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Department of Health and Community Services

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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: Mark Jerrett

Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
Andrea McKenna, Deputy Minister
John McGrath, Assistant Deputy Minister, Corporate Services (via video conference)
Gillian Sweeney, Assistant Deputy Minister, Population Health and Wellness
Fiona Langor, Assistant Deputy Minister, Programs
Vanessa Mercer-Oldford, Assistant Deputy Minister, Regional Services
Blair White, Assistant Deputy Minister, Digital Health
Chad Antle, Departmental Controller (via video conference)
Melony O'Neill, Director of Communications
Alicia Anderson, Executive Assistant to the Minister

Also Present
Hon. Steve Crocker, MHA, Minister of Tourism, Culture, Arts and Recreation (via video conference)
Hon. Gerry Byrne, MHA, Minister of Immigration, Population Growth and Skills
Paul Dinn, MHA
Lela Evans, MHA
Perry Trimper, MHA
Steven Kent, Third Party
Benjamin Pollard, Government Members' Office
Bradley Russell, Official Opposition
Bobbi Russell, Policy and Communications Officer, House of Assembly

Pursuant to Standing Order 68, Steve Crocker, MHA for Carbonear - Trinity - Bay de Verde, substitutes for Sherry Gambin-Walsh, MHA for Placentia - St. Mary's.

Pursuant to Standing Order 68, Gerry Byrne, MHA for Corner Brook, 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.

Pursuant to Standing Order 68, Lela Evans, MHA for Torngat Mountains, substitutes for James Dinn, MHA for St. John's Centre.

The Committee met at 6:03 p.m. in the Assembly Chamber.

CHAIR (Reid): Okay, we're ready to go now, I think.

So the first thing I have to do is announce the substitutes. The Member for Corner Brook is substituting for the Member for Burin - Grand Bank; the Member for Carbonear - Trinity - Bay de Verde is substituting for the Member for Placentia - St. Mary's; the Member for Topsail - Paradise is substituting for the Member for Placentia West - Bellevue; the Member for Torngat Mountains is substituting for the Member for St. John's Centre.

That's the list of substitutes. The first thing, I guess, the usual process – there's no unaffiliated Members here, so I guess if someone shows up we can deal with that later on. We'll have a break a little while into the process. What time did we suggest for that, around –?

AN HON. MEMBER: (Inaudible.)

CHAIR: We'll see how things are going; 7:15, 7:20, we'll try to have a break at the end of one of the headings.

Just a few instructions there, a reminder to witnesses, departmental officials, always identify yourselves and wait for the red light on your microphone to come on each time. If the light doesn't come on, maybe just wave your hand so that the Broadcast Centre identifies where you are.

Consistent with protocols effective in the Confederation Building complex at this time, masks must be worn in the Chamber by employees unless they are speaking. It is at the discretion of Members. Members and officials are reminded not to make any adjustments to the chairs that they're sitting in. Also, the water coolers are located up here and down at the other end, each end of the House.

First, I'm going to ask the Committee Members to introduce themselves and their research staff as well. So we'll start right here.

P. DINN: Paul Dinn, Topsail - Paradise.

B. RUSSELL: Brad Russell, Opposition Office, Director of Communications and Digital Strategy.

L. EVANS: Lela Evans, Torngat Mountains.

S. KENT: Steven Kent, Sessional Political Support for the Third Party.

G. BYRNE: Gerry Byrne, Corner Brook – beautiful and historic as it is.

L. STOYLES: Lucy Stoyles, Mount Pearl North.

B. POLLARD: Benjamin Pollard, Political Staffer, Government Members Office.

CHAIR: Next I'm going to ask the minister to introduce the staff here.

J. HAGGIE: Thank you very much, Chair.

John Haggie, MHA for District of Gander.

What I'll do is that I'll let my staff introduce themselves; I'll start with the two online. So we can go to John McGrath; say a few words, John.

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

C. ANTLE: Chad Antle, Departmental Controller.

J. HAGGIE: Thank you, Chad.

Now to my left.

A. MCKENNA: Andrea McKenna, Deputy Minister.

F. LANGOR: Fiona Langor, Assistant Deputy Minister of Programs.

G. SWEENEY: Gillian Sweeney, ADM for Population Health and Wellness.

B. WHITE: Blair White, Assistant Deputy Minister of Digital Health.

V. MERCER-OLDFORD: Vanessa Mercer-Oldford, ADM for Regional Services.

A. ANDERSON: Alicia Anderson, Executive Assistant to Minister Haggie.

M. O'NEILL: Melony O'Neill, Director of Communications with Health and Community Services.

CHAIR: Okay.

I think everyone has introduced themselves, right?

S. CROCKER: Mr. Chair, it's Steve Crocker; I'm online.

CHAIR: Okay, Steve Crocker is online.

To hear the online participants, you'll need an earpiece. If anyone doesn't have one, we have some extras up here. We can circulate those. Does anyone need one?

So masks are mandatory for employees. The first order of business is the minutes from our last meeting, April 3, 2022. Do I have a mover for that? I think the copies have been distributed.

The Member for Corner Brook; seconded by the Member for Mount Pearl North.

On motion, minutes adopted as circulated.

CHAIR: So in terms of time allocated for unaffiliated Members, the same process we've been using is that at the end of the session, the unaffiliated Members have 10 minutes each to ask questions, once the Committee has concluded its business towards the end of the meeting.

Does the Committee agree to allow unaffiliated Members to have 10 minutes at the end of the meeting? Okay, Members are agreeable to that.

So the minutes are passed. The next thing we need to do is I'll ask the Clerk to call the headings.

CLERK (Jerrett): Executive and Support Services, 1.1.01 to 1.2.02.

CHAIR: Okay, and usually we give the minister 15 minutes to make any introductory remarks.

J. HAGGIE: Thank you, Mr. Chair.

I will not use all of my 15 minutes, conscious of the fact that Members opposite I am sure would wish to pose some questions at the time rather than listen to me.

At the beginning, from my point of view, I would like to point out that the staff you see before you, both here and virtually, have been actively involved and continue to be actively involved in our COVID response. Whilst in the media this may have subsided to a dull roar, there is still an awful lot of work that is going on in the background and I think some of the answers to the questions that will be posed today can be answered by the statement I am going to make at the moment, that these people have put down their pens from their regular work over the course of the last two years and I would say 80 to 85 per cent of their time has been preoccupied with responses to COVID in terms of operationalizing the orders when we were under special measures orders and the state of emergency of the chief medical officer of health and also liaising with the regional health authorities and providing the logistic support necessary to mount what I would argue has been one of this country's most successful responses to COVID-19 over the last two years.

I say that not by way of any excuse or diminution of the fact this budget will stand on

its own merits. The work they have done is of their usual, extremely high standard. This is the third time they have done this in a two-year period and I think the results will speak for themselves as far as the process is concerned.

Health and Community Services is the largest of the government departments in terms of its expenditure. We have and continue to try and shift further our focus to be on outcomes rather than process and we are also committed with our older initiatives and with the upcoming Accord to make sure we get the best value for the dollar that we spend on health care, recognizing that whilst we compare ourselves and are compared with other provinces, at least 48 per cent of our population, effectively, live in areas where the density is the same as that of a territory. So we are in a unique mix of fish and fowl when it comes to the delivery of health care. That poses challenges from a delivery point of view, but it also poses challenges from a cost point of view.

Historically, this government and its immediate predecessor, which I was a part, have contained health care expenditure to way less than the inflationary percentage each year. This year, however, we do have a noticeable increment. Happy to talk about that as the evening wears on. These are easily explicable by some of the changes that we need to bring about, and also we have seen some federal money flowing through our budget, which would account for our increased expenditures over the course of the last little while.

But the fact is, some of these expenses are baked into our budget because they are factors outside the direct control of the Department of Health, and particularly relate to labour costs. Of our budget, of the order of 65 to 68 per cent is in actual fact related to salaries, and that makes us subject to the collective bargaining process for the bulk of these individuals. That is one that is managed by a different department, in conjunction with advice from this department.

With that really, happy to work our way through and see what questions come out, and I will do my best to answer them. If they're really difficult, I'll pass them to staff.

CHAIR: The Member for Topsail - Paradise.

P. DINN: Thank you, Chair.

I do appreciate the efforts made by staff during the last two years. Don't take that as I'm going to be easy on you this evening, although it will be pretty straightforward, no doubt.

I'll just proceed. I have some general questions to get started with.

CHAIR: Yes, as the first speaker, you have 15 minutes.

P. DINN: I'll go through some general questions first, just to get those out of the way, and I'll proceed then to the first section.

The obvious question is: Can we get a copy of the minister's briefing book?

J. HAGGIE: We will provide it electronically, in the interest of preserving our forests.

P. DINN: Okay, thank you.

In that Estimates book, are there are any errors or omissions that we should be aware of?

J. HAGGIE: None that I am aware of. Just for the record, in terms of sharing it, we'll certainly be making copies available to the Third Party as well. It's accurate to the best of my knowledge.

P. DINN: Thank you.

In speaking to the attrition plan, is the attrition plan being followed? If so, are there any changes over the last year?

J. HAGGIE: The attrition plan still exists. It is based mostly now on retirement, and some of that in actual fact, in certain areas, has accelerated. We rely on the health authorities to follow their mandate through the attrition plan. We'll be happy to provide details of staff within the department, when we get to that point.

P. DINN: Thank you.

How many are currently employed in the department?

J. HAGGIE: We currently have 271 employees, of whom 189 are based in West Block. The others are divided between Stephenville and Grand Falls-Windsor.

P. DINN: Okay.

And you did mention retirements. How many retirements have we seen in the last year?

J. HAGGIE: My understanding from the information I have is …

Retirement, we have had 13 in '21-'22 for a cost of $176,700, compared with five in '20-'21 fiscal year for a cost of $206,600.

P. DINN: Perfect, thank you.

In terms of vacancies, any current vacancies in the department, and how many, if there are?

J. HAGGIE: One moment, I have a – I was looking for this before and I found the damn thing, knew you'd ask for it, and now I put it down somewhere.

We actually have a 5 per cent vacancy factor we factor in each year. We do, however, have an increase of 16, which were new positions which were announced in October for the bridging plan, as you may recall. And with that we lost seven contractual positions that were pandemic related.

P. DINN: Okay, and that's related to this then.

So how many layoffs have occurred in the department in the past year.

J. HAGGIE: No one, to my knowledge, has been laid off. Contractual positions terminated as a result of the end of the pandemic.

P. DINN: Okay.

And the number of new hires?

J. HAGGIE: New hires. Well, I lost my place again now. I had 16 there for a minute. Hang on a second.

There were 16 new hires. I can break that down or we could provide you with a list of them. They're all essentially related to the bridging plan that was submitted to Treasury Board before.

P. DINN: Okay.

So outside the bridging plan, that's where most all the new hires occurred?

J. HAGGIE: No, we have an ADM for Digital Health here behind me, and the 16 were in addition to that.

P. DINN: Perfect.

And you touched on this. So how many contractual or short-term employees are currently hired with the department?

J. HAGGIE: I have that here. We have 206 permanent, 30 temporary and 35 contractual, for a total of 271.

P. DINN: Thank you.

And talking about COVID, how much money has the department received from the COVID fund and what was that amount used for?

J. HAGGIE: We had a total COVID cost for '21-'22 of $30,927,000. There is a variance there of – well, there's a projected shortfall across COVID of $69 million; we have broken that down or can provide that by health authority, should you wish it.

P. DINN: That would be nice if we can get that, I'd appreciate that.

Did the department receive any funding from the contingency fund? If so, what was it put toward?

J. HAGGIE: Yes, we did. In actual fact, that's where the bulk of it came from. We received money for COVID, which came out of contingency, which was $69 million. We have had expenditures related to the cyberattack which were just fractionally under $16 million. They were flowed through to the health authorities and the Centre for Health Information.

P. DINN: Perfect.

Just moving into the actual section now. I'm looking at 1.1.01, Transportation and Communications. I note that in the budget last year it was budgeted for $40,000, it dropped to $20,000 revised and you kept it at $20,000. What was the issue in terms of decreasing that amount and keeping it there?

J. HAGGIE: Technology. We do a lot of our work through Zoom or platforms like Webex or the RHAs use Teams and it's made a significant difference in our ability to utilize our time more efficiently as well as less on the Transportation budget.

P. DINN: Perfect. I was thinking that, but we've still got to ask it.

J. HAGGIE: No, no, fair enough.

P. DINN: So just moving down here to 1.2.01, I'm looking at the Salaries and, of course, there was a difference last year from the budget to the revised of about $300,000. What happened there to cause that increase?

J. HAGGIE: We now have someone who is unfortunately not here tonight, an associate deputy minister of Health, in addition to the ADMs on executive and that's the change you see there, the bulk of it.

P. DINN: And just on that same line, we see an increase of just shy of $83,000 for the coming year. Is that an additional position as well?

J. HAGGIE: Is that on 1.2.01?

P. DINN: Yeah, Salaries, and that's just going from the revised of last year to the current estimates.

J. HAGGIE: Yeah. Essentially, the variance is a cumulative effect of the addition of a senior position in associate deputy minister and an additional media relations manager, so our communications staff have increased as well.

P. DINN: Okay, thank you.

Just looking at Operating Accounts, we see an up and down and up there as well. So if you can explain the drop from the budget to the revised of last year and then the increase again to $25,000.

J. HAGGIE: Sorry, what are we looking at?

P. DINN: Operating Accounts under 02.

J. HAGGIE: Oh, 1.2.02, okay. Yes.

P. DINN: 1.2.01.02, I guess.

J. HAGGIE: Now hang on, 01 or 02?

P. DINN: It is just where we talked about Salaries, 01; it is 02 we're talking about, Operating Accounts.

J. HAGGIE: Okay, right. Yes, I got you.

So the issue there is an addition. You'll see a reduction in –

P. DINN: So that's the Transportation piece, I guess, is it?

J. HAGGIE: Yeah, well, I mean, again, Transportation, we've taken out savings of $11,000. Supplies, we've gone through zero-based budgeting exercise. Purchased Services, again, zero-based budgeting we've gone down slightly.

P. DINN: Okay, thank you.

Just a clarification, we're going to 1.2.02 or no? Is it finished?

CHAIR: 1.2.02 is my understanding.

J. HAGGIE: That was called as well, I believe.

P. DINN: Okay, so I'll continue on then.

So we're looking at 1.2.02, we're looking at Salaries again. We're look at the budgeted amount there of $16,700,000, we'll say, and it dropped to $15.9 million.

J. HAGGIE: Right.

P. DINN: A decrease of about $800,000. Can you explain that decrease, please?

J. HAGGIE: The shift there for that year, between the budget and the revised, some of those posts were held vacant over the course of the year and some of them were used then to offset the overage in Executive Support. The difference between the revised and the Estimates have other reasons behind it and that is a money in and a money out; I can explain if you want.

P. DINN: Okay. And, of course, we see it going back up in '22-'23.

J. HAGGIE: Yeah.

P. DINN: So what is happening there; that is actually increasing more.

J. HAGGIE: Yeah, there are 16 new positions that account for $1.2 million, offset by a reduction in overtime from '21-'22 and the vacancy factor of around $330,000 because we didn't fill some posts because of COVID.

P. DINN: Perfect.

I'm looking at Transportation and Communications, we see there that you're going to spend $78,000 more, apart from what you had last year. Can you explain that one?

J. HAGGIE: Yes, the dollar change is about $86,000. There are travel costs for the health professional recruitment office, per bridging plan. Some money went out to Grand Falls-Windsor postage budget. If you recall, there were a lot of people who, when they came to access their VaxPass and results data, their MCP wasn't valid, so there's been a surge in renewal of MCPs and those are provided by postage.

There's just under $40,000 to increase phone budget for cellphones and landlines because of our increase in staff and a small increase through zero-based budgeting of about $3,000, which is based on previous year's actuals.

P. DINN: Just to extend that a little bit, when you talk about travel for recruitment and retention, how much is exactly allotted to the recruitment and retention?

J. HAGGIE: $25,000 for travel.

P. DINN: I just assume that's travel you can't do through Zoom; you have to actually go?

J. HAGGIE: You have to go to national conventions like the Society of Rural Physicians of Canada, the CCFP national, these kind of things. These are places where you will build networks of students, residents, these kind of things, that you will then use to capitalize in future years for recruitment. You can't easily or even practically, I would argue, based on personal experience, do that over the phone or through Zoom.

P. DINN: No, I agree. I just would have thought actually $25,000 would be on the low end of that.

J. HAGGIE: Well, I think a lot of the – it's going to be a mix, because there is a lot less still, for the coming year, I would imagine in terms of face-to-face encounters, compared with say 2019 or 2018.

P. DINN: Okay, thank you.

Just moving along to Professional Services here and we see it was about $1.7 million in the budget last year, which it dropped to about $1.4 million, that's about $389,000 that wasn't spent. Then it jumps back up to $1.778 million. Can you explain the up and down in that as well, please?

J. HAGGIE: The savings were due to savings related to various contracts. The Medical Consultants' Committee didn't meet for MCP because of COVID so that saved us about $70,000. There was some delayed expenditure on mental health-related initiatives, around $30,000. There was some delay in expenditure related to ePCR and CME and we had delays with our software solution for paramedicine, the regulatory aspects that we took in the department.

The reason it's gone back up again is a *Personal Health Information Act* statutory review will occur this year. That accounts for $100,000 of it and then there is a zero-based budgeting adjustment as well.

P. DINN: So just on the same line, I'm thinking of the Medical Association negotiations. Where were they accounted for? Were they last year or this year? Are they still in this budget?

J. HAGGIE: The contracts related to the NLMA negotiations were reduced expenditure, but the negotiations themselves are actually conducted by HRS, Human Resource Secretariat. We've never, in my experience here in previous occasions, had a line item for expenditures, other than maybe some consulting contracts. And there is one I refer to where we spent less.

P. DINN: You went through a number of contracts: MCP, mental health, ePCR, CME –

CHAIR: The Member's time has expired.

P. DINN: Oh, I'm sorry. Okay, I'm good.

CHAIR: We'll move to the next Member, the Member for Torngat Mountains.

L. EVANS: Yes, thank you.

I'll just start off with some general questions.

Has the new position for the Assistant Deputy Minister of Health Professional Recruitment and Retention been filled yet?

J. HAGGIE: Yes, it has.

L. EVANS: Okay, thanks.

J. HAGGIE: Sorry, I misheard the beginning. Maybe I should use my earpiece, forgive me. I'm not used to it these days. I apologize.

L. EVANS: Also, can the minister provide an update on the plans to enable IVF services within the province?

J. HAGGIE: There are discussions ongoing between Eastern Health and Newfoundland and Labrador Fertility Services. The travel treatment subsidy for people who have to go out of province went live today. The application process is up and Eastern Health are operationalizing that. They have a PSA out about how it can be done.

Claims will be backdated to the date I announced that the plan was coming. So anything after August 4, I think, of 2021 is eligible.

L. EVANS: Thank you.

Can the minister provide an update of the two collaborative team clinics that are supposed to be opened, one in Central and one in Western?

J. HAGGIE: Yes, the one in Central and the one in Western have locations identified. There are jobs posted, certainly, for the Central one and I don't know that they have closed yet. There were discussions in both health authority areas with the communities to try and identify any unique needs for those communities to make sure that the skill set matched the need.

L. EVANS: Thank you.

The closing dates for the RFP for a Health Human Resource Plan is April 8. Can the minister comment on when we expect a decision on which of the four bids will be selected. Also, can you comment on the selection criteria that's being used?

J. HAGGIE: Not in detail to the latter. The issue of when the decision will be made, my understanding is those are fairly inclusive tenders or submissions, so that process is under way. I don't have a timeline and my deputy doesn't either currently, so we're working through it.

L. EVANS: Thank you.

The Health Accord is calling on an improved and more integrated IT system for the RHAs. In light of the previous reports that highlighted long-term cost-saving opportunities of such an upgraded system, does the department plan on conducting a review of the IT systems used by RHAs just to gauge the need for updates?

J. HAGGIE: I think it's generally accepted that some of our systems – and there are a lot of systems in Health – are legacy. One of the things

we have done very well through the department – and I think we'll improve upon there; we have an ADM of Digital Health – is the ability to put interfaces and translators there to actually let one module that wasn't designed to, speak to others.

Certainly I do know, for example, with the new acute care hospital in Corner Brook, the health information system is going out to the market through the P3 process, but the requirements around scalability and interoperability will be key, I think, in informing what the market currently has. We have plenty of assessments; I think the next stage is to see what the Corner Brook acute care RFP comes back with, because that's going to be our current market sounding.

L. EVANS: Thank you.

The *Towards Recovery* report called for the adoption of harm reduction as a fundamental approach to mental health care and addictions. That sentiment was also echoed by a group of MUN medical students during their day of action earlier this year. Can the department comment on the level of harm reduction and also trauma-informed care training provided to front-line medical staff?

J. HAGGIE: Both of those were key recommendations from *Towards Recovery*. I think even before the *Towards Recovery* report was actually inked, we started down the road of harm reduction. We introduced a free Naloxone kit policy; we have embedded harm reduction as part of the key for really all elements. It's kind of like a lens that we have used for each of the teams working on various areas within the mental health *Towards Recovery* implementation process.

Certainly, in terms of trauma-informed care and education and awareness about that, that is an ongoing program in each of the regional health authorities. I think it would be very hard to quantify it, because quite frankly a lot of those things would have required staff to leave their acute care duties to physically or virtually attend that training. My latest reports from staff, that has been delayed but still under way.

L. EVANS: Thank you, Minister.

The last of my general questions: During the last Estimates there were seven FACTT, which is Flexible Assertive Community Treatment Teams, mobilized with another six planned. Have those new teams been mobilized?

J. HAGGIE: Yes.

L. EVANS: All six?

J. HAGGIE: My understanding is all six and I think there might be another two in the works.

L. EVANS: Okay, thank you.

Just going to section 1.2.02, Departmental Operations, can the minister comment on what plans the department has on streamlining air ambulance services as per the Health Accord recommendations?

J. HAGGIE: In this budget you will see the base budget for air ambulance has been increased to reflect actuals. In terms of plans for the future, we certainly have had frequent discussions with the co-chairs. We're waiting to see what their blueprint produces before taking any final ideas to Cabinet. But, certainly, in terms of options, we have worked on several options for ground and for air. It's simply a matter then of putting them into context and seeing what makes sense in light of the Health Accord recommendations.

L. EVANS: Okay, still staying within the same subsection, under Purchased Services, last year the actuals were $91,300 under budget, yet this year's estimate has increased by $18,200. What's the reason for this?

J. HAGGIE: That's a mix. There's $20,000 in there for the operating costs related to the Health Professionals Recruitment Office that was approved by Treasury Board, and then there is a slight decrease through zero-based budgeting that balances out $18,200.

L. EVANS: Thank you.

Under Revenue - Provincial, what was the source of the extra $100,000 in revenue last year?

J. HAGGIE: This is in actual fact an increase in MCP overpayments and refunds from vendors. So it's very much an ad hoc issue. It's part of our audit process to go back to audit billing. There's a very active program, for example, and the bulk of that was physician overpayment.

L. EVANS: Thank you.

I'm finished.

CHAIR: You have a minute and 40 seconds left.

L. EVANS: I'm finished with the questions for this section.

CHAIR: Any other Members of the Committee want to ask questions of this round before we move back?

The Member for Topsail - Paradise.

P. DINN: When I left off, I was looking at Professional Services, and you spoke to savings and you mentioned various contracts: MCP, mental health, ePCR, CME. Can we get a listing of those, of what contracts are contained in that section?

J. HAGGIE: Certainly.

P. DINN: Okay, appreciate that.

It's been mentioned a few times here, in Transportation and Communications and Professional Services, talked about so much that's allotted to recruitment and retention. Can we get a breakout of what costs are associated with the new recruitment and retention process?

J. HAGGIE: Certainly yes, we can give you a breakout of the bridging plan post, the ADM costs and then the money allocated for travel and for operating costs.

P. DINN: Perfect.

J. HAGGIE: They're all contained in here, but we can –

P. DINN: And some of that will probably be in these questions I'm going to ask now. Just looking at Property, Furnishings and Equipment, we saw you budgeted $62,100 last year, it went up to $80,000 and it's dropped off. Is there an explanation for that?

J. HAGGIE: Yeah, there was computer equipment purchased for that because of people needing laptops rather than desktops, and there was also some kind of routine purchases like desk chairs, filing cabinets and, of course, the increase in body count as it were with the staff.

P. DINN: Would the new office for retention and recruitment take in any part of that expenditure?

J. HAGGIE: Actually, no, I think I may have misspoken in that sense there. The projected revised is money that has been spent. So in terms of some of the bridging staff, yes. Whether it's all of them or just some of them, I wouldn't be able to tell you.

P. DINN: Okay.

Looking at Grants and Subsidies, I'm looking at the $891,000, basically, that was approved in the last two years and the drop-off to a little over approximately a quarter million, we'll say. Can you explain that, please?

J. HAGGIE: That's accounting moving. The money for tobacco control is gone out of the healthy living grants, which is what you're looking at here, and it's moved to mental health and addictions grants, which are under RHA Grants and Subsidies. So that money's not gone, it's just moved on to a different head.

P. DINN: Perfect, thank you.

Looking at provincial revenue, we saw a $360,000 increase in the revised of $100,000 and then drop off again to $360,000. Just an explanation for that jump and decrease.

J. HAGGIE: The jump was $100,000 in recovery of overpayments from physicians. This is an ad hoc revenue, so it does vary modestly from year to year. So that is an estimate of what we could probably get this year. It may be under; it could be quite a bit under. But it also is reasonable, based on historical.

P. DINN: Okay, thank you.

And I'm good with that section.

CHAIR: Okay, good.

Any other Members have further questions for those headings? No, okay.

I'll ask the Clerk to just remind us of the headings.

CLERK: Executive and Support Services, 1.1.01 to 1.2.02.

CHAIR: Shall headings 1.1.01 to 1.2.02 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: Before I carry that, I'll ask Minister Crocker how he votes.

S. CROCKER: In favour, Mr. Chair.

CHAIR: Thank you.

Those headings are carried.

On motion, subheads 1.1.01 through 1.2.02 carried.

CHAIR: So we'll move to the next headings.

CLERK: Client Services and Support, 2.1.01 to 2.3.01.

CHAIR: Next headings are 2.1.01 to 2.3.01 inclusive.

The Member for Topsail - Paradise.

P. DINN: Thank you.

Just before I start a general question on the drug program. In the budget, you announced $8.6 million to fund new drugs under the Provincial Prescription Drug Program to treat cancer and other illnesses. Can we get a list of the current drugs and the new ones that have been approved?

J. HAGGIE: Certainly the new ones won't be a problem at all, yes.

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

I'm looking at 09, Allowances and Assistance. If I look at this, you had an increase of about $5 million over the previous year. Can you explain that increase?

J. HAGGIE: This is the difference between '21 budget and '21 revised, or is this the difference –

P. DINN: Yes, you're right.

J. HAGGIE: '22 actuals to the budget, basically it's higher use of biologics in cancer chemotherapy and hepatitis C that have driven those. Those are drugs which are not often prescribed in necessarily large numbers in terms of some of the biologics and hepatitis C, but they are hideously expensive. There are also new indications for Eylea Lucentis for degenerative vascular eye disorders. There's a higher spend on pharmacists administering vaccines, so that's figured in this area here as well. They were very helpful during COVID, and that's why you see the cost.

P. DINN: And I would suspect then the new estimates are to account for that?

J. HAGGIE: The new estimates are related to the new drug therapies that are coming on board this year. In here you'll see $134,000 for new oncology and $5.7 million for non-oncology therapies. The bulk of oncology therapies are actually under Eastern Health, because they fund the provincial cancer program. These would be those elements that relate to the NLPDP and therapies that could be administered at home.

P. DINN: Thank you.

Provincial - Revenue, so we see a little bit of a fluctuation there from $8.7 million to almost double and then drop back down again. Can you explain that up and down there, please?

J. HAGGIE: We get rebates under the NLPDP from drug listing agreements. These are standard in the world of pharmaceuticals. They vary and as you can see there, there is the variance.

P. DINN: Okay. Thank you, Sir.

I'm looking at 2.2.01, Professional Services: I see a huge variance there – well, not so much from the budget and revised but you have jumped up to $405 million. Can you explain that jump there?

J. HAGGIE: NLMA Memorandum of Agreement is the bulk of it: $27,426,000 is the new agreement with the NLMA and then there are other elements in there so there is $5.5 million which is increased utilization of the fee-for-service budget; $250,000 was reprofiled back from departmental salaries because of less overtime.

On the other side, we have reprofiled $1 million out of here. The Athena Health Centre was funded through this Professional Services budget, but we have reprofiled it to RHA grants for block funding for security from their point of view, from a financial viewpoint, they were very keen on that and that was something that was fairly straightforward; $4.7 million has been reprofiled to Central Health to cover Health Hubs so that goes out of this area. Then we have added in some family practice sessions with the new CTCs and that adds $312,000. So it is a netting of those.

P. DINN: I'll keep one question for later.

So looking at Allowances, 09, we see an up and then a down and up there again as well. Can you speak to that, please?

J. HAGGIE: Yeah. That is out-of-province billing, so patients who are out of the province require care and we reimburse the province for that care under reciprocal billing arrangements. So payments on behalf of residents of other provinces for whom we do the same, comes in under revenue. This is where the expenses go. You can see that the budget and the revised dropped because of a lack of travel and we're anticipating that travel going back to pretty well normal levels and added a little bit, $500,000, for probably an increase in travel and utilization.

P. DINN: Can we attribute that to COVID?

J. HAGGIE: I think that is probably pretty safe, yeah.

P. DINN: Okay.

Looking at Grants and Subsidies, that's line 10, you budgeted for $117 million, you didn't utilize all that, dropped by $2 million, but then you've increased it again. An explanation on that. I believe you're increasing about $13 million from the previous – it looks like.

J. HAGGIE: Yeah, that's the salaried portion of the NLMA MOA; that would be where that would appear. Included in there as well is the NLMA get subsidy to their Canadian Medical Protective Association fees. We provide a 75 per cent subsidy for physicians; it's a retention and recruitment strategy, which has been there for some time now.

P. DINN: Okay, thank you.

Looking at the Revenue - Provincial, we see an up and down there as well; it went down one-third and came back up a third. Can you explain that variance as well, please?

J. HAGGIE: Yeah. That's the come-from-away crowd who get sick here, we'll bill their province. So, again, it went down because of travel and we anticipate it going back up because of the hopeful successes of Come Home Year '22.

P. DINN: We all hope.

I'm into the Dental piece, 2.2.02, and I'm looking at the Operating costs, they drop by – just one second. Yeah, I see a decrease of about $3 million and then back up again. Can you explain that as well?

J. HAGGIE: We've attributed that to COVID. But, you know, some of this was more discretionary than others and people kind of voted with their feet.

P. DINN: Okay, thank you.

I do agree with you on the COVID. It's after affecting a lot when it comes to travel and that, no doubt about it.

I'm looking under 2.3.01.

J. HAGGIE: 2.3.01, okay.

P. DINN: Memorial University Faculty.

J. HAGGIE: Yeah.

P. DINN: I'm looking at 10, Grants and Subsidies, and we see a variance there; last year they actually needed about, I'll say, $3.5 million or $4 million more and then we dropped it back down to $54 million. Can you explain that, please?

J. HAGGIE: We assisted them with a projected operating deficit and a negotiated salary increase. The operating deficit was a one-off and was after discussions with the faculty. One of their accreditation criteria as a medical school is related to financial solvency and we felt the risk of jeopardizing a satisfactory accreditation was not worth the $2.5 million.

P. DINN: Okay.

J. HAGGIE: They had reduced that deficit progressively on their own, but it was a question of they couldn't do it all in that fiscal year. We've done it, and then the undertaking is that they will continue with their expense reduction as planned.

P. DINN: So just related to that, and maybe it's a question for Memorial, maybe it's not, what measures would the faculty be taking to stay within this budget?

J. HAGGIE: Again, that question would be better directed to the faculty. My understanding is that they have removed discretionary travel where at all possible. They have looked at administration support. My discussions with the dean would suggest that none of these reductions in expenditure have impacted directly on faculty. But I'm speaking here from memory and third hand. You'll get a better answer if you speak to the dean or to the president of Memorial, should they come to Estimates.

P. DINN: I appreciate it.

I'm not going to squeeze one in in 20 seconds, so I'll pass it along.

CHAIR: The Member for Torngat Mountains.

L. EVANS: Yes, thank you.

Under 2.1.01, the Provincial Drug Programs. So we're back there again now.

J. HAGGIE: Yeah, no that's fine. I just need to catch up with the placeholder.

L. EVANS: When was the last time there was a review of the income eligibility thresholds for the provincial drug card program under The Access Plan?

J. HAGGIE: I wouldn't be able to tell you in detail. I know we have looked at them within the department. But in terms of a formal review, I don't have that to hand.

L. EVANS: Okay, thank you.

Under the same heading, how many requests for an internal review of income support and drug card cases were received by the department in the last year?

J. HAGGIE: I don't know, but I can find that out for you.

L. EVANS: Okay.

Moving on down to 2.3.01, Memorial University Faculty of Medicine, the *Towards Recovery* report recommended increasing health care professionals involvement in addictions medicine. The report specifically calls for the MUN Faculty of Medicine to establish a clinical program director of addictions medicine.

So is the department still encouraging the faculty to make that change?

J. HAGGIE: We want to develop a provincial hub for addictions medicine and the academic backing for that, as it were, would come from within Memorial. I do know there are people in the field of addictions medicine with teaching positions related to Memorial who have stepped up from a clinical perspective, but I wouldn't be in a position to provide you with much more detail on the background. Certainly, we need to build up that expertise locally and if that was the way that Memorial felt was the best way to do it, then we would be happy to help them in whatever way we could.

L. EVANS: The Member for Topsail - Paradise was too efficient in asking my questions. So I have run out of questions for this section.

Thank you.

CHAIR: Does any other Member of the Committee have questions they would like to ask?

The hon. the Member for Topsail - Paradise.

P. DINN: Thank you.

Just to finish off this section on when we were talking about Memorial University, the faculty – and I understand that they are thrown at the dean for questioning. But because the shortage of doctors has been so huge and we are looking at ways to recruit and retain and, perhaps, one of the best ways is to retain our own as you graduate, do you see the grants and subsidy piece affecting the ability of the faculty to increase seats for Newfoundlanders and Labradorians and, secondly, to keep them here?

J. HAGGIE: I think you make an interesting point about retention. I think family medicine, particularly, is undergoing something of a resurgence of interest as a career choice, and quite rightly so. We have had the first iteration of what is called the CaRMS match. The Canadian Residency Matching Service placed 32 residents into our 35 seats. The second iteration is not yet completed and the two vacancies, according to my memory, are in Central.

We, according to CIHI, are second only to Quebec in this country in our long-term retention of medical school graduates from the province. I would like to be first, but we beat out the others. Again, we are all in the same HR storm, but our boat isn't leaking anywhere near as badly. I think the ADM of recruitment and retention will go further to help with that. I do know that we are looking at ways to increase the number of residents, particularly in family medicine, and I do know that there are going to be challenges beyond a certain point.

There are also changes to the training requirements for family medicine coming that will factor into that which may impact any short-term decisions. We were talking to the College of Family Practitioners as recently as this morning and there are changes planned to the length, on paper, of a family medicine residency but equally there is then talk of moving to competency-based training which removes the time factor.

Universities' post-graduate training schemes have struggled with that, because they really don't know how to do it. It's easier if you're a year one, two, three or four, but if you're in year three and have all your competencies for year four and are on paper ready to do the exams, the system nationally, the College of Physicians and Surgeons, for example, can't quite cope with that yet.

It's an interesting time from that point of view. I think in terms of a coordinated response from – we've got the Department of Health, now with the ADM, and plans for an umbrella. We'll have the RHA or RHAs singing the same song. We've enlisted Municipalities Newfoundland and Labrador, because it's true, we can recruit a physician but you attract a family. It's a lifestyle issue as much as anything else for them.

We've got the College of Physicians and Surgeons now who've agreed to join us to explain the licensing process, and have also recognized that in certain circumstances some of their requirements can be interrupted as a barrier to applicants from out of the province, or even out of the country, and they've committed to work with that. We're going through parallel discussions with nursing regulators, College of Licensed Practical Nurses and myself and the staff will be meeting in the near future. They're all interested in what they can do to help. If all you hear out there are the negatives and the positives don't get a chance to shine through, what you will see is it will become a self-fulfilling prophecy.

The College of Family Practitioners, for example, and the RNU have each said, we can make this a great place to work and we've got ideas. We've listened to the NLMA, they have

presented some and we got a checklist to go back with them at our next meeting. The RNU, the same, and the recruitment piece is just part and parcel of it.

P. DINN: I know there's a lot of negative, of course. Opposition does a good job with that. But I will say when you spoke a while back about welcome baskets, it's probably not far off, in terms the grand seduction in getting individuals to come here, to stay here, or not even come here, but just to stay here right out of school. But you mentioned excelling in keeping graduates here long term. How would you define long term? Is it once they get past their return-for-service agreement, or are they staying here a lot longer than that?

J. HAGGIE: I'd have to check with the CIHI data that came from. My understanding is it was looking five, 10 years out from training. Certainly, physician and health care workers in general have changed from – I hate to say my day – where you went to a community and you stayed there for 25 years. By and large now, families make a decision to move as their life circumstances change.

So you will see a young couple who likes the outdoors who will go to a rural area; once they have a family, particularly once that family reaches a certain age, they look around, schooling becomes an issue, extracurricular activities are really important and they choose to go where those places have what they may be particularly interested in, whether it's ballet or hunting or whatever. Then later on, as their nests empty, they think again.

So you will see periods where you'll have stability and you'll see periods where life circumstances generate a turnover. And that's going to be true for all of the health care professions; we talk about physicians simply because that's topical. It's the same with registered nurses; it's the same with licensed practical nurses and PCAs. Their qualifications are portable and our challenge is to distribute them where they're needed or make arrangements to provide those services somehow.

The facts of the case are eight to 10 years in one spot and you're probably going to find people are going to want to move.

P. DINN: I'm good.

Thank you.

CHAIR: Any other Members of the Committee have questions they'd like to ask on these headings?

Okay, so I'll ask the Clerk to remind us of which headings we've been dealing with.

CLERK: Client Services and Support, 2.1.01 to 2.3.01.

CHAIR: Shall headings 2.1.01 to 2.3.01 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

I'm going to ask Minister Crocker for his vote?

S. CROCKER: In favour, Mr. Chair.

CHAIR: Thank you.

The headings are carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

CHAIR: I think we're about at the point where we thought we'd take a break, so we'll take a 10-minute break. Is that standard? Yeah, so we'll take a 10-minute break. We'll be back at 7:16.

Recess

CHAIR: Okay, we're going to get started again.

I just want to check with the virtual participants to make sure they're still there. Okay, they're saying they're there.

S. CROCKER: I'm here, too, Chair.

CHAIR: Okay, so I'm going to ask the Clerk to move to the next series of headings.

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

CHAIR: Okay, so we're calling the next headings, 3.1.01 to 3.2.03 inclusive.

I'll look to the Member for Topsail - Paradise.

P. DINN: Thank you.

So we're looking at Purchased Services, under 3.1.01. I'm looking at between the budget last year and the revised, it increased approximately $1.5 million and then it dropped back down to the previous amount. Can you explain what was happening there?

J. HAGGIE: Two factors there. We charter an air ambulance to take people out of province. We have a standing offer kind of arrangement but it is done under charter. We spent $1 million on that and there was another $500,000 in there for increased utilization and costs related to HealthLine 811. That explains the $1.5 million difference.

P. DINN: So for that whole budget under Purchased Services, can we get a breakdown of the budget itself? The full $14 million.

J. HAGGIE: Sure. It is HealthLine, air ambulance and interpretive services contracts. That is how it will break out under headings, but we can get you the dollar amounts for each.

P. DINN: Perfect. Thank you.

Looking at Allowances and Assistance, I'm assuming this amount goes towards MTAP and bursaries and such. You spent $2,000 less than you budgeted for previously and then you increased it by $3 million, again. Can you explain that?

J. HAGGIE: The decrease of $2 million was a decrease utilization of MTAP due to travel restrictions. Then the increase funding for family medicine bursaries in the bridging plan comes under the difference between '21-'22 and '22-'23 budget.

P. DINN: Okay.

Moving along to 10, Grants and Subsidies, we see a fluctuation there as well. You went up from last year's budget and then – well, you continued to go up. Can you explain the gradual increase in the Grants and Subsidies?

J. HAGGIE: The '21-'22 actuals over the budget were pandemic costs, salaried costs, cyberattack not accounted for. There were savings in other departmental areas that were flowed in. So that's the $144,399,600 difference between '21 budget and '21 actuals.

In terms of the $165 million, there is a shopping list in your binder that adds up to that amount. Essentially, I can go through them if you want, but they're things such as: Cancer Care Western, which is new so there'll be an increment this year, which will ramp up in subsequent years; the Alcohol Action Plan of $2.49 million; the Suicide Prevention plan of $2.46 million; Collaborative Team Clinics, $7.8 million, rounded up; additional ambulance services in Eastern as part of the bridging plan for paramedicine, just over a million; tech in ER, $280,000; increase in cash operating grants of $45 million to the RHAs; $15.7 million in oncology drugs for Eastern Health. You've got $12 million there for direct client costs and, like I say, they're all broken down in the table. It's Equifax and so on and so forth. It rounds out to that when you factor in the adjustments. There's a whole list here and we can provide it, it's in the binder.

P. DINN: Okay.

Just a question on – because I guess this is where the biggest chunk of funding falls for the department, what would be the cost of – because we have three collaborative hubs operational now; I assume fully staffed, maybe not. What would be the costs of operating a collaborative hub?

J. HAGGIE: We're looking at anywhere from $1.87 million to $2 million per hub per year.

P. DINN: That's salaries, the works?

J. HAGGIE: That's physician payments, that's leases of buildings, that's clerical support, those

kind of things. Now, that's not a net increase, that's a shifting of money.

P. DINN: Yeah.

J. HAGGIE: Some of those people are already employed, those physicians who take money out of, say, a sessional budget for that time would be billing less for fee-for-service or there would be salary savings from whatever other compensation that they're using.

Now, there is some new blood coming in, but that's the whole purpose of trying to keep our own physicians and lure them back, attract them back into family medicine, because they've maybe gone off and done other things.

P. DINN: Okay.

We talk about, or it's been talked about, of course, the Centre for Health Information: Is there any funding in this current budget to deal with upgrading of that system?

J. HAGGIE: There is money for IT infrastructure for NLCHI and for the RHAs and I believe other departments would also have some for things like OCIO, for example. There is money itemized in the variance analysis for NLCHI so there is a line item there for cybersecurity enhancements, for example. The integrated workforce management project has some money in this list; eDOCSNL, which is the provincial electronic medical record, there's an increment there for support; and then there's money there for ongoing public health priorities. So there is money for projects within NLCHI.

P. DINN: Okay.

I think my colleague here mentioned the IVF program. I'm glad to hear that it's – I think you said went live today.

J. HAGGIE: The application process did.

P. DINN: Right, right. So what's the estimated amount or the budgeted amount for that, for the IVF program? Where would I find it, or would that fall in this section as well?

J. HAGGIE: It's operated through Eastern Health for sure; I'm not sure that it is broken out in these agreements.

One of the things is we've put in a placeholder. Again, my guesstimate – and we'll get the accurate figure for you – is it's just over three-quarters of a million. We don't know what the annual uptake will be; we expect it to increase over time because it's three-cycle eligibility and by and large my information is that each cycle takes nine to 12 months to complete.

P. DINN: Okay.

And the Canadian Health Transfer grant.

J. HAGGIE: Yeah.

P. DINN: It's mentioned about another additional $27 million for that. Is that accounted for here in this budget?

J. HAGGIE: CHT transfers don't occur in here. You don't see them here. They go to consolidated revenue. We do have targeted money from the federal government for specific programs, but the money, as I understand, was allocated as part of a change to the CHT. So that money is in general revenue.

P. DINN: Okay.

I am just looking at some of the financial questions here. It looks like you spent about – I think you may have talked to it already, but let's hear it again, I guess. You spent about $144 million or 5.9 per cent more than budgeted. I think you did talk about that in a roundabout way.

J. HAGGIE: I did. I actually listed it out, I think.

P. DINN: That was the list you were going to tell me that was in the book.

J. HAGGIE: Yeah. It was pandemic costs, salary increases, cyberattack not accounted for.

So we've had some pay increases, and that would be where you would see that money for

the difference between ’21-’22 budget and then the actuals and then I have referred to this kind of shopping list, which is the $165 million that we have referenced and, again, provided in here in detail. I am not sure how fruitful it is to go through it line by line, but there are some gems in here.

I mean, there is $2.9 million for virtual emergency rooms in Central Health. There are the hubs in Grand Falls-Windsor and Gander at $1.77 million. Those are, if you like, the equivalent of walk-in clinics for people who, as yet, haven’t registered or been able to register with a CTC or find a primary care provider. Those see between 50 and 70 individuals per day, per site. So they are important, sort of, pieces to sustain and bridge us until we get the CTCs widely spread and up and running.

P. DINN: And you are looking at, what, 35 of those? Did I read that somewhere?

J. HAGGIE: My understanding from the Health Accord is that it would be between 32 and 35. By and large they are looking at population of between 7,000 and 9,000, but recognizing that in some rural areas you might have to have a kind of CTC rural where they would only be able, in reasonable travel times, to generate a population of maybe 5,000 or 6,000.

P. DINN: Do I have unlimited time? Because I notice all zeros up there. Or did you start the clock?

CHAIR: You just ran out of time.

P. DINN: That was quick.

CHAIR: So you will get another –

P. DINN: Yes. No, I’ll come back. Thank you.

CHAIR: The hon. the Member for Torngat Mountains.

L. EVANS: Thank you.

Just looking at 3.1.01, Regional Health Authorities and Related Services. The Medical Transportation Assistance Program has been repeatedly panned by residents of Labrador for not adequately offsetting the costs related to air travel for travel to the Island for treatment and testing. Also there have been changes announced in January 2021, but we know, as residents of Labrador, that this has done little to improve the situation, unfortunately.

I was wondering if the department was considering revising its policy to increase the caps for reimbursement of expenses, or for providing an upfront assistance with air travel.

I’ll just use the example now from St. John’s to Goose Bay, which is the centre of Labrador, a ticket can cost, one-way, up to $900. Usually it’s around $600. But for people travelling from Lab West, where there are fewer flights, the cost is much more expensive, and for people going to Northern Labrador, a return ticket from Nain can be up to $1,000.

A lot of transportation for patients, it’s not something you can really plan on, so we were just wondering about these questions. Are you considering revising the policy to increase the caps for reimbursement of expenses or providing upfront assistance for the air travel?

J. HAGGIE: Yeah, I mean we have recognized the challenges faced by rural communities, and particularly Labrador, where the airfare is such an issue and, I suspect, unfortunately will continue to be one for the predictable short-term.

The short answer is, yes, we are looking at those. There is we believe some recommendation that will come out of the task force, but certainly we’re trying to look at a more equitable way of allocating funds, as I say, bearing in mind we have done what we could within the budget we had at the time, back last year, I think, if memory serves me correctly. But no, we’re certainly looking at that.

L. EVANS: Okay. Thank you.

Looking at Allowances and Assistance you mentioned that last year’s actuals were $200 million below estimated and that was because the MTAP travel was less due to travel

restrictions. To me that indicates $200 million because people didn't actually travel.

J. HAGGIE: I think it's $2 million actually if you're looking at all answers and subsidies –

L. EVANS: Yes, $2 million, I'm sorry with the zeros.

So $2 million spent less in travel for patients. That indicates COVID did put a damper on people being able to access health care.

That's a yes?

J. HAGGIE: Oh, well, I mean, we've said that in terms of a variety of things, but people chose not to travel if they felt they had any discretion about it. I mean, our message through Public Health from the get-go was if you feel you need help, talk to your primary care provider. If you feel you need help now, that message needs to go across and then that's a discussion about clinical priorities about which we do not opine.

But the facts of the case are it did put a damper on peoples interest in travelling and obviously those were decisions they must have made personally to weigh the risks and benefits.

L. EVANS: Yes, and I'm sure some of the appointments were cancelled because they were deemed less of a priority due to the COVID restrictions as well. That would have impacted the travel for people accessing MTAP as well.

J. HAGGIE: Well, I think appointments were not made for a variety of reason. Sometimes we had provider issues, in that there was COVID in the facility and it was probably deemed less safe to attend. There was COVID in the providers and I'm pleased to announce for the Committee that we are now down to less than 200 health care workers who are actually self-isolating today because of COVID, which is the lowest it has been in this wave and is a thousand less than at peak. And sometimes the patients themselves decided not to travel.

So I think it would be very difficult to generalize as to why some of these appointments were not kept.

L. EVANS: Yeah.

And we are assuming that the numbers are this low; we can't really substantiate them because of the lack of access to testing.

Looking at the Grants and Subsidies there, last year's budget in the Estimates was written as $2,455,509,000, but just looking at the book last year, in last year's Estimate book, the Estimates for '20-'21 was written as $2,453,522,300. So I think we gave a photocopy to you of last year's Estimates that show these numbers. So there shows a discrepancy of $1,986,700. So I was just wondering: why the discrepancy and what accounted for it?

J. HAGGIE: Yeah, that was money that was moved back from JPS for Health in Adult Corrections and it was restated after the Estimates were published. That was a decision, if you recall, that was made some years ago and was deferred and then was put into the beginning of fiscal '21, so it would appear in our book but not the previous one.

L. EVANS: Okay, thank you.

Under Revenue, for federal, what was the source of the extra $30 million in federal funding?

J. HAGGIE: $42.3 million, in actual fact, was the amount that was moved from Finance to Health and Community Services, but there was a reduction in revenue of $12.2 million, so that nets out at the $30 million. Some money came out from infrastructure but the principal was federal program revenue that was sent over from Finance in that fiscal year.

L. EVANS: Okay, thank you.

For revenue, under provincial, what was the reason for the $6 million loss in revenue?

J. HAGGIE: Reciprocal billing revenues were down, so we didn't get from other jurisdictions the revenue for looking after their patients because they never came. They didn't travel because of COVID.

L. EVANS: Thank you.

Section 3.1.02, Support to Community Agencies, under Grants and Subsidies, this

year's estimate is increased by $500,000. Just wondering what the reason for the increase is.

J. HAGGIE: That's related to the sugar-sweetened beverage, and it's going into the healthy eating initiative.

L. EVANS: Thank you.

3.2.01, the Low Carbon Economy, under Grants and Subsidies; last year's actuals were $325,000 less than budgeted. I am just wondering what the reason for that was.

J. HAGGIE: That was delays in receipt of project approvals; it was a cash flow issue.

L. EVANS: Thank you.

3.2.02, Low Carbon Economy, under Capital, Grants and Subsidies – last year's actuals were $4,610,000 less than budgeted; however, this year's Estimates have increased by $1,045,000. So just wondering what the difference was.

J. HAGGIE: Those are cash flow adjustments again, related to delays, so they mirror the Capital of which the previous question was the Current.

L. EVANS: Good, okay. Thank you.

3.2.03, Building Improvements, Furnishings, and Equipment, under Grants and Subsidies – this year's estimate has increased by $5 million. Just wondering what the explanation for the increase was.

J. HAGGIE: We asked for that. In actual fact, we would have probably liked a little bit more, but that is to replace aging equipment, principally radiology equipment, which is getting to the end of its working life. A lot of these scanners and things like that have a defined age, and we've asked for an increment now conscious that a lot of these are going to age out over the next few years, and that's the delta that we got this year.

L. EVANS: Okay, thank you.

And that's the end of my questions.

CHAIR: Okay, thank you.

Before we start a second round, are there any other Members of the Committee that would like to ask a question in the first round?

Not seeing any, we can move to our second round.

The Member for Topsail - Paradise.

P. DINN: Thank you.

Let me catch up where we were.

J. HAGGIE: Yeah, I've lost my place so please tell me –

P. DINN: No, I'm just asking some general questions actually.

We're talking about combining the RHAs. Do you have an estimate or a forecast estimate of what their financial position is expected to be at the end of this current year?

J. HAGGIE: No, it's difficult to be sure. I mean what we're aiming to do is to remove duplication and to get better value for the dollar we spend. How that will shake out really depends on the work of the transition team.

P. DINN: So in relation to that, do we know if, this year, they'll record any deficits?

J. HAGGIE: Let me have a look. There probably is something somewhere about that. I don't have any information specifically on deficits. My recollection is that comes through Public Accounts, but I'm going to get – oh, here we go. Maybe I do have something after all; I'm just not looking at the right page. Hang on a second and I will just see what I can tell you.

Oh yeah, we do have a breakout – silly me. So the difference between the original expense limit and the actual expenditures breaks out for each regional health authority. We can supply these for you in a table.

P. DINN: Perfect.

J. HAGGIE: You're looking at around $89 million for Eastern; $14 million for Central; $8 million, $9 million for Western; and $9 million for Labrador-Grenfell. For example, in Eastern

Health – and it's mirrored in all of them – the bulk of single biggest item out of that $89 million was $20 million for COVID operating pressures, $16.8 million for COVID salary pressures, and $15 million for salary increases. If you add that lot up, you can see you're looking somewhere at $50 million out of the $89 million.

P. DINN: And there is funding provided to cover those deficits?

J. HAGGIE: The negotiated salary increases, that flows through in the grant from us, and there is a mechanism to flow that from Treasury Board.

P. DINN: Okay, thank you.

I'm just thinking of the integrated corporate services model, looking at streamlining the delivery, the functions of these four authorities: payroll, accounting, HR and such. In July 2017 you announced plans to implement a province-wide shared services model for supply chain management in the health care system, which includes procurement.

Can I ask you this? How will this initiative be impacted by the new decision to go to one RHA?

J. HAGGIE: Well, I mean it will hopefully lead to standardization so that when you have purchasing requests, they work from a common dictionary. Prior to that, MEDITECH, which is the background module for doing the inventory and stock control, had over 400,000 items in their dictionary in 4,000 headings. So by the time you do the math, you see that there's a considerable number of similar products within the same category. So this should make that role easier.

In terms of the other elements about standardization of HR scheduling, we have initiatives in place, after discussions with the RNU, for example, about workforce management software. So that's a piece there. We've been moving in that direction and I think this will just help accelerate it and standardize it.

P. DINN: Okay.

And I'll put this all together. Can you give us an update on where we are in implementation? I suspect we're only in early phases of it. But is there any indication of the amount of savings and potential job losses?

J. HAGGIE: We are not looking at affecting front-line delivery at all, in terms of the numbers that we need. We know we need more and we've increased our LPN enrolment by 70 per cent. Actually, more than that, I think. I think PCAs was 70 per cent and LPNs was 90 per cent. We saw that coming and we did that a couple of years ago. So, for example, in Central their entire graduating class from CNA, which graduated just before Christmas, they're all employed. All 30 of them got jobs. And if we hadn't had done that back in 2018-2019, you can see we would be in a much worse position.

So the front line is not where we're looking to do anything except make people's lives easier to access standardized booking for holidays and vacations, to enable people to use that kind of HR module in a way that works from them and their collective agreement. And that's the challenge of tuning it.

In terms of savings on the back end, obviously there'll be duplication. Quite frankly, it's going to be a process that will take a year or two. The transition team haven't really got themselves in place yet. We have a CEO and that's it.

I think what you will see happen is what's been happening now, that people will either find a new job or a different one within the same umbrella organization, or they will retire rather than go that route. So I'm not necessarily seeing that as anything other than just a robust amalgamation.

P. DINN: I agree. There will be a reduction and some duplication. You mentioned HR and you've just hired a candidate for the ADM position for Recruitment and Retention.

Is that position solely dedicated to physicians or is it one that's going to be dedicated to front-line staff across the four RHAs or the one RHA?

J. HAGGIE: It's health human resources. It's not specific to one field or another. We know topical issues or access to family doctors, shortages of RNs because of a whole variety of reasons, but we also know that we have challenges with respiratory therapists, with hospital-based pharmacists. We have challenges with medical physicists. They don't grow on trees. We've got a gem in Eastern Health here, who is doing some real cutting-edge work with a cyclotron in a way that maybe us people outside the field would never have known. Those people are going to be really hard to find.

Health human resource professionals, people with accounting background, if they decide to move out of health that's our problem because they will be moving to another job in this province. There is no shortage of jobs. The shortage – if you do like I did last week when you talk to your constituents – is people to employ. I have construction companies that can't find labourers; I have aviation companies that can't find mechanics or pilots, the list goes on.

P. DINN: Just on the Centre for Health Information, which of course focuses on eHealth and provides health information, that will become a part of the department. That will move into the department. I'm just wondering is this a positive move? Can you explain why it's a positive move? How do you hope to accomplish this? How will it improve the delivery of eHealth services?

J. HAGGIE: How is the subject of a consultation process. Work is under way. We need experts in the field of IT to suggest how best to do that – who goes where and does what. So that work is back and being analyzed.

I think from sitting where I sit, real-time decision support is crucial and having that information, the dashboard at your fingertips within the department, certainly stuck in my mind during COVID. I think by integrating better that real-time decision support with NLCHI structures, as they exist at the moment, it's a lot easier if we do it this way. You've seen the department now has an ADM of digital health, digital information and management.

The electronic health record, the electronic medical record need to speak together seamlessly, needs to be standardized across the province. I think, again, it's reduction in duplication, HR, payroll, these kind of things. We can have one mechanism that does it rather than four or five.

P. DINN: So related to that, and from my experience and I'm sure with any department – will I get my question in?

CHAIR: Depends on how quickly.

P. DINN: With anything with IT, there's a big training curve for it. So I ask you this: Can you give me an update on implementation. Any savings, any job losses?

J. HAGGIE: We're not anticipating job losses; we're anticipating people moving with their skills. They have skills we don't want to lose. I mean, I talked about pilots and ambulance drivers who we can't hire because there's no one to hire and we're dealing with that through the recruitment and retention strategy, but there are huge private business out there who look for these individuals. They are valuable; we need to keep them. We need their skills.

In terms of dollar figures around savings, I've come to the conclusion that we may not actually end up saying: Minister Coady, here's some money back, we didn't need it; but here, this is the better value we're getting for those dollars that we spend. That, I think, is as much, if not a more important gain than simply moving some numbers around on a balance sheet. Well, I think that's probably heresy to say in an Estimates Committee.

CHAIR: Okay, we're going to move to the next questioner.

Anyone else have questions to ask in this round? Do you have more?

P. DINN: Yes.

CHAIR: Okay.

P. DINN: Thank you for that.

Just related to, like I said, the implementation and you talk about getting the right staff. I know in my past career when we dealt with like provincial engineers, they always left and went to greener pastures, especially when the oil industry started, because of their benefits, because of their wages. We know from the cyberattack how important good IT, good supports and good security are.

So do you perceive – and you're talking about people moving but, again, there'll be a demand on that – any increases in the cost in terms of salaries for these individuals?

J. HAGGIE: I think that's totally unpredictable from where I sit at the moment. I mean, people move, but we are actually seeing also repatriation of Newfoundlanders and Labradorians. If you look at the data from Immigration, Population Growth and Skills, some of our increase has been from people who have chosen to leave Toronto, have chosen to leave Calgary and have come back to a lifestyle they want to live in Newfoundland and Labrador.

Again, in terms of the specifics of the Centre for Health Information, the work from the consultant is being analyzed. I think that will be very helpful, if not crucial, in deciding on how to do the implementation, because there'll be a sequencing to this that makes sense of matters. We'll leave that to the experts.

P. DINN: Thank you.

Will there be any money there for upgrading the MEDITECH? Is there any money here to upgrade the MEDITECH program?

J. HAGGIE: Our aim at the moment is to see how the Corner Brook acute care HIS RFP goes. That's going to be our test bet, because at the end of the day that's going to tell us what the market is like. It's the best way of doing a market sounding, is to say here's a hundred-and-whatever-bed hospital, 150 beds, tell us what's available.

NLCHI and the RHAs have been very good with their networking in terms of translating and integrating things. There are some systems out there that have been bought fairly recently, and the direction from the department through the RHAs is that these have to be scalable, they have to interoperable and so the newer systems should not be an issue.

We do recognize that legacy systems provide a challenge, both in terms of their integration and in terms of their security. Those are, not disparagingly, kind of geek questions; I leave it to them to tell me in language ideally I can understand, and we'll deal with that. But we do know that we need to look at our IT infrastructure. I think with having one RHA and one department looking after that, you've got far less fingers in the pie and you're far more likely to get it right at a price that is reasonable for the people of this province.

P. DINN: So related to that, in terms of the one RHA – and you've hired, from all I've heard, and I know the gentleman; a great CEO to look after that from Eastern Health – are you replacing that position, though, within Eastern Health?

J. HAGGIE: Those are discussions we've been having with the board. Obviously, the work of Eastern Health, as it currently is constituted, needs to continue. We're engaged in discussions with the current CEOs so that there is some stability in their lives during the transition process, but we can't leave Eastern Health leaderless either.

P. DINN: Thank you.

Just let me move along because my colleague here got ahead of me this time; so that's all good. A few questions here.

I'm looking at 3.2.03. The question was asked about budget increase by $5 million. Are we there, yes?

J. HAGGIE: Yes, got it.

P. DINN: So my question is what is the impact of this increase? What's the relationship with that and the RHAs in terms of is there an impact on the RHAs in that increase?

J. HAGGIE: Well, that's money that will be available for capital asks to the RHAs. Our information from them is that there are pieces of equipment that are clinically important that need to be evergreened, replaced, whatever the appropriate word is these days. This gives them some more leeway in a new CT scanner or a new MRI or upgrading to match the clinical demand and needs.

That is where we went with that, but this is a generic pot. It doesn't just include medical equipment and health-related equipment, but that is our main interest in that delta this year.

P. DINN: So the main portion of that would be furnishings and equipment as opposed to building improvements.

J. HAGGIE: No, it is building improvements or health equipment improvements. So that is what comes out of this pot. Our request through Treasury Board was for $5 million, and the case we made was predicated mainly on medical and health-related equipment having to be replaced. The background activity about keeping the roof from leaking still goes on.

P. DINN: I was just clarifying that it was mainly driven by equipment.

I'm just looking at the budget document and appendix – I don't know if you have it in front of you.

J. HAGGIE: No –

P. DINN: I can pass it over to you.

I am looking at Appendix VI. It is the summary, restatements by department. Health and Community Services in the original budget was $3,220,030,300. You had an adjustment of just under $2 million – $1,986,700. Can I just get an explanation of that variance?

J. HAGGIE: Yeah, that money was originally removed in the original Estimates because health in corrections and the budget for it lay with Justice and Public Safety. That was a policy decision that we move it into Health. That was part of *Towards Recovery* and the action plan. And in actual fact should have occurred earlier but didn't because of some delays. Then COVID compounded those delays.

But it was restated between the Estimates document from last year and the budget document you see here. That's $1.9867 million.

P. DINN: Yes.

So I guess this is the last question. You mention at the onset of I think it was 271 departmental staff?

J. HAGGIE: Yes.

P. DINN: I think that's what you said.

If I look at the salary details and they're showing us 210 staff, I'm curious as to why there's a difference of (inaudible) –

J. HAGGIE: It depends on the day the document was written. We always provide staffing numbers by date, because they do vary significantly. We have hired a significant number of contractual staff over the course of COVID. Some of their contracts have expired. So on any given day, the number could be different by five or 10 individuals. Certainly for example we've had a turnover in some of our claims processors in Grand Falls-Windsor: they're retired; moved on. And so on the Monday you may find that there are two missing, and by the Friday they've been replaced, or probably two months later, the Friday, they've been replaced.

So those are snapshots that I would encourage you if you have a number, look at the date to see what you're comparing it with and look at the date on that.

P. DINN: So it's not unusual to see a discrepancy of almost, well, 60-odd people.

J. HAGGIE: It depends on what the category was. If was full-time, permanent then that number is about right. Because that's the other thing, was it a reference to permanent full-time staff of the department? Because that number's probably nearly accurate, plus or minus one. But if you then say what else have you got in terms of temporary staff and in terms of contract staff, you'll find it turns out to be 271.

P. DINN: Okay.

I'm just about done. I just want to say thank you for taking the time. I know you were dying to be here tonight.

J. HAGGIE: Wouldn't have missed it for the world.

P. DINN: Especially when the playoffs all start.

So I am done. I thank you for your time. I'm not sure about my colleagues here.

CHAIR: Do other Members of the Committee have any questions?

The hon. the Member for Lake Melville.

P. TRIMPER: Thank you very much, Chair.

Thank you for the opportunity just to take a few minutes to also express my own appreciation to this department. I think all of us as MHAs in this room know the importance of this department. It dominates so much of the life of an MHA and I thank so many of you across the way for your help in my office, and I'm sure all those across the province.

I just had a few additional questions. I just wondered – it's a bit of a theoretical, and I think everyone in this room is hanging in their hat and hoping with a great deal of optimism for positive change that will come with the Health Accord. I just wondered if the minister could talk a little bit about how – is this going to be on one extreme, thank you very much and full implementation, or how do you see vetting this through, given so much work has been done by those two co-chairs and all the supports and all the other contributions by yourself and everyone else? Do you see a carte blanche acceptance, or are you vetting? I see that you're already moving on so many of the other recommendations to date. I'm just wondering if you had any thought on that.

J. HAGGIE: I think the reason they chose the word "accord" was that their principal document in their view and in the view of all stakeholders – the task force is over 150 individuals, although the core group is considerably smaller – was that this would be an accord. An agreement amongst all the members of the task force that this was what they felt, what they saw and a consensus opinion.

I don't think anybody who's read that report or/and spoken to the co-chairs really would take much issue with that direction at all. I think in terms of what happens with the implementation plan, which is part B, the blueprint, I think several things will play into it. One will be the pacing of it in terms of certain elements. I mean, we could wish we had another 200 social workers or psychologists or councillors, or whatever that core group is. We're not going to get them tomorrow and it would be a fallacy to think we'd get that kind of number over a period of anything less than three or four years.

It is a five- to 10-year plan. This is the goal; this is where we want to be. Now, whether you go that way to get there or this way, or this way, I think is one of the things that as government you would have to discuss. Because some of it will also be tied to investment and new monies. The budget for the accord plan B doesn't exist because we don't know, in granular detail, what's in it. We've spoken about the CTCs. That money in some respects may have to be new now. But that money will come in from other sources later as existing practitioners join, bring their patients with them and onboard themselves into this process. It's far easier at the moment to start with the gaps where there is no coverage, for example, and build a CTC from scratch.

Our challenge, and the challenge of the accord, and the challenge of the department, and the NLMA, and the College of Family Physicians, for example, is to figure out how to take a person who's five or 10 years into practice, doing things their own way, and say, do you want to join this, and if so how do we make it work for you? That's going to be a slower process.

So I think if you take a snapshot in time of the accord, you'll say, well, you've cherry-picked; you've left this, this and this out. But to be fair, that, that and that may not be possible until you've done A, B and C over here. And you know the challenges about sequencing things, as well, and it may well be that Harbour Breton, St. Alban's, Connaigre gets attention faster than another group of communities who feel they're

just as badly off. But the objective view from the RHA is that that is a bigger need, a bigger pressure at that time, and that's the awkward bit because you've got to manage the messaging around it.

I think no one is in agreement with part A, but part B will be where the rubber meets the road with implementation.

P. TRIMPER: Absolutely.

Minister, I wonder if you could provide an update on one item that I know frustrates probably both of us, and anyone who's aware of it. That's the professional certification of new Canadians who come to us with the academic qualifications, the experience, and they are doing much less than what we need them to do. I just find this a shocking hurdle that is very frustrating, and I look at a certain minister who is also here in the room. I'm just wondering if you have any comment or update on that.

J. HAGGIE: Well, I know I can speak personally; we've certainly reached out to, for example – and it's just an example, it's not the be-all and end-all – the new Registrar of the College of Physicians and Surgeons, and she has acknowledged that there's a challenge with their processes, and also once wants to be part of the solution; she wants to come to recruitment fairs.

In the specifics of overseas sort of graduates, as it were, there are mechanisms here. I know Dr. Adey's predecessor did want to look at broadening the act to allow different categories of licence here than the ones we currently have, and certainly that kind of stalled lately; we're in the process of working through that.

We continue that discussion with Dr. Adey. We have opened a dialogue with other regulators as well because, as I said earlier on, we talk about doctors and nurses, but they're really a metonym for the whole health care provider field. We need RTs, we need paramedics, we need advanced care paramedics and we need medical physicists, yada yada yada.

So I think, to be fair, they have a tightrope to walk and a balance to hold. Their prime aim is to safeguard the public well-being and interest, but they also know and have actually said, you've got to have some care providers to actually deal with care issues. So somewhere in the middle a reasonable person will land.

P. TRIMPER: Certainly provinces – and I asked a question of it in the House a few months ago. When Ontario announced a sort of accelerated mentoring process, some jurisdictions just seem to have figured this out. Anyway, I just wish everyone the best because we need them.

Two more questions I am going to try to get in. One is a COVID question; I have to ask a COVID question. Why are we going forward with a longer waiting period for that fourth dose, for that second booster, versus other provinces? We're looking at, I think, it is a minimum of 20 weeks versus others at 12 weeks.

J. HAGGIE: That's based on advice from Public Health and the science table, which I think includes immunologist and virologists. If you remember, that was the gap, or pretty well the gap between the original course of vaccination and booster dose one. That is a clinical question; we don't influence that directly in the sense of if the Public Health team says 20 weeks, we're not going to argue. We might say could it be 21 or 22 or does it need to be 18, but we're not going to go and say something completely different.

I think each of the jurisdictions does their own numbers, crunches their own numbers, and sees their own need. We are in a better situation; the wave came to us first, has passed over and is now heading out there. So the question is if these boosters wear off, when is the next wave coming and should you actually time your booster to give you the best protection then when your risk of getting the disease is going to be higher rather than simply stick to a plot. And those are the factors –

P. TRIMPER: The gamble lies in the – of course with every week and the fatalities that we are seeing as a result of the latest wave of this virus, that is the trade off, of course –

J. HAGGIE: Well, I mean, the hospitalizations lag behind the case numbers. We have seen the hospitalizations start to drop. Deaths and ICU stays lag behind hospitalizations. We, according

to our modelling, expect that fall in those areas to come now so those numbers should start to tail off.

But, again, Public Health make these recommendations. They are based very much on NACI guidelines, and I don't see much daylight between the two.

P. TRIMPER: Thank you.

Minister, do you have a metric that just can help put in perspective how much this province spends on locums – doctors, nurses, other specialists we need – flying in regularly who aren't resident to this province?

J. HAGGIE: We can certainly look for that. We don't have an easy metric in the sense that that's done very much at an operational regional health authority level. We do know that we are building collaborative relationships with other jurisdictions whereby someone will come in nominally as a locum, but they're coming for two months every six months and they are like visiting regulars. They have a clientele as it were; they have a practice built up.

They come to provide specific expertise or specific relief in a specific area, and they do it with a medium- to long-term commitment. I think the challenge is they would be called locums as well from out of the province, but in fact they add a huge value beyond the two months or whatever that they provide.

It is possible to find out what proportion of the MCP budget goes on locums. I'm certainly happy to provide that for you. I don't actually have it to hand. You can then do the percentages based on fee for service versus salary.

P. TRIMPER: Thank you.

I'm out of time.

CHAIR: I think we've exhausted the time for questions.

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

CHAIR: Shall headings 3.1.01 to 3.2.03 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

I'll ask Minister Crocker how does he vote.

S. CROCKER: In favour, Mr. Chair.

CHAIR: Okay, carried.

On motion, subheads 3.1.01 through 3.2.03 carried.

CLERK: The total.

CHAIR: Shall the total carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Again, I'm going to ask Minister Crocker how does he vote.

S. CROCKER: In favour, Mr. Chair.

CHAIR: Those are carried as well.

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.'

I'll ask Minister Crocker how does he vote.

S. CROCKER: In favour, Mr. Chair.

CHAIR: Carried.

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

CHAIR: This concludes our Estimates meeting on this department. It's always interesting to see the congenial nature of these meetings and the back-and-forth dialogue; it's something the public doesn't get to see that much. It maybe shows a different side of politics.

I don't know if the minister has any input, or any Member of the Committee has any closing comments?

J. HAGGIE: No, I'd just like to thank everyone for the time and quality of the questions. I look forward to seeing the same collegiality at about 1:48 tomorrow.

CHAIR: Unless anyone else has anything, any comments, thank you all very much.

We need a motion to adjourn, apparently. So moved by the Member for Topsail - Paradise.

That has to be seconded as well. Seconded by the hon. Member for Mount Pearl North.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Motion carried.

The Committee is adjourned until Friday at 9 a.m.

On motion, the Committee adjourned.