HOPE FOR HEALTH

INTRODUCTION

The Need

Listening to Nova Scotians from Glace Bay to Digby, the most common area of concern we hear is with respect to our healthcare system. First among all concerns is the lack of access to care. Access to care, for them, means either having a family physician (or a primary care provider), who is able to see them and provide timely access to the care they need (i.e. surgeries, consultations, etc.) when they need it.

As of April 1, 2021, over 64,921 Nova Scotians were registered on the waitlist for a primary health provider. We understand that there are likely many more who have given up and are not registered in the system.

What's more, waitlists for some specialties have become potentially fatal. As of September 30, 2020, the wait time for a consultation for an amputation in Halifax was 455 days, with an additional wait time of 364 days for the actual surgery, for a total wait of approximately 819 days to receive the necessary treatment.

It takes approximately 269 days for a consultation on a knee replacement in New Glasgow, with an additional wait of 757 days for the actual surgery, totaling 1,026 days to receive the necessary treatment. As we endure the pandemic, these wait times are increasing.

The current wait time for a consultation for brain surgery in Halifax is 192 days. Following the consultation, the average wait is 195 days, resulting in an approximate 387-day waiting period for brain surgery.

We are fortunate to have incredible healthcare providers in Nova Scotia. Once in the system, the care you receive is generally second to none. Unfortunately, those healthcare providers are often overwhelmed, overworked, micromanaged and they lack the resources necessary to ensure more people have access to that top notch care when they need it.

The supports needed range from more staff to the ability to make decisions at a local level, to less administration. We need to improve the freedom to make decisions on a local level, with less bureaucracy and administration interrupting the flow of delivery of healthcare.

Access

As noted, access to timely care is one of the largest barriers in our health system. The research clearly demonstrates the importance of early detection, treatment and continuity of care.

Too frequently, the only option for Nova Scotians is their local Emergency Room ("ER"). ERs have become a venue for treatment of non-emergent issues, from prescription refills to treating the common cold. ER doctors often feel that they are essentially the family doctor to those they treat.

It is necessary to ensure that all Nova Scotians have access to primary care, locally, conveniently and when they need it. Good and timely care will result in savings for the health system. This means offering modernized access to those who don't have it.

Telehealth or virtual care for everyone on the waitlist for a primary health professional is not a replacement for a primary care practitioner but is a placeholder to ensure that every Nova Scotian has immediate access to a form of primary care.

Another aspect of access to care that has been amplified in recent years, is the waitlist for surgeries. Some individuals are living in pain, awaiting surgery to improve their joints, while others worry about the potential exacerbation of conditions as a result of extended delays.

Presently, the hours that Operating Rooms ("ORs") are open are generally limited to business hours, with the exception of emergent surgeries. The only way to address the backlog is to open our ORs to allow surgeons to do their work outside of normal business hours. Once we are making the most efficient use of our ORs, we will start to see significant improvements in the waitlist.

Recruitment

While we need to focus efforts on recruitment and retention of our current health professionals, we have to fix the system if we want to fix the doctor shortage. It is cheaper and easier to keep those we have than it is to recruit new.

To begin to repair the system, we need to make Nova Scotia an innovative place to practice medicine. This means putting the proper resources in place to set doctors up for success. We must empower and motivate them to work here. We can do this by:

- giving them the ability to make decisions on a local level;
- providing more competitive and fair wages and payment models; and
- ensuring a better quality of life, particularly in rural areas, where too often everything falls on their shoulders.

In short, we need to ensure our doctors have a respectful and healthy work environment. Let's decrease the burnout with a focus on respect and modernization and make this a place where people want to be doctors.

Communities know their needs best. Team leads should be appointed in each health region, who are accountable for establishing recruitment and health plans for their respective areas.

Thousands of Nova Scotia students leave Canada to further their health education. With some medical schools, return to Nova Scotia can be straightforward. However, too many students face barriers such as minimal residency seats for internationally trained students and minimal study supports.

We can never lower the standards expected of our health professionals; however, we can give those students the same supports provided to locally-trained students.

Too many of our students are training and staying in the United States, simply because the cost of entry into the Nova Scotia system can be prohibitive and more supports are in place for those students in the

US. Once they enter that system, the salaries are frequently higher, and they begin to build a life there. We shouldn't make it hard for them to come home. Of course, at the same time, these physicians will always have to meet our Canadian standards.

Modernization

Virtual care is here to stay and is the way of the future for medicine. It will also act, in the immediate future, as a temporary mode of access for those who do not currently have any. At the same time, it does not replace all in-person care. While many ailments can be diagnosed over the phone or video, others will always require in-person consultation. We need to establish a concentrated effort on recruiting primary care providers to Nova Scotia to ensure we have the right care, for the right patient at the right time and in the right place.

This also means expanding the current virtual care framework to allow specialists to see patients virtually. Often, a patient may be required to travel from Yarmouth to Halifax for a consultation. When possible, these consultations could move to a virtual venue.

This may allow specialists in areas of the Province with shorter waitlists to assist, assess and consult with more patients much sooner. At a minimum, this will lead to more efficient use of time in situations where, for example, there is a last-minute cancellation. Instead of that spot going unused, a new patient can be slotted in on a moment's notice using technology.

Expanded specialties for Telehealth will assist with post-operative care as well, particularly for individuals who may be less mobile. Having access to a physiotherapist over their phone or computer from their living room will help with patient accountability and monitoring patients' progress.

Chronic Illness

Approximately, 5% of Nova Scotians consume 70% of our health dollars. Much of this spending and care is in relation to chronic illnesses: diabetes, heart disease, COPD, frailty, obesity, arthritis, etc.

Band-aid solutions to our health system do not work. Simply treating the illness, as opposed to working to address the root cause and focus on prevention, is no longer working. Our current healthcare crisis shows that.

Nova Scotians recognize that our health system is not meeting our needs. We are spending $4.6 billion on health for fewer than one million people. That is more per person than Ontario, Quebec and British Columbia, but we are not achieving the results they are achieving. Our administrative costs are 35% higher than the national average and are the highest in the country.

The health system is stressed. To address that congestion, we need to expand in-home care for patients with chronic illness. The INSPIRED program is a proven model that we need more of. INSPIRED focuses on individuals with COPD and means teams of professionals visiting patients in their homes. For every $1 invested, this program saved $21 in the traditional system. Fewer visits to emergency rooms and fewer nights spent in hospital means fewer dollars spent. Better care saves lives. Better care saves money.

We need to examine what is working in Nova Scotia and expand on our successes. Expanding a program like INSPIRED to other chronic illnesses will help to reduce the burden on the primary health system. It will free up family doctors' offices, ERs and hospital beds for those with more acute needs. It will also assist in reducing the progression of these illnesses to a point of acuity.

Prevention

A sturdy foundation is built on strong, long-term health practices. This means having the tools to live a healthy lifestyle.

We must place a heavy focus on early learning about healthy living in our schools. The importance of an active lifestyle must be instilled at a young age and consistently throughout their education. Physical fitness should be mandatory in our schools each year.

Similar to the importance of physical activity, our students should learn about healthy and balanced diets and they should be required to participate in healthy cooking courses prior to graduating from high school.

Learning to eat and exercise properly will help to form the foundation of a healthy lifestyle as our students become adults and start living on their own and making their own decisions.

For adults and seniors, we have to work with our communities to establish more walking/fitness programs. The Province should sponsor healthy cooking programs in conjunction with local grocery stores and restaurants. Ready access to dietitians within communities to give Nova Scotians the ability to address their nutritional needs and questions must be established. This can be accomplished through the expansion of virtual care for more remote and rural communities.

While nutrition-based health concerns have surpassed those health issues related to tobacco, over 20% of Nova Scotians continue to smoke. Tobacco is the number one cause of preventable disease and death in Canada. An estimated 45,000 Canadians die each year as a result of smoking. Countless others live with chronic illness. The cessation of smoking is a key ingredient to living a healthy lifestyle, reducing the need for healthcare and saving overall costs on our system.

Administration

One of the biggest problems in our health system is that it is now far too centralized, to the point that the Nova Scotia Health Authority (“NSHA”) in Halifax has provided very little autonomy outside of Halifax to our four health zones.

In discussions with health providers, they frequently express frustration with the inability to make appropriate decisions on a local level.

In addition to the problems around centralization, there are too many managers within the system who are practicing stale management tactics.

We need managers with a broader range of expertise, and we need fewer managers. There appear too frequently to be redundancies in the work being done. We need regular financial reporting and human resources metrics. We need an NSHA that measures outputs. We need to establish limitations on position vacancies.

We can establish this by optimizing the administration, based on the needs of the patients and the communities, to recognize different frames of expertise and backgrounds, more diversity and empowering patient-driven decision-making.

The status quo is failing Nova Scotians. Change is needed.

WHAT CAN WE DO?

Our goal should be to make Nova Scotia the healthiest province in the country based on the regular health report cards issued by the Conference Board of Canada. It starts with:

- Establishing access to a telehealth/virtual care system for any individual on the waiting list for a primary care health provider;
- Opening our ORs beyond Monday to Friday 9-5, to clear the backlog of surgeries;
- Having a focused recruitment strategy around internationally trained graduates;
- Expanding virtual care to more healthcare providers;
- Focusing on prevention in school and in communities;
- Investing in chronic illness treatment and prevention; and
- Restoring local decision-making by restructuring the administration at the NSHA.

1. Improved Access to Primary Health Providers

Our acute care system was not designed – and cannot handle – the needs of Nova Scotians today. Patients are telling us the system must change, doctors are telling us the system must change, families and communities are telling us the system must change.

Nova Scotians deserve more than 19th century tools for 21st century conditions.

A PC government believes that every Nova Scotian should have access to primary care. We recognize that recruiting all the primary care practitioners we need is not something that can happen overnight. However, while we are doing the work to recruit, we must provide care to those in need. This will allow patients to have immediate access to care. It will also help to alleviate some of the pressures on our acute care system.

We are committing to providing those Nova Scotians on the waitlist with immediate access to a virtual care service. We are seeing the growth of programs like “Maple” in the private sector. These services provide online access to primary care practitioners and offer virtual care and prescriptions. They allow subscribers access to care from their own homes via their phone, tablet or computer - anytime, 24/7.

Functionally, the Province would issue a tender for this service, and, within 60 days of issuing that tender, would offer telehealth/virtual care to anyone without a primary health provider while we go about the hard work of redesigning the primary health system to meet the needs and desires of the patients.

Costs

The initial cost of showing up in an ER is approximately $250. The cost of a visit with a family doctor is approximately $35-$60. The cost of a telehealth visit is in the range of $40-$50.

With over 50,000 individuals on the waitlist for a primary care practitioner and estimating that half of those individuals would use the telehealth service at least twice per year, the cost to the Province of giving everyone access to primary care would be: $2,500,000 [25,000 individuals x 2 uses x $50 per call].

The costs on the system of not receiving the diagnosis and treatment you need when you need it are not quantifiable based on publicly available information. However, based on the data we do have on preventative programs like INSPIRED, there are massive savings in early detection, prevention and treatment.

Giving Nova Scotians timely access will result in better care.

2. Improving Surgical Wait Times

One reason for our large surgical backlog is a lack of operating room (OR) time and recovery beds, which are too often held by patients who are actually ready for discharge. Presently, our ORs are generally only being used during business hours, Monday through Friday and are used outside of those hours exclusively for emergency surgeries. You would never invest in equipment and then purposely not maximize its use and not use it to full capacity and the health system shouldn't either.

We need to let our surgeons operate.

A PC government will cut out the inefficiencies related to the operation of our ORs and allow them to run outside normal business hours (Monday to Friday, 9-5) until the backlog has been addressed.

We need a goal that is more than just shortening the waitlist. Our goal will be to meet the benchmark standards for wait times, within 18 months of being elected.

To accomplish this goal, work will need to be done to ensure that any new hours are consistent with the terms and conditions of the Collective Agreement with the Nurses' Union and with other support services, such as environmental service providers (cleaners, porters, sterilization).

In an effort to be accountable and transparent to Nova Scotians, they should be able to see how fast the wait list is moving and how efficiently the system is being used. We will commit to establishing a website that tracks, in real time, the number of surgeries taking place in a day, what types of surgeries, and how each day's numbers impact the waitlist.

Costs

The cost of early treatment is much less than the cost of late treatment where diseases progress as a result of not having timely access to care.

The majority of cost to the Province of opening up our ORs will be related to personnel costs. Most surgeons are fee-for-service, and should remain as such, particularly in the Central Zone. Fee-for-service drives efficiency and helps with demand. Outside of the Central Zone, particularly in more rural areas, there may be a need for salaried specialists and surgeons, based on the demand and needs of the community.

For the purposes of costing this service, our considerations are based purely on the fee-for-service model. We have approximately 352 active surgeons in Nova Scotia. The average salary is in the range of $300,000. This salary is for time spent operating as well as consultations and patient follow up.

We presume that not all surgeons will want to change their hours. Our assumption is that around 40% (being 140 surgeons across different specialties) would be interested in a change of hours. If each of these 140 surgeons were to increase their OR time by 25%, they would see pay increases of

approximately $75,000 annually [$300,000 x 25%]. The total cost of increasing physician hours would be in the range of $9,356,550 [$75,000 x 140 less payroll taxes of $1,143,450].

Similarly, there would be an increase in the cost of staffing the ORs with nurses and other necessary personnel. For each surgeon, we will assume a need of three supporting practitioners, for a total of 420. Assuming average wages of $75,000 and increased working hours of 25%, the total approximate cost of increased staffing would be $7,017,413 [25% of $75,000 ($18,750) x420 less payroll taxes of $857,587].

Additionally, there is an entire support team related to every surgery. There are porters, cleaners, recovery personnel, ICU staff, anesthesia techs, medical records staff, physiotherapists, occupational therapists, respiratory technicians, as well as countless others. For each surgeon, we will assume the need for 10 support staff, for a total of 1,400. Assuming average wages of $50,000 at an average increased working hours of 15%, the total approximate cost of increased staffing would be $9,356,550 [15% of $50,000 ($7,500) x 1,400 less payroll taxes of $1,143,450].

The total cost of opening up our ORs would be approximately $25,730,513.

3. Recruitment

Between the extended waitlist for a primary care practitioner, patient outcomes and long ER wait times, the need for more healthcare professionals - both doctors and other professionals - is undeniable. We need to rebuild our human resources. We also need to ensure that those choosing to give back and work in the health profession are valued.

Like any business, you have to care for your employees, and they have to know it. Unfortunately, whether it is health workers or teachers, there is currently a culture around us of people not feeling respected by their employer - the Province. This has resulted in many health professionals leaving the profession, leaving the Province, or, in the case of many family physicians, leaving their speciality in favour of another.

The culture must change to one of respect and recognition of gratitude. We, as a province, need to take care of the people we are asking to take care of us.

Retention of Family Physicians

One of the things that has made access to primary care in Nova Scotia more challenging is the imbalance in wages amongst physicians.

In 2017, the Province renegotiated the wages of hospitalists, who are similar to family physicians, but take care of patients in hospitals rather than in offices. Once their patients are discharged from the hospital, their responsibility for treating those patients essentially ends. Family doctors, on the other hand, maintain their patient files in perpetuity.

Both provide incredibly valuable services. However, the renegotiated contract for hospitalists resulted in a pronounced funding disparity between hospitalists and community-based physicians. This divide doesn't even begin to account for the overhead that many family doctors pay for their practices. With that in mind, the difference in pay is in the tens of thousands. This new rate also had an unintended consequence of a culture shift, resulting in less incentive for physicians to practice family medicine.

We all know that practicing medicine is about more than money to most physicians. It's about a number of factors, including lifestyle and work environment. Nova Scotia has a lot to offer and is second to none in terms of places to live. We cannot engage in a bidding war with other provinces and other countries over physicians, but we can and should pay family doctors fair, comparable rates that demonstrate that they are valued. We have to show them that not only can they live in the most spectacular place in the world, but they can earn an excellent living in an environment where their dedication is respected and valued.

The PC government is committing to restoring a positive relationship with family doctors. As a starting point, it is necessary to level the playing field with respect to remuneration and pay family doctors at a rate that is in line with that of hospitalists.

With the increasing burden of care placed on our primary system and its practitioners, we have received much feedback that it can be overwhelming for new graduates who do not feel confident or fully competent to provide comprehensive care. As a result, they are moving to other roles. Overcoming these challenges may be alleviated with mentoring and providing support to these new doctors by experienced practitioners who can guide them as they improve their competence, experience and confidence. Mentoring will also be crucial for rural specialties.

The matching of new graduates and mentors can be addressed in a clinical health services plan and will help in community care succession planning, allowing new practitioners to transition into practice under the tutelage of retiring practitioners. This will improve recruitment and retention and will create a smoother transition of patient load.

In our commitment to restoring the relationship with doctors, we will lift the gag order imposed on those who wish to speak out about physician-related issues. At present, we hear from too many who wish to remain anonymous out of fear for their jobs. Allowing them to speak freely will create a better work environment for our healthcare professionals.

Recruitment at the Local Level

Historically, some of the most successful recruitment of our health professionals was done at the local level. In addition to provincial-wide recruitment efforts, our PC government will recognize the need for more local involvement and will work with communities to give them the tools for successful recruitment.

The removal of local decision-making has hurt recruitment. The centralization of the NSHA in Halifax resulted in many recruiters working within the NSHA not having a personal relationship with the medical community, resulting in a disconnect that does not produce results. Local physicians and other health professionals must be involved in the planning and delivery of recruitment strategies.

Nova Scotia's current recruitment strategy is a provincial one. It's not practical to think that the same approach used to attract someone to Halifax would work to attract a physician to Neil's Harbour. Our Province is so diverse in our geography, population, physician workforce and in job opportunities for spouses. There is limited local involvement when it comes to recruiting doctors. As is the case in most facets of health – there needs to be more local decision-making capability for local recruitment efforts.

We should have physicians front and centre when it comes to introducing doctors to our communities. This is why every region needs **a clinical health services plan**. This plan would outline what staffing *should* look like in each region, overlapping staffing with the needs of each community. For example, based on the current demands and the waitlist, how many orthopaedic surgeons are needed in a given area?. A full assessment needs to be done comparing the current resources to the needs and demands, recognizing that each area will have different needs. The CBRM may have a higher demand for more oncologists, whereas New Glasgow may need more orthopaedic surgeons.

This clinical health services plan should also include some level of succession planning. It should recognize the age of some physicians and have a sense of when they may expect to retire. In a perfect world, if Amherst had a 65-year-old orthopaedic surgeon who planned on retiring at 70, succession efforts could be underway to seek out a new surgeon. This plan would drive recruiting and residency placements.

Within three months of coming into government, local leadership teams would be empowered in each region to complete their clinical health services plan. A framework would be provided to each team. These teams would be established by the chief of staff at the local regional hospitals (or another person as determined in working with the chief of staff). The chief of staff would have the best understanding of the local needs and demands of the community, as well as a sense of the players on the ground.

While the committee work would be volunteer in nature, the team lead would receive a salary top up of approximately $50,000 to lead the team and be accountable for results.

Once the clinical plans are established, it will allow those working groups and communities to create their own models of how to attract health professionals. In those models, each community will have access to a dedicated pot of funding for physician recruitment. Recognizing that all efforts and strategies will not look the same, $2 million will be divided amongst the four health regions to assist in their local recruitment efforts and strategy. This funding can be used in a variety of creative ways by each region.

On a provincial scale, when the NSHA in Halifax sends recruiters to recruitment conferences, physicians and/or other relevant health professionals who work on the ground should also attend - Individuals who could actually speak to the working conditions, the resources available and the community should be supplementing our recruitment efforts.

Relying on Halifax and the central decision-making body is simply not working for Nova Scotians. We can't fix our health professional shortage until we show we are serious about fixing the system.

Pension

It is unlikely that Nova Scotia will be able to win bidding wars for doctors. However, we do have to be competitive in salary. In addition to more fair salaries for our doctors, our PC government will provide them with a benefit offered by few other jurisdictions - a pension plan.

Three years ago, doctors were shocked when the federal government took away one of their main retirement planning tools in their small business tax regime. The changes severely harmed their ability to save and, in some cases, erased decades of retirement planning.

To address these concerns and as a show of good faith and respect to our doctors, our PC government is prepared to help invest in the retirement of clinical, practicing physicians.

A PC government will establish a retirement fund for full time physicians who practice patient-facing services and will match a portion of their retirement savings contributions. Not only will this help to retain our doctors, it will act as a tool for recruitment as well.

Contributions would be established as follows:

- For physicians practicing for 0-5 years, no contribution is necessary from the new doctor, given that it would likely be harder for them to contribute, the Province will contribute $5,000 per year.

- For physicians practicing for 5-15 years, the Province will match physician contributions up to $10,000 per year.
- For physicians practicing more than 15 years, the Province will match contributions up to $15,000 per year.

Given that this is a taxable benefit, we will negotiate with the Federal Government to allow Nova Scotia to keep the federal portion of this taxable benefit, to be reinvested in health care in our Province.

In order to qualify for this benefit:

- For physicians practicing 0-5 years, the physician would have had to practice full-time in Nova Scotia for the entire five years, plus provide an additional two years of return of service. Upon satisfying this practicing requirement, the savings contribution would be payable to the physician in year seven of their practice.
- All applicable physicians must demonstrate they are FTEs who deliver patient-centred services (i.e. this benefit is not meant for physicians in administration or teaching roles).
- Physicians must show they have invested their portion of the contribution into a retirement savings fund (RRSP, TFSA).

We would work with Doctors Nova Scotia ("DNS") to refine eligibility criteria and would work with DNS on the administration of this program. We would provide them with a stipend for administration.

Physicians would simply have to submit a one page electronic form and the assigned individual at DNS would process the form. The Department of Health would then deposit the funds to DNS for a transfer to the doctor into the savings plan of their choice. Investments would be at the physician's discretion and the physician would have to provide proof of the investment.

Logistically, a data sharing agreement would be required between DNS and the Department with reciprocity provisions allowing the two organizations to communicate with one another. Currently, DNS has a hard time accessing Department/MSI data.

Foreign-Trained Doctors

There is real recruitment potential in Nova Scotians who have studied medicine abroad and want to return home, but face barriers to entry. While some medical school graduates are able to easily transition into medical practice in Nova Scotia, the road is more challenging for others.

In bringing these graduates and practicing physicians into Nova Scotia, we absolutely have to recognize that our province has among the highest standards in the world for our physicians, and we will not sacrifice quality.

When discussing foreign-trained physicians, there are two groups to consider:

1. Students who have graduated from a foreign medical school and wish to do their residency (and ideally practice medicine) in Nova Scotia; and

2. Accredited physicians who are practicing in other countries who wish to practice medicine in Nova Scotia.

There are approximately 100 Nova Scotians annually obtaining their medical education in other countries. For recent graduates wishing to practice in Nova Scotia, there are a limited number of residency seats available, as Canadian-trained medical students have a priority on these placements.

Seats that are essentially left over after the first round of matches are then opened to Canadian graduates AND all of the internationally trained graduates.

An increase in residency seats, targeted to areas of specialty and need across the province is absolutely essential to our recruitment. It will provide additional opportunities for foreign-trained graduates.

There are also thousands of physicians across the world who were trained, accredited and practicing in foreign countries in which we may not recognize their training. When these physicians come to Nova Scotia, they have to pass the Royal College exams. While Canadian-trained physicians receive supports from Dalhousie to assist them in preparing for these exams, foreign physicians receive little to no support from either the government or Dalhousie.

These exams are extremely intense. For example, in a five-year anesthesiology residency, the fifth year of the program is largely spent in preparation for the Royal College exams.

Our PC government would ensure foreign physicians, wishing to practice medicine in Nova Scotia, are given an opportunity to do so under a clinical associate program. These foreign-trained and practicing physicians could provide service to an area and assist physicians who are currently practicing. They would receive mentorship in conjunction with improving their skills to Canadian standards. The program would facilitate training and preparation for the Royal College exams and would include a return-of-service requirement after they pass the exam.

A clinical associate program would facilitate retention in the longer term as the candidate is already familiar with and incorporated into the community. Our PC government would work with the College of Physicians and Surgeons to establish this program, as it would require a specific class of license and supporting structure.

Costs

More healthcare providers will result in more access to care, and thus better care for Nova Scotians. If we invest more in our recruitment efforts, resulting in more health providers, we will see our outcomes improve.

With respect to matching the pay of family doctors to hospitalists, the exact numbers of practitioners is not readily available. We use estimates to determine our costs.

There are approximately 500 full time family physicians practicing in Nova Scotia, earning an average daily rate of $800. There are approximately 60 hospitalists, earning an average daily rate of $1,300. There is an average difference between the two of $500. To meet the hospitalist rate for 440 family physicians, the cost would be approximately $55,000,000 [430 x $500 x an average of 250 shifts per year]. Of this amount, the province would recuperate approximately $5,853,375 in personal income tax, for a total cost of this initiative of $47,896,625.

The fee-for-service model will continue but, to determine the cost, our estimate is based on an average family physician's daily rate as compared to the average daily rate of a hospitalist. This will likely mean an increase in the rate of many billing codes to account for the increase in salary.

A pension plan for physicians who practice patient-centred care will show a much needed sign of respect to doctors that not only is their service valued, but they are wanted here.

We estimate approximately 2,000 patient-facing physicians in the province who would qualify for this program. Assuming 80% (1,600) of those physicians participated and contributed the maximum (for the purpose of costing, we will assume a $5,000 contribution by everyone), the cost would be in the range

of $8 million annually [1,600 x $5,000]. Additionally, an administrative stipend in the range of $40,000 would be provided to DNS.

Because this is a taxable benefit, the Province would receive in the range of $2 million back in personal income tax. The Federal Government would be entitled to a similar share in federal income tax. We would negotiate with the Federal Government to have this additional $2 million in tax revenue directed back to Nova Scotia for healthcare.

The total cost of the physician pension plan (without the federal share) would be approximately $6,040,000.

Increasing our recruitment efforts will ensure we not only understand the needs of our different communities, but are able to address them. In addition to a $1.5 million fund to be shared amongst the regional groups, we will also incur the cost of a top up for the team leads. The top up will cost approximately $311,111 [$50,000 per team lead x 7 team leads less payroll tax of $5,556].

Establishing a pre-residency program will draw on many of the resources we already have in place. The largest cost associated with this new program will be in insuring these medical students. The average cost of annual insurance for residency students is approximately $1,524. If 100 international students were to participate, the cost to the Province would be approximately $152,400.

The total cost estimate for recruitment under a PC government is approximately $55,900,136.

4. Expanding Telehealth/Virtual Care

The future of healthcare is obvious. Virtual care can offer a new means of seeing a doctor for many Nova Scotians. By finally fully embracing technology, we will reduce wait times.

Within weeks of COVID landing in Nova Scotia, virtual care was embraced by all, particularly patients. The lockdown demonstrated that virtual medicine is a viable means of health delivery. It limited travel and exposure to waiting rooms for both the patient and physician and just made sense.

There are still many issues requiring in-person assessments and we have skilled health providers able to make the determination as to when a patient should be seen in person. We need to permanently embrace the obvious technological advances in healthcare delivery and make necessary changes to the doctor fee codes that commit to, and expand, virtual care.

Enabling existing practicing physicians to more easily “see” patients virtually, may allow those physicians to see more patients in a day and potentially take on more patients, which would further reduce the waitlist. At present, a vast majority of these consultations are occurring over the phone. A PC government would enhance the virtual care service to include the option for video conferencing capabilities, meaning health providers could literally see their patients via phone, computer, tablet, etc., for issues that justify video conferencing consultations.

Offering the opportunity to practice medicine from home, expanded virtual care will be attractive to retired physicians and some physicians on maternity/paternity leave who may want to practice with a more flexible schedule.

For the past few months, many doctors and patients were part of our Province’s pilot run of virtual care. COVID-19 forced the government to begrudgingly embrace virtual care advances that the rest of the world has enjoyed for years. Now it has been proven once and for all that the status quo is no longer acceptable or necessary in Nova Scotia.

Nova Scotia offers health advice from a Registered Nurse through the 8-1-1 phone system in addition to virtual care, which connects patients with health providers from the NSHA and IWK Health Centre. There is a reduction in services when compared to other provinces. For example, virtual care in Nova Scotia is only available to those with existing health providers, whereas British Columbia has "Virtual Doctor of the Day" to assist those who may not otherwise be able to access care.

As previously discussed, our plan would see virtual care options expanded to those individuals without a primary care practitioner. Similarly, we have previously laid out a plan for the delivery of mental health services virtually.

Looking at other jurisdictions, Manitoba has had success with virtual programs such as Dial-a-Dietician and smoking/vaping cessation programs. With an aging population, having a focus on dementia advice, as is available in Alberta, should also be considered as a priority expansion of service.

Nova Scotia has only scratched the surface on what is possible. A PC government would further increase virtual care to include some primary consultations with specialists, which could increase the efficiency of the system and would reduce wait times. For example, in a system in which virtual care was properly organized and supported, a significant amount of orthopaedic triage could be done virtually with a physiotherapist and occupational therapist. Some patients have limitations on their number of steps, meaning going to assessment clinics can be challenging. Virtual care is one way of assessing those patients in a manner that can potentially reduce further strain.

A full consultation will be completed within our first three months in government, in conjunction with Doctors Nova Scotia, to determine what specialties and health providers can expand the scope of their practice to telemedicine. Proper billing codes will be established to support those services.

Certainly, paramedics, physiotherapists and occupational therapists, along with nurse practitioners, would be included in the plan for expanded services. Primary care will need to leverage their skills in a new model of care delivery, where collaboration with virtual care will assure that any Nova Scotian needing medical attention gets it.

We can't talk about modernizing our system without referencing One Patient One Record ("OPOR"). The current seven-year timeline for OPOR is too long. This is not demonstrative of an innovative environment. Physicians need to be given the choice of the best option for them in order to truly provide patient-centric care. We need to adjust the scope and delivery time and change the steering committee for the current process to increase the speed of innovation and deliver the best possible service for patient care.

Costs

We must invest in technology now to make sure our health system is ready for the future. Other jurisdictions are starting to take incremental approaches to virtual care. There is no reason why we can't learn from their successes and surpass them to have the most advanced and progressive virtual care model in the country.

Many of these personnel costs would be included in current salaries (for example, dieticians, physiotherapists and occupational therapists). For others, billing codes must be updated.

For retired physicians and physicians on leave, we estimate to have in the range of 150 participants in this program. Their payments would depend on their time spent. Assuming an average of four shifts per month, for a total of 48 shifts per year at an approximate rate of $1,000 per shift ($48,000), the annual

cost for personnel for this expanded service would be approximately $6,415,920 [$48,000 x 150 less payroll taxes of $784,080].

The cost of the technology is more challenging to assess as we do not have all of the relevant information from the current provincial government. However, we are estimating start up and operating costs of the program to be in the range of $10,000,000.

Our total estimate for expanding virtual care (excluding offering telehealth to everyone who is on the waitlist for a primary health provider), is approximately $16,415,920.

5. Chronic Illness

Approximately 5% of Nova Scotians consume 70% of the health dollars. Most are dealing with chronic conditions. Nova Scotians have among the highest rates of chronic disease and disability in the country. Every year, over 5,000 Nova Scotians die of four types of chronic diseases: cancer, cardiovascular diseases, chronic respiratory diseases and diabetes.

Two-thirds of deaths in Nova Scotia are attributable to these diseases.

While there are many health concerns related to chronic diseases, instead of simply treating the illnesses as we have been, we need to determine why our chronic illnesses are so pronounced, address the root cause and talk about a redistribution of the workload. We have to ask why we've been treating chronic conditions with acute strategies when it's not working. Our system should place more of an emphasis on providing *health* care so as to lessen the need for *sick* care.

Although chronic diseases are among the most common and costly health problems, they are often also among the most preventable, making a focus on preventive care crucial in addressing the challenges of our health system.

Some of the plans we have established for the expansion of virtual care services would work by encouraging the adoption of healthy behaviours, such as more accessible contact with health providers; access to dieticians to provide guidance on eating nutritious foods; and smoking and tobacco cessation programs, can prevent or control the effects of these diseases.

Treatment and Prevention Program

In addition to our focus on the expansion of telemedicine, a PC government will establish a new Chronic Illness Treatment and Prevention Program that focuses funding on an in-home treatment model for patients with chronic illnesses, based on the INSPIRED model for COPD patients.

Our plan means experts coming to the patient - into their homes to monitor and enhance their care so they can prevent their COPD or chronic illness from getting bad enough that they would need to sit in an ER for hours or even be hospitalized. If you are not affected by chronic illness, this program will still help free up capacity for family doctors. Fewer individuals needing our ERs will make access to healthcare easier for everyone.

The INSPIRED program means more self-management of chronic illnesses. It is a proven model that saves $21 for every $1 invested.

Frequently, it is patients with chronic illnesses who are making repeated doctors' visits to monitor their conditions. They are also regularly making trips to the ER.

Chronic illness patients will determine, in conjunction with their primary care provider, if a program like this makes sense for them. Largely, the program will be virtual, with healthcare providers checking in via digital devices. When necessary, house calls will be made.

To staff this program, all resources will come from the NSHA in Halifax. Once the number of patients for the program is established and their needs determined, pursuant to the clinical health plans for each region, staffing adjustments will be made based on that need. However, a respiratory therapist treating a COPD patient does not necessarily need to live in the same community if the treatment is coming via telehealth.

It is likely additional hires will be needed to satisfy the demand of the program and an initial investment will be required in staffing.

Costs

We are currently spending as much as a billion dollars of our $4.6 billion health budget on chronic conditions. We need to ensure these dollars are being spent for maximum efficiency and best possible outcomes.

Looking at the results of the INSPIRED program, we can see there is a model that already exists and is excelling at improving health outcomes. The program came about as a response to huge gaps in care identified via an earlier research program involving patients and families with COPD. It has been incredibly successful. With every $1 invested, $21 has been saved in emergency room visits, hospital stays, and more. Patients who participate have demonstrated a:

- 58% reduction in ED visits (resulting in savings of approximately $2.3 million in ER costs);
- 62% reduction in hospital visits (resulted in savings of approximately $19 million in hospital costs);
- 60% reduction in hospital bed days; and
- The average number of hospital bed days for participating INSPIRED patients decreased from 10.6 to 7.3.

There is significant benefit in expanding upon the success of this program to support Nova Scotians with other chronic conditions. This program shows we need a focused spending plan.

The cost to run the INSPIRED program is about $1,000/year per COPD patient, with projected net savings in health spending of $20 million.

The Department of Health has estimated that two-thirds of Nova Scotian adults live with some form of chronic illness. Assuming there are approximately 600,000 adults in Nova Scotia, there are as many as 400,000 Nova Scotians who experience chronic illness.

With respect to COPD, Nova Scotia has the highest rate in the country for this disease, with it impacting 5.9% of the population or approximately 53,000 individuals. Fifteen hundred patients have been enrolled in and benefited from the INSPIRED program, meaning there is uptake of about 3% of patients.

For the purposes of our costing, we will assume uptake of 3% of those 400,000 living with chronic illness, totalling 12,000 individuals. With an annual cost of $1,000 per patient, the approximate cost of the program per year would be $12,000,000 [12,000 individuals x $1,000]. This does not begin to take into account the savings spread across the healthcare system.

Our total estimated spend on chronic illness treatment and prevention is approximately $12,000,000.

6. Prevention

In-School Programming

At present, grades 7-9 students participate in a physical education program at least three days per week for a total of 150 minutes. High schools have one compulsory credit (between grades 10-12) for a physical education class.

High quality physical activity among youth has shown that those students demonstrate better attention in class, achieve better grades, better physical and mental health and better health outcomes across their lifespans.

“Quality Daily Physical Education” is a standard through Physical and Health Education Canada of a planned school program of compulsory physical education that provides for a minimum of 30 minutes of activity each day to all students from grades Primary to 12 throughout the school year. This programming places an emphasis on fun, enjoyment, success, fair play, self-fulfillment and personal health and includes activities that enhance cardiovascular systems, muscular strength, endurance and flexibility. While this would ideally run as an intramural program encouraging high levels of participation, uptake for supervisors would depend on each school and each centre for education.

A PC government will work with the regional centres for education in conjunction with the Teachers’ Union to determine what is possible to expand personal fitness opportunities for all students. However, in an effort to encourage physical education and make it a mainstay for students and instill active living choices at a young age, students will be afforded the opportunity to earn school credits for physical activity outside the classroom.

Another component of healthy living is healthy eating. While the Canada Food Guide is taught in schools, many students graduate without seeing the Food Guide’s recommendations being put to use. Many move on from school without knowing the basics of nutrition and healthy meal preparation. These are skills, if taught at a young age, will guide them throughout their lives.

Studies have demonstrated that hands-on cooking education has a very positive impact on behaviours and attitudes toward healthy eating, such as increased consumption of fruits and vegetables, improved food safety behaviours, higher frequency of cooking, increased nutrition knowledge, higher self-efficacy and less money spent on food. Findings suggest cooking programs positively influence children’s food-related preferences, attitudes, self-efficacy, dietary intakes and behaviors.

A PC government will make it a priority to educate high school students about healthy eating and cooking. We will be guided by programs like the one being offered by the YMCA of Southwest Nova Scotia and SchoolsPlus. It offers to assist youth entering grades 9-12 and youth preparing for college, university or independent living.

It is a two-day program covering topics that include basic food safety; budgeting tips; how to use leftovers and stretch meals; cooking shortcuts and simple meals on a budget; nutrition; healthier cooking; what you need in your pantry; and organic versus conventional foods.

All groceries, program materials and a pantry supply kit were provided. Each participant received a complimentary cookbook and two meal cooking packages to try at home. SchoolsPlus is in almost every

school in HRCE and is all across Nova Scotia. They act as a service provider and liaison for programs and services.

Similarly, the New Glasgow-based organization Pictou County Roots for Youth Society offers programs to support rural youth homelessness in Nova Scotia. For the past two years, they have had a chef volunteer to teach youth how to prepare accessible meals. In 2019, this program received full funding through the Pictou West and Central and East Pictou Community Health Board (CHB) Wellness Fund.

Our government would work with SchoolsPlus to find local partners within the community and would provide financial support to each regional centre to be allocated specifically for healthy eating programming.

This education could come in the form of a “PD Day” for grade 12 students prior to graduating.

No legislative changes would be necessary for either the increase of the physical education component of the curriculum or the healthy eating programming. Amendments to the Ministerial Regulations under the *Education Act* would enact these changes.

We also acknowledge the barriers in cost to eating healthy and will examine policies and programs to reduce costs of healthy foods for consumers.

Smoking Cessation Program

As of 2017, 17.8% of Nova Scotians smoked tobacco. Nova Scotia has the highest rate of smoking in the country. The health risks of smoking are well-known. There are more than 20 diseases and conditions associated with smoking (including cancers, respiratory diseases and cardiovascular illnesses). Second-hand smoke can also be fatal, as more than 200 Nova Scotians die annually from exposure to second-hand smoke.

Smoking cessation programs improve health outcomes and can impact individuals more likely to experience disparities.

Previous PC governments have demonstrated a commitment to smoking cessation. In 2004, the Office of Health Promotion launched the “Sick of Smoke” workplace program. In 2005, the PC government of the day introduced amendments to the *Smoke-Free Places Act that* banned smoking in all indoor public areas, workplaces and eating and drinking establishments in Nova Scotia.

It is our goal to expand upon our Party’s previous commitments to battling tobacco use.

Programs like our Chronic Illness Treatment and Prevention Plan will help address some of the side effects and impacts of smoking. However, given the high percentage of Nova Scotians who smoke, more must be done to encourage those individuals to stop smoking.

Our PC government will offer a virtual care program to anyone wishing to stop or cut back on their tobacco use (including the use of e-cigarettes). Similar to the programming we will offer to anyone without a family physician, we will establish an anti-tobacco virtual care service whereby anyone seeking guidance on how to quit, supports throughout the process or general information, can login at any time to receive the support they need.

This program will be heavily advertised in schools to target youth and provide additional support to help students stop smoking at a younger age. Information about this program will be provided in health classes across all schools in Nova Scotia.

Costs

It is challenging to quantify the savings of teaching healthy living and instilling active values at a young age. However, the research is clear that learning a healthy lifestyle at a young age will have health benefits (and minimize health concerns) over a lifetime. It may take decades to truly see the benefit, but, in time, we will see statistics, like the number of Nova Scotians living with chronic conditions, decrease significantly.

We also know that healthier people are often more productive at work and in society. So not only will this investment result in reduced costs, but it will also very likely improve our economy.

Additional physical education teachers may be needed to meet the demands of the expanded physical education curriculum. A true accounting of the needs must be done with the centres of education.

For the purpose of estimating the cost of this initiative, we assume that of the approximately 53 high schools across the province, at least two thirds would require an additional physical education teacher. Assuming that 35 new teachers would be hired at an average salary of $56,782 (less payroll taxes of $216,425), the cost of this initiative would be approximately $1,770,945.

With respect to funding for the healthy eating initiative, there are approximately 7,263 grade 12 students across the province. We estimate the cost of this program, per student, to be approximately $50. The total cost would be in the range of $363,150 [7,263 students x $50]. These funds would be allocated to each of the seven regional centres for education to be used in conjunction with community organizations to provide this program.

In an effort to promote more activities that benefit the physical and mental health of our youth, we are offering a $500 tax credit per child. For costing purposes, there are approximately 238,900 children 18 and under in Nova Scotia. Research suggests that there would be uptake in this type of programming of about 45%, meaning of the 238,900 children, there would be approximately 107,505 claimants [238,900 x 45%].

At a cost of $500 per child, this tax credit would save Nova Scotians approximately $4,730,220 [107,505 x $500 x 8.8%].

There are currently several resources available that work to address smoking cessation. However, we feel it would be most efficient to consolidate our resources in a one-stop shop. There is a Secure Chat with a Counselor program available through the Tobacco Free Nova Scotia website that allows for online chats with counsellors. Similarly, Tobacco Free will send out information packages on smoking to those who request them.

As opposed to counsellors operating solely on an online chat function, these counsellors would be moved to the other end of the virtual care program so that they can be called or available for video chat, etc. This represents a more personalized approach to coaching and counselling those individuals trying to quit.

While the cost of the counsellors on the Tobacco Free website is not information that is readily available, we estimate start-up costs of this program to be in the range of $2 million. This virtual care program would initially be staffed with five counsellors. Our estimate on these salaries with operational costs would be approximately $350,000 annually.

Our estimated total spending on prevention, enhanced education and smoking cessation supports is approximately: $9,214,315.

7. Fertility

One in six Canadian couples face infertility. There is no comprehensive, national coverage for assisted fertility treatments. Treatments can cost between $10,000 and $20,000 per cycle, making it inaccessible to most individuals.

A PC government will recognize the struggle that hopeful parents face in becoming parents. Not only are infertility challenges extraordinarily stressful, but the cost of attempting to address those challenges is prohibitive. As such, our government will offer a tax credit equal to 40% of the cost of fertility treatments provided by a Nova Scotian licensed medical practitioner or infertility treatment clinic.

There is no limit on the number of treatments an individual can claim, but the maximum they are eligible to claim in total is $20,000 in eligible costs, up to a maximum yearly fertility treatment tax credit of $8,000.

Costs

According to Statistics Canada, there are approximately 161,464 female Nova Scotians between the ages of 18 and 44.

Statistics on the number of women who experience infertility and wish to seek fertility treatments are difficult to find. For the purposes of costing this initiative, we have extrapolated data from the Ontario program.

Ontario funds about 5,000 IVF cycles per year. One specialist pegged the anticipated need of the program at about 16,500 cycles per year for a population of 13.6 million. If we derive those numbers based on a population of one million, the need would be about 1,200 per year for Nova Scotia.

At a cost of approximately $8,000 annually for approximately 1,200 parents, this program would have an annual cost of $9,600,000.

8. Presumptive Coverage for Firefighters

We hear daily from Nova Scotians expressing concerns over the cost of some life saving and life sustaining medications. Our commitment to Nova Scotians when we form government, is that we will conduct a full review of the formulary that decides what drugs are covered and which are not. We need to make sure that the formulary meets the needs of Nova Scotians.

One change that is needed immediately however, pertains to firefighters, who put their lives on the line every day for our safety. Firefighters perform a valuable service to their communities that unfortunately puts their health at risk. We want to ensure they have the best possible insurance and health coverage available.

Studies show that firefighters are more likely to develop cancer from exposure to certain chemicals in fires. In 2019, the average Canadian has a 44% lifetime risk of developing cancer. That number jumps to 53% if that Canadian happens to be, or has been, a firefighter.

The PC Party has a strong history of recognizing the potential health consequences of being a firefighter. In 2003, the PC government introduced and passed the *Firefighters Compensation Act*, which provided Workers Compensation benefits to firefighters who contract certain types of cancers, making Nova Scotia the first province to include volunteer firefighters in this kind of coverage.

The PC Party wants to expand on this initiative and ensure our volunteer firefighters receive the coverage they need to cover treatment of diseases linked to their work. Currently, only six forms of cancer are covered (brain, bladder, kidney, non-Hodgkin's lymphoma, leukemia and colorectal cancer). There is data that supports the connection between many more types of cancer and firefighters. For example, female firefighters have higher rates of reproductive cancers as compared to non-firefighters.

In government, we will extend prescription benefit coverage for volunteer firefighters to cover the following additional forms of cancer linked to firefighting: ureter, penile, testicular, breast, esophageal, prostate, skin, digestive tract, multiple myeloma, pancreatic, ovarian and cervical cancers.

Costs

The costs associated with updating the formulary are to be determined based on our consultations in government.

With respect to the extended coverage for volunteer firefighters, we have approximately 6,000 volunteer firefighters in Nova Scotia (paid firefighters would already have benefits that cover the requested prescriptions).

Assuming, 53% of volunteer firefighters (6,000) are diagnosed with one of the listed categories of cancer, approximately 3,180 firefighters would be impacted ([6,000 x 53%]. Many would already have private health insurance coverage that would cover these medications. Approximately 61% of our population in Nova Scotia has private coverage. Extrapolating this percentage onto the projected number of firefighters to be diagnosed with cancer would mean that approximately 1,240 would require coverage [3,180 x 39%].

The annual average cost of many cancer drugs is in the range of $60,000. As such, the cost of this program would be approximately $74,400,000.

9. Administration

We know that healthcare deteriorated when the government removed local decision-making from local communities. Government must listen to the people they represent. Local doctors and other health professionals understand local challenges and potential solutions much better than someone sitting in an office tower in Halifax. Even moreso, our patients understand their needs and wants better than anyone.

Our health professionals are doing an incredible job, but they need more authority to address concerns and find solutions on a local level, which is why we need a focus in Nova Scotia on patient-driven decision-making.

Our doctors and other health professionals are holding our broken system together, but they are maxed out. Providing more autonomy on a local level, based on the needs of the patients within each community, is a strong signal that we respect their expertise and contributions.

Despite the inspiring efforts of our health professionals, the health system is in chaos and has been since the formation of this new health authority. There is a real opportunity here for a reoptimization that

would give more power back to our communities and potentially improve access to care for Nova Scotians.

Health professionals across the province are our greatest asset to combat the growing crisis in healthcare. Health professionals are reaching out with ideas based on the needs of their patients. We need to harness those good ideas and give them a real voice at the table.

Patient-Driven Decision Making

Function follows structure.

Governments continually focus too much on structure and organize health operations from the top down. This has not served patients. We need to start with the individual, allow them to choose the care they want and from there, build up the organization in a way that makes sense, based on patient and community needs.

A PC government will start with the individual and allow them to choose the care they want. Part of returning local decision-making, is personal decision-making. We need to let patients and communities make decisions for themselves about what works.

As a starting point to get a sense of the needs of the patients in each region, we will convert the current waitlist to allow patients to choose from one of three options to best suit their needs:

1. A family doctor for in-person care only;
2. A family doctor who provides both in-person and virtual care; or
3. A nurse practitioner.

By identifying the options on this list, we recognize that different patients have different preferences. Some want a more traditional approach to medicine whereby they attend in person at their physician's office. Some will want a more modern approach by accessing their care provider virtually, while others may prefer the model of having a nurse practitioner who is able to spend more time with the patient per visit.

Our PC government will also establish a website for anyone who currently has a primary care practitioner with the same options noted above. The purpose of this website will be to gather regional data in an effort to give us a greater understanding of the needs of as many Nova Scotians as possible. More information will lead to better care.

By starting with the individual and allowing them to choose the care they want, this change to the waitlist model will help to give us a better understanding of what each community needs based on the individual. Although we have a demographic profile as a province, the needs of each region and each community within are very different. We will also see that these consistent personal decisions in geographical areas will align with what we need for long-term community health.

The demands of each region will likely be consistent to the point that 60% of a community will want the same thing. It is a recognition that part of local decision-making is personal decision-making.

Structural Reoptimization

Recognizing the preferences and different needs of individuals will start to demonstrate trends in communities. These trends and preferences will drive demand and will begin to build the new structure of organization.

At present, the health zones have very little autonomy. They are limited in their ability to make decisions impacting their regions. Many of the problems within the system will be addressed with a reoptimization of the administration and allowing for more local decision-making.

Our PC government will take the trends identified by individuals and their communities. Within 12 to 18 months, a new organizational structure will be established for healthcare in Nova Scotia. This new structure will be driven by patient decisions and behaviour. It starts with the individual picking the care they want and from there, building the structure in a way that makes sense.

Before we can establish a new structure, we recognize that there is too much administration in the system. There are too many managers using stale management tactics. There are few accountability measures in place, including the lack of measuring outputs and a requirement for reporting regular finance and human resources metrics. For example, there are no limits on the duration of time between position vacancy and hiring.

Nova Scotia has approximately 35% more administration in its health system per capita, as compared to the rest of Canada. Our health outcomes are certainly not reflective of this being a beneficial use of our health dollars. We will reduce the duplication within the system and consolidate the Department of Health and Wellness and the Nova Scotia Health Authority to save the administrative burden that is pulling resources away from patient care. Extra administration is taking away from patient service providers.

Unfortunately, the NSHA appears to view governance only from a structural or organizational perspective. There does not appear to be any continuous improvement built into the current model. There are no natural constraints in place. We need to establish and share what the benchmarks of a healthy system are and encourage our own system to aspire to meet them. This includes reducing duplication and redundancy in administration and management.

Many of our health workers go to work every day in a toxic environment. Most have no conflict resolution process available to them. Our PC government will change this and establish conflict resolution policies.

We accept that change is necessary. We want to ensure that changes are implemented with reasonable, evidence-based and fully costed decision criteria. For example, the collaborative care model is being implemented without a clear understanding of the total cost per patient visit or the long-term benefits to the patient.

We will optimize the structure of our health organization and administration by putting the patient first and being guided by the patient's needs. We will stop the government interference in the process that is getting between Nova Scotians and the health system. We recognize that one size does not fit all patients or health providers. Patients and communities need to be involved and make choices, within an approved budget, about their own health investments.

Decisions should be made as close as possible to the patient.

Healthcare Auditor

A PC government would establish a culture of continuous improvement by implementing a Healthcare Auditor. This individual would be a new Officer of the Legislature, whose purpose would be to collect feedback from public use of the system, conduct performance audits and risk analysis of any new innovation or change planned for the health system. They would measure, monitor and adjust the model regularly based on both inputs (costs) and outputs (results).

We need to develop this robust tool for patients and families to offer feedback on health system performance.

The role would be an arm's length mechanism to collect both patient and provider feedback for oversight of health system performance.

The Office of the Healthcare Auditor would have access to all data measurements and patient/family/provider feedback to oversee performance and financial accountability of the health system.

Costs

The current total cost of the administration of healthcare in Nova Scotia is approximately $171,046,000. That makes nearly 4% of our $4.6 billion health budget.

These administrative costs are driven primarily by:

- Duplication between the NSHA in Halifax and DHW.
- Poor governance. The NSHA board needs to be made up of at least 30% physicians. The model, as established, has proven to be ineffective and not aligned with best practices in medical governance.
- Poor benchmarks and standards.

With respect to the establishment of the Office of the Healthcare Auditor, we anticipate the costs to be in the range of $1.2 million. This costing is based on one quarter of the cost of the Office of the Auditor General of Nova Scotia, whose mandate is to oversee the finances of all departments.

CONCLUSION

Our health system is paramount to the functioning of all aspects of society: from our economy to our education system. Without a strong, well-oiled health system, we are constantly putting the rest of our society at risk.

We can no longer settle for the status quo - which has proven to be far from adequate.

We need to strive for excellence. We have the talent in our system. We just need to give it the tools and support and remove the politics for true patient-centred healthcare.

The commitments outlined in this plan will benefit everyone from those without a primary healthcare provider to those waiting over 1,000 days for a knee replacement to individuals waiting hours at the ER. Our plan will:

1. Ensure that everyone on the waitlist has ready access to a primary care provider.
2. Decrease wait times for surgeries.
3. Modernize the delivery of our health services.
4. Demonstrate respect and show value for our healthcare providers.

5. Attract new healthcare providers to Nova Scotia.
6. Focus on preventative care, beginning with early education and extending to patients suffering with chronic illnesses.
7. Restore local decision-making.

Proposed investments:

Telehealth for everyone on waitlist:	$ 2,500,000
Opening ORs:	$25,730,513
Recruitment:	$55,900,136
Expanding Virtual Care Service:	$16,415,920
Chronic Illness Treatment and Prevention:	$12,000,000
Health Prevention Programming:	$ 9,214,315
Fertility	$ 9,600,000
Pharmaceuticals	$74,400,000
Local Decision-Making:	$ 1,200,000

Total Costs: **$206,960,884**

For our system to excel, we need to share a common vision for healthcare, a common destination, philosophy and desired end state.

This requires the leadership and vision of the PC Party.