PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

First Session
Fiftieth General Assembly

Proceedings of the Standing Committee on Social Services

June 8, 2021 - Issue 5

Department of Health and Community Services

Published under the authority of the Speaker of the House of Assembly
Honourable Derek Bennett, MHA

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Sherry Gambin-Walsh, MHA

Vice-Chair: Joedy Wall, MHA

Members: James Dinn, MHA
Jeff Dwyer, MHA
Paul Pike, MHA
Scott Reid, MHA
Lucy Stoyles, MHA

Clerk of the Committee: Kim Hawley George

Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
Chad Antle, Departmental Controller (A)
Alan Doody, Assistant Deputy Minister, Regional Services (A)
Tina Follett, Assistant Deputy Minister, Policy, Planning and Performance Monitoring
John McGrath, Assistant Deputy Minister, Corporate Services (A)
Andrea McKenna, Associate Deputy Minister
Tina Newhook, Director of Communications
Karen Stone, Deputy Minister

Also Present
Hon. Lisa Dempster, MHA, Minister Responsible for Indigenous Affairs and Reconciliation
Hon. Elvis Loveless, MHA, Minister of Transportation and Infrastructure
Paul Dinn, MHA
Perry Trimper, MHA
Steven Kent, Researcher, Third Party
Denise Tubrett, Deputy Chief of Staff, Official Opposition Office

Pursuant to Standing Order 68, Lisa Dempster, MHA for Cartwright - L'Anse au Clair, substitutes for Scott Reid, MHA for St. George's - Humber.

Pursuant to Standing Order 68, Elvis Loveless, MHA for Fortune Bay - Cape La Hune, substitutes for Paul Pike, MHA for Burin - Grand Bank.

Pursuant to Standing Order 68, Paul Dinn, MHA for Topsail - Paradise, substitutes for Jeff Dwyer, MHA for Placentia West - Bellevue.

The Committee met at 6:04 p.m. in the Assembly Chamber.

CHAIR (Gambin-Walsh): Order, please!

We'll call the meeting to order.

I just wanted to present the minutes from previous meeting on June 7, and ask if there aren't any revisions or amendments and ask for a mover of those minutes.

E. LOVELESS: So moved.

CHAIR: Okay, Minister Loveless has moved that they be accepted.

On motion, minutes adopted as circulated.

CHAIR: What we'll do is if it goes on really long, we'll take a break – actually, I think we need to take a break because the broadcaster is back there by himself. In about 90 minutes, we'll need to take a break if we're still going.

What we'll do is the same as we've done the previous: We'll go 10, 10, 10 and 10 and the independent have a total of 20 for the evening.

The substitutes for tonight: For Burin - Grand Bank we have Minister Loveless – okay, Minister Loveless is a substitute so he couldn't move the minutes, could he?

CLERK (Hawley George): He's an official substitute.

CHAIR: So he can move the minutes, okay.

He's substituting for Burin - Grand Bank; substituting for St. George's - Humber we have Cartwright - L'Anse au Clair, Minister Dempster; and Placentia West - Bellevue substituting is Topsail - Paradise, MHA Dinn.

I'll just remind everyone to wait until your tally light comes on to speak.

We'll start with introductions and then we'll give the minister a few minutes before we go into questions. We'll start here on my left with Health and Community Services.

J. MCGRATH: Hi, John McGrath, Acting Assistant Deputy Minister of Corporate Services.

J. HAGGIE: John Haggie, MHA, Gander and Minister of Health and Community Services.

K. STONE: Karen Stone, Deputy Minister of Health and Community Services.

A. MCKENNA: Andrea McKenna, Associate Deputy Minister of Health and Community Services.

T. FOLLETT: Tina Follett, Acting Assistant Deputy Minister of Policy, Planning and Performance Monitoring.

A. DOODY: Alan Doody, Assistant Deputy Minister of Regional Services, Health and Community Services.

C. ANTLE: Chad Antle, Departmental Controller.

CHAIR: MHA Wakeham.

T. WAKEHAM: Tony Wakeham, MHA, Stephenville - Port au Port.

P. DINN: Paul Dinn, MHA for Topsail - Paradise.

J. DINN: Jim Dinn, St. John's Centre, MHA.

S. KENT: Steven Kent, Researcher for the Third Party caucus.

P. TRIMPER: Perry Trimper, MHA for Lake Melville.

L. DEMPSTER: Lisa Dempster, MHA for Cartwright - L'Anse au Clair.

L. STOYLES: Lucy Stoyles, MHA, Mount Pearl North.

E. LOVELESS: Elvis Loveless, MHA, Fortune Bay - Cape La Hune.

J. WALL: Joedy Wall, MHA, Cape St. Francis.

D. TUBRETT: Denise Tubrett, Chief of Staff for the Official Opposition.

CHAIR: Just, again, I remind you to wait for your lights and you're probably going to have to wave. I don't have a list of everyone's name here in front of me. Usually when your light doesn't come on, I say the names, so I'm going to ask you to make sure you wave.

I'm going to ask the Clerk to call the first subgroup.

CLERK (Hawley George): For the Estimates of the Department of Health and Community Services, Executive and Support Services, 1.1.01 to 1.2.02 inclusive.

CHAIR: Shall 1.1.01 to 1.2.02 inclusive carry?

Just another note, you can remove your mask when you're talking also.

We're going to start with MHA Dinn – MHA Paul Dinn. See, now here I'm stuck with a double whammy.

J. DINN: (Inaudible.)

P. DINN: I have absolutely no problem with that.

I'm looking at this here now. I'm looking at Salaries in 1.1.01 and we see a change there. There's a small change in Salaries of $2,500; however, there's an increase in a position in the Minister's Office. I'm just curious of what's happening there?

J. HAGGIE: The Salaries fluctuations under 1.1.01 are down to salary increases, step-wise increases. What you will see in all of the Salaries is first reflected here. There's also a drop because last year there were 27 pay periods. For every salary comment that you see going forward, you will see a change. Some of that will net positive and we can talk about that; otherwise, some of the negative will be accounted for by a dropped pay period between last year and this year.

P. DINN: Just to confirm, there was an increase in a position there as well. The increase in salary doesn't seem like it's sufficient enough to accommodate a new position.

J. HAGGIE: Well, are you looking under 1.1.01 or are you looking under the next head?

P. DINN: The Minister's Office, 1.1.01.

J. HAGGIE: Yes. The net change dollar value is a drop of $2,500. You will see $6,800 was allocated for salary increases, and $9,300 came out for the pay period. And that's the adjustment there. Or is there a bit I'm missing? That's what I'm seeing under 1.1.01 in Salaries.

P. DINN: No, because if I'm looking at salary positions in the minister's office –

J. HAGGIE: Oh, well, that might not be in there. The salary change there from 2020, the budget was $252,400, and this year it is $249,900. That's a drop.

P. DINN: Okay. Thank you.

I'm looking at Transportation and Communications. Of course, we see it was budgeted for $40,000, dropped to $10,000 and back up to $40,000. I can make an assumption there on that, but can I get an explanation there for the drop?

J. HAGGIE: COVID-19. Nobody went anywhere.

P. DINN: Yes.

J. HAGGIE: It's as simple as that. We put it back in for next year in the hope that COVID-19 won't stop us going anywhere.

P. DINN: Right, right.

J. HAGGIE: Rationally or otherwise.

P. DINN: And I assumed that, but I have to hear it from you.

J. HAGGIE: Yes, fair enough. Not a problem, Sir.

P. DINN: Thank you.

Moving on to Executive Support, Salaries. Let me see what we have there.

In '20-'21, you went over budget by a little over $350,000, or 26 per cent. Why the increase?

J. HAGGIE: We had an extra ADM created for the department. We had the addition of a senior advisor and an additional director of communications. We actually increased our comms staff from two to three. That's the netting out of those positions: a COVID response coordinator, an ADM position, a senior advisor position and the director of communication for pandemics.

P. DINN: We see a decrease, then, from the revised to the current estimates. What's the reason for the decrease?

J. HAGGIE: Under Salaries, we have a netting out change – the dollar change is $110,000 between the budget for last year and this year. We've seconded a member of staff to the Health Accord NL secretariat. We have $36,800 for salary increases, $11,600 for step increases. Set against that we have the 27th pay period, which takes out $48,000, and we have $40,000 out because we didn't pay allocated money for overtime for communication staff.

P. DINN: Okay, thank you.

Moving along – are we going to 1.2.02?

CHAIR: 1.1.01 to 1.2.02 is called, so anything in those two.

P. DINN: Okay, perfect. Thank you.

Moving along to 1.2.02, again, I'm looking at Salaries there as well. You budgeted for just over $16 million. You spent $15,800,000, a decrease of $320,000. Explanation for that, please.

J. HAGGIE: The differences over the course of the budget versus the actuals, we had – this covers the departmental controller, director of Audit Claims and Integrity, director of Information Management, Pharmaceutical Services, and Physician Services and so on and so forth.

We had some netting in and out over the course of the year, some of which were due to vacant positions and some of which were due to less work requirements as a result of COVID. The difference between budget '20 and budget '21 is a netting effect, which I can list if you want, because we've had some new bodies come into the department.

P. DINN: That may be useful because I'm looking at the plan for this coming year and seeing an increase of just under $900,000.

J. HAGGIE: What we have is we brought in PMO, which is Provincial Medical Oversight, from Eastern Health. That was as a consequence of the emergency medical services and paramedicine act.

We separated licensing from operations. They came in and they are part of the department, and that brought with it a bill of $622,600, which came out of Eastern Health. There's $90,000 for incremental overtime. There is $470,900 for allocated salary increases.

We lose $578,600 because of the dreaded 27th pay period; $4,400 goes out for an executive director's adjustment for the 27th pay period; $17,600 for the 27th pay period for reorganization, because we got wellness come in as well, which we haven't got to yet; and $50,100 out for incremental changes to step allocations as a result of all those ins and outs.

P. DINN: Can we get a list of the positions in and out?

J. HAGGIE: I didn't get the preamble, but we usually supply our binder electronically on a password-protected (inaudible) so you can have that.

P. DINN: Perfect.

J. HAGGIE: So that's all in (inaudible).

P. DINN: So you have answered one of my questions. We're getting a copy of the binder, correct?

J. HAGGIE: Yes.

P. DINN: Okay, perfect.

Just moving on to Professional Services. We see that you are planning to spend almost $400,000 more. Why the increase there?

J. HAGGIE: So the increase again is down to PMO. There's a netting out of a ZBB exercise. But the savings this year against budgeted were down to the fact that we didn't utilize the consultant that we had planned for negotiations with the NLMA. So that money was simply not spent in the last fiscal year.

P. DINN: Okay, thank you.

I'm just looking at the issue there. I'm just looking at Operating Accounts, Purchased Services.

J. HAGGIE: Sorry, say again? Operating Accounts?

P. DINN: Operating Accounts, Purchased Services.

J. HAGGIE: Yeah.

P. DINN: So you budgeted $579,000, you spent $483,000 and a decrease of $95,000. Explanation on that, please?

J. HAGGIE: I'm sorry. I was looking at the wrong line of Operating Accounts.

P. DINN: Yeah, so it's the 1.2.02.

J. HAGGIE: Yeah.

P. DINN: And it's 02 just under the salary part, Operating Accounts.

J. HAGGIE: Yeah, where it says $3,554,000.

P. DINN: That's correct, yes.

J. HAGGIE: Yes, okay.

Sorry, and the question was?

P. DINN: Just a decrease in the budget, I'm just wondering why.

J. HAGGIE: That's the netting effect of some of the lines above it, which I went through. The cumulative effect of adding up columns under 01 gives you – oh, sorry, yes, I'm with you. It's a summation of the columns above. That $3,554,000 is a sum of $252,000, $753,000, $123,000, so on and so forth. So the difference there on that line is made up of differences in the lines we've just gone through.

P. DINN: So if I jump up a little bit there and go to Purchased Services as an example, you see a decrease there.

J. HAGGIE: Yeah, and I was just explaining we didn't spend the money on the NLMA negotiation's consultant. If you'd give me a second, I can give you the net there. We didn't spend $138,300, specifically on that.

P. DINN: And, of course, that figures goes up again. So I assume there's money being (inaudible).

J. HAGGIE: Yeah, I mean this was simply money not spent. We'll need to spend it to get the services we need, and we'll be getting them this year, fiscally, instead of last year.

P. DINN: Okay.

The Grants and Subsidies piece I'm looking at there, can you explain to me what the Grants and Subsidies are for?

J. HAGGIE: Yes.

P. DINN: Like, what programs they relate to.

J. HAGGIE: I can, indeed. They are wellness and support of wellness initiatives and they will be listed in your binder here, when I can find the right bit. I lost a tab here somewhere, one second. It's under annex B, I think.

Tobacco Control, School Food Guidelines, Baby-Friendly Counsel, Family Resources Centres, Nobody's Perfect, Healthy Built

Environment grants to Communities Collaborative – there's a list here, I can keep reading them or is there something specific?

P. DINN: No, if you're going to provide it, that's wonderful.

J. HAGGIE: Yeah, it's in there. There are five wellness coalitions as well that get $30,000 apiece.

P. DINN: I assume for the plan for this coming year, you have a list as well of what that (inaudible)?

J. HAGGIE: Those are the ones for this year and the amounts allocated in the budget.

P. DINN: Excellent, thank you. We'll get a list of that, thank you.

I'm looking at the provincial revenue.

J. HAGGIE: Provincial revenue, one moment.

P. DINN: I understand that's for bursaries, MCP overpayments and the like.

J. HAGGIE: Yeah.

P. DINN: It varies from year to year; however, only $82,000 was spent in '20-'21. An explanation for that, please.

J. HAGGIE: Those are for bursaries and for refunds from venders and ad hoc revenue. So some of that is kind of a placeholder sum. The principal difference this year was less recoveries from bursaries; i.e., less people defaulting on them and less MCP overpayments.

P. DINN: You mentioned the bursaries and less people defaulting. Do we have information on that, as well, in your binder?

J. HAGGIE: We have had it in the past. I'm not sure whether it's in this binder, but certainly I do know that we can supply a list of bursaries. I do have a list here but there are no defaults listed that I'm aware of. We can certainly find that for you.

P. DINN: Thank you for that.

So you will supply us with a list to the extent –

J. HAGGIE: No, we can supply you with a list of bursaries and any defaults that we're aware of in the last couple of years.

P. DINN: I just want to go back. I just have a question on Salaries. I know in Salaries, as of April 1, 2021, there was a complement of 210.

J. HAGGIE: Aha, I knew (inaudible).

P. DINN: That's an increase of nine from last year. Now, I'm looking at it, there are 25 positions that were offset and there were 16 that were deleted. I'm just curious: Can we get a breakdown of those positions, the ones that were in and out?

J. HAGGIE: We have a table here, which I'm – there we go.

We now have 261 in the salary plan for this year. In no particular order: We've admitted six healthy living positions because we took over Wellness from CSSD; five provincial medical oversight positions from Eastern Health for PMO; one executive director of Public Health; one quality improvement consultant; one project manager for air and road ambulance; four contractual Public Health positions for the pandemic; one policy division position; one contractual primary care position, audit claims integrity; and we lost a pharmaceutical services contractual and a mental heath contractual. The variance is 22 and that's the – oh, and we have a senior advisor, an associate deputy minister and a contractual communications position added. So the net is 22. Last year's salary plan was $239,000 and we're up to $261,000 on the arithmetic.

P. DINN: And we can get a list of that, please?

J. HAGGIE: Yes.

P. DINN: Thank you.

CHAIR: The Member's time has expired.

MHA Jim Dinn.

J. DINN: Thank you, Madam Chair.

I'm assuming, too, Minister, that answers to questions, regardless of the side, will be provided to both sides.

J. HAGGIE: Whatever he gets, you get. Don't worry.

J. DINN: That's good. It's all about competition.

P. DINN: Mom will be happy.

J. DINN: Mom will be very happy. She's going to be upset knowing that her name is taken in vain.

A lot of the questions, the specifics, were asked by my colleague from Topsail - Paradise. We do have a number of general questions that might fit in here and elsewhere, if we could.

The first one deals with ambulance accessibility. There have been reports of severe understaffing in the metro ambulance service. I have spoken to a few where paramedics were unable to immediately respond to calls and there have been incidents in Labrador where the lack of ground and air ambulance services have, in some cases, endangered the lives of residents there. I'm just wondering: Are there provisions in this budget to address this issue?

J. HAGGIE: We are doing a review of ground ambulance and air ambulance. There's also a patient safety review of air ambulance related to the Labrador issue. Yes, is the short answer.

The other piece – again, I didn't really get much of a preamble – the background to a lot of what's going to happen over the course of the next 12 months will be determined by the Health Accord. There is that document that's coming our way, which is going to provide, if you like, a straw person, a new model for the health care system. I do know that transportation, be it elective or emergency, ground or air, is going to be likely a feature of some of their comments.

J. DINN: Perfect. Thank you very much.

With regard to midwifery, the provincial midwifery service launched in late 2019 with three midwives in Gander and later going to four. How many mothers have received assistance from this service so far? Are there any plans to expand this program?

J. HAGGIE: I don't have the number offhand, it's a modest number, and the answer to the second question is yes.

J. DINN: Thanks.

Any idea where you think it would expand next, within the city or …?

J. HAGGIE: The original was that we would have a phase-one demonstration project in a kind of regional referral centre, not too rural but not urban. The next place would be somewhere in a more urban environment. Certainly, there are a couple of areas in Eastern Health that we've looked at. There's also a rural area within Eastern Health and there's certainly a rural centre in Labrador-Grenfell. Those are the subject of discussions between the midwifery consultant and the RHA/medical staff.

J. DINN: Thank you very much.

Minister, the Greene report is calling for a reduction in funding to health care authorities and there are currently five new health care facilities being constructed under the P3 structure. I'm just curious: Will long-term operation contracts associated with these buildings be flexible enough to accommodate less funding?

J. HAGGIE: You would have to ask someone with the knowledge of P3s. They were, in a sense, negotiated by a different group than Health. In terms of the funding and flexibility around that, these five facilities that you refer to will actually be core buildings that will need to be incorporated into the system for some time to come simply on the basis of clinical demand.

Any actual discussion about renegotiating the terms of their P3, if it's actually possible, would be best addressed to somebody else.

OFFICIAL: (Inaudible.)

J. HAGGIE: And the man says TI, yes. I wasn't going to put their name in the frame, but I can blame them because they're not here.

J. DINN: Thank you.

A few questions on mental health. The department launched their FACT – Flexible Assertive Community Treatment – team service in August-September of 2020 and seven teams were mobilized with plans for another six by the end of the year. Is it possible to have an update on the status of this project? Have the other six teams been established and where? Will this project shrink, expand or remain the same in the budget, do you think?

J. HAGGIE: The second tranche of six, as far as I'm aware, are not up and running yet. The first group are. There are no intentions to do anything but support that in its existing and planned format, simply because the whole of *Towards Recovery* is predicated on a distributed system of mental health and addictions care, not facility-based.

So that's actually an integral part of the kind of rough financing that was done around the replacement of the Waterford Hospital. The money that was originally allocated for a big replacement has been parcelled up, some of which will go to the new adult mental health and addictions facility, which is smaller. The rest will go to investments across the province in more community-based and defuse kind of local supports.

J. DINN: Thank you.

The 13 long-term recommendations of the *Towards Recovery* report will be due at the end of this fiscal year. Is it possible to have an update on the status of the implementation of these recommendations?

J. HAGGIE: The 13 outstanding ones, I couldn't give you a detailed analysis of those. I mean, obviously some of them are things like the adult mental health facility and some of them are new community crisis beds. Some of that process, quite honestly, about crisis beds outside of Labrador and the Melville addition there, they have been held up by COVID, quite frankly. So I don't know yet that we've had time to analyze what the impacts would be on those elements of *Towards Recovery* in terms of delays.

J. DINN: Thank you. If that is, indeed, available I guess we can have access to that. Thank you.

With regard to fertility treatments, this government made an election promise to provide immediate funding to support residents who need to travel out of the province for in vitro fertilization treatments. Furthermore, the government committed to increasing in-province access to IVF services. Is the minister able to say where in the budget provisions for either of these promises are being made?

J. HAGGIE: The budgetary provision would come through Eastern Health because that's where the fertility clinic is physically and financially located for support. We do provide support. We are currently finalizing a jurisdictional scan to see what the range of offerings is in other jurisdictions, because currently under the existing legislation there are varying approaches to the level of insurances' support for fertility treatments across the country.

J. DINN: Thank you, Minister.

With regard to the Auditor General report from April 2021 and updated in 2017, we notice that there is one recommendation regarding Central Health not implemented, five from Eastern Health and five from Western. I'm just wondering: What is the status of the uncompleted AG recommendations from the 2017 AG annual report?

J. HAGGIE: Not having them in front of me in detail, what I do know from recollection is that one of them in actual fact has been superseded by events and is now not topical or relevant. I couldn't remember which one it was without actual reference to the document. The other had been partially implemented. Again, I can't give you a detail on that. There is a response somewhere – if not ready, in preparation. That will be shared in due course.

J. DINN: No problem. I understand that. If they can be provided that would be great, too.

Again, another one – don't worry; I'm not expecting an answer right now – from the 2019 update of the 2016 annual report, there were a number of recommendations there regarding the

road ambulance service and acute care bed management. There are six recommendations to the department and all health authorities with mixed levels of implementation. I'm just wondering if you could provide a status of the uncompleted AG recommendations from the 2016 Auditor General's annual report.

Again, not looking for it now, but an update on those.

J. HAGGIE: I think you could actually just simply cut and paste my previous answer to that, because, again, I'm aware, I think, of one of those that have been superseded by time and events and changes in other directions.

J. DINN: Perfect.

How many employees are there again in the department?

J. HAGGIE: Two hundred and sixty-one.

J. DINN: Perfect. Thank you.

J. HAGGIE: That's split. They're not all in St. John's; they're scattered across Stephenville, Grand Falls, Major's Path and the Confederation Building.

J. DINN: Excellent.

In 1.2.02, Departmental Operations, last year the minister mentioned that the wellness portfolio of the former Seniors Wellness and Social Development was being absorbed back into Health and Community Services, and at that time, the transition had not fully materialized. Is it possible to have an update on how that process is going?

J. HAGGIE: My understanding is it's complete.

J. DINN: Complete.

Has there been any progress in developing the Population Health dashboard based on the health indicators the department tracks?

J. HAGGIE: Again, that kind of got held up by COVID because the dashboards that we do put up now, which are new and are available to everybody, are actually COVID-related. I'm thinking of things like the vaccination data and those kind of things. That is something that was high on our list of priorities and I suspect that will cycle around again with the Minister of Finance's comments about accountability framework and particularly the Health Accord work that will come out at the end of this year or beginning of next.

J. DINN: Thank you.

CHAIR: Thank you.

The Member's time has expired.

MHA Paul Dinn.

P. DINN: Thank you.

We're on the same section?

CHAIR: Yes.

P. DINN: And we're going as far as …?

CHAIR: 1.2.02 inclusive.

P. DINN: I do want to say something. I meant to say it upfront. Because of what we've gone through with COVID. I'd certainly want to applaud all those that work within the Department of Health and Community Services and all those who work out in the regional health authorities for what you have been able to accomplish through this trying time. I wanted to just say that before we moved along here.

J. HAGGIE: A significant number of the people who have not had a day off for 16 months are sitting in this area.

SOME HON. MEMBERS: Hear, hear!

P. DINN: Thank you for that and I do appreciate everything that has been done. Thank you so much.

I just want to go back. I know we talked about the salary pieces here. I'm looking at – I guess there is a point in time. Just for clarification, what the minister is providing in terms of salary details, that is the most current we're talking about there?

J. HAGGIE: As far as I am aware, yes.

P. DINN: Okay. I just wanted to make sure of that.

J. HAGGIE: John, is there a date stamp on this?

J. MCGRATH: What the minister was going through was the budget to budget so that are the positions that we are budgeting for this year. He was reconciling to the positions that we budgeted for last year. I think what you are looking at are the salary details –

P. DINN: Yes, correct.

J. MCGRATH: – that's in the book. That is captured at a point in time.

P. DINN: That's right.

J. MCGRATH: So that would include vacancies, I don't think the wellness crowd were in there at that point in time, I don't think the ambulance group were in there as well. They are kind of two different pieces of information.

P. DINN: So if I can get that piece of information as well at that point in time of positions and that are listed.

J. MCGRATH: Sure.

P. DINN: Both are going to be quite helpful.

I just want to go back to salary here again. The attrition plan, are we still following that? If so, what changes from the last year to this year?

J. HAGGIE: Yes, we are. We are on target and I think we have one position to give up for this year and we have two potential PCNs available to do that.

P. DINN: Thank you.

We'll get a list of those positions that are transitioning out?

J. HAGGIE: I think it is in here somewhere.

P. DINN: Perfect. I'd appreciate that.

How many retirements have occurred this past year?

J. HAGGIE: I don't have that information. John or Chad, would you be able to supply it? Oh, actually do I have that information? Am I misspeaking?

OFFICIAL: Page 32.

J. HAGGIE: Page 32. Yes, I do.

Retirement numbers, one from Exec and Communications, four from Departmental Operations for a total of five.

P. DINN: Perfect, thank you.

In terms of as people go do we have any open vacancies in the department?

J. HAGGIE: Again, probably on a snapshot basis. Do we have any vacancies, Karen?

K. STONE: Yes, we have a vacancy right now for assistant deputy minister of Population Health and there are the normal ins-and-outs vacancies. Some of the entry-level positions, you'll always find a certain percentage of those to be vacant. We account for between 5 per cent and 10 per cent vacancy factor throughout the year.

P. DINN: Thank you.

In terms of positions, are there any positions – I'm sure there are – that have been eliminated? If so, which ones?

J. HAGGIE: I would defer to staff, but I don't seem to have a detail here unless I'm missing a page, which is possible.

J. MCGRATH: There were two contractual positions. One in Pharmaceutical Services that's not included in this year's salary plan, and there's one mental health contractual position where their work was complete. That's not included in this year's salary plan as well.

P. DINN: Thank you.

I'm looking at the number of new hires. How many new hires in the department over last year?

J. HAGGIE: It's the same list. I found it.

Six Healthy Living positions moved in. I don't think they were new hires. We have provincial medical oversight, which are not new hires – they were transfers – executive director of Public Health, which I believe was; quality improvement consultant; project manager, road and air ambulance. There are four contractual Public Health positions, one policy division contract and one primary care contract. Audit and Claims Integrity, one, and then less the two that we just referred to, the Pharmaceutical. It's one, two, three, seven, eight, nine. Nine.

P. DINN: Thank you.

I assume those – well I won't assume anything – the contractual positions what are the, I guess, the average duration for them. Are they less than a year? What is the duration on these?

J. HAGGIE: I wouldn't be able to speak with confidence on that. My experience in most of the contractual positions I come across is I seem to see them around for a bit.

P. DINN: Yes. I get that feeling as well.

J. HAGGIE: Now, by "a bit," I mean they do come and go, even in my time, and I've only been there since late 2015. So I've seen them come and go, but they don't disappear overnight, if that's what you mean. That's not a very precise answer, but I'm sure we could get you a mean and a median, if you wanted it.

P. DINN: No, I appreciate that.

Moving forward, of course, looking at the attrition plan: Do you have any projections in terms of where you see that going in terms of the overall complement of staff?

J. HAGGIE: Well, I mean, one of our challenges this year is it all was thrown into a cocked hat, quite frankly, with COVID, because one of the things we did discover was that we needed more public health resources. We, just in common with every other public health department or agency across the provinces and territories, did not have enough.

So I think in terms of a formal request from government for attrition, once we fulfill this year I'm not aware that there are any outstanding. But there is a 0.5 per cent factor built in to the regional health authorities somewhere.

P. DINN: When we look at COVID, of course, one of the issues with – I guess you look at it as a positive, because we're able to transition quicker into things like Telehealth and the like. Do you see a big change happening with regard to the skill sets that would be required in a new tech-driven, as opposed to the traditional way we're doing it now?

J. HAGGIE: Well, I mean, the person who runs the department and determines what skill sets are necessary is not actually myself. I'm the policy person. That question would be better addressed to the deputy.

K. STONE: Sorry, can you rephrase that question?

P. DINN: Yeah. I guess it was just a question based on where we've seen the world change since COVID, in terms of more people working at home, more access to things like telemedicine and the like. So there's obviously some change in skill sets that would be required.

Do you see a big change from the current skill sets you have in government and those that would be required? So you obviously see some that would be redundant and you'd need new skill sets, new people. I'm just thinking: How do you project that or how do you envision that, and is it going to be a big issue?

K. STONE: At the moment, the skill set of the staff at the Department of Health and Community Services is appropriate for our mandate. What it's really about – in my opinion – is change management, so people need to learn to provide services virtually in the RHAs and people need to become better with technology. But I think the people of the department are generally a professional staff who have the skills to change as required. So I don't see us needing any particular new skills at this time.

P. DINN: Thank you for that.

Just to follow up, and I know it's a bit more of a blue-sky-type question. If staff are requiring some training in technology and we're not physically in the same location right now to learn that, what kind of plans do you have in place to get them that training?

K. STONE: At this particular time, any training that has been required has been provided virtually to people using Zoom or whatever appropriate platform the provider is using. I'm not aware of an unmet need at this time for any training.

P. DINN: Okay, I appreciate that.

I'm good. I'll donate the 30 seconds.

Thank you.

CHAIR: The Member's time has expired.

MHA Jim Dinn.

J. DINN: Thank you, Madam Chair.

Is it possible, Minister, to have an update on the staffing review being conducted with the Registered Nurses' Union, NAPE and CUPE? These, we understand, were all pushed out of last year due to COVID. Are we back on track now?

J. HAGGIE: They were pushed out by mutual consent because there were some changes that the RNU wanted and then they were deferred due to COVID. The RFP is in its final draft, subject to their approval and then it's ready to go.

J. DINN: Thank you very much.

Government announced increased funding for MTAP in this budget. Will this program be continuing under its current structure with a bigger pot of funds or is MTAP going to be restructured in terms of eligibility and a reimbursements policy?

J. HAGGIE: MTAP is actually sometimes misapplied. MTAP, to me and the people in the department, means Medical Transportation Assistance Program and that is a cost-offsetting program, which is universal and pro-rated. The bulk of our expenditure on medical travel actually lies in what we call ISMT, which is Income Support Medical Transportation, which is different. It is means tested, you have to be on income support and it is a payment scheme. Currently, that pot stands at somewhere over $9 million.

We are continually revising some of the policies because some of them, quite frankly, are quite old and reflect attitudes and problems of yesteryear rather than current issues. The plan is to keep some form of assistance for everybody whilst taking care of the most vulnerable as far as is practically possible.

J. DINN: Thank you very much.

With regard to change management, I think your deputy minister talked about the challenges of people needing to learn how to provide services virtually and the comfort level. Now, I may be clumsily rephrasing that. I'm just wondering with the comfort level, though, it's not only change management for staff; it's also a change for the people using the service. I'll use the example: Not everyone wants to go to the emergency room at the hospital and calling up a nurse and saying, should I, and you never get a clear answer. I guess people aren't going to want to make a diagnosis unless they see you.

I'm just wondering: How is it working, I guess, in evaluation of the service? On one hand, as a person, I wouldn't want to go into an emergency room unnecessarily tying up people, but how do I know that the situation I may be facing is serious enough that it would warrant, you know – and diagnosis. It's one thing to call up my doctor to get a prescription and another thing to have a diagnosis. I'm just wondering in terms of that, when it comes to providing a service virtually. Any problems or challenges along the way?

J. HAGGIE: I think one of the challenges is around acclimatizing people to a slightly different way of accessing services. We have had a good uptake with 811. It has been popular and it has been useful.

Its original intent, when it was set up before my time, as HealthLine, was to divert people from emergency rooms by providing them with advice. Certainly the data that was generated from those original pilots still holds true, in that if you look at a group of any 100 callers whose intent is to go to the emergency department for assistance out of hours who call in, somewhere north of 65 of them will actually stay home with alternate lines of approach outlined by the practitioner on the end of the phone. We've added a virtual nurse practitioner to that service as well, which can either be done by phone or by whatever medium you like. This will add the ability, for example, to have prescriptions renewed. It's for intermittent, occasional non-life threatening kind of situations. So it is ring-fenced.

I think what you're talking about in other respects is the comfort of nurse practitioners and physicians in actually diagnosing over the phone. The only place I can go is published literature because I think individual practitioners will vary. But, overall, if you look at the published literature, it is generally regarded that a virtual consultation, depending on how you define it, that often includes video, will provide comfort for physicians that their diagnosis is reasonable and safe, again, in two-thirds of cases.

Certainly, our approach during COVID has very much been to say we will pay you for a phone consultation but if, as a result of that phone consultation, you feel that a face-to-face consultation is necessary then you kind of need to do that, and provisions were always made around that.

That's a professional practice standard. That's something we, in the department, would not legislate or regulate. There are guidelines from professional bodies, from our local College of Physicians and Surgeons here, all the way up to professional speciality groups in the Royal College for example.

J. DINN: Two questions: Of the 65 per cent, the data that was diverted from the emergency room – and here is I guess what I'm getting at: Of those 65 per cent, were there any of those whose conditions worsened as a result of staying home, or where they successful in that alternative approach?

J. HAGGIE: Well, usually they were offered an alternative route. It was simply not that you don't need to see anybody. It was you don't need to go to the emergency room tonight; tomorrow, you can call whomever. Certainly, we've made a conscious effort there. Indeed, one of our next ambitions would be, in actual fact, when the iteration of the electronic medical records system gets far enough, to actually be able to have the practitioner on 811 make an appointment for their regular care provider.

We're not there yet because we don't have the IT hookups and that kind of buy-in, but that's where we would like to go as a department. I think that's an aspirational goal at the moment.

J. DINN: One last question – this may not be in your purview at all, but in terms of medical students, I know that you would have hired patients. They had to practise their diagnostic skills on the patient, be it someone who was an actor or someone who was paid to come in, present with problems. I don't know what the training was before. I certainly don't remember my daughter talking about learning to diagnose over the telephone.

I would assume that there's a different set of questions and a different approach, maybe not. I'm just wondering in terms of training, since this seems to be the way we're heading for our physicians, whether they're currently in the field or in med school.

J. HAGGIE: I think there is an idea of introducing some of the concepts to medical students, but the real thrust seems to have been providing residency training of a fairly granular level to enable them to get some more detailed experience. I know Dean Steele at the medical school and the post-graduate dean there have been engaged in discussions internally about how to that better. Again, not something we would interfere with, but certainly it is something we have watched with an interest and I await their deliberations with interest.

J. DINN: Thank you.

Just one last question with regard – certainly, when I first took office here the term was zero-based budgeting. Then there is attrition and now we have the promise and the commitment in the Budget Speech to balanced budget legislation. I am just thinking of the potential impacts on your department in terms of if it is balance-based budgeting – and I am looking at the next section coming in terms of drug programs and I am just looking at the amount of money there. Sometimes that is going to be hard to predict what is going to be covered, as we well know. I'm looking at a general idea; are there some concerns with that approach?

J. HAGGIE: I know as much about the process of a balanced budget legislation and how that would be crafted as probably you do, probably less. I think that is a work in progress, quite frankly. Not to give you a sneak preview of the next subheads, which haven't been called yet, but the short answer is you're right; it is impossible to predict.

J. DINN: Okay.

Thank you very much. I am done for that section.

CHAIR: Thank you.

The Member's time has expired.

MHA Trimper.

P. TRIMPER: Thank you, Madam Chair.

First of all, Minister, thank you for the opportunity to be with you and to the Committee for an opportunity to question.

Just an opening comment, your ears should be burning often because I meet people – I remember on the weekend, people were saying my goodness, we've been so lucky during this pandemic. And I said no, no, no. We've been good. You and the chief medical officer, your team, there are people here that, as I said jokingly when I came in, I want to put on my Christmas card list. But I sincerely mean it, our constituency office and I am sure very many in this province thank you for the clean, crisp, responsive communications. They are so important for us; we really appreciate that.

I guess my next sort of umbrella window – let's face it; Health and Community Services represents 40 per cent of the budget. I can tell you it probably represents 75 per cent of the constituency office, especially in a rural area. Highways and Health, those are the two. And if I could say Crown Lands with an H, then I would have all three.

Has the department ever thought about an orientation session for MHAs in terms of who does what, what are the no-go-to zones, in terms of the ethics of political offices, interacting with yours and so on, and staying the heck out of the way out of the triage decisions made by trained professionals? I'm always very conscious and sensitive to those things. So two or three opening thoughts.

J. HAGGIE: Yeah, we're actually, according to the Finance Minister, down to 36 per cent of the provincial budget this year, so something's going in the right direction. But not to belabour the point, I think that's a very good idea, that last one. I've certainly done that with some of my colleagues here on an informal basis.

I think if it's felt to be a benefit to this group, we can certainly do it. I think the challenge would be not necessarily for me in my position, but were I to be shuffled out at the next election and find myself in a different portfolio and a new minister here, it might be quite difficult for the minister to provide that kind of education at the same time as drinking from a firehose trying to figure out where the washrooms are in the Department of Health as well. So I'm not sure how it could be done, but it's certainly worth exploring.

P. TRIMPER: The weekly calls that you established with – I have her on my saint pile – Alicia and with all of the corresponding CAs across the province were brilliant. And during that pandemic, there are so many questions we could've easily swamped the department, but having that nice, calm voice who was well plugged in and so on was a great way to get a lot of information out across the province. So I thought that was a really key move to so much of the success that we had these last 16 months.

J. HAGGIE: Oh, thanks.

P. TRIMPER: I want to go back to, first of all, on the bursaries. This has been brought up with me before. Does the department establish how many bursaries it wants to have in place, for example of our medical school, or do the regional health authorities allocate money? Because I'm often hearing from certain professionals that we are not sufficiently supporting our bursary program to the point of securing, hopefully, folks who would take a lot at perhaps rural parts of this province, including Labrador, to establish a practice.

J. HAGGIE: The short answer is that we have a budget for bursaries and they break out under physician initiatives into undergraduate, medical residents and travelling fellowships. The dental crowd are also poked in there as well for convenience.

There are varying criteria. So, for example, a medical student bursary offers one bursary to a fourth-year medical student in return for one year of service in the province on completion. The Medical Resident Bursary Program offers a one-time award that varies. They have a sliding scale depending on how rural you go and how long you prepare to commit to and the difficulty of filling a position. You can find, occasionally, a person in the same geographic location having a different bursary because if one job was not difficult to fill but rural, they get so much; and if one was difficult to fill and rural, they get a bit more.

Then there's a travelling fellowship, which is for specialty training usually outside of the province. Those are slightly different. There is a budget set for those.

In addition to that, we have some more generic bursaries that amount to almost the same amount, maybe slightly more, for a variety of other health care occupations such as OT, radiation therapist.

P. TRIMPER: Has the allocated funding for bursaries waned in the last 10 years? Have we maintained that or has it dropped?

J. HAGGIE: I do know that at some point around 2015 it dropped. We have restored some of it because we found that it was very successful. To speak to a question earlier on in the sort of principle of it, we've had very few people default, as far as I'm aware. I think the number that now sticks in my mind – and I'm famous for misremembering numbers, as some of you might know. I think we had one default out of 75 bursaries. That was a figure that was given to me a couple of years ago, so it's probably not current. That's kind of the order of magnitude you're talking about.

P. TRIMPER: Thank you.

I'm feeling a little bit like my dog Cracker with a big bowl of food in front of me. I have 20 minutes allocated. I think I'm going to wait and hope no other dogs or independents show up and I'll jump in as there is an opportunity.

I'll clock it there, Madam Chair, thank you.

CHAIR: Thank you.

MHA Paul Dinn.

P. DINN: I have no further questions on that section.

CHAIR: MHA Jim Dinn?

J. DINN: No further questions.

CHAIR: I'll ask the Clerk to recall the grouping.

CLERK: 1.1.01 to 1.2.02 inclusive.

CHAIR: Shall 1.1.01 to 1.2.02 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 1.1.01 through 1.2.02 carried.

CHAIR: I ask the Clerk to call the next subgroup.

CLERK: 2.1.01 to 2.3.01 inclusive.

CHAIR: Shall 2.1.01 to 2.03.01 inclusive carry?

MHA Paul Dinn.

P. DINN: Thank you.

I'm looking at 2.1.01, Allowances and Assistance. In '20-'21 the department went over budget by just under $4 million, a 2.5 per cent increase. Can I ask why this occurred and what was the source of the funds for the overrun?

J. HAGGIE: We had new drug therapies approved. That amounted to just over $2.2 million and that was in '20-'21. Then we had some new drug therapies in '21-'22 that were also approved. We have the overage here of $3.997 million. It essentially amounts to what are called antineoplastics – that's cancer drugs – and immunomodulating drugs, which are immune modifiers. That would be not just necessarily used to treat cancer, but they've also spread into diseases like MS. They're generically known as biological agents and they would be used for kind of autoimmune disorders, things like Crohn's disease, things like the rarer diseases.

Unfortunately, by and large these drugs are not cheap per dose. You're looking at thousands and, in the case of some, hundreds of thousands per dose.

P. DINN: Thank you.

In the same line item there, I'm looking at the increase from last year's budget of about $10 million – $10,792,000. Of course, in *Budget 2021* you announced $8.6 million to fund new drugs under Provincial Prescription Drug Program to treat cancer and other illnesses.

J. HAGGIE: Yes.

P. DINN: Is this why the increase now of just over $10 million and can we get a list of the new drugs that are involved?

J. HAGGIE: That's a net and yes. There's about $7 million for non-cancer conditions and just around $2 million for cancer-related conditions. It's a shopping list of things all over the place, quite frankly.

P. DINN: Thank you.

Under that, can we get a breakdown of the number of clients under the Provincial Prescription Drug Program by type?

J. HAGGIE: It is in the binder by 65Plus Plan, Access, Assurance. The total is 113,554 and it's laid out for you in the binder.

P. DINN: Thank you.

Moving on to Revenue - Provincial: I'm looking at the $8,750,000 that was budgeted, and then it was $10,043,300 received. Can I ask why the increase?

J. HAGGIE: That $8,750,000 is a placeholder. We get rebates from product-listing agreements, which are based on utilization and prescriptions, so they would've been higher in '20-'21 to reflect volume and we just keep $8.75 million in as a placeholder.

P. DINN: Okay. Just to clarify, that could be up or down next year?

J. HAGGIE: It could be up or down. That's just a ballparkish guesstimate so that the numbers aren't too far off at the end of the year and we're scrambling.

P. DINN: I know I might be asking – well, it's not a crystal ball because you're going back in history. What has been the biggest difference over the years in that particular allocation?

J. HAGGIE: The rebate?

P. DINN: Like, for example, you said it went up by just over $2.1 million. I mean, is that the normal fluctuation or have we seen bigger fluctuations?

J. HAGGIE: Oh, I see. I wouldn't be able to tell you. There's always a fluctuation in there every year. If you were looking to see what year set records, I think we'd just have to go back and find out.

I don't know if John has it at the tip of his tongue.

J. MCGRATH: Last year there was – these are presented on a modified-cash basis, right? At the end of last year there were some delays getting them in due to COVID, the rebates coming in the door. So they actually came in and they were receipted during the prior period. That's why it's up this year. But on an accrual basis, so in Public Accounts, we would cash that as a receivable.

P. DINN: Yeah, I was just trying to get a handle for how far the pendulum swung either way there.

Thank you for that.

I'm jumping ahead to 2.2.01, Physicians' Services, and I'm looking at the Professional Services section. I see in budget '20-'21 you spent just under $8.5 million and was budgeted. Now, I can say is this related to COVID or less individuals visiting doctors, but I'll leave it to you to answer that one. Why the decrease?

J. HAGGIE: Sorry, are we looking at 2.2.01, Physicians' Services?

P. DINN: Professional Services.

J. HAGGIE: Professional Services, okay.

That is fluctuation in billing for fee-for-service physicians. We have an estimate based on utilization. We always add a little factor in each year when we set the budget and then you see what the actuals are compared with that. There was obviously a decrease in fee-for-service billing globally of that magnitude between the '20-'21 budget and the '20 to '21 actuals.

P. DINN: Thank you.

I think you've answered it in that response, but I'm going to ask the question: In budget 2021-22, you plan to spend $377 million, an increase from the previous year. Do you expect demand for physicians' visits to increase in 2021?

J. HAGGIE: We nearly always see an increase year on year and we've put $4.7 million in to reflect that. As I say last year, really, was COVID, quite frankly. I think it kept people away and reduced the frequency of visits. If you remember, we had that business of 90-day prescriptions instead of 30 day and this kind of thing. That's actually a standard for chronic disease, but not every primary care provider sticks to that for various reasons, clinical or not. We always factor in a little bit of an increase.

P. DINN: You did mention COVID there in your response. Are you concerned that medical conditions, if left untreated due to COVID, are you concerned about some cases there like that?

J. HAGGIE: Well, we're always concerned about that. Other jurisdictions have looked at that in a very crude way in terms of excess mortality. We've done the same thing and, to the non-statisticians, we've seen no difference on month-by-month death rates comparing COVID with pre-COVID. There may be, as yet, some difficulties.

We were in a very fortunate position, though, as a province because urgent and cancer surgeries were not deferred, unlike Ontario where they actually stopped giving chemotherapy at one stage because of the weight of COVID patients. We never got to that stage. We've done our best to mitigate that as far as possible. If your bypass graph was deemed urgent by the cardiac surgeon, you were done, COVID or not.

P. DINN: Okay, thank you for that.

Can we get a breakdown – because I understand this covers physicians' fee-for-service and salaried – of the number of physicians in the province by salary versus fee-for-service by specialty (inaudible)?

J. HAGGIE: I have that lurking around somewhere. I always struggle to find it; here we go. We have some statistics somewhere and I've just pulled out a sheet of paper, which is the wrong one.

OFFICIAL: Twenty-four.

J. HAGGIE: Twenty-four – yes, thank you. I love doing this. There are 1,332 active, licensed physicians in the province as of May 21 this year, which is up from just over 1,200 this time last year; 656 are family medicine, 676 are specialists and, in terms of who gets what billed by whom, I'll have to dig a little bit further to find that one for you.

K. STONE: Bullet four.

J. HAGGIE: Bullet four.

P. DINN: That's why he's keeping you, Karen.

J. HAGGIE: That's the allocation, if we're looking at the same page. That's just the money. I thought you wanted the numbers, didn't you?

P. DINN: Oh no, if you can get me the numbers and by their speciality and by regional health authority that would be wonderful.

J. HAGGIE: Okay, I have seen it somewhere. We paid out $357 million last year for fee-for-service and $116 million for salaried physicians and $15 million for on-call services.

P. DINN: When we say an active, licensed physician …?

J. HAGGIE: Yes, I got them: 909 fee-for-service (inaudible), 345 salaried physicians and 78 on what are called alternate payment plans. So they're neither salaried nor fee-for service. They are regarded by CRA as fee-for-service, but they kind of get a blocked funding arrangement.

P. DINN: Okay, and we can get a copy of that, please.

J. HAGGIE: Yes.

P. DINN: For my own information here now when you say active, licensed physicians – because I'm stuck on the word "active" – would some of those be probably instructors at MUN that don't practise or …?

J. HAGGIE: They have a licence and have used it to practice medicine. How that is defined is a matter of professional standards. I wouldn't necessarily be able to tell you. What I do know is the bulk of the teaching faculty, numerically, at Memorial are actually physicians, surgeons and internists out and about who have an honorary title and do it for the love of it more than not.

P. DINN: Okay, thank you.

CHAIR: The Member's time has expired.

P. DINN: Okay, thank you.

CHAIR: MHA Jim Dinn.

J. DINN: Thank you, Madam Chair.

In 2.1.01, Provincial Drug Programs, with regard to Allowances, I think, Minister, you mentioned the fact that there are new drug therapies approved and the biologic drugs. I know that was one of the things with our insurance that we were dealing with. I'm just curious: While we have new drug therapies, is demand expected to increase – I guess coverage of the program has expanded, but is the demand expected to increase?

J. HAGGIE: I think the short answer is probably yes. You can speculate a lot about that – in this context, not necessarily, but most drug manufacturers, when they have a biologic, will want to maximize its revenue. You have seen cancer biologics being licensed for injection into eyes, for example, to deal with macular degeneration. That's kind of market expansion – market creep, for want of a better word. As that happens, then that becomes an expense that you might not have considered, particularly if it displaces a cheaper therapy that's already there. By and large, I have not yet found a new treatment that was cheaper than the old one.

J. DINN: No, and I don't think you will either.

That was where I was going also with the question – I know one of the issues, when I was first elected, had to do with the intravitreal eye injections. I think Avastin, Lucentis and I forget the other one. I'm just wondering has the uptake on that – I think at that time you removed the cap after and I applaud you on that decision, but I think you mentioned at that time it was going to add another $5 million to the budget.

I'm just wondering: Has that increased the number of people using it? I know I talked to a few people who didn't realize that they could avail of that, but I'm just wondering if you tracked that at all.

J. HAGGIE: We do. I just don't have that data. Our Pharmaceutical Services Division would be able to pull that out for you if you want to know

what, say, this last fiscal year's expenses for Eylea were compared with –

J. DINN: That was the other one.

J. HAGGIE: – the previous one. I don't have that at hand.

J. DINN: No, no. Just more out of curiosity to see how well it did.

I guess a national pharmacare program will be significantly useful here then.

J. HAGGIE: Well, I mean, national pharmacare – I can remember sitting with Dr. Hoskins when he was first appointed, having vacated his role as provincial minister of Health.

I think the framework and the discussion documents are all out there. The challenge is around what that would look like and what would be the federal government's share on it, because at the time that was touted as a kind of fill-in to bring everybody onto the same playing field, not a universal one, and I think it would tremble this sum you see here in terms of Allowances and Assistance. We were looking at figures around $400 million. So the question was then where would that money come from, particularly if that was a federal requirement.

J. DINN: When you're looking at – I guess, I don't know if this is a question for you or not – in terms of buying in bulk, do you coordinate with the other Atlantic provinces when it comes to looking at –?

J. HAGGIE: We have a thing called the pan-Canadian Pharmaceutical Alliance, which is basically a council-of-federation being. It was put in place when the then-prime minister declined to get involved in this area and the premiers put together a process whereby drugs could be assessed and evaluated. Then there's a process called the product-listing agreement, which is where the drug that's been approved then goes through a process with individual provinces to work out some kind of funding arrangement.

I'm sure there are ways that could be streamlined and I know that's an active topic for a provincial-territorial working group at the moment. Similarly, there is another buying group, HealthPRO, which supplies hospitals with drugs through a separate mechanism.

We'd certainly be keen on looking at bulk buying. I mean, we're 1.4 per cent of the Canadian market from a population perspective, but Canada is only 2.5, 2.8 per cent of the world global drug market. We're small players. So even collectively our leverage isn't very good.

J. DINN: Okay, thank you.

Under 2.2.01, Physician Services, what is the progress on provision for cataract surgeries to be performed at private clinics under MCP coverage?

J. HAGGIE: That's been done, and the first year is complete. I think somewhere north of 4,000 cataracts have been done through that arrangement. I could get you the exact information. I think it was split 3,000 and a bit and 1,000 and a bit. I know the 3,000 and a bit is gone for last year, and this year is already in process.

J. DINN: So you're talking about individual eyes, as opposed to 4,000 people?

J. HAGGIE: They would be individual procedures; one eye at a time.

J. DINN: Okay, thank you. Sounds like a strange question, but some people have two and some people only need one.

Under Allowances: What is the reason for the $4 million in savings last year, and what's the reason for the $500,000 increase in this year's Estimates?

J. HAGGIE: Okay, the savings are the result of COVID, basically, and travel restrictions, because these allowances provide payment for services received by Newfoundland and Labrador residents out of province and for residents of other provinces while here.

So those are very much travel keyed and because there was very little travel because of our COVID measures you see that number goes down.

J. DINN: Thank you.

Provincial revenue, what's the source here, and why was $1.6 million not collected last year?

J. HAGGIE: Those are a guesstimate of anticipated audit recoveries from physician audits, combined with reciprocal billings for money that we would get back for services provided for out-of-province patients. So that's a placeholder, we guess at around $3 million a year and then we adjust it at the end of each fiscal.

J. DINN: With regard to the physicians, the amount is increased a bit, the fees. I'm looking here at – or seeing that the number of physicians have actually gone up, that's what it was, over 1,200, I think 1,300?

J. HAGGIE: Thirteen, thirty-two.

J. DINN: Over 1,200 from last year. So here is my question: One of the things that I'll get every now and again from a number of constituents are people whose family physician is retiring. This is in the centre of the city. They cannot find a doctor. Now, I have sent them on – I've tracked down a few – some of the physicians are on the West Coast, up in Labrador. But if indeed we seem to have more, have you been tracking, not only tracking, but how you're dealing with what seems to be people who are now finding themselves – more and more people it seems – without a physician, a family physician that they can go to?

J. HAGGIE: We have an access issue, not a numbers issue. That is politically unacceptable to certain quarters outside, but essentially the numbers speak for themselves. You can argue over whether or not so many of those practice and so many of those practice part-time, but the facts of the case are we do not have the access we used to. There are reasons for that, one is geographical distribution. There are sites where people chose to live and work, preferentially, and not all areas of Newfoundland and Labrador appeal to all physicians. Set against that, if you look at the number of physician services provided by that group, as a whole for that denominator, it has not increased anything like the number of doctors over the course of the last 10 years.

J. DINN: Okay. I'm thinking specifically within the city. I've changed physicians a number of times, as one retires, but I do remember some physicians saying they're looking at the age range, they're not interested in taking on the older more complicated patients, I guess where I'm probably heading in the next few years or whatever. I guess within the city it seems to be a challenge as well. I'm just curious about how we're addressing that.

J. HAGGIE: Well, I think one of the ways from a strategic policy, overarching point of view is to talk about primary health care teams, collaborative teams. I know Dr. Parfrey is a great fan of this. We've spoken, we've actually put money – we put, I think, $4 million or $5 million a year into an NLMA held fund for family practice renewal. The aim of that is to generate these teams and the idea is physicians work and professionally live inside a collaborative – for want of a better word – which encompasses nurse practitioners, midwives where we can get them and the flavour of the local disease patent. For example, in Botwood they may need a mental health and addictions counsellor and a diabetic nurse, for example; whereas, in St. John's we actually have a housing support worker on the team.

It needs to be tailored to the flavour of the community. A cookie-cutter approach has been very difficult, but it's been very slow to get going. One of our challenges around change management is to actually figure out what it is that's slowing that up.

J. DINN: Thank you.

CHAIR: The Member's time has expired.

MHA Paul Dinn.

P. DINN: Thank you.

The Member for St. John's Centre has covered a few questions so I can jump ahead a little bit here. But just before I leave Medical Care Plan, 2.2.01, and you may have already answered this, the Revenue - Provincial, you're budgeting – you see how the figure went up and down.

Are you taking any actions here to – no, sorry, forget the revenue, I'm going back to Grants and

Subsidies, sorry about that. I'm just looking at the amount there. You're budgeting just over a million less for salaried physicians. Are you taking any actions to reduce the number of salaried physicians this year or is that an indication of that?

J. HAGGIE: No, what's happened is that comes from the recommendations of what's called a Salaried Physicians Approval Committee, SPAC. They have identified salaried positions that we have converted to nurse practitioners.

P. DINN: Okay.

I think there was a plan to reduce the number of salaried doctors over a number of years. I assume that's part of that process, is it?

J. HAGGIE: I think that is part of an approach to see what the right number of salaried physicians are. I wouldn't quite characterize it the way you have.

P. DINN: Okay.

Then back to Revenue - Provincial, I'm seeing the $3 million down to $1.4 million, back up to $3 million. I'm assuming that's related to less people travelling.

J. HAGGIE: By and large it is. There is an audit component of that where we do recover billings from audits from physicians. That process was fairly slow. It's been rebooted and is back on track, but we agreed a new mechanism with the physicians in the last agreement and it required populating certain committees. They were a little bit difficult to do, particularly prior to and into the run into COVID. They're up and running now, but that process, now that they are constituted, is actually somewhat lengthier than it was before. It's a kind of mutual gains alternative dispute resolution process rather than adversarial unless it has to be.

P. DINN: Okay. Thank you.

Jumping ahead to 2.2.02, I'm looking at Operating Accounts, Professional Services. We see that you spent just about $52 million, which was a decrease from what was budgeted. Now, I assume it's related to less dentists' visits but I'll ask you to confirm.

J. HAGGIE: Did you say $52 million?

P. DINN: It was a decrease, looking at Professional Services, it went from –

J. HAGGIE: Oh, $5.2 million?

P. DINN: What did I say?

J. HAGGIE: $52 million.

P. DINN: Sorry, I probably did.

J. HAGGIE: It's usually me who gets the decimal point in the wrong place, which is why I have John.

P. DINN: No, it's $5.2 million, you're correct.

J. HAGGIE: Okay.

Basically elective dental work suffered quite a lot during COVID because of the lockdowns, firstly at the beginning of the year and then through into this winter. So I think that reflects that. It's a reflection of the fact that a lot of dentists chose to close their offices rather than just the emergencies.

P. DINN: Okay, thank you.

I'm moving to – and this is interesting – 2.3.01, and of course there's been some discussion of this recently. Actually, it was on the radio this morning talking about Memorial University and their budget. I'm looking at the Grants and Subsidies, and we see that they went over budget by about $3.8 million. Can you describe or explain why that happened?

J. HAGGIE: I think there is a structural deficit that was in Memorial. The best description is it arose from some confusion, possibly as long ago as 2015, maybe 2016, whereby Memorial was doubly hit, the faculty was doubly hit and they have worked year upon year to reduce that deficit and had, but this time there was an issue because of accreditation and the creditors require a balanced budget. So the direction to Memorial was: Here it is, this is your $3.8

million, you're at zero now and don't come back again, live within your means.

P. DINN: Staying with that, of course we see the faculty's budget is being reduced by about $4 million from what it received in '20-'21. I'm just looking here – so what measures are the faculty taking to live within this budget? Have they indicated anything that's happening there? Because, as you said, it seems to be an ongoing issue.

J. HAGGIE: Yeah, I mean, the bottom line is that while we fund them and have the financial piece of it, we are very conscious that this is a really good medical school.

P. DINN: Oh, no doubt.

J. HAGGIE: So whatever we do we have not wanted to do it suddenly and risk jeopardizing the clinical component of what is a really good first-class, I would argue, medical school. Our discussions with the dean have been around back-office functions, have been about travel, have been about those kind of support services where there is, if not duplication, certainly maybe some largess that doesn't quite fit with how the public service would be paid. Those directions have been conveyed quite clearly. So that's basically been our approach.

The bulk of the faculty, the clinical teachers, as I've said, are actually volunteers. I actually had a faculty position in my previous life at Memorial, but I never got a cent, and it took me four years to get a library card.

P. DINN: Thank you for that.

Like I said earlier, it was on the media today and, in fact, I believe in a press release you were quoted. I don't like using press releases as the bible here. But you already touched on it. There was talk about some duplication of back-office functions. And it's been an unfortunate problem for a number of years. You also indicated in that press release that this would be corrected within the fiscal year.

So am I to assume that the items you just touched on, is that part of the process?

J. HAGGIE: Well yeah, basically. Here's your money; you're whole now. Go away and don't come back anything other than whole. You have a year.

P. DINN: Perfect, and you hope for the best.

J. HAGGIE: Well, I mean the margin that they have to deal with now is not the hole they had to climb out with over the last three or four years.

P. DINN: Okay. I appreciate that.

I'm good, thank you.

CHAIR: Okay.

MHA Jim Dinn?

J. DINN: Thank you, Madam Chair.

Under 2.2.01, Professional Services, is it possible to have a breakdown of the number of clients and the expenditures of the adult and children's dental programs?

J. HAGGIE: I don't have the number of clients with me here for the – sorry, the Adult Dental Program, did you say? I was looking at 2.2.01.

J. DINN: Oh, sorry. That was under 2.2.01?

J. HAGGIE: That's Physicians' Services.

J. DINN: Okay.

J. HAGGIE: Sorry, I must have misheard your question then.

J. DINN: No, I'm looking under the number under the adult and children's dental program (inaudible).

J. HAGGIE: Okay, that's 2.2.02. What I can give you only here are the sums of money; I don't have the clients. So we can get the numbers for you.

J. DINN: That would be great.

The only question I really have, just out of curiosity – no, not even curiosity – in terms of people accessing the emergency room. I'm just wondering, has there ever been or is it even

feasible to look at whether it's a clinic – we have walk-in clinics, but they're not open after-hours. That's a problem for a lot of constituents in my district.

So is it possible to have, let's say, whether it's a family physician or a clinic attached to a hospital that has 24-hour service, whether it's just simply to see that immediate – so that if they're triaged when they come in, they're shunted and you don't need to see an emergency room doctor, we have a family physician here. I don't know how you would work this. Basically, you need a prescription, done, in and out, and the more serious concerns stay in the emergency ward. Because there are a lot of people in there who are probably there for flus and so on and so forth. Is that even feasible?

J. HAGGIE: It's been done. It hasn't achieved the results everyone would have liked. I know Central Newfoundland Regional Health Centre has done that for some time. They've had a kind of B-stream. I do believe St. Clare's may have done it on and off as well. The preferred method, quite frankly, is to find a mechanism that avoids these people ever going anywhere near a hospital in the first place, because it doesn't seem to work once you get there.

It isn't the panacea that people would like it to be. The logic behind doing it was there is a thing called a Canadian Triage and Acuity Scale, CTAS, which describes, in statistical terms, how sick you might be when you present to an emergency department. One is you have a cardiac arrest and you need stuff now. Two is bits hanging off. Three is leaking slowly. Four and five are basically stuff you could go to your family doctor or nurse practitioner for. The vast majority of attendances at an emergency department, up to midnight in some places and certainly up to 10 in others, are CTAS four and five.

The challenge is around the other piece you alluded to, which is access. Primary care is available 9 to 4, Monday to Friday. There are walk-in clinics at the weekend, but until very recently they were strictured, they were constrained and they were geographically few. They asked that there be one in Gander but if you wanted to see a family doc in Harbour Breton, for example, the only place you could go was the emergency department and it was category B. That was kind of the category-B philosophy, which was you were a walk-in clinic but if you were really sick, we also had the resuscitation skills available.

It's, as yet, an unsolved problem. There are ways of making dents in it, but I think the idea of the collaborative team approach, combined with low-barrier access, not necessarily to physicians at 10 at night but a nurse practitioner, an advance care, community care paramedic, those kind of things, would actually manage the vast majority. There are very few people actually pitch up much after 10:30 or 11 o'clock.

J. DINN: I'm thinking of the St. Clare's hospital, I've been there a few times. I'm just interested in the clientele who are there and a lot of them may not be emergencies, nevertheless just an idea I wanted to talk about.

With that, Chair, I'm done.

J. HAGGIE: I have an answer fed to me by my trusty right-hand person here.

There are 4,064 patients in the Adult Dental Program as of 2020 to 2021.

CHAIR: Okay.

We'll go to MHA Trimper and then we'll take a break.

P. TRIMPER: Thank you.

I think I just have one question here, Madam Chair.

I've always been interested, and the minister and I have had a few conversations about compensation for those specialists, even family physicians to lure them to the more rural parts, including Labrador. I wonder if you could comment, Minister, just on what is happening now.

As I look to your two financial folks around you, I always call this orchestra conducting because the money going out in one pot in terms of what we spend on MTAP, what people themselves spend or their insurers for folks to get to that specialist – wow. If we were just to consider

what it would take to maybe lure that specialist to where all these patients are lined up and just whether there would be those financial arguments.

What strategies are being used now by the department to help the regional health authorities out, lure those folks away from the metropolis of St. John's and Mount Pearl?

J. HAGGIE: Well, it starts at medical school, we have the bursaries – well, actually, I'd argue it starts with recruitment because there is evidence that if, by and large, you recruit from a rural or a small community or an Indigenous community the student is more likely, not guaranteed, but simply more likely, by a factor of two or three, to go back and work in those kind of communities once they finish their training. So it starts there.

We will support them through medical school with bursary programs and we can support them in addition through residency programs with return in service. Now, if you go and work in a rural, a remote or isolated community, each of those tiers of isolation attracts a retention bonus. I couldn't tell you exactly what they are now, but back in my day I got between $15,000 and $20,000 extra for working in Gander, which was regarded simply as rural –

P. TRIMPER: Now, it's home.

J. HAGGIE: – not remote or isolated. So I would have to go back and check what those current values are.

What we do know from other jurisdictions is you can throw all the money you want at a job, and it will get a person there, but it will not keep them. The biggest single key to retention is actually the community effort in making people feel welcome.

The psychologist in Gander, I joke – we bought for a bowl of fruit. She arrived with her husband from overseas several years ago and my constituency assistant and I went round with a bowl of fruit – and there may have been a bottle of wine in it. We hid that until we know whether she drank or not. She has not forgotten that. I ran into her at the vaccination clinic in Gander a few weeks ago and she still talks about that five years later. She says, you know, 'we ain't leaving.' Husband's got a job, she's got a job. That one simple act made a huge difference.

Now, I'm not saying you can buy everybody with a bowl of fruit, and your success may vary, as they say. But there is no magic bullet. The rural and isolated portions of the province are beautiful to go to. I used to do travelling clinics, but I'll tell you what, it wore me out. I mean, just to go to St. Anthony to Nain and do a couple of days there, a couple of days in Hopedale, not get fogged in, and come home again, it wore you out.

I did travelling clinics going to a clinic. I'd drive out there in the morning and I'd drive back in the afternoon and it was three hours on the road. Three hours during which I could've actually seen patients. It became a toss up in your own mind as to how tired you wanted to get when you got home.

So there are ways of ameliorating that. But certainly I think one of the great treasures of Labrador, which has really never been mined properly, if you'll pardon the excessive puns, is I don't think we use the Telehealth system that's built there, that was the pioneer of North America there, I don't think it's used anything like the way it should. But that requires change management and a culture shift by groups of people who it's very difficult to control. You certainly can't dictate to them, and if you try to buy them, it becomes gamesmanship. I've seen that.

Virtual care offers similar potential riches. You can't inject someone's eye virtually. You can do a lot of ophthalmology with good image transfer software; a lot of diagnostic ophthalmology. So you can sieve out those people either you need to go to or need to come to you.

So there is a huge amount of room to be done. I think COVID has provided a boost around virtual care. What we really need to do, though, is we need to get more image intensive. Funnily enough, Telehealth and Max House and all that was based on TV, old TV technology and yet it seems that we've now abandoned that during COVID and the vast bulk of virtual care, as far

as I can tell – although we don't distinguish from a fee point of view – is actually telephone. It's preferred by a lot of the really older people who still live at home. The 75, certainly the 80-plus are much happier on the telephone than they are with that. The younger group like FaceTime, because they're used to it with the grandkids. That's not an issue.

So, I mean, there's a whole lot you can mine here – I already have the clock blinking – I could go on for ages about this. But it's not to say we're devoid of ideas or possibilities, it's just that none of them come easily. There isn't a silver bullet, a magic one.

CHAIR: MHA Trimper.

P. TRIMPER: Thank you.

I'm just going to clue up just by saying I think there's an idea there for MHAs, perhaps, to work on that community welcome.

J. HAGGIE: Indeed, there is indeed.

P. TRIMPER: Thank you very much.

CHAIR: So, MHA Trimper, your first 10 minutes is used up. Do you want to proceed?

P. TRIMPER: I'm good there now.

Thank you.

CHAIR: Okay.

MHA Paul Dinn.

P. DINN: Are we going to a break?

CHAIR: We are. We could probably finish this. Do you have more –?

P. DINN: Well, I'm fine on that section.

CHAIR: Jim, are you finished with that section?

J. DINN: (Inaudible) section, too. I'm finished with that section.

CHAIR: Do you have more in this section? Will we call it or go to break?

P. DINN: 3. –

CHAIR: 2.1.01 to 2.3.01.

P. DINN: I still have questions?

CHAIR: Okay, we'll take a break and come back, yeah.

J. HAGGIE: How long, Madam Chair?

CHAIR: Ten.

J. HAGGIE: Ten, okay.

CHAIR: 7:40 to 7:50.

Recess

CHAIR: (Inaudible) again, with MHA Paul Dinn to see if you have any more questions for section 2.1.01 to 2.3.01.

P. DINN: No, I do not.

CHAIR: Okay.

MHA Jim Dinn, do you have any more questions for that section?

J. DINN: (Inaudible.)

CHAIR: No.

MHA Trimper? No?

P. TRIMPER: (Inaudible.)

CHAIR: Okay.

I'll ask the Clerk to recall the grouping for that section.

CLERK: Client Services and Support, 2.1.01 to 2.3.01 inclusive.

CHAIR: Shall 2.1.01 to 2.3.01 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

CHAIR: I'll ask the Clerk to call the next grouping.

CLERK: Health and Community Service Delivery, 3.1.01 to 3.2.03 inclusive.

CHAIR: 3.1.01 to 3.2.03 inclusive.

MHA Paul Dinn.

P. DINN: Thank you.

We've had some questions already answered, so we can jump ahead a little bit here hopefully and make up some time. I'm looking at 3.1.01, Operating Accounts, Purchased Services. You spent $586,000 more than in budget 2021; can I get an explanation of why?

J. HAGGIE: Yes, that is for out-of-province air ambulance charter and for an increased utilization of contracted services for air ambulance.

P. DINN: Thank you.

Just a little further, can you explain why there was an increase? Was it just more use of it?

J. HAGGIE: There is a year-on-year, slow, steady increase in the number of medevacs.

P. DINN: Okay, thank you.

You announced, in 2021, $3.3 million annually for the recently launched nurse practitioner virtual care services. I think you already spoke to it earlier. Again, now you have another $3.3 million put into that. Is this an additional $3.3 million, or is it the same amount you announced in 2021?

J. HAGGIE: That's the HealthLine piece you're referring to?

P. DINN: Yes, you spoke to it earlier; you touched on it.

J. HAGGIE: The actual expenditure for HealthLine is based slightly on utilization, but my understanding was that that was an annual recurrent cost for the increment to add the nurse practitioner there for 12 or 14 hours a day, which ever it turns out to be. I'd have to go check the time.

P. DINN: Okay, I appreciate that.

I am also looking at – it seems to be the same amount – $3.3 million to fund the structural deficit in the budget for air ambulance. Can I get some details on the budget, including are they running a deficit?

J. HAGGIE: No, we have an air ambulance, which is a hybrid, and it consists of two air assets with government Air Services: Beechcraft King Air 350s, with a maintenance crew and crew. We supplement that for operational reasons with a charter with both Provincial Airlines and EVAS Air. They each provide one aircraft; PAL provides a Beech 200 and EVAS provides a bariatric, fully capable, centre-mounted stretcher for one Beech 1900D.

Utilization: We need those four aircraft to cover off maintenance and downtime for each of the government Air Services aircraft and rotate around so we've always got an availability. We have one stationed in Goose and one on the Island.

P. DINN: So it's an increase in funding required to run it.

J. HAGGIE: It's an increase in workload and the service is challenged sometimes, and we've heard about some of these issues, but without four assets, we would not be able to provide the service.

P. DINN: You touched based on something earlier, too, about, I'll call it, the conversion of utilizing nurse practitioners in areas where physicians can be, I guess, freed up for elsewhere. Do you have any information on where that's happening?

J. HAGGIE: It happens in an ad hoc way. I know there have been nurse practitioners in Bonavista. We had a situation some years ago now, I think it was Jeffrey's or Black Duck

Cove, where it was impossible to recruit a solo physician. That individual, amidst great fuss, was replaced by a nurse practitioner and six months later when we went back to ask them if they would take the nurse practitioner away and get a physician, we were yelled at again. So I think that's a success. There are a variety of locations where that has happened and it's down to the regional health authority to make those requests, more often than not.

P. DINN: Okay, I appreciate that.

It was a common question, actually, that I got on the election campaign from actual nurse practitioners at the door, you know, asking to be utilized to (inaudible) –

J. HAGGIE: We utilize all we can graduate. We have our in-house program here and we do know of a number, which is difficult to quantify, who train distance learning through Athabasca and I think through UWO. They only come to light if they do their clinical preceptorship because otherwise we wouldn't know what they're doing in their spare time and online studies.

P. DINN: Okay, thank you.

Jumping ahead to 09, Allowances and Assistance: Can you give me a breakdown of what's involved in this budget item?

J. HAGGIE: In there you have the medical transportation, so that's $9.8 million; you have various bursary programs for physicians' services that we talked about already; and workforce planning is also in there as a pot of $2 million for various workforce planning initiatives in there. So that totals up to the –

P. DINN: $13 million.

J. HAGGIE: Yeah.

P. DINN: Thank you for that.

Of course, in the last budget you actually had a decrease in what you spent. Any explanation on that, please?

J. HAGGIE: I think that was simply down to the fact that there were travel restrictions early on. Medical transportation and ISMT dropped as a result of that.

P. DINN: Thank you.

You noted the $9.8 million was announced in *Budget 2021* for the Medical Transportation program, it looks to me that this is not new money. I just need some clarification on that. Is this new money or is it –

J. HAGGIE: This is what we budgeted for transportation for next year based on our understanding of demand.

P. DINN: Perfect.

I'm jumping ahead here to Grants and Subsidies, that's the big one; that's in the billions.

J. HAGGIE: It's only $2.4 billon.

P. DINN: I'm just looking at that, you talk about – there are a number of things that fall under this. Is there anything being done currently for long-term mental health supports? Long-term mental, I know we do a tremendous amount on the short term but in terms of long-term mental health?

J. HAGGIE: Well, the short answer is yes. We don't refer to it in quite that way. We work on a needs based kind of matrix. What we've done is adopted a model that was pioneer here in Memorial, so-called Stepped Care program. Peter Cornish developed it for students and it was translated into more broader use in the community. In actual fact, it has now reached the international stage. We've been out kind of advocating for this.

Basically, the steps consist of varying components. At step zero, you might have some wellness initiatives; it could even be yoga. Step one: Bridge the gapp and that electronic en suite. One and a bit might be Doorways, usually two, which is open access, go in single session.

Now, if you go into one of those – you take 100 people and turn up at Doorways, by and large 50 plus or minus a couple of those individuals will regard that session as having dealt with their issues. Of the others, the counsellor who sees you then can arrange for onward treatment,

whether that's medium term or long term depends on need and the passage of time. They might be referred to a psychology. They might be referred to mental health and addictions counselling and then they would take up a course of treatment. The duration of that is determined by the clinician.

At the very top end, you would have intensive, in-patient, maybe multidisciplinary treatment, and I would refer to something like the eat disorders unit, which is both physical, psychological, psychiatric and family management for people with complex eating disorders. Not everybody with a diagnoses of an eating disorder would need to go to that level, but that's step five, that's the top of the ladder, as it were, and that's currently located in the Health Sciences Centre and will be adjusted in terms of position when the new mental health and additions hospital opens up because it spans that border where you have family treatment, you have individual psychological treatment, psychiatry treatment and often intensive GI and medical support. In actual fact, we've had patients wanting to come here from New Brunswick for that.

P. DINN: Thank you.

CHAIR: Okay, the Member's time has expired.

MHA Jim Dinn.

J. DINN: Thank you, Madam Chair.

With regard to this section, would new hospital infrastructure be covered under this?

J. HAGGIE: The new capital builds would not; that comes under a bit further down. The operating costs of facilities will come in there. I mean, the bulk of this money, in actual fact, is salaries.

J. DINN: Okay. Thank you.

Under 3.1.01, the Purchased Services, I think you mentioned that there has been a steady increase in the medevac and the ambulances. I'm just wondering: Is that a function of, let's say, an aging population, that we're seeing more people with more need for this, as to why we're seeing the steady increase?

J. HAGGIE: I think a part of it is a success of the reorganization of the cardiology and the cardiac surgery program, the role of percutaneous intervention in acute coronary syndromes and STEMI and this kind of stuff. That is the mode of transportation for most of these patients. One of our unfortunate distinctions is having this significant incidence of cardiac disease compared with the Canadian national average. So this reflects, in some respects, the skills of our interventional cardiologists who have now increased their throughput significantly.

With workflow redesign in the cath lab, help from the Health Care Foundation to endower a fourth room, help from Medtronic to do the workflow stuff, it's really been quite an exciting time for Dr. Connors and his team and they're to be congratulated.

J. DINN: Thank you.

Under Grants, the estimate for this year has increased by about $200 million. The reason for that increase would be what?

J. HAGGIE: Okay, we have a list here. The variance is essentially, it's a cash-flow issue to make sure the RHAs do not run through their line of credit, and it reconciles at the end of the year. There are some fancy accounting terms for this which I don't really pretend to understand but basically what it is, is this doesn't effect the deficit but it does effect the borrowing because it's paid back at the end of the year but we have to borrow it upfront.

J. DINN: Thank you.

Under 3.1.02, Support to Community Agencies, last year's budget book estimated $6.43 million for community supports. This year's book shows that it was estimated for $3,843,000. What's the reason for this change?

J. HAGGIE: Where do you see $6 million, sorry?

J. DINN: Last year's Estimates book.

J. HAGGIE: I'm sorry, Jim, I'm not with you. I'm at 3.1.02.

J. DINN: 3.1.02 that would have been from last year's Estimates book. I was looking at the same thing. I said that must have been a previous estimate. You wouldn't have it in this one but I'm just wondering what the changes, it seems to have dropped, the Estimates book shows that it was estimated that community agencies was basically $3,843,000.

J. HAGGIE: The only figures I have here for Community Support Agencies is under 3.1.02, for our Estimates it's $3,843,000. I'm not sure what other number you could refer to. I can't speak to it.

OFFICIAL: That's coming from looking at last year's Estimates book for last year's Estimates. For that year, the previous 2019-2020, and then gave an estimate for '20-'21 and that estimate for '20-'21 was in the ballpark of $6.43 million. But then looking at this book, this year, the Estimate for '20-'21 was $3.8 million. So the books from year to year didn't sync up.

J. HAGGIE: John will have to deal with that one because I don't have last year's book.

J. MCGRATH: That's the transfer that came over from CSSD with the wellness, the Support to Community Agencies. It's a restatement that went on after the Estimates book last year. If you recall, the departmental organization was really close to when the budget was last year. It wasn't finalized. What they did is they went and they restated it, so really there's no change. It was just working with the other department to figure out what's going where.

J. DINN: Okay, thank you.

And 3.2.01 and 3.2.02, both Low Carbon Economy. I will give you a two for one here. Basically it's the same question for both. What projects will the funds be used for in each of these?

J. HAGGIE: They are fuel switching to public buildings project. That's the Health share. The Current is a reflection of some reallocation from Capital. The Capital – let me see if I can find out what that is. Just bear with me. Does anybody have the Low Carbon Economy page? It's missing from this book.

We have $5.6 million this year, and it's basically about fuel swaps. It's to take people to electricity off diesel or oil. That's $12 million over a three-year period. So this is this year's aliquot of that. Thank you very much, you will find it in here.

J. DINN: Thank you very much.

Under 3.2.03, Building Improvements, Furnishings, and Equipment, this section didn't exist last year. Where do these figures come from? I would assume that's probably your explanation for the previous transfer from one department. Can the minister provide a list of how these grants were used?

J. HAGGIE: Basically what happened is that all infrastructure money was snaffled by TI. Then they realized that they didn't want to know about leaky roofs in Botwood or in Corner Brook or wherever. So they felt, in their wisdom, that we should have this back because it basically is our repairs and renos fund for the RHAs and has sat at this figure, plus or minus, for some considerable length of time.

Thrown in there is also some forecast adjustment for Capital for the electronic medical records project. So it may differ slightly from a build up of what the previous year's R and R fund was.

J. DINN: Thank you, Madam Chair.

That's all the questions I have on this section at the moment.

CHAIR: Okay.

MHA Paul Dinn.

P. DINN: Thank you, Madam Chair.

I'm going to totally confuse you jumping around here.

J. HAGGIE: Just give me time to catch up. I'll be all right.

P. DINN: That's right. It's not the intent.

I'm just stepping back here on the – and you may have answered it in another response, and it's dealing with the RHAs for their fiscal year

ending 2021-22. Can you provide me with an estimate of the financial position of the RHAs for the last fiscal year? Basically, did they record any deficits and did you provide them with funding to cover these deficits? Now, I think you touched on that, but if I could just get another answer on that.

J. HAGGIE: One moment and I will give you the bits and pieces.

Basically, they have had variances from their expense limit, reflecting pressures. So, for example, there is a variance in Eastern Health and that adds up to $54,661,000. That's $17 million of COVID-related cash flows; $12.4 million was negotiated salary increases; $7.4 million was cash flow not related to COVID; direct-client costs, presumably mostly community, was an increase of $6.1 million; it was $6 million related to COVID overtime and salary increases; $3.5 million for mental health and additions initiatives; and a sort of random hodgepodge of another $2 million. So we can supply you with those numbers and a summary of their lines of credit; that's not a problem.

P. DINN: Okay, I appreciate that. Thank you.

In the budget, of course, last year you announced $3.3 million for the new Insulin Pump Program and I think that was prorated, I don't know, maybe, $1.7 million last year.

J. HAGGIE: It was because it was only half the fiscal year because –

P. DINN: Right.

J. HAGGIE: – we had all these fun and games in October, as I recall.

P. DINN: Right, and so we see another $3.3 million this year. Is that an additional or are we just –?

J. HAGGIE: That's annualized based on our data from, essentially, what is aging out of a pediatric program with a few kind of adult add-ins.

P. DINN: Okay.

J. HAGGIE: Most of them come through the Janeway program.

P. DINN: Right.

You also announced just over $715,000 for mental health services through 811. Can you give me some details on what this funding is being used for?

J. HAGGIE: Yeah. Now, just off the top of my head while I rummage around for the right page, mental health 811 we do have a process in place by which anybody who leaves before being seen in an emergency department gets a callback from 811 the following day to make sure they're all right.

My recollection as well is that we have started calling round some Mental Health and Addictions clients specified by Mental Health and Addictions. I don't seem to be able to find the sheet here. HealthLine, where are we?

P. DINN: So just while you're looking there. So the 811, you say they get a callback. Is that a callback if they been seen or if they registered?

J. HAGGIE: If they leave without being seen.

P. DINN: Perfect, okay.

J. HAGGIE: There is a follow-up arrangement for some people with mental health services who attend for that. I don't seem to be able to find that here, but we'll get you the details of what the MH and A piece is.

P. DINN: Okay, no, that's fine.

J. HAGGIE: It might be under this one in statistics here. Bear with me for a second.

P. DINN: If it's not readily available, that's (inaudible).

J. HAGGIE: No, I've got other figures, but I don't actually have the details of that handy. We can get it for you, not a problem.

P. DINN: So I'm just looking at some other issues that have been announced. For example the Newfoundland and Labrador Centre for Health Information will become part of the

Department of Health and Community Services. Can you explain why that's a positive move and what we hope to accomplish by doing that?

J. HAGGIE: What we want to do is several things. Principally, we want to integrate the analytics piece of NLCHI more closely with ourselves in the Department of Health. We've found their input very helpful over COVID, but even virtually it's been sometimes a challenge to link us in a meaningful way all the time. So there's that integration piece.

I would see analytics very much as part of government's decision-support mechanism. You look at real-time data and you make better decisions the more accurate it is. I think it speaks very much to the principle behind Minister Coady's accountability framework. It will enable us to have far better visibility into MEDITECH and the administrative data that is generated by the RHAs directly without us having to trouble them all the time. We have to wait for a data dump at their leisure. We can work round that and so it takes some of the load off them.

Then I think there are areas there, which would lend themselves to corporate service delivery. For example, IT and IM, whilst it's 24-7 and has to be, may not necessarily be that much more unique in health care than it is in running some other government departments, and certainly not different from the RHAs. So that may be a better place for that.

There are certainly back-office functions that would be possible to deal with the duplication there. We started down that road in the era of – someone on the other side who would know – shared services and purchasing. My discussions with the Finance Minister is that we would, certainly within the RHAs, want to extend that to matters of payroll, matters of scheduling and workforce management. Now, indeed, within the course of the next year we'll have a common platform for workforce management across all of the RHAs. So we see NLCHI as becoming an integral part of the day-to-day operations of Health and the RHAs, more broadly.

P. DINN: Thank you for that.

Some people will say that it doesn't seem like a match with the department to be involved in front-line delivery of services when you move over the Centre for Health Information to the department. How do you plan to mitigate any risks of operations? You're dragging over – I won't say dragging – you're bringing over the Centre for Health Information and you're putting it in the department.

J. HAGGIE: I think we would see ourselves maintaining some degree of separation from operations. It's not our intent in the department to become a super-regional RHA within the department itself and bypass Eastern Health, or Central or whomever. I think it's very much more a question of seeing what elements will be operational, like IT and IM, and saying: Where would they best live? The department is really a holding place for the entirety of the lines of business of NLCHI. Some will stay there and some may move on.

P. DINN: Thank you for that.

That leads to my next question when we're looking at this. Can you give us an update on the implementation of this, how it's going to move forward or what's been happening? Are there any savings or job losses related to this move?

J. HAGGIE: The issue of the process, we would anticipate seeking advice on what lines of business are there and how best they would fit with the RHAs and/or the department. Then moving forward on that in terms of savings we don't see that we could quantify that until we know exactly what the results of that first discussion would be.

But, again, if you're removing back-office functions or merging them into other entities – back-office functions as a collective – then you can see that you would have possibilities there for attrition and downsizing, yet maintaining efficiency and effectiveness.

P. DINN: Okay, thank you for that.

A big question here, I guess, comes out of the Premier's Greene report: Do you plan to consolidate the four RHAs?

J. HAGGIE: I think I would bow to the wisdom of the Health Accord NL group. They're certainly looking at the model. As one of the members of the panel said, governance – one RHA, two or whatever – is kind of a tool. Let's build the engine, rather than build the engine around the tool. Make the tool fit the engine.

P. DINN: Second time you used that analogy the week.

J. HAGGIE: Yeah, well, you know, it stuck. It seemed to bring –

P. DINN: I think it was a wrench first.

J. HAGGIE: Yeah, well, you know, I was being technical.

P. DINN: Thank you.

CHAIR: The Member's time has expired.

MHA Jim Dinn, do you have any additional questions?

MHA Trimper.

P. TRIMPER: I just have about one or two minutes here.

I think, Minister, this evening one of the real positive comments I heard was that you look forward to the Health Accord and seeing that as a real way forward. I must say I enjoyed my – and found it very productive in the discussions I've had with the folks that are leading that. So I'm really happy to see that.

I guess things like MTAP and further details on what you might do would be rolling out from that.

J. HAGGIE: I think one of the things around the model is we'll ultimately start to discuss questions of how best to deliver services, particularly in rural areas. You and I, just continuing a discussion we had earlier on, it's not possible or practical to have a neurosurgical service in Goose Bay, for example. The question then is how you would move patients requiring those services with maximum safety and minimum fuss. So transportation, be it ground, air, elective medical transportation, MTAP: those would be all matters that would need to be woven in to whatever Health Accord NL looks like.

P. TRIMPER: Right on.

Just a final thought, then. I have a list of issues that we're dealing with in Lake Melville. They're, frankly, I would say, 100 per cent within the purview of Labrador-Grenfell Health and I'm working closely with the CEO and her team, and I thank her for that. Mostly around specialist positions, equipment and, further to what you just said, what is the best way to deliver the services to folks who live in the more rural parts of this province, yet we're trying to provide equal health care and so on.

With that, I'll sign off and say thank you very much. I'll carry on working with the CEO and we'll watch for that Health Accord.

Thanks very much.

J. HAGGIE: Good. I'm glad you have a good relationship with the CEO.

P. TRIMPER: We do. Very good.

Thank you.

CHAIR: Okay, I will ask the Clerk to recall the grouping.

CLERK: 3.1.01 to 3.2.03 inclusive.

CHAIR: Shall 3.1.01 to 3.2.03 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 3.1.01 through 3.2.03 carried.

CHAIR: I shall ask the Clerk to call the final vote.

CLERK: The total.

CHAIR: Shall the total for the Department of Health and Community Services carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, Department of Health and Community Services, total heads, carried.

CHAIR: Shall I report the Estimates of the Department of Health and Community Services carried?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, Estimates of the Department of Health and Community Services carried without amendment.

CHAIR: The date of the next meeting will be at the call of the Chair.

Can I ask for a motion to adjourn this meeting?

J. WALL: So moved.

CHAIR: MHA Wall.

The meeting has been adjourned.

Thank you very much.

On motion, the Committee adjourned *sine die*.