PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

First Session
Forty-Ninth General Assembly

Proceedings of the Standing Committee on Social Services

June 20, 2019 - Issue 3

Department of Health and Community Services

Published under the authority of the Speaker of the House of Assembly
Honourable Perry Trimper, MHA

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

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Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
Chad Antle, Audit Manager
Alicia Anderson, Executive Assistant
Kathy Dicks-Peyton, Media Relations Manager
Heather Hanrahan, Assistant Deputy Minister, Regional Services
John McGrath, Departmental Controller
Colleen Simms, Assistant Deputy Minister, Population Health
Paul Smith, Assistant Deputy Minister, Corporate Services
Karen Stone, Deputy Minister

Also Present
Hon. Siobhan Coady, MHA, Minister of Natural Resources
Hon. Bernard Davis, MHA, Minister of Advanced Education, Skills and Labour
Hon. Sherry Gambin-Walsh, MHA, Minister of Service NL
Derrick Bragg, MHA
Alison Coffin, MHA
Paul Lane, MHA
Sandy Collins, Researcher, Official Opposition Office
Denise Tubrett, Deputy Chief of Staff, Official Opposition Office
Susan Williams, Researcher, Third Party Office

Pursuant to Standing Order 68, Siobhan Coady, MHA for St. John's West, substitutes for Derek Bennett, MHA for Lewisporte - Twillingate.

Pursuant to Standing Order 68, Alison Coffin, MHA for St. John's East - Quidi Vidi, substitutes for James Dinn, MHA for St. John's Centre.

Pursuant to Standing Order 68, Sherry Gambin-Walsh, MHA for Placentia - St. Mary's, substitutes for Scott Reid, MHA for St. George's - Humber.

Pursuant to Standing Order 68, Bernard Davis, MHA for Virginia Waters - Pleasantville, substitutes for Elvis Loveless, MHA for Fortune Bay - Cape La Hune.

Pursuant to Standing Order 68, Derrick Bragg, MHA for Fogo Island - Cape Freels, substitutes for Pam Parsons, MHA for Harbour Grace - Port de Grave.

The Committee met at 6:08 p.m. in the Assembly Chamber.

CHAIR (Bragg): Okay, folks, thank you very much. Thank you for taking time out of your busy evening and being here for Estimates today. I thank the minister and his team and the Members opposite and their team.

We'll start by doing a few introductions. We will start with the minister's team first. When you see your light come on, wave to get it started. After that I think it flows pretty good so carry on.

MR. MCGRATH: John McGrath, Departmental Controller.

MR. HAGGIE: John Haggie, Departmental Minister.

MS. STONE: Karen Stone, Deputy Minister.

MS. HANRAHAN: Heather Hanrahan, Assistant Deputy Minister.

MR. SMITH: Paul Smith, Assistant Deputy Minister of Corporate Services.

MR. ANTLE: Chad Antle, Audit Manager.

MS. SIMMS: Colleen Simms, Assistant Deputy Minister.

MS. DICKS-PEYTON: Kathy Dicks-Peyton, Media Relations Manager.

MS. ANDERSON: Alicia Anderson, Executive Assistant to the Minister.

MR. BRAZIL: David Brazil, MHA, Conception Bay East - Bell Island.

MS. TUBRETT: Denise Tubrett, Deputy Chief of Staff, Official Opposition.

MS. COFFIN: Alison Coffin, MHA, St. John's East - Quidi Vidi.

MS. WILLIAMS: Susan Williams, Researcher for the Third Party.

MS. GAMBIN-WALSH: Minister Sherry Gambin-Walsh, MHA for Placentia - St. Mary's.

MS. COADY: Siobhan Coady, MHA, St. John's West.

MR. DAVIS: Bernard Davis, MHA for the beautiful District of Virginia Waters - Pleasantville – and historic.

CHAIR: I'm Derrick Bragg and I'll be chairing this evening. I'm the MHA for Fogo Island - Cape Freels.

We're going to start off and we're going to give the minister 15 minutes as a preamble. If you choose to not use your 15 minutes, we'll move right into the Opposition for their questions.

Okay, I'll call the subheads first. We'll do it by subheads. We'll start off with 1.1.01 and we'll move on into 1.2.02.

Minister Haggie.

MR. HAGGIE: Okay. Thanks very much.

I hope the House protocol will excuse my attire, but given the climate control I think comfort is important. I'd like to thank my staff for all the hard work they have put in, in preparing the documents that you see before you and the Estimates process itself. With consummate skill

they had prepared some excellent speaking notes for me which I have lost, so I will start again in the way that I have in previous Estimates.

The mantra for the department has been around the three-legged stool, if you like, of better clinical outcomes, better population health and better value for the dollar. It's a three-legged stool, if you saw one leg off too much, the whole thing will kind of tip over.

The health care budget for this province is a significant portion of provincial revenue. What I'm pleased to be able to draw people's attention to is that by and large it has stayed static since we took office in 2016, and it has done so in a way that has still allowed us, through reprioritizing, to expand the range of services that we provide. This really speaks to the better value for the dollar that we spend. We are one of only three provinces who have managed to do that.

The other metric, I refer people to CIHI's report which is around per capita expenditure on health where we have not faired well as a province. I have argued in certain areas that we are, in actual fact, more accurately a territory, in which case we do very well. Regardless of that, accepting the fact that we are the country's newest province, if you now plot our line, it is almost flat. It is less than the rate of inflation and has been for three years, and with this budget it will remain there.

As you watch the rest of the country, you will see their lines of per capita expenditure on the same graph have a significant upward gradient. If you plot that out and extrapolate over time, those lines will cross sometime between 2025 and 2027, at which point we will be at least in the middle of the range of other provinces, and I would argue fairly near the lower end. If we can do that, then I think we will have fulfilled the triple aim because we are now starting to measure outcomes and we are seeing those metrics that we're using trending in the right direction, too.

That's not to underestimate the challenge. We have a significant chronic disease burden, we have a significant set of comorbidities. We are not the healthiest province according to any of the metrics. Between myself in this portfolio and the Minister of Children, Seniors and Social Development – who actually has the mandate for wellness and social development – we are working together to try and remedy those.

We have a landmark piece of legislation, the one which title I always confuse, but it's essentially the *Public Health Protection and Promotion Act* which was passed the last session of last year. This is germane in several ways because it requires us to provide a five-year plan on public health issues and identify matters of public health. It allows the chief medical officer to designate her or someone to mark us out of 10 on the results of that five-year plan. It also allows her to designate important non-communicable diseases about which we need to have a strategy; so, for example, she could designate diabetes as one.

Built into that is a philosophy of Health in All Policies. We're only the second province in the country to actually bring in legislation in regard to that, which mandates essentially that any government Cabinet decision has to be assessed through a Health-in-All-Policies lens. We are second after Quebec, and I think New Zealand is probably the furthest along with that approach.

Basically what it says is when you're doing municipal planning, when you're doing transportation and works, these kind of things, you look at factors in municipal planning that will encourage health. Walking tracks, green spaces, these kind of things become something that is of relevance and importance to municipalities. This will obviously roll out as it becomes more fully fleshed out and as the regulations develop.

I'm not going to use all of my time to speak about that. We have several initiatives we've highlighted in the Budget Speech and the Throne Speech around things that we would like to do that are financed through this budget. I'll be happy to talk about those as we go through, but I think in the interest of maximizing everyone's time and the whole process, I'd probably draw my opening remarks to a conclusion there and throw it back to the Committee.

Thank you.

CHAIR: Thank you very much, Minister.

We'll start off and we'll call the first subhead.

1.1.01 to 1.2.02.

Mr. Brazil, the floor is yours.

MR. BRAZIL: Thank you, Mr. Chair.

I appreciate the opportunity here in the Estimates for Health and Community Service to have some discussion, get some clarification and outline exactly the direction for the department.

I'll probably take a little bit of a different approach than directly into line items. That will come also. I think we can elevate some of those by some of the general questions I'll ask up front and get some answers there. That will speed the process up so I'm not having to be asking questions on every particular detail.

My questions will be more relevant to what I think are significant changes in salary items or grants or contract work and these type of things. My general start at questions is about getting around the salary units as such to see where they are and how they tie in, so I ask for your indulgence as I take you through that. I do ask the general concept: Can I get a copy of your binder? Somewhere before –

MR. HAGGIE: We have it here.

MR. BRAZIL: Oh, even better. Appreciate that.

MR. HAGGIE: High-tech, paper-free Digital by Design.

MR. BRAZIL: Even better.

I want to start: Are we still applying the zero-based budgeting in your process in the department?

MR. HAGGIE: Yes.

MR. BRAZIL: Okay. All in play? No issues?

MR. HAGGIE: Yes.

MR. BRAZIL: Fair enough.

MR. HAGGIE: And, it's done on an annual basis to refresh.

MR. BRAZIL: Perfect.

Under attrition savings in '18-'19, do you have an estimated number, what it was? And what particular positions, for example?

MR. HAGGIE: Yes. We had financial targets of $69,400 in '18-'19, and this budget has $55,700 baked into it. The '18-'19 target was met, and the financial analyst position was removed. We have some retirements coming this year, and we have altered the clerk typist position for reception in the department. So, I think you'll find we're on target to meet those for the department.

MR. BRAZIL: Okay.

In salary details for '19-'20, the total staff complement was 213; in salary details from 2018-'19, the total staff complement was 180. This is an increase of 33 positions. Can you explain why that occurred, and can we get a breakdown of what type of positions we're talking about there?

MR. HAGGIE: That really relates to the bringing in-house of the Medical Transportation Assistance Program from AESL. So, there are 27 from MTAP, there were two temporary positions in Grand Falls-Windsor for out-of-province billing, and then we've got three – sorry?

OFFICIAL: Contractual.

MR. HAGGIE: Contractual. Yes, sorry, the hieroglyph was wrong. We got three contractual, and we've got three for mental health and addictions.

MR. BRAZIL: Okay.

You mentioned the contractual there. We've noted that 20 per cent of your total staff complement – 43 positions – is either contractual or temporary. Do you plan to target contractual and temporary positions as part of the attrition plan?

MR. HAGGIE: The attrition plan for this year is baked in on the basis of the figure I gave you and the retirements, plus the change of the clerical position on the front desk. The

contractual thing is related to specific programs, and that's expertise we bring in as and when appropriate. So, that tends to fluctuate, anyway, from year to year.

MR. BRAZIL: Are there stringent timelines on these contractual ones? Are they one year, six months, two years?

MR. HAGGIE: I would have to have a list – we have a list in the back of the binder of the individual positions, but I couldn't tell you how long a contract runs for.

OFFICIAL: They vary.

MR. HAGGIE: Yeah.

MR. BRAZIL: No, fair enough. If that's going to be shared with us, I'm happy with that.

MR. HAGGIE: They vary. I mean, there's a full position, there's PCN number and there's an active staff complement by division, and it's whether they're permanent or contractual.

MR. BRAZIL: Yeah, so we'll know which division it's in and then, from there, we can extrapolate exactly what the responsibilities would be, I would assume, based on that.

MR. HAGGIE: Yeah.

MR. BRAZIL: The duties. Okay, fair enough.

How many retirements have occurred in the department in the last year?

MR. HAGGIE: We'll find that number out for you. I thought we had it, but we haven't actually.

MR. BRAZIL: Yeah, that's fair enough. Once you get that, you can get back to me on that or let me know on it. That's fine, yeah.

Were there any direct layoffs this year in the department?

MR. HAGGIE: We haven't had any layoffs.

MR. BRAZIL: Okay, fair enough.

How many new hires have been there in the past year, in the department?

MR. HAGGIE: Sorry, I'm looking at the A in my notes here, and it's under S for salaries.

The new hires I think I enumerated were medical transportation, two temporary positions in Grand Falls-Windsor for out-of-province billing, long-term care contractual and three mental health contractual. The total there was 27 plus eight – so that's 33.

MR. BRAZIL: Okay, fair enough.

In fiscal '18-'19, gross expenditures excluded of capital was almost $130 million more than budgeted. Can you give us an outline of why that was, the additional expenditures?

MR. HAGGIE: On the global number?

MR. BRAZIL: Yes.

MR. HAGGIE: I think some of that really will relate to monies that came in, in terms of federal monies. We've had money under the mental health and addictions, federal money; we have had money coming in from the long-term care, federal money. Some of that may also be – is that under capital, too? Yes, severance. We had the payouts for severance. They would go through us, but we will claim them back again as finance.

MR. BRAZIL: Do you have a breakdown on how much went out in severance? A general concept, was it a million, $2 million?

MR. HAGGIE: I do. I've seen that.

Approximately $127 million.

MR. BRAZIL: In severance?

MR. HAGGIE: Yes.

MR. BRAZIL: Thank you.

A couple of the line items here under Minister's Office. I just wanted to note some things there. Under Salaries in 2018-19, you spent $375,000 or 35 per cent more in Salaries for Executive than budgeted.

Can you explain that, Minister, please?

MR. HAGGIE: Sorry, which head are we looking at now?

MR. BRAZIL: That's under heading 1.2.01, Salaries.

MR. HAGGIE: 01?

MR. BRAZIL: Yes.

MR. HAGGIE: Okay.

The over expenditure was paid leave and severance: $375,000.

MR. BRAZIL: Okay, fair enough.

In the salary details, you had three contract positions listed. Can you provide details on those within the office?

MR. HAGGIE: In the ministerial office?

MR. BRAZIL: Yes – or in Executive Support, 1.2.01.

MR. HAGGIE: They will be in the back of the binder.

MR. BRAZIL: Okay.

MR. HAGGIE: They're enumerated on a salary tab at the end of the binder. I can read them out if you want, but –

MR. BRAZIL: No, that's fair enough.

Under Salaries, 1.2.02, Departmental Operations, in 2018-19 there was $275,000 less in Salaries than budgeted. Why were positions eliminated or kept vacant there?

MR. HAGGIE: The decrease between 2018 and 2019 is related to rightsizing of the salary plan based on requirements as of April 2019, and it requires a lower budget by about $91,500.

MR. BRAZIL: So, are there particular salaries that were dropped there?

OFFICIAL: (Inaudible.)

MR. HAGGIE: Vacancies throughout the year is my right ear telling me.

MR. BRAZIL: Okay, fair enough.

So, just to get a little bit clearer on it, when you're saying rightsizing, are we talking about particular positions there that are coming and going, or is it going to be a consistent flow of those positions no longer existing within the system?

Define to me what rightsizing would be, as you perceive it in your office right now.

MR. HAGGIE: What happens is the salary plan is based on the number of positions that we have. Obviously, there are some contractual folk going in and out, and the permanent people will be permanent. We have lined up, as best we can, our organizational chart with the programs we have to deliver.

MR. BRAZIL: Okay.

That would then, in turn, mean that your budget line will be down next year also because the contract people go out?

MR. HAGGIE: Well, I mean, obviously there will be increments as people go up the scales.

MR. BRAZIL: Okay, fair enough.

In salary details '19-'20, under Acute Health Services and Emergency Response, you have five contractual positions listed. Can you provide the details? Are they in the back of that one also?

MR. HAGGIE: Under which tab is that?

Sorry, could you just rephrase the question again, Mr. Brazil? I'm not quite sure what it was. I found the area in the binder now, and I'm –

MR. BRAZIL: Fair enough.

In salary details '19-'20, under Acute Health Services and Emergency Response.

MR. HAGGIE: Yes.

MR. BRAZIL: You have five contract positions listed. Give us some more details and are these new contracts or are they reallocated ones or realigned ones.

MR. HAGGIE: Why don't you – Heather.

It isn't a button.

CHAIR: Just wave your hand.

MR. BRAZIL: You're new.

MS. HANRAHAN: Sorry.

MR. BRAZIL: Everybody tried that when they first come in the House. Hit the button, yeah.

MS. HANRAHAN: Three are working on long-term care, home support – contractual people, so it's project work. As well, we got one person who's working on shared service as project work and another one working on some nursing initiatives. So, these are time-limited positions.

CHAIR: Excuse me for a second.

If you speak outside the minister, which I think (inaudible), just identify yourself first, please. I know we're past press the button, so we're good now. For Hansard reasons.

MS. HANRAHAN: Okay.

CHAIR: Thank you.

MR. BRAZIL: Okay, thank you.

I just wanted to go back again because I just made a note there and I'm trying to get my head around it.

We talked about in '19-'20, $91,500 less is going to be budgeted, but the minister – as I thought I heard it said – it'll balance out and the budget will go up again the following year, but, that obviously is a reduction. Is there a loss of position there or is it a loss of non-renewed contracts that are going to go out the door?

MR. HAGGIE: So we're talking 1.2.02 and we're talking Salaries.

MR. BRAZIL: Yes.

MR. HAGGIE: Okay. So you want to see the variance there.

MR. BRAZIL: Yeah.

MR. HAGGIE: Okay.

We've got vacancies in Pharmaceutical Services, Audit Services and information and policy planning. So that explains the lower figure.

MR. BRAZIL: Yeah, but in '19-'20, the budget's going to be less. They're vacant now. Are they going to be filled again or are they permanent positions that are gone?

MR. HAGGIE: One moment.

MR. BRAZIL: Yeah

MS. STONE: That's rightsizing the budget. There is no position elimination there at all.

MR. BRAZIL: So with the reduction, that still balances? All the same staff stay intact, as are?

MS. STONE: Yes, that's right. There's no change in staff.

MR. BRAZIL: Okay, fair enough.

Professional Services, under 1.2.02. Can you please provide some details of these expenditures in 2019? What will the budget of $1.1 million be used for in '19-'20 under Professional Services?

MR. HAGGIE: Okay, I have a list.

There's a shopping list in your binder. It covers areas such as: Audit Services; Pharmaceutical Services; NLPDP assessment; regional health services; long-term care division; Provincial Blood Coordinating Program; awareness campaigns and such under mental health; and addictions and primary health care. It also covers a series of policy and planning label things, which are our payment subscriptions to the C organizations, things like CADTH, CIHI, FPT ministers' forum, provincial contributions to the blood portfolio, committee on health workforce and that kind of thing. It's in your binder. It's all enumerated there.

MR. BRAZIL: Okay, that's perfect.

MR. HAGGIE: And it totals up to $1.105 million.

MR. BRAZIL: Perfect.

Under Purchased Services, in '18-'19, over budget of $104,000. Can you just explain what – was there a special project? Was there something purchased that was necessary?

MR. HAGGIE: Yeah. We needed new tamper-proof prescription pads for the Prescription Monitoring Program. If you remember, we altered that so that there had to be a licence number and a signature by the physician who was prescribing a controlled drug. We also had some overages when we did some advertising around the public health nurses' flu campaign.

MR. BRAZIL: You don't anticipate any one-offs that may be necessary relevant to that that may change the expenditure?

MR. HAGGIE: The tamper-proof prescription pads is a one-off increment because we had to replace the old ones. It will be an ongoing expense, but it won't be that magnitude.

MR. BRAZIL: Okay, fair enough. Thank you.

CHAIR: Mr. Brazil, do you have anymore questions? Your 15 minutes has expired.

MR. BRAZIL: No, I'm good.

CHAIR: If you were down to one question, I would give you leave. If not, Ms. Coffin, you have 10 minutes.

MS. COFFIN: Thank you very much.

First thing I would like to do is thank you all for coming and all your hard work and expertise that you've put into making the Estimates possible and all that background work because I know it's not as simple as here's the binder. There's an enormous amount of work. Thank you for that and thank you for giving your evening to be here for us. I appreciate that.

I am so happy we're measuring outcomes. This is a wonderful thing. Can you tell me a little bit more about the types of outcomes that you're measuring and how long have you been at it? So I just kind of get a sense of what those outcomes are, how long we've been measuring them, how they've been tracking over time. That's a nice big nebulous question.

MR. HAGGIE: It is a nebulous question, because it really kind of depends on which program you want to pick. So, for example, with JASPER, the Joint Attention Symbolic Play Engagement Regulation program under autism.

MS. COFFIN: What now?

MR. HAGGIE: That is part of an ongoing project with UCLA. We have actually partnered with them to bring in the next iteration of JASPER.

We submit a variety of metrics to CIHI for their database. Things like 30-day readmission rates, complication rates post-surgery, post-surgery readmissions. We use that database and we have been interactive with the CIHI data. We actually had an examination, for example, of the cardiac cath lab and the cardiac surgery program – well, the cardiac cath lab and leading into the cardiac surgery program – that has produced significant reductions with a co-operation between the cath lab, the reviewers that came in as a result of the outcome data we were measuring and the Medtronic firm.

So, for example, we now have a shrinking wait time for cardiac caths for outpatients. If you're an inpatient, with the exception of Western Health, it's a day wait to get a cardiac cath as an inpatient; 1.5 in Western, and most of that is seasonal, it's related to weather because we use planes to fly folks in from Western.

So, again, it really is almost contextual. It depends on what you want to look at.

MS. COFFIN: Right.

MR. HAGGIE: Some of the areas we aren't measuring what we should. We are investing, for example, in Eastern Health in a monitoring and reporting system for emergency room visits, for example. We haven't been able to submit data to CIHI because of a lack of that, but that's something we're correcting.

MS. COFFIN: Okay, interesting. Can we just kind of keep going with that?

When you're saying outcomes, it's specific to programs, which is just wonderful.

As an aside, is there a wait-list for colonoscopies? Because I know – and I'm not sure why someone is tried so hard that they want a colonoscopy. Maybe for Christmas? I don't know if you're measuring something like that, but that's just an aside I've heard, right?

MR. HAGGIE: Yes, in actual fact, the RHAs are at different stages with that.

MS. COFFIN: Right.

MR. HAGGIE: There is a plan to try and provincialize that program but, for example – I can speak from my own previous experiences – in Central Health we have a central intake program, the request of triage into one of three, four categories. So, if you are an urgent, we have a 14-day window and if you are elective, then there is a longer window. I couldn't tell you now exactly what it was. In my day it was a bit longer than I would have liked but I think it's something in the order of 90 days now.

MS. COFFIN: Okay.

MR. HAGGIE: Those are measured and they're reported and, in actual fact, we have five databases/registries which were amalgamated into one body through NLCHI when we amended the Newfoundland and Labrador Centre for Health Information Act.

We have the Cancer Care Program, we have the Cancer Screening Program and there's data there that can be reported on a regular basis about those kind of things for colonoscopy, for cervical smears and for mammography, for example.

MS. COFFIN: Okay, interesting.

I come at this from a slightly different perspective. Are you familiar with the Community Accounts?

MR. HAGGIE: I'm not –

MS. COFFIN: Very interesting. It captures a lot of qualitative data that we don't see captured in other places. It's a database that's online. Have a look, it's housed in the –

MR. HAGGIE: I have vague recollections of something like that.

MS. COFFIN: Yeah.

MR. HAGGIE: I think my staff slides something like that across my desk from time to time, yes. No, I just didn't recognize it then.

MS. COFFIN: Totally fair.

That's something that is really interesting and some of the outcomes that you're talking about might fit neatly into that. I know a lot of people who work in economics, but also in health research and a pile of other places, would be more than grateful to have access to some types of things like that. Just as an idea, it might be an interesting place to put that data. Do we have ownership of the data?

MR. HAGGIE: The NLCHI data?

MS. COFFIN: Yeah.

MR. HAGGIE: Yes, it's ours.

MS. COFFIN: Oh lovely. Okay, so if that's something that's shareable, without identifiers and all of that, then that might be a really valuable research tool that could be partnered with independent researchers, but also the university.

In that, in some of the things there when we say outcomes, now that I realize it's specific to a program, one of the things I think about is looking at overall health of our population. We're an aging population and with that comes different rates of incidents and things like that. We win when it comes to diabetes it seems; obesity we're out ahead of that.

These are, I guess, indicators of health, so kind of teeing in our outcomes that are associated with that, but that's much more of a general measure of the well-being of the people in the province.

MR. HAGGIE: Those exist; we have a Population Health division as it were –

MS. COFFIN: Yes.

MR. HAGGIE: – an area within the department. Those matrixes are collected –

MS. COFFIN: Oh lovely.

MR. HAGGIE: – and they are reported on both provincially and through the national mechanism, through CIHI, for example.

MS. COFFIN: Excellent, okay.

So let's take that and we'll tee into now the Health-in-All Policies lens. I notice over here in Departmental Operations they talk about prevention of illness and disease as well. When we get to that piece there, the larger indicators of obesity, diabetes, smoking, drinking and all of that good stuff – or bad stuff – what are we doing to kind of map our prevention strategies into some of the key things that we're seeing there?

MR. HAGGIE: Well, there's a coordination piece there because in 2014 there was a kind of a great divorce and the prevention strategies were moved into Children, Seniors and Social –

OFFICIAL: Development.

MS. COFFIN: What?

MR. HAGGIE: – Development. Yes, I was going to say wellness for a minute. That decision predates my arrival here.

MS. COFFIN: Right.

MR. HAGGIE: So there is a considerable amount of overlap in the department and liaison between ourselves and them. It's always a dynamic discussion as to what kind of promotional material, who sends out kind of thing.

With some of the more acutely focused things like, for example, the opioid issue, we have tended to roll that into Mental Health and Addictions and be the lead on that. With things like exercise, healthy eating, each of the RHAs has its own staff and its own area, but at a provincial level the coordination of that would come through CSSD.

MS. COFFIN: Right. Okay, interesting.

I haven't even hit the questions that I listed here; I'm just kind of taking off some of the things that you have spoken about. Do we have, I guess, a policy or do we have an ability for doctors to prescribe healthy eating and exercise? I know that's been captured in some jurisdictions.

MR. HAGGIE: It has. We have had discussions in the department about that. By and large, where those initiatives have been taken up, particularly around the exercise piece, it's been done with the collaboration of business, basically.

For example, in Alberta, the groups around gym operators said we will give you a free month at our expense, but you have to write the prescription, so it didn't actually cost government anything. The motivation behind that for the gyms was that those people who actually went and stuck it out for a month had a far better likelihood – it was like a loss leader, and then they would enrol and then they would pay their regular rates, whereas their retention rates for cold clients were a lot lower.

MS. COFFIN: Right.

MR. HAGGIE: Basically, it was leveraging the physician, sort of, blessing, which has a power of its own.

MS. COFFIN: Wonderful. Okay, that's very interesting.

I have 36 seconds so I don't know if we can actually ask and answer a question. In the Departmental Operations I understand that a large number of these pieces were all kind of combined together into one. I guess that's why the Salaries in this section are a tenfold increase of many of the other sections that we see in many of the other departments.

Is it at all possible to maybe break that down a little bit so it kind of maps a little bit more into some of the programs that were all combined? If

it's in the book, you don't need to go through a list of it.

MR. HAGGIE: If you go to the position breakdown, you'll see each of the divisions within –

MS. COFFIN: Okay.

MR. HAGGIE: – the operations sphere itemized with PCNs, so you get a subhead of each of the salary elements for those.

MS. COFFIN: All right, that'll be interesting. I'll definitely have a look at that and turn it over.

CHAIR: Ms. Coffin will turn it over to Mr. Brazil.

Mr. Brazil, any more questions on this subhead?

MR. BRAZIL: I have no more questions on that subhead, Mr. Chair.

CHAIR: No more questions?

Ms. Coffin?

MS. COFFIN: Oh yes, I have to get to the ones that were written out for me. They're not bad.

Can we have an update on the activities of the Mental Health and Addictions teams?

MR. HAGGIE: Certainly. In actual fact, I can think of no better person than Colleen to do that. She gave birth to them in many respects –

MS. COFFIN: Oh my.

MR. HAGGIE: – if you don't mind using that term.

There are eight of them, and over to you.

MS. SIMMS: We do have a series of project teams under *Towards Recovery*. As the minister mentioned, we have eight teams. We actually recently collapsed one team together because we were looking at provincial programs as well as service redesign. The two of them came together as the provincial Service Redesign Team.

Each one of the teams is chaired either by somebody from Health and Community Services or from CSSD, EECD or a regional health authority. We have a really good cross-section of government departments involved, as well as Justice and Public Safety. We have over 300 individuals, people with lived experience, family members, RHA staff involved in each one of the project teams, and they're focused around a group of recommendations that came from the All-Party Committee report –

MS. COFFIN: Right.

MS. SIMMS: – and came into our Towards Recovery Action Plan. So, we're right at the two-year mark right now with that action plan.

MS. COFFIN: Yeah.

MS. SIMMS: There were 54 recommendations and 29 of them have now been completed. The rest of them are in progress.

The focus for us right now is really on the service redesign, so really looking at what we need to have in community, as close to home as possible for people, to keep people well and also to treat people with severe and persistent mental illness and additions, so the full continuum.

MS. COFFIN: Lovely, okay. I guess there's a set of outcomes associated with that as well?

MS. SIMMS: There are. There's a full indicator set.

MS. COFFIN: Yeah.

MS. SIMMS: Yeah.

MS. COFFIN: Good. I look forward to maybe chatting with you more about that.

MR. HAGGIE: Just to elaborate on that, there have been a variety of initiatives and some of these, of course, while the coordination and the provincial element comes through the department and you see it in operations, a lot of this is enacted through the regional health authorities. It's provincially coordinated and run but it's actually Central or Western who will do that. So for things like the act and the fact teams – the assertive community treatment and the

flexible assertive community treatment teams – we've rolled out those three.

In terms of hubs, for example, which is around addiction services hubs. So those would be a nurse practitioner with suboxone and methadone prescribing to get an experience in addiction services, mental health support, addiction support, and they would be located in a regional centre. They would provide support to practitioners in Spoke.

For example, a physician out in Brookfield will have clients who he/she can discuss with a hub or refer to the hub for extra support. In turn, those hubs connect to a provincial centre of excellence which is set up and is in the process of bootstrapping itself. There are opportunities there for patient orientated research in that area if we can attract some more funding, and we've done that with a combination of federal money, provincial money and the opioid emergency money that came out in the last interprovincial meeting.

MS. COFFIN: I hear scary things about the opioids, for sure. Certainly, what I'm hearing is primarily affecting the opioid users. So much of a burden is being placed on their parents. Quite often there's like a whole generation that is being affected by that. Grandparents are often stepping up to take care of grandchildren because the parents are absent or unable, right, which is an unfortunate thing. So that's what I hear in some places, but that's not the question.

Where was the federal Health Accord money spent in 2018 and where is it planning to be spent in 2019?

MR. HAGGIE: The Health Accord money was, basically, allocated in two pots. It is in your binder. I couldn't for the life of me just tell you which tab it's at, but, essentially, it was spent in two main areas. One around mental health and addictions and the other is around seniors and palliative care.

So that's where that money will go. The exact amounts are in the binder somewhere, and if I went from memory I would misspeak.

MS. COFFIN: It's okay, we don't need the exact amounts. If they're in the binder we can get them.

MR. HAGGIE: It's in here somewhere. I think it amounts to just shy of $29 million over the first five years.

MS. COFFIN: Okay, good.

Thank you.

Let's see; have you completed the revised policy for the Medical Transportation Assistance Program for Income Support clients?

MR. HAGGIE: No, is the short answer. That work is underway.

MS. COFFIN: Okay.

MR. HAGGIE: I'd be happy to elaborate further on that. Essentially, we have brought in some additional resources in terms of supervisory management, and that was referenced in the question earlier, but we've also now tied into ASL's database so that we can run reports and generate the indicators in that area, too. But we really need to look at the policies and reboot them completely. They were written, some of them, nigh on 20 years, 25 years ago –

MS. COFFIN: Yeah.

MR. HAGGIE: – and I think there is a huge room for improvement there.

Now we have responsibility for all of the medical transportation budget, we can look at what makes sense from a health perspective because whilst it's moving from one head to another, there are significant savings to be had in medical transportation; for example, for methadone services. We've moved – spoke out to Bell Island to deal with issues there, but the upside of it is the money you save on transportation, it still stays in the Department of Health and can be redeployed to provide staff to provide that service locally.

MS. COFFIN: Oh, wonderful. That's nice to hear.

I'm wondering about the insulin pumps for people over 25. When will it begin, and will it only cover people who are currently in the program at 25? So it will only be used for people to get a new pump after they're 25?

MR. HAGGIE: The moment the situation was – the ask from various groups was to lift the age restriction, and we've done that. So, there is money. The pump program is funded through Eastern Health –

MS. COFFIN: Right.

MR. HAGGIE: – so there isn't a line item as such here. It's in Eastern Health's operational budget. It is a provincial program, and I think when it first started it was capped at 15 and then it went to 18 and then it went to 24.

The intent for this coming year is two-fold. One is we remove the age restriction so anybody who's 24 will not age out. The other thing is that program is undergoing a reboot, too, because there are significant opportunities for it to be run in a way that would yield better value for money, and there is a new clinical need as well.

So I think there's a huge opportunity here to say, well, how do we do business in that program? And there are opportunities through shared services. Whilst it's run through Eastern Health, we could have a more centralized procurement and we could actually save money per item and we can redeploy that money.

The challenge with that is through the diabetes registry. Our data is now so much better than it was before, and people have come to us and said: Well, you've got a sudden increase in the number of Type 1 diabetics in this province. We haven't; what we do is we're recognizing them now.

MS. COFFIN: Right.

MR. HAGGIE: Basically, at the moment, only 10 per cent of people simply labelled as Type 1 diabetics are actually enrolled in the program.

Now, you've got to remember that not everybody with Type 1 diabetes is suitable for a pump.

MS. COFFIN: Right.

MR. HAGGIE: Sorry; is eligible for a pump, clinically.

MS. COFFIN: Yeah.

MR. HAGGIE: And of those people who are, not everybody who is offered a pump can actually manage it.

MS. COFFIN: Right.

MR. HAGGIE: There is, depending on who you talk to, anything up to 40 or 50 per cent of people with the condition end up not being able to use a pump.

MS. COFFIN: Oh.

MR. HAGGIE: But the expansion there is such that we haven't yet identified the source of funds to go backwards and say, well, who would be next? Where would be the next group to expand it to?

Our intention is, ultimately, to end up in a place where anybody of any age who's got Type 1 diabetes – who needs a pump and the physician says it's a reasonable thing – would be able to be supported in that way, with us as the insurer of last resort, I hasten to add –

MS. COFFIN: Right.

MR. HAGGIE: – in the same way we are with some of the children services also.

We are not there yet, and until we find ourselves with some fiscal leeway, quite frankly, it's going to be very difficult to do anything other than an incremental program.

MS. COFFIN: Right. And this will only be for Type 1, not Type 2?

MR. HAGGIE: There is a great debate about Type 2 in terms of whether or not insulin pumps are actually the treatment.

MS. COFFIN: Right.

MR. HAGGIE: They are two different conditions.

MS. COFFIN: Oh, I'm well aware.

MR. HAGGIE: One is insulin resistance, the other is not producing any insulin. So they are, I am told, managed completely differently.

MS. COFFIN: Right.

MR. HAGGIE: So that has not come up as a question.

MS. COFFIN: Okay. Yeah, and I didn't figure they were –

CHAIR: Excuse me, your time has expired.

MS. COFFIN: Okay.

CHAIR: I'll turn it back to Mr. Brazil.

MR. BRAZIL: I'm still good on that subhead until you move to the next subhead, yeah.

CHAIR: You're still good. Okay.

Ms. Coffin –

MS. COFFIN: I have a couple of other quick questions.

CHAIR: – can we do line by line this time?

MS. COFFIN: Can we have an update on the activities under the home support action plan and the Home First philosophy?

MR. HAGGIE: Yes. The Home First philosophy has made significant differences. For the first time I can ever remember, it has actually enabled patients to be repatriated home from long-term care.

MS. COFFIN: No way.

MR. HAGGIE: Yeah.

MS. COFFIN: Wow.

MR. HAGGIE: So there is significant benefit to this. In 2018-19, we've had 1,000 people access services that have avoided hospital admissions through this Home First policy. We got $43 million in funding from the feds, over five years starting in fiscal '17, to support home and community. So that's where that has gone in terms of some simple, high-level matrix. In 2017-18, we spent $4.6 million and, in '18-'19, we spent $8.5 million.

We do now have a home care dementia approach. We have a dementia plan, which is valued at $1.7 million, in addition to that, and that is a case-managed approach. So you would have behavioural management specialists – it's based on the nurse practitioner model. That would be the hub there.

So if you want specifics, there is a whole pile of things in terms of better assessment tools, better coordination between the various elements there. We've been working very closely with the home care sector. That's divided between individual pay and what we call self-managed care where the person simply goes to somebody and asks would they look after them at home or, alternatively, agency work.

One of the challenges identified in the Deloitte report was around verification of services. The traditional matrix for home care is hours. There is a huge opportunity with the work we're doing with the home care sector to reboot that and to talk about services needed, so it doesn't become a matter of hours, it becomes a matter of care needs and how those are met in a coordinated way.

Obviously, if you have a more urban area and a fairly dense area, I'm sure a lot of modest-sized communities do have areas where there are seniors clustered in affordable housing or seniors housing, there are huge opportunities there to have care provided at almost a street level by a group of people in a needs-based way, which is much more focused on the individual care needs. We think that with that, we can generate significant efficiencies in the dollars we spend, better outcomes for the individuals concerned and better health for the group of seniors.

MS. COFFIN: This is very reassuring. I had experiences with home care from a couple of different perspectives, one of which my brother has home care for his son, so we've had very good interaction and some wonderful, wonderful people there who have been helping take care of our Little B, and that's particularly special.

I've also talked to a number of people who work in home care, and some of the things that they have told me about their work environments are a little concerning. They say sometimes if they're assigned to a home or they're assigned to an individual, they often don't know what they're walking into. It could potentially be a dangerous environment; it could be someone who might have some mental illness and they're not quite sure what that mental illness is and that person is there just to manage some other issues, and they've told me stories of being told how to give medications by the parents of the person they're there to care for or by someone who perhaps was not the most appropriate person to give training on delivery of medication, say, via G-tube or anything like that.

I think it's an important piece to balance that as well, and I know that that's a very difficult thing because it's a very special relationship between a home care provider and a home care recipient. It's not exactly like employer-employee, but certainly that's something that I have heard. It wasn't one of my questions; it's just another piece that I hope that is being balanced along the way.

I am wondering now: Has the department completed the new personal home care standards?

MR. HAGGIE: They are in process. They're actually part of another kind of three-legged stool because the standards are linked to the levels of care, and, in turn, those feed into the funding model. Each of those areas is being currently addressed, so we have some work out in terms of informing jurisdictional scans of funding models.

We have been working very closely with the personal care home operators association and the Quality Living Alliance, certainly prior to the election, on a new set of standards. Currently, we have four levels of care: 1, 2, 3 and 4. One and 2 are manageable in personal care homes and the standards are geared around that; 3 and 4 tend to fall into RHA facilities, which are designated and called long-term care.

Now, one of the earlier developments was we kind of designated a 2-plus and we had a pilot scheme that we inherited, and it ran very well. We debugged it a little bit further and we've expanded that, and there is what we a call an enhanced care arrangement for personal care homes who want to apply for it and is extra funding that goes with that.

We do have a level 3 transient payment arrangement as well, where a home would take a level 3 patient on a short-term basis with extra resources – not just financial for either of these, they would involve RHA staff and accessibility to services that wouldn't typically be provided there. That was, in part, to try and take some of the strain off long-term care while the beds situation was being addressed. But what we've done is we've gone back to the association and we've said: What about a seven- or eight-point scale?

How about something that is nuanced that allows you to score for severity of mental illness for example? Because we heard some questions about that earlier on today. Whilst those are addressed in the old standards, they are done in an older way of thinking and it doesn't really line up with best practices. So once you've figured out what the levels of care are, you set the standards for those levels and then you figure out how to match the funding with the levels of care. At the moment, there is little recognition financially between level 1 and level 2. So there's no real incentive for a personal care home operator to take a level 2 because their staffing requirements change but their compensation doesn't – 2 plus does, but 2 doesn't.

MS. COFFIN: Right.

MR. HAGGIE: So those are the challenges of their business model and we're trying work that with them. We're kind of on the cusp of where we need to be but there is one piece of outside information that's needed, and that's the discussion on funding models and our outside consultant work about what to do. The rest of it is pretty well nearly nailed down. But again that feeds in with the standards around education. So there's some discussion there around who pays for what because we've had some surprising comments about what some home operators think is the training requirement or not, or people who work in that (inaudible).

MS. COFFIN: Right. I look forward to that, but it's nice to hear that that movement is happening.

One last question: I just want to know what will be done in the 2019-2020 with autism strategies. Was there some specific initiatives?

MR. HAGGIE: Really glad you asked me that question. The short answer is there are. Everything that was actually written into the strategy is there. In essence, it goes at it from several directions. One is access for diagnosis and improving access to clinics.

There are five pillars. I'm not going to go through that. It's in the plan; you can read it online.

MS. COFFIN: Right.

MR. HAGGIE: But the number of ASD diagnosis clinics, we need to look at ASD assessment tools. There is a variety out there. But one of the things that we're doing is revamping the Special Child Welfare Allowance Program and we're moving that to what we're going to term supporting services for children. I think the name change is just to really signal that the old is gone and the new is in.

What that does is it looks at function. It looks at the needs of the individual in terms of what support they may need. So it gets rid of IQ 70, but it's actually a diagnosis-agnostic tool. At some point, children with any impairment will actually be able to access this program.

This is where the integration exists between the Autism Action Plan and our more overarching strategy of a disability program through community support services.

The focus has always been, and the pressure point in the public eye has always been, around autism, but that's not the only diagnosis, and we're trying to move away from diagnosis to function. We've got JASPER expanded, we're going to teach the family, in the same way we've done through Strongest Families dealing with anxiety. We found that if you treat the family – the parents as well as the child – the results are not only better, but they're more lasting.

MS. COFFIN: Of course it would.

MR. HAGGIE: The I CAN anxiety thing for the kids through Strongest Families has an 82 per cent success rate.

MS. COFFIN: Wonderful.

MR. HAGGIE: So that was a metric for you.

MS. COFFIN: Yes.

MR. HAGGIE: The education piece, an ABA up to 21 when they age out of the school system. So there are lots of tangibles there. There is $2.5 million for the rest of this year.

There will be a little bit of a delay because we've got to get the tool right, because we've already heard very clearly from some groups that it's too medicalized. The ones that are out there that everybody loves are based on very much a medical model. So we need to figure out how to get round that, train the staff, then we pull the trigger. That's why there's less in this year's budget than there is annualized afterwards.

MS. COFFIN: Right. Wonderful. Thank you very much.

That is my question, thank you.

CHAIR: Okay, thank you.

So hearing no other speakers, I'll ask the Clerk to call the subhead, please.

CLERK (Hawley George): 1.1.01 to 1.2.02 inclusive.

CHAIR: Shall 1.1.01 to 1.2.02 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Motion carried.

On motion, subheads 1.1.01 to 1.2.02 carried.

CHAIR: Moving on to the next subhead.

Clerk, if you could call the subhead, please.

CLERK: 2.1.01.

MR. HAGGIE: Before we start, Mr. Chair, I am reliably informed there were six retirements from the department in 2018-2019.

CHAIR: Okay, Mr. Brazil, that's the information you required, right?

MR. BRAZIL: Yes.

CHAIR: Okay.

So shall subhead 2.1.01 carry?

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

Just a number of questions here for some clarification.

Under the Professional Services, can you tell us the nature of the Professional Services? What they're for and some type of contractors that might have been contracted for these services?

MR. HAGGIE: Okay, the 2.1.01 is an agreement with Bell Aliant for real-time processing for the NLPDP, and that's a contract price. Its current contract is extended until the next financial year, and we're working on a new RFP.

MR. BRAZIL: Okay, perfect.

MR. HAGGIE: That's real-time adjudication. There are 11,000 claims a day processed by that system for NLPDP eligible clients.

MR. BRAZIL: When did that come into play?

MR. HAGGIE: Well, going back to the dawn of time it was Xwave and then it morphed through several things.

We have a challenge in that whatever replaces it has to be bulletproof, so we've been very careful about writing the RFP because whoever comes in needs to make sure it will run, first time, right. So it may need a period of shadowing running with two systems, the changeover. But if that changeover isn't done properly, that's our main worry because, as I say, 11,000 a day.

We have had odd little downtimes, but it's got a 99.999 per cent uptime reliability. So it's only been done for half an hour, kind of thing, on those occasions.

MR. BRAZIL: Fair enough.

MR. HAGGIE: That's what that is. That came out of the dawn of Xwave.

MR. BRAZIL: Yeah, I'm quite aware and sat in, as a minister, and had discussions around how do we move it, and knowing that it hasn't moved.

How close are you guys to being able to put an RFP for another provider or equal provider just with a new type of service?

MR. HAGGIE: I don't think we're that far off. We would anticipate –

OFFICIAL: (Inaudible.)

MR. HAGGIE: Okay, we're well advanced. The proposals are in. It's out and back.

MR. BRAZIL: Okay.

Thought so, that's why I only asked because I–

MR. HAGGIE: See that's what happens when you go and have an election, you see, you come back and you have to catch up.

MR. BRAZIL: Yeah. That's why I ask because I had heard a rumour it was out there but I wasn't quite sure if they had closed and they were accepted back in.

MR. HAGGIE: No.

MR. BRAZIL: Okay, fair enough. That will be curious.

Do we know the opening date, or closing date, I should say?

MS. STONE: It has closed

MR. BRAZIL: It has closed, yeah, but the opening date I meant. When are we going to open to know the awarding of the contract itself?

MS. STONE: Very soon.

MR. BRAZIL: Okay, fair enough.

Allowances and Assistance under 09, you're $2 million budget difference there, it went over in '18-'19. Can you just explain what that was relevant to?

MR. HAGGIE: Yeah. It's actually pretty much the same reasons as last year. It's higher utilization of antivirals, principally Hep C antineoplastics, which are hematological oncology drugs and methadone and Suboxone.

MR. BRAZIL: Okay. So the money to cover that, is that federal money coming back in?

MR. HAGGIE: We do have some revenue in this heading.

OFFICIAL: (Inaudible.)

MR. HAGGIE: We have revenue from the PLAs, the product listing agreements, we have rebates, and they are based on agreements that we have with the drugs companies. So, we had a change between 2018-19, revised in the 2018-19 budget, which was an issue around submission of claims.

MR. BRAZIL: Okay.

So, just so I'm clear, the $2 million extra, that was transferred in from another line area or from the revenue that –?

MR. HAGGIE: We just had savings in other areas to offset the cost increases.

MR. BRAZIL: What kind of programs would you be able to save $2 million in?

MR. HAGGIE: I think it was across …

OFFICIAL: Capital.

MR. HAGGIE: Capital.

MR. BRAZIL: Okay, capital costs. Fair enough.

In *Budget 2019*, you announced 15 new drug therapies at a cost of $4.9 million. The budget for drug costs in 2019 has only increased by $200,000, plus you also went over budget in '18-'19 by $2 million. How are you going to fund the new drug therapies as it doesn't seem to be through in the budget right now? Can you just clarify where that money will come from?

MR. HAGGIE: Okay, let me just have a look and see. I have a list of (inaudible).

So your question was: Where's the money coming from for the new drugs?

MR. BRAZIL: Yes.

MR. HAGGIE: Okay.

MR. BRAZIL: Keeping in mind, your budget lines are only up $200,000.

MR. HAGGIE: Yeah.

No, I mean, this is where we anticipate savings in other areas, cumulatively, to be able to move those in.

MR. BRAZIL: Can you give me an example of where those savings potentially could come from? It seems fairly substantial, almost $5 million.

OFFICIAL: (Inaudible) capital savings.

MR. HAGGIE: Most of the time it has come from capital and that seems to be where our eyes are set at the moment.

MR. BRAZIL: Fair enough.

Can you just outline here the revenues that are outlined in 02, an additional $4,750,000 was received in '18-'19, can you outline where that came from and what it was for?

MR. HAGGIE: Which one that came?

MR. BRAZIL: Yeah, revenue in 02, the difference there between what was anticipated

and what came in after, the $12 million that actually was revised to the $7.250 that came in.

MR. HAGGIE: Those were rebates. What happened was the ’17-’18 claims for rebates were submitted late so they appeared in ’18-’19.

MR. BRAZIL: From previous fiscal?

MR. HAGGIE: From the PLA, product listing agreement, we had $4.75 million that was late going in 2017 fiscal and came in 2018.

MR. BRAZIL: Can you outline a little bit more about the new drugs that are going to be added to the system?

MR. HAGGIE: I have them here. Certainly.

There’s one for hidradenitis suppurativa, there’s one for primary biliary cholangitis, there is one for type 2 diabetes with high cardiovascular risk, one for infantile hemangiomas, one for multiple sclerosis, one for the prevention of stroke in coronary artery disease, giant cell arteritis, polycythemia rubra vera, acute myeloid leukemia, one for ovarian cancer, two for lung cancer, one for chronic lymphoblastic leukemia and one for lung cancer.

MR. BRAZIL: Okay, that’s a good cross-section and good additions to the drug list itself. My concern is that we were over budget before and had to take it from capital. Now we’re adding new and you’re anticipating taking from capital again the savings.

Is that not a risk to ensure that you’re going to be able to cover those drugs within the system? I mean is your priority that these drugs will stay and there will be no limit on the access for those who qualify?

MR. HAGGIE: The criteria around the drugs and their availability is clinical, not administrative. I mean the facts of the case are there are two pressure areas on the health budget globally; one is the price of drugs. We participate in those pan-Canadian negotiating arrangements – the pCPA and such, pCODR – that allow us to leverage nationally volumes. A lot of it is not directly within our control.

Adding on to that, of course, now, is the federal announcement about pharmacare and it is not clear in any way, shape or form how that is going to work. The final report is fairly vague except for the fact it’s a universal single-payer system.

It is a challenge, and it always is every year, to try and make sure that we cover the cost of drugs because the only other alternative is to reduce the number of new drugs we bring in each year. That then puts us at odds with other provinces and creates inequalities. Every year this area is subject to a lot of hard work by staff to try and find a way to fund it.

MR. BRAZIL: Fair enough. I applaud the fact that there are new drugs being added and I understand the agreement of the provinces in having to have that in play, but my concern still lies in the fact of knowing that it’s going to cost additional revenues that you don’t have earmarked right there.

Have you talked about it? Is there already an earmarked capital cost that you’re not going to go through with this year?

MR. HAGGIE: We haven’t –

MR. BRAZIL: Or is there somewhere you’re anticipating savings? Is there some piece of equipment? Is there some facility?

MR. HAGGIE: Well, as you are probably aware, capital cash flows are very unpredictable. We’ll get into that when you come down to the capital piece, when we go through that line item.

There are a modest number of inflow and outflow gaps over the course of a project and it is robbing Peter to pay Paul. The main thrust has been around generics and the opportunities to replace expensive patent drugs, particularly biologics. Biosimilars is the new buzz category and we are often subject to considerable lobbying by what could be charitably called patient groups but are often, in fact, agents of the manufacturers to restrict physicians’ abilities to prescribe cheaper drugs.

One of the things that we have looked at doing is trying to advise physicians of the costs of

therapies. That hasn't, on an evidence-based way, produced some of the behaviour changes that we would like to see but it's a start; it is part of an education piece. The facts of the case are that there are increasing numbers now of biosimilars and we will be looking to those to reduce costs because some of them are a factor of 15, 20 cheaper than an equivalent, patented medication.

That's one of the challenges around the drug-pricing system and one of our concerns about changes on the national level that might affect our ability to do that.

CHAIR: Thank you, Minister, and we'll be moving on.

Mr. Brazil, I'll get back to you, but before I do, I remind everyone that we will be moving to 2.3.01 before we call the subhead –

MR. BRAZIL: Yeah.

CHAIR: Okay. So, we're good.

Ms. Coffin, your 10 minutes, Ma'am.

MS. COFFIN: (Inaudible) questions. The first one: Can we have a list of the expenditures and number of clients in each drug plan in 2018, please?

MR. HAGGIE: I think that might actually be in your binder.

MS. COFFIN: Oh, wonderful. And that was an easy answer.

MR. HAGGIE: Yes, there is a list of numbers, and there is another table with expenditure for each of those plans.

MS. COFFIN: Okay.

MR. HAGGIE: So it's not one table; it's two.

MS. COFFIN: Okay. That's fine.

How much is budgeted for the Smoking Cessation Program?

MR. HAGGIE: I would have to look for that. I think it's $10,000. 2.1.01. Yes. Yes.

Sorry; yes, it is. I was actually staring at it in front of me.

Annualization of the Smoking Cessation Program is $10,000. We had 1,779 people avail of it in 2018.

MS. COFFIN: Did they stay stopped smoking?

MR. HAGGIE: Good question. I'd have to go back and ask that specific question.

MS. COFFIN: Sure. Yeah.

MR. HAGGIE: We do have that, but CSSD would be the people who would tell you the answer.

MS. COFFIN: Right. They are the keeper of the data.

MR. HAGGIE: Yeah.

MS. COFFIN: Yes. Okay.

One more other question here, and this is something that is of interest to me, but also something that I heard on the doors from a number of people who are involved in this program. I'm wondering about the coverage of medical marijuana. Certainly, a couple of very astute doctors in that area said she's having remarkable success with that and it's gotten people off a lot of the other drugs, but because medical marijuana is not covered, people sometimes can't afford it and stay back on drugs that tend to have some very negative side effects.

MR. HAGGIE: Yeah. I mean, the first problem is that, by legal definition, marijuana is not a drug.

MS. COFFIN: Yeah.

MR. HAGGIE: So, your first problem there lies at the federal level because it requires a DIN number, a Drug Identification Number.

MS. COFFIN: Right.

MR. HAGGIE: Without that, it cannot be prescribed, and without a Drug Identification Number, it can't even be considered for a provincial formulary.

MS. COFFIN: Right.

MR. HAGGIE: So, that's your first challenge around that. There is no doubt there is evidence out there of, certainly, anecdotal benefit, and I would suggest there is probably some more structured research that would back it up. The problem is a federal regulatory piece, and it's outside my jurisdiction.

MS. COFFIN: I'll happily write a letter for you – or on our behalf.

That's all my questions in this section.

Thank you.

MR. HAGGIE: Thank you.

Oh, sorry. We have some updated money for Smoking Cessation. The $10,000 was an annualization of our bit, but the bill for the total cost of Smoking Cessation was $1.068 million.

MS. COFFIN: Thank you.

MR. HAGGIE: Thanks.

CHAIR: I'm sorry, we're going to have to pause, just recess for five minutes, if you don't mind.

OFFICIAL: (Inaudible.)

CHAIR: Okay, you usually do it at 7:30, so we'll come back at 7:30, if that's fair. Okay?

MR. HAGGIE: I don't mind. Yeah.

CHAIR: Thank you very much.

Recess

CHAIR: Okay, we're ready to go again. Thank you, and I hope everybody enjoyed the little recess.

Mr. Brazil, you're up for your 10 minutes, Sir.

MR. BRAZIL: Thank you Mr. Chair.

Under Medical Care Plan, 2.2.01, Physicians' Services, can we get a breakdown of the number of physicians in the province by salary versus fee for service and specifically by the regional health authorities?

MR. HAGGIE: I can read it out; it's in the binder.

MR. BRAZIL: Okay, it's in the binder.

MR. HAGGIE: We have both of those there. Just as an overview, in the last 10 years our physician numbers have increased by 19 per cent but physician compensation has increased by 57 per cent.

MR. BRAZIL: Okay, fair enough.

Under Professional Services, fiscal '18-'19, you went over budget by $2 million. Can you explain what that was for?

MR. HAGGIE: And that's under Physicians' Services.

MR. BRAZIL: Professional Services, 2.2.02.

MR. HAGGIE: 2.2.02, that's the Dental Services one you're looking at now.

MR. BRAZIL: No, MCP fees for service (inaudible).

MR. HAGGIE: Oh, sorry, 2.2.01.

MR. BRAZIL: Under Physicians' Services.

MR. HAGGIE: Under Professional Services, 2.2.01, two things driving that: We have increased utilization and the increase in surgical dental. Some years ago, really, as a precursor to the idea of doing in private offices what was only done in regional health facilities, some of the dentists were allowed to bill fee codes for surgical procedures in their own offices and that has driven the cost increase.

MR. BRAZIL: Okay.

How did you cover that off, the $2 million?

MR. HAGGIE: Same discussion really, as before. We have identified savings in other areas, and moved the money in.

MR. BRAZIL: Any particular one that stands out, where the money was saved that was moved in?

MR. HAGGIE: Again, last year was capital – we had a significant amount of leeway there because of timing of some of the projects, and we'll get down to that bit further down.

MR. BRAZIL: As you know, during the election, myself and you were in a debate around chronic diseases. We obviously had a conversation with what the demand was, and particularly most agencies there would talk about the aging population as part of it, knowing that there's going to be a bigger demand as we move forward. I notice there hasn't been any dramatic increase in the budget. Shouldn't that be taken into account, knowing that the needs are going to obviously increase?

MR. HAGGIE: It's difficult to project what increase in demand is going to be. The budget there is a modest increase, 2019 over 2018. I think, really and honestly, beyond that, the forecast there is predicated on an increase for more doctors and higher frequency of visits, but also realignment between fee for service and salary. When the funding for the last agreement was put in, there was more money put in one pot than another, and that's been moved back to the – I think it went from salary to fee for service, didn't it? Yeah, it went from salary to fee for service. They were put in the wrong pot when the – sorry, the other way, fee for service to salary. So it nets out.

MR. BRAZIL: The full $2-million overrun?

MR. HAGGIE: No, what happened was the overrun is a netting out – oh, sorry, I misspoke. I've been looking at the wrong section here. The cost overrun of $2 million was around increased utilization, essentially as I said before.

MR. BRAZIL: Okay, fair enough.

Under Allowances and Assistance, under 09, budget '19-'20, the budget increased by $1 million over the revised budget. Can you explain that?

MR. HAGGIE: This is for payments for services received by residents out of the province, for residents of other provinces while in, under reciprocal billing. That's totally unpredictable. In that sense, we don't know how many Newfoundlanders and Labradorians are going to be out of the province and require coverage. Likewise, the other way around.

MR. BRAZIL: So there are more projected for costing for patients moving out the province than it would be for investing in having additional doctors here to provide services?

MR. HAGGIE: No, these are people who are resident in the province but are actually outside. For example, if you went to Fort Mac to work, we would cover you. If you're ill out there, we pay, and that's where this appears.

MR. BRAZIL: Okay, fair enough.

MR. HAGGIE: The rates are set under reciprocal billing arrangements.

MR. BRAZIL: Okay.

Under 2.2.01.10, Grants and Subsidies, in fiscal 2018-19, you went over budget by $6 million. Can you explain that one for me?

MR. HAGGIE: The following funding was removed related to efficiency initiatives. In the last couple of years there's been development of a physician hiring approval committee, salaried physicians' compensation benefits in lieu, and limited use of salaried physicians' locum. The full realization of those services has not been achieved yet, hence the overrun. We only got $800,000 of it, so that's the difference.

MR. BRAZIL: So, how did you cover that overrun?

MR. HAGGIE: We've, again, realized savings in other areas and moved them over.

MR. BRAZIL: Similar to other line items there, are we talking capital or are we talking change in program services?

MR. HAGGIE: Capital last year – there was some comment about some savings on the blood program.

MR. BRAZIL: Okay, fair enough.

You spent $6 million more in budget ’18-’19, yet the budget ’19-’20 only increased by $3.5 million. Do you feel it’s reasonable that you can cover that and there wouldn’t be any additional increase? We’re noticing there’s obviously, because of the uptake and the demand and the change in the demographics, always an increase in particular lines. Have you budgeted enough there to cover the change from last year, and what potential additional uptake there may be this year?

MR. HAGGIE: It’s a reasonable estimate of what we think the change will be based on past performance.

MR. BRAZIL: Okay.

Because of the changes in the costing there, is there a plan to cut some salaried physicians in the regional health authorities in ’18-’19?

MR. HAGGIE: No. The salaried physicians’ position numbers are fairly static. New positions are reviewed through a needs assessment. Some physicians who are fee for service will transition into salary as they get near the end of their career. As long as there’s enough billing on their fee-for-service budget, we will transfer the salary over from fee for service.

MR. BRAZIL: Okay, fair enough. But it just seems like we’re consistently over budget in the salary units and there’s no realization there of how to be able to sustain that as we move forward.

Last year in Estimates you said that $1.7 million was removed from the salaried physician budget because some physicians were getting two sets of benefits. Has this change been made for this year?

MR. HAGGIE: My understanding is it has, yeah. It’s out.

MR. BRAZIL: And we don’t anticipate any issues with that? That’s a savings?

MR. HAGGIE: Yes.

MR. BRAZIL: Any idea how many physicians we’re talking here?

MR. HAGGIE: I can find that number out for you but I’m not sure it’s the GFT (inaudible)? We can find that number out.

MR. BRAZIL: Okay. Fair enough. That’s good.

Under 2.2.02, Dental Services, Professional Services, fiscal ’18-’19 you went over budget by $300,000. Can you explain what that covered?

MR. HAGGIE: 2.2.02. Stainless steel crowns and complicated extractions in children.

MR. BRAZIL: How many patients are we talking? Twenty, 50, 100, 500?

MR. HAGGIE: We can find out for you for sure.

MR. BRAZIL: Oh yeah, fair enough.

Any note like that, it’s not immediate to get it but it’d be nice information to have as we assess the Estimates themselves. The additional money to cover that?

MR. HAGGIE: Again, the same discussion as before.

MR. BRAZIL: Okay.

MR. HAGGIE: The finances of the department are dynamic; it isn’t just cast in stone. If we have areas that are overrun, we will look internally for savings and move them over rather than go and look at the contingency fund or special warrants.

MR. BRAZIL: Is it the norm, though, that you would save on a program? Because normally – I’ve worked in government for many years and Health was one of the departments I was in for a period of time – once program money is allocated, 99.9 per cent of it gets spent, and I understand.

Coming from another background, I can see in capital a project doesn’t move forward, so you can realize that savings internally and make the transfer. Is this where most of the additional

costing will be covered off on capital projects so that they'll move forward in a timely fashion?

MR. HAGGIE: Capital is the place where we've gone. We have a lot of capital projects of varying sizes on the go, so, yeah, that's our go-to place first. Then there may be vacancies in some areas and they're not filled for a couple of months and there's a couple of months of salary there. Again, it's a dynamic process.

MR. BRAZIL: Fair enough.

CHAIR: Thank you, Mr. Brazil.

MR. BRAZIL: Yes, Mr. Chair, you can come back to me after.

CHAIR: I'll move on.

Ms. Coffin, your 10 minutes.

MS. COFFIN: Thank you very much.

A few relatively easy questions I think. I guess the first thing that stood out for me was that Professional Services is about three times as Grants, or Grants and Subsidies represent about a third of the Professional Services budget. Grants and Subsidies include locums, malpractice insurance and there are a number of other things in there, yes?

MR. HAGGIE: Are we talking about physician services?

MS. COFFIN: Yes, sorry.

MR. HAGGIE: Oh we went back, okay.

MS. COFFIN: 2.2.01. I'm sorry. I should have said that.

MR. HAGGIE: No, that's all right. I just want to make sure that I'm on the right page with you.

MS. COFFIN: Right.

MR. HAGGIE: You were asking about the ratio of Grants and Subsidies to …?

MS. COFFIN: To Professional Services. I mean, that seems like quite a large number. If it's locums that represent the bulk of Grants and Subsidies and that are Professional Services – so we're looking at a large chunk of money being used for locums to fill in for those Professional Services.

MR. HAGGIE: The professional bit covers the fee-for-service physicians. The Grants and Subsidies covers the salaried physicians. Locums would, by and large, fall under the Grants and Subsidies, because the vast majority of locums actually come on a salaried basis.

MS. COFFIN: Right. Okay.

MR. HAGGIE: This is where you would see the subsidy for CMPA. We pay approximately 75 per cent of their costs.

MS. COFFIN: I'm glad I asked that question. Okay, so actually that's quite interesting.

Let's go over to here. Can we have a breakdown of the current number of family physicians, the number of specialists, broken down by salaried versus fee-for-service and by region, please?

MR. HAGGIE: It is in the binder.

MS. COFFIN: Lovely.

MR. HAGGIE: We have, I think, the second-highest number of physicians per capita in this province in the country.

MS. COFFIN: Wow.

MR. HAGGIE: We actually have the highest per capita of nurse practitioners in the country. We're double the national, the Canadian average for nurse practitioners per capita.

MS. COFFIN: Good on nurse practitioners. You say we have the highest number of physicians?

MR. HAGGIE: No, we have the second-highest per capita.

MS. COFFIN: How come I can't find a doctor?

MR. HAGGIE: Yes, good question. The problem is not the number; the problem is where they are.

MS. COFFIN: Right.

MR. HAGGIE: Because of our critical mass issues, if you look at it, the first thing that would strike you is that we have way more specialists than we do family doctors.

MS. COFFIN: Right.

MR. HAGGIE: Some of that is simply critical mass. We have various locations and you need three, four specialists to provide 24-7 service, even though under other circumstances workload may only warrant one or two by day.

Having said that, if you look at family physicians and add in nurse practitioners the numbers balance out. They're about 50/50. The difference there, of course, is the pattern of work, because nurse practitioners, by and large, work shifts and regular hours. They will not do a call, whereas family practitioners do in certain areas.

MS. COFFIN: Right.

MR. HAGGIE: The difficulty when you say finding a doctor, it's all around primary care. That's why we've put our emphasis on primary care teams and we have started to roll these out, because it allows a range of practitioners to support. What would have been, say, a five-person family practice, may actually end up as a primary health care team which has three GPs, a nurse practitioner, a mental health counsellor, social worker, foot care nurse, a diabetic educator: these kinds of things.

MS. COFFIN: Good.

MR. HAGGIE: When you make an appointment, in the ideal world and when it's fully iterated, you will find yourself in a situation where they'll say, well, why don't you go and talk to the foot care specialist nurse rather than the GP?

MS. COFFIN: That's wonderful. Like a dietician –

MR. HAGGIE: They're there if you need them, but that then frees the physician up to do what they're best at, which is managing complex, chronic conditions where you have, say, four or five conditions and the algorithms, the treatment guidelines actually compete with each other, which is not at all uncommon. Then you have to have that discussion with the patient about what their goals and treatments are. Is it more important to you that your exercise tolerance is better, or is it more important to you that you have less breathing trouble or these kinds of things?

MS. COFFIN: Right. Okay, that's very reasonable.

I will tell you, the couple of times I've called the doctor to get in to see someone the first question they ask is: Do you require opioids? Which is a disturbing first question, right? I don't, so I get in, right, but that's an unfortunate –

MR. HAGGIE: Well, we brought that up with the college actually. It is a standard-of-practice issue. The College of Physicians and Surgeons here doesn't actually have required practice standards in the sense that the pharmacists would, for example; the Pharmacy Board has required practice standards.

That's part of it but, in general, the College has expressed disapproval about screening of patients. We haven't here seen the same kinds of problems that you've seen on the Mainland where it's one visit, one problem. The College frowns on that, too, and has actually been, I think, fairly overt in saying that.

MS. COFFIN: Right.

MR. HAGGIE: The availability piece, we've also tried to supplement with other things like HealthLine and this kind of stuff. That's been very successful indeed. If you take a hundred people who ring HealthLine stating at the beginning they want to go to the emergency department, by and large 80-odd per cent of them will not after the HealthLine consultation.

MS. COFFIN: Yeah.

I've actually called the HealthLine. Apparently I don't need to go if my toe is broken. The HealthLine is an excellent thing. They were very competent and very professional so I must say good on them.

What is the status of the memorandum of agreement with the NLMA to set up interdisciplinary teams in doctor clinics around the province, so kind of that team thing? You have the memorandum of agreement. Is that being implemented?

MR. HAGGIE: The primary health care teams were actually set up previous – maybe two pervious – memoranda ago. We have a primary health care renewal program. We provide the NLMA for funding and they have a coordinator there. We have dedicated stuff in the department here who work with them. That program in gaining momentum; it's certainly out here.

MS. COFFIN: Good. It is an excellent approach for sure.

Question: Can you give me the number of malpractice suits that are currently outstanding?

MR. HAGGIE: Wouldn't be able to tell you.

For fee-for-service physicians, that's not a figure we would collect. If you want to get that data, the Canadian Medical Protective Association would be my first suggestion. That's data we don't collect.

MS. COFFIN: Okay, that's grand. Thank you.

Can we have a list of the expenditures and the number of clients in the Adult Dental Program and the Children's Dental Health Program in 2018?

MR. HAGGIE: Yes, we do have a breakdown of costing between the two. If you pause for a moment, I will endeavor to find this in here. Unless someone here can get that before me, which is highly unlikely.

Children and youth, $9.5285 million; adult, $2.251 million. That was the expenditure. We can get you numbers, I don't actually have those (inaudible).

MS. COFFIN: Okay, that's great.

Just teeing into perhaps another question or another discussion that we had a little bit earlier. When it comes to around prevention, I know that flossing is like the best thing you can do for your teeth.

Is there any thoughts to having flossing in schools?

MR. HAGGIE: You'd have to speak to Education and Early Childhood Development for what they teach in schools.

We did get a shout-out from the president or CEO, I can't remember, I think it was the president of the Newfoundland and Labrador Dental Association about how good our child dental program is in terms of the issues that they see or don't see. That was in the media, I think, earlier on this week, for example.

So we do have a comprehensive dental program for children. We are the insurer of last resort, ideally. I think that's been working very well.

MS. COFFIN: Lovely, okay. Thank you vey much.

That's all my questions for this section.

Thank you.

CHAIR: Mr. Brazil?

MR. BRAZIL: I need to go back on something Ms. Coffin just – the discussions here on Grants and Subsidies; get my head around the numbers again weren't quite – not that they weren't adding up but just what I think is underestimating here.

I just went back, and it's not in the Estimates book, it's '17-'18 under Grants and Subsidies, 2.2.01, Physicians' Services. In '17-'18, there was $121 million-plus budgeted under that line item. In '18-'19, it was $116 million budgeted so, obviously, there was an indication there was going to be a $5 million decrease in some way, but the revised was $122 million, which was actually $1 million more than the previous year, but in '19-'20, now we're at the $118 million.

Looking at the trends, there are two things here. One, I have a concern that we're definitely underestimating where we're going to be in '19-'20 to cover that. The other is, if we were at $121 million the previous year and we're

cutting, estimating cutting by $5 million, how were we saving the $5 million? Were we cutting physician positions or were we transferring responsibilities out through some other system we have?

MR. HAGGIE: There's a realignment of funding there. We took $2.6 million out from the fee – which way did this go? It went from fee for service to salary, is that correct or the other way around?

OFFICIAL: Yeah, fee for service to salary

MR. HAGGIE: Okay.

And we've taken money out permanently to transfer to Eastern Health for a salaried nurse practitioner. So, that explains the variance between 2019 budget and 2018 budget.

MR. BRAZIL: Yeah, fair enough.

So tell me about '17-'18 to '18-'19, the $5 million savings that was trying to be realized, which didn't materialize?

MR. HAGGIE: Sorry, '17-'18?

MR. BRAZIL: Yeah, '17-'18, it's obviously not in the Estimate books, but I just looked it up on Public Accounts. There was $121 million plus allocated, so it's a difference of a $5 million decrease. How were you going to realize that savings?

Obviously, it wasn't realized because it actually became a $6 million addition to the bottom line.

MR. HAGGIE: Okay, I don't have 2017-18 figures here, so you have me at a disadvantage.

Paul, do you have some comment?

MR. SMITH: When it comes to physician services, there were reduction initiatives that the minister mentioned that the presumption being we would have realized the savings from those during '18-'19. Hence, $6 million came out, but the anticipation is that we will get the expenditure base down because, ultimately, we will realize those savings. They'll just be in '19-'20 onward.

MR. BRAZIL: So would these have been physician positions?

MR. HAGGIE: These were the initiatives, I think, here listed in the binder under the physician hiring approval committee. There was a saving there that was attributed for $3.2 million. The compensation benefits have started to come out, that's the double accounting from before and a limit to salaried physician locum coverage, an expectation that less than three days wouldn't provide for coverage. Where possible, where practical, it would be between the existing physicians. That's an annualization issue.

MR. BRAZIL: Yeah, fair enough.

The $3.2 million that you'd mentioned as a saving, what would that have been for?

MR. HAGGIE: That's as a result of a physician hiring approval committee process.

In the past, we had control, to some extent, with the medical association over where it would be reasonable to put salaried physicians. This mechanism wilted, shall we say. We've proposed bringing this back in. It's only just started. We had anticipated it would go a little bit earlier and a little bit further.

We see rationalization of salaried physicians in locations where their services are being provided by other practitioners, such as fee for service or nurse practitioners. So, when those positions come up for renewal, they turn over, then there would be a decision as to whether or not another physician was needed to provide that service or whether it was already being provided by a nurse practitioner or fee-for-service physicians.

MR. BRAZIL: Fair enough.

Unfortunately, it wasn't realized in the savings for the revised, and I do still have a concern if it's going to be obtainable in '19-'20, but I guess we'll have that conversation this time next year and see –

MR. HAGGIE: Yeah. No, I think –

MR. BRAZIL: – if it worked, perfect, even better.

MR. HAGGIE: – that will be a check on that.

OFFICIAL: (Inaudible.)

MR. HAGGIE: On the issue of the $1.7 million in benefits, I have information that it affected 160 geographic, full-time equivalent positions. These are ones who have joint appointments with the health authority and with Memorial.

MR. BRAZIL: Okay, fair enough.

Under 2.3.01, Memorial University Faculty of Medicine, Grants and Subsidies, budget ’19-’20 had decreased by $721,000. Can you just explain why?

MR. HAGGIE: That was the last year of a five-year phased reduction from budget ’16 of the funding envelope for the Faculty of Medicine.

MR. BRAZIL: Okay, fair enough.

Public Accounts in ’17-’18 show that they received additional funding. Can you outline what that was for?

MR. HAGGIE: The Faculty of Medicine?

MR. BRAZIL: Yeah.

MR. HAGGIE: I don’t have ’17-’18 details here. We can go find that for you.

MR. BRAZIL: Okay, fair enough.

Now a decrease in ’19-’20, again, not knowing why it was decreased and why it was added, adds me to think that there’s still going to be a challenge again this year.

MR. HAGGIE: I mean, the issue around the funding envelope for Memorial University is there was a plan in place with the previous dean, maintained by the current dean, which was talking about rental space reduction, using teleconference. They had a very high travel budget, as far as I can remember. They were looking at office management. They have been asked to do the same as we do, if we have a lunchtime meeting it’s pack your own lunch rather than have it catered.

There were reorganizations of the Office of Professional Development at Memorial and deferred recruitment of positions, and two positions by attrition. So those were discussions we had with Dean Rourke and currently continuing under Dean Steele.

MR. BRAZIL: Yes, fair enough, and we all see the value of investing in the university, particularly the faculty of medicine. No doubt, I suspect this time next year we’ll have a discussion around what the needed number was at the end of it and if there were monies that was transferred in. Because I look at it from ’17-’18 to what was budgeted of $56 million to actually what was spent of $66 million. It’s a substantial $10 million increase.

MR. HAGGIE: I don’t have that information here.

MR. BRAZIL: No. No. And I realize that.

MR. HAGGIE: I have vague memories of things, but, quite honestly, we’ll get you the information.

MR. BRAZIL: Okay. I appreciate that. I’m just curious to see how we go next year on that.

Mr. Chair, that’s it for me on subheading 2.1.

CHAIR: Okay.

Ms. Coffin.

MS. COFFIN: No, I’m good.

Thank you.

CHAIR: You’re good? So we’re good all the way through?

MS. COFFIN: Yeah, always good. And all my questions have been answered.

CHAIR: I’ll ask the Clerk to call the subhead, please.

CLERK: 2.1.01 to 2.3.01 inclusive.

CHAIR: Shall 2.1.01 to 2.3.01 inclusive carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

CHAIR: Moving on; I'll ask the Clerk to call the next subheading, please?

CLERK: 3.1.01 to 3.2.02 inclusive.

CHAIR: Shall subheading 3.1.01 to 3.2.01 carry?

Mr. Brazil.

MR. BRAZIL: Thank you Mr. Chair.

Under 02 heading, Supplies, in fiscal 2018-19 you went over budget by $300,000. Can you explain what that was all about? What that covered, please?

MR. HAGGIE: Two things; principally, around vaccines and the price of vaccines, and there were increases in TB medications because of the outbreak in Nain. We had a very successful vaccination program. So we had to pay more for vaccines as well as a higher cost.

MR. BRAZIL: Okay. So other than the TB additional vaccine, there were no other new vaccines approved were there?

MR. HAGGIE: Not that I'm aware of.

MR. BRAZIL: Okay, fair enough. Good.

MR. HAGGIE: I think there may have been some additions to the pediatric vaccines.

OFFICIAL: (Inaudible.)

MR. HAGGIE: Oh, right.

Yes, sorry there was. Tdap vaccination to all pregnant women.

MR. BRAZIL: Okay.

Under Purchased Services, in fiscal '18-'19 you went over budget by $2.6 million. Can you explain that one to me please?

MR. HAGGIE: Yes, that was air ambulance medevacs.

MR. BRAZIL: How did you cover off that shortfall?

MR. HAGGIE: Primarily, the same answer. We had capital money that we could access to defer – well, to cover those costs. So keep that one for last year.

MR. BRAZIL: The overruns there, known for your ambulance, but exactly what would that entail to be $2.6 million? Another contract, extra flights?

MR. HAGGIE: Yeah. There are two private companies we use for medevacs for charter when the government air services planes are unavailable, and that was essentially split between the two of those.

MR. BRAZIL: Is that a standing offer between the two as it exists?

MR. HAGGIE: They're on a retainer. They were paid, in '18-'19, $2.62 million for PAL, $1.45 million for EVAS, and $470,000 for out-of-province air charters.

MR. BRAZIL: Okay, perfect.

So they were the only contracts awarded in '18-'19, EVAS, PAL and the out-of-province flights.

MR. HAGGIE: We've had a situation where we've used contracts in one form or another going back well before last year; simply because of the fact that we only have two government air service aircraft.

MR. BRAZIL: Are there still existing contracts with PAL and EVAS Airline?

MR. HAGGIE: Yes.

MR. BRAZIL: Okay. Are there any deadlines on those?

MR. HAGGIE: I think they've both been short-term contracts of several months, and I couldn't tell you exactly when they expire.

MR. BRAZIL: What's the competitive process for – like, is it a tender or RFP, or just a standing offer for the contracts to put these in place?

MR. HAGGIE: RFP.

MR. BRAZIL: They're offered how often?

MR. HAGGIE: Well, we had been doing some thinking around how to provide air ambulance services, along with TW, because it's a hybrid service and Health is a customer; but, TW supplies some of service and it's covered off out of their budget and we, in Health, go and buy the other. The reissue will be done for a longer period.

MR. BRAZIL: Has there been any discussion on privatizing the air ambulance service?

MR. HAGGIE: Only in an abstract sense.

MR. BRAZIL: No formal –

MR. HAGGIE: No.

MR. BRAZIL: – internally or externally?

MR. HAGGIE: No, not that I'm aware of. It did come up for consideration as a concept but, in actual fact, that would've been TW that would've been leading that kind of thing. From my point of view, we're kind of the customer. At the moment, we're getting a very good service from both PAL and EVAS.

MR. BRAZIL: Perfect.

Has there been any consultants contracted to do some analysis of the air ambulance service?

MR. HAGGIE: Was that TW?

OFFICIAL: TW.

MR. HAGGIE: I think Transportation and Works had something done.

MR. BRAZIL: Recently, or is it still in the works? Do you know?

MR. HAGGIE: I think it was done last year, was it? Yeah.

MR. BRAZIL: Any concerns about the government owned air ambulance and the reliability, particularly with the downtime and maintenance issues?

MR. HAGGIE: I think those questions would be better addressed to Transportation and Works. We have an arrangement with government air services. They do the dispatching. We're simply, you know, send us an airplane.

MR. BRAZIL: Fair enough.

Do you have all the positions filled with the medical flight teams?

MR. HAGGIE: There has been some recruitment recently but I think they're all filled now, yes.

MR. BRAZIL: Okay.

Under the HealthLine contract, I just have a few question around there. Give us some utilization stats for the HealthLine for the last year. Has it been up, down, stable?

MR. HAGGIE: It's slowly growing. I'll see if I can find a number for you.

Okay; 2018-'19 saw 42,725 inbound calls and 2,562 outbound calls. The volume of inbound calls has been stable since fiscal 2015.

MR. BRAZIL: Perfect.

Is that in line with your projected utilization of the program and the service?

MR. HAGGIE: I think, if memory serves me, it's within what we expected; it's within the contracted price.

MR. BRAZIL: Okay, fair enough. Because I know there was a full media program there, or a media approach, to try to get the word out there because of the value of the thing, and I didn't know if it was a big spike that you would see just after the campaign itself.

MR. HAGGIE: That was a couple of years ago, and I couldn't tell you offhand. I vaguely recall an increase in utilization, but it certainly doesn't show up in the long-term statistics. It has grown since it was changed from the old 1-800 number to the 811. We, in *Budget 2018* or *Budget 2017*, added Dial-a-Dietician into there. I think it was *Budget 2018*. There's a lot of scope, actually, for expanding the range of services there.

The outbound calls that they make are actually mental health clients and people who leave emergency departments without being seen. We actually actively go and seek them out within 24 hours. That's what the outbound calls are for.

MR. BRAZIL: What was the number on the outbound?

MR. HAGGIE: It is 2,562 in '18-'19.

MR. BRAZIL: Fairly substantial. Okay, fair enough.

Any plans to further expand the program itself and the access?

MR. HAGGIE: It's funny, actually, we've had some high-level discussions about where we could go with the next iteration, but there's nothing other than ideas I have in the shower at 8 in the morning or 7 in the morning, as yet.

MR. BRAZIL: Fair enough.

I want to move on, now, to Allowances and Assistance under the MTAP program. Fiscal '18-'19, you spent $1 million less than budgeted. Can you just explain that one to me? That's in 3.1.01.09.

MR. HAGGIE: Sorry, the 2018-19 revised compared with the 2019 budget, is that correct? That's what you're looking at?

MR. BRAZIL: Yeah.

MR. HAGGIE: We had some remaining funds from 2017-18 before we got into it. It was a one-time saving from some money in the RHA. Again, it speaks to the dynamic budget approach we've referenced before.

OFFICIAL: (Inaudible.)

MR. HAGGIE: Yeah, that was it. Bursaries were not taken up to the extent we anticipated, so we had money there and we moved it in.

MR. BRAZIL: Okay.

Can you just give me a little outline on the revised budget now and the breakdown of the $12.53 million?

MR. HAGGIE: The $12.53 million – we got $3.4 million for medical transportation reimbursement; $6.4 million for income support; just over $2 million for Workforce Planning; bursary programs, just under $1.7 million.

MR. BRAZIL: Fair enough, thank you.

On the MTAP, what's the processing time? What's the average – we all get a number of calls from people saying they're still waiting. What's the norm?

MR. HAGGIE: For the reimbursement process, there is a turnaround time of between four and six weeks currently. We had several staff members leave. We have replaced them but there is a two-month lag time in terms of training. We have a high staff turnover at the client services level there because it is regarded as an entry-level job into government.

CHAIR: We're going to move on now.

Ms. Coffin.

MS. COFFIN: Thank you very much.

MR. HAGGIE: Just to steal a minute or two of your time, you asked about the number of clients in dental programs.

MS. COFFIN: Yes.

MR. HAGGIE: We got 18,119. We have 40,420 in children. That's the denture program, is it?

OFFICIAL: (Inaudible.)

MR. HAGGIE: Okay.

MS. COFFIN: Lovely, thank you.

A couple of questions – some of these are just numbers that I'm looking for – the number of individuals of subsidized home support clients and how many of those are in the Paid Family Caregiving Option.

MR. HAGGIE: Okay. This is where I look under L, is it?

I have it somewhere – one moment.

MS. COFFIN: Okay.

MR. HAGGIE: Okay. Sorry, could you repeat the categories you were looking for?

MS. COFFIN: Just the number in the subsidized home support and within the Paid Family Caregiving Option.

MR. HAGGIE: I don't have the paid family caregiver – oh, here we go. We have 270 individuals who are availing of the Paid Family Caregiving Option as of March 31, 2018.

MS. COFFIN: Okay.

MR. HAGGIE: Sorry, '19. My eyesight is failing.

MS. COFFIN: And the total number of subsidized home support clients. So that's a subset of paid family caregiver – right?

OFFICIAL: No, it's the other way around.

MS. COFFIN: Oh.

OFFICIAL: Paid family caregivers are a subset.

MS. COFFIN: Yes, that's what I meant.

MR. HAGGIE: We got 216 here is the number I've been given.

MS. COFFIN: It is 216 in the home support clients? That doesn't sound right.

MR. HAGGIE: No, that's the Special Child Welfare. We have 3,339 adults under 65 and 4,026 seniors.

MS. COFFIN: Okay. And then children is a separate –

MR. HAGGIE: Well, the SCWA is Special Child Welfare Allowance Program – the one I referenced when we talked about the Autism Action Plan. That would be rebadged as something else.

MS. COFFIN: Okay.

MR. HAGGIE: That's as of June. That's as of this month.

MS. COFFIN: Right.

MR. HAGGIE: So these are snapshot figures, obviously.

MS. COFFIN: Of course, yeah, and then some people would transition in and out of that if whatever is requiring to get home support is temporary. And I imagine there are also some individuals who are in for as long as they're alive, I guess.

MR. HAGGIE: Well, Special Child Welfare Allowance Program, they age out I think, don't they? They fall into the adult program.

MS. COFFIN: Right, but they're still somehow receiving home support, but they just fall into another program.

MR. HAGGIE: Yeah, but they just fall into a different label, different pot.

MS. COFFIN: Yes, right. That's what I understood.

How many personal care homes are providing level 3 nursing home care through the enhanced care program?

MR. HAGGIE: The enhanced care program is not level 3, the enhanced care program is 2 plus.

MS. COFFIN: Oh, okay.

MR. HAGGIE: The level 3 is a transient arrangement done for individual clients who, you know, there may be delay in getting them a bed, but the personal care home is able to provide that level of extra care. I don't have the number of level 2-plus enhanced clients at the moment, but we can get that for you.

MS. COFFIN: Lovely, thank you.

Can I have a list of the number of people on wait-lists for nursing homes by region – with the number of waiting in hospitals?

MR. HAGGIE: So, that would be long-term care homes, when you say nursing homes?

MS. COFFIN: Yes, nursing homes, long-term care.

MR. HAGGIE: Yeah, okay. We can provide that for you for sure.

Have we got it here?

OFFICIAL: Yes.

MR. HAGGIE: Oh, right, okay.

MS. COFFIN: Oh, boom, all right.

MR. HAGGIE: Number on placement list – for long-term care, there are 78 in Eastern, 87 in Central, 55 in Western and 15 in Labrador-Grenfell, for a total of 235 as of this month.

MS. COFFIN: And that's in general, is there a number that we know that are waiting in hospitals?

MR. HAGGIE: I haven't got that breakdown here.

MS. COFFIN: Okay. That's fine, thank you. I'm sure you can get it for me if that's all right.

MR. HAGGIE: That's no problem.

MS. COFFIN: Wonderful.

What's the percentage of hospital beds that are occupied by people waiting on a nursing home or home care, or I guess long-term homes or –?

MR. HAGGIE: We refer to that, for data collection, as Alternate Level of Care patients. It's a broader bunch; it's basically people who are medically dischargeable from hospital but need something.

MS. COFFIN: Right.

MR. HAGGIE: So that figure would also include people who are simply waiting for a toilet rail in their house.

MS. COFFIN: Oh yes, of course.

MR. HAGGIE: As well as someone who was waiting for, maybe, personal care or long-term care. We have some numbers here. The numbers of ALC patients awaiting long-term care in Eastern is 37, Central is 54, 36 in Western and 11 in Lab-Grenfell, for a total of 138. They represent, over average, 50 per cent of the ALC patients that are in hospital; the other 50 per cent are waiting, usually, for something else.

MS. COFFIN: Okay. Thank you.

Can we have a list of the expenditures and numbers of recipients in the MTAP program and out-of-province travel by region?

MR. HAGGIE: By region. We don't have it by region but we can get it for you.

MS. COFFIN: Lovely. That's great. Thank you.

Under the same section, 3.1.01, the numbers here are enormous. There is lots and lots of stuff going on, so sometimes it's difficult to get the right question to get at some of these things. I've had a lot of experience with a lot of the nursing staff in the Janeway and the PICU and they are just remarkable, really, really great staff, but I know that they're quite overworked.

I'm trying to get now at the staffing and overtime. I know this is an issue because someone has the wrong number in the Health Sciences and occasionally I get phone calls to see if I want to do overtime. The last call was the day after the election, which was a little traumatizing because that was the day I really, really, really wanted to sleep in. I know that's an issue.

Is there anything being done to address the staffing and overtime issues? I know we're spending tremendous amounts of money there, the staff are overworked, it's hard on them and it's hard on their families. How is that being approached or is it, even?

MR. HAGGIE: The overtime issue in the RHAs – each RHA does have a sick leave and overtime policy.

MS. COFFIN: Yes.

MR. HAGGIE: It varies slightly from region to region, but there is a significant bill associated with that. I'm not sure that we have that breakdown here, but we can find it for you.

MS. COFFIN: That would be lovely.

Does the department have any authority over doing a staffing review and maybe changing the number of positions so they can offset the number of overtime hours? Is there anything like that?

MR. HAGGIE: The staffing levels on the floors are related to the acuity of care, a kind of national standard. As a result of discussions with the RNU, the agreement was that we would review samples of acute care and long-term care to try and see whether or not the fact that we meet the national standards or exceed them was actually doing it for the acuity in those areas.

There is workforce management software and a joint committee with the RNU, particularly, around the management of staffing to acuity. There are several threads on the go all at the same time and it's a problem that is not unique to this province by any manner of means.

MS. COFFIN: I'm aware of that. I know when my nephew was in PICU he has a nurse full-time, which is just fantastic. When he moves out just onto the ward, one of us is always signed up for night duty. I'm the Auntie Al so I get to go in quite often which is nice; the beds are kind of comfy. I understand that ratio; I guess this goes a little bit beyond, though. The nurses' union and LPNs and PCAs as well are having a lot of overtime. They're saying that they are stressed, they're burnt out and they're angry enough to protest.

Is that same model being –?

MR. HAGGIE: Yeah, I mean the workforce management program, the software that we're putting in place, works for health care providers. It will work within the categories. The short answer is, yes, they are factored in. We've had discussions with NAPE, for example, and CUPE and the staffing review will look at the case mix as well – the staff mix, the skill mix, sorry.

MS. COFFIN: Right.

MR. HAGGIE: There are certainly significant changes over time with skill mix, for example, in long-term care. There's far more emphasis on the Mainland, for example, in a mix that really is 70 per cent PCA, maybe 25 per cent LPN and 5-10 per cent RN, that kind of ratio.

MS. COFFIN: Right.

MR. HAGGIE: We don't achieve that in all our regional health authorities. Some do and others don't. There's still a predominance of RNs in certain areas. Those are things that one would work through with the workforce management software and matching workload to skill set.

MS. COFFIN: Good. Thank you.

CHAIR: Mr. Brazil.

MR. BRAZIL: Mr. Chair, I just want to go back again under Allowances and Assistance when the minister noted that the million-dollar savings or less spent was around some of the bursary money. Can you explain some of the particular bursaries that we're talking about there?

MR. HAGGIE: There are 22 bursaries that are offered across the system. They cover a variety of disciplines. It includes physicians, it includes midwives and it includes nurse practitioners. It also is broken down into whether or not these folks are undergrads or residents, for example, in the case of medical students.

If you look in the Bachelor of Nursing program we have health professionals, nurse practitioners, dentists, medical residents and undergraduate medical school. There's a significant breadth. I think there's 22 and we have had around 228 individuals enrolled in the bursary program.

MR. BRAZIL: Okay. Thank you.

Under Grants and Subsidies, 10, I'm just looking there but I'm looking at the bigger picture here. You spent $117 million more than budget of '18-'19, yet budget '19-'20 decreased by $88 million.

Is this even reasonable, to be able to think that you could sustain that? How are you going to manage for lower budgets? Are there certain things going to be cut? That's a dramatic amount of money.

MR. HAGGIE: Yeah. The big bit there, the bulk of it, was severance. That was reimbursed by the Department of Finance. Let me just have a look to see if I can elaborate still further.

Yeah, there was $126 million paid out in severance. We had a $5-million savings in Canadian Blood Services, we had savings in primary health care, long-term care, needing some further analysis around the home support review, so there's some money deferred there. This is in the binder but the variance nets out to $117 million.

MR. BRAZIL: Okay. Thank you.

Under the regional health authorities' projected financial positions, what's the projected financial position of the RHAs for '18-'19? Can we have a breakdown and any deficits that may be noted?

MR. HAGGIE: They're currently being audited as we speak. That's not cooked yet or baked, whatever the appropriate financial term is. I bow to the experts.

MR. BRAZIL: Fair enough, but somewhere in the budget it's reflected about the estimated monies that are going to go to the authorities I'm assuming.

MR. HAGGIE: Okay. There are some figures here and they're in the binder for you.

MR. BRAZIL: Okay.

MR. HAGGIE: Provincial planned revenue for the RHAs and NLCHI is in the binder there.

MR. BRAZIL: Okay. Perfect.

MR. HAGGIE: That will save me reading out telephone numbers.

MR. BRAZIL: Yeah.

The stabilization funding in '18-'19 to the four RHAs to cover deficit – can we have a breakdown on what was paid out for there?

MR. MCGRATH: Stabilization provided – the most recent ones – $6.6 million for Eastern Health, $1.9 million for Central Health, $1.9 million for Western Health, and $1.3 million for Labrador-Grenfell.

MR. BRAZIL: Has that been factored into your Estimates for this upcoming fiscal?

MR. MCGRATH: Stabilization funding is not part of the departmental budget; it's usually achieved through savings throughout the year, and whatever is kind of left, we flow out for stabilization funding.

MR. BRAZIL: Okay, thank you.

Just curious though, I understand why the fund is there, but in this case now, what were the incurred deficits that the health authorities ran into? Was it consistent across the board? Was it all over the place? Any particular line items that stood out?

MR. MCGRATH: The audit is ongoing right now for 2018-19, for March 31, 2019, so to my knowledge, it's coming in very shortly.

MR. BRAZIL: Fair enough.

Again, the concern I have here, budgets are put in play, and I know there are also some discrepancies to that, but there was nearly $12 million additional given to the regional health authorities. Is that a healthy way to do business right now, knowing the fiscal challenges that we have?

MR. HAGGIE: The balancing of budgets is a dynamic process, and the facts of the case are we have committed to controlling our cost at the same time as expanding our service. We need to make sure we get the best value for the dollar we spend, and if there is deferred money in one area, then, as a process of getting from where we

are know to where we need to be, we've taken the opportunity to use that.

Over time, as the fiscal situation improves, the pressures on there will also slacken. If you go back over the previous years, back to 2016, you'll see that the deficits of the RHAs are slowly shrinking at the end of each financial year. It's been extrapolated that if we keep on with the same rate of shrinkage, then in about three or four more years' time, we should be down to deficits on the order of $9 million and, within a year or so of that, a balanced budget.

That's been the approach we've taken. We accept that it's not ideal to have to juggle money between heads, but if we save money in one year, in one area, I think it's responsible to try and use it for the purposes, in general, for health, for which it was intended.

MR. BRAZIL: Yeah, fair enough, but if the regional health authorities have had an increase in their demand, financially, in a particular year, particularly '18-'19, why do you expect that they'll be able to maintain it this year, knowing the demands are obviously increasing dramatically on each of the regional health authorities? Wouldn't it be better to give them a stabilizing fund up front so they now know, from an accounting point of view?

MR. HAGGIE: One of the challenges is that initiatives that have been announced in previous years, particularly in the last two budgets, have been delayed. We have a significant savings to be realized through things such as shared services, but the implementation of that had to be delayed pretty well 18 months because of sequential collective bargaining, during which we had a freeze on changing work of the bargaining unit.

There are significant savings to be realized through that, but the delay has led to some of the budget pressures. As that program ramps up, you'll start to see those savings begin and then annualize, but they are at least 18 months later than anticipated.

MR. BRAZIL: Can you give me some examples of what some of these initiatives may be?

MR. HAGGIE: The shared services one, for example. There was projected savings of the order of, initially, $20 million that would be phased in over a period of a couple of years. By altering the purchasing arrangement, the RHAs on average will buy $4 million worth of consumables and medical supplies in a year. The shared services model will allow economies of scale and inventory control, particularly, to realize significant savings.

That's the big one that hasn't happened because it's at least 18 months behind. The management structure could change but it had to wait for the bargaining process to be done. We're in discussions now with the unions around how the work of the bargaining unit will shift to align with the new structure and the new methodology. So, that was, in my view, a principle source of challenge.

MR. BRAZIL: Fair enough, and realized savings obviously is another plan for reduction.

Do you have targets of how much you'd like to reduce the health care spending?

MR. HAGGIE: I think philosophically long-term inflation will do it for you because, at the end of the day, if you can do what we have done over the last three years, and I'll go back to the CIHI data on the per capita expenditure, those lines will cross. I think you would be very optimistic if you ever thought you were going to reduce the budget in health, but as time goes by, you will realize those savings.

If you want to do just a rough back-of-the-envelope calculation, if inflation has been running at 2 to 3 per cent per annum for the last four years, then, in actual fact, the fact the budget has stayed pretty steady means you've saved 6 per cent already. Which, on a $3 billion budget, is actually quite a large dollar figure.

So, I think a slow steady balanced approach is the way to go. You could turn around to the RHAs and say I want you to save $20 million each next year, and that's been tried and it's always failed because they can't do it.

CHAIR: Ms. Coffin.

MS. COFFIN: Thank you very much.

(Inaudible) what I think might be quick questions and then I'm done.

Purchased Services under Health Care Infrastructure, so 3.2.02. So, we're moved over to the Capital section of this now. It's the very last section.

The thing that jumps out to me, I suppose, mostly significantly is the, well, I guess, the Allowances and Assistance, which is $5.5 million. That's a big chunk of money there. Do we know what that's for?

MR. HAGGIE: Yes, Pomerleau. That was a lawsuit we paid out through a mediated settlement on Lab West.

MS. COFFIN: Is that the one that was at the university?

MR. HAGGIE: No, Lab West Health Centre construction. It was a settlement for a suit against the government.

MS. COFFIN: Okay, very good.

MR. HAGGIE: It was determined through a mediation process –

MS. COFFIN: Fair enough.

MR. HAGGIE: – in the last fiscal year.

MS. COFFIN: Okay, all right.

I guess the other thing that jumps out is the money from budget '18-'19. Budget versus revised was down by about $20 million and it seems that a big chunk of that change went over into the budget for this year.

MR. HAGGIE: Sorry, which area are we looking at?

MS. COFFIN: Purchased Services, I'm sorry.

MR. HAGGIE: Okay. No, it's all right. I'm a bit slow this evening. I get there in the end, I just slow down a little bit after 8 o'clock.

MS. COFFIN: That's good, the tortoise does that as well.

MR. HAGGIE: Sorry, rephrase your question, I'll catch up.

MS. COFFIN: I'm sorry. I just noticed that there was – we started off at $35 million in the budget, it was revised down to $15 million. So the carry over was there was a difference of about $19 million. Then when you flip over to '19-'20, we see that the total number in Estimates is $51 million. So we're up by $15 million from the budget of – so what's going on there?

MR. HAGGIE: Those are the changes in capital projects, some of which did not proceed as they could have –

MS. COFFIN: Right.

MR. HAGGIE: – in the original timeline. So money that you didn't spend in 2018-19, it's deferred and it crops up again.

MS. COFFIN: Right.

MR. HAGGIE: The money doesn't go; there's no savings. It's just it's shoved from one –

MS. COFFIN: It just rolls along, yeah. That's what I had thought.

MR. HAGGIE: – year's pot to the next year's pot.

MS. COFFIN: So what's being delayed here? Is that the Corner Brook hospital?

MR. HAGGIE: Actually, that isn't.

MS. COFFIN: Oh.

MR. HAGGIE: Well, sorry, not the Corner Brook long-term care. That's on track.

MS. COFFIN: Good.

MR. HAGGIE: The principle variances are around the electrical substation, for example, for the Health Science Centre. There is felt to be insufficient power from the existing substation because it now has to feed the core science building and some facilities in MUN.

MS. COFFIN: Oh.

MR. HAGGIE: So a second substation has been there, but I got really mired. It's been a glacial process because it involved Newfoundland and Labrador Hydro –

MS. COFFIN: Right.

MR. HAGGIE: – it involved the City of St. John's, it involved MUN, it involved the Department of Health and it involved Pippy Park Commission. So I think we're finally working our way through that.

MS. COFFIN: Yes.

MR. HAGGIE: But that's been one of the principal problems there.

So, we have a list of these. There's the Central Newfoundland Regional Health Centre, lab redevelopment, medical device reprocessing. There's some money there that had been allocated a little bit earlier in planning for Central Health long-term care, but that's because of the way the money will flow. It's not going to be needed until next year, and the expansion of the Hugh Twomey Centre. The protective care beds, that kind of thing.

MS. COFFIN: Right.

MR. HAGGIE: And Springdale is the new hospital there.

MS. COFFIN: When I was working with MUN – what feels like a lifetime ago, which was actually back just in January – I remember those giant extension cords that they were plugging in, because my office was right next to the core science, so you step over the extension cords. So, I understand that part, which is good.

I've also, on a personal note, always lived very close to a hospital. I'm really near St. Clare's now, and I used to live very close to the Health Sciences. I never lost power. It's awesome. So, that's good.

Okay. Under our capital budget there, does that capture the public-private partnerships that we're seeing to facilitate the development of a lot of these new areas, a lot of these (inaudible)?

MR. HAGGIE: Some of the funds under Professional Services and Purchased Services will actually relate to the Corner Brook long term care and some of the development work for the other P3s as well.

MS. COFFIN: Okay.

I have some concerns in that, and there are some inherent concerns in P3s; but, beyond that, I have been talking to – I think he was an oncologist, and he's been helping with the plans for – I hope I get this right – the new hospital out in Corner Brook that is being developed under a P3 model.

MR. HAGGIE: Yes.

MS. COFFIN: He's been consulting on that a little bit, and he's saying some of these negotiations are a little bit ridiculous because the contractor comes to him and says: So, the big, thick walls that are needed to house radiation units and materials that need to be housed in big, thick walls, the contractor is saying: Well, can we make them smaller? They seem like they don't really have the comprehension to realize that this is international and national standards, and these are some of the bare minimums that they have. So he's finding those negotiations a little bit difficult.

The other thing he's talking about is because of the model that's being used, where it is a design-finance-maintain, part of that means that the maintenance refers to everything that is attached to the physical structure. So if it's attached to the structure, the contractors will maintain it or the individuals involved in that public-private partnership will maintain it.

What's trying to happen now, and he said he's having a little bit of difficulty with it, is they're attaching everything to walls. Like desks are getting attached to walls and I guess like chairs, or whatever that can possibly be attached to a wall so it can get captured in that maintain bundle is happening. He had some concerns about the issues around, well, what are the long-term implications of that?

So I'm starting to already see some of the problems that we hear about in P3 models, and

I'm wondering if there's anything being done to mitigate that.

MR. HAGGIE: Yes, that's exactly what I was just (inaudible). We're thinking along the same lines.

MS. COFFIN: Uh-oh, that's dangerous.

MR. HAGGIE: Yeah. At financial close, the design is only 30 per cent complete. What that means is that the bulk of the detail work you're describing has yet to actually be designed. So the issue around the construction company coming to an oncologist, radiation oncologist about the construction of a bunker –

MS. COFFIN: And I may be wrong about the type of doctor (inaudible).

MR. HAGGIE: No, I know. It probably was a radiation oncologist. I mean, that's not an unreasonable person to go talk to about a radiation bunker because that's what they use. It will be at a later stage that the design standards, the national standards and the assessment by the appropriate nuclear agencies, if they're involved, like they were with the PET scan –

MS. COFFIN: Right.

MR. HAGGIE: – and the cyclotron. That will be factored in to the next 70 per cent of design. They don't have to have that detail to rough out the price envelope that they want. For example, the PET scanner room will have a slab that is capable of taking the weight of a PET scanner, and the walls will be built to radiation standards as if they were in there. They'll be part of the X-ray department.

So those are questions for the next phases. That is why you have a very close link between the project teams, and there is a huge cast list of project teams for the acute care in Corner Brook. There's a non-clinical lead, there's a clinical lead, there's an infrastructure and IT group. There is a group such as that.

Similarly, with the maintenance thing, there has been discussion around the long-term care about what's in and what's out, and there would be some maintenance staff from the RHA on site. What would they do versus what would fall under the M of the DBFMP3 –

MS. COFFIN: Right.

MR. HAGGIE: – and those will be settled nearer the time.

It's broad brush at the moment. Particularly with the acute care one, I really wouldn't get too concerned and I would reassure your radiation oncology colleague that they'll be coming back to him later on and say, you know, we're building to this Canadian standard for a radiation bunker.

MS. COFFIN: Right. Okay.

I have fears that this is going to cause cost escalations if the individuals or the company that's designing and will eventually take over the maintenance of it.

MR. HAGGIE: The specifications will somewhere have in there that you have to build to those specifications. The one reassurance we have with this mechanism is that once it's signed at financial close it's their problem if they need to spend more, not us.

MS. COFFIN: Okay.

CHAIR: Mr. Brazil, your turn, Sir.

MR. BRAZIL: Under personal care homes, I have a few questions there and some general comments for the minister.

How much did we spend in personal care homes in '18-'19, and what is the budget for '19-'20?

MR. HAGGIE: Sorry, and what's what?

MR. BRAZIL: What is the budget for '19-'20?

MR. HAGGIE: Okay.

Long-term care in community supports area is flowed through the RHAs. If you look at the personal care home program, for 2015-16 we spent $34 million, for '16-'17, $39 million, and for 2018-19, $43 million. The number of subsidized residents has gone from 2,650 to

2,760 from 2015-2019. The average monthly RHA subsidy is $1,100.

So those are the broad brush stats. We have 2,685 subsidized residents currently as of March 2019.

MR. BRAZIL: Is there any movement, contract time for renegotiating the costing for the subsidies or any of that, or is that a long-term commitment?

MR. HAGGIE: The funding model for personal care homes is part of the work that we're doing with the PCH owners association and other representatives of the personal care home fraternity to revamp the whole system. So it's tied into standards.

We have a consultant out on an RFP to produce a funding model and we are working on revised levels of care standards, as well. That, when it all comes out, will inform how much an individual resident would be compensated for a specific level of care, were we to be totally responsible for their funding, because they are private businesses and there are people who can just choose to go and pay if they don't meet our financial eligibility criteria.

That's where this will shake out. Those negotiations have not stopped, say, for a pause over the caretaker period.

MR. BRAZIL: Is there a time frame, is there an end time, outlook time that you want to get it achieved by?

MR. HAGGIE: We're expecting the report back from the consultants over the course of the summer. That's the last piece of external work that needs to be done over which we have some uncertainty about the time. The rest of it, the levels of care are not far off and the standards of care that go with those are not far off. It's simply just got to be tied up and tweaked so it all lines up properly.

MR. BRAZIL: Perfect.

During the election we all heard about the Lionel Kelland Hospice in Grand Falls-Windsor. Is there a budget line somewhere, or under one of the programs any budget money for the hospice to move forward?

MR. HAGGIE: We've had meetings with the committee and they have some work to go away and do yet so that we can see what their numbers actually look like. There is a budget for capital for the RHAs which is uncommitted and that's one option for there.

The operational costs, again, we don't know what those are. It really rather depends on what nursing model they use and so that's still a subject of discussion. The answer is we will find the money; we just simply haven't got the number to go looking for yet.

MR. BRAZIL: From the department's additional funding for Central Health, or would it come out of Central Health's system budget?

MR. HAGGIE: Well, the capital piece – there is a capital part. If there is extra staffing that is required, then obviously, there are sources of, for example, federal money, that could be reprioritized from palliative care because this would fit under end of life. Again, until we know exactly what we're talking about, it's a little difficult to be more specific than that.

MR. BRAZIL: Fair enough.

Can we get an update on the implementation of the EMRs and how many doctors' offices have EMRs implemented?

MR. HAGGIE: We can indeed, yes.

MR. BRAZIL: Perfect.

MR. HAGGIE: One moment. I kind of hoped you'd ask that question.

We have 275,393 patients enrolled in the EMR as of June 4. There are 304 physicians and 18 nurse practitioners on the EMR. This is the fee-for-service piece and that's the data that I have here. I think they're all as of June 4.

MR. BRAZIL: What percentage? Is that 100 per cent, 80 per cent, 50 per cent?

MR. HAGGIE: Of physicians?

MR. BRAZIL: Yes.

MR. HAGGIE: Well, in terms of primary care physicians, I don't actually have the denominator, but we only have 449, I think, in the province.

MR. BRAZIL: Okay, perfect. Thanks.

Can you give us an update on the rollout of the automated appointment reminder system in the RHAs?

MR. HAGGIE: Yes, I can. I can indeed, just bear with me a minute.

I'm slowing up even more. But don't worry; I have stamina if not speed.

It's currently doing endoscopy, rheumatology, DI, cardiopulmonary, respiratory, cardiology and ophthalmology outpatients. Eastern Health had a 30 per cent reduction in no-shows there, and there's work under way to expand it for psychiatry, counselling and ambulatory care specialists.

OFFICIAL: (Inaudible.)

MR. HAGGIE: Sorry, I misspoke. Everything is across the province, with the exception of ophthalmology outpatients, which is unique to Eastern Health.

MR. BRAZIL: Is that information in the binder or is that a separate document that we could get a copy of?

MR. HAGGIE: We can give you those figures, yes.

MR. BRAZIL: Okay, I appreciate that.

Obviously, we've had discussions; we've had it here in the House and it's been out in the general public. Any plan on the cardiac centre of excellence that's been discussed? I know you've had meetings with the various numbers of people in the speciality.

MR. HAGGIE: I spoke to Dr. Connors not long after Christmas. Work is under way in Eastern Health to allocate space within Eastern Health, within the Health Sciences Centre, to put the whole lot in one co-located area and have it there. That's predicated on some shuffling around of ambulatory care services in Eastern health. So that is in discussions with Dr. Connors and the cardiology group.

MR. BRAZIL: That's good to know. Thank you for that. That's moving in the right direction from what I understand.

MR. HAGGIE: Oh, yeah, Dr. Connors seemed quite happy.

MR. BRAZIL: Good.

Can you give us an update on the road ambulance program? Central dispatch, obviously. Any rumours, dispelled rumours that it's being looked at as a sole provider for the service in the province?

MR. HAGGIE: The dispatch in Eastern Health has been upgraded very recently; they have a new software package. The current agreement has been extended by two years with the private operators, with the aim of giving us all time to sit down and talk about it.

I've had some preliminary discussions with Max Taylor from the Community Ambulance group. Just for background, we have currently 60 ambulance services providing 179 funded ambulances across the province: 13 are RHA; 25 are private, for-profit; and 22 are community, not-for-profit.

We've also met with and are going to meet again with the Paramedic Association of Newfoundland and Labrador. We have significant opportunities now with the passage of the emergency health services and paramedicine legislation last year. We're the last province, I think, in the country to actually have proper emergency health service legislation. There will be a process of regulation drafting there and a move to get paramedics to become self-regulating.

Currently, Provincial Medical Oversight deals with licensing as well as quality assurance. Whilst they have different people involved in that, it's in the same organizational structure. That inherently is a conflict in my view and we're working to move that out. The question is

whether we can do it in a clean (inaudible) and the Paramedic Association would be interested in taking it up as a regulator or whether we have to do it a phased way. Those are the subjective discussions at the moment.

MR. BRAZIL: Okay, fair enough.

Can you give us an update on the shared services? The purchasing, the IT, anything else that was talked about?

MR. HAGGIE: I alluded to it in my previous answer around the delays with inventory and stock control. There has certainly been a challenge there around that. We are looking at payroll. The challenge in some respects is how to integrate it with Digital by Design across government. We've not really come to a conclusion on that yet.

That work has really progressed slowly, I think, would be the most accurate way of saying it. I think people are conscious of the delays with the shared-services model and they had hoped to learn from that before they walk down another road. I think, again, speaking to the delays, it's kind of caused some difficulties there, but those are still on the blocks for the next iteration.

IT, in a sense, we did through a different route because we brought it all under the remit of Newfoundland and Labrador Centre for Health Information. The network, the pipes, purchasing and that kind of stuff, the provision of services, housing the data and that kind of thing are actually all under their mandate now.

MR. BRAZIL: Okay, thank you.

CHAIR: Ms. Coffin.

MS. COFFIN: That's the last of my questions, so I want to thank everyone for your time and your professionalism. And I want to congratulate you; this has been the shortest Estimates that I have gone through.

Thank you very much.

MR. HAGGIE: So far.

MS. COFFIN: I'm done.

MR. HAGGIE: Oh, you're out, are you?

MS. COFFIN: I'm tapping out on Jim now. He's got the next two.

MR. HAGGIE: Oh, you're out of Estimates jail.

MS. COFFIN: Yeah, I got my badge.

MR. HAGGIE: Very good.

CHAIR: Thank you, Ms. Coffin.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

I have a couple questions, here around the laboratory services. Last year we had talked about it here in Estimates that it would be centralizing under Eastern Health. Can you provide an update? Are we getting there? Is it viable? Has it been assessed?

MR. HAGGIE: Heather has some information. Did you want to share that? And you'd be accurate, rather than me being waffling.

MS. HANRAHAN: There are a couple of different initiatives happening under laboratory. We have streamlined and created a provincial formulary for all our laboratory sites. We have implemented point-of-care testing, which means the testing can go on right at the patient's bedside, and can be quicker than actually getting someone to come and taking the test and processing it back to the lab. There is opportunity to increase point-of-care testing.

A lot of our lab equipment, periodically, needs to be replaced, particularly the very expensive analyzers that are in the main labs in the province. And we're looking at, this time around, driven by shared services out of Central, having a provincial RFP. So that would allow us to look at the lab equipment needs, provincially, as well as, in our purchasing, if we purchased standardized equipment across the province, I think we'd get better pricing and we'd use the same kind of reagents, same supply source, supply costs would be reduced. And looking at, really, how we can work together with labs more

strongly provincially. So those are the main things that we're thinking about in terms of that.

MR. BRAZIL: Okay, that sounds good. It's moving in the right direction, perfect.

The Botwood emergency room, it was talked about by everybody during the election. Is that a reality? Is it being assessed? Is it something that's planned to move forward?

MR. HAGGIE: The discussion around Botwood is actually predicated on the new 20-bed protective care unit – that's the phrase I'm looking for – that will be added there. There was discussion about the availability then of extra staff and whether or not this would make sense to revisit the concept of the emergency room. There's no clear guidance yet because that decision won't be up for grabs until 2021.

The other interesting piece, as well, is around some of the possibilities with emergency services in smaller places using other care providers around community emergency centres, such as has been done in Nova Scotia. And I think you might find that by 2021 those kinds of initiatives may already have made a change in thinking – the new way of doing business.

The answer is, it depends on what the situation is in 2021, but the undertaking was to look at it if that was a reasonable thing to do.

MR. BRAZIL: Okay. So there will be no movement in the immediate future, obviously?

MR. HAGGIE: It's all predicated on the staff availability and that staffing won't change until the protective care unit opens. That was, I think, quite clearly stated on several occasions. The build may finish in late 2020 or early◌'21 but we won't staff up until 2021.

MR. BRAZIL: Okay, fair enough.

Can we get an update on the roll out of the healthy living assessments?

MR. HAGGIE: We went to look at a particular model and we ran into some challenges with how it would be delivered as a pilot scheme. So, this has gone back to the drawing board. We thought we were ready to move and there were some significant flaws that we uncovered at the last minute. The discussion, now, is very much around how this would be done on a proactive basis through the regional health authorities and an existing model.

The short answer is that's stalled a little bit because of the model that we thought we got.

MR. BRAZIL: Okay, fair enough.

The Health-in-All–Policies – and I know it was a program that was going to move forward and I wasn't overly adverse to it and I know your former DM was going to be tasked to do that and I understand he's since retired. Has somebody else been tasked with that program or process?

MR. HAGGIE: He was seconded to Executive Council because, at the time, that's where Health-in-All-Policies had resided. It was put there as a placeholder while we fleshed it out. He did all the policy work and all the background work and was well equipped to do so because he had experience with it in Ottawa and across the country.

That work is completed and he has decided to move back into the private world. The department has an identified lead and it's been repatriated into Health.

MR. BRAZIL: So it'll come back to the department for (inaudible).

MR. HAGGIE: The lens exists. It's simply physically located, from a staff point of view, in Health and the policy work that the previous deputy had done is there as the basis for their operation.

MR. BRAZIL: Okay, fair enough.

Can we get an update on the IQ 70 process? Any changes?

MR. HAGGIE: Certainly. Once the budget passes, if that's the will of the House, then the assessment for people with home care needs around Autism Spectrum Disorder will no longer have IQ 70 in it at all. It will be a functional assessment based around their needs in the community, because it is a spectrum.

Some people range from needing 24-hour care and some people actually function independently.

The needs of the individual will determine what services are necessary and it will have nothing to do with an IQ test.

MR. BRAZIL: Fair enough.

MR. HAGGIE: Now, it will take a little bit of training time to get the tool out there into the community. So that's why there's only $2.5 million in this year's budget.

MR. BRAZIL: Okay, so we're talking six months a year, 18 months before everything is in play.

MR. HAGGIE: I would really like it sooner than that. I think the challenge is around the assessment tool that I mentioned before. There are some out there. They are, in some people's minds, too intensely medically focused and we want to make sure it's individual focused and family focused and needs based, based on their functional issues, not their diagnosis.

MR. BRAZIL: Yeah, fair enough.

MR. HAGGIE: Because that tool will then be cloned for our disability plan.

MR. BRAZIL: Exactly. It would make sense.

Rather than get in the House and ask questions about rumors we're hearing about, you know, wait-list and long-term care, do you have a wait-list number for long-term care beds in the RHAs?

MR. HAGGIE: Yes, in actual fact, I referenced it earlier and I think we'd be happy to provide it. The short answer is there are 235 people on a placement wait-list between community, personal care homes and acute care waiting for long-term care as of March 2019.

Over the last year, we've repatriated 25 people from long-term care back into community, either home or a personal care home, which is a first. I honestly can't recall that having happened in the past.

We're looking at concepts around restorative care. Indeed, that's part of the idea around the new long-term care beds that we physically located in the hospital in St. Anthony, that the people there might be suitable for rehabilitation.

MR. BRAZIL: Those 25 repatriated, are they all different regional RHAs; not one specific area?

MR. HAGGIE: Principally Central, but it's across the province.

MR. BRAZIL: Okay, fair enough.

Any changes coming to the Special Assistance Program?

MR. HAGGIE: Yes. The medical device bit, I think the RFPs – has the RFP been awarded? Where are we?

Yeah, it's been awarded to Eastern Medical Supplies starting 5th of July, 2019, so that takes the medical equipment out of SAP.

There is a request for information being worked on by shared services in Eastern Health, and then that will be used to develop an RFP for the Special Assistance Program. We had had some earlier thoughts that it might be possible to incorporate that in some other services with, unfortunately, no success.

MR. BRAZIL: Perfect.

CHAIR: Mr. Brazil, your time is up, but are you – a few more questions?

MR. BRAZIL: Yeah, a few more questions here.

CHAIR: Ms. Coffin, good?

Okay. We'll reset the clock.

MR. BRAZIL: Okay, thank you.

We hear rumours about the different number of nurses and that. Can we get an accurate number of how many nurses we have in this province? I'm curious how it compares from a standard across the country itself.

MR. HAGGIE: We have the second-highest number of RNs per capita of any Canadian province. We will get you the – hang on, here it comes; 6,300 and 5,500 of them work in regional health authorities. That's RNs.

MR. BRAZIL: RNs, perfect.

Your perspective after the campaigns from the nurses' union and that, do we need more nurses or do we need a different approach on how we provide nursing services?

MR. HAGGIE: I think we need to go back and look at skill mix.

One of the challenges that the nurses have identified I've seen from my own previous experience before and I think we're all agreed on is there's a significant amount of nursing time – and I think one of the surveys by the RNU itself suggested that figure was about 25 per cent of nursing time – spent doing what they describe as non-nursing duties.

From my own experience, someone to answer the phone after 5 o'clock up to midnight, someone to maybe help with some of the more straightforward tasks on the floor. Because LPNs have a hugely increased scope of practice now, and I think in some areas they are underutilized. Similarly, the PCAs can take some of the more routine work off them.

I think the issue around documentation and charting, there are mixed messages from the electronic health record, and I think we can do better at how data is entered on nurses' behalf into the electronic health record. Those would certainly be things I would stress.

Again, big picture, we have the workforce management software, which will match acuity to staffing. We've also talked to the RNU about undertaking staffing review more broadly in areas such as speciality acute care, regional acute care and long-term care.

MR. BRAZIL: Yes, fair enough.

I'm going to take you back to the binder there now because I have a couple of questions around line items there.

3.1.01, Regional Health Authorities and Related Services, under Revenue - Federal. The $16 plus-million in budget line. Can you just outline what that's for? It would be nice to know.

MR. HAGGIE: Yes, sure. I just need to flick back. 3.1.01, you say?

MR. BRAZIL: Yes, Sir, federal revenues.

MR. HAGGIE: Revenues – I'm getting there.

Okay, federal revenue, we have First Nations and Inuit Health Funding Agreement – and there's a number there, but that's for medical transportation for Inuit and Innu of Labrador, that's $432,000. It's in the binder. We got money from the feds for Vera Perlin.

MR. BRAZIL: Okay.

MR. HAGGIE: We have the combined home care and mental health care transfer, which is, for this year, $15.5 million. We have provincial revenue – you asked about federal though, was that correct?

MR. BRAZIL: Yes, federal. Provincial's fine.

MR. HAGGIE: It's in the binder.

MR. BRAZIL: Okay, I'm going to go with the binder and move along under 3.2.01, Health Care Infrastructure and Equipment. Under Grants and Subsidies, the difference here, you spent $3,700,000 less in the budget. Can you outline why?

MR. HAGGIE: Yes. The decrease was related to $3.7 million not being advanced to NLCHI for the EMR as NLCHI had deferred revenue balances to fund it. So we didn't give it to them.

MR. BRAZIL: Okay. In the binder, would it be a breakdown of what this budget covers in '19-'20, the rest of it?

MR. HAGGIE: For the '19-'20 budget?

MR. BRAZIL: Yes.

MR. HAGGIE: Yes, it's RHA furnishings and equipment, $22 million and building improvements, $10 million.

MR. BRAZIL: Okay, fair enough.

MR. HAGGIE: That's a broad envelope.

MR. BRAZIL: Under Health Care Infrastructure, can you provide an example of why you had planned to spent $46 million on capital infrastructure projects, but you only spent $21 million in '18-'19? A significant drop. Is there one project or group of projects that didn't go forward, or equipment?

MR. HAGGIE: There is an item in the binder that describes the changes in cash flow over time. Again, sometimes you spend a little bit more one year and sometimes you don't get to spend any and move it out to the next year.

MR. BRAZIL: Fair enough, Minister. Perfect.

I'm getting to the end of it there now.

Under Allowances and Assistance, can you just explain the $5.5 million? It maybe already one that you said but I'm just curious of what –

MR. HAGGIE: That was Pomerleau for the Labrador West lawsuit.

MR. BRAZIL: Can you give me a little bit more detail?

MR. HAGGIE: Sorry?

MR. BRAZIL: A little bit more detail on the settlement with them, on the Labrador West facility?

MR. HAGGIE: I'm told there's something called settlement privilege, which I am not supposed to talk about.

MR. BRAZIL: Okay, fair enough.

MR. HAGGIE: I've told you all I can.

MR. BRAZIL: Fair enough. I do understand that.

With that being said, I, too, thank the minister and his staff, the Table Officers, the Chair and the Committee themselves for the indulgence tonight. We got a lot of good answered to a lot of questions. I appreciate the copy of the binder and that other report that we noted, it will go a long way in keeping us knowledgeable on what's happening within the department.

Thank you for that.

CHAIR: Thank you.

Seeing no further questions, I would ask the Clerk to call the subheads, please.

CLERK: 3.1.01 to 3.2.02 inclusive.

CHAIR: Shall 3.1.01 to 3.2.02 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

On motion, subheads 3.1.01 through 3.2.02 carried.

CHAIR: Shall the total carry?

SOME HON. MEMBERS: Aye.

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

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

CHAIR: Earlier this evening, the minutes of the last Social Services Committee were distributed.

Can I ask for a mover for that?

Moved by Mr. Brazil.

I don't need a seconder, do I?

CLERK: No.

On motion, minutes adopted as circulated.

CHAIR: Alison, do you have any closing remarks?

MS. COFFIN: No, I said mine, I can't second this because I wasn't there.

CHAIR: Okay. We don't need to seconder anyway, that's fine. So we're all good.

The next meeting is gong to be Tuesday, June 25 at 9 a.m. It's the Estimates of Education and Early Childhood Development.

Now I look for a mover to adjourn.

MR. DAVIS: So moved.

CHAIR: Mr. Davis.

So adjourned.

Thank you very much.

On motion, the Committee adjourned.