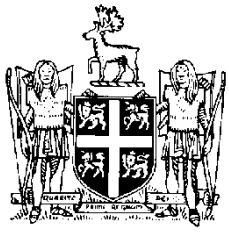

PROVINCE OF NEWFOUNDLAND AND LABRADOR
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Proceedings of the Standing Committee on Social Services

May 19, 2026 - Issue 4

Health and Community Services

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Honourable Paul Lane, MHA

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Joseph Power, MHA

Members: Paul Pike, MHA
Jim McKenna, MHA
Jeff Dwyer, MHA
Sherry Gambin-Walsh, MHA
Hal Cormier, MHA
James Dinn, MHA

Clerk of the Committee: Evan Beazley (A)

Appearing:

Department of Health and Community Services
Hon. Lela Evans, Minister
Colleen Stockley, Deputy Minister
Katie Norman, Associate Deputy Minister
Justin Garrett, Assistant Deputy Minister, Regional Services
Robyn Hayes, Assistant Deputy Minister, Corporate Services, Governance and Accountability
Gillian Sweeney, Assistant Deputy Minister, Population Health
Chad Antle, Departmental Controller
Victoria Barbour, Director of Communications
Jennifer Konieczny, Media Relations Manager
Bradley Russell, Executive Assistant

Also Present
Lisa Dempster, MHA
Jim Parsons, MHA
Angelica Hill, Official Opposition Caucus
Margot Pitcher, Official Opposition Caucus
Scott Fleming, Third Party Caucus

Pursuant to Standing Order 68, Lisa Dempster, MHA for Cartwright - L'Anse au Clair, substitutes for Paul Pike, MHA for Burin - Grand Bank.

Pursuant to Standing Order 68, Jim Parsons, MHA for Corner Brook, substitutes for Sherry Gambin-Walsh, MHA for Placentia - St. Mary's.

The Committee met at 9 a.m. in the House of Assembly Chamber.

CHAIR (Dwyer): Order, please!

We are looking at the expenditures of Health and Community Services. There are some substitutes. The Member for Cartwright - L'Anse au Clair, Lisa Dempster, will be substituting for the Burin - Grand Bank MHA, Paul Pike. Then the substitution for the Member for Placentia - St. Mary's, MHA Gambin-Walsh, is the Corner Brook MHA, Jim Parsons.

We're starting at 9:03; we'll look at 10:30 for our 10-minute break. Once we hit that mid point, we'll take a little stretch and we'll come back in 10 minutes.

Just a reminder to the Members of the Committee and the departmental officials, each time you're asked to speak, just wave your hand to identify that you are looking to talk. When we go through the different heads of expenditure, I will certainly recognize the person to talk. So just wait for the tally light; there will be a little red light that will come on in front of you, and then you can proceed. Say your name and state your position each time you speak for transcription purposes.

Do not make adjustments to the chairs. That's not my rule; I don't mind you making adjustments to the chairs. Water coolers are on both ends, two on each end, and you're welcome to that at any point in time.

There are no unaffiliated MHAs present today.

I now ask that the Committee Members and the substitutions and caucus employees to introduce themselves, starting in the front row closest to the Chair.

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

A. HILL: Angelica Hill, Director of Research, Official Opposition Office.

J. PARSONS: Jim Parsons, MHA for Corner Brook.

M. PITCHER: Margot Pitcher, Opposition Researcher.

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

S. FLEMING: Scott Fleming, Policy Analyst, NDP Caucus.

J. POWER: Joe Power, MHA for Labrador West.

J. MCKENNA: Jim McKenna, MHA for Fogo Island - Cape Freels.

H. CORMIER: Hal Cormier, MHA for the scenic District of St. George's - Humber.

CHAIR: We'll start here with the department officials, starting with the minister.

L. EVANS: Lela Evans, MHA for Torngat Mountains, Minister of Health and Community Services.

C. STOCKLEY: Colleen Stockley, Deputy Minister of Health and Community Services.

R. HAYES: Robyn Hayes, ADM for Corporate Services, Governance and Accountability.

C. ANTLE: Chad Antle, Departmental Controller.

K. NORMAN: Katie Norman, Associate Deputy Minister of Health and Community Services.

G. SWEENEY: Gillian Sweeney, Assistant Deputy Minister of Population Health.

J. GARRETT: Justin Garrett, Assistant Deputy Minister of Regional Services.

V. BARBOUR: Victoria Barbour, Director of Communications.

J. KONIECZNY: Jennifer Konieczny, Media Relations Manager of Health and Community Services.

B. RUSSELL: Brad Russell, Special Advisor to Minister Evans.

CHAIR: Before we start the Estimates process, the Committee will now consider the minutes of the previous meeting. If there are no errors or omissions, I ask for a mover for those minutes.

J. POWER: So moved.

CHAIR: The minutes are moved by the Member for Labrador West.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Motion carried.

On motion, minutes adopted as circulated.

CHAIR: We will now proceed with the Estimates review process. Once I ask the Clerk to call the first subhead grouping for this head of expenditure, I will proceed to recognize the minister who will get 15 minutes for opening remarks. Then I will proceed to introduce the first responder/questioner from the Committee who will get 15 minutes for questions in the first round. After the first round, questions will proceed in rounds of 10 minutes each, alternating between Members of the Committee.

I now ask the Clerk to call the first subhead.

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

CHAIR: Shall 1.1.01 to 1.2.02 inclusive, Executive and Support Services, carry?

I now recognize the minister for opening remarks.

L. EVANS: Thank you, Chair, and thank you for the opportunity to deliver some introductory remarks.

Estimates is an important part of the budget process, and I'd like to thank the Members of the Social Services Committee for their work in reviewing the budget and the expenditures. I'm very pleased to have members of the Health and Community Services team here with me. We will do our best to answer your questions. For any questions we cannot actually have the details for, depending on how deep into the weeds we get, we will actually be able to provide those answers in a timely fashion to you.

Before I begin, I'd like to take a minute just to extend my thanks to all our front-line health care workers. They do their best to help our communities every day. It's something that I recognized when I became Minister of Health just how important our front-line workers are to us.

I want them to know that I recognize and we, as a department, recognize the skills and commitment they bring to their jobs and to their services. That does not go unnoticed. Certainly it does not go unappreciated by our department and the general public out there. It's so important for them to feel valued and feel recognized.

I want to note that our front-line workers come from many diverse backgrounds, cultures and nationalities. This makes our health care system stronger and more grounded with many lived experiences. Our health care workers care for all of us – and I will repeat: all of us.

They deserve our respect and appreciation. There are instances where we learn of unacceptable behaviours directed at our front-line workers. I want to say, unequivocally, that there's no room in our society for disrespect, animosity or racist actions toward anyone. That's unacceptable.

The Department of Health and Community Services is responsible for the overall strategic direction and priorities for health and community services throughout our province. Our mandate is to provide leadership and direction for effective and efficient delivery of health care services to everyone in our province.

We do this through our work to support and guide Newfoundland and Labrador Health Services and other entities that deliver health care programs and services across the province. We need to recognize that it takes co-operation, it takes working together to make sure that we can – to use the old ship analogy – turn the ship around.

Right now, our health care system needs a lot of work, and we need to work together. It has to be extended – it's so important for me to say that it's not about politics; it's not about policy. Anyway, for me, when I became Minister of Health, I realized just really how deep a lot of the problems go and the problems are rooted in a deep culture and we need to co-operate and we need to root out the problems and make sure that we're putting solutions in place. It's very, very important.

The department is also responsible for effectively administering and providing funding for insured medical and hospital services, dental and pharmaceutical services, the purchase of seats and bursary programs for students in select health professional or technical fields to build capacity and to help create a stable health workforce.

As minister, I'm committed to working with all stakeholders, especially those on the front line, as we plan ahead on how best to address our government's priorities for delivering better health care. This includes connecting residents to doctors and nurse practitioners, improving access to health care regardless of where people live in our province. Our province is large and there are a lot of barriers when people are trying to access services.

Supporting health care workers and improving access to mental health and addictions services; we must recognize that providing better health care cannot be done in silos. When we were sworn in, our Premier told us, as Cabinet ministers, ministers responsible for departments, we cannot work in silos. To be a better government, we have to be a better government together and that's working together. That's one thing that we're committed to.

I welcome dialogue with other government departments as we work on many of our priorities. But, also, it's very important for people to realize that my door is always open has been a saying, it's been an expression, but a lot of times when I was in Opposition, I found that door was not open. It wasn't. Even if I had the opportunity to talk about problems in my district or in Labrador or in the province, it basically fell on deaf ears.

So one of the things that we do is, if people in the Opposition want to engage us on health issues and find out what's at the root of some of the problems their constituents bring forward, we actually invite them and we actually have meetings and briefings with them so they can understand. Also,

too, is we can work together on solutions. That's one of the things.

My office is always open or my door is always open cannot be just expressions. We actually have to listen to everybody out there, including those who bring forward issues with their constituents because a lot of times even us, we sometimes find out things are not as what we were told they were from people in the capacity that you thought would be properly informing you.

Since becoming the Minister of Health and Community Services, I focused much of my effort on meeting with other partners through the province to hear first-hand about the issues. A lot of times I was very surprised at how grateful and appreciative stakeholders, advocates and people were just to meet and just have the conversation. They talked about not being able to have that conversation with department officials and the minister of Health. To me, that was shocking. Moving forward, I don't think any minister of Health or any people in the Department of Health should not make themselves available.

I know sometimes our schedules are blocked, but eventually people need to be able to have a voice and be able to actually engage with the department, especially when there are serious issues at risk that could impact delivery of health care and also be able to enlighten us on some of those barriers that we're facing in our health care system.

The meetings have been really helpful. They've guided us and informed decisions that we made for *Budget 2026*. Basically, the Premier has told us that we have a serious responsibility as ministers of departments. We have to listen to the people on the front lines, but also the people who are supporting the workers on the front lines. That is where the answers are; that is where the solutions are. That's what we're working on. I hope that's reflected in this budget and in future budgets.

Just looking at the budget for this year, 2026: Investment of $5.4 billion, which includes an addition $370 million to support people, health care providers and better health care for every Newfoundlander and Labradorian.

This is a historic investment in health care in this province and certainly deserves discussion in this Committee. We're here to answer your questions and also to be able to actually inform the public who may be out there listening to these Estimates, because it's a significant list of expenditures and I believe that all should be read into the public record in this House of Assembly.

We are investing $54.3 million to recruit and retain health care professionals and increase access to health care in rural and remote communities. Our budget, this *Budget 2026*, includes $6.5 million to implement a provincial nurse travel team to reduce reliance on those agency nurses. We will be implementing this in collaboration with the Registered Nurses' Union of Newfoundland and Labrador.

There's $6.3 million to implement the nurse practitioner funding model so that residents can see participating nurse practitioners for medically necessary services without paying out of pocket. That was our commitment during the election. We will make sure that's happening and we're being engaged with the nurse practitioners out there.

Chair, $8.4 million to support 64 new acute care beds in St. John's; $8 million to train and recruit local nurses and nurse practitioners, this includes additional support to ensure existing seats are filled as students complete their training; $5 million to provide paid work terms for students pursuing health care careers in hard-to-fill areas; $3.5 million to help recruit and retain doctors, this includes ER doctors for our small communities; $3.3 million to provide

24-hour care in Botwood with plans to later expand to Whitbourne; $3 million to hire mental health professionals to reduce wait times for programs and services; $1 million to train, recruit and deploy anaesthesia assistants to free up capacity within anaesthesiology and expanding cardiac surgery programs surgical capacity; $935,000 to expand mobile crisis response teams to strengthen and support people with mental health and addictions issues; and $400,000 in additional funding to the Lionel Kelland Hospice in Grand Falls-Windsor.

To support Newfoundland and Labrador Health Services to reduce the wait times and ensure services are more efficient, we are also investing $28.9 million to support the Newfoundland and Labrador Prescription Drug Program and to expand the vaccine program; $1.8 million to increase fertility treatment subsidies to make reproductive care more affordable and easier to access; $1.1 million for security updates to technology.

Building and upgrading health care facilities and equipment strengthens our communities care now and into the future, while modern infrastructure makes our health care system more attractive to health care professionals. Therefore, *Budget 2026* includes $21 million to renovate additional spaces within the former Western Memorial hospital to create 45 new long-term care beds; $12.1 million for a development of the Janeway Children's Hospital; $7 million for the new MRI machines in Grand Falls-Windsor and Happy Valley-Goose Bay this year, that's our commitment for this year, two new MRIs; $5 million for the advancement of a long-term care home in the Stephenville-Bay St. George region; $4 million for the advancement of the new Downtown Health and Well-Being Centre in St. John's; another $4 million for the planning and construction of new long-term care beds at Valley Vista Senior Citizens' Home in Springdale, and also in Labrador West; $3.7 million for the expansion of Humberwood Centre in Corner Brook; $2.9 million for 20 transitional and alternate level of care beds in Happy Valley-Goose Bay, $2.5 million for the advancement of 54 new long-term care beds in Clarenville, $1.9 million for planning of the new urgent care centre in Conception Bay South, $1.5 million for the planning of the redevelopment of St. Clare's Mercy Hospital, $1.5 million for planning for additional acute-care beds at the Health Sciences Centre, $1.1 million to purchase six echocardiogram machines, $800,000 for the expansion at the Health Sciences emergency department to increase treatment spaces and allow health care providers to maintain safe care and $479,000 for hyperbaric oxygen treatment therapy equipment.

Finally, this budget has to take on heavy work for properly funding health care. That's a big thing that was quite a shocker as Minister of Health, to see how many really necessary programs and care and infrastructure was underfunded. The burden was on the workers, the staff, to still deliver. That is something we should never, ever do. We should never put our public service workers in that position to have to deliver but not give them adequate funding to do so. It's shocking – it's shocking.

For me, that's one of the things that made me really disappointed and upset when I became minister, to uncover that. That is really, really unfair to our health care workers and the department staff that are actually out there to support them in Newfoundland and Labrador Health Services, and very, very frustrating for people over with Health and Community Services.

CHAIR: I will remind the minister that her time has expired.

L. EVANS: Thank you.

CHAIR: The Chair recognizes the Member for Cartwright - L'Anse au Clair.

L. DEMPSTER: Thank you, Chair.

I think after going through the Labrador Affairs, which is so small in comparison to Health and we didn't get too far in, because it's a full 10 minutes on either side, we're finding out, so we're not getting to ask the questions that are necessary in the process.

If it's okay with the minister and the Third Party, I don't think we need to be addressed if we just follow you. I feel like that's taking time.

L. EVANS: No, no. I think it's very important, because this is going into *Hansard*, that the person who speaks is recognized. That's the way it was. You've been in government for 10 years; now you're in Opposition. I was in Opposition for seven years; we followed along with the way it was.

L. DEMPSTER: It's good. I don't want to waste further time. It's an opportunity for us to ask questions. I was just looking at how to maximize that.

L. EVANS: Yes, just ask the questions.

L. DEMPSTER: Okay.

Under 1.1.01, can the minister advise which staff are budgeted from the Salaries line in the Minister's Office?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. DEMPSTER: Chair, could we reset the clock, because we lost some time there? There's a minute gone.

CHAIR: Sure.

L. DEMPSTER: Thank you.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Thank you, Chair.

We have five funded positions, two of them are permanent and then three are contractual.

L. DEMPSTER: Thank you.

Under Executive Support, Salaries here have decreased, can you advise why?

CHAIR: The Chair recognizes the minister.

L. EVANS: Are you in 1.1.01?

L. DEMPSTER: Under 1.2.01 now.

L. EVANS: Okay. Sorry.

The Salaries, yes, did decrease. It's a $151,000 decrease, actually, and that's mainly attributed to the removal of two contractual positions, a legislative position and a senior advisor. In actual fact, they were promoted; they weren't let go.

L. DEMPSTER: Okay. Thank you.

Still on 1.2.02, what is the reason for the increase of $730,000 in Revenue - Provincial in the revised last year?

L. EVANS: So that's 1.2.02 and the revised revenue? I'm looking at the line item there, a $730,000 decrease?

L. DEMPSTER: Increase.

L. EVANS: Okay.

This revenue reflects ad hoc revenue from miscellaneous sources, including recoveries on bursary defaults, MCP overpayments and vendor refunds. More revenue was received in 2025-2026.

L. DEMPSTER: Okay. Thank you.

Down under the Medavie contract, my question is a couple of days old because I did read the story that came in last night at 11:30. Has the minister made any changes to the contract with Medavie? I think the

story I read had to do with the hub for St. John's being retendered. Sometimes I'm on a line item and sometimes I'll go to something related.

CHAIR: The Chair recognizes the minister.

L. EVANS: For the Medavie contracts, one of the things that we're looking at, actually, is the contract for the medevac service for Northern Labrador and Southern Labrador communities.

In actual fact, when that contract was signed, it reduced the level of service from the old service. So what we have to do now is we are going in and we're visiting that, but actually nothing has been done yet. We need to actually bring the level of medevac service for Northern Labrador communities and Southern Labrador communities, which is in the MHA's district.

There is other work being done. I can defer to my associate deputy minister for the fine details.

K. NORMAN: Thank you for the question.

As the minister noted, this is a relatively new contract between NL Health Services and Medavie Health NL, which is a new organization established to deliver the consolidated paramedicine services for the province. We're still very much in the implementation and planning phase with the department, with Medavie and also with NL Health Services to look at the fine details. Key performance indicators have to be set for this year.

You might have noticed there are some things in the media; I think you referenced about where basing stations are going to be. NL Health Services is going through the leasing process for those. That's all about improving the quality of the facilities; because, really, what we had was a piecemeal process in the past with a number of private operators. The goal of that contract is to increase the standard of care and the responsiveness.

To the minister's point, we're actively working with all parties involved to look at areas of improvement, notably medevac and schedevac for Labrador. We're looking at a number of things there, specifically, the number of planes had decreased under the contract that were available on standby. We're looking at that to ensure that the level of service meets the needs of people in those communities, because it's really important when you don't have access to a lot of acute-care facilities, and many of those communities, you have just, potentially, one or two nurses, maybe a handful of other medical professionals. People are travelling long distances which –

L. DEMPSTER: It's my home so I know that part.

K. NORMAN: Yes.

So we're looking at that and looking at the way people avail of those services, both from the volume of flights, but also looking at the service delivery model and ensuring there are some improvements made in that regard.

L. DEMPSTER: Okay. Thank you for that.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I just want to add, too, we are getting four new planes on for the air ambulance service. That's going to actually make the service more reliable.

Right now, sometimes we are suffering from problems with a government aircraft being out for maintenance. The Member for Cartwright - L'Anse au Clair will know some of the struggles we have with actually trying to get patients from Labrador and other regions of the province into St. John's or to a hospital.

We are looking at recruiting more paramedics and increasing the level of expertise our paramedics will have. That should improve our rural region for medical emergencies. Also, we're increasing the number of ambulances. We, as government, when we were looking at making that one service across the province, we inherited a lot of old ambulances that needed repair. So we are looking at that, but, of course, anyone now who's trying to purchase any kind of supplies or equipment anywhere realizes that sometimes there can be quite lengthy delays.

Medavie is basically championing all that. We're looking at serious improvements. As time goes by, the benefit of this new system will become evident, and that's very, very important. I just wanted to add that.

L. DEMPSTER: Thank you.

One point I want to make on that before I move on because I know the minister said it a couple of times and in an interview that I'd heard and I'm not sure where it came from. It hits very close to home because it was said that I signed onto a less of a service.

Well, I wasn't the minister in the department, but right in the news release that went out on September 9, 2025, "Medavie is partnering with Provincial Aerospace as its sole air operator, which will sub-contract any other required aviation service providers, including Air Borealis. There will be dedicated medevac and schedevac services for coastal communities in Labrador, and the frequency of schedevac flights will be increased, with north and south coast flights available each day Monday to Friday, depending on demand."

That's what I knew from the Department of Health and Community Services and NLHS, and that is what I supported. The frequency would be increased. So I just wanted to share that for the record as well.

Still on Medavie, has the deadline passed for any of, I'll say KPIs, but for the purpose now, key performance indicators – that Medavie was supposed to meet as part of their contract? If so, have they met those targets?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Thank you, Chair.

I'd just like to address what MHA Dempster had said about the contract. There was erosion of services. When the contract was actually being developed, it came back to the government at the time, the Liberal government, that it was too expensive. So cuts had to be made.

I was told, in actual fact, that the reductions were for the medevac service, the flight to Northern Labrador, that is totally isolated without any road access, so you couldn't put somebody in a ground ambulance. You had to rely on the medevac service.

To me, it was very upsetting and very, very frustrating because sometimes we can have three or four medevacs going on in one day. The Member for Cartwright - L'Anse au Clair has witnessed it herself, in actual fact, trying to struggle to get somebody medevaced. Then we're dealing with weather delays and then you're dealing with triage.

If you don't have the flight, the aircraft available, then what ends up happening is the hospitals, the doctors have to triage to a really high level. So you're saying who's the most urgent, what person. Families get upset because their person, their loved one who needs to be medevaced should be considered urgent, too.

In actual fact, when you don't have the resources for communities that don't have access to ground ambulance and you have to rely on the airlines, on the medevac system, what happens is you're triaging to a really high level. I've witnessed where

somebody was actually waiting for a medevac, trying to get a medevac out of Nain and passed away. This is recent. I've witnessed it over many years where sometimes the medevac is not coming quick enough.

That is so important for us to put in, and I'd actually like to call on my associate deputy minister to explain what I mean by the contract was eroded, what was available before and when the new contract was signed and what I'm trying to do now is I have to go back and address that. I have to go back and try to at least build up the medevac service for Southern Labrador and for Northern Labrador to be what it was before the last government negotiated this new Medavie contract.

It's not a reflection on Medavie. Medavie is a really good provider. They've done a lot of decent stuff since they took the contract and they're leading the way. In actual fact, they're doing a lot of things quicker and more effectively than we thought they would. So it's not a reflection of Medavie but I would like for you to actually be able to talk about what I said.

K. NORMAN: Certainly, Minister, thank you.

Under the previous state, there were two aircraft dedicated for medevac services. One that was available wheels up within 60 minutes and another within 90 minutes. Under the current contracts signed with Medavie, the new state will be one aircraft wheels up within 75 minutes.

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: I'd like to add to that. In actual fact, there's no second aircraft guarantee that Air Borealis would have to make available. Under the old contract, the times were quicker and there was a second aircraft that would be available within a certain time length, that was a part of the contract.

Now what it is, if you need a second medevac, you have to go back and try to negotiate with Air Borealis and a lot of times they have their aircraft committed for other services like charters, passengers, freight in the summer going into the flight camps.

In actual fact, basically it eroded the service, that's what I wanted to be in *Hansard*, what I meant by erosion of the services. Really, what's happening is medevac is supposed to be timely.

L. DEMPSTER: I'll ask my question again around has there been any changes made to the contract, to the KPI. Has the deadline passed for any of the KPIs Medavie was supposed to meet as part of their contract?

I guess what I'm getting at is if they haven't met their targets, how many breaches occurred since the contract was signed and has the department imposed any penalties or corrective action plans?

L. EVANS: I'll refer to the intimate details with my associate deputy minister, but I will add maybe you could talk a little bit about the oversight that was supposed to be set up as well, that wasn't set up and money was actually put in year after year for that oversight.

K. NORMAN: Thank you.

No, right now, there are no KPIs or other performance-related targets under the Medavie contract that Medavie Health NL has not met. Medavie is required to follow a 17-month implementation phase, which we are still within. So, right now, what's happening is Medavie is managing the current state. The minister referenced a government aircraft, those pieces, those are all being managed by Medavie and there is a transition plan underway. It won't be until after that period that we would be looking at compliance with those KPIs that we referenced. In fact, the standards are currently being set, the baseline data is being captured to determine what the key

targets will be for performance under the contract.

Beginning in 2024, just under $1 million per year was provided from the Department of Health and Community Services to Newfoundland and Labrador Health Services to set up an oversight office. That is currently still in process. It has not been fully implemented. The staff have not been hired. The oversight has been provided at the vice-president level, as opposed to within the office. That funding that was provided in both *Budget 2024* and *Budget 2025* was not utilized to establish an office.

This past winter, we sent correspondence from our department to NL Health Services to advise them that in order to have proper oversight of the contract, this must be established as a priority. My understanding is that they're going through the final phases now of hiring for the director who will lead that office. The intention there is very much to do exactly what the Member opposite referenced: monitor the key performance indicators, monitor the contract and, if there are any issues with compliance or adherence to those standards, to take corrective action as outlined in the contract.

L. DEMPSTER: Thank you.

I think my time is up, Chair

CHAIR: Thank you very much.

That was our opening round of 15 minutes for remarks and questions.

I now recognize the Member for St. John's Centre and the Leader of the Third Party.

J. DINN: Thank you, Chair.

A question with regard to the Health Accord. The Health Accord has a number of documents, including The Blueprint, I'm just wondering if the Health Accord is still the guiding principle in our health care?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Yes, our government and myself, as minister, and the Premier as well, we've committed publicly to supporting the Health Accord and the social determinants of health. In actual fact, we can go into a little bit more detail of what that looks like.

K. NORMAN: As the minister mentioned, social determinants of health continue to guide everything that we're doing within the Department of Health and Community Services, and implementation of the Health Accord still remains a priority. In fact, a lot of the focus of the department right now is making sure the implementation of the Health Accord is done correctly and within the intent of those who drafted it. For example, our urgent care centres, they were part of the Health Accord. They were intended to alleviate pressure on our emergency departments in an effort to get down wait times.

As the minister has mentioned publicly, there's an ongoing human resources review to look at what are the barriers to getting the necessary family medicine doctors and nurse practitioners that we need to have that as an effective entity.

Another thing that we're looking at that the minister has commented on publicly are the Family Care Teams, which were also another centerpiece of the Health Accord. We're focused very much on trying to make sure that those are successful, which is all about recruitment, as I just mentioned. That continues to be a key focus but also ensuring that once people are attached to a Family Care Team, that they're able to get timely access and that enough patients are actually rostered to those Family Care Teams.

So from our perspective within the department, I can say that the Health Accord is something that gets talked about regularly. Really, the key emphasis now, a

few years out from its launch, is making sure that it's being delivered on and implemented and ensuring that the structures are in place to effectively have the necessary health professionals that we need to fully deliver on those commitments to improve access to primary care and alleviate some of the pressures in our acute health care system.

Does the minister have a further comment?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I just want to mention, too, we are making sure we're addressing the mental health and addictions needs for the province. We're actually creating a separate assistant deputy minister position that will lead that and champion it to just make sure that mental health is a huge priority and treatment for addictions is also prioritized as well.

CHAIR: The Chair recognizes the Leader of the Third Party.

J. DINN: Thank you, Chair.

So much of the Health Accord and social determinants of health really has nothing to do with the medical care system, the acute care system itself. We know that it has to do with the social spending as well, that actually more social spending leads to a decrease in the need for spending on health care.

The minister had talked about how the Premier had talked about we cannot be working in silos in the department. So I'm asking here, what specifically can your department point to, to show that you're working with other departments, Housing, Income Support, Climate Change, anything along those lines, specifically to address the social determinants of health?

I'm not talking about acute care beds but the things that will prevent people from ending up in acute care beds or long-term care beds for that matter.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: As Minister of Health, I've met quite frequently, sometimes almost every week, with the Minister or deputy minister of Seniors. I've met quite frequently with the Minister of Social Supports and Well-Being and, also, who's responsible for Housing as well. I've met with the Minister of Justice many times in her role in terms of justice but also supports for people in corrections, when we look at Indigenous people, when we look at women in terms of my dual role as Minister of Women and Gender Equality.

I just want to hand it over to my associate deputy minister again to add a little bit more of the finer details that the Member may be looking for.

K. NORMAN: Thank you.

Currently, we're looking at a number of matters directly with the Department of Social Supports and Well-Being as Minister Evans mentioned. Equity and firm policy and program development is being advanced and we're currently piloting a well-being policy lens, use of health impact assessments and health equity impact assessments, to try to look at the impact of health disparities on particular programs, including an initiative right now ongoing related to the income support program.

Another initiative that we're actively involved in is the Healthy Students Healthy Schools programming with the Department of Education and Early Childhood Development and we're also looking at safety in schools. There's been a working group struck across multiple entities to look at that perspective.

There's a lot of work underway within the department to support the social determinants of health. Dr. Fitzgerald is

leading some of that work in collaboration with other entities. There's lots more work, I guess, still to be done in that regard, but it certainly is a focus for us.

J. DINN: Thank you.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I just wanted to add, too, I don't think I mentioned my meetings with the Minister of Education. We met on many occasions, several occasions, one was to address safety in schools and basically moving forward with a wellness and health lens with Education. But, also, say for example, just looking at the needs across the province in health care, discussing programs such as at the College of the North Atlantic and Memorial University, the need for social workers, pharmacists, all the different professions, nurses, nurse practitioners. Those are the conversations we're having. We're certainly not working in silos. We're basically working together to make sure that no one is falling through the cracks.

J. DINN: Thank you.

I guess meetings are fine. In the end, it comes down to the person who's hungry and cannot afford to put food on the table, cannot afford a place to live, who's living in shelters, the person who's taking her chemotherapy while living out of a backpack with no place to go. Those are the things that matter an awful lot, or the people who use St. Clare's as a warming centre because they've got nowhere to go.

So when I'm looking for specifics, I'm looking for more than meetings itself. Meetings are fine. As a teacher, I've heard that one my whole career, we're meeting, we're meeting, we're meeting. In the end, I'm looking for specifics.

However, I'll move on to something specific with regard to pharmacare. A lot of people just cannot afford medication, especially when it comes to diabetic-related medication. Now, it's my contention that both parties missed the boat on this. I've heard that this current government, they have asked.

What I'm asking for now is what specific actions has your department taken – and I guess I'm looking for a timeline – to engage the federal government to implement pharmacare. I'm hoping it's going to be more than just writing a letter.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Well, first, I'd just like to address the comments made by the Leader of the Third Party where he said both parties missed the boat. Well, in actual fact, Sir, the boat was no longer in the harbour when we were sworn into government. As Minister of Health in October, the door had already closed. In actual fact, I did defend the past government, the Liberal government, when they were in for having the door closed on them.

I think the reality that exists was that the federal government was looking at a national pharmacare program, but what happened was they engaged and signed on three provinces and one territory, then called it a day – called it a day; closed the door on Newfoundland and Labrador. It didn't matter if it was a Liberal government or a PC government in place, the door would have been slammed shut.

One of the delays, why we weren't first to sign on, was that there was a lot of problems with the deal, and what it was for me was that the medications that you talk about for our diabetics, a lot of them that were going to be covered, weren't the ones that we were using.

So in defence of the previous government, they were trying to negotiate actually having the medications that people were using, that

they needed, that they wanted to use, put into the agreements. I certainly don't mind supporting a Liberal government that was doing that. In actual fact, if I was in government then, I would have been doing the same thing; I would have been trying to negotiate a proper deal for Newfoundland and Labrador.

My criticism is with the federal government. The federal government probably realized that it was going to be expensive and, in actual fact, having a little pilot of four provinces and a territory was probably more efficient.

Do you know what I did? When I became minister, the first conversation I had with the federal minister of Health, I asked about pharmacare and when can we actually be open again for negotiations, because we have an aging population. We have 25 per cent of our population over the age of 60, so we actually need it as a province. We are not a rich province. We actually did want to engage in the program. Then my next meeting, which was quite soon after I became minister, was with all of the Health ministers of the provinces and the federal minister, and I raised it again. When I raised it, I talked about equity across the Nation. This was supposed to be a national program, across the Nation, and we were excluded. Where's the equity in that?

After I finished speaking, actually, another provincial Health minister spoke up and agreed with me and talked about equity.

In actual fact, the fault lies with the federal government, not with the past Liberal government or with our current PC government.

Facts matter, and we did learn what the facts were, but there's more to it than that. I'll actually let Robyn, my ADM, add a little bit more detail to that.

R. HAYES: What the minister says is correct. We have been advocating repeatedly with our readiness to resume the active discussions with the federal government. We are looking to work collaboratively towards a national program that is implemented fairly, that respects our provincial realities and benefits people in every region of Canada.

Canada has not commenced active discussions with us, despite our advocation for resuming negotiations.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: In actual fact, the Premier went to Ottawa and I joined him, we met with the federal minister of Health, and the Premier raised it at that meeting and I raised it again at the meeting.

We do have to be diplomatic, and I can tell you, I was as diplomatic as I could be. I talked about the provincial need and the fact that we would like to enter the negotiations and we would actually like to be able to have those meetings. I also talked about equity again. The Premier very diplomatically stressed that we're interested in this and this is something that they should basically open it up to renegotiation again.

But do you know something? I don't think a national pharmacare program should be talked about when they only engaged three provincial governments and a territory and then called it a pilot project. It's not national pharmacare. The commitment made by the former prime minister was that he was going to negotiate a national pharmacare program, so where is that?

For me, it is a bit upsetting when we look at the missed opportunity, but not because we missed the boat, but because the boat left the harbour without even telling us they were leaving.

CHAIR: The Chair recognizes the Member for Corner Brook.

J. PARSONS: Thank you very much.

Thank you all for coming here today. It is a great opportunity to get into the nuts and bolts of some of this. I appreciate the work you're doing.

Minister, I'm going to ask just a few follow-ups there just to clean up a few issues.

Back to the Medavie contract, you've expressed multiple concerns. Now you've just said earlier that you don't fault Medavie itself, but the contract.

In addition to the issue with air access in Northern and Southern Labrador, what other erosion do you see in service because of this new Medavie contract?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Well, in actual fact, I think your colleague from Cartwright - L'Anse au Clair talked about improvements and having daily service. That daily service was already in existence before the contract was signed. We did not see – because I have lived experience, I have friends and relatives and family and my constituents in Northern Labrador – in terms of the frequency of flights, was less. In actual fact, that is something that we're working on in terms of being able to deliver.

I think my associate deputy minister talked about the role that Medavie is playing. They haven't taken over total leadership of the operations right now.

Did you want to actually just clarify for the Member again?

K. NORMAN: Certainly.

We're just about halfway through, I guess, the 17-month implementation phase of the Medavie contract. Medavie is standing up management oversight but there is a significant lift required to get to the full final state. As the minister mentioned earlier, there are four new aircraft coming on: the first one in July; then August, a second; in September; and then the fourth in November. So we're actively now working to recruit NL Health Services primarily, with Medavie Health NL, to fill more than 100 vacant positions for primary care paramedics and advanced care paramedics.

We've also stood up a number of significant benefits in the interim in terms of the oversight. There has been a clinical chief hired of Emergency Services. They're an emergency room doctor who has expertise in paramedicine overseeing the whole system. We have implemented clinical support in dispatch. So when somebody calls the dispatch centre now, if there's a decision to be made on when a patient gets move, an emergency room doctor, known as a medical transport physician, are there 24-7 providing that service. That is effective as of just this month.

As part of the CorCare rollout, there is now a Care Coordination Centre which helps to ensure that when a patient is moved, there's an inter-facility transfer, if they're being moved from one hospital to another, that there's a bed ready for that individual. What was happening in the past was that people were just being put in ambulances by their local paramedics in consultation with their physician in that hospital and then being moved, and sometimes that was resulting in issues like off-load delay.

Those are some of the things that we're looking at, putting the right structure in place so that once all the new assets, both road and air, are available, that they're fully staffed up. That's going to require a heavy lift.

We are also in active discussions with College of the North Atlantic and some private operators to expand the delivery of EMR programming, primary care paramedics and advanced care

paramedics. We have a significant shortage of advanced care paramedics in our province. In order to meet the goals and objectives of the Medavie contract, there's going to be a significant upskilling.

Perhaps if you'll indulge me just for a second, I'll give an example. We had an instance where there was a family that was upset about what happened with a transfer between one facility and another. When we went and looked into it, Medavie was extremely responsive in terms of looking into the issue. What happened was that there was an individual who hadn't had a lot of professional development before they came under the Medavie contract. They were able to put a professional development plan in place for that individual, to coach them through so that in the future, when they're dealing with a patient, they're able to provide more appropriate care.

So Medavie now has a whole clinical education arm that has been established where there are people who are directly supporting those paramedics. What I can say, looking at it from the vantage point of the Department of Health and Community Services, is that once we get to the final state, I think people will be able to have a lot more confidence in the system and there's going to be a lot of work between the Department of Health and Community Services, NL Health Services and Medavie Health NL to get to that final state.

The key focus right now, if you go on the NL Health Services board, you'll see probably 200 positions on any given day, being recruited for in paramedicine. So there's a lot of work under way to get the right number of people to deliver on that. Medavie Health NL told us recently that they manage the service in Nova Scotia, and they're the only jurisdiction in Canada that doesn't have chronic vacancies.

So we're confident that working with them, listening to some of their experiences in other jurisdictions, adopting some of those models in terms of the level of service that they provide, how they do, some of the training they do, some of their own in-house training, that we will get to a much better service that people of the province will have much more confidence in in the coming years.

J. PARSONS: Thank you.

So what I'm hearing is that I'm not hearing any contractual violations or anything like that. It is just part of the process, implementing the contract that is in place. We won't belabour that because I think that we could go all morning talking about this issue. It's very important.

I was really glad to hear, Minister, you say that it's important to take the politics out of this. Providing health care services is something that goes long beyond the terms of government. It's very important. It takes a long time to fix and change. It is a ship. It takes a long time to turn a ship around –

L. EVANS: Exactly, yes. A big one.

J. PARSONS: – or to change the direction, absolutely. But I'm also glad to hear that the department has a commitment to the Health Accord and the social determinants of health, as my colleague was talking about. I think it's really important that NLHS is at arm's-length.

What does the minister see as the role of the board of trustees for NLHS?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: The board of trustees is basically to provide guidance when it comes to the implementation of our health care delivery systems. Like, for me, they're totally independent of our Health and Community Services and Newfoundland and Labrador Health Services. But, in actual fact, it seems like with Health, the associate deputy

minister could probably add a little bit more of the technical answer to that.

J. PARSONS: Sorry, Minister, I was looking more from a philosophical, what you think, I guess, the role of government versus NLHS is. I know that I've received correspondence from your office before about operational issues and deferring to NLHS. I guess what is the distinction between something that – you mentioned Open Doors and the ability to address problems. How do you see your role in terms of addressing specific problems versus deferring to NLHS and the Board of Trustees?

L. EVANS: Well, I'm also the minister responsible for Newfoundland and Labrador Health Services, so when somebody in Opposition brings forward issues on behalf of constituents, where it shows gaps in the service, it's very, very important for us to be able to go back to Newfoundland and Labrador Health Services to identify it so that they could investigate.

More importantly, we talked about taking politics out. For me, it's not just about one person. You bring forward an issue with one constituent. But is that a chronic issue where other patients will also suffer the gaps in delivery of health care?

For us, it's working with Newfoundland and Labrador Health Services, because you talk about philosophy, I see Newfoundland and Labrador Health Services as the delivery end. Health and Community Services does a lot in terms of working together, in terms of policy and improvements for the service delivery, but Newfoundland and Labrador Health Services are the ones that are actually doing the delivery.

We can't also have a break between Newfoundland and Labrador Health Services and Health and Community Services because if there is, then that's where some of the gaps in the delivery will happen.

J. PARSONS: Okay, I guess I'll get one last one in here.

With regard to the Board of Trustees, I know Ross Wiseman was recently appointed as the interim chair there. That appointment, I'm assuming, didn't go through the Independent Appointments Commission, but will the next chair go through the Independent Appointments Commission and then through Cabinet?

L. EVANS: It is my understanding that it would. His title is interim.

J. PARSONS: Yes.

L. EVANS: You just want to speak a little bit to that –

K. NORMAN: Right now, on the Independent Appointments Commission webpage you'll see that there's a posting for recruitment for the provincial health authorities board of directors. That's there now for individuals who are interested in applying.

J. PARSONS: So we can assume that position will be reappointed soon.

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: In actual fact, it would have to go through the process.

J. PARSONS: Okay, thank you.

CHAIR: The Chair recognizes the hon. Member for St. John's Centre.

J. DINN: Thank you, Chair.

Just a follow-up with regard to pharmacare. I think it was said that the department has been advocating repeatedly, which means obviously numerous times. I'm just wondering, is it possible to have sent to us the list of advocacy efforts, whether it's through the phone call, correspondence? I

know the minister referenced meetings at the federal level, too, but I'm just wondering, is it possible to have a list of those repeated advocacy incidents?

The other part – and this is the question I'm asking here, too, because the minister talked about having a plan that respects provincial realities. Prior to that, I think the minister said that a lot of the drugs, they covered. If I heard her correctly, presumably pharmacare was not being offered here in Newfoundland and Labrador. Now, maybe I heard that incorrectly, but that's what I thought I heard that a lot of the drugs weren't going to be –

L. EVANS: Used.

J. DINN: – used here, so is that a concern more or less with the provincial drug plan as opposed to the pharmacare itself? Because we, in the past, have had to deal with drugs that are recommended but are not on the provincial formulary of the NLPDP plan. I know in my own teachers' plan any drug that has a DIN is covered. That's not the case for the provincial drug plan.

I'm just curious if, indeed, the problem there wasn't with the pharmacare program, it was the fact that a lot of the drugs didn't make it to the provincial formulary.

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: That's a really good question.

First, I'll just respond to your first question about list of our advocacy for all the meetings where we discussed it with the federal minister of Health, myself and the Premier and also at the meetings, but also the advocacy from the department. We can get that to you.

Regarding the list of drugs, I said that the drugs that were being used by our diabetics, a lot of the drugs that they were using weren't on the list. I'm explaining it in a layman's terms, so the department was going back trying to actually negotiate.

I'll ask the ADM to clarify what I said.

R. HAYES: The drugs that our population is using weren't being covered under the pharmacare program. The drugs being prescribed here, the ones that are effective for our population, they are not included under pharmacare, which is what the minister mentioned.

Drugs that our population are using, the ones that are effective and being prescribed here are not included in the pharmacare program; therefore, it was not beneficial at the time for us to sign on to a program that wasn't covering what our population was using.

J. DINN: Thank you.

Would it possible then to have that, as to what were the drugs? Again, it's great to say the drugs weren't being used, because I would say again, if you're using the provincial drug plan, the drugs that you're going to be using are the ones that are on that formulary, and I know it requires an awful lot of work just to get an exception made. I can think of several examples along those lines, so I wouldn't mind knowing what were the drugs that the population here is using according to the drug plan versus what was being covered under pharmacare.

With regard to St. Clare's, you mentioned that there was money for renovations. What exactly is being proposed to renovate and upgrade St. Clare's?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: In actual fact, when I became minister and we were looking at what was needed to repair and renovate St. Clare's to make sure patients were comfortable, and also that it was able to be properly

maintained for years to come, one of the things that was a missed opportunity was that, a couple of years ago, there was a request in to have an infrastructure assessment done on what was needed to maintain and repair St. Clare's. The past government decided not to do that. What we have to do now is we have to go back and do a proper assessment of what needs to be done moving into the future.

MHA Dinn, I will say, in actual fact, it was very disappointing to hear that, because if the new replacement for St. Clare's would have approved and built, it would have been at least six years before patients could move in.

What the patients are being exposed to right now through social media, talking about cold in the winter and hot in the summer, that wouldn't have been addressed. For us, it was basically failing to address patient needs, also staff needs, which are so important.

But I'll ask Robyn to provide you with more details on what that looks like.

R. HAYES: Currently, the most recent facility condition index we have for St. Clare's is dated for 2018. So obviously we need to have a more up-to-date, comprehensive facility assessment performed that will provide the detailed information required to prioritize the renewal and refurbishment efforts.

The assessment will include a comprehensive review of the building envelope, such as the curtain wall, the roof, the windows, as well as the core infrastructure systems such as ventilation, plumbing, electrical systems and elevators. It will also look at the capacity of those utilities, the water, electricity, the power plant, et cetera, and the potential for expansion of St. Clare's.

J. DINN: Thank you.

You'll get no argument from me with regard to St. Clare's, especially if it's renovating and updating it. The newest part of that hospital is only six years older, I think, than the Health Sciences. That's there on St. Clare Avenue.

I think the minister mentioned the fact that there are paid working terms for health care professionals – nurses in this case, I guess – paid work terms for nursing students who go to hard-to-fill areas. I'm making sure I heard that correctly. That is my understanding.

L. EVANS: Yes.

J. DINN: Okay.

I guess two things, what constitutes a hard-to-fill area, whether it's geographical or a specific field? The other one, my concern is why not implement a paid work term for all nursing students and not just for the ones who are going into hard-to-fill areas? You can deal with the incentivizing when people get out into the workforce. My fear is that what you are doing here in the nursing students is you're sort of creating a two-tiered system as well.

When it comes to nursing, we want to encourage people to go into the nursing profession itself. So why not implement it for all nursing students, a paid work term? That's what we've been calling it, and not just in health, but in education and social work as well. But here, we will deal with Health.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: MHA Dinn, you asked a really good question. In actual fact, I –

J. DINN: I'm looking for a really good answer.

L. EVANS: You're looking for a really good answer.

AN HON. MEMBER: Here it comes.

L. EVANS: Yes.

One of the commitments in the blue book, and what was at the heart of the commitment in the blue book, was, first off, respecting and supporting our students doing the work terms. That was something that was looked at.

Also, for us, one of the ideas being tossed around – and it's very logical – is that if you have somebody doing a work term out in a region that they've never been in before, in actual fact, it might be something that they would get used to and become familiar with and want to work out there. One of the barriers to being able to attract people to a region that they're not familiar with is the unknown. That's one of the reasons why we were looking at the paid work terms in hard-to-fill regions.

In terms of the overall information, I'll just defer to my associate deputy minister to talk about the details.

K. NORMAN: Thank you.

Budget 2026 included $5 million to provide paid work terms. There hasn't been a release of the specific details on exactly which occupations, locations, et cetera, for exactly the kind of reasons that the Member opposite is referencing.

The final design of this program will be announced later this year. We're actively working with the Department of Social Supports and Well-Being and Education and Early Childhood Development, because this is intended to be a phased implementation in line with the commitment in the blue book, which focuses on health, social and education services. There will be more details forthcoming on the design of that. The final decisions have not yet been made on exactly what that will look like.

L. EVANS: Thank you. I just want to add to that.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: This is the first budget. What we're looking at, MHA Dinn, is an eye to the future in building on what work terms we would be able to cover, paid work terms in the future.

Also, we actually did do a commitment during the election campaign to the Nurses' Union about the nurses. That's why, to start off with, one of the priorities would be looking at the nurses, but that's not the be-all and end-all. We are looking to expand it in future budgets. We're hoping to be able to do that.

CHAIR: The Chair recognizes the Member for Cartwright - L'Anse au Clair.

L. DEMPSTER: Thank you, Chair.

Back to 1.2.02, I'll continue on there, starting with: Can the minister provide current vacancy rates for RNs, NPs, LPNs and PCAs, as well as the number of current physicians licensed in NL?

L. EVANS: Yes, we can provide that information. I'll just ask the deputy minister to talk a little bit about it, and then be able to supply, maybe, the details.

C. STOCKLEY: We're working very closely with the Nurses' Union with regard to filling positions. We have a very good relationship with them at this point, as well as working with the Nurse Practitioner Association.

I don't have that level of details with the current vacancy rate, but we will certainly get that for you.

L. DEMPSTER: I appreciate that. Thank you.

We did just talk a little bit about this, the Third Party Leader did, the budget didn't include any increase to nursing seats as promised in your platform, but instead committed to filling existing seats in the nursing satellite sites that we had created.

I guess I'm just wondering what exactly is the plan for the $8 million in order to achieve that objective? I was trying to find where that $8 million is in the Estimates line.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: One of the things we looked at and, as minister, what I was told when we were looking at the budget is that our satellite seats weren't being filled totally. In actual fact, every seat that's not filled or we don't actually have somebody graduating is a lost position to the system.

We want to support rural regions, we want to enable nurses and nurse practitioners to be able to attend school in their region, if at all possible, so one of the things we wanted to do was be able to invest in the satellite seats to ensure we could fill it to capacity.

In actual fact, we're having quite good success with that. I'll just let the associate deputy minister add more details to that.

K. NORMAN: As mentioned in the Budget Speech, there's almost $8 million – $7.7 million to be exact. You won't find that in Health and Community Services Estimates; that's actually in Education and Early Childhood Development under Memorial University. That's a historic ask that had come from the faculty of nursing to properly, I guess, resource those seats.

In addition, there was $150,000, which you will find under the RHA vote within our department, to do a feasibility study to expand the number of seats both within the Bachelor of Science in Nursing program and the nurse practitioner program. There's work underway this year to inform a future budget decision on expansion of both of those programs.

The satellite seats, historically, had about 66 per cent filled on average. There are 72 seats there but, typically, only about 48 of them had been filled; furthermore, only 84 per cent of that 66 per cent were actually completing their program. So when we looked at it in terms of the most efficient way to get more nurses into the system quickly, the satellite seats were seen as an opportunity, really, to make an investment to support delivery.

What we're seeing, too, is that, when students are studying in those communities, they're more likely to be retained within those regions. If we look at Central zone and we look at Labrador-Grenfell zone, that's where we have higher nursing vacancy rates, getting closer to 10 per cent as opposed to under 5 per cent, which we're seeing in Western and the two Eastern zones.

Practically, that money is going to support trying to get student success from 84 per cent to about 90 per cent. We'd like to see at least 90 per cent; 100 per cent would be great but recognizing life happens and not everybody completes their program. The goal being a 90 per cent target is adding nurse educators, lab instructors, health and wellness navigators and student peer mentors.

There's also work undergoing with the Department of Jobs, Growth and Rural Development to support marketing and awareness of these programs for individuals who may not know that you can actually study to be a nurse in Gander, Grand Falls-Windsor or Happy Valley-Goose Bay.

So those are some of the things that are occurring to support that, and then, as I mentioned earlier, the nurse practitioner seats expanded in 2023 going from a 20 to 40. Right now, this year, there are 23 nurse

practitioner students on track to graduate, so the goal is to look at how do we get more people graduating within that program and, also, how do we look at opportunities to expand seats beyond the existing capacity for both the undergrad and also for the nurse practitioner program.

L. DEMPSTER: Okay. Thank you.

We know that it's difficult to fill in rural areas, and that's why we were offering things like partial tuition and things like that. I do know there's a huge need here, I think there are not enough seats in urban areas, but, still, we need to have that opportunity as best as we can in rural for all the reasons you alluded to and from way back in my employment counselling days. We ran a program with nursing cohorts in places like Happy Valley-Goose Bay, in which your students were able to go because they were close to their families, and some of those nurses – even in my hometown, the nurse has been there for 20-something years, came through that program, she stayed. She's my cousin actually.

I want to ask about the medical radiation technologist. I did ask in Question Period the other day. I know that there were two new MRIs in the budget, with a promise for two new additional in future budgets. I had several people email me – you get lots of emails when you're the shadow minister, I'll tell you that. They were saying there was no mention of the staff needed and kind of outlining the challenges around that. We know that, in reference to Medavie, you mentioned earlier 100 vacant positions right now, so that's something I may come back and visit in a minute, if time permits.

Is there a plan to increase the number of medical radiation technologists in the province? I suppose I can ask here, too, do we have estimated timeline for the machines, staff and all of that? Those are some of the questions I'm getting as well.

Thank you.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Yes, just before I answer the questions about the MRI, I do recognize the Member for Cartwright - L'Anse au Clair did say she understands about the seats not being at capacity and the value of having people out in rural, like in your region and in my region, as well. The students that went through the nursing program a few years ago in Happy Valley-Goose Bay, they're either working with Newfoundland and Labrador Health Services in our clinics or they're with Nunatsiavut or Innu Nation health in our region. That's so valuable.

You said there's not enough seats in urban, right, but one of the things that was looked at was, in actual fact, out in rural parts, the seats weren't filled to capacity and they needed more in urban. One of the logical conclusions was, well, why don't we take those seats and move them in, but we wouldn't do that. We wouldn't do that to the rural regions. We have to support making the courses available so the nurses can graduate in rural parts of the province with a hope that they will stay. That was a really good investment. I think everyone will support that.

Two MRIs this year, and in Estimates for Labrador Affairs, I did say I had to ask the Premier: Are you sure, Premier? I mean, it was more than I could have hoped for and it was more than most people would hope for – two MRIs out in rural parts of the province in the first budget. It is an investment in rural health care and, MHA Dempster, we know that this MRI for Labrador is going to be a recruitment tool for doctors, for health care professionals. It's going to modernize health care in Labrador. It's such a positive thing.

As for the staff, one thing I realize is that we do have a serious problem in recruitment and retention, but we are doing more to actually attract more, but we're also looking at supporting students while they're going through the programs for a return in service.

I'll ask my associate deputy minister just to go into some of the things we're doing to try and recruit, but I want to say, at the end of the day, we couldn't leave this problem of, well, what are we going to do for the workers, not to build it? There's a saying: If you build it, they will come. We have to invest in rural. These MRIs are so important; it's a commitment. We can't allow saying, oh, we're worried we're not going to be able to get the positions filled.

I'll just refer to you, Katie.

L. DEMPSTER: When you answer, can you just speak to timelines for the MRI and the staffing piece.

Thank you.

K. NORMAN: Okay.

I'll start with the staffing piece because I have that more top of mind.

The medical radiography program at the College of the North Atlantic currently graduates 15 student per year and typically most of those go on to work in X-ray. Within NL Health Services, individuals can work in X-ray, mammography, computed tomography, CT and MRI. Right now, with the addition of the new MRI scanners, we're in active discussions with the College of the North Atlantic and our colleagues in Jobs, Growth and Rural Development to look at increasing the seats. There are a couple of different options underway that that department could potentially speak to as well, because we know we need to increase the pipeline.

To operate an MRI, you need more than just the CNA program. Most individuals who are working as MRI technologists in the province go on to complete a post-graduate diploma. Part of the conversations that we've been having are about laddering programs and opportunities for people who are currently working in medical imagining in those sites to complete additional training by distance education in order to be ready when those MRIs come on stream.

Right now, there are 12 CNA graduates of the 15 seats who are expected to graduate and 10 of them have accepted full-time employment. The other two are currently going through final discussions with NLHS. We expect that all the individuals coming from that program at the College of the North Atlantic will be retained this year.

When it comes to the timelines, Justin, do you have timelines for MRI, when they're up and running?

J. GARRETT: We don't have the exact timeline right now because it happens in two stages. First, we need to go ahead and do the renovations on the site that are very specific to technology being purchased and installed. So once we have a handle on when the renovations are concluded, that's when the order of the equipment or – sorry, the accepted delivery of the equipment will be finalized to ensure that you maximize the warranties under the equipment. You could try to time it so that the equipment is right and installed the moment that the very site-specific renovations are concluded.

L. DEMPSTER: Thank you.

CHAIR: Okay, I thank everybody for their participation, I guess, in the first half.

As Chair, I will now call a break. It is 10:30; we're about halfway through. So we'll reconvene in 10 minutes

Recess

CHAIR: Order, please!

We are coming back from our recess break halfway through.

We are still on the head of expenditure with Health and Community Services. We are currently under subhead 1.1.01 to 1.2.02 inclusive, Executive and Support Services.

The Chair recognizes the Member for St. John's Centre.

J. DINN: Thank you, Chair.

With regard to recruitment and retention, I know that certainly with doctors and medical students, they do get rotated through rural areas, and I guess what you might consider hard-to-fill areas and so on and so forth. So that's part of their training.

The other issue is, if you look at family practice, a lot of medical students are not going into family practice, and I would say that there are other factors there as well. Specialists, I guess the thing – and I can think of my daughter and her colleagues who went into specialists – they are not necessarily going to move to a hospital in a remote area, regardless of how well they like it or how much they get paid because it comes down to keeping the skill level up. Even you compare a hospital here compared to a hospital in the middle of Toronto and the skill levels. I think there are other factors that are at play here, other than the incentivizing it. But I think we'd also need to find a way to get people into family care as well.

Even with the MRI, I don't know what the rate of use is, but it's going to come down to attracting people who actually are able to maintain their skill level and their certification and so on and so forth. Just something to keep in mind, whenever we're looking at providing services, it comes down to the people trained in these areas, they want to maintain their skill level as well.

With regard to CorCare, which has been in the news and even prior to, since its release, prior to that we had an awful lot of physicians come to us with concerns about the delay it was going to cause and the impact on care. I have a question, sort of related to that, and it has to do with personal information. Where is that information ultimately stored?

I'm assuming it's in the United States somewhere and maybe not, but that's what I need to know. How are we going to make sure that it remains personal? I do have the App on my phone. There's a certain level of nervousness around this, considering the breach a few years ago with the health department and recently with that AG report on PowerSchool.

I'm just trying to get an idea here, what measures are we going to take? I'd like to know where the data is stored. Is this an American company or a Canadian company? If they're an American company, are they subject to the laws that govern, like in the States with regard the PATRIOT Act and access by the government to information of American-owned companies? What protections are in place to reassure me that my data is not going to end up somewhere, in the hands of people I do not want it to end up in?

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: That's a really good question. That's a question that I, myself, was concerned about.

As you know, Meditech was the old system. I'm not sure, MHA Dinn, if you had access to the same ATIPP that I did regarding Meditech and the warnings that were given to past Health ministers repeatedly about how this system was vulnerable. In actual fact, the warnings weren't followed and nothing was done to protect the system from being hacked, until we had the hack where there was a lot of personal information that was stolen, basically, up for ransom.

That is a very legitimate question, but the CorCare, Epic, the system that we have in place now, is much, much better. It has a lot more layers of protection built in. I'll just ask the ADM to go into more details.

Gillian, did you want to add to that?

CHAIR: The Chair recognizes Gillian Sweeney.

G. SWEENEY: Thank you.

To answer your question, the data in CorCare is, indeed, housed in Canada. There was a very thorough PIA that was done as part of the contract with Epic, who is the vender.

Certainly, as well, just with regard to the concerns that you raised about personal health information, there continues to be an investment in IT infrastructure, as well as in cybersecurity, to ensure that personal health information is protected. In *Budget 2026*, there is an investment of a further $14 million as part of a multi-year cybersecurity program at NLHS.

J. DINN: Thank you.

With regard to – I guess I've seen the benefits of it – having an X-ray on one day and the results the next day on my phone, that's great. It wasn't life-threatening or anything like that, pretty straightforward. But for someone in regard to getting a cancer diagnosis, for example, something that is potentially life threatening and life changing and everything else, and getting that information while you're out at a meal with your spouse or partner or friends and all of sudden this comes up without the benefit of having the ability to speak to your health care provider, I'm just wondering, what are the protections built in there so that, if it comes to a life-changing type of diagnosis or information, so that the person is not left stranded in some situation where they've got no one to speak to or a health professional? I'm just curious, has that been considered?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Yes, actually. That's a really good question.

I do understand what the Member is getting at; I think he's alluding to say, for example, a cancer diagnosis. If you're going to have a biopsy done and then the results come back as cancer, that can be quite upsetting to somebody. In actual fact, the way MyChart works is you get a notification that your results are in. You don't actually see what the results are until you click into it. You actually decide to reveal your results. You know it's either going to confirm that you have something that could be quite upsetting, like cancer, or that you don't, which would be good news. The decision is yours.

So if you see that, if you need supports, you then have the option to call family or friends or supporters to come over to support you while you access your results, or you can actually call your family doctor or whomever is your care provider and say: My results are in, can I come in and we discuss them before I actually know what they are.

To be quite honest, I'm speaking from a lived experience. I just had a biopsy done on a tumour for cancer, and it came into my phone. It was very quick. So what I did was I called my doctor to inform him that the results were in and he made an appointment but, in actual fact, I chose to look at what my results were before I actually went in to see him. That was my decision. If I needed extra supports, I could avail of them. There will be people who will need supports, whether it's going into a doctor or going into a care provider or a nurse practitioner to have that support or actually have family members or whatever.

At the end of the day, we can't stop progress. We have to address the needs of the patients. If the patient needs support, your physician or whoever is looking after you in terms of a diagnosis, then, of course, you have the conversation. When will your results come in? What are your supports? That's something that could be easily solved.

At the end of the day, your results come in much quicker because you don't have to wait for your doctor to call to let you know he's got the results or for you to call to make an appointment to go in to see if he has them. In actual fact, I saw it probably the same time my doctor did. It is an overall improvement to health care.

J. DINN: Thank you.

I would agree, we can't stop progress, but progress has got to benefit the people as well.

I have a question with regard to the Aging Well at Home Grant. How many people availed of it last year?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Could you just –

J. DINN: I'm just wondering how many people availed of the Aging Well at Home Grant last year?

R. HAYES: We don't have that information. We can certainly get that for you though.

J. DINN: Thank you.

Thank you, Chair.

CHAIR: The Chair recognizes the Member for Cartwright - L'Anse au Clair.

L. DEMPSTER: I will say that was one of my questions, so I'll park that and we'll get a copy as well. Also, at the onset today, I neglected to say, can we get a copy of the binder after?

L. EVANS: Yes.

L. DEMPSTER: Thank you.

The lights are little bit annoying here, going up and down. For someone whose vision is not what it was when I was 25, it's a nuisance.

CHAIR: I've been assured that it is being worked on. I appreciate everyone's patience.

L. DEMPSTER: Thank you, Chair.

I wanted to ask, what is the status of the implementation of the report of the All-Party Committee on Mental Health, Substance Use, and Addictions? It's forefront in my mind because I had a gentleman reaching out for a little while to meet. I did meet with him last week, and quite a tremendously sad story in his life. He did mention he too had presented and was anxiously awaiting this report.

One of the key findings from the report was around the social determinants of health and the need to support positive, active and enriching environments for children, youth and families. One of the initiatives that we had launched related to that was the Child and Youth Community Health Model, which was launched in phases. So I'm kind of interested in knowing the current status of that as well, but just overall the report. Actually, a few weeks ago I did an interview and, before we logged on, the reporter asked me if I had an update, which I didn't. So there are a few people that are wondering.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Thank you, MHA Dempster. That's a really good question.

One of the things I talked about earlier, too, is that we are creating a position, assistant deputy minister of Mental Health and Addictions, to sort of address the findings of All-Party Committee report. I participated, and I know the Member from the Third Party was a part of the All-Party Committee as well, so the findings are very, very important.

Budget 2026 includes base funding for 49 permanent full-time positions to assist in stabilizing the models and reducing wait times for mental health and addictions services. There are many details but, for me, I just want to say mental health and addictions is something that really needs to be supported across the province. We have people now falling through the cracks. A lot of times people don't even know about the supports and services that are out there, so that's something that we need to work on.

I'll just let Justin actually go through some of the details in the new budget.

J. GARRETT: Thanks, Minister.

As you mentioned, yes, we have received the report of the All-Party Committee on Mental Health, Substance Use, and Addictions and, in that, there were 10 recommendations including social determinants of health, wait times and timely access to care, consistency and continuity of service delivery, harm reduction and support with community-based agencies. Within those 10 recommendations there was probably about 54 calls of action.

We're currently looking at that within the department with the view of releasing a second action plan in response to those specific recommendations. However, as the minister alluded to, we are still investing in a number of initiatives that support the recommendations of that report. Within this current budget, there is an expansion of Mobile Crisis Response Teams to focus specifically on those struggling with substance use; we have additional funding to support mental health and addictions staff, the expansion of Doorways into schools and, of course, we have additional funding of $3.75 million to support the expansion of the Humberwood Addictions facility.

There are a number of initiatives happening to support the recommendations of the All-Party Committee report, and we're looking at releasing something soon.

L. DEMPSTER: Okay, that sounds good. Thank you.

Before we move to the next section, I have three things, and a couple are just to comment. Lots of people in the department and things, and hopefully someone through a connection with NLHS will see this, because I know the minister may not have an answer today.

When we were talking about air ambulance systems, one of the things that I've experienced this winter on three different occasions – well, actually, the first one was around the 4th of December and then there was two this winter – that may have been happening before but I hadn't quite recalled it, was when a medevac comes off the Coast or comes out of Blanc-Sablon.

Recently, it was a man who was on dialysis, things like that, so they know the system inside and out. He came out of Blanc-Sablon and the family said, we're going to St. Anthony? That doesn't work for us. We have to go direct to St. John's. Everything was set for him to come here and then the shift changed at 8 in the evening and they said, no, we have to take him to St. Anthony. We're just following protocol.

The long and short is there was a flight that took him to St. Anthony. As soon as he got there, the folks said, we can't deal with him here; he has to go – they waited the next day, and the folks who were flying the plane said, we told you we'd be back.

There was that case and there were two other cases; one the minister would be familiar with around a brain tumour – neurology. He left the Coast after multiple days to get him out. He got to St. Anthony and then it was multiple days to get him in here and the neurologist in here was waiting.

So I would just offer to try and make improvements as we go forward. I know that you and I probably know this system better than anybody else, I would say, but the most important thing, it's time and it's lives, but it's also money.

These three individual occasions within the last six months, left the Coast and went to St. Anthony, because that was protocol but they needed to be in here. There should be something in the charts. I know the dialysis has been since 2019, so his story would be well known. I just wanted to share that piece.

A comment I'll make on CorCare is, I agree, we can't stand in the way of progress. I have an individual at my place here in town that made the long trip from Labrador yesterday, who's on a cancer journey. This is an individual who will often check her blood work and things, she has been on this journey for a year, but when she had her CAT scan done and was told she needed a face to face with her oncologist, she couldn't get that for more than three weeks. That was one time where she said, I'm not going to check because I may misread or it may look really bad. She made that decision, but she made the comment to me, the system is good, but if we have to wait three or four weeks after, and she has access, there's that gap that seemed like a long period of time. I just wanted to share that.

Then I had a comment around St. Clare's, the facility condition indicator, I think what I saw was in 2018, it scored 53, which was the lowest of any facility in the province. So my thought is, to all the folks here, if it was that dilapidated eight years ago – and, I know, I was down there a couple of Friday's ago to see three constituents. Actually, it was the day the CorCare started to roll out, I spent the evening there and there were lots of comments about the hospital, concerns.

But my question, before I lose my time on the clock, is around Medavie. Between the minister and the ADM, what I heard was there are four new planes, one coming in July, one coming in August, one coming in September. I guess I'm just wondering when that was announced in early September, it was at a cost of $561 million, correct? I'm just wondering, Minister, do we have any idea of what the cost will be now with the extra planes and things that weren't in the initial contract?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Okay, thank you, Chair.

Yes, regarding the air ambulance where a patient was taken to St. Anthony and the patient thought they should go to St. John's. From what you're saying is that they ended up in St. John's anyway, eventually. There are protocols, and I'm not sure if that was a miscommunication between the staff at the clinic and the doctor, because the decisions to move a patient always falls to the doctor for air ambulance and for medevac. That's something we can't overrule, as politicians or as MHAs. So that might have been something to do with – because that seems like more of a communication problem. That's something that probably needs to be addressed.

Regarding the brain tumour, I was quite familiar with that one. You referred to it as a patient with a brain tumour. The problem was around triage because we talked about the fact that our aircraft are older, they're out for servicing a lot and we tend to actually struggle – and this is something that's been going on for years. These new planes now, the four new planes under Trepel, that will actually increase the ability to move patients faster and in a more timely manner. That's something that will solve that problem. But like I said, it's something that we inherited. It does take time for the planes to come online.

Going back to CorCare, where somebody came into St. John's. You said that she said she had to have a CAT scan and waiting

three to four weeks to see the oncologists. We know there are delays in people being able to see their doctors. That's something we're working on in terms of recruitment and retention, trying to improve that. That's something that hopefully now, with the new initiatives, the wait time won't be so long.

Also, that's a conversation she can have with the oncologist, if this happens again. I need a face-to-face, is there another alternative that they can access?

Looking at the St. Clare's facility, 2018, you referred to about the indicators, a score of 53 and that was the lowest and you referred to St. Clare's as dilapidated. Well, it's still functioning as a hospital, but to be quite honest, in 2018, the hospital didn't get like that all of a sudden. Basically, there's been a failure to maintain and keep the hospital up to date. There's been a lack of inspections that would actually identify a lot of these problems and lack of maintenance.

As the Member for Third Party talked about, parts of that hospital are fairly new, but for us, we're going to do a comprehensive inspection and start the maintenance as was answered in a question previous.

I just wanted to address those comments because they are in *Hansard* so I'd like to also have some of our answers put into *Hansard* as well to address them.

The last question the Member for Cartwright - L'Anse au Clair had was on medevac and she talked about the four planes. Three will be flying and I think one will be there to ensure if some plane has to go down for servicing or maintenance that we will be able to maintain a fleet of three active planes.

Looking at the cost of $561 million, that cost is not changing for the planes. What we have to look at now is the needs for Southern Labrador patients and Norther Labrador patients in terms of trying to bring up these services to a better standard for the medevac. That will be a separate item, a separate cost.

I'll actually let Katie continue on to answer the question there about that $561 million and change.

K. NORMAN: Thank you.

The $561.7 million, that's the cost of the in-contract components for Medavie from September 1, 2025, to March 31, 2035, which basically covers off the management. There are 100 management staff within Medavie, that's what that is. The subcontracts to PAL and Air Borealis are part of the $561 million and then there's a management fee that we pay to Medavie every year.

In addition, just over $100 million is the operating budget of NL Health Services. That's where we've had to make some additional investments in this current budget, which is mostly covering costs with leasing the ambulance bases and staffing. There was additional funding of $2 million put in the budget this year to support expansion; some of that has to do with fatigue management and the scheduling of the paramedics – paying overtime, effectively, so we put additional funding in the budget for that.

Medavie, as we talked about earlier, there has also been an effort to consolidate some of the leasing bases. There are tenders and things that are out for new lease space. NLHS is also responsible for that, but that's not part of the $561 million.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Just to add to your question, too, when we do go back, if we do actually change the contract with Air Borealis, then the $561 million will have to increase, just to clarify.

CHAIR: Just for a way of reference and noticing the time, we do have a stop 12:15 and a hard stop at 12:17. Being on the first subhead, I just wanted to remind Opposition that you don't want to run out of time.

The Chair recognizes the Member for St. John's Centre.

J. DINN: Thank you, Chair.

One question: How far along is the department in implementing the 23 recommendations from the *Long Term Care and Personal Care Home Review* released in February 2025?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I wouldn't know the details offhand. That's something that would be covered under Seniors. We have been working with Seniors in terms of the information.

Do we have anyone here that would actually have access to that information? No.

MHA Dinn, we can actually get the information from Seniors and make that available to you and to the Official Opposition as well.

J. DINN: Thank you.

Chair, we are going to the technical briefing on the Churchill Falls MOU.

CHAIR: Okay.

Thank you.

J. DINN: Thank you.

CHAIR: The Chair recognizes the Member for Corner Brook.

J. PARSONS: Are we done with this subhead?

CHAIR: We can be, yes, if you have no more questions.

J. PARSONS: Yes.

CHAIR: Okay.

Seeing no further questions, I now ask the Clerk to recall the subhead.

CLERK: 1.1.01 to 1.2.02 inclusive, Executive and Support Services.

CHAIR: Shall 1.1.01 to 1.2.02 inclusive, Executive and Support Services, carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 1.1.01 through 1.2.02 carried.

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

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

CHAIR: Shall 2.1.01 to 2.3.01 inclusive, Client and Support Services, carry?

I now call on the Member for Cartwright - L'Anse au Clair.

L. DEMPSTER: I'm going to give my colleague a chance (inaudible).

J. PARSONS: That's right.

CHAIR: The Chair recognizes the Member for Corner Brook.

J. PARSONS: Thank you very much.

Actually, I probably have more policy questions in the next section, the next set of

subheads, but I do have one set of questions. Again, I know this is a very hot topic, and, Minister, I apologize for the consternation I'm sure that this has caused you. But obviously, we've heard a lot of criticism about the paying of a physician through MCP for his role in the Premier's office.

What I'm wondering is can the department tell us how many physicians are being paid for administrative services in government right now?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: What subheading is that? Physician Services, sorry about that. My tabs are a little bit different.

In actual fact, just looking at that, we do have four under administrative services.

J. PARSONS: Could you tell us where they're placed and what their role is?

L. EVANS: Okay, I'll just ask my deputy minister to answer it.

C. STOCKLEY: We have three physicians embedded in the department providing administrative services. There is one physician that has an office in the department but is also in the Premier's Office, as I understand.

J. PARSONS: Okay, and that is the one we'll be speaking of, of course.

C. STOCKLEY: Yes.

J. PARSONS: Who, I guess, approves the hiring of physicians into core government or into political roles?

L. EVANS: In terms of political roles, you're talking about special advisors, EAs?

J. PARSONS: Yes.

L. EVANS: That usually rests with the minister. Say, for example, my EA under Health was hired through me, in consultation with the department. For me, as Minister of Health, I've also got an EA over in Women and Gender Equality and I also have a special advisor.

J. PARSONS: In terms of like other roles in core government, the three others that were mentioned, how are they hired? I know that there is an approval committee for salaried positions within NLHS; is that the same kind of process or is it done through the departments?

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: I'll let the deputy minister go into the details regarding that.

C. STOCKLEY: It actually depends on who they're reporting to. There's one that provides advice to the deputy minister's office, so I would sign that contract. There's one that provides advice to the director of Physicians Services, and I believe the ADM signs off on that one. Then the other one is a similar situation, a director type of position, so that would be assigned in the department as well.

I know that the one that provides advice to the deputy minister is signed off by the deputy minister, because I did that. The other two were done before me, so I believe it's deputy minister or ADM.

J. PARSONS: Okay.

Is the physician that's working in the Premier's office paid through this budget item that we're talking about here 2.2.01?

L. EVANS: The position you're talking about is paid through Grants and Subsidies.

J. PARSONS: Under that subhead, though?

L. EVANS: Under that subheading there, yes.

Actually, when you're looking at the line items, 10, Grants and Subsidies, he is currently being paid out of Grants and Subsidies.

J. PARSONS: Okay, thank you.

Does that advisor work exclusively for the Premier's office or does he also provide advice to the department itself?

L. EVANS: I'll speak to it and then my deputy minister. He also performs an advisory role to me as Minister of Health. If I do have some questions or concerns, or just want to run some things by him, we do have those conversations. Sometimes it's by phone.

Sometimes he comes over to the office; we schedule in a meeting. Sometimes, with our busy schedules, he'll drop by and we'll actually have conversations about different things.

Also, when he's there and he's talking to me, he's also in the advisory role of the Premier's office. It's really, really important for the Department of Health to be in line with the Premier's office in terms of communication. It's important for the Premier's office to have that line of communication. That's a role he also plays as well, just having that relationship with the Premier.

He is a rural emergency doctor. He is actually very, very knowledgeable. He also has a lot of expertise on the issues facing rural medicine and some of problems and some of the solutions. He also has a great working relationship with the doctors out there, whether they're in Family Care Teams or they're Family Care doctors or they're working in hospitals in specialties, his advice and his leadership is invaluable.

J. PARSONS: Is the advice given technical advice to the department or is it political advice through the Premier's office and his staff?

L. EVANS: In actual fact, for me, I can only speak from my relationship with him. His advice has always been about health. It has not been about politics or the party. I can honestly say we don't talk about politics. Most of our conversations are about issues, barriers, wait times or family doctors may have some issues. Even in terms of recruiting, his experience in the rural regions and in rural medicine is invaluable.

J. PARSONS: Okay. Thank you.

L. EVANS: I'd also like my deputy minister to add a little bit to that for clarification.

C. STOCKLEY: I, of course, would not be receiving any political advice as a public servant. It's just technical advice when any is needed. There have been instances of some advice with regard to upcoming discussions with the NLMA, with MUN school of medicine, with the dean and looking at different programs and different ways to get more physicians coming into family practice with regard to the College of Family Physicians. Those are the kinds of discussions that I have been party to. I have no been party to or witnessed any political discussions.

J. PARSONS: Okay. Is there any concern, like, in the past when we've employed physicians as technical advisors in the department, of course. They are acting on behalf of the people of Newfoundland and Labrador. They're providing partial advice, non-political advice, of course, does the deputy minister have any concern that she's being provided advice that may not be pure from a technical or a public service perspective?

C. STOCKLEY: No, I haven't. I've been part of the health care system since 1988, including a stint as deputy minister of Health

in Nunavut. The advice that I've been provided by this particular individual is consistent with the advice that I've been provided throughout my career as a public servant and, as well, in keeping with my experience in Nunavut.

J. PARSONS: Thank you.

L. EVANS: Chair, I'd just like to add to that.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Also, for me, I'm an elected individual. I'm a politician, right, sitting at the head of Health. For me, as I take my responsibility very, very seriously, maybe I'm limited in terms of my vision, but it's really hard when you're dealing with problems, like barriers for people access health care, recruitment issues, patient relation issues. When you're looking at trying to balance family physicians who are out in rural parts of the region compared to the urban, dealing with a lot of these things. So, really, honestly, it's really hard to see how something would be political.

So I would like for you to give me an example of what would be political advice. For me, when it comes to health care, I don't think there's any room for politics right now. Maybe when we get our recruitment up and we have very little vacancies and we have all the nurses and doctors that we need and we've got all our Family Care Teams fully staffed and we have all the equipment that we need to be able to deliver health care out in rural parts of the region, maybe then we'll have the luxury of being political. But for me, it's very difficult.

So maybe you could give us a couple of examples of what you would consider to be political advice.

J. PARSONS: Again, I appreciate the weight on your shoulders, absolutely. But what's good for, I guess, your political party or the Premier or yourself or the PC Party, might not be the same as the best use of funds or tactics or strategies from the Department of Health.

We've heard, of course, already this morning that there is some disconnect, I think, between the criticisms of the Medavie contract and the actual improvement in service that we've seen. How you're advised or how your staff could be advised by someone who is primarily employed to advise on a political survival or a promotion of a party could be a conflict of interest.

I think, Minister, you could appreciate that problem. I'm not accusing you of doing that, of course, but you can see, I guess, how that can be a problem.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: No, and I appreciate you asking and also offering up an example.

When you look a the Medavie contract, right now, as Minister of Health, I'm trying to address Coastal Labrador medevac issues. Both of them are in my district, which is a PC district, and the MHA for Cartwright - L'Anse au Clair, which is a Liberal district. So, for us, we're going to address the issues for both districts.

At the end of the day, like I said, we wouldn't have the support of the public if we were partisan right now. Being in Opposition, if you see something that may seem political, just ask us in terms of health care delivery, we'll be able to rationalize our reasons for things.

CHAIR: Noticing that there's not going to be questions from the Third Party, I'll ask the Member for Cartwright - L'Anse of Clair to proceed.

L. DEMPSTER: There was some benefit to having something else scheduled; we get more time here now. That's good.

Thank you, Chair.

Still in 2.1.01, we are hearing concerns from seniors and low-income individuals that modest increases to their support payments are likely to eliminate their Drug Program coverage. I'm just wondering, is there any discussion within the department to increase those eligibility thresholds to ensure that the coverage continues? That's something that comes up to me quite a bit.

Thank you.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: No, I'm glad to answer that question. That's a very good question.

I'm just looking at our budget. Our budget for 2026 has a $22.5-million expenditure but looking at $8.8 million in revenue, so the net would be $13.2 million. We are investing in the Newfoundland and Labrador Prescription Drug Program.

Just in terms of that issue, with seniors and affordability and being concerned about having their access to drugs eliminated, I'll actually refer to the assistant deputy minister, Robyn, again.

R. HAYES: Under the NLPDP, we have five programs of which residents would be eligible for. The one you're referring to, I believe, MHA, is the 65Plus Plan. That plan provides coverage of eligible prescription drugs to residents 65 years of age and older who receive Old Age Security benefits and the Guaranteed Income Supplement, so they would be covered under that program under NLPDP.

L. DEMPSTER: I might come back and revisit that, but for now I'm going to move on.

Around the NLPDP, Minister, can you provide us with a breakdown – if you don't have it in front of you now, later is fine – of what new drugs are being added to the program this year?

L. EVANS: Yes.

We actually produced some of the drugs that we've already had go through the process. I'd just like to refer back to Robyn, I guess, to educate the public who may be listening here on how that process works and when we can actually make the list available, because there might be some misunderstanding or miscommunication.

R. HAYES: The 2026 budget investment in the NLPDP will allow the listing of new drug therapies as national price negotiations for each therapy reach a successful conclusion. These therapies include both oncology and non-oncology treatments.

We've already announced that we are adding – and I apologize for my pronunciation – Winrevair, W-I-N-R-E-V-A-I-R, for the treatment of pulmonary arterial hypertension; Fruzaqla, F-R-U-Z-A-Q-L-A, for the treatment of colorectal cancer; and Tagrisso, T-A-G-R-I-S-S-O, for the treatment of non-small cell lung cancer to the benefit list, which can be accessed by NLPDP beneficiaries who meet the financial and clinical criteria.

Further therapies will be added to the NLPDP benefit list in this fiscal year for those therapies which successfully conclude national price negotiations. We don't provide the listing until we've concluded that process for fear that they won't end up being eligible on the list. To avoid any that may not meet the approval process and people getting their hopes up that those drugs would be covered, we keep that listing confidential until they've concluded with the process.

L. DEMPSTER: Thank you.

L. EVANS: Can I just add one quick one?

L. DEMPSTER: Yes.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: One thing we do also look at is sometimes drugs are not covered or they may be going through the process of being covered. We do have an avenue where the patients will be reviewed and there's a possibility of a compassionate listing with the drug company. That's something that is worked on quite often when people are in need of a prescription.

Did you want to just discuss that a little bit more as well, Robyn?

R. HAYES: As the minister referenced, when there is a drug that has been prescribed for an individual seeking treatment that isn't covered under the NLPDP, they can apply to the manufacturer of the drug for compassionate care. Sometimes that does require documentation from the department, that it's not covered under the program, which we fully support residents with their applications for compassionate care to the drug company.

L. DEMPSTER: Okay. Thank you.

I recall in past years, sometimes there was something in HCS that former ministers would refer to as a hardship clause. If someone fell under a hardship clause, then they could – so we might be talking about the same thing.

I found what I was referring to. Your answer didn't align with what was in my head last night, but Angelica kind of knows my thinking because we work together a lot. I was referring to the Access Plan which gives individuals and families with low income access to eligible prescription medications: Families with children – including single parents – net annual income of $42,870 or less, which is pretty low.

Those are the folks that I hear from, saying modest increases to their support payments likely then eliminates their drug coverage. So I was just wondering if there was going to be any increase in those thresholds or if it's something that was being looked at?

R. HAYES: That would be under our policy, the threshold for income and the number of dependents that an individual may have. It is something, to change a policy, that we would have to seek the appropriate approval levels for that, but it is something we can, I believe, explore.

L. DEMPSTER: Yes. I just wanted to kind of bring it to the minister's attention, because I would say she knows folks the same as me. You're giving a little bit here but then it causes them to lose on the back end.

I want to move on to 2.2.01. We saw a significant spend, almost $123 million, over last year's budget. I'm just wondering what was the reason for that?

L. EVANS: Under 2.2.01? Are you talking about Professional Services?

L. DEMPSTER: Was it under Professional Services?

L. EVANS: Which line are you on? Just look at the lines there.

L. DEMPSTER: It was under Professional Services, Operating Accounts, yes.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Thank you, Chair.

Yes, under Professional Services, it was $122.8 million – almost $122.9 million – primarily related to an increase in physician billings for services provided to an older population. As I said 25 per cent of our population now is over the age of 65. There was $82,874,000 received ex gratia to address retroactive and projected 2025-2026 costs associated with the 2023-2027 MOA.

L. DEMPSTER: Okay. My time is winding down again.

We all talk about the need for recruitment and retention across every sector but paramount in health, which is so, so, important. I know, during our time, there was a litany of incentives and initiatives that we put in place because we knew that we were competing on a national stage. I'm thinking that – well, I do know. I read this: Our government invested more than $10 million annually in recruitment and retention incentives including six-figure signing bonuses and family practice start-up programs, alongside a new physician agreement and Family Care Team expansion.

In the budget that just came down on the April 29, we saw that it contained just $3.5 million for physician recruitment. If we had $10 million in and a litany of incentives, and now budget '26 is showing us $3.5 million, I'm wondering, specifically, how that smaller investment is expected to succeed where far larger investments were struggling, as I said earlier, in the case of physicians against a national doctor shortage.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I'll just summarize here.

When you're looking at the line items there for Grants and Subsidies and when you look at the amount there, there's actually $23,362,600. When you're looking at that, the budget for CMPA is allocated here, and the department had $1.5 million in savings.

So you may be looking at some savings there, MHA Dempster, due to lower insurance rates; $23,362,600 was keyed in to address retroactive and projected 2025-26 costs associated with the 2023-2027 MOA negotiated and signed with the Newfoundland and Labrador Medical Association.

In actual fact, I'll defer to Associate Deputy Minister Katie Norman to clarify some of the differences.

K. NORMAN: Thank you.

The incentive programs previously announced are continuing. There was a decision taken with regard to the structure of how recruitment and retention is done; that occurred in the summer of 2025, wherein a new entity within NLHS called Work in Health NL was established. There was some funding that was transferred from the department to NL Health Services, which is part of why you're seeing a difference in that amount. It's just where the funding is actually sitting.

I want to assure the individuals asking the question that incentive programs for physicians are still very much in place. I guess what I would say is that a lot of them began in 2023, and some of them were for three years. So we're getting to a point now where the redesign of some of these is really critical in terms of looking at retention. Because some of them were framed up as recruitment incentives that have now really been considered by physicians as part of their base salary, the way that they were designed.

We're having discussions about even flipping recruitment and retention to retention and recruitment and placing that at the forefront.

We work closely with Work in Health NL, which, as I mentioned, was a new entity established within NL Health Services last summer, and some funding now rests with them that was previously with the department.

L. DEMPSTER: Okay, that's good.

Yes, as it's evolving, the challenges I guess from one year to the next can change the landscape, then you want to be responsive to that. But it sounded like, maybe what the

minister said earlier, the $3.5 million showing, there's actually more. If there's $23 million that was left over, you said CNPA, is that Canadian nurse practitioners association? I didn't quite get the acronym.

L. EVANS: That's insurance for the physicians. It's an insurance thing.

L. DEMPSTER: Okay.

I'll keep going, I think. Do we start the clock again?

CHAIR: What I was going to suggest is that since there is not going to be questions from the Third Party, that amongst yourselves in the Official Opposition, you can just wave your hand over your mic and recognize who is asking the next question.

Seeing no more questions on this subhead, I ask the Clerk to recall the subhead.

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

CHAIR: Shall 2.1.01 to 2.3.01 inclusive, Client Services and Support, carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

CHAIR: I now ask the Clerk to call the next subhead, with a reminder that we do have to stop at 12:15 and there are two minutes extra that would be a hard stop at 12:17.

CLERK: 3.1.01 to 3.2.02 inclusive, Health and Community Service Delivery.

CHAIR: Shall 3.1.01 to 3.2.02 inclusive, Health and Community Service Delivery, carry?

The Chair recognizes the hon. Member for Corner Brook.

J. PARSONS: Thank you very much.

This is the meaty one. First question is around the nurse practitioner pilot, or I guess the new program for nurse practitioners. The budget referenced – and I know there has been numerous stories to comply with the federal government's regulations that nurse practitioner services have to be paid for. How does the minister see the future of nurse practitioner services in NL? Will it be like an extension of the pilot where nurse practitioners are salaried and associated with Family Care Teams, or will it be a mix of that and a fee-for-service model?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Well, right now, we refer to this as a pilot because it's bound to change based on the needs. We want to make sure we get our nurse practitioners up, properly situated, properly funded and working to their full scope of practice.

Of course, this nurse practitioner funding model is about having nurses providing medically necessary care. So that's the most important thing. Right now, we have, to date, 48 nurse practitioners who have signed up to be a part of the pilot and they're at various stages of finalizing their contracts.

In actual fact, the Member for Cartwright - L'Anse au Clair did ask a couple of times if there was any differences in the model from when it was originally envisioned, I think it was last year, with the government. One of the things that we did add was episodic care and we're actually looking at having those contracts now rolled out, starting on May 11.

The longitude of the contracts began in early April.

But in terms of the vision, I'll just let Justin add a little bit more details.

J. GARRETT: Yes, thanks, Minister.

So to your question with respect to the *Canada Health Act*, there is a one-year grace period embedded in that before any penalties apply. We're working very closely with both nurse practitioners that have signed up for the program, as well as nurse practitioners that have not signed up just yet.

This is an open program. We have 25 nurse practitioners that have expressed interest, but said we're going to wait a little while to see how the pilot goes. So, as the minister noted, this is a pilot. We're going to evaluate it. We'll consult with NPs in the program, as well as those that decided to not join just yet to develop what the permanent model looks like.

J. PARSONS: Okay, thank you.

I'll jump around a little bit, but we'll continue on, I guess. Family Care Teams – could the minister tell me the status of the following Family Care Teams: Bonne Bay-Port Saunders, the South Coast of Labrador, Corner Brook-Bay of Islands and Brookfield-Centreville?

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Looking at the Family Care Teams, one of the things we committed to is making sure the Family Care Teams that have been already rolled out are properly staffed. Some of the Family Care Teams, because of staffing issues, are vulnerable to having to close temporarily. Also, we do have a lot of people who are still waiting to be rostered with Family Care Teams.

Our commitment right now is to making sure that they're properly staffed so that they're successful and people can have confidence in the Family Care Teams and that they're functioning the way they're supposed to be as designed and as planned.

I'll just let the assistant deputy minister talk a little bit about the future plans and some of the Family Care Teams that you have mentioned.

J. PARSONS: Okay.

G. SWEENEY: There are 22 teams that are operational throughout the province. The teams that you mentioned, can I just get you to repeat them once more for me? I want to make sure I give you the latest.

J. PARSONS: There was Bonne Bay, South Coast of Labrador, Corner Brook-Bay of Islands and Brookfield-Centreville.

G. SWEENEY: Was that Brookfield that you mentioned there?

J. PARSONS: Brookfield, yes, the last one.

G. SWEENEY: Okay.

Bonne Bay-Port Saunders, South Coast of Labrador, as well as the Corner Brook-Bay of Islands, those are all in planning stages. Corner Brook-Bay of Islands, there has been some recruitment that has already happened with that team. They're not ready for a full launch yet but planning is ongoing, and same with Brookfield and Kittiwake.

J. PARSONS: Okay.

G. SWEENEY: I'll also add that we are now into year three or four of implementation for some of the teams, and certainly the feedback that we're getting from the providers that are working in this new model is really important.

What we are doing now is, there are eight teams that we're really doing a bit of a

deeper dive with them to understand what's working well, what they could use some extra supports with and then we plan on taking those same lessons and applying them to the other teams, recognizing that this is a new model of primary care delivery for the providers themselves and we want to support them the best way we can.

J. PARSONS: Do we have any timelines at all for those pending teams?

G. SWEENEY: For the other teams?

J. PARSONS: Yes.

G. SWEENEY: I don't have those with me right now.

J. PARSONS: Okay.

Travel nurses – there was $6.5 million allocated in the budget to a provincial travel nurse team. I know in a *Radio-Canada* interview, there was mention of 25 nurses being associated with this team. Do we have any information on what this team will look like, how it will be deployed, how it will be managed, what the design of the team will look like?

L. EVANS: Well, the team would be as part of the delivery of health care services, so they would be under Newfoundland and Labrador Health Services. What it is, is it would be a team that would actually travel to fill vacancies, whether it's temporary vacancies where you could have a nurse absent due to sickness or needing extended leave.

What we want to do is we want to reduce our reliance on the expensive agency nurses.

Also, with this new team, what it is, is they'll be unionized nurses from our health care system. So they'll be familiar with the system, they'll also be more aware of the geography and the culture and the regional differences. Over time, we expect to actually have a lot more success in reducing our reliance on agency nurses.

J. PARSONS: Okay. How will they be incentivized to become a travel nurse as opposed to a fixed position?

L. EVANS: Well, the incentives, actually, we're still working that out. One of the things is we've engaged with the Nurses' Union to sort of bring that side, like, in terms of making sure that we're adequately supporting the nurses so that we'll be able to actually have nurses on the team that will actually stay and become a permanent part of the team because we don't want to have high turnover rates with the travel team as well because it defeats the purpose.

I can refer to the associate deputy minister there to discuss a little bit more but, right now, we're still working on the incentives.

K. NORMAN: Yes, thank you.

That's exactly right. I think success for this is going to be working very closely with the Registered Nurses' Union of Newfoundland and Labrador. This past February, they presented a proposal – a quite substantial proposal that I believe is in the public domain that talked about incentive structures, it talked about weather delays and how people will be compensation in that regard. So there was quite a bit of fine detail.

When we costed it, we agreed that the cost to implement the travel team is about $6.5 million. The incentives would be separate and on top. So that's something that's still ongoing and under discussions with the Nurses' Union.

In terms of where they can be deployed, I mean, if you take CorCare, as an example, there were times where we had superusers of CorCare, something that was planned, that we knew there was going to be a gap because a nurse was trained to work with their colleagues at the elbow, and then we

brought in other nurses to support in particular clinics at that time.

Sometimes they'll be planned. There could be vacancies where something is occurring, where we're going to want to assign a travel team. So there's things like how long a travel team will be deployed. All of that is fine detail that the provincial government has committed to work with the Registered Nurses' Union on those details.

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: One thing we can't lose sight of is that there are two things at issue, a lot of our cost is not actually going to that nurse. They're getting a salary, but there's a third party, a company involved and, in actual fact, in a lot of ways that's almost a symbol of privatization. For us, it's very, very important that we want to employ the nurses directly. We want to have unionized nurses and we want them to be a part of our health care system. What that does is it secures our publicly funded health care system.

The other component of it, for me, as the Minister of Health, is first off, health care delivery is the most important thing, because when you have patients waiting and we have patients delayed in accessing health care, you can't put a cost on that. But, also, we want to work and make sure that we're not increasing the cost, that we're reducing the cost down from the cost of having these travel nurses.

At the end of the day, that's why we're working through those details. We have to make sure that we're delivering fiscally responsible health care and delivering health care.

CHAIR: The Chair recognizes the hon. Member of Cartwright - L'Anse au Clair.

L. DEMPSTER: Thank you, Chair.

Getting down to the timeline, so I'm kind of going to move around a little bit, not necessarily follow. I'll just take a little bit of time in this section, Minister, to talk about the Health Accord. I'm just kind of wondering if you remain committed, as the minister now, to implementing the recommendations and the transformation vision that we often talked about in the Health Accord?

I've got four or five questions, in particular, but it might be too much to throw out all at once, so I'll just pause there and let you respond and we keep going.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Yes, we're still committed to rolling out the Health Accord over 10 years, also, working with the other departments to make sure that we are addressing the social determinants of health, which is a major part of the health care system.

In terms of transformation, we're getting to a good place now where the Newfoundland and Labrador Health Services who are delivering the services, they're familiar with the rollout plan. Also, the new CEO of Newfoundland and Labrador Health Services, he was leading transformation and innovation. He has a clear vision, as well, with us over in Health and Community Services. We're staffing up, we're going to create another position for the assistant deputy minister for mental health to make sure that the mental health and addictions part – sorry, we need to talk about the mental health and addictions – is being addressed in our delivery of the Health Accord. It's very, very important for us to continue on with the vision, as you put it, so yes.

L. DEMPSTER: Thank you for that.

I know, right now, nearly all of the senior leadership within both the department and the health authority that you referenced

have been replaced since your government came into power, so I am happy to hear that you are making it clear to these new individuals that implementation of the Health Accord is your priority. That's very important.

Two or three things around data and tracking that I've been wondering about. Which Health Accord recommendations are currently on track for implementation in this fiscal year? As a part of my questioning there, there used to be transparent public updates regarding the status of implementation of the Health Accord as well as updates on statistics related to health care delivery, on a regular basis, and I might have missed it, but I haven't seen one since October.

I guess I'm kind of wondering where we are with recommendations implementations and I'm very interested in knowing if we'll be returning to that little, I'm going to say, dashboard, but it might not be the right word for it.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: Thank you.

Just addressing the change in senior leadership, yes, we did have a change at the chair for the board of trustees. Also, we did have a change with the CEO of Newfoundland and Labrador Health Services, but we do have a strong continuum there. The new chair has extensive history with our provincial government and the Department of Health. He was the former minister of Health and he has a lot of knowledge and expertise there. He's bringing a lot of that leadership and vision to the board. He has a really good relationship with Health and Community Services and Newfoundland and Labrador Health Services as well.

In terms of communication, I think we're all on the same page. The new CEO, like I said, came from Innovation and it was very, very strategic to having a CEO with the rollout of Epic, which is CorCare, which is probably the greatest change that our health care system will encounter in our lifetimes because that was basically in his wheelhouse. To have him, as the CEO of Newfoundland and Labrador Health Services, really, really did help and prevented, I think, a lot of complications that could have arisen out of implementing the CorCare right across the province.

In terms of the dashboard, I'll just ask our assistant deputy minister behind me to basically give an update about how that change came about and if we're looking at having something similar.

CHAIR: Gillian.

G. SWEENEY: Certainly, the data and tracking progress for the Health Accord and the 10-year vision continues to be a top priority and it is for the ADMs within the department as well as our counterparts at NL Health Services, on the delivery side. The implementation of CorCare is going to be really important for that. The data that we're going to get now from that provincial system, with the standardization that has taken place because of that implementation, that will significantly improve the dashboards and the reporting that we will have.

We're still only three weeks into that implementation, but that really has been a key focus. I know it was in the Health Accord; the modernization of the health information system was seen as a key enabler. So certainly now the launch there positions us really well to be able to share that data as time goes on and we have more data to share.

L. DEMPSTER: Thank you.

It will continue, it's just right now – okay, that's good.

I'm just going to close out my few minutes, before I'll go back to my colleague, on an area that is near and dear to both our hearts – I just keep coming back. I know, Minister, when the one health authority rolled out, you had your thoughts on that, strongly. I maybe not have been too offside, but one of the things is that you were concerned about the erosion of leadership within NLHS and, I guess, where your thinking was, was around Labradorians being represented in those senior leadership positions.

So I, too, had those concerns. For a long time I've served the people of the province, and in particular Labrador, and I always had easy access to the CEO. We deal with, as you know, a lot of unique challenges. So when we moved to one CEO, after I kind of got over that, I had a very good relationship with the COO, who was a very strong individual. She spent a full career in health and she was from – or at least she worked in Lab West; I think she was from Lab West.

So in all the early period of the one health authority, I had contact with the COO at a decision-making table, a part of the executive that was in Labrador, knew the travel challenges, all of that. She left for health reasons within the family, kind of abruptly, and then we had an acting COO out of Grand Falls, which I always made it known that I think we have to have somebody on the ground in Labrador. I do hear it, in particular, in Happy Valley when I go because that's kind of the hub, as you know.

So since sometime in January, my last meeting with that acting COO was the 31st of January, and then I was introduced to an individual. This is nothing about the individual – absolutely nothing. I have a lot of respect for the public service, tremendous respect over my 13 years here. So I am concerned about that.

As the clock winds down, I'll just throw in the other concern. I was going to ask some questions; I might just stick with one around our CAC, the community advisory committees. You were referencing the CEO and somebody in Central Labrador had raised with me recently – I guess he did an interview or something and talked about being up there several times but the CAC was not aware. So, I guess, that's just another little area where we can improve communications.

But I really kind of want to get your thoughts on the leadership. If my throat gets any worse, I might need a doctor or some health care here, too. I'll take that.

Thank you.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: I did have a lot of concerns when we were going from the regional health authorities. Labrador-Grenfell Health was the health authority for Labrador and for the Northern Peninsula, also, we had the Western health authority, Central and Eastern health. I was really worried because I saw such an erosion when it came to the school boards.

When we went to one school board, the English school board, we certainly saw an erosion of services for Labrador, especially for Northern Labrador. I'm not sure but, probably, Southern Labrador saw similar erosion because, what happens is, when you get basically one health authority, we knew that a lot of decision-making was going to happen out of St. John's.

The things that I've seen when I come in as Minister of Health, just in patient relations, people trying to access information, put in concerns or queries or complaints, it was ridiculous the way the patient relations were set up for one health authority. It was not right. I could talk a lot about the deficiencies when we look at what happened when we went to one health authority.

Regarding the COO – being in Opposition, I did have to call the COO of Labrador-Grenfell health and she was very attentive; a lot of times she didn't do anything to help, but at least she was talking to us.

I honestly don't equate availability and conversations and chats and supports with action, just totally different. I'd been disappointed, in actual fact, where I was on a call about a medevac out of Nain and the CEO actually told me stuff that was not right. Then, when I corrected them, they came back with something else, the reason why the medevac wasn't happening, and it wasn't right.

Do you know when somebody says something to you that's false, it's not truthful. When you can tell it's not truthful and they intentionally told it to you, it can be very, very upsetting.

For me, even with one health authority or regional health authorities, at the end of the day, we need action. We need regional representation. Yes, we do. We certainly do.

The current interim CEO, I'm not sure where we're getting our lines crossed –

L. DEMPSTER: Do you mean COO?

L. EVANS: COO, yes.

L. DEMPSTER: Yes, okay.

L. EVANS: What did I say?

L. DEMPSTER: CEO.

L. EVANS: Yes, the COO. We used to also refer to as the VP, right?

L. DEMPSTER: Yes.

L. EVANS: So we do have a new interim COO. I've heard nothing but positive things from the physicians.

The physicians actually, when you talk about Happy Valley-Goose Bay, they're so impressed with her action. When an issue is brought up, a concern that impacts delivery or racism or lack of services or any kind of confusion, she's on it. Most of the time when I do call to try and communicate with her, she's up in Labrador or going up to Labrador.

I know that a complaint was made that she's not actually residing in Labrador, but in actual fact, that's benefited us in Labrador quite a bit because when she's not in Labrador, she's here and she's basically meeting with senior management. She's meeting with the CEO, she's meeting with the other COOs, and in actual fact, we have a voice at the table, which is very, very important.

Like I said, the physicians have been all complimentary about her action and how quick she responds. The Indigenous groups, I've gotten emails and letters. At our meetings, I've been told, that this is the first time they've actually had somebody at that level get back to them and talk to them about their concerns and put actions into place.

Actually physically at the hospital in Happy Valley-Goose Bay, she's gone in and made assessments based on patients' complaints and it started to put action into place; increasing security and safety of the patients; also about the respect for patients; and very, very importantly, the protection of the workers.

For me, these are very, very important things that we got to make sure we address. At the end of the day for me is I never would have chose one health authority. I certainly would not have. Not with our regional differences. But one of the things that we've got to work on now is basically making sure that the regions are represented and the regions are represented through the committees, all regions, but also in terms of leadership and making sure that the regions

have a voice at the table so local issues are addressed.

It's not just from a patient perspective but from a physician perspective. If our physicians who are out there and our nurse practitioners and our nurses that are on the front lines delivering health care, if they find that their issues and concerns are not being addressed, are not even being entertained for solutions, then, of course, what's going to happen is retention is going to suffer because you're going to have people just discouraged and leave.

In actual fact, when I became Minister of Health, I saw some serious gaps in how our physicians' and nurses' concerns are addressed. Seriously, if you want to talk about retention and how to successfully do retention, then in the book you have your synonyms and your antonyms, I've actually witnessed the opposite – what to do to drive out doctors; what to do to drive out nurses, technologists. In actual fact, when I talk about we all have to work together, we have to make sure the voices of the regions are heard but also the front-line workers are heard.

For me, I really can't stress that enough.

CHAIR: The Chair recognizes the Member for Corner Brook.

J. PARSONS: Just a quick question. This is a really technical question.

There was $23 million allocated for 45 long-term care beds in Corner Brook. What does the staff complement look like for those new beds? Maybe the ADM can answer.

L. EVANS: The staff complement for the new beds that we're going to be rolling out this year and next year?

J. PARSONS: Yes.

L. EVANS: While she's looking up the answer, one of the things, the Member, MHA Eddie Joyce, was looking at the timelines because he said the first 45 was rolled out and opened quicker. He asked the question, one of the things that we have to look at is the capacity, like in terms of being able to feed the kitchen, also the hospital needs work, on the envelope, on the roof, and also the rooms now that are left that we're going to utilize are the ones that are in worse shape. So it takes a little bit more to actually build them up and get them turned over, converted into functional rooms.

We don't have that information, so what we'll do is we'll provide it to you.

J. PARSONS: Perfect.

The reason I asked, I guess, is this related to earlier about travel nurses. I know there's been a desire to get the number of agency nurses down. How are we going to staff those 45 beds, when I hear in Corner Brook already, it's difficult to find enough nursing staff to provide that?

With that, we're talking about 25 nurses in this travel team now. Presumably, I would imagine – we don't have the numbers; we asked earlier – we have in the hundreds of vacancies still in place. How do we see being able to do both things at once?

L. EVANS: Well, like I said, we're increasing the seat capacity for nurses, but I just want to –

J. PARSONS: We didn't do the seat capacity.

L. EVANS: Sorry, we're filling the seats to capacity. The other thing I wanted to mention, too – where I misspoke and then I had to correct it, I lost my train of thought. Our vacancy rate for the nurses are down to before COVID. So we're down to 4.5 –

CHAIR: The Chair recognizes Katie Norman.

K. NORMAN: Right now, the latest data I have, as of April 2026, was that there were 281 registered nurse vacancies, which is 4.8 per cent. So, to minister's point, less than 5 per cent is seen as kind of a typical vacancy rate.

I will say that, right now, the latest data we have is that 285 registered nursing students from Memorial University across all various sites have accepted positions with NL Health Services; so continuing to focus on recruitment of locally trained nurses is really important. I'm pleased to say that's more than 90 per cent of those students who have accepted positions with NLHS.

J. PARSONS: I was at the Western Regional school of nursing. Again, important to have, like you said, nurses trained in areas outside of the St. John's area as well, and 50 of 52 nurses did accept positions, but that number has been consistently high for a number of years now. So continue that work, please.

CHAIR: The Chair recognizes the Minister of Health and Community Services.

L. EVANS: We've allocated $150,000 in this budget to actually do up an action plan on how we're going to expand the nursing seats at MUN, in Bachelor of Science nurses and the nurse practitioners. What we're going to do is, looking ahead, a long-term plan to increase the capacity. We will actually be able to train more nurses and have more nurses graduate.

CHAIR: The Chair recognizes the Member for Cartwright - L'Anse au Clair.

L. DEMPSTER: My other question I was going to ask was about the regional health council. I know I referenced the Community Advisory councils. I think that's really important.

When we were going through the process, someone had raised this to me some months ago, and I actually talked to the former Health minister, the second last one there. We were going to somehow have a mechanism in place so that there would be one person that would have a seat on the board table, and somehow it didn't materialize that way.

I did notice in the blue book there was a commitment for a regional health council. I'm just looking for a status update on that?

L. EVANS: Actually, we're looking at, now, how to actually have Labrador have its own regional health council, basically its own regional representation.

In actual fact, we're finding out that it may be a little bit more simpler and easier than we thought it was. I thought it was going to be very complicated and tangly.

What we are going to do now is we are putting steps in place on looking at what that looks like and addressing it. Also, having its own council, what's the regional needs? How are they going to change? We have to make sure we have supports in place, also with the Grenfell part, the St. Anthony part, what does that look like, but I'll refer to my associate deputy minister for more details.

G. SWEENEY: Briefly on that point, as you mentioned, the Regional Health Council and the relationship between them and the overall board of trustees, there's work underway because this is a new structure to make sure that we have the appropriate representation of the regional councils on the overall board. That's work that's under way in discussions between the policy teams at NL Health Services and Department of Health and Community Services.

CHAIR: The Chair recognizes the hon. Minister of Health and Community Services.

L. EVANS: I guess the most important thing is to make sure that there is regional representation on the board, at the board

level, to make sure that that's in place. That's the most critical thing.

L. DEMPSTER: I do want to say thank you to the minister. Thank you to all the staff for answering our questions here today, it's appreciated.

L. EVANS: I don't think I got to the point where I actually thanked our staff, but I want to say about not being partisan. The team that we have here is a team that's really interested in improving access to health care, delivery of health care. We couldn't have a more dedicated team. Like I say, it's a lot of irony to have a politician sitting at the head, so it's good when you're supported by well-meaning, dedicated people who really make this their life passion.

CHAIR: Seeing no further questions for this subhead, I now ask the Clerk to recall this subhead.

CLERK: 3.1.01 to 3.2.02 inclusive, Health and Community Service Delivery.

CHAIR: Shall 3.1.01 to 3.2.02 inclusive, Health and Community Service Delivery, carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 3.1.01 through 3.2.02 carried.

CLERK: The total.

CHAIR: Shall the total carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

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

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

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

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

CHAIR: As the Chair, I'd like to thank the minister and the department officials and the Committee for your attendance. I think it was a good session with quality questions and quality answers. So I appreciate all your time today and thanks for doing this for the province.

So our next meeting is scheduled for May 21, 2026, at 6 p.m. to consider the Estimates of the Department of Education and Early Childhood Development.

I ask for a mover for adjournment.

H. CORMIER: So moved.

CHAIR: It is so moved by the Member for St. George's - Humber.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

Thank you, everybody.

On motion, the Committee adjourned.