kept in a system called Panorama. They have a good line of sight on where we are and where we need to go.

SUSAN LEBLANC: My understanding is that because of all the things the minister has just said, we aren't in a good place right now. If Panorama is monitoring that, where do we need to go, and how are we going to get there? I just think about when I had my babies, with those first many sets of vaccinations, the doctor would say, you have to come back in six months for the next one, or whatever. I would never know when you're supposed to get kids immunized, at what age, or whatever. Then at a certain point, because you don't have those frequent visits, that drops off. I remember finding myself in a position where my kid was going to pre-Primary, and he didn't have his vaccinations. We had to get him all caught up and all that. I think about that, and I have a family physician, a family care provider. Presumably, even with the unattached baby clinic, there are going to be people who aren't - what's the word I'm looking for? Those reminders are not going to be there.

Is there something being done to get at those kids who need those vaccinations? I'll say it right now: one of the best things that we see that could be done is school vaccinations. We do it for HPV, and we do it for certain things. Does the minister see a time when we could be doing COVID-19 vaccines in schools or other types of vaccination clinics in schools?

MICHELLE THOMPSON: In terms of our Early Years - vaccinations are Early Years - Public Health Early Years folks are back out in the field, which will help. The majority of our vaccinations actually happen in pre-school - 2 months, 4 months, 6 months, 1 year, 18 months, and then I think it's 4 years old, if everything is still the same. We are caught up with our school-aged vaccination program. Grade 7, all those kids who would have missed that staggering. It does take a lot of resources to go into schools. With that model of 2 months, 4 months, 6 months, 12 months, 18 months, 4 years, we have a cohort of people we work with. It's the same with Grade 7. They get all their vaccinations at the same time.

The issue with COVID-19 vaccines, number one, is that in an age-appropriate way, it would be really hard to immunize littles, particularly. Often, when you see school-based vaccination programs - I remember years ago, there was measles, mumps, and rubella vaccination, as an example. With a certain age group, it's easier when you have a cohort of individuals who will stay on the same schedule. With COVID-19, everybody is on a different schedule. Their boosters are all different. Their doses are all different, in terms of their ages and stuff. I don't foresee a time, which is why the pharmacies were such an important part of that rollout. People know their pharmacies. They can make appointments in their communities. Parents or a trusted adult can accompany kids to get COVID-19 shots, just as they would if they were accompanying their children to get their pre-school vaccinations.

SUSAN LEBLANC: It's possible that the reason why everyone's on a different schedule is because we didn't roll out the COVID-19 vaccines in a way that was super-accessible for everyone at the same time. You know who was in power then, folks - those guys. Anyhow, I hear that at this point it would be very complicated.

I'll take the last bit of my time in this hour to say - and I've said this before, the minister knows this - that there have been a lot of issues with getting COVID-19 vaccines, for children in particular, in one's community and at a time when it's not school hours. When I have looked for my kids - in fact, my kids still don't have their boosters because I've tried three different times, where I've booked and then it's impossible to get them out of school for a variety of reasons. I look at what's available, and it's all between 11:00 a.m. and 2:30 p.m. I'm working. They're at school . . .

THE CHAIR: Order. The time for the NDP has passed.

The honourable member for Bedford Basin.

HON. KELLY REGAN: I just want to take a few minutes here. Thank you for your answers the other day. I'm sure the minister is tired of seeing our faces over here, and I'm sure she's looking forward to the weekend.

I got an email from a constituent this week, and I thought I had better share that with the minister because I want her to know what's happening on the ground. This constituent wrote and she said she was - I'm assuming it's a she, but it's a name that could be either, so I'm going to say "they."

They were baffled about the nursing shortage, following experiences both her sister and her mother had, and they're nurses. She says her mother moved back from Australia. She was a nurse for 35 years, and she was looking for a casual position for months with no luck. When she contacted the IWK Health Centre recruitment department, they simply emailed her back with postings for full-time work only. She was very clear she wanted casual work. She wondered why there is not a casual roster being hired for when we're at a crisis level of staffing.

Then they go on to note that their sister is a highly specialized pediatric intensive care nurse who recently moved back to Cape Breton but continues to travel back and forth for work and was eventually hired for casual at the neonatal intensive care unit in Sydney. It took HR six weeks to send her onboarding letter, and she has to redo all of her paperwork - criminal record check, occupational health, everything - even though she's already employed here in the province. So she can't start helping out the department until May.

The constituent wrote to me saying they can't believe this is the kind of thing that's happening on the ground. Government may be putting all kinds of money in, may be saying more health care faster, but in fact what this constituent is seeing is roadblocks. I thought I would leave that with you, see if you have any response to that. I wanted to make you aware of what is happening on the ground, as nurses are moving, are coming back to the country, and they're facing roadblocks. While I understand that the IWK Health Centre would want to hire full-time nurses, I would think probably a casual nurse is better than no nurse. If the minister could just speak to that.

THE CHAIR: If the honourable member is quoting, I ask that you table a document. If not - paraphrasing, okay.

[12:15 p.m.]

MICHELLE THOMPSON: This certainly is not something that is unfamiliar to us. We have heard. In terms of the onboarding process, the program that's used is called SAP SuccessFactors. It was recognized that - it's been there for several years - there were some functionality issues that were discovered fairly recently. There is a team that's looking at this. That email, if you wanted to send that, we could send that to the Office of Healthcare Professionals Recruitment and they'd be happy to look into that for those folks.

There have been some barriers, and there is a team of people looking at the functionality and how we can streamline it.

Also, we heard from people who leave jobs and want to come back as casual. When they leave the system, there has to be a definite break in terms of their employment, but when they come back into the system, how do we shorten that runway, as well, so that they can come back and contribute as casuals?

If you want to send that along, we'll be happy to send that to the Office of Healthcare Professionals Recruitment.

KELLY REGAN: I will check with the constituent and make sure that they are comfortable with me sending on their email directly. Otherwise, I'll just paraphrase what happened, and they can send an answer back to me, and I'll send it back to them. We will do that.

I just want to make sure that I understand. When you said there is a program called SAP SuccessFactors, was that about the six-week delay or was that about the other one, where they got back the list of full-time positions?

MICHELLE THOMPSON: SuccessFactors is the platform that the Nova Scotia Health Authority and the IWK Health Centre use in terms of onboarding folks. You would apply through that, the websites, and do it with that, and it's all connected in the background. There was some functionality that hadn't been realized fully after its initial implementation, but that has been corrected.

In terms of the casual positions, I think that's why it should come to the Office of Healthcare Professionals Recruitment, so that they can help bridge that gap with the IWK. If they're licensed, the other thing that may have also contributed, but maybe not, is the licensing process, which is now - I think two weeks ago, the Nova Scotia College of Nursing also talked about how they will accept licences for people who are trained in

Australia within weeks rather than months. That, too, will further shorten the licensure process and then the onboarding time will be great.

KELLY REGAN: Finally, I would just like to say that often you hear a lot of complaints from our side of the House, for some reason I don't understand. It has to do with being Opposition. Just kidding. I did want to say I recently had an experience where I had to reach out to your EA - I think his name was Jermal - and he got back to me, and he was very helpful. I just wanted to pass that along.

THE CHAIR: The honourable member for Kings South.

HON. KEITH IRVING: I would like to thank the minister for the marathon. I know you hope you're getting close to the end. We'll see how long I can keep you. First of all, I want to reiterate my appreciation for your work. We're fortunate to have people to step up and do public service, and the job of the Minister of Health and Wellness is the most difficult, I believe, on that side of the House. I think we're very fortunate to have someone with the health background that you have. I am sure that that has been really appreciated by your staff and has probably cut down briefing time considerably. I wanted to acknowledge that.

I'm going to begin with a question more on the policy end and program end, then move to the Budget Book, and then finish up with some questions on capital, if we can get there.

First of all, with respect to physician community navigators at the local level, I wrote the minister, and I think perhaps asked questions in the House, about the value of these physician community navigators. I know that the government has expanded it, spending $2 million and has announced 20-some community organizations receiving about $70,000 on average. One thing I really urged the government to do was to allow those funds to be used to pay for a physician community navigator. My understanding is that the proposal call did not allow those funds to be paid, and I'm wondering why the government decided not to help those communities with the cost of salaries.

MICHELLE THOMPSON: I know we've talked about this in 45-second increments here in the past. I will try to give you an answer. The recruiters that you talk about are generally, in my experience, being paid by the municipalities, supported through the work of the municipalities. There are often a few groups - I think about Healthy Pictou County, the Mid Valley Region Physician Recruitment & Retention group, Lunenburg, etc. It is kind of grassroots work, and it is important that those folks are in community, working with municipalities, looking at settlement. The money that we recently provided to a number of groups across the province was for that. They wanted some support around promotional opportunities - more like operational funding. That's what they are, one-time grants to support their initiatives.

I'd encourage you to talk to the Minister of Labour, Skills and Immigration when she is up for Estimates. There is some work happening around settlement coordinators in communities. Just to that end, we are not only looking at physicians but now starting to look at health care workers, as well as bringing families so that it is a more palatable arrangement for people to stay. I know that that there has been some investment, but I don't want to commit anything. I think if you talk to the minister about the work they're doing, it would work nicely with the work that's happening in the Department of Health and Wellness and with those municipally funded navigators.

KEITH IRVING: Just a comment on that, and I made that point before. Sometimes with municipalities and community funding, there are ebbs and flows that change with the politics in the Chamber or the business support or whatever. I know the South Shore lost Tina Hennigar because she didn't feel she had any job security, and she had to find job security. We've been very, very fortunate in the Valley. I've been sharing our group with a couple of municipal leaders and the Chamber. We have an absolute star; don't steal her. In fact, between September 1, 2021, and February 1st of this year, the Annapolis Valley/Kings district is the only district that didn't go up. We stayed at 15.1 per cent, and I think that's due to the talent that we've been able to hold on to. It's so important for us to be able to retain and give good employees the confidence that they'll have a job the next year. That's why I've been encouraging government to have some money for salary.

I will make one last comment on this to flag for the minister: the continued frustration that we have had at the local level with respect to the Nova Scotia Health Authority giving information on site visits. It has been extremely frustrating to get 24 hours' notice of a site visit. We would like several weeks' notice. We would like information on the physician, their family, and their interests so that we can make the most of that one- or two-hour site visit to show them the best of what we have to offer. I'm sure every community across the province would like that information. That is absolutely key.

We've also just recently had a doctor join our committee. She has come to one meeting and has been very, very helpful. What we've learned is that doctors are recruiting doctors, and people interested in the area are not going through the NSHA. They're calling up a local doctor. We see that as an opportunity for us because we are frustrated with NSHA as much as doctors who might be exploring a new area to practise. We hope to capitalize on that physician being part of our committee. She's an emergency doctor. I don't know how she'll find the time, but hopefully we can grab her for more meetings and capitalize on her experience and her network.

I'd like now to move to the overall numbers for the Department of Health and Wellness with respect to the spending this past year. I think that's clearly indicated on Page 13.1 of the budget documents. You went over the budget, and obviously everybody has realized that the additional revenue has encouraged and allowed going over budget, so I'm not criticizing the overspend. The $275 million, or 6.4 per cent, that was spent in the last

fiscal year - were there one-time costs as part of that? Is that where we find the additional monies given to nurses this fiscal year? Is that part of that $275 million?

[12:30 p.m.]

MICHELLE THOMPSON: This always makes me wonder why you can't just talk to her directly, but anyway, I'm going to translate. The 6.4 per cent is incentives and a good portion of that $202 million. Also, there were some operational increases related to COVID-19. When we looked at the assessment centres, et cetera, that's what has driven some of it. Between the incentives and increased spending on COVID-19 for operations is what has created that variance.

KEITH IRVING: If those are one-time costs that have been expended in 2022-23 - and those numbers seem to indicate that a lot of that $275 million was this one-time spending, in actual fact, moving from $4.2 billion to $4.8 billion - your lift between the 2022-23 and the 2023-24 budget is in fact about $587 million, which would probably be in the order of 13.5 per cent. Is that correct?

MICHELLE THOMPSON: You are correct. It is a $587-million increase in this budget, this fiscal year.

KEITH IRVING: That's a lot of money, and it reminds me of words of my wife, who spent several years as a deputy minister: when a lot of money comes in quickly like that, it's difficult to spend it well. I think you have given your staff a considerable challenge to spend that money well in a short period of time.

I'd like to move now to the four-year fiscal plan. The overall departmental expenses for the province over the next three fiscal years after this one are increasing 1 per cent, 3.7 per cent, and 0.5 per cent. That's all of the departments. We're talking $13.8 billion to $13.9 billion to $14.5 billion to $14.5 billion. I'm wondering if the health forecasting contributes to those numbers and whether you can tell me what you're forecasting to spend in 2024-25, 2025-26, and 2026-27.

MICHELLE THOMPSON: Our budget is approved annually, so for the four-year fiscal plan, you would have to speak to the Minister of Finance and Treasury Board about that. I wouldn't have a line of sight onto that. Our budget is approved annually, so I can't speak to how it impacts the - we don't have any indication of future-out years.

KEITH IRVING: What you're telling me is that all the work you're doing to bring in new doctors and to build new facilities, you are not putting that into the government's four-year fiscal plan.

MICHELLE THOMPSON: We do submit annually. There are estimates into our out years, but they're based on a lot of assumptions. The overall corporate fiscal plan can

certainly change. Just speaking about where we were a year ago or two years ago, there would not be the assumption that we would be spending this amount of money, perhaps, on whatever. Think of pre-COVID-19, et cetera. There is some estimation that happens, but overall, the corporate fiscal plan can change. That would really sit with Minister MacMaster to be able to give you that fuller picture.

KEITH IRVING: I would like to move now to physicians. Did you say earlier today that you had a net increase of X number of physicians this past fiscal year? Could you provide that number and, as well, provide a number of where we need to be in our current situation? For instance, if there's 137,000 people on the wait-list, at 1,350, there would be 100 family physicians needed, presumably 50 to 100 specialists needed. I don't know if you have those numbers, but I'm interested both in terms of net new physicians this year and, in a perfect world, if you could wave your wand, how many physicians would be on the payroll to meet our current needs?

MICHELLE THOMPSON: In the province, we've had a net gain of 41 physicians - 31 specialists and 10 family physicians. We're recruiting to - 123 family physicians are the vacancies that we have right now, and 76.4 specialists. We are recruiting. We have 35 vacancies in Western Zone, 21 in Eastern Zone, 23 in Northern Zone, and 42 in Central Zone.

KEITH IRVING: I was pretty close. I put my guess at 200 needed. We recruited 41 new physicians. I wonder if you can reconcile why our physician services line item went up only $7 million. That's on Page 13.2, Physician Services, $1,038 million, only up to $1,045 million.

MICHELLE THOMPSON: There has been an increase of $12.5 million: $3.1 million in AFP physicians, $4.3 million in APP physicians. It has kind of remained stable for fee-for-service, but some of the physicians would be employed by NSHA directly. The other issue would be that sometimes, even though there has been a net gain, some of the physicians we recruited will have been a replacement, so if there has been someone who has left, and they have come to replace, it's like one for one. There has been an increase of $12.5 million in physician services, but there would be some that are paid directly by NSHA.

KEITH IRVING: Okay, so some are outside of that line item, directly in NSHA. Budgeting moving into next year, I thought you were going to come back and say some have been onboarded in February. Reconciling that moving out in terms of our estimate for 2023-24 - I asked this question last time: We got 41 new ones last year; presumably, you're hoping for 41 or more this year. Does the $1.051 billion reflect new doctors that you're anticipating hiring this fiscal year?

MICHELLE THOMPSON: Recognizing that they are net new, some of them may be fee-for-service. We need to understand what their billings will be. That impact will be

monitored through the forecasting that happens on a regular basis. The other thing may be that we add a physician, a whole person, but they may work part-time in their office and somewhere else, so they are a bit of a moving target. The billings will help us understand through forecasting the impact of net new physicians.

[12:45 p.m.]

KEITH IRVING: On Page 13.3, I was wondering if there is an explanation with respect to what appears to be 44 unfilled positions. You had 253 positions funded in the department. The forecast is, in essence, 210. We're back, in the estimate, to 263, an increase of 10 year over year. Is there an explanation for 44 vacancies in the actuals that occurred this year?

MICHELLE THOMPSON: The vacancies are attributable to the natural churn of the department. There's no reduction, and they are vacancies that are in varying degrees. Some might be open for a few months or several months or whatever. There were a couple of people who were transferred to the Office of Healthcare Professionals Recruitment. There's no reduction in numbers, it's just the vacancies that are present right now, and it is part of the internal churn of people moving throughout the civil service and the departments.

KEITH IRVING: Let's move then to Page 13.6 and Health Information Performance and Planning. There has been an underspend there and a decrease of budget. I had sort of picked up that this government felt there was much need in terms of data and health information to do proper planning, so I was caught by the underspend and then the reduction in the budget in that line item. Could you explain the drop in investment in that area?

MICHELLE THOMPSON: It's actually a transfer of individuals to a different part of the Department of Health and Wellness.

KEITH IRVING: On Page 13.9, under Programs and Services, I note both the underspend and then a further cut from last year's budget in Acute and Primary Health Care, that line item going from $24 million to be budgeted this year at $16 million. Could you explain the change in investment in that area?

MICHELLE THOMPSON: There was an internal transfer of $2.6 million for the Early Intensive Behavioural Intervention program to the Office of Addictions and Mental Health. There was $5 million allocated in 2022-23 for surgical wait times. That has been reallocated to the NSHA operations budget.

KEITH IRVING: The IT system budget is increasing by $40 million. I assume that's One Person One Record. The OPOR was something, obviously, the previous government was dealing with. We had proposals and RFPs, et cetera, for OPOR. The

numbers that the previous government was looking at were substantially bigger than the contract that this government has, I guess, signed with a service provider. One of the big components of the previous - where we thought we were heading, was ensuring there was proper training for staff. I'm wondering if that has been exited from the work that is being done on designing and then implementing the new IT systems. I'm curious about why the number ended up being significantly smaller than was being discussed by the previous government.

MICHELLE THOMPSON: The training is actually the most essential part, and there would be funding available for FTEs through NSHA. I did have the opportunity to see the product, Day 2 in a 50-bed ICU. I thought the roof would be coming off, and it was just so peaceful. The company itself has trainers and then there's actually clinical staff who are assigned to do the training as well. That was the most important thing. They call it at-the-elbow support, and that will be part of the program, absolutely, because if not, it will not be successful.

KEITH IRVING: I do applaud the government for moving that forward. It is critical.

The Public Health budget obviously increased over the last number of years with the great work of Dr. Strang and his staff. There's no surprise there. It looks as though Public Health is now returning - I didn't get a chance to go back four years before COVID-19 to see how much we were funding Public Health. The $78 million there is only 1.6 per cent, which I understand is perhaps the lowest in the country, that Nova Scotia invests in public health. I think COVID-19 showed the error of our ways in terms of underfunding public health. There are documents out there suggesting that public health should be 5 per cent to 6 per cent of the health budget. I'm just wondering why the government has chosen not to increase capacity in public health for all of the values in terms of preventive medicine easing the long-term cost of health to the taxpayers. In essence, why are we not increasing funding to Public Health?

MICHELLE THOMPSON: Last year, Public Health was increased by $9 million. In terms of supporting this year, they have an increase to raise their workforce for another $2.1 million. This is the Public Health department proper. Also, there's another investment of $3.2 million for Early Years and the Children's Oral Health Program.

There are also things in Public Health that aren't obvious. The Nova Scotia Health Authority also has front-facing - this is departmental expenditures. The Nova Scotia Health Authority would have public health staff who are directly part of their operations, as well as funding that goes out to community organizations, so it's not easy to draw a straight line. There has been - $9 million last year, to your point, to increase the capacity of Public Health, an additional $2 million to top them up to $11 million, and there's also an additional $3.2-million investment for Early Years programming and the Children's Oral Health Program, in addition to what's in NSHA.

KEITH IRVING: I'm happy to hear that we are making some progress on increasing that number. I think we're still a long way from 5 per cent or 6 per cent. Anyway, I'll leave it at that.

[1:00 p.m.]

Moving on to Page 13.10 and the Health Authorities. The forecasted administration costs of the health authorities are coming in some 270 per cent over budget. The estimate was $91 million, and the health authority actually spent $302 million on - these are the NSHA and the IWK Health Centre combined. They both do go up. Maybe we should just talk about the NSHA moving from $79 million to $270 million and then back to $179 million. It's a dramatic increase in administration. Maybe a lot of people have been moved over there, but it's still more than we have in estimates going into next year. Can the minister explain the increase to administration costs at the Nova Scotia Health Authority?

MICHELLE THOMPSON: That change essentially is the incentive - is captured in that line. Also, the day of mourning for the Queen was a cost of over $5 million.

KEITH IRVING: I see. So, you were parking - I think now in the current fiscal year - another $100 million for the incentive in administration of the health authority to bring it to $179 million. Is that what's happening there, then?

MICHELLE THOMPSON: That's actually next year's incentives. It is so much for the health authorities, IWK Health Centre, for the Office of Addictions and Mental Health, as well as the Department of Seniors and Long-term Care.

KEITH IRVING: With so few lines in the budget, it's sometimes hard to understand why a nursing bonus would appear in administration of the NSHA, but anyway. We've explained that.

If we look at the Nova Scotia Health Authority and several of the line items, is it fair to say that what's happening there is an underspend in operations, an underspend in in-patient services, and then the increase to acute care - significant increase there - is that symbolic that our actuals are actually showing that we're underspending in our operations and in-patient services because we don't have the people to work there, and thus people are ending up going into emergency and acute care expenditures, and those are dramatically going over budget? Is that the story behind at least those three line items?

MICHELLE THOMPSON: The majority of that money is actually reallocation of funds through operations. As an example, there would have been money reallocated to the ambulatory care program, which is the renal program. C3, the Care Coordination Centre, would have some reallocation of funds. Also, in terms of the estimation for capital, sometimes the operating is less than anticipated, so there would be a gap in terms of what was estimated and what is actual for operating costs for capital.

KEITH IRVING: Let's move to capital. I'm trying to make a list of the capital infrastructure projects that we are doing in health. Clearly, we've got facilities under construction now in Cape Breton. We have the Halifax Infirmary. I'm going to ask you at the end of this list to correct me or add. In Cape Breton under construction right now - I guess there are two projects up there in Cape Breton under construction? The Halifax Infirmary site I believe has been announced to have more beds. We're expanding Dartmouth General Hospital. We have a new in-patient - I presume - wing in the Cobequid Community Health Centre. There are two transition-to-community centres in HRM, the mental health and addictions campus, a new rehabilitation and arthritis centre, and a new heart centre. Is that an accurate reflection of your ambitions in capital?

MICHELLE THOMPSON: I didn't catch all of that, but I'll just go through a few things. There is the Halifax Infirmary expansion. There is MRI replacement and relocation. There is some planning going on for the HI, Dartmouth General Hospital complex. There is the Bedford transitional care facility, some capital investment in terms of equipment in some of the facilities, Glace Bay Hospital cancer centre, Cape Breton Regional Hospital, Northside General Hospital, the energy centre in Cape Breton Regional Hospital cancer centre - you're right. Those are the things. That's generally it. There's some equipment, but those are the major redevelopments.

KEITH IRVING: I'm really interested in the builds and the scheduling of these. I want to know if we know when any of these builds are coming online. Have you seen any Gantt charts, project management, that are giving the department some indication of when some of these facilities will be coming online and needing to be staffed?

MICHELLE THOMPSON: I'm not sure if this is detailed enough. I'm just going to give you kind of a where-we're-at. We're currently in the design phase of this happening now and into this quarter. The enabling and early work for a number of the projects will start in the Summer. I don't have it all right in front of me, but certainly we can see what we can break down for you.

KEITH IRVING: I think there's probably a lot of information there, and Nova Scotians are obviously very curious about when they're going to see these health care facilities. It's a huge agenda and significant planning, et cetera. Can the minister tell us what is the next new facility that is going to open and when? I mean in terms of a significant build.

MICHELLE THOMPSON: First of all, Pugwash is one that's coming up. That will be June 2023. Then we expect Bayers Lake Community Outpatient Centre occupancy November 2023 and a scheduled final completion of February 2024. That's the next one to come online.

KEITH IRVING: In Pugwash, for instance, will there be additional staffing requirements for that new hospital?

MICHELLE THOMPSON: In scope and on time.

THE CHAIR: Order, please. The time allowed for this hour of Liberal questioning has elapsed.

I will now turn to the NDP caucus. The honourable member for Halifax Needham.

SUZY HANSEN: I'm grateful to be able to ask a few questions of the minister today, specifically on Black health. There was an announcement about a social work cohort by the Minister of Advanced Education. I have been asked, will there be funding of Black health care professionals' degrees or doing something similar for a cohort in nursing, medicine, occupational therapy, physiotherapy, recreational therapy; there's a number of them. We know that there are nine schools at Dalhousie University and the Nova Scotia Community College that have health programs. I'm curious to know if there's any funding in the budget to possibly support that.

MICHELLE THOMPSON: I'll start, and if we have to clarify, you can let me know. Some of the work that has happened around the Health Equity Framework will help inform next steps. Identifying focus areas - of course, increasing representation is one of those focus areas. There are designated seats, but working, as well, with our partners in Advanced Education around entrance criteria, et cetera, making sure that there's a clearer pathway to ensure that we increase representation. That's some of the work that's happening in the Health Equity Framework. There's no designated funding per se yet, but there is some work happening to lay the groundwork and see where we need to go next.

SUZY HANSEN: I just want to clarify one thing. You said it was the Health Equity Framework? Okay. That particular framework, I'm wondering, would the recruitment and support of Black health professionals be within that particular breakdown, as well, for recruitment?

MICHELLE THOMPSON: I'm not sure if I'm answering this properly or not, but the Health Equity Framework - is that what you asked, around the development of it? Increasing representation, I believe, will be part of that framework. If that's what you're asking, yes.

SUZY HANSEN: Is there increased funding for research with a focus on the health of people of African descent?

MICHELLE THOMPSON: There isn't anything specific for research in the budget. There's no specific line item for that.

SUZY HANSEN: Is there any increased funding to provide permanent positions to grassroots organizations like the Health Association of African Canadians?

[1:15 p.m.]

MICHELLE THOMPSON: There's multi-year funding for the Health Association of African Canadians to support education, services, capacity, et cetera - $275,000. Also supporting increased funding for the Nova Scotia Brotherhood Initiative and Nova Scotia Sisterhood, an additional $243,000.

SUZY HANSEN: I'm glad you mentioned the Brotherhood and the Sisterhood because that was one of my questions. It would be really nice to be able to think that we could possibly have a Black clinic with Black clinicians and Black doctors, similar to the one that the Indigenous community has as a clinic. I'm wondering, is there a focus to do that within the next few years? I see that you said multi-year agreements with these organizations. I'm curious to know, is that a direction in which the Department of Health and Wellness is going?

MICHELLE THOMPSON: The Health Equity Framework, we feel, will be an avenue for moving forward with community. It will help - we want to improve the level of safety, representation of equity-seeking communities in the workforce. I think there are opportunities. We haven't had a business proposal or anything similar to that, but this framework will allow us to open the gateway in order to understand what the possibilities are. Working with HAAC and through the Brotherhood and the Sisterhood, I think there are opportunities for discussions about how the community wants the services to be delivered.

SUZY HANSEN: I just want to swing back to the previous question about HAAC and the multi-year agreement. I'm curious to know, is that new funding or is that the same funding that was given in the previous year?

MICHELLE THOMPSON: Last year, the business case came forward and it was an addition of $275,000, and so we have annualized that now. It's ongoing funding.

SUZY HANSEN: I'm wondering, is there support for vaccines, such as the shingles vaccine, for members of the Black community on a fixed income? We know the shingles vaccine is $300. I'm just wondering, is there money in the budget for that particular type of program?

MICHELLE THOMPSON: This year, the investment in the expansion of the vaccine program was for high-dose flu. We do not have targeted Shingrix funding in this budget, no.

SUZY HANSEN: We know that we have a commitment to race-based data and data storage. I know that's something that through the Fair Care Project has started. We need to continue to educate and get our community members on board. I'm curious to know - some of these community members have volunteered to sit on these committees.

This is a question that was brought forward, that they should be compensated in some way for their information or their data gathering. I'm just wondering, is there any funding for the community-based consultations or any of that stuff that goes on within community to gather information?

MICHELLE THOMPSON: What I would say is, if there was a community organization that felt it was a barrier, they could work with an equity and engagement group to identify that. There is no targeted funding, funding through HAAC, as an example, or a variety of different community organizations. Certainly, the Equity and Engagement Division would be interested to know if it does present a barrier, and if it does, they would work with the community to reduce those barriers.

THE CHAIR: The honourable member for Dartmouth North.

SUSAN LEBLANC: When I left off, when our hour ended last time, I was talking about vaccines, and particularly the access to COVID-19 vaccine for children and how difficult it was sometimes to access vaccines that were at times that made sense for families, i.e., in the late afternoon, early evening, and also vaccines within a certain travel time - kilometres, whatever. For me and for a lot of people, it's not an issue. I'm an MLA, so if I need to take a couple of hours off, I can go and get my kids from school and pull them out and do that. That's not a big deal for me. I mean, it is - generally, I have a packed schedule, but I can make that work. But a lot of people can't do that. A lot of people can't just say, sorry, I have to go and take my kids because I can't get them a vaccine at any other time.

The other thing is - I have asked this question or I've talked about this before, and it has been sort of made clear to me that a 10-kilometre trip to Spryfield, for instance, from Dartmouth North, is not a big deal. But it is a big deal for many, many people in my community.

Again, for me, it's an inconvenience to have to take my kids to Spryfield to get their COVID-19 vaccines. I would much rather take them to the Lawtons on Primrose Street, which is a block from our house. For lots of people, it would mean a two-hour bus ride or just not doing it at all, because who wants to travel on a bus with young kids? Let's face it, it can be tough. I put that out there because I feel like when I have voiced concerns about this before, depending on who I'm talking to, I'm heard, and I'm definitely heard by staff people in the department, but I feel like nothing really changes. They say, we're going to look at that. We're going to make sure there's more vaccine available, and then there's not.

I haven't looked lately, admittedly, and it might be perfectly accessible right now. I do appreciate the COVID-19 vaccine clinics that have happened in Dartmouth North. That has been excellent. Again, I went to one of those, and it turned out my kids had their flu vaccine too close, so it was another example of getting them somewhere and then it not working out. I'm just wondering if the minister can comment on that. Does the minister see

the need for in-community vaccines and see that for not everyone it's an easy thing to just take their kids out of school and get them an appointment at 11 o'clock?

MICHELLE THOMPSON: I do want to let the member know that actually the mobile units also provide vaccination, so that's another opportunity that perhaps folks aren't sure about or didn't know about. We recognize that there are barriers, and Public Health is looking at ways to reduce these barriers, like the mobile unit.

The other thing I would say to those folks who experience barriers, and to your point around the hours, I have found pharmacists for the most part to be fairly accommodating. There may be opportunities for people to reach out and talk to someone if they're having a particular issue and call directly. I know there's the online booking, but I do think if there's a relationship that exists with a pharmacy, there may also be an opportunity to schedule appointments. There's always a little bit left in the bottle at the end of the day, maybe. There might be opportunity to do it that way as well.

SUSAN LEBLANC: We in the NDP caucus were glad to see that as part of the Action for Health, the government is now publishing the percentage of endoscopic and non-endoscopic surgical services completed within the benchmark. Several years ago, the Auditor General asked the government to release, specifically, the percentage of orthopaedic surgeries that are taking place within the benchmark of 182 days. We have what's available on the wait times website, and we have the delayed data from the Canadian Institute for Health Information, but we do not have this specific ask from the Auditor General. Can the minister make this data or begin to make this data available?

MICHELLE THOMPSON: I would say that in terms of the dashboard for Action for Health, the things we're putting there, I think we're maturing. That's what I would say. Initially, we tried to pick things that we felt would resonate with individuals, and not everybody loves dashboards or finds them easy to digest. We're certainly open to looking at what some of the indicators are that we think would resonate with folks, so we're happy to look at that as a potential indicator, moving forward. Just trying to nuance that, find out what the things are that people are most interested in seeing on a regular basis on the Action for Health dashboard.

SUSAN LEBLANC: Yes, I get it that the dashboard is newish and Action for Health is newish. This request from the Auditor General came several years ago and it was a request, not a light suggestion. I hope that could be incorporated. I do think that surgery wait times, especially orthopaedic wait times, do resonate with people, as it is one of the things, if not the biggest thing, that people are waiting for, for surgery.

Speaking of orthopaedic surgery wait times, there was some discussion - I can't remember if it was last year in Estimates or at Health Committee - of implementing a program that is similar to - when someone's waiting for orthopaedic surgery, there is a program that helps prepare them for surgery. I forget what that's called, but there are

exercises, there are check-ins. In my own family, a family member has been going through this for the last two years, unfortunately, because they had to have a re-do. We understand that the checking in, the exercises, the prep stuff helps in terms of the waiting because there's something you're working toward. There's something you're doing while you're waiting. It's not just: I know I have to have this surgery some time, but it might be two years before I get a phone call.

[1:30 p.m.]

We talked about this before, but I'm wondering if there has been any thought or progression on this concept for other types of surgeries, surgery wait times. Not necessarily orthopaedic but in other types of surgery, so for when people are waiting, that they're checked in with, that they're communicated with as the time goes by, so that they feel hopeful and assured that they will eventually get their surgery.

MICHELLE THOMPSON: We appreciate that suggestion. There currently is nothing like that, like there would be with the orthopaedic assessment clinics, which do prehab and then rehab. But I think there are opportunities - certainly the eReferral process and a single-entry point and a single-entry booking, I think, is going to make a big difference. We're going to go from - first of all, we're not really sure from time of referral to time of consult - that's the first indicator to help us around wait times - and then understanding from consult if surgery is indicated and so where the gap is. I think we'll be in a better position, as the data starts to come in, to understand where the best place for us to intervene is. It is a good suggestion, so thank you.

SUSAN LEBLANC: The minister is welcome. I know that her colleague the Premier thinks we have no suggestions over here, but we do have suggestions. We have lots of good ideas over here on this side. That new system, the entry, the surgical - when is that up and running? Today? Literally today? Today's the first day? Okay, well, we look forward to hearing some feedback about that soon.

The Progressive Conservatives promised to meet national surgery wait time benchmarks within 18 months of the election, which was in August 2021. So far, it seems like we are nowhere near the benchmarks. In fact, it seems like the numbers are getting worse. When will surgeries be at the benchmark?

MICHELLE THOMPSON: I know that the surgical teams have really been focusing on those folks who have had considerably long waits, in terms of removing them, getting their procedures done. Nova Scotia is tracking to the national benchmark for cataract surgery by Fall 2023 - that's encouraging. We are heartened - certainly seeing a significant increase in the number of outpatient arthroplasties. Year to date, the teams have completed 1,098 hip and knee outpatient arthroplasties compared to 72 year-to-date in 2019-20. There is progress happening. Also, the surgical growth rate ratio has been under the target of one for the last three quarters. That tells us that we're taking more people off

the list than are actually going on the list. These are early indicators that we're really starting to move through some of those long wait-lists and we do expect to see - and I know the Premier will be very anxious for us to meet that target by Fall 2023 for cataract surgery.

SUSAN LEBLANC: Can the minister update on us on progress toward the promise of opening operating rooms 24/7?

MICHELLE THOMPSON: There has been some opportunity to do elective surgeries on weekends, as an example. There have been some opportunities for that. Really, it has been around stabilization of the workforce. We are back to 2019-2020, at or just above 100 per cent capacity from the pre-pandemic time, which is terrific because it has taken a while to get there based on staffing.

The other thing we really struggle with, obviously, is occupancy rates in hospitals. It is really important. The work that's happening in the Department of Seniors and Long-term Care is essential to the success. Certainly, there has been a great deal of work done. The transition-to-care facilities, as well, will really support us in having ideal hospital capacity, which is at 85-86 per cent, and we are running at 100 per cent a lot of the time. There are a couple of things: staffing, which is improving; and then there's also the capacity within the hospitals. We do have designated beds at the Dartmouth General Hospital to support those people who need to stay in-patient after surgery. It's really important that we have the space for them. There is some early work happening, but we are very hopeful that we'll - it is a system, and it will make a big difference over the coming months.

SUSAN LEBLANC: Does the minister think - once a couple of transition-to-care units are open, say the work in long-term care is progressing, and all of those pressures on the surgery wait times are relieved, will there be a need for 24/7 operating rooms? Is the 24/7 operating room idea a way to get at the backlog? When everything is running properly again, will that be in place?

MICHELLE THOMPSON: The expansion to longer hours, whatever they may be, is ideally to get through the surgical backlog. Then we would look at what the opportunities are. Maybe there is opportunity for us to continue elective surgeries on weekends and things like that. Really, it is around the occupancy rates. We have inflow - there are lots of people trying to get in. It's the outflow that really is a barrier. Respectfully, we are under bedded in the province - under bedded in long-term care and under bedded in terms of our population growth, and where we are in chronic disease rates, and aging population, et cetera. Those beds will make a significant difference, particularly here in the metro areas. Those additional beds will have significant support.

We do have some transition-to-care units in the province, in other places. I think really it is to sort and support people moving to the right place in community in order to be able to bring people in more efficiently. I think there may be some folks who would be

happy to have our teams working into the evenings and into the weekend to keep that. A wait-list is not zero, either. That's the other piece. The hope is not that the wait-list would actually go to zero. There will always be a wait-list of whatever that number would be. As long as we stay within benchmarks, that's the goal.

SUSAN LEBLANC: Can the minister talk about any other transition-to-care facilities that are planned or being looked at for HRM? We know about the Bedford one – we've asked about the Bedford one. Are there any others?

MICHELLE THOMPSON: In addition to the place you mentioned, we're also looking in Bayers Lake, at a purpose-built facility there.

SUSAN LEBLANC: The Canadian Cancer Society has called on the government to create a public plan for clearing the backlog for cancer surgeries. Is that something the government is undertaking?

MICHELLE THOMPSON: We do monitor benchmarks for those surgeries. The surgical strategy really is not just specific to hips or what-have-you. We really are going to look at those major surgeries and the surgical services. We want to get all of those things into benchmark. We just have to check on the rates right now to see how far out we may possibly be. That is the goal, that we would have everybody within benchmark as soon as possible. Time-sensitive surgeries continue. If it's urgent or emergent, those things continue to happen. That's what I would say. They're certainly prioritized, which is why the elective surgeries also take longer, because those urgent and emergent clinical cases are brought forward first.

SUSAN LEBLANC: Two or three days ago, an RFP went out for a health centre facility in Dartmouth North. I'm wondering if the minister can talk about that space and what the timeline around that is.

MICHELLE THOMPSON: The RFP indicates that we are looking for a space, but it would be a collaborative practice model that we would be looking at putting there. I think based on the space and location, et cetera, that planning will continue, but to identify the space is the first step.

SUSAN LEBLANC: I'm sorry, I don't understand how to read RFPs. Is there a timeline? There's obviously a closing date for the RFP, but is there a plan for a ribbon-cutting? Do you know what I mean? What is the idea?

MICHELLE THOMPSON: The idea is we get the space and we move forward. The planning is under way, there's no holdup. This is this fiscal initiative. We get the space, and we keep moving through the process of establishing that clinic. The planning is under way. There's no lag. We'll be looking at having it up and running as soon as we are able.

SUSAN LEBLANC: That's great to hear. I have been asking about a clinic in Dartmouth North since I was elected. I'm happy to hear that it's in this budget. (Interruption) What's that? I was going to say, I'll thank the minister in a more formal way another time, but I am very pleased to see this investment, obviously - very happy. Enough about Dartmouth North.

[1:45 p.m.]

Moving back to more difficult questions perhaps, rural emergency rooms are routinely and unexpectedly closed. This has a carry-on effect for the entire system, as paramedics and patients have to go further and wait longer for help. How many emergency medicine vacancies are there today? How does that compare to this time last year?

MICHELLE THOMPSON: It will take us a bit to gather that information. We don't have it on hand.

SUSAN LEBLANC: We know that people can wait months to see a mental health professional in the public system. Many sites are exceeding the target wait time of 28 days for non-urgent appointments. The question is, how many psychiatry vacancies are there currently?

MICHELLE THOMPSON: We will try and get that number for you. It actually does sit with Minister Comer - we're just trying to reach out - the Minister Responsible for the Office of Addictions and Mental Health. It'll just take us a couple of minutes, but we'll have a look through.

SUSAN LEBLANC: Moving right along on the vacancy questions, how many paramedic vacancies are there currently, and how does that number compare with this time last year?

MICHELLE THOMPSON: There are 276 vacancies, and this past year saw the highest inflow of paramedics over previous years, but there has been a net decrease of 13 paramedics, somewhat related to - moving into the system. This is only within EHS. It doesn't account for the paramedics who have moved to the Nova Scotia Health Authority, and also some folks who are off due to illness.

SUSAN LEBLANC: Now I would like to know how many nurse vacancies there are, and I guess I would like that broken down by type. How many LPN vacancies are there? How many RN vacancies are there? How many nurse practitioner vacancies? How does that compare to this time last year?

MICHELLE THOMPSON: I'm going to just confirm these numbers and get back to you. I just want to make sure.

Registered nurses, there are 1,307 vacancies; LPNs, 403; nurse practitioners 94. Continuing care assistants, I don't have a vacancy number for that.

SUSAN LEBLANC: How does that compare to last year? Do you have those numbers?

MICHELLE THOMPSON: There has been a net gain. I don't know if I have the actual numbers, but there has been a net gain of 261 registered nurses this year. We brought in 950 registered nurses and 689 left the system, so a net gain of 261. Licensed practical nurses, we had a net gain of 264, and we had a net gain of 47 nurse practitioners. We had an inflow of 57 nurse practitioners and 10 out. We had an inflow of 532 licensed practical nurses and an outflow of 268. There should be an improvement overall.

SUSAN LEBLANC: We hear so many different bits of information, it would be nice just to hear it all in one spot. Can the minister break down the most recent recruiting trips and who is coming from where and when? I know we have heard people are coming from, I believe, Nigeria or Kenya, maybe, and the Philippines. It would be great to get a summary of that.

MICHELLE THOMPSON: The Office of Healthcare Professionals Recruitment, working with partners on a calendar of recruitment, events, and activities, has been on 20 recruitment events, both in Canada and internationally, for occupations needed across the health system - particularly exploring market potential in Australia and Germany, as well as the Philippines and India. There have been a number of trips to the United Kingdom as well - very fruitful discussions. There has been a trip to Kenya that was attended by the Office of Healthcare Professionals Recruitment in support of bringing folks from the refugee camps there into the system to train and work as CCAs.

I know that one of the partners in that work is the Shapiro Foundation. Also looking at Nova Scotia's International Community of Healthcare Workers Engagement Program, we have been working with Ukrainian nationals. There's a variety of different touch points. Certainly, the work the college has recently done around identifying those seven colleges, where we can very quickly license people from those countries, will make it a lot easier on recruitment trips: Here's your offer, here's your licence, let's go. That's very helpful. There's some real momentum gaining in terms of the work of the office, but also in collaboration with the colleges. We're pleased with that.

SUSAN LEBLANC: The Nova Scotia Health Authority website only lists current specialist vacancies and is not broken down by specialist type. This means that it is difficult to tell what our progress is over time, which specialist areas are doing well, and which are not. I understand that we publish recruitment numbers, which is not as helpful a metric to understand the full picture as vacancies. I understand that there are reporting minimums for privacy reasons, but beyond those, does the minister think it would be helpful for Nova Scotians to see our progress over time in addressing physician vacancies?

[2:00 p.m.]

MICHELLE THOMPSON: It's really hard to know what people would want. I think they want to know that we're trending in the right direction. I think the biggest and most important thing is that people know there are health care providers in their local hospitals when they're there. We do know that we struggle particularly, as do all jurisdictions, with psychiatry, anaesthetists, OB/GYN, and emergency room physicians, as an example. Those are the hardest to recruit. I think there would be some people who would be interested in it specifically, and I think there would be some people who - it's hard to answer that, I guess. It's around people's personal preference.

SUSAN LEBLANC: I get that. I get that people have different thoughts on that. I guess, for my money, I'm interested. I'm going to ask if the minister's office could provide vacancies by specialist type to the NSHA for publication, and if not to the NSHA for publication, to me, and we'll publish it.

MICHELLE THOMPSON: The vacancies actually are tracked and monitored by NSHA. That's where we get the data from. They would have those numbers already.

SUSAN LEBLANC: One silver lining from the COVID-19 pandemic was everything we learned about how to test for things in community and also how to keep people safe. Advocates have been asking that we take some of those learnings and apply them to HIV rapid testing. We were glad to see a small bump in funding to Sexual Health Nova Scotia, but we need more action on sexual health, especially HIV. There was a bump in HIV cases in Nova Scotia last year and very well may be again this year. I'm wondering, is there any new funding specifically for HIV in the budget? If so, how much?

MICHELLE THOMPSON: There is an increase of $213,000 for support to community centres to understand the increase of HIV problems in the community. There is exploration happening this fiscal around self-testing for sexually transmitted infections. I don't have all the details of that just yet. The program is evolving, but we are looking at self-testing.

SUSAN LEBLANC: When the minister says for community centres, can she clarify what that means? Does it mean community health centres, like the North End Community Health Centre, or does it mean community centres, where there are basketball courts?

MICHELLE THOMPSON: The organizations that are receiving the grants are the AIDS Coalition of Nova Scotia, Halifax Sexual Health Centre, and Ally Centre of Cape Breton - for HIV specifically.

SUSAN LEBLANC: The initiative that the minister referenced around STI self-testing, does that include HIV testing? Is there a specific test and a specific program for HIV testing? If so, is the department funding the HIV tests specifically?

MICHELLE THOMPSON: We will have a proof of concept first. We're doing a test-and-try environment, and there was $3 million invested in that test and try, but it is under development right now, in terms of what tests will be offered and where the proof of concept will happen. There is a business case put forward and it has been approved, but all details are not fully developed yet.

SUSAN LEBLANC: We also need more prevention strategies around HIV, like pre-exposure prophylaxis, contact tracing, and trying to improve public education on HIV/AIDS. Is there any new funding in the budget for this work? If so, how much?

MICHELLE THOMPSON: That is the work of Public Health, so not specifically, but there is an increase in funding to Public Health this year.

SUSAN LEBLANC: My understanding is that the Public Health budget is part of the Department of Health and Wellness budget because it's not a different department. Does that mean that there's no breakdown for Public Health spending?

MICHELLE THOMPSON: Public Health sits in two places. The Department of Health and Wellness is increasing capacity. There was a $9-million investment last year and $2 million this year. There's also another part of Public Health that sits at the Nova Scotia Health Authority, which is where that frontline staff are - the operational budget is for there. That's also part of Public Health. We have a portion of it, but there is a portion that also sits in the Nova Scotia Health Authority operations. The Public Health nurse does not work for the Department of Health and Wellness, they work for the Nova Scotia Health Authority.

SUSAN LEBLANC: Well, it would be really good to know, as Nova Scotians, the breakdown of Public Health spending, or where the breakdown is. Is there a way to request that breakdown so that we can see: this much is going into disease prevention, this is going into vaccines, this is going into new moms - that kind of thing? It would be really good to have that breakdown.

MICHELLE THOMPSON: It isn't that easy to break it down like that. There would be certain programs that are - it isn't that easy to gather. We are investing in the Department of Health and Wellness, adding $1.2 million in the Early Years and $2 million in the Children's Oral Health Program. To break it down for you, the generalist Public Health nurse, how much time does she spend on communicable disease, how much time do they do Early Years - it's just not that easy to draw a direct line in terms of programs all the time. There would be programs - Early Years, CDC. There's also environmental health. It sits somewhere else. It's not easy to just draw that direct line.

SUSAN LEBLANC: With six minutes left of this hour, I just feel like I need to push a little bit more. I get that if we're talking about the funding of a Public Health nurse, that nurse might be going and doing a bunch of different things with Public Health. I get that. But also, there are program costs. If there's public money being spent on, say - and this is always my touchstone - an arts organization, it is possible to find out what that arts organization spent its public money on. It's required, actually, and that's an organization outside of the government. We're talking about a budget line that's inside the government, on the government public accounts. I just don't see how we wouldn't be able to get a breakdown of what Public Health spends its $9-plus million on.

I'll ask again. Are we able to get a breakdown of the way Public Health money is spent?

MICHELLE THOMPSON: Yes, we can get it, but it'll take a little bit.

SUSAN LEBLANC: All I got is time. Great, thank you for that.

Moving on to safe supply, I know that safe supply work is shared between Public Health and the Office of Addictions and Mental Health. Can the minister tell us if there is an increase in investment in safe supply projects in this budget?

MICHELLE THOMPSON: That all sits under the Office of Addictions and Mental Health.

SUSAN LEBLANC: Can the minister tell us if there are - and when I say mental health, I think it still seems like it should fit under this budget. Are there investments in the budget for mental health supports for the Nova Scotia Health Authority and IWK Health Centre employees?

MICHELLE THOMPSON: There is some investment this year in a wellness strategy. It's under the health transformation workforce planning initiatives. There will be more around those details as the year unfolds, but there is an investment of $1.5 million in a wellness strategy - wellness and resiliency supports with innovative, just-in-time access for frontline health care workers.

SUSAN LEBLANC: What key indicators does the government collect on 811? For instance, can the minister provide some information from those, for example, response times, call-back times, that kind of collection of data on the 811 system?

MICHELLE THOMPSON: There would be some data, but the contracts are fairly dated, so key performance indicators would be something we would be looking at in a future contract, just to modernize those contracts a bit. There is some data that's reviewed, but I wouldn't necessarily say there would be, as an example, targets or KPIs set in this current contract.

Things that they would monitor would be the primary reason for the call or how many calls actually get diverted. There's certainly more maturity that would be helpful in that contract going forward.

SUSAN LEBLANC: Just to clarify, some information is collected, not with the robustness that would be perhaps wanted in a new contract, but somebody collects that data, and therefore is that data available to the public, to us?

THE CHAIR: Order, please. The time for this hour of NDP questioning has elapsed.

I think it's appropriate now to offer our minister and guests a five-minute break. We will reconvene at 2:17.

[2:12 p.m. The committee recessed.]

[2:17 p.m. The committee reconvened.]

THE CHAIR: Order, please. We'll reconvene the Committee of the Whole on Supply.

KEITH IRVING: Just going back to capital projects, what was the capital plan for health facilities last year, estimated and actual?

MICHELLE THOMPSON: The estimate was $204 million, and $156 million was the forecast, so the slippage was $47 million.

KEITH IRVING: An underspend of $47 million. What is your capital plan budget this upcoming year?

MICHELLE THOMPSON: This year's estimate is $296 million.

KEITH IRVING: Presumably, the underspend of $47 million was primarily the slowing down of the Halifax Infirmary project. There would have been intentions to spend capital there.

MICHELLE THOMPSON: The majority of that slippage was the South Shore Regional Hospital redevelopment related to funding that went to out years due to significant supply chain issues. The Cape Breton Regional Hospital redevelopment was around furniture, fixtures, and equipment delays that pushed it a bit. The IWK Health Centre emergency department - the work began later and is just moving a little bit more slowly than anticipated.

KEITH IRVING: The $296 million anticipated to be spent this year, could you give me a list of the major projects that would be using that $300 million?

MICHELLE THOMPSON: There's a ton of projects. Is that what you want, the list of them? I guess that's what I'm trying to figure out. Those big redevelopment projects, there would be the continuation of those. There would be some investment in capital equipment. It generally is One Person One Record. The QEII redevelopment accounts for $210.2 million of that money.

KEITH IRVING: That's great. The $200 million is the number I'm trying to get at. That's fully two thirds of it. Maybe you could give me the next two or three capital - I'm interested in the buildings that are in that capital.

MICHELLE THOMPSON: I hope this answers your question. It's continued investment in Glace Bay Hospital, Cape Breton Regional Hospital cancer centre, Northside General Hospital - all of those projects continue - the energy centre, the clinical services building, New Waterford Consolidated Hospital. It is just a continuation of all those projects. The other money would be around capital medical equipment investment, and capital renovations as well.

KEITH IRVING: Minister, could you give me the capital plan for Glace Bay Hospital, Cape Breton Regional Hospital, and I think you said Northside General Hospital?

MICHELLE THOMPSON: Glace Bay Hospital is $8.5 million. The Cape Breton Cancer Centre would be equipment, furniture, fittings, and fixtures, et cetera - $3.6 million. Those would be the biggest. Cape Breton Regional Hospital, there's another $1-million investment. Cape Breton Regional energy centre is $26 million. The clinical services building is almost $36 million. The laundry is $36 million. New Waterford Consolidated Hospital is $6.5 million.

KEITH IRVING: Of that list, Minister, are any of those anticipated to be complete this year?

MICHELLE THOMPSON: Really, just the ones I talked about before, like the North Cumberland Health Care Centre in Pugwash, will be completed. Then Bayers Lake Community Outpatient Centre will be occupied in November and then open in February, so essentially complete at the end of November and then open in February of next year.

KEITH IRVING: In the last session, I think I caught your last three words that implied there would be no additional staff costs at Pugwash, the change in scope of their work, that staffing will be the same. Are there any additional operational costs for the new facility?

MICHELLE THOMPSON: There are no targeted operational increases there, no. It appears to be on time and in the same scope.

[2:30 p.m.]

KEITH IRVING: Similarly for Bayers Lake, opening near the end of the year, are there going to be additional staff costs to the department to populate that building, and an estimate of the operational costs for this new facility?

MICHELLE THOMPSON: The operation of the Bayers Lake Community Outpatient Centre would be $16 million allocated for that.

KEITH IRVING: Does that include the cost of staff in that building?

MICHELLE THOMPSON: Yes.

KEITH IRVING: The reworked Halifax Infirmary project, I believe, was announced to add additional beds to that site. Can you remind me - was there something about 100 new beds? Or am I mistaken?

MICHELLE THOMPSON: The project will add around 400 new beds, increase emergency department capacity, and expand operating room capacity, with the intention of allowing for 2,500 more surgeries per year.

KEITH IRVING: Four-hundred new beds is significant. Has the department quantified the additional annual operating cost to bring on 100 new beds and, obviously, the other additional spaces? Do we have an estimate of, when we build, that you would be adding to your budget additional operational and staff costs?

MICHELLE THOMPSON: I would say that that planning is under way. It's quite far out, in terms of the model of care, et cetera, and it would be a bit hard to predict right now, but as we get closer, that will happen, of course. Yes.

KEITH IRVING: Do you have any ballpark indication of when that project may be reaching completion?

MICHELLE THOMPSON: I think some of these questions might be better answered by the other minister. I have some information up to a point, but with infrastructure work, perhaps the minister responsible for infrastructure would be in the best position. His timelines may be different from mine. I'm not telling you. I just don't have what I think you're looking for.

KEITH IRVING: Minister, does your department, in the planning of these facilities - we obviously have a huge roster of projects here that we're investing in. Can you tell me

if your department officials are involved in the energy and sustainability aspects of these buildings? These are huge opportunities to deal with issues of energy efficiency and greenhouse gases. Is that a priority of these builds?

MICHELLE THOMPSON: I believe that there are some government policies, but that would sit with Build Nova Scotia and the minister responsible for those infrastructure projects.

KEITH IRVING: I appreciate that. I just thought you might have staff involved in that with respect to the operations of a building and how those function on a day-to-day level to deal with the design of the building. Maybe I'll leave it at that.

I would like to thank the minister for responding to some of my detailed questions. You can tell I enjoy a number or two. (Interruption) I can have your binders? Anyway, thank you to you and your staff for all the responses this afternoon. I wish you the best of luck for your last few minutes.

THE CHAIR: The honourable member for Halifax Atlantic.

HON. BRENDAN MAGUIRE: I think you might have been wishing her luck because I stood up. I don't know. I will not be asking about the numbers because I don't like numbers as much as that member does.

The first question I'll start with is: Are you able to give us the off-load times for every regional hospital in the province?

MICHELLE THOMPSON: We'll get them for you. I have it in a different format. We have percentages. We'll look at the regionals. I know we have it because I know Aberdeen Hospital and St. Martha's Regional Hospital are the two best off-loads in the province. I just don't have them at my fingertips, but we'll get them for you.

BRENDAN MAGUIRE: I look forward to those numbers.

I'm just going to localize it for a minute. I'm sure you know where I'm going to go with this. Obviously, with the clinic in Spryfield, there's an issue. Are we able to have a discussion about what resources were requested and what resources you feel are needed to keep the clinic open and running? Is there potential - for the thousands of individuals in the local community who are going to lose their family doctor - for the department and NSHA to work with the clinic to add to the clinic and ensure that those individuals have a family doctor replacement?

MICHELLE THOMPSON: There have been ongoing discussions with both physicians regarding replacement, recruitment, and any supportive resources. Some of those discussions, I feel, are quite personal to the practice. I think I'd be uncomfortable

sharing them here. I would really encourage those physicians to call the hotline to really look and see if there are opportunities for us to support their practice, in terms of replacement physicians, as an example. We're very open to those discussions. We want to make sure those folks are attached to the best of our ability. If there are more conversations to be had through the hotline and through physician services, we would be happy to continue those discussions.

BRENDAN MAGUIRE: Are you confident that there will be some type of agreement between your department, NSHA, and that clinic to ensure that the resources are provided - without going into detail? I know, like you said, it's confidential, and we wouldn't want to get into this. Are you and your staff confident that there's an agreement that can be reached and will be reached to ensure that the remaining two physicians at the clinic stay in the community?

MICHELLE THOMPSON: We want to make sure that any decision is mutual as we move forward and that the services are mutually agreed-on by the Nova Scotia Health Authority and the physicians in the practice. Again, we're committed to working with them, and hopefully, we would be able to find a place to land. It really is around that negotiation of what they need and what we have. That can be ongoing, absolutely.

BRENDAN MAGUIRE: From my discussions with the physicians and the staff at the clinic - and I've had discussions with several other clinics, not just in HRM but across the province - I think the holy grail, I would say, is that people want a nurse practitioner or family practice nurse. We understand how important they are, how vital they are. My question is: What would be the criteria that these clinics need to meet in order to have a nurse practitioner or family practice nurse come aboard?

MICHELLE THOMPSON: What I would say is that any additional resources we would look at the opportunity with that additional resource - for two things. Number 1 would be attachment of patients, and the other one would be access. As an example, if we were to add a clinician who is able to carry their own roster, we would be looking at an additional number of people coming into the clinic, unless it's replacement. If it's replacement, it's one for one, like you said. If we add resources, it would be an opportunity for attachment. If it's a clinician who doesn't necessarily carry their own roster to deliver primary care, we would be looking at increased access. That's why that optimization team is really a very helpful team to go in and have a look.

With the addition of particular resources, what would be the opportunity for clinics to, say, go to same-day/next-day appointments, as an example, to improve access, or what would be the scope of practice of the additional practitioner that they were looking for, whether it be social work or pharmacy or a family practice nurse? How could that allied health care professional support them in terms of access for their patients, so that not everyone would have to see the physician or the nurse practitioner when they came into the practice, but actually that group could carry on some of the work that, perhaps, was taking

up more time of the physician? That's the work of the optimization team. What are the practice supports? Could there be a different scheduling or billing system? Would an additional admin be someone who could help move access and flow?

[2:45 p.m.]

There is an expectation with the addition of resources: (1) to potentially increase attachment and (2) to increase access. Again, that's where the negotiation is. What is it? Where are the gaps? Who aren't you seeing? Who do you find hard to get in? It's those types of things. Every practice would be unique. There's an art and a science, but I think that's how we would look at it, and that's the beauty of the optimization team.

BRENDAN MAGUIRE: Just to understand, you're saying that one of the main criteria to get a nurse practitioner or family practice nurse would be to take on more patients? Is there any scenario where the clinician or the physician is stretched thin, and they would be given the resources for a family practice nurse or nurse practitioner and not have to take on more?

The reason I ask that is because - I'll use the Spryfield clinic as an example. One of the things that all four physicians - technically five, but four who were left - had told me was that even with a nurse practitioner or someone like that, they couldn't take on more, that they needed that individual to help offload and take some of the weight off their shoulders from their already full roster. Is there any scenario where you - I say this respectfully because I know that everybody wants a nurse practitioner, everybody wants those resources. I think you could talk to any family doctor - not just now but for the last 10 or 15 years - and they're pretty loaded. Is there any scenario where you would go to them and say: we realize that your roster is large, you're exhausted - maybe keeps them in practice - we'll give you a nurse practitioner, and you don't have to take on any more clients?

MICHELLE THOMPSON: I wouldn't pre-suppose that. I think it's really important - that's why I think there's so much value in the optimization team. We speak about the Dalhousie Family Medicine clinic so frequently because that's exactly how I think they felt - I didn't have a direct discussion - feeling stretched thin and looking at the possibility of decanting patients because they did feel very overwhelmed. With the help of that optimization team, they were able to go in and actually support them. When we say find efficiencies, I don't mean work harder or be more productive.

I will give you another example. I was very, very fortunate to travel to Denmark last year and met with a physician who was in a practice, and he did feel totally overwhelmed. I think there were five doctors. Working with a group of individuals, he changed his practice from booked appointments - like weeks and weeks and weeks - to same-day, next-day. He's fee-for-service. He showed us his schedule for the following week - not a

patient. He said, when you're fee-for-service, that's a bit stressful at first. It has changed his practice and it has allowed him to provide better access as a result.

I'm not saying that those physicians are inefficient in any way. What I'm saying is sometimes with technology now and looking at red tape reduction, there are opportunities to increase access. There are ways we can optimize the practice, and also take some of that burden off. It doesn't feel good. When people are done - it is fully and truly in an effort to support them.

A family practice nurse would be a different resource than a nurse practitioner. If we did add a nurse practitioner - if a physician was leaving - then the rosters would switch. A physician would be outgoing, and a nurse practitioner would take on some of the patients of that outgoing physician. It really is unique, but I think there are opportunities to support those practices in taking some of that mental and emotional strain off.

If they're retiring, they probably opened their practices 30 years ago, and the flow of patients and the illness of patients and the expectations have changed from the day they opened their practice. I just think there are opportunities there. Maybe that would happen, but I think the optimization team is really well-suited to support practitioners to see if there are things. Then if that person does retire, do they want to continue to participate in some way in there or in a different part of the system. That's also another important part of the conversation.

BRENDAN MAGUIRE: When it comes to retention with doctors - I know when we talk about the health care system, we talk about doctors a lot, but hopefully in the next 25 minutes or so, we'll get around to a whole bunch of other things. I do want to touch on a topic when it comes to doctors. One of the campaign promises that was made was around pensions for doctors. Where is your department at - we're two years in, two budgets in - I didn't see anything in the budget anywhere pertaining to pensions for doctors. This was a big promise from the Premier as a way to attract and retain doctors. Is there any money in this budget to start the process of creating pensions for doctors? When do you expect, or when can Nova Scotians expect, this to be fully implemented?

MICHELLE THOMPSON: I know there has been some work under way between not just the Department of Health and Wellness but also the Department of Finance and Treasury Board. They would have to do that together. What I will commit to is that it will happen before end of mandate - is really the work that will happen. There are a number of different initiatives that are happening, but we do anticipate that that will be delivered. It's in my mandate letter, so by end of mandate we will deliver.

BRENDAN MAGUIRE: Speaking of the mandate letter, one of the things in the mandate letter was - again, one of the promises was meeting surgery times within 18 months. I know that's very complicated. It's easier said than done. We know that. There are a lot of moving parts when it comes to that. I do know that in Health Committee, the head

of the Nova Scotia Health Authority had said that this will be met, we'll be at that by 2025. Are you confident in our ability to bring our surgery wait times down to the national average by 2025? How many surgeries will have to be - let's just say hip and knee surgeries - how many will have to be done per month in order to reach that? Are we on track for that?

MICHELLE THOMPSON: I am feeling encouraged and confident. Nova Scotia is tracking towards meeting the national benchmark of no longer than 112 days for cataract surgeries by Fall 2023. That's positive. There have been almost 3,300 patients since April 1, 2022, off the list. The surgical wait-list growth rate has been under the target of one for three consecutive quarters, which means there are more people coming off the list than going on. Those are early signs. This time in 2019-20, year to date, the Nova Scotia Health Authority had completed 72 arthroscopic hip and knee outpatient surgeries. This year, year to date, we did 1,098. The teams are really making good progress. We are leveraging public-private partnerships for low-acuity surgeries, and day surgeries are easier to go through than those who require in-patient.

Again, the work that happens in the Department of Seniors and Long-term Care is really very helpful, and the transition-to-care facilities. It's bed availability - 24 beds added to Dartmouth General Hospital, designated beds, where there's no off-service patients in those beds to support. There has been a number of initiatives, but I do expect that we will see momentum building as these initiatives stack over the next two years.

BRENDAN MAGUIRE: Is it possible that we're going to see Nova Scotians moved outside of provincial jurisdiction and federal jurisdiction for surgeries and procedures? Has there been a jurisdictional scan for capacity when it comes to different surgeries? I know people feel differently about this, one way or another, and this isn't a gotcha thing, I promise you that. We've had discussions about this. I think that if I need a knee surgery, I need a knee surgery. Let's be frank. If you need a life-altering or life-changing surgery, I don't think the majority of people really care where it comes from as long as they get it. I'm just wondering, have you or your department initiated any type of jurisdictional scan outside of the province or outside of the country to see if there's capacity when it comes to off-loading some of those surgeries, so that Nova Scotians are able to get those surgeries in a more timely manner?

MICHELLE THOMPSON: Currently, we do leverage public-private partnerships, to the best of our ability to do that. I would say that our Canadian counterparts are in a similar situation in terms of surgical wait times. In fact, we have actually had some other jurisdictions, other health departments, reach out to us because they see that we have had some early success and want to know what we're doing here. There have been other jurisdictions that have gone outside of the country. We're wondering what the success rate has been. There are a few folks that have gone before us, and we are watching to see if there are opportunities. Nothing's really off the table. We want people to get care. We want to get within wait times and then maintain our system. I would say that across Canada, our

counterparts are in a very similar situation that we are and actually looking to us for strategies.

[3:00 p.m.]

BRENDAN MAGUIRE: The reason why I brought that up is we know that, for example, with endometriosis, individuals are leaving the province and going to different countries for procedures. There was a young lady in my community who had a different issue, and she left the country. I don't know, I always think that it's kind of unfair, if you know what I mean, if you have the financial capacity to go get a surgery and you're leaving the province or the country to go get it. Some people have that financial capacity, and it obviously makes their life a little better. Then there's a lot of people who don't have that financial capacity who unfortunately have to live with that until the process comes up. Maybe it gets me in trouble, but I hope you do look at all possibilities to make Nova Scotians' lives better and make it a more level playing field.

One of the things that I have run into in my years of being an MLA, and I know that you as minister have talked about this, and it's something that I have brought up to previous Health and Wellness ministers is there's almost - there's obviously the red tape that you run into within the health care system. I'll give you an example. There was a young gentleman in my community who had a very rare blood disorder - it's already been dealt with. Essentially, if you even rubbed up against him or touched him, it would cause bleeding. There were only a handful of children in Nova Scotia who had this very rare blood disease.

At the time, we know that talking to the parents, our health care system was paying upwards of over $1 million per year to help this young boy. When I say help, he was completely wrapped. He was on medicine that was not really helping. He was unable to function and do anything. He couldn't go to school because if he fell in the playground, if he did this - his life was very limited.

Then they heard about a medicine in Alberta for this rare disorder that was changing people's lives. Not only was it not over $1 million, it was just over $100,000 a year. We fought and fought and fought. In fact, I ended up calling the vice-president of the pharmaceutical company that produced that drug and essentially begging them to give this young boy the medicine for free. It took about two and a half years of process to get through it. A lot of it was: We have to meet with other provinces to see if this is something we want to cover. Anyways, he was able to get the medicine. He now plays hockey. He's back in school. Of all things, he's playing hockey. His life is completely transformed.

My partner, Rena, her best friend has a young son who has - not speaking out of turn, as Katie has been very open about it - a genetic disorder. They were getting amazing treatment at SickKids when they were living there. They moved here, the treatment changed, and there was a lot of fighting and back and forth to have the parents' voice - I

think sometimes the parents' voice is lost in all of this. Nobody can advocate better or more for that person than the parent. I don't know if there's anything you can really do. It's the frustration for me that when we know that there are other processes and other procedures that not only can save money for the health care system but actually will change lives - we have to go through this fighting. There's absolutely no reason why as an MLA I should be calling the VP of a pharmaceutical company begging them for this procedure. Not that you don't have enough things on your plate, but I think this is something we need to look at.

Sometimes our health care system gets stuck in the mud, and there's this one-track way of thinking. The way the process and the procedure was forever is the way it's always going to be, and then it takes an immense amount of advocating and fighting and yelling and screaming. As a health care professional, I'm sure you have advocated and had similar cases like this. I don't know if you've looked at this, about the health care system being more nimble and not afraid of being first, second or third, always waiting for everybody else to do something. I don't know if there's a question there, but if you would like to comment on that, I would appreciate it.

MICHELLE THOMPSON: That's actually part of the transformation work that we hope to do, that we will be nimbler, first in class, best in class, moving forward.

Just a couple of things. If there is somebody - we do look at individual cases in the department. I know that there are things that are sometimes reviewed and wherever possible we do help people, particularly life-saving, cost-saving, quality-of-life. Those things are balanced. I would also like to get a plug in here for the Nova Scotia Health Innovation Hub and the Atlantic Clinical Trials Network. We are working with other provinces, our Atlantic colleagues, as the Atlantic Clinical Trials Network. I will tell you, it's very appealing to drug companies for 2.5 million people. They want to do their trials here, creating a commitment of - from time of proposal, if accepted, to time of trial beginning - 90 days. It's very appealing. It brings cutting-edge care to Atlantic Canadians in order to offer cutting-edge treatments and study drugs and treatments and therapy. That's another step forward.

Again, I had an opportunity to do the announcement last year at this conference with our Atlantic colleagues, and it really was appealing to drug companies - 2.5 million people, 90-day start-up, a very robust team to support the research that's happening. I think that's an important way that we can bring cutting-edge treatments to Nova Scotians.

BRENDAN MAGUIRE: I'm just going to fire off a couple of quick questions, if that's okay with you. What's the update on the app that was announced during the actions to improve emergency care announcement?

MICHELLE THOMPSON: That's coming very soon. You'll see that very soon. I have off-loads, if you want them.

By region: Cape Breton Regional Hospital off-load, 124 minutes; St. Martha's Regional Hospital off-load, 24 minutes; only to be outdone by the Aberdeen Hospital off-load, 22 minutes on average; Colchester East Hants Health Centre, 79; Cumberland Regional Health Care Centre, 53; Dartmouth General Hospital, 104; new Halifax Infirmary, 162; Cobequid Community Health Centre, 110; Valley Regional Hospital, 63; Yarmouth Regional Hospital, 50; and South Shore Regional Hospital, 66.

BRENDAN MAGUIRE: How many nurse practitioners have been hired to work in the ERs?

MICHELLE THOMPSON: Nurse practitioners are active in Cumberland Regional Health Care Centre and in the planning phase in Colchester East Hants Health Centre and the Aberdeen Hospital. In Western Zone - looking at a couple of sites in Western Zone, as well as Eastern Zone. Physician assistants are in place in Dartmouth General Hospital, and they're recruiting for South Shore Regional Hospital. Pending recruitment by the end of Quarter 2, if we can find the people, the physician assistants will be implemented in a number of emergency rooms across the province.

BRENDAN MAGUIRE: Are there none in Halifax?

MICHELLE THOMPSON: There's one nurse practitioner at the Halifax Infirmary.

BRENDAN MAGUIRE: How many more are needed in Halifax?

MICHELLE THOMPSON: I'll just add that there are two at the IWK Health Centre as well. We sometimes forget about them.

I think what I would say about that is that if the teams come forward with innovations, we would be open to understanding. If there are people who want to work in the emergency room and they feel that that's part of the team-based environment - whether it be a physician assistant, a nurse practitioner or both, I think that would come through the planning teams in those departments. Certainly, the waiting room care provider, as an example, has been very, very successful - the extension, as well, over at Dartmouth General Hospital, the expansion of that. That was actually a test and try that was brought forward by the staff at Dartmouth General to try. If people have ideas, they should bring them up through their internal management structures to talk about what it could look like there.

BRENDAN MAGUIRE: I'm not trying to be disrespectful by remaining standing. My fibula is still not fully healed, so it's still a lot of pain to get up and down.

Are we going to keep the patient advocates on full-time? Is this a permanent, forever position, or is this an interim position and temporary?

MICHELLE THOMPSON: I would say that those positions are for the foreseeable future. It would be wonderful if we got to a time when they weren't required, but certainly we know that they have a lot of benefit right now. Yes, they are positions that will be there for an extended period of time to support the comfort of patients waiting in the waiting room.

BRENDAN MAGUIRE: How many nurse practitioners are in Dartmouth General emergency?

MICHELLE THOMPSON: We have physician assistants in Dartmouth General, but not nurse practitioners. There would be - they're not there 24 hours. They would be there for the highlights, those really high travel times. I would say there were probably two or 2.5 FTEs in order to staff that fully - two to three. In order to have somebody there every day, you'd probably need 2.5 FTEs in order to pull that off with the hours worked. There would be a complement, but there would be a certain number of hours per day in order to staff it.

BRENDAN MAGUIRE: Is that something you're looking to staff full-time with nurse practitioners? Or were you talking about patient advocates? Physician assistants, okay.

THE CHAIR: Order.

BRENDAN MAGUIRE: Sorry, cross talk. I apologize.

THE CHAIR: I would like to give the minister a chance to answer that on the record.

MICHELLE THOMPSON: Dartmouth General Hospital is using physician assistants. They have already tested and tried and implemented the care provider. The advocate is there, as well, but the care provider came from that team and is being scaled across the province as a result of the work that they did there.

BRENDAN MAGUIRE: We have about four minutes left on the Liberal side for Health and Wellness. I want to thank the minister through the ups and the downs of Estimates.

I do want to say, though, that I'm a little concerned about - not necessarily with the planning for what's happening at the Dartmouth General Hospital - I'm a little concerned about that being released publicly. What I mean by that is we have heard, I think from Dr. Alex Mitchell, in allNovaScotia, CBC, and a few others - we have heard from the minister and the Premier - that the plan is to build a bigger footprint for the Dartmouth General and to buy up the properties around. What we've seen and has been reported is that the latest acquisition of land, I think from Scotia Surgery, was significantly overvalued for the price

of the land. The government paid more than what it was actually assessed at - quite a bit more, actually.

[3:15 p.m.]

I guess my concern would be that if I knew somebody wanted to desperately buy my house and was willing to pay anything for it, there is a chance that the property is going to be overvalued. I will give you time to respond to this. I'm not killing the time, I promise you. I'm a little concerned about that, that the strategy has been released. What's being said by the Nova Scotia Health Authority is that they want to buy up all the land around the Dartmouth General. There are still more properties to be purchased. If you own a piece of land and you know that the government desperately wants it, you know the government has overpaid for a piece of land - is there some concern from your side - not necessarily about the project, because I think the idea is fantastic, and I know that the land is limited, there's only so much land around it.

Is there a little bit of concern about that strategy being released and that we've already seen a piece of land that the value of that land has been increased by the government's need to purchase that land? Is there a concern about the price of the remaining land being overinflated and government maybe not getting the best possible price? Millions of dollars - we know that money is a valuable resource especially when it comes to health care. Is there some concern that that money may be better used in other places and now is going to be used on property that the value is going to be overinflated because they know that government wants that land?

MICHELLE THOMPSON: What I will say to the member is that the plan was released after we had line of sight on those properties. It's that they are closing now, and that's why we're seeing them in the news and what-have-you. We're actually closing the deals we had prior to. Those costs were negotiated before the plan. We couldn't announce an expansion of the Dartmouth General Hospital without knowing how we were going to do that. Those deals were done prior to, and now we're actually announcing them. So, it's the opposite, in fact. We were able to negotiate those deals before the plan was made public.

THE CHAIR: The honourable member for Annapolis.

CARMAN KERR: I just want to thank the minister on behalf of my colleague.

THE CHAIR: Order, please. The time for the Liberal hour has elapsed. We'll move back to the NDP for what we believe will be the last 32 minutes of Health and Wellness questioning.

The honourable member for Dartmouth North.

SUSAN LEBLANC: When we last spoke, I was asking about 811, and the minister was explaining, I think - not to put words in her mouth - that there needs to be an updated KPI system or collection of information from 811. I think I followed up by asking, that being said, are there any things that are collected that the government can report on in terms of indicators at 811?

MICHELLE THOMPSON: The predominant things would be the types of calls, as I said: how many individuals get diverted to in-person care; probably emergency room care, as the primary place where they would be referred; and then understanding the primary reason for the call. A little bit around the demographics, as well, of who is calling. Those would be some of the things that are tracked. It's just that there's an opportunity for us, I think, to look at this current service - what it could be and how we could measure and create some KPIs.

SUSAN LEBLANC: What about callback times on 811? I remember in the olden days of 811, you could call and if you didn't reach someone right away, they called you back within a half-hour, and they would even say that on the recording: You will receive a callback within a half-hour. Now it seems like the wait is much longer. Do we have any data on that?

MICHELLE THOMPSON: We don't currently have wait times for that - callback times. They're not currently tracking that. (Interruption) Incoming calls and serviced calls only - the number of incoming calls and the number of serviced calls only. They're not tracking those times currently.

SUSAN LEBLANC: Thank you for the clarification because it sounded like you were saying that no one waited, but that's not the case. You just don't have that data.

Can the minister say how many vacancies there are at 811?

MICHELLE THOMPSON: They'll reach in and check on the vacancy numbers.

SUSAN LEBLANC: That would be great. While that checking is going on, could we find out how many people at 811 are full-time and how many are casual - a breakdown of those positions?

I want just to ask a couple more questions about the Action for Health indicators. I know the minister and her staff will be paying close attention to the indicators. I'm hoping to get some clarity about what's going on with them. In 2021-22, there was only a 13 net new increase in family doctors, fewer than 2020-21. There are currently 97 family doctor vacancies in the province. Does the minister know how many net new family doctors have been recruited in 2022-23, and what is the goal for 2023-24 - family doctors?

MICHELLE THOMPSON: There was a net gain of 41 total physicians in 2022 - not the fiscal but calendar: 10 family physicians and 31 specialists. There are 200 physician vacancies according to NSH data - 123 family doctors and 76 specialists.

[3:30 p.m.]

SUSAN LEBLANC: Can the minister clarify that the goal for 2023-24 is to reduce those vacancies to zero, or is there an interim goal?

MICHELLE THOMPSON: That would be ideal. Certainly, we always want to incrementally exceed our previous year. I am very hopeful that with the change for the U.S. physicians we're going to see an impact. We've heard from a number of folks who wanted to come home. I think the change in licensing process will have an impact. Of course, we want to exceed that. We would love to fill those 123 vacancies. The likelihood in a year - not impossible, but won't we be happy if we're there? Obviously, incrementally every year to have net new gain, year over year.

SUSAN LEBLANC: When we talk about the vacancy for family doctors, for instance, is the top number - the number we need - based on the number of practices already in place? Is it based on population? Is it based on how many people are on the list? How does it work? Say we need 100 doctors. What would that look like if all of those doctors were in place? Does that mean no more list? Does that mean all the clinics are working to their full capacity again, but there's room for more clinics? Can the minister just explain what that would look like?

MICHELLE THOMPSON: The 123 vacancies would be FTEs. If we had the 123, of course there would be retirements, so the number would be moving. These are the vacancies now. Certainly, it would be based on our population.

The issue with it is it doesn't mean it's 123 individuals. We know that we have physicians who come in who want to practise 0.5 in an office and 0.5 OB/GYN or 0.5 palliative care or hospitalists or what have you. Some will absolutely come in as FTEs and fill a full roster position, whereas in some cases it may take two physicians, where friends or couples or colleagues may share a position and then do other things, like oncology or what have you. Similar, not fully to the old days but somewhat, we see that our GPs were very officed-based. Now we're starting to see folks who want to do some OB/GYN in some of our rural communities and supporting palliative care and medical oncologists and all types of things. Working with physicians - which is why the fit is so important, why the match of the individual and the practice to the community is such an important part of the recruitment process.

SUSAN LEBLANC: That's helpful, but based on that, even if we're talking FTEs, say we have 123 FTEs that are filled with 123 people who want to work full-time, just to make the math easy, what would that look like in terms of our attachment? I guess my

question is this: Do we have more need than we have vacancies for? For everyone in Nova Scotia to be attached to a family care practice, how many FTEs would we need?

MICHELLE THOMPSON: If nothing changed and we had 123 full-time family physicians with a roster of 1,350 patients each, that would service 166,000 people, which is by simply doing straight math. The other issue is we could have a family practice where this person has a family practice nurse, a social worker, and a pharmacist, and so perhaps can roster 1,600 people as a result of all the different folks. We have fee-for-service physicians who have - the 1,350 is the smallest roster, ideally, although we do adjust them somewhat for APPs, who have a higher rate of patients with a chronic disease, but that's what it would be: 1,350 times 123 is 166,000.

SUSAN LEBLANC: Do we know how many patients each of the family doctors at the clinic that closed in the South End had? I guess we do, but I can't remember the number. It's thousands, right?

MICHELLE THOMPSON: We can do some work around algorithms and things like that, but the information actually sits with the physicians around the size of their rosters.

SUSAN LEBLANC: I guess I'm going to ask this question in another direction. In 2021-22, there were 125 family doctors per 100,000 Nova Scotians. What is the expected date that we will hit the target of 135 doctors per 100,000 Nova Scotians?

MICHELLE THOMPSON: I'm just wondering where the target of 135 doctors to 100,000 Nova Scotians came from.

SUSAN LEBLANC: Well, now it's my turn to say I'll get that information for you.

Speaking of information, I just wanted to ask because we have 16 minutes left, and I wanted to know, first of all, how many minutes the minister needs for closing remarks and to do the resolution, but also how will we collect all of the information that we've asked for and it has been said that we'll receive? Will the minister write to us with all the information that hasn't been answered today or during Estimates? I just want to know how that will work.

MICHELLE THOMPSON: I need about five minutes at the end. The staff are getting the information. They're collecting it as we are talking. They'll compare it to Hansard, and then we'll submit it to the clerk in a timely fashion.

SUSAN LEBLANC: I just wanted to talk about a letter we received from a full-time nurse practitioner student and full-time registered nurse working at the QEII. This nurse, they're a full-time nurse at the dialysis unit, and they are studying full-time to become an NP. They began the nurse practitioner program in January 2022 as a full-time student while continuing to work full-time as a dialysis nurse in the renal program. Their

decision to pursue the NP program as a full-time student while continuing to serve the community as a full-time RN was due to three reasons: they were unable to afford leaving their position as a nurse to pursue the NP program; they would have lost their seniority and health benefits for their spouse and themselves; and they felt obligated to work full-time due to the high level of staffing shortages we're seeing across the province.

Despite these constraints, they were committed to becoming a nurse practitioner in Nova Scotia with the goal of continuing to work in the renal program. Their passion in caring for patients with kidney disease began in 2016, during their final clinic placement as an RN student. Since then, they have continued to demonstrate their loyalty and provide leadership to the renal program by investing in themselves and others as outlined below. They are currently instructing a course in the RN program at Dalhousie University - if you can imagine that they have time to do that. They worked as a clinical nurse educator, focusing on optimizing nursing scope of practice, while onboarding and supporting over 100 staff during the pandemic. They worked as a charge nurse responsible for emergency planning for COVID-19, scheduling and staffing levels, and conflict management, all while advocating for patients. They were a preceptor to Dalhousie University RN students for clinical hours and continue to act as a mentor and role model for new RNs.

In some remark - and I have heard Ms. Oldfield as CEO of the Nova Scotia Health Authority say this before at different committees and community meetings and stuff: if you are a nurse practitioner in Nova Scotia, we want to hear from you. This person is calling out for help. Here they are asking for help from - this letter goes to Karen Oldfield and Gail Tomblin Murphy, the Premier, and the minister.

The person writes: The province can support me by providing tuition reimbursement for the NP program, providing financial incentives to practise as an NP in Nova Scotia, and employing me as an NP in the renal program. By leveraging my experience and skill set in nephrology, the Province of Nova Scotia has an opportunity to alleviate emergency department utilization rates by a population that is known to disproportionately utilize emergency health care services.

I'm reading all that into the record because I would love to know the minister's response to that. I'll ask the first one: Is there a plan to provide tuition reimbursement for people taking the NP program?

MICHELLE THOMPSON: I will have a look for that correspondence. It probably went to my very busy Health and Wellness minister email. Certainly, we are happy to review that with the Office of Healthcare Professionals Recruitment. There is some support through the provincial nursing network for registered nurses who are looking to bridge in hard-to-recruit-to areas, where there's a lot of primary care need. Around specialty NPs, I'm not sure that there's actually a program specific to that. If the member would reach back out, or we'll reach back out, we'll get the data, the correspondence, and we'll speak with that person and see if there's anything we can do to support.

THE CHAIR: Order, please. I'm just going to ask that if there are conversations to maybe take them out, or we'll call for a recess.

[3:45 p.m.]

SUSAN LEBLANC: I kind of missed the answer, but I heard that you will reach out and see what you can do for the person. I'm wondering also, are there financial incentives to practise as an NP in Nova Scotia? Central Zone or not Central Zone, whatever, are there any incentive programs?

MICHELLE THOMPSON: There would be some positions where there would be hiring bonuses. It is a bit specific in terms of if it's a hard-to-recruit area, whether that's urban or rural, sub-specialties, et cetera. There would be some. I don't know that they're across the board, but we do have hiring incentives across nursing designations at the Nova Scotia Health Authority.

SUSAN LEBLANC: We've heard about the 14 collaborative care clinics. Do we know where those will go yet? That's my first question about that.

MICHELLE THOMPSON: All I can offer right now is that there will be new collaborative care clinics in each of the zones. Every zone will have additional clinics.

SUSAN LEBLANC: When planning for collaborative care clinics is going on, when the business plan is brought forward - I have some intimate knowledge of how that all works, at this point - what are the deciding factors? Do you have a priority list of things that you're looking for for a plan? Is it meeting actual attachment need? What other things go into it besides attachment need?

MICHELLE THOMPSON: We would look at attachment, as you said, but also practice readiness. Sometimes it's retirements. Sometimes there are four or five doctors who come into an area and say: We should all be working together. It really is around practice readiness and attachment - the two primary things that we would look at, in terms of community readiness. In your case, it's very clear that there's a readiness there and an interest and a willingness to move that model forward.

THE CHAIR: Now I'm going to offer the Minister of Health and Wellness an opportunity for closing remarks.

MICHELLE THOMPSON: In closing, I would like to thank my colleagues for their thoughtful questions. I appreciate the opportunity to discuss this transformation budget, and I know health care is important to every one of us. There are not many things, I don't think, that haven't been said, with the exception of a few thank yous.

I do want to thank Deputy Minister Lagassé and Shelley Bonang for their help, and also Associate Deputy Minister Beaton for his cameo appearance last week to help us get through our first day of Estimates. Behind us, as others know, is a team of people who help respond to Opposition questions. These folks are brilliant, committed, dedicated people working every day, and they make a difference to Nova Scotians. I extend my gratitude to each of you.

I want to thank the constituency assistant in my office, Wendy, who is keeping things together, and to Jean and Jermal, the special assistants who work with me and help me do my job and help support my colleagues on all sides of the House. I also want to thank my mother-in-law and my husband, the only two people not paid to watch Estimates.

I want to acknowledge the health care workers across this system, across this province. Action for Health is a plan built on their voices, on their solutions. I want them to know that it will take time to transform health care, and I hope that as we do, all of you feel our commitment and feel our support. I want to assure Nova Scotians that the Premier, myself, and the government have our shoulder to the wheel. We are investing in health care workers. We are investing in health care teams. We are investing in technology and innovation and in your communities. There's $6.5 billion worth of investments in health care to provide access and attachment, and deliver on our election promises, and give you the health care system that you want and deserve.

Finally, I would like to thank the Premier for giving me this privilege to serve as the Minister of Health and Wellness, as well as the Minister responsible for the Office of Healthcare Professionals Recruitment, and to my colleagues for their ongoing support and wisdom as we carry out our first mandate.

THE CHAIR: Shall Resolution E11 stand?

Resolution E11 stands.

Resolution E29 - Resolved, that a sum not exceeding $7,902,000 be granted to the Lieutenant Governor to defray expenses in respect of the Office of Healthcare Professionals Recruitment, pursuant to the Estimate.

THE CHAIR: Shall the resolution carry?

The resolution is carried. (Applause)

I want to thank the honourable Minister of Health and Wellness, in my last act as Chair of the Legislature, and your staff who were beside you every step of the way, colleagues on the other side of the room who challenged you and were patient enough to ask the questions, and you answered.

The time allotted for consideration of Supply has elapsed. The honourable Government House Leader.

HON. KIM MASLAND: Madam Chair, it's a pleasure for me to be here with you on your last day as well.

I move that the committee do now rise and report progress and beg leave to sit again on a future date.

THE CHAIR: The motion is carried.

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

[The committee adjourned at 3:49 p.m.]