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Department of Health and Community Services

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Honourable Scott Reid, 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
Alicia Anderson, Executive Assistant
Chad Antle, Audit Manager
Heather Hanrahan, Assistant Deputy Minister, Regional Services
John McGrath, Departmental Controller
Andrea McKenna, Assistant Deputy Minister, Policy, Planning & Performance Monitoring
Tina Newhook, Director of Communications
Paul Smith, Assistant Deputy Minister, Corporate Services
Colleen Stockley, Assistant Deputy Minister, Population Health
Karen Stone, Deputy Minister

Also Present
Derek Bennett, MHA, Minister of Environment, Climate Change & Municipalities
David Brazil, MHA
Gerry Byrne, MHA, Minister of Immigration, Skills and Labour
Alison Coffin, MHA, Leader of the Third Party
Paul Lane, MHA
Elvis Loveless, MHA, Minister of Fisheries, Forestry & Agriculture
Denise Tubrett, Deputy Chief of Staff, Official Opposition Office

The Committee met at 6:19 p.m. in the Assembly Chamber.

Pursuant to Standing Order 68, Derek Bennett, MHA for Lewisporte - Twillingate, substitutes for Carol Anne Haley, MHA for Burin - Grand Bank.

Pursuant to Standing Order 68, Gerry Byrne, MHA for Corner Brook, substitutes for Christopher Mitchelmore, MHA for St. Barbe - L'Anse aux Meadows.

Pursuant to Standing Order 68, Elvis Loveless, MHA for Fortune Bay - Cape La Hune, substitutes for Sherry Gambin-Walsh, MHA for Placentia - St. Mary's.

Pursuant to Standing Order 68, David Brazil, MHA for Conception Bay East - Bell Island, substitutes for Helen Conway Ottenheimer, MHA for Harbour Main.

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

CHAIR (Trimper): First of all, I'm Perry Trimper, the MHA for Lake Melville. I will be your Chair this evening for the Estimates for the Department of Health and Community Services.

Let's do some introductions first. I'll start with my left and I'll ask the minister to introduce himself and his team.

MR. HAGGIE: Thank you very much, Mr. Trimper.

John Haggie, MHA for Gander and Minister of Health and Community Services.

We'll probably start over there and just go back into …

MR. MCGRATH: Sure.

John McGrath, Departmental Controller.

MS. STONE: Karen Stone, Deputy Minister.

MS. HANRAHAN: Heather Hanrahan, Assistant Deputy Minister.

MS. MCKENNA: Andrea McKenna, Assistant Deputy Minister.

MS. STOCKLEY: Colleen Stockley, Assistant Deputy Minister.

MR. SMITH: Paul Smith, Assistant Deputy Minister.

MR. ANTLE: Chad Antle, Audit Manager.

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

MS. NEWHOOK: Tina Newhook, Director of Communications.

CHAIR: Okay, thank you.

Then over on the other side, to my right, I'll start with Mr. Byrne.

MR. BYRNE: Hi, I'm Gerry Byrne and I'm the Member for the historic and beautiful District of Corner Brook.

CHAIR: Perfect.

Mr. Brazil.

MR. BRAZIL: David Brazil, Opposition House Leader.

MR. LANE: Paul Lane, MHA for the District of Mount Pearl - Southlands.

MS. COFFIN: Alison Coffin, MHA for St. John's East - Quidi Vidi and Leader of the New Democratic Party.

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

MR. BENNETT: Derek Bennett, MHA for Lewisporte - Twillingate District.

MS. P. PARSONS: Pam Parsons, MHA for the District of Harbour Grace - Port de Grave.

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

CHAIR: Thank you all very much.

Just a couple of housekeeping items. First of all, we'll see how it goes. I was here last night. We had a ruckus evening that went for over four hours, so we'll see how the energy level is tonight.

I propose we'll stop around 90 minutes in and take a 15-minute break and then come back. We'll target that and we'll see how we're making progress through. If the questions and stories are interesting, we could take longer. But we'll try to finish in about three hours from now.

There's a little issue with the broadcast and how we're working. What we'll do is as you go to speak you'll say – and this gets very informal after a few minutes. The minister, will say, John, and the broadcast will know to turn on your mic and then you'll speak. So if you could just pause for a second to see that light and that way we can capture everybody's comments.

With that, I will turn to the Clerk now and we will introduce the first sections. We'll go through this in sort of a logical fashion. She'll propose the first sections and we'll ask that the questions will come from the Opposition Members relevant to those sections.

Before I go there, though, Madam Clerk, maybe we'll have the minister make some opening remarks. Would you like to do that, Sir?

MR. HAGGIE: Yes.

CHAIR: Okay.

MR. HAGGIE: Thank you very much, Mr. Chair.

I was looking back through *Hansard* to last year's Estimates and on that occasion I'd actually mislaid my speaking notes. This year, I had a beautiful set of speaking notes, but they're all totally irrelevant now because they were for March of this year, and as everybody knows, the world has kind of turned somewhat since then.

I would like to point out that the staff who are with me are the same staff who have worked very hard on the budget and have continued to update it, whilst at the same time being the very same people who, not just during the working day but I would argue around the clock and through the weeks, have actually been very operational in managing issues related to COVID in this province, a pandemic. If there are some pieces of information that we have to go back and get because we may have omitted to bring them, I would not like anybody here to take that as a reflection of the diligence of the staff, it's simply we've kind of had a lot on our plate.

This time last year, ironically or interestingly, one of the key pieces of my introductory speech was around the groundbreaking new act about which I enthused, which was the *Public Health Protection And Promotion Act*. None of us – certainly not me in my wildest dreams – would've imagined that rather than concentrating on, say, a five-year plan for wellness from the chief medical officer, we would've found ourselves exercising other sections of that act to protect Newfoundlanders and Labradorians.

To speak specifically to financial issues around the Estimates, the bottom line for our department is that whilst we are the biggest in terms of expenditure in government, once again we have flattened another curve and that curve is the curve of health care expenditure. We have done this for the fourth if not fifth successive year keeping health care expenditures well below inflation and almost zero-dollar change at all.

I think the Conference Board of Canada have referenced the hard work of the department here as an exemplar for cost containment, cost avoidance and cost control in health care. I would commend the work of the current staff here, as well as their predecessors, in working hard to achieve what very few jurisdictions in Canada – and I would argue in the world – have actually been able to do.

We have done it, however, at the same time by actually enhancing services, repurposing money, moving from reactive mode to a proactive mode and trying hard now in the future to look towards the more social determinants of health. For 30-plus years everyone has realized that the true predictors of health don't actually lie in the activities of the health care system, they lie in the way that we can look after the other social determinants of health. That is going to be thrust

over the next little while in terms of our longer term and late medium-term planning.

We have a very clear strategy for the immediate term and the short term. I would argue that when you look at the fiscal numbers here – that we have rightsized the budget; we have corrected structural deficits where possible – there are still more to be done. In doing that, we have enhanced a whole suite of services from virtual and e-health all the way through more traditional hands-on, drop-in clinics. At the same time as demand for mental health services has increased, we have kept waiting lists and waiting times on a downward trajectory, for example.

I think with those comments just to kind of preface things, I would wait and look forward to the discussion to come.

Thank you.

CHAIR: Thank you.

A couple of more housekeeping items. I think now is the time to introduce them.

First of all, Minister, as you know – this is your fifth budget – you can handle every question you'd like or direct them to your team as you could. Again, for the aid of broadcast, the Clerk has had a nice little guide chart so we'll be able to find, if you identified somebody else to speak or they wanted to offer some additional comment, but sometimes – what we were doing last night was just waiting. They will see you and they will find you and activate the microphone. You can say your name first, of course, always.

What we're going to do is start with 10 minutes with the Official Opposition, then go to 10 minutes for the Third Party. Mr. Lane has joined us here and knowing him well as I do, he, I'm sure, is interested in also being able to ask questions. He's not a Member of the Committee but with leave of this Committee, we would be able to grant him the ability to ask questions. Is that acceptable to the Committee?

AN HON. MEMBER: (Inaudible.)

CHAIR: Okay, so be it.

We'll go two rounds and then over to Mr. Lane. So, 10, 10, 10, 10, 10 to Mr. Lane and we'll keep going until you run out of energy or questions, one or the other.

We have to introduce the sections.

CLERK (Barnes): So we're doing the subhead Executive and Support Services.

It's 1.1.01 through 1.2.02 inclusive.

CHAIR: Thank you.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

I only have a few quick questions in this particular heading. I thank the minister for his opening comments and would just ask if it would be possible that we'd be provided with a copy of his briefing notes after the discussion.

MR. HAGGIE: Certainly, we will supply that in an environmentally friendly paper format as in previous years.

MR. BRAZIL: Perfect, I appreciate that.

Just so we clarify so there's no misconception on numbers, are there any errors that we should be aware of in the book?

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

MR. BRAZIL: Perfect.

A couple of quick questions here under Transportation and Communications, under 1.1.01. The $40,000 in '19-'20 was budgeted, $24,700 was used, but there's still $40,000 there. Do you still expect to use that with the situation being minimal travel or is there some particular use that you may have for that?

MR. HAGGIE: I think that was a result of zero-based budgeting and rightsizing. Yes, you're correct that we do have a minimal travel policy; however, we can't predict the future and we felt it prudent to include it at that current rate.

I have been very careful about trying to work from home, for example, and minimize the

ministerial travel, but there are still occasions when, because of the nature of the pandemic, my presence here is required. That can be somewhat unpredictable; hence, we stuck with last year's number.

MR. BRAZIL: Fair enough. I figured it would be around that just to be prepared.

I want to go to 1.2.01 under Salaries. Just to refresh me from last year – I remember being here, I'm trying to get my head around it – the original budget was $1.128 million. Then it went up to $1.336 and now we're looking at $1.347. I'm assuming it was either payout or another salaried position. Can you just reflect on what that would have been?

MR. HAGGIE: The increases are related to overtime for our Communications Division, and that probably works out to about $40,000. There was a 27th pay period included in 2021, and we have an extra assistant deputy minister for Population Health, compared with last year's budget. So that would account for the variance under Salaries.

MR. BRAZIL: Okay, fair enough.

Same thing, I'm assuming, on Transportation and Communications, the same issue, just to be prepared you'll have enough money budgeted, even though, in comparison to what you spent in '19-'20, there's an extra $10,000 there as such.

MR. HAGGIE: Yes, it's basically to try and predict the future, given the fact that we did manage to reduce expenditures because of COVID in the latter part of March.

MR. BRAZIL: 1.2.02, are we on that same heading?

CHAIR: Yeah.

MR. BRAZIL: Under the Salaries base there, there's an over $2 million increase. Can you outline exactly what that's for, what positions?

MR. HAGGIE: Yes. The Auditor General did some work for us and advised us that the staffing level for the Medical Transportation and Assistance Program was inadequate and recommended 21 temporary positions. That accounts for $926,500 of that variance. There is $660,000 in there for overtime related to COVID-19. There's the 27th pay period again to be budgeted for.

On the other side, we have been able to take out the $38,700 planned for, for attrition and the $135,500 for the creation of the assistant deputy minister in Population Health came out of there and was moved to Executive Support.

MR. BRAZIL: Okay. So these extra positions, have they all been filled, at this point?

MR. HAGGIE: I would have to go back and check. Maybe the staff would be able to answer that.

MS. STONE: Yes, they have.

CHAIR: Just wait for your light to come on there. There you go, okay.

MS. STONE: Yes, they have.

MR. BRAZIL: Thank you, Karen.

Okay, under Professional Services there, it seems to be substantially up from what was actually used last year to this year – half a million dollars. Can you outline what extra professional services are going to be contracted under that?

MR. HAGGIE: Yes. There are some – as one of my colleagues would say – puts and takes. We've reduced it by $79,000 for zero-based budgeting. We have there a consultant for the negotiations for the Newfoundland and Labrador Medical Association and government. There's a $61,000 increase because of a new CIHI bilateral agreement, and $73,000 for extra review board hearings for physician audits, which we'd not been able to get off the ground in the previous year.

MR. BRAZIL: So the consultant, has that been contracted to this point?

MR. HAGGIE: Yes, it has been awarded and we're in discussions and kind of on-boarding with Invictus.

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

Purchased Services, the extra $240,000, do you want to outline what you expect will need to be purchased under that program?

MR. HAGGIE: That's for advertising for the COVID response, $240,000 and there's also an increase through zero-based budget to account for a more vigorous flu vaccination, campaign, advertising. We've seen significant successes year over year with that but this year, particularly, there is an emphasis on the flu vaccine.

MR. BRAZIL: Okay, fair enough.

The extra Property, Furnishings and Equipment, the extra $50,000 basically from what was budgeted in '19-'20. Is there new furnishings or additional office spaces? Is it for these additional people that you've hired?

MR. HAGGIE: It was $50,000 worth of laptops to try and make sure we had adequate resources for people working from home during COVID. There is a HRS policy about only providing that material to people of a certain managerial status. We found that we needed to operationalize getting the client support officers, for example, to work from home during COVID. That was the laptops and then it was $2,300 for phone purchases for the same reason. These are recycled so they go with the role; they're not necessarily attached to individuals.

MR. BRAZIL: Okay, I appreciate that.

We're sticking to headings, aren't we, straight through?

CHAIR: Yes.

MR. BRAZIL: Okay, so you'll call for that heading first?

CHAIR: That's right, we'll vote on this first section and then move on.

MR. BRAZIL: Okay, can I just have one general question.

How many employees are in the department now?

MR. HAGGIE: I thought you would ask that. You just give me a moment and I will find that number for you.

MR. BRAZIL: Perfect.

MR. HAGGIE: It was on the tip of my tongue earlier on. I think it's 247. It is 247.

MR. BRAZIL: Thank you.

I'm good on that section, Mr. Chair; I may come back to other questions.

CHAIR: Ms. Coffin.

MS. COFFIN: Thank you very much.

Welcome everyone. Thank you for all your hard work. I thanked the folks last night because they were working extra to get ready for the budget and all of that, but you folks, not only have you gotten ready for the budget but you've been preparing for it during a pandemic so kudos to you all. Thank you very much for your dedication and hard work, I do appreciate that.

Perhaps I need to apologize now because as our Chair has mentioned we'll keep going until the questions run out or the energy runs out. I have an unfortunately large amount of both so sorry ahead of time. Perhaps the questions will run out before the energy, but let's start.

Under Departmental Operations, I'm not going to ask much about the numbers because I think my colleague just talked a little about that, but I do have a number of questions. Minister, you had said that health care expenditures have remained relatively flat or decreased. The flip side of that is we have an aging population; we have an awful lot of diseases and disorders.

In Newfoundland, I think, we win when it comes to obesity and diabetes, as well as a number of other unfortunate conditions. With our aging population and an increase in what I assume will be demand for medical care, how can we possibly reconcile keeping costs even or decreasing them, as I notice in the mandate letter you are working to find ways to reduce health system costs and eliminate waste. Perhaps you can elaborate on that in the context of the health of our population and the age of the population.

MR. HAGGIE: Certainly. It's an extremely good question.

It really is answered in the change of policy emphasis in the department to move from facility-based care and institutional-based care for seniors, to kind of age at home, age in place. It is not going to be possible for all but, certainly, we've seen a whole variety of initiatives around, such as the Home First program. By investing in those, we can provide better care at less cost to the system, but better value overall.

With regard to the chronic disease burden, one of our challenges up until very recently is that wellness and health promotion prevention was somewhat fragmented because of the way the departments had been organized after what was jokingly referred to as the great divorce in 2014, when wellness went off to what was then Seniors, Wellness and Social Development. The realignment of portfolios in the recent Cabinet shuffle has now brought wellness back into the Department of Health. That transition has not yet really materialized in any great way and, certainly, there are lots of operational issues there.

What that will do, ultimately, will be then to align wellness and health promotion initiatives with what we know from morbidity and outcomes later on, and rationalize the process to some extent. It will also allow this kind of dynamic management where cost avoidance or cost savings in one sector could then be repurposed. We know that in terms of dollars spent in prevention and health promotion, they are said to be worth $20 per dollar, but that is not seen for maybe a generation. So our challenge is whilst it's Health and Community Services, it's actually illness and community services and we're trying to move back to that wellness and health approach.

There's lots of scope there, but one of the hopes I have of the task force is that over the medium and long term we will identify ways of using some more of our cost avoidance and savings to actually repurpose it maybe into the more social-oriented determinants of health, which traditionally don't actually fall inside the Department of Health in an illness, or a wellness even, kind of system. They're the things like some of the green initiatives around waste water management and these kind of things, things about poverty reduction strategies, basic income, these kind of things.

I think that's a very woolly, non-financial description, but we can provide some tangible examples should you want to go a little bit further into the weeds on that. That's the high-level piece in terms of where I see the department going and fitting into the problems you've described.

MS. COFFIN: That's very reassuring. The first question I have as a follow-up for that would be in helping seniors age at home. I think that's such an important piece. We know with dementia when you move people from the home that they've lived in to somewhere else they often deteriorate much more rapidly. So that's a wonderful thing.

However, with our aging population it means we have less people left to take care of the people who want to age in place. I see that as an impending problem along the way, especially in rural areas. My father and I played the game of who used to live in that house with the lights turned out on Fogo Island a while ago. That family has moved away, that family has moved away and that family has moved away. We are going to have communities of seniors with no one to care for those seniors, so I think that might be an impending issue along the way.

One of the other things that I wanted to ask – that's probably not an ask, more of a comment on a potential problem down the road – we have the Community Accounts and we also have a series of indicators that can measure wellness and well-being. Is your department using any of those indicators, in addition to the financial indicators, of guides on how money ought to be spent? Identifying: Have we improved our health outcomes? Are people living better lives as a result of that?

Not how much money we're spending, but what does it result in. Are people safe in their homes? Do they feel like they can have access to health care? Are they eating well? Are their lifespans lasting longer? Things like that. Is that something that's been actively incorporated into a lot of the policy development?

MR. HAGGIE: Yes, in actual fact, those indicators are examined and there's a whole raft of them. I remember you referencing Community Accounts in this process last year.

We have a variety of mechanisms and now we have a formal section, a department for want of a better word, based around population health. That's kind of where the home for that will be in terms of using that kind of data, that kind of information to highlight areas of need or highlight areas of success, and to compare various techniques in one area of success and see if we can move them over and this kind of thing.

Again, a kind of nebulous answer but the short answer is, yes, those indicators are there. Some of them we supply to CIHI, some of them other departments supply. We've tried to find a way and we are still working on a way of kind of amalgamating those into a dashboard or a scorecard, or something like that, for our section of Population Health to be able to help advise policy development.

MS. COFFIN: That's rather exciting. I look forward to that.

You've also referenced the issue of time as one of the other variables that we measure. We plan our budget on an annual basis, but our health is a continuum and, like you say, it's half a generation or a full generation before some initiatives, like eating well at home and eating more raw foods or foods that have less processing associated with it, before that actually filters through the health system. That's kind of reasonable.

Let's see. These are just the scribbled questions; let's go over to the ones that are actually written out here now. Can we have an update on The Mental Health and Addictions Action Plan? Certainly, I know we've had an ongoing conversation about the use of a lot of mental health supports that have happened during COVID. I know we had a huge spike. I'm not sure if that's gone down again because I don't think I've asked for that recently, but that certainly would be an interesting segue into how that action plan is coming along.

MR. HAGGIE: Yes, *Towards Recovery* was a 54-point-beast, the recommendations from that. I can provide a little bit of an update there.

In terms of the recommendations, there's progress on all of them. The short- and medium-term ones – I think there were 26 of those – those are all done. We've laid out the groundwork, almost literally as well as figuratively, for the new adult mental health and addictions facility. We have a financial target in terms of trying to increase the percentage of health expenditure that goes to mental health and addictions. We are on time or slightly ahead with pretty well all of our indicators. I had thought I had a little list of them here in terms of that but certainly we can get you that.

We used to produce the score card, if you remember; we committed as part of the process. Again, that's one of the boxes that were ticked; we'd give an update at six months and then 18 months. In actual fact, I think we gave one at two years as well.

The success in mental health through COVID –

MS. COFFIN: There's a note being handed to you.

CHAIR: There's a little birdie trying to reach you.

MR. HAGGIE: Now, in the good old days it wouldn't be a problem.

MS. COFFIN: Old school.

MR. HAGGIE: Twenty-one is the answer to your question, not 26.

The facts of the case are, we are not complacent but we're comfortable with where we are there. There is still work to be done. We've done very well with our e-health suite. We've been recognized internationally for that work. New Zealand, where we originally went to look to see how it was done, have now come back and said how did you actually get it done, which was quite an interesting conversation. We're part of the e-mental health collaborative internationally and that gives us access, for example, to app developers who will rank the utility and appropriateness of apps for us so we don't have

to do that work and that's all part and parcel of that.

In the e-mental health we are actually leaders. We have BC, we have Ontario, looking to borrow, clone or get a lot of the stuff we use on Bridge the gApp. Doorways has been a smash hit really and wait times for mental health, formal mental health services, the number of people waiting is now done at 51 per cent compared with 2017 numbers.

There has been an increase in demand for services such as Channal and the Warm Line and we've put extra money into that. We have funded HealthLine for the mental health crisis line to try and get that on to a more formal call-centre basis. It had been run basically off a cordless phone tucked in the back pocket of the RN on for the PAU. The community work in terms of the mental health crisis beds, the hub-and-spoke for opioid dependants' treatment, as they develop, then those will lay a different kind of foundation on which the new adult mental health facility will be able to practice so that, again, we're moving away to community-based treatment.

We have FACT teams out in areas that never had them before; we're increasing the number of FACT teams in St. John's. We have signed and operationalized an arrangement with the RCMP for their jurisdiction to do the mobile crisis response teams in the way that the RNC already had rolled out.

Again, those were all things from the All-Party Committee. Any one of those, if you have a specific question about timelines or a location, I'm conscious of the time, but rather than read through a long list I can supply that. It's no problem.

MS. COFFIN: That would be lovely. Thank you.

CHAIR: Okay. Thank you.

Mr. Brazil, any further questions? You had indicated – or did something come up?

MR. BRAZIL: Yes, appreciate it, Mr. Chair.

When we talked about the staffing, has there been turnover, any retirements within the department last year?

MR. HAGGIE: I would have to check.

MR. BRAZIL: Any substantial notice? If there are 10 or 15 people out, it's a different – if there are one or two gone, it's very minimal. Fair enough.

Are there any existing vacancies there at this point?

MR. HAGGIE: There's only one retirement I would like to read into the record, and that is Ms. Simms, the architect in many ways of the new adult mental health and addictions facility. I don't think that's hyperbole or exaggeration to say that. That was her dissertation as a bachelor of nurse candidate. At the end of her career, she retired happy on that score. We certainly miss her. We have excellent staff coming behind, but I think it was worth acknowledging Ms. Simms.

MR. BRAZIL: No, and I agree, very diligent, committed civil servant who did great work.

The numbers of vacancies that we have in the department now, are they substantial?

MR. HAGGIE: I'm not aware of a substantial vacancy factor. I will refer to my page here and see what I can find for you.

No, we don't have any substantive vacancies in the department according to the figures I have. I'm pleased to be able to say that.

MR. BRAZIL: That's good.

One more on that: Were there any positions eliminated during the last year?

MR. HAGGIE: Karen, would you be able to answer that.

MS. STONE: There were no positions eliminated.

MR. BRAZIL: Okay. I'm good on that heading.

CHAIR: Okay.

Ms. Coffin?

MS. COFFIN: I warned you about this. It's not that bad.

Since we were talking a little bit about the mental health and addictions, do you have any idea of the number of suicides that we have seen this year and are you able to say whether that's more or less than we've seen in the past?

MR. HAGGIE: Those statistics are collected by another department. We're in the process of trying to work with Justice and Public Safety through the chief medical examiner. The new chief medical examiner is very open to data sharing.

We have not been made aware of any excess in the first quarter of this year. The second quarter data has not passed our ken yet, but certainly we can get those statistics for you. In general, we have not been made aware of any particular hot spots in the way we were, say, with Marystown or Lab West where we actually felt we had to put additional resources on the ground.

MS. COFFIN: Fair enough. I imagine we're probably not going to see a spike until we see CERB run out and people's mortgages will come due. I have some concern about what kind of situation that's going to create.

I guess the next one would be overdoses. Do we have any sense of the number of overdoses that we are seeing, certainly the types of drugs and the volume of drugs that have been coming into the province? I think because of the lockdown, people creatively mixed drugs is what I am hearing. I think that may have meant that we saw – only anecdotally do I hear this, there may be more overdoses.

Are you seeing anything like that, prevalence of other drugs, drugs that are mixed and the likelihood of overdoses?

MR. HAGGIE: It's interesting – and just as an aside, I'm always a bit ambivalent about using the term "overdose" because I think in actual fact a lot of these overdoses are really poisonings. There is an adulterated drug supply out there and some people are really not aware of what it is they're taking or how much.

MS. COFFIN: Fair.

MR. HAGGIE: I think there are some inadvertent opioid poisonings, for want of a better word, because doses are hard to determine.

In terms of the number of fatalities as a result of that, again, that information comes through OCME, the Office of the Chief Medical Examiner.

We did actually look, because of questions I think you'd raised in the joint All-Party Committee, at that data. There was toxicology pending. My understanding, as a result of that, is there is still some toxicology pending, but there is, at the moment on the face of it, no significant difference between this year and the previous three or four years. It goes up and down for reasons that we haven't been able to identify, but taken over that period, so far, the information I had wouldn't show any significant difference this year.

MS. COFFIN: That's overdose resulting in death.

MR. HAGGIE: Yes.

MS. COFFIN: Right. Do we capture overdoses? Some overdoses can't – poisonings, I like that term a little better, as much as one can like a term like that. Do you have any sense of the number of people who are getting, not an EpiPen, the other one?

MR. HAGGIE: Naloxone.

MS. COFFIN: Thank you, yes.

Any sense of the use of that? Are you seeing admissions as a result of poisonings?

MR. HAGGIE: There is data available through the hospital reporting system on overdoses that were – they're classified as either intentional or accidental, usually. There is some national data to show an increase in accidental opioid overdoses with therapeutic drugs rather than recreational drugs in the elderly. We have not analyzed our data with that in mind.

Certainly, I'm not aware of any increase in the numbers of either category being admitted, but that data is something we could certainly go back and see if we could find for you. It comes on what's called a data dump from the regional health authorities and that's either monthly or quarterly.

MS. COFFIN: That would be very interesting to see. Thank you.

I think that might show some unfortunate trends. Hopefully not. Maybe we can get you a little string to pass.

Let's turn to something somewhat related. Sexually transmitted infections and rates of things like HIV, I've certainly heard that there has been prevalence from time to time. I see a news release go out saying be aware, there is an increase in hep C or there's an increase in whatever. Do we have any data on that that can give us some sense of what's happening in our communities?

MR. HAGGIE: Public Health does provide that data on a periodic basis. Quite frankly, the last data I've seen in that area has been towards the end of the last calendar year. My recollection at that stage was there was a significant rise in the number of cases of syphilis in the Eastern region and that there was a problem with an increasing number of chlamydia cases, particularly in Western.

In terms of other truly sexually transmitted diseases, hepatitis C kind of confuses the issue a little bit. There are certainly increasing numbers of those on the West Coast as of last year but, again, I don't have the exact numbers at hand.

The notes from my partner in crime to the left, there is – in actual fact, in reference to Mr. Brazil's question, there was a front desk position in the Department of Health that was not replaced when the incumbent retired. That's the only job loss as it were, position loss, and that was accounted for as part of our attrition targets.

MS. COFFIN: Can I do a follow-up question on sexual health?

MR. HAGGIE: By all means.

MS. COFFIN: No, I totally understand.

MR. HAGGIE: I was just trying to get it out before I got buried in paper and forgot about it.

MS. COFFIN: Totally understand.

One of the things that I have heard pretty loud and clear is a need for sexual health clinics and that's not just you can get a Pap smear or you can get some condoms and you can just learn about sex. It needs to be a little bit more comprehensive. It needs to address a lot of the issues head-on.

That demand is there and I think there is a real need for that. Certainly, life is very different for 20-year-olds than when I was 20, for sure, so I can well imagine the sexual health clinics need to be dramatically modified. Are there any plans to have some comprehensive sexual health clinics beyond St. John's?

MR. HAGGIE: Well, we have supported Planned Parenthood and found them a new accommodation and helped them set up there because it is a very valuable service. We certainly appreciate the work they've done.

In terms of across the province, we have really an opportunity now, with wellness coming in and some of our links with more Public Health nurses being supplied through the education system, that we can actually start to look at sexual health in a more coordinated way through a variety of prongs now through the formal education system, as well as from a wellness perspective. I have not had any direct discussions with the RHAs about whether or not a specific Planned Parenthoodish kind of clinic would be suitable, but these are discussions that we have with the primary care teams and the communities about what they feel they would like in their area.

Our approach with the primary care teams – which is going to be our comprehensive hub, really, for primary care for a region or a community – very much requires community involvement. We like to hear what they think they need and then that's a discussion to be had with the practitioners to see if that demand exists there. That's a work-in-progress.

MS. COFFIN: Okay, let's open up that box just a little bit more. I can't speak to prevalence, but I do know that it has become more prominent. There are men, women and transgendered individuals working in the sex trade all throughout Newfoundland and Labrador. Has this department addressed that in any specific way?

This is something that used to be very well hidden, very hard to find and now you open up the right website or you walk down the right street and it is right there. I think that's a very, very important thing given the higher prevalence of STI, higher prevalence of drug addiction and the fact that we're in the middle of a pandemic now. Are there any specific initiatives targeting the sex trade industry in helping those individuals either make a living or be safer in that industry?

MR. HAGGIE: We haven't really taken the lead on the sex trade. That would, I think, have fallen to then Women's Policy – well, now Women's Policy Office. I think that question might be better addressed to them. I do know in metro there are clinics that are more attuned to that.

We have street nurses, for example, whose primary role was probably, in the first instance, addictions and street drugs, but I think they are also flexible and will deal with those kinds of things on a case-by-case basis. I think in terms of a strategic approach to the sex trade, we're followers from the lead of Women's Policy.

MS. COFFIN: Okay (inaudible) those questions there.

CHAIR: Thank you, Ms. Coffin.

Mr. Lane.

MR. LANE: Thank you, Mr. Chair.

Thank you, everyone, for coming this evening. I echo my colleague's remarks that I certainly appreciate all the hard work that you guys have done through the pandemic and in preparing the budget.

Minister, I do just want to say, for the record – and I don't want to swell your head too much here but as it relates to COVID-19, yourself and Dr. Fitzgerald in particular, I think you've done a great job in communicating with the public on this pandemic. I hear an awful lot of positive remarks from people in my district over that. They may not necessarily agree with every decision, nor do I necessarily, but I'm not the expert, you guys are. I think you've done a great job so I did want to say that for the record.

Minister, I'm going to ask you the same question now that I asked last night; I'm going to ask every one of these to each minister. If there was sort of a bright spot – and it's hard to find a lot of bright spots through this whole pandemic – in terms of the operation of government at least that I think has been presented as perhaps an opportunity is that we've seen that government can operate differently in the delivery of services, and perhaps more cost-effectively and efficiently.

I think of things like the use of technology, people accessing government services online. I think of the use of Zoom, for example, for meetings so that we're not having to incur travel costs, things of that matter. I think of people working from home and perhaps the opportunity to be able to consolidate office space and get rid of more leased office space, again, to save money.

I'm just wondering from the perspective of the Department of Health, the RHAs and so on, is there any thought in making this sort of a permanent thing? I understand there are certain services that have to go back to the way they used to be for good reasons, but if we have people that are working from home now and doing everything they always needed to do, the job is getting done, and we can shut down some office space or we can avoid some costly travel and everything else, is there a plan or a thought about let's start doing this even when COVID is over to save the taxpayers some money?

MR. HAGGIE: Thank you for your comments at the beginning. I do appreciate that. I think it's easy to look good when you have a good team behind you.

MR. LANE: Very true.

MR. HAGGIE: I'm just a figurehead in many respects.

The short answer to your question about efficiencies or bright spots in COVID is yes. From our department's point of view, we've seen, I think the most glaringly obvious one is the acceleration of virtual care. We had spoken about virtual care for some considerable time and there had been great debates about how to do this, what we should use and what technology was right and this kind of stuff.

Basically, the needs of the people of the province to access primary care particularly, or indeed any kind of care during COVID, really kind of threw all that planning back into the melting pot. Virtual care has accelerated at a speed that we would never have achieved without COVID, quite frankly. It's been done in a way that really seems to suit people.

We've had some very positive feedback around even simple telephone consults between primary care provider, nurse practitioner or family doc and a patient, and even specialists because I know specialists are using it as well. I think the phone has been the quick and easy. It suited particularly the demographic who are a little bit older and maybe less technologically savvy or familiar. I would see that being built on.

We're agnostic about the platform. We do have ones for new entrants if they want to start. NLCHI, who's been tasked with IT across Health, will support a couple of particular applications. Other than that, however, we've not stipulated you have to use this to get the fee code.

We introduced an access system for patients who don't have a regular family doctor and need episodic – low-level as it were – low-intensity care, not emergency room kind of care, through the nurse practitioner or 811 program. That's been very well received indeed. It's integrated with the electronic health record so it's accessible by anybody else in the health care world who has the appropriate access through eDOCSNL and HEALTHe NL.

That has been a great success. We have virtual fee codes for family doctors as well as specialists. I know from my own background that there are certain clinics where the addition of video and the ability to have a camera that you can move around, even on a phone it would work with the technology that's available there, without any fancy apps or add-ons. I think I would see that as the next logical progression.

Some of my colleagues, who I used to work with who are family physicians, have found integrating virtual phone or whatever into their workflow very straightforward. They can use it to triage those people who can be managed over the phone and then also say, well, you need to come and see me. There is a mechanism there whereby there isn't kind of double-dipping; you don't dip for a real live consult and a virtual one. We're looking at that from an audit point of view but we haven't really found anybody misusing it, as far as we can tell as well.

We have MyGovNL up; it had massive increase in uptake. We started online renewals of MCP cards and, again, 95 per cent, 90 per cent satisfaction with that instead of going to a desk service somewhere.

Working from home is, from our point of view, working very well. I know that across government you'd be better having that conversation with Human Resource Secretariat. They are the ones who would devise such policies. Certainly from our point of view, we found some technological challenges with reliability in the first instance of VPN and access remotely. I burnt out one of those surface tablets because they're not very good for prolonged video. It heats up and things inside break, so that was part of the expenditure on laptops that we had to go find.

Skype, WebEx and Zoom are now part of our routine. We'll even be in our offices and we think nothing now, instead of walking down the corridor and hanging out in someone's doorway, to just do a Skype call. That's become routine. Every morning I have a Skype call, particularly when I've been working from the office in Gander, and kept up to date very easily with things that are going on. My executive is really very happy with it. We've saved on consumables; we've saved on some temporary things.

One of the other spinoffs, as well, has been the ease comparatively with which we can call up folk in other jurisdictions. It's not the big enterprise it used to be of trying to organize a face to face or some big affair. There was a period where we were having two Health ministers' FPTs a week. I believe the deputies were almost saturated with them daily at one stage, which probably was not as productive as it sounds.

That has forged links with other jurisdictions and it's told us one thing, we're all in a very similar boat and we've learnt from them. Funnily enough, we have skills that they don't and they work for us. That's a précis of where we are with the department and virtual.

MR. LANE: Thank you, Minister. I appreciate that.

That was a pretty detailed answer and that was a good answer. I'm glad to see it and, like I say, I hope that's a road we continue to go down.

I'm just looking at my time here. It's hard to know where to categorize some of these questions because they're more general questions, but I'm going to ask this one anyway. I want to ask a question about the international rotational workers. I understand that they fall under a federal piece of legislation.

I've been contacted, for example, by a person in my district. He's in the oil industry. He's working over in some part of Africa. I can't tell you where but somewhere in Africa. He said the camp that he has been in, ever since COVID-19 started, there have been zero cases of COVID-19, ever. Yet, he can't get the same consideration as someone coming from Alberta where they do have cases of COVID-19.

I understand that it's federal legislation but I'm asking on his behalf, I guess, and other people in my district and throughout the province who are in a similar boat. Is there any opportunity – when you're meeting with the federal minister perhaps or the other provincial ministers or something, is that something you brought up or is being discussed to look at people in that situation so that they can have some time with their families just like everybody else?

Understanding the overall health issue, I totally get that.

MR. HAGGIE: From my point of view, I certainly have sympathy with these individuals. It is, from a provincial perspective, possible to add on to federal requirements, but it's not possible to subtract from federal requirements. That's our challenge.

Certainly, I think, through the public health mechanisms, this group have been discussed. It hasn't been a prominent feature of discussions at the Health ministers' FPT, but certainly that's something I could raise. We would certainly look to see what kinds of numbers were involved, but it's a topic I can bring up. How much traction it will get, obviously, is not up to me; it is a federal issue.

MR. LANE: Thank you.

I can only ask that you ask, as I asked on his behalf.

Thank you.

CHAIR: Mr. Brazil, any questions?

MR. BRAZIL: Yes, I just have a quick question there on the salary, the contractual work. Can you outline how many positions that is and the necessity for those, please?

MR. HAGGIE: Yes, thank you.

Contractual workers – I have so many pieces of paper here with little jottings on – we have 10 contractual positions outside of the salaried plan, which are funded through vacancies, and these are work-specific, task-specific jobs. That's 10 out of a total of 247.

MR. BRAZIL: Thank you on that.

Quick question around the COVID funding. How much did the department receive under the COVID funding?

MR. HAGGIE: Well, the COVID funding, in actual fact, if you're talking about the Safe Restart money, that is actually held in a block in Finance and, because of the *Financial Administration Act*, can't be released until the

budget is passed because these all came in as part of this fiscal year; can't be done under Interim Supply. I think there is a pot of money and I will find out the exact value of that held in Finance. Again, just give me a moment.

OFFICIAL: (Inaudible.)

MR. HAGGIE: 85?

OFFICIAL: 35.

MR. HAGGIE: $35 million.

OFFICIAL: No, page 35.

MR. HAGGIE: Page 35. We have to get the code words worked out here guys.

We've got testing and contact tracing and data management, which is done on a per capita basis and would roll out, I was going to say, $41.118 million. We have another pot of exactly the same size, because it's done on per capita basis, for securing PPE. We have health care capacity money, which is targeted; the feds put the restrictions around these, not us, around mental health and substance use, which totals $16.447 million. The vulnerable population piece, which we would share with CSSD and Housing, caps out at $10.143 million. The total adds up to $108.826 million. That's held in block in Finance.

MR. BRAZIL: Okay, thank you for that.

Did you receive any funds from the contingency fund, and if so, what did you put that towards?

MR. HAGGIE: That's a good question. Maybe, John …

MR. MCGRATH: No, we never.

MR. BRAZIL: Okay, fair enough.

I'm good on that section, Mr. Minister.

CHAIR: Okay, thank you.

Ms. Coffin.

MS. COFFIN: It's a smaller list now, but let's keep talking about sex, since we were talking about that a lot lately.

I have spoken to a remarkable number of individuals who really, really, really want to have babies, but they haven't got access to fertility doctors or clinics or they have to spend enormous amounts of money to travel and quite often the treatment doesn't work.

Are there any plans to improve access to fertility clinics and support for individuals who are having difficulty conceiving?

MR. HAGGIE: Well, several things in no particular order, just to provide a little bit of context. There is no jurisdiction regarding fertility treatment as an insured service, and we are consistent in that approach. However, having said that, we provide monies to the fertility clinic run through Eastern Health to support that. That clinic is now in a position to do significant diagnostic workup. The problem with travel there falls into the fact that IVF techniques are very much volume dependent.

We do not have, in this province, sufficient volume to acquire and then maintain those competencies in a way that would make the results acceptable in the eyes of the experts. Indeed, one would argue that even going to a clinic in Halifax you would not get the volume necessary to get good – you would maintain your skills, but, again, to polish them you need that extra increment. Paradoxically, the best results in the country are actually obtained in Alberta, rather than Toronto. When you think it was purely population issue, then the bigger populace centre would do it.

So we do provide support in the province, which is monetary and through Eastern Health, but we go, I think, further than a lot of jurisdictions in doing that. It's certainly a problem for the individuals concerned, but, again, given the fact it is an uninsured service and given the fact we have already made some contributions towards that, it's very difficult in times of fiscal constraint to put in new measures. Particularly, as I say, when the procedures that people have to travel for – quite frankly, if you want a good result, you're going to have to travel for anyway.

MS. COFFIN: That's really unfortunate for those people. I heard a lady say I've been waiting for a year. I would love to have a dozen children but I'm waiting a year to get an appointment to get in to see a fertility doctor. Do you have any sense of the wait-list, number of people and time for a wait-list, just to see the local clinics?

MR. HAGGIE: No, my last figure that I was given was somewhere in the 120ish clients for the clinic in total. That may be me misremembering. I have done that on occasions. Certainly we can find that out for you.

The wait times, certainly – the fertility clinic did continue to operate during some of the alert levels for COVID. I'm not so sure that it operated during Alert Level 5 but, certainly, I think by Alert Level 3 it had started. There were time-critical treatments that, I think, were at the discretion of the physician at any stage in COVID, because we left the discretion with physicians in this province. We were fortunate that we were able to.

Some jurisdictions, such as Ontario, just simply shut down anything that wasn't related to a burst appendix or COVID. We did allow clinical discretion to decide whether or not a consult, a meeting, a treatment needed to go ahead based on time and urgency.

MS. COFFIN: If there's anything that I would suggest, I would recommend doing everything we can to help boost our population.

Let's move over to talk about some other things. Can we have an update on the various staffing reviews being conducted with the Registered Nurses' Union, NAPE and CUPE, please?

MR. HAGGIE: I'm sorry …?

MS. COFFIN: The staffing reviews being conducted with the RNLU – no?

MR. HAGGIE: RNU –

MS. COFFIN: Thank you.

MR. HAGGIE: – NL.

MS. COFFIN: And CUPE and NAPE, please.

MR. HAGGIE: Yes, there is a process that was a side letter around the RNU collective agreement that was negotiated with Finance. That undertook a core staffing review. This was to address the RNU's concerns, particularly, at that point, around the number of staff, the acuity of patients and these kinds of things.

That was determined to – originally was going to do, I think, four facilities. After further discussion, we increased it to five with the agreement of the RNU. Essentially, this is a snapshot. There has been a steering committee; it contains us, the RNU and RHA representatives.

The actual going out to get the consultant was kind of stalled a little bit. The RFP was not completed at the time COVID started, so it looks like the core staffing review will get pushed out into next year, possibly even into next fiscal year, say, into April. The cost to complete it is unknown. We are kind of working on the half-a-million-dollar mark.

Separate from that were discussions with NAPE around long-term care staffing. There are two mechanisms there that were put in place; one is a provincial working group to look at the issue from a provincial perspective. There were also concerns that were brought forth, particularly about Eastern Health, so there is also a second group focused more particularly on the issues that might be particular to Eastern Health.

We met with NAPE and their senior representatives virtually, of course, and had a very good meeting about moving ahead with this. Both parties accepted that it had kind of gotten, not mislaid or sidelined but everyone else's – the focus of all parties had really been COVID, worker protection and dealing with the kind of hot-button issues there. That's been rebooted and certainly the provincial committee has met. If I'm not much mistaken, the Eastern Health committee has met. Everybody there now is conscious that we need to do something with this.

Mr. Earle acknowledged that we had made significant inroads in terms of allocating extra places. I think there are 96 new PCA seats with CNA and I think there are 168 new LPN seats across various places. Some of them are

completely enrolled. I know the course in Gander is full; they have 24 out of 24. I think Grand Falls still has some vacancies.

We also acknowledge that it's 26 weeks for a PCA to graduate. There are some mechanisms that we can use to address in the medium, in the shorter term, but we have acknowledged that we need to seek their views on what solutions they think might help because we need to do something sooner than later.

The other interesting discussion was around what we could look at and monitor that would be like the canary in the coal mine, to keep an eye on whether the situation in any facility was getting better or worse. NAPE said they would come back with some suggestions for that and we'll be happy to implement that.

That's kind of a snapshot of where we are with those processes. We don't have all the answers immediately, but I think there's a real desire on all parts to get it fixed.

MS. COFFIN: I concur; I've heard it from all parties. It's very good to hear that we're making a little bit of progress on that, so that's excellent.

Oh dear, my computer just shut off. Darn.

MR. HAGGIE: It's nice to know it does it to you as well.

MS. COFFIN: Oh totally. It hates me, but that's choice words flung at it.

Can I ask how many people have accessed services under the Home First philosophy and avoided hospital admission?

MR. HAGGIE: You can indeed. I just need to find the right page and I'll let you know.

CHAIR: Ms. Coffin, I'm going to perhaps rule that might be a little bit outside of the sections that we're dealing with.

MS. COFFIN: Okay.

CHAIR: I think you're kind of in the Community Services. Maybe it's just the Chair being bored but I am trying to keep us focused on the sections.

MS. COFFIN: Sure and I wasn't quite sure. I have it grouped under the first section, but I wasn't quite sure. There are a lot of large aggregations of numbers.

Personal home care standards, in this section?

MR. HAGGIE: I'm sorry, I –

MS. COFFIN: Would personal home care standards fit in under this section?

MR. HAGGIE: I'll leave that to the Chair. I mean personal home care standards would probably fall under long-term care, Community Services.

CHAIR: Community Agencies. Yeah, same.

MS. COFFIN: Okay, I'll move that. That's no problem. Enhanced care as well.

Autism strategy?

MR. HAGGIE: That would probably be Community Care too.

MS. COFFIN: Okay, no problem.

MTAP, she says hopefully?

MR. HAGGIE: Yeah, that's a departmental program.

MS. COFFIN: Excellent. Okay, let's go with that one.

MR. HAGGIE: Departmental Operations, yes, for sure.

MS. COFFIN: Have you completed the revised policy for the MTAP for income support clients?

MR. HAGGIE: No.

CHAIR: Your time is up, Ms. Coffin.

Mr. Brazil, any further questions on these first sections?

MR. BRAZIL: No, just waiting to move on to section two.

CHAIR: Mr. Lane?

MR. LANE: I had one question, I suppose. It's a COVID-related question so I'm not sure where that falls. There's no section here called COVID-19, so I guess it covers everything.

I just have a question, Minister, about essential workers and COVID. The question is kind of spurred by what happened in Labrador. I understand it's under investigation. I'm not asking for any specifics about the investigation but in a general sense, because a number of people have asked me and I'm trying to get my head around it, I understand that if you are deemed an essential worker, say, on a construction site – we've seen it in the past at the Core Science. A person can come in, they don't need to self – well, they can come in, they can get off the plane, they can go to work. After they're finished their shift, they go and they self-isolate and they go back to work. But the bottom line is they get off the plane and they go to work.

I understand that to be, generally, the policy and has been, certainly, with construction, but in the case of health care it seems to be like now we're into a totally different realm altogether. Now you're taking someone off an airplane from somewhere that has COVID-19 – a province that has COVID-19 – outside the Atlantic bubble and placing them right in a health care facility.

So I'm wondering is that possible? Again, I'm not asking about this situation, the investigation, but, under the current rules, could an essential worker get off a plane, outside the Atlantic bubble, and go right into a health care facility and go to work, without having to be tested, without having to self-isolate for a week or two weeks before they go into that health care facility?

MR. HAGGIE: The issue around essential workers in health care has been a balance about maintaining services and having some services and the issues that we're dealing with. So around essential workers in health care, if they are from a discipline that will allow you to come and work from home and isolate – and there are some, I'm thinking of radiology, non-interventional radiology – that is the preferred approach.

The designation of whether or not they're essential is made by the RHA, the regional health authority. The exemption is you are exempt from the requirement to self-isolate whilst travelling to and from work and at work. Having said that, there are COVID-specific precautions that are expected to be taken by the worker while at work. Those vary, but, in general, they would be things like masks.

Now, on top of that, the regional health authority may well have additional requirements in terms of PPE usage by the worker who's come in, but that is the current situation.

Obviously, given the issues that we're discussing now, part of the inquiry will be whether or not Public Health feels that should change. Certainly, there is unanimity of viewpoint that the tests that are currently available do not answer the question: Does an asymptomatic person reliably not have COVID? That has been the challenge for Public Health across the country. You can mitigate against that by various strategies. Whether ours is enough will become apparent as a result of the inquiry and discussions with Public Health across the country.

MR. LANE: Okay, I appreciate the answer.

I'm sure a lot of people would – I do have a concern about someone getting off a plane and going right to a health care facility.

If somebody, for example, again is going – even if they're not going to a health care facility, even if they're going to a construction site, for that matter, is there a plan, for example, somebody is hired by the government to go into a health care facility, they can get off the plane, they can go to work. There are PPE and all that good stuff, I understand.

Now, this person is supposed to go home, is there like – are they met by someone? Would there be a contact person in place for them to say, listen, you've got to go home, but if you had some sort of emergency that you required something at the store, besides a bag of potato chips, I'm just going to say something that would be an essential item or something, that there's a plan to get that to you so that you're

not feeling that you have to break the rule and go out to the store and get it yourself?

MR. HAGGIE: There is an expectation that for an essential worker who is self-isolating, as a requirement, the employer would make sure that their ability to self-isolate is safeguarded. So, for example, they would arrive, a car would be there for them at the airport or transportation arranged in a COVID-friendly fashion. They would have a fridge stocked with goodies and arrangements would be made to replenish that over the course of the two weeks that they would have to follow that modified isolation. So, that is there.

What an individual RHA might do, I would have to point you to the regional health authority in terms of how that was actually operationalized. Whether it was the manager or the director or someone from HR, it would probably vary, but that's the expectation.

There is also an on-boarding process, anyway, for people who come in from outside to this kind of work; there always has been. Labrador-Grenfell has used these kind of workers for decades in one way or another and each of the RHAs has a need for some from sometime or another.

In terms of that, that's modified for COVID so that there is an understanding of what the terms and conditions of their isolation and work are. My understanding is, in actual fact, that's even signed by the employee.

Those are the kind of broad-brush outlines of what would happen in the circumstances you described.

MR. LANE: Okay, and I appreciate that.

Just to be clear, I'm not talking about – I'm glad that they're going to stock up the fridge, that's all great. But it was suggested: Well, what about if that person had a bad headache and they needed some Tylenol, or whatever, or they needed maybe a feminine hygiene product, or something, that unexpectedly you needed it, how do you get it? Would there have been some process that I can call someone who's going to get it for me? Given the fact that I'm not from here, it's not like I can call my brother or my sister because they're over in Saskatchewan, or wherever they're to. So make sure there's a plan that if someone did need something that that wouldn't give them a reason to breach their agreement, so to speak. I don't even know what happened in this case, but I do appreciate that.

That's all I have. I have other questions, but I think under this category, I'll put them somewhere else.

CHAIR: Okay, thank you.

Ms. Coffin, anything final?

MS. COFFIN: Nothing on this section.

CHAIR: Okay, great.

Madam Clerk, let's vote in this section.

CLERK: 1.1.01 through 1.2.02 inclusive.

CHAIR: Shall 1.1.01 through to 1.2.02 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

This section of the Estimates is carried.

On motion, subheads 1.1.01 through 1.2.02 carried.

CHAIR: Madam Clerk, next section.

CLERK: 2.1.01 through 2.3.01 inclusive.

CHAIR: Thank you.

Mr. Brazil, you may commence.

MR. BRAZIL: Thank you, I appreciate that.

I'm going through some of the line items there, particularly around the allowances part of that.

You announced funding for $2.3 million for 14 new drugs. Can we get a list of those drugs?

MR. HAGGIE: Yes, you can.

MR. BRAZIL: Okay, fair enough.

MR. HAGGIE: In actual fact, one of those drugs was actually withdrawn on an emergency order yesterday, so I'll make sure the list is modified.

MR. BRAZIL: Okay, I appreciate that.

Under Professional Services, what are the amounts there for?

MR. HAGGIE: This is 2.1.01?

MR. BRAZIL: Yes.

MR. HAGGIE: Yeah, okay.

The increase under Professional Services is for the new updated drug – hang on, what's the expression – the Newfoundland and Labrador prescription drug real-time claim adjudication system, and it's an increase of $44,000. The countervailing is we had budgeted $100,000 for system enhancements, which were actually not required in 2019-20.

MR. BRAZIL: How was this set up again? Just explain that to me.

MR. HAGGIE: Every claim for NLPDP recipients, when they go into the pharmacy and show their drug card, this is routed through this system, reconciled with their eligibility and then the payment is then allotted to that pharmacist.

MR. BRAZIL: So this is on a contract basis?

MR. HAGGIE: It is. It's been renewed and retendered, or re-RFPed repeatedly. Bell are the current winners of that process. This is a new contract and it is $44,000 dearer.

MR. BRAZIL: When does this one expire? When you say new, like this year done, last year?

MR. HAGGIE: It was started in 2019.

MR. SMITH: The current one is three years and this is year one.

CHAIR: (Inaudible.)

MR. SMITH: Sorry?

Three years, starting this year. Bell actually provided the service before. It went to market and they won it again. It commenced this year.

MR. BRAZIL: Okay.

Any challenges with the vendor providing the services?

MR. HAGGIE: No, it was a seamless transition, in actual fact, because they already provided the service before. That was one of the features of the RFP. To become eligible to submit, they actually had to get a separate transition plan – if they were a new vendor – approved before they'd be eligible to submit a claim for the service.

MR. BRAZIL: Okay, appreciate that.

Under Medical Care Plan, 2.2.01, Physicians' Services, can you give us a breakdown on what that would cover under that heading?

MR. HAGGIE: 2.2.01.

MR. BRAZIL: Professional Services.

MR. HAGGIE: Yeah, sure.

MR. BRAZIL: A substantial amount of money, $372 million.

MR. HAGGIE: Yes, it is.

It will cover all fee-for-service physicians, on-call payments and surgical dental work under the heading of 2.2.01. There is an increase there which is $2.89 million. $5.5 million is allocated for increased utilization. That's been a kind of ballpark figure year on year.

$44,000 was reprofiled to the NLPDP for the cost increase on the contract. $250,000 was reprofiled to Departmental Operations to hire a consultant. $61,000 was reprofiled to Departmental Operations for the CIHI agreement. $73,000 was reprofiled to operations for the review board hearings for physician audits. $80,000 was reprofiled to Debt Expenses to cover the lease payments of the Burgeo, Port Saunders and St. Lawrence health centres.

$2.1 million was reprofiled to RHA Purchased Services for the increased uptake to the 811 HealthLine. That covered Fonemed and you remember the Red Cross were also accessible for people who had difficulties with physical self-isolation in terms of shopping and that kind of thing. $2,423,000 of the $2,610,000 reprofiled was one time only. That's available due to reduced activity during COVID.

MR. BRAZIL: Okay, appreciate that.

The difference, the $11 million less in 2019-20, was that the last few weeks of COVID that this money was spent?

MR. HAGGIE: It's basically a drop due to less than anticipated utilization. The payments go out biweekly so they do fluctuate, but they were significantly lower towards the end of the year because of, actually, Snowmageddon, not COVID.

MR. BRAZIL: Okay, fair enough.

There is a little over a $500,000 increase there in the next year. Is that to cover anything specific or is it just natural increases?

MR. HAGGIE: That's part of the puts and takes with an increased input for increased utilization.

MR. BRAZIL: Okay.

The Grants and Subsidies are pretty even across the board. Outline exactly where that goes.

MR. HAGGIE: Those are a mix. The salaried physician payments come out of this pot, rather than fee-for-service. The Canadian Medical Protective Association subsidy is the physicians' medical malpractice insurance. They are subsidized for all physicians, but it comes out of this pot. It's subsidized at the rate of about 75 per cent.

MR. BRAZIL: How many physicians would this cover?

MR. HAGGIE: That would be the salaried ones. I can get you the number. It will be a snapshot. I have it possibly in one of two places and it's not there.

Can somebody give me the page number again?

CHAIR: Look to your left.

MR. HAGGIE: Page 25. Thank you.

It said nurse practitioners first; I didn't read the next page. Better not tell the NLMA that.

We have, as of May 1, 2020 – so it's a snapshot on that day – a total of 1,447 licensed physicians in the province, of whom 707 are family medicine and 740 are specialists.

MR. BRAZIL: Fair enough.

Question: Your budget is actually going up; could you just clarify what additional things will be there for 2021, the $14 million?

MR. HAGGIE: Sorry, which line is going up, Mr. Brazil?

MR. BRAZIL: Pardon me?

MR. HAGGIE: Which bit did you say? I missed the beginning.

MR. BRAZIL: Under the budget line it's up by $14 million from 2021 from what you spent in 2019-20.

MR. HAGGIE: Under Grants and Subsidies are we talking about?

MR. BRAZIL: Yes, under the Professional Services.

MR. HAGGIE: I'm sorry; I still haven't quite caught which line it is. Could you just tell me again?

MR. BRAZIL: Okay, sorry, I jumped back up in the drug program.

MR. HAGGIE: Oh right.

MR. BRAZIL: I'm sorry, I just noticed. Sorry about that.

MR. HAGGIE: Okay.

2.2.01 – I'm sorry I'm kind of lost; I'm trying to find $14 million here. Would you just enlighten me as to which line we're actually looking at?

MR. BRAZIL: $358 million to $372 million what was actually spent in '19-'20.

CHAIR: That's under Physicians' Services.

MR. BRAZIL: Yeah, under Professional Services.

MR. HAGGIE: Oh, sorry. That's under Physicians' Services. Sorry, I was looking at the wrong page again. My apologies here.

$358 million to $372 million – the difference there between the Actuals and the Budget, I explained, I thought, with the variance there in the list of $5.5 million for utilization and so on and so forth. That would account for the difference between the $358 million and the $370 million.

Am I missing something, John?

MR. MCGRATH: I think you're looking at the Actuals compared to the 2021 Estimates, correct?

MR. BRAZIL: Yes.

MR. MCGRATH: That's our fee-for-service budget. It realized savings in the previous year due to less than anticipated utilization throughout the year. The payments are biweekly and they do fluctuate. They were significantly lower towards the end of the year, as the minister said, as a result of the state of emergency, Snowmageddon, and also due to COVID-19 towards the end of March as well.

MR. HAGGIE: We saved $11,471,609 on the less than usual utilization. That was Snowmageddon because COVID, under Physicians' Services – we actually have a physician income support top-up payment, so the bulk of this is that eight days and the cleanup.

MR. BRAZIL: I'm trying to remember – and I'm going to try not to bring politics into this – but the former deputy minister only recently saying that there was a plan presented to save $200 million in the health care system to the department. Would that have been included in these salaried physician positions? Would that have been part of the savings plan?

MR. HAGGIE: My understanding of where the bulk of that money was going to come from, it was in out years and I cannot link that to anything in this document.

CHAIR: Okay, thank you, Mr. Brazil.

Ms. Coffin, you are next.

MS. COFFIN: Thank you.

I think there are less questions in this section than the last one, so we can breathe a little sigh there.

Let's start with the provincial drug program. Do you have any biologics included in that?

MR. HAGGIE: Yes, they would be covered under the drug program. Yes.

MS. COFFIN: Okay, that's wonderful to hear.

Have any drugs covered under the drug program been removed? I know we increased the scope. I assume that's under the provincial drug program. We recently announced an increase in – or a number of new drugs have been added to the coverage. Have any of them been taken away?

MR. HAGGIE: I would have to check to get you that list.

By and large, we tend not to concentrate too much on the drugs that have come out because they're usually cents compared with the hundreds of dollars that we add at the other end.

MS. COFFIN: Yeah.

MR. HAGGIE: Over the years, my experience of sitting here is that the drug budget never goes down and that the amount that we need to find some years has been a challenge to get the drugs that we've agreed and got product-listing agreements there. We rightsized the budget somewhat this year and we will just need to keep an eye on that because that is a pressure.

MS. COFFIN: Certainly, I would imagine, as we work more into wellness then perhaps our reliance on drugs will reduce somewhat as a result of that, which will be something to look forward to in half a generation, hey?

I was wondering, you have said that the budget increases this year, amount allocated for the insulin pump, by $1.7 million, and promises a further $3.3 million for next year. Can you expand on how that's going to be allocated? Is there going to be a change in age requirements? Are you going to add people in who were not previously eligible? How do you plan to expand that?

MR. HAGGIE: It will essentially become a universal program for all eligible Type 1 diabetics. It's Type 1 diabetes only.

MS. COFFIN: Yes.

MR. HAGGIE: The issue there in more granular detail – again, I'm trying to avoid relying on my memory in case I misspeak. The $1.7 million is for the remaining six months of this year and it will annualize to $3.3 million.

What it will essentially do is it will be a universal coverage without income tests for children and youth up to the age of 18. Then at the age of 18 it will be provided on an income basis with this program as the payer of last resort, so if there's insurance or income sufficient to cover it within the parameters that are set. So there will be no other constraints on that, except it is for Type 1 diabetes.

MS. COFFIN: That's wonderful. I knew that had been a problem for a number of individuals, especially those who are going to age out of the program. There was some concern if I need my pump before I turn 25 or else I won't get a new pump.

MR. HAGGIE: We dealt with that by removing the age cap as a first step so no one would age out. They'll just keep rolling up, but you're right there were people who had aged out but this will hopefully address that.

MS. COFFIN: Fantastic, that's great news. Thank you.

Is the number of client expenditures in each drug plan in this current year, or in the past year, in the binder?

MR. HAGGIE: I think it is, in actual fact. Yes, it is. We have the various plans listed and we can provide you with the numbers within each segment of the plan. The total coverage is 121,620 recipients across the plans.

MS. COFFIN: All right, that's great.

I think my other questions on that particular section were asked by my colleague here, so we'll go on to Physicians' Services

Do you have a breakdown of the number of family physicians and specialists for each region broken down by salaried and fee-for-service?

MR. HAGGIE: No but that's not too difficult to get for you.

MS. COFFIN: That would be lovely.

MR. HAGGIE: Again, I'll just point out, it will be a snapshot because literally these vary week by week. We tend to simply take a date and use that. That's what we did when I gave the figures earlier to Mr. Brazil, it was May 1.

MS. COFFIN: I imagine they don't vary incredibly throughout the year. You're not going to see variances of 10 or 20 per cent.

MR. HAGGIE: No, no they fluctuate. Sometimes it will be 1,401 and then it will be 1,460 and these kind of things, depending on people coming and going and that kind of stuff because of the temporary nature of some of our staff. We have people who come and visit, want to work while they're here, do so for a few months then their licence lapse and go back again.

MS. COFFIN: Okay, interesting.

I notice that we spend more money on fee-for-service than we do salaried physicians. Can you, for the benefit of everyone here, just explain that a little bit and how that might be good or bad for whoever chooses that particular method of payment? Do doctors get to choose if they want to be a fee-for-service or a salaried? I guess that

kind of depends on where they're employed as well.

MR. HAGGIE: No, it's entirely their choice. If they have the desire to be fee-for-service, they can be fee-for-service. Included in that are a couple of alternate compensation mechanisms. There are things called an alternate payment plan, which is recognized as fee-for-service self, small business income, even though in a sense it would be regarded by others as a fixed payment every two weeks. There are a few of those. There's also sessional where you get paid for a period of four or five hours, that kind of thing. The choice of remuneration is entirely down to the physician.

There is a bit of a shift. Traditionally, going back 10, 20 years, a significant majority were fee-for-service. That percentage has slowly dropped and been balanced by a rise in salary. A lot of newer grads of programs really don't want to be business managers, so they are opting for salary in the first instance.

Just as a further aside, there are challenges in terms of equity to both schemes. So one of the things that is on the table with the Medical Association is around new methods of compensation, particularly in primary care, where the issues you brought up before about seniors, complex patients and these kinds of things aren't really fully addressed by the current fee structure and probably are not recognized in some respects either by salary. So we'll be happy to explore what options exist with the Medical Association as we kind of move forward over this next year or so.

MS. COFFIN: Okay, I look forward to that. That's a very – okay, I have time, excellent – interesting piece.

I guess one of the second questions that would come from that is in terms of the services that we receive for physicians being paid under both of those, physicians being paid under fee-for-service, do you see that they are providing more or the same or less amount of service than the salaried physicians?

I imagine if you're salaried you have a workday and you see as many patients as you possibly can in that workday. You do whatever you are being salaried for, but in your fee-for-service you're being tracked as a business manager. You get paid for the service that you provide. So if you want to see 50 patients in the run of a day then your fee would be incurred appropriately, and if you want to work for 12 hours that's up to you.

So in terms of what we're getting, do you find that you get an equal amount of output or services provided by the salaried physicians as you do by the fee-for-service, or is that even something that you track?

MR. HAGGIE: It has, quite frankly, been a challenge to track salaried physician workload. In the past, we tried a whole variety of things. I can remember back in my day when I was on the other side of the table, as it were, we actually had a shadow billing system. So salaried physicians could've received 10 per cent of the fee-for-service simply to submit billing as a way of tracking their workload. That failed. Nobody even bothered to do it in sufficient numbers to track.

The regional health authorities do have the data on clinics on site, and these kind of things, for salaried physicians and I think one of the challenges there is simply getting that data, amalgamating it and making it into usable information. That's one of the things that we're certainly looking at with the consultant that we've hired because one of their fortes is data management and analysis. Again, that is harder to track. The fee-for-service is very straightforward. You can look at the billing codes for a given day and you can determine volume from that point of view.

MS. COFFIN: I say this because I don't have my own physician, but when I have gone to them, occasionally, I'll save things up. So I might need a hearing test and I might need something checked out or a prescription refilled and things like that. When you go in you can only talk to the doctor about one thing. You can't save all your stuff up and go in and say: Hey, there's all of this stuff that needs to happen. I guess, that's more of a fee-for-service thing, you can come in and talk about A, but if you want to talk about B you need to make another appointment, versus perhaps the salaried

physician when I can come in and say: I got 15 minutes, here's the things we need to talk about.

MR. HAGGIE: That, actually, is a professional practice issue and the college have a very definite view that there is no such thing as one visit, one problem.

MS. COFFIN: That's kind of what I was thinking.

MR. HAGGIE: They have been quite categorical about that because it has been a challenge, particularly for complex patients and for complex care. I think that has generated some significant heat in the past. The college have said quite clearly that that is not – they don't use the term: standards of practice. They have advised practitioners that they do not expect them to maintain that approach.

In terms of what actually happens during a consultation, fee-for-service is fairly broad in what the requirements are, you simply have to be able to supply documentation to support the billing. In terms of any further discussion about that, that has been a challenge, but my understanding is that it's supposed to be remedied through the physician's own licensing body and standards and that kind of thing.

MS. COFFIN: Okay, thank you.

CHAIR: Okay.

Thank you, Ms. Coffin.

I propose a 15-minute break, so I ask everyone to be back here at 2011, 8:11.

Recess

CHAIR: I think we better – for the interest of recording – ask Mr. Brazil to repeat your question, please.

MR. BRAZIL: I was just talking about the fact that myself and the minister have had some discussions around the number of individuals who don't have access to a physician in Newfoundland and Labrador. Looking at the budget lines here and the different types of models that we have, particularly around salaried physicians or fee-for-services, would the minister share or give me some insight on what he thinks would be the most equitable way to provide it financially while, at the same time, providing the services with the uniqueness that we have in this province, geographically and that?

MR. HAGGIE: Yes, it is a good question. I think the short answer is, there is no perfect way to remunerate physicians. It depends on a whole variety of factors. One of the things we'll want to talk about with the NLMA, in negotiations, is what kind of changes make sense to get the best access for the money and the physicians that we have.

Fee-for-service, by and large, in sense volume and throughput, and there are circumstances where that is exactly what you want. It doesn't, however, value time with the patient in the same way that maybe a salaried physician may have the luxury, in the sense if some people call it that, may be able to do a more thought through discussion about things that patients find of concern.

That's very simplistic and not meant in any way to be a reflection on whatever choice of remuneration physicians have. There are upsides and downsides to both of them. There is no perfect way. The NLMA and us have recognized that and hence some of the discussions from their 10-year college document around the Patient's Medical Home and maybe blended capitation and these kind of things. Because there isn't a way to use compensation alone to address the access issue.

I think one of the things we're seeing very clearly from COVID is that virtual care has a place and it is widely appreciated, but access is our problem. We have argued over the numbers and we'll probably continue to do so, but, I think, physician compensation in a binary sense of either/or isn't the answer.

MR. BRAZIL: I appreciate that. I'm glad you brought up the virtual care because that has been a hot topic and people have utilized it. For all intents and purposes, what I've heard from individuals, it has been beneficial and maybe become a mainstream for some remote communities or access to particular types of specialists and all that.

I know we talked about it a little under the dollar figures, but is there a move to expand that beyond the COVID concept? I would suspect the COVID concept has upped it to a level we wouldn't even have comprehended a year ago, but is this the intent to continue to do that and expand it where possible?

MR. HAGGIE: I mean, I think, virtual care will now become just a part of the way the health care system does business. What we've seen is a migration from physicians who previously would use telehealth, and I use that in the sense of the infrastructure in facilities that Dr. Max House set up back in the '70s and was a world leader at the time, but that hardware is now being used more by allied health professionals who deal with clinical issues in smaller facilities where their services aren't as readily available. It's been a way of defusing some of those outlet, but in terms of physicians, primary care providers and specialists, it's kind of exploded.

I don't see us putting that genie back in the bottle and I would not want to because I think it's really coming in to its own. So it's how best to use the technology, how government, as a whole, fills the gap with broadband so there's a video component and that more face-to-face connection for those people who desire it. But there's certainly convincing evidence even now that the telephone has been an acceptable way of doing business for a significant number of people, not-COVID related; prescription refills, simple, straight-forward acute stuff and the clinician makes a determination as to their comfort level of dealing with it over the phone or virtually. The option is entirely theirs.

MR. BRAZIL: Totally agree and I think it's a great tool in the medical toolbox to address some of the shortfalls that we have or some of the challenges in a province like this.

I did, ironically, have a discussion with a physician from Ontario last weekend on Bell Island who – he doesn't see clients. He has never seen a client in about five years, it's through telephone and discussions back and forth between the pharmacist and these types of things. A full, total different service that seems to be very unique in doing it. He did talk about talking to some of his friends here, the physicians here that since telemedicine because of the COVID or since we've upgraded that and made that a mainstay, that it would see the benefits in particularly to some of the rural and remote communities. So I'm looking forward to seeing how we expand that.

I do ask: Has there been discussions with the NLMA about how we move that to the next level? Because I would suspect some are comfortable, some are not. There may be some additional training, some additional resources that may be necessary. Maybe even some new types of approaches in the medical school in advance of moving this forward.

MR. HAGGIE: Well, certainly to deal with the latter point, we've had exchanges with Dean Steele at the faculty about how to not just train residents, but also how to train preceptors so they can mentor residents in virtual care, because that's not necessarily a skill set they would've had before, simply because of the fact that they don't necessarily have an awful lot of experience with virtual care.

We had put in place what was originally a time-limited, temporary, virtual care code system. We have lifted the time restriction on that without really any concerns. In terms of how that looks and how that goes forward, I think that would probably now morph into as much a discussion with the NLMA. There may be a negotiations piece rather than necessarily a great policy piece.

MR. BRAZIL: Fair enough, I appreciate that.

I'm going to a line item now, and try to keep moving as part of that. Under the Dental Services, 2.2.02, under Allowances and Assistance. We originally in 2019-20 had budgeted $200,000. The actuals were $63,000, now we're budgeting $100,000. A little bit of clarification on why the $63,000 and, obviously, that may have a bearing on why the $100,000?

MR. HAGGIE: It's the way that the accounting is done. This is for dentists that are paid opted out, so they charge the patient and we reimburse the patient. Less dentists are opted out and so that amount goes down, but there may be a corresponding rise under Professional Services where the direct payments to the professionals is recorded. So that's why one's gone down. But if

you look at the Professional Services line, you'll find that that's adjusted.

MR. BRAZIL: Okay. So I'll assume there that there's no reduced service being offered, it's just being picked up in a different manner.

MR. HAGGIE: No, it's simply a mode of payment. They've gone from one box to another.

MR. BRAZIL: Okay, fair enough.

I just want to go back a bit. The attrition plan that was put forward, is that still being followed within the department?

MR. HAGGIE: There were various attrition plans that were being put forward. The short answer is that we're probably coming to the end of attrition in a sense of yielding significant reductions in the workforce in Health. There are still workforce adjustments that need to be take place and where we need to alter skill sets we're not minded to lay people off, but we would wait until that individual transitioned into something else and fill the post with a different skill mix.

MR. BRAZIL: Fair enough.

One last question there. We've all been lobbied by certain interest groups, particularly around the seniors' dental program. Has there been any discussion around expanding the seniors' dental program in the coming year?

MR. HAGGIE: It's a source of continuing discussion. The bottom line is that we're in the middle of the pack from a provincial point of view. I think the comment I made in answer to an earlier question is: Given our fiscal restraint what we would like to do and what we're able to do fiscally don't quite match up.

Certainly, we are aware, in terms of wellness and this kind of thing, that oral health is important. It's a question of how to find the wherewithal to do that. Maybe in time there would be an opportunity to shift resources, but at the moment we haven't been able to find that. Where we are is not the best place. It's not the worst place either.

MR. BRAZIL: Fair enough.

I'm good there.

CHAIR: Thank you.

Ms. Coffin.

MS. COFFIN: Thank you very much.

Let's chat a little bit about Physicians' Services. Can you tell me how many new primary health care teams were established in private clinics under the primary health care renewal program in the last year and how many do we expect for the current year?

MR. HAGGIE: I can't give you the exact number for that. That program, the Family Practice Renewal Program, is funded by the department, but the money is held and the secretariat is located in the NLMA. I would have to go and find that out for you. No problem.

MS. COFFIN: That would be lovely. Thank you.

This question is especially for my colleague in Labrador West. He would really love to know what we are doing to recruit more doctors.

MR. HAGGIE: It's interesting. We have had a very good meeting with the new president of the NLMA. I think both parties acknowledge that recruitment and retention is an issue. We don't do badly. Sixty-five per cent of Memorial residents are still practicing in the province at 10 years, which is on a par with other jurisdictions.

I would like to see that a lot higher. It's actually not usually an issue about compensation; it's more an issue about lifestyle. It's more an issue, I think, as well, about support for entry into practice as they come off their residency programs.

We alluded to the discussion about salary versus fee for service. I think there is a certain reluctance now for physicians to engage in business management. There are those who still like it, are adapted to it and wired that way, but not everybody is. I think that mitigates against fee-for-service practice.

They would also like to work in the environment that they were trained in, which is very much a

team-based approach. I think one of the synergies, as we roll out more with the primary health care teams, is that they will become more attractive to a larger proportion of residents. Those are more medium- and longer term issues.

The challenge quite frankly, locally in Labrador West, was about air services, because these physicians, while they lived in Lab West, they did turn around with their families who lived in other jurisdictions. I don't know that we have an answer yet – certainly not in Health – to what to do with the airline industry. If you have a magic bullet, then please share it. I think that will certainly help.

We have increased nurse practitioner positions in Labrador West to provide extra primary care. Again, I would reference for the non-urgent episodic care there is now virtual consultation by phone or by video with a nurse practitioner. That will help take some of the strain off. It is not a substitute but there is continuity available there, through that nurse practitioner consultation process, because it's wired into HEALTHe NL. The other doctors there would be able to access that without any difficultly at all times, should they need to.

MS. COFFIN: Two comments on that a little bit. I was in Corner Brook over the summer and the hotel I was staying at – it was a new hotel, it's a lovely spot. There was a guy going around with a video camera and we were curious: What are you doing? He said I'm doing a recruitment video for, I think, doctors; it might have been for the university, I'm not sure which one.

They were showcasing what Corner Brook had to offer and that was going to be a part of the recruitment strategy for professionals, so good job on that. It was a lovely sunny day and a beautiful hotel, so that's a really special piece. I think that will help change people's minds. I certainly hope so.

In particular, in Labrador, the conversations I've had with individuals up there, there's an underground network, of course. When you talk to people about flying out and getting an appointment and, then, when you get your appointment, you find out then you have to come back and you have to have your procedure, but you knew you were going to have your procedure before your appointment.

What they do now is they say: Well, do I have an appointment for a tonsillectomy – I don't know what services are provided, that's just an example. I have an appointment for a consult on a tonsillectomy, so I'll get that consult but I'll also try and book the surgery while I'm there so I don't have to fly twice and make another claim on MTAP, because my first claim on MTAP is 100 per cent, my next claim on MTAP is somewhat reduced from that and it takes a really long time to roll the claims through.

They've had the good sense to at least try and book a procedure at the same time as the consult, if it's all available. It helps them, it's a cost savings for them, but I assume it would also be a cost savings for the department as well. I don't know if that's something that the department or the people who are making these appointments are even considering along the way, because it sounds like a more efficient process.

MR. HAGGIE: Yeah, to coin a phrase of a famous politician: It's not rocket surgery. I did that in Grenfell when it was the old Grenfell Regional Health Services. I knew that people coming to St. Anthony for a consult in my clinic on a Tuesday, who will likely need a hernia repair of a colonoscopy or whatever, I would arrange for the space for them for the following day. In the event there was a no-show or a weather issue, there was nearly always a similar case you could bring in from a more local community.

That's been out there for a long time. I think we need to build in some encouragement to do that. It becomes a challenge in the fee-for-service environment where those physicians whose offices are physically located outside of the hospital or the facility. That has been highlighted as a significant issue with wait-time management and we've had discussions with the previous president of the NLMA, the other Dr. Fitzgerald, about how we can better access information that's held in private physicians' offices about wait-lists, because we really don't know what we don't know.

By and large, in that scenario in Eastern Health, the wait-list that's given to the regional health authority is really an allocation for the next two weeks of operating time for that particular physician. Beyond that, we have no way of knowing what the demand is.

The NLMA undertook to get in touch with their members in that category and feed it back to us. Our wait-time coordinator is waiting to process some of that and see how we can look at a more centralized approach.

MS. COFFIN: I look forward to seeing that. The efficiencies there could be good.

Dental Services: Is the number of clients and the expenditures in the Adult Dental Program and Children's Dental Program for '19-'20 in the budget? So number of clients and expenditures.

MR. HAGGIE: One moment.

MS. COFFIN: That can be a yes or no, because if we're getting the budget it will be great.

MR. HAGGIE: I just need to have a quick look at my stuff.

MS. COFFIN: Sure.

MR. HAGGIE: I'm not sure that it is but we can certainly find that number out for you and make sure that it is provided.

MS. COFFIN: Excellent.

I think the answer to this was already given. I have a question here about the Professional Services was slightly under budget at $1.5 million, but I think that was because of the Snowmageddon?

MR. HAGGIE: Yeah.

MS. COFFIN: Yeah, that's what I thought. Okay, good, I have been paying attention.

Faculty of Medicine at MUN. The faculty has the same budget amount this year that it had last year, after five years of cuts. They've actually spent almost $5 million more than budgeted in the last fiscal. Is the budgeted amount realistic or ought it be – well, I guess a little too late to adjust it now.

MR. HAGGIE: The feeling was in discussions with the dean that this was a one-time structural issue that could be addressed and that thereafter we would examine it on a year-by-year basis and see. We felt, from the department's point of view and from Finance's point of view, that this was where the number should be. Obviously, we'll find out if we're right in a year or so time.

MS. COFFIN: Good enough.

Oh, and good news, that's all my questions for this section.

CHAIR: Okay, Mr. Lane.

MR. LANE: Thank you, Mr. Chair.

So a couple of questions I had have actually been asked. I would just add to what my colleague from the district of –

MR. BRAZIL: Bell Island.

MR. LANE: Bell Island, there you go.

MR. BRAZIL: Bell Island is good.

MR. LANE: Bell Island is good – that I, too, have received a number of calls from people about the seniors' dental program. I understand it's a budgetary issue and it was removed in 2016, I believe. I hope we get to a point that we can get it back. I've personally seen some pretty sad, heartbreaking cases, I'll say. A couple of them we got resolved because of underlying medical conditions, but some of them are still tough on people.

Just a quick question on the Insulin Pump Program. I know this was asked as well, I think it's great news, I just want to confirm that it is what I think it is. Of course, in last year's budget, we expanded the insulin pump to once you were older than 25 you would continue on with the insulin pump, which was great. The problem was, at the time the policy came in, if I was 26 or I was 30; you said, well, it would carry on if you were younger than 25 at the time. So am I to understand now if somebody is 27

years of age today that now they are going to get an insulin pump?

MR. HAGGIE: If that is the recommendation of a physician –

MR. LANE: Yeah.

MR. HAGGIE: – and they have Type 1 diabetes, they are eligible for the program.

MR. LANE: Yeah.

MR. HAGGIE: The only question then would be around the financial piece as to whether or not they had insurance.

MR. LANE: They qualify and the means, yeah.

MR. HAGGIE: If they did, we would expect them to draw down on that first.

MR. LANE: Yeah.

MR. HAGGIE: We are going to be the payers of last resort.

MR. LANE: Okay, but it does resolve that issue. That's excellent. That's a proactive move there, for sure.

I'm just wondering, Minister, are there any current issues around people skipping appointments and stuff? I know there has always been this issue of trying to get to see a specialist, or whatever, and then people don't show up and then that's a space that someone else could have had. Then there was the issue of: Was the health authority calling, were we calling people to remind them of their appointments and all this kind of stuff? Is that issue kind of resolved now or are there still a lot of people missing appointments?

MR. HAGGIE: The situation has improved. There is an automatic notification system now in use across a variety of clinics and a variety of locations. Any no-show is a double opportunity loss because the person, obviously, has missed their care opportunity and it deprives somebody else of the opportunity.

MR. LANE: Correct, yeah.

MR. HAGGIE: My information – although, I don't have a number at the moment to quantify it in any particular place – is that the automatic notification system has gone some considerable way to help reduce that.

MR. LANE: Okay, that's good.

MR. HAGGIE: It's a work-in-progress. I doubt you will ever get to zero. The system engineers will tell us that somewhere between 3 and 5 per cent is ideal, and maybe up to 10 per cent is acceptable. We were running at 30 per cent in some areas and that seems to have faded.

MR. LANE: Good. Well, that's good news. I'm glad to hear that because, as you say, what a waste of resources.

I guess this would relate to Physicians' Services, even though I'm not going to ask about a physician, per se. Nurse practitioners, I know last year, I believe, there was a move made, as it related to nurse practitioners, they could have their own practice and so on, which I see could possibly be helpful in some of the more rural areas and stuff, where you can't get doctors and so on. Not to replace a doctor, but, certainly, would be a good help, I would think.

Obviously, if those nurse practitioners are working for the health care authority and they're doing their travelling clinics, or whatever they do, that's all fine and dandy, that works. It was also said that a nurse practitioner could open his or her own clinic, but that is not going to work unless they can bill MCP because most people are not going to go and pay a nurse practitioner, or anybody for that matter, out of their pocket for the service.

Is there any plan to expand the program that you currently have for doctors, for physicians, to allow nurse practitioners to have a clinic and actually charge MCP?

MR. HAGGIE: I'll take a backwards answer. I think that there's a role for nurse practitioner-led clinics. We certainly opened that kind of discussion with the RNU and, through them, the Association of Nurse Practitioners. One of the challenges, and we've discussed it before, around physician compensation is what exactly do you get with a salary? What exactly do you

get with fee-for-service? The general dissatisfaction in primary care and complex care with fee-for-service as a method of compensation.

From a philosophical point of view, I don't think it is any merit in repeating the mistakes as it were or the errors that have come out with using fee-for-service for nurse practitioners in the primary care setting. The question then is what model of compensation would be appropriate? I think that's a discussion we have yet to engage in with the RNU who do the kind of other side of the table discussions.

I think the other thing is as well, MCP is probably not the place to put a budget for nurse practitioners, necessarily. That would be how I would answer that question, it's a kind of categorical approach, but I think there is a role. Certainly, we're looking to Ontario and other such jurisdictions to see how their nurse practitioner-led clinics are working and see what we can learn from that.

It's difficult, and I've said it before, to transpose directly a model from one jurisdiction to another simply because the environment, the ecology of health care here is different than in Ontario or other provinces.

MR. LANE: Sure. Thank you for that, Minister.

I guess my next question is – it kind of ties into it to some degree and we've talked about this many times in this House of Assembly and so on, over the years – scopes of practice. I guess that does kind of tie into the whole nurse practitioner piece. It ties into pharmacists. I know that you expanded some of the things, but do you see more – and you would know, I honestly wouldn't – opportunities to expand scopes of practices whether it be through nurse practitioners, whether it be through pharmacists, whatever, more things we could be doing to help alleviate some of the strain and perhaps even make the system more efficient and possibly more cost effective?

I know that's a big, broad question but –

MR. HAGGIE: It's a very good one. I think there are a lot of opportunities just on a fairly low-hanging fruity kind of approach is community paramedicine. We have community-run ambulance services who are really keen to get into the idea of paramedics doing wellness checks. We have some pilot schemes. I think Lourdes on the West Coast is one where there is a paramedic-delivered primary care kind of a community outreach approach. With now growing our own advanced care paramedics, I see the possibilities just keep opening up in that regard.

Similarly, we have midwives. They have a really expanded expandable role in women's wellness, sexual health and reproductive health. Their scopes of practice cover that from an education and a treatment point of view. I would love to see them, as we get the numbers to grow, to use them in that kind of setting.

If you look there are other disciplines, almost anywhere, where they do not actually practice to their full scope of practice. They practice the way that history has kind of dictated it. We have optometrists who would love to do some simple screening for simple eye conditions or even things like glaucoma, maybe get involved in the management of simple eye conditions or eye aliments.

You referenced pharmacists. Now the clinical components, as it were, of that, the diagnosis and assessment piece, is baked into the Pharm.D. degree. Now all our pharmacists, when they finish, will have that degree. We transitioned away from the B.Sc., where they tried to introduce some of that, but you kind of needed add-on components. Now for a Pharm.D. it's simply maintenance of competence approach, which is common to physicians and nurse practitioners, for example.

So, yeah, is the short answer and I just elaborated on a longer version.

MR. LANE: Thank you, Minister.

I do have a few other questions but I think they would probably fall under section three, so I'll leave it for now.

Thank you.

CHAIR: Mr. Brazil, do you have further questions on this section?

MR. BRAZIL: No, I'm good on that section.

CHAIR: I think Ms. Coffin said she was happy.

Madam Clerk, let's vote on this section.

CLERK: 2.1.01 through 2.3.01 inclusive.

CHAIR: Shall 2.1.01 through to 2.3.01 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

This section of the Estimates is carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

MR. HAGGIE: Mr. Chair, I have some numbers related to questions, rather than sully the next heads of expenditure.

CHAIR: Let's not sully.

MR. HAGGIE: Let's not sully, okay.

Home First clients to date: 3,700. Adult Dental 2019-20: $2.26 million, 5,695 patients; and Children's Dental: $7.89 million, 37,697 patients.

CHAIR: Okay, thank you.

Madam Clerk, final section.

CLERK: Health and Community Service Delivery, 3.1.01 and 3.1.02.

CHAIR: Thank you very much.

Mr. Brazil, you may commence.

MR. BRAZIL: Thank you, Mr. Chair.

Under Supplies I just noticed the $1.6-million difference there. Can the minister outline the difference there from 2021 to now?

MR. HAGGIE: Certainly. Additional flu vaccines due to the anticipated increased uptake. Funding was reprofiled from our out-of-province payments budget. Not that many people are out of the province and seeking care. That's flu, that's in anticipation.

We have bought well over 400,000 doses of this year's flu vaccine and we have the supplies to deliver that too. The feds, at some point, have agreed to do it but I'm not sure where the money is yet. They have agreed to pay for seniors in personal care homes and long-term care.

MR. BRAZIL: For their vaccines?

MR. HAGGIE: Yes.

MR. BRAZIL: Okay.

MR. HAGGIE: That was part of their COVID initiative. Because of the way it was defined originally, it would only have included people in formal long-term care facilities, but yours truly had a word with the minister and she came back with an amendment for us.

MR. BRAZIL: So they'll pay for the vaccine but not the actual administering of it?

MR. HAGGIE: No. I mean we actually administer it anyway and always have done. It obviously requires staff but that's kind of built into our system. It's usually rolled out in advance of the publicly available flu clinics so they get a head start.

MR. BRAZIL: I read somewhere the other day and I saw three different numbers, three different payment schemes – or scheme is not the right word, processes – one for doctors, one for pharmacists and the third one was for, I'm going to say, licensed practical nurses, but I don't think that's what it was. I saw three different amounts.

MR. HAGGIE: We only have the two that I'm aware of. The physician code for vaccines, which was removed, has been temporarily reinstated for this flu season with a series of riders about involvement and using documentation. We have a new vaccine surveillance documentation system which is electronic, so we need to use that. There is their old fee code re-established.

The pharmacist fee code is simply an extension of eligibility for the code. We previously paid for NLPDP clients; it's now available to all.

MR. BRAZIL: What's the difference in the costing?

MR. HAGGIE: It's 13 versus 1706, I think.

MR. BRAZIL: Okay.

MR. HAGGIE: Those are historical fees. We didn't mess with them; we just got on with it because it was COVID.

MR. BRAZIL: Historically, where are most being administered?

MR. HAGGIE: The vast majority of vaccines last year were administered in Public Health clinics. The physicians beat out pharmacists last year. The pharmacists had been increasing. They never got past 9,000. Their eligible base at that time was 127,000, but they only ever managed to vaccinate 9,000 of them. The physicians – I was speaking from memory but it is 6,000 or 7,000.

MR. BRAZIL: Okay, thank you.

Are the vaccines here now? Do we have them or are they …?

MR. HAGGIE: I think the first lot has been delivered but we can check on it. It comes in two or three tranches because –

MR. BRAZIL: Are they distributed equally? Like physicians so much, your own health officials and then the pharmacists when they apply?

MR. HAGGIE: It's distributed through – the vaccine program is based in Public Health. The bulk of the storage, I believe, is in Eastern Health and then it's sent out to the RHAs. There has been a mechanism in the past for supplying physicians who are going to hold vaccine clinics. I think that's going to be reactivated. I'm not sure of the exact arrangement with pharmacists. That may have changed but I'll check.

MR. BRAZIL: Okay, I appreciate that.

Under the same heading, 3.1.01, under Professional Services, the change from $430,000 to $1.26 million in 2020-21, what does that include?

MR. HAGGIE: The increase is due to $300,000 for the core staffing review which we allocated, which I referenced earlier on with the RNU. $530,000 was reprofiled from Grants and Subsidies. It's funding for a new contract for lab accreditation. It was in the wrong place before. It should really have been allocated to Professional Services. It wasn't, so that's been moved over. It was in Grants and Subsidies and shouldn't have been.

MR. BRAZIL: Okay, appreciate that.

Under Purchased Services, the almost $15 million, up $8.7 million, what's included in that now, or is it (inaudible)?

MR. HAGGIE: The increase is money that's come in to cover increased uptake for the HealthLine. That's $2.1 million. $3.3 million has been reprofiled into this for funding nurse practitioner virtual care and $3.30 million was provided to address a structural deficit in our component of the air ambulance service which is around contracts with PAL and EVAS.

MR. BRAZIL: What approvals are there now for capital equipment and how are these connected to the regional health authorities?

MR. HAGGIE: The capital equipment, there's been some discussion – and I would have to defer to staff, potentially – around the fact that all infrastructure money was to be held by Transportation and Infrastructure. There is a discussion at the moment about bringing some of that back because of the fact that it relates to repairs and renovations. At the moment, I think, just shy of $100 million has been taken from our Capital and moved to TI, but TI and us both agree, some of that, maybe $30, $35 million may have to come back.

MR. BRAZIL: Okay, fair enough.

Under Allowances and Assistance, give us a breakdown on what normally would be covered under that.

MR. HAGGIE: The Allowances and Assistance is insured services. It's MTAP which is $3.34 million and $6.4 million for income support medical travel. There's bursary programs for physicians' services which amounts to $1.69 million and there's money there for workforce planning which is $2.034 million.

MR. BRAZIL: The big heading, Grants and Subsidies, take us through the breakdown.

MR. HAGGIE: Do you want a breakdown by regional health authority or –

MR. BRAZIL: No, just a general concept of what's covered.

MR. HAGGIE: So what's in there is care and services received by the residents of Newfoundland and Labrador in RHA operated facilities. That's health centres, long-term care, acute care facilities and group homes are included in there, too. Direct services would include: nursing, diagnostic, therapeutic and such. Indirect include: dietetics, corporate services, planned maintenance and things like that.

It also includes community-based services, so that would be public health, continuing care, home support. It's a share the province pays towards the Canadian Blood Services, the recruitment program for donors, fractionated products and those kind of things.

There is money in there for NLCHI, the Centre for Health Information. Public health lab comes out of that. Emergency medical transportation services come out of that and there are some renovation monies in there, too.

The overage and actuals is related to severance reimbursements, nurse retro and some stabilization funding that wasn't accounted for in the original budget. The savings from stabilization were one-offs.

MR. BRAZIL: Okay.

We talk about the regional health authorities, and again the budget line, trying to keep them flat. What's the plan if a regional health authority, particularly in this situation now, runs over budget?

MR. HAGGIE: The regional health authorities have expenditure caps on a line of credit and the mechanism there is that the line of credit would deal with that. We have gone some ways towards correcting the structural deficit, but the discussion about the rest would be with the Department of Finance.

MR. BRAZIL: Okay, fair enough.

The new monies that were announced, the $3.3 million recently for the nurse practitioner virtual care services through the 811, where is this budgeted? Can you give us a few more details on how that will be rolled out?

MR. HAGGIE: Yeah, sure. It was reprofiled into the nurse practitioner program. I would have to find my sheet to figure out where it came from to go in the nurse practitioner program. You wouldn't happen to know offhand would you, John?

MR. MCGRATH: That money was placed (inaudible).

CHAIR: John, your mic, yeah.

MR. MCGRATH: $3.3 million was placed into the Purchased Services appropriation. It's under 3.1.01, Regional Health Authorities and Related Services from budgeted to 2021.

MR. BRAZIL: Perfect, okay.

Mr. Chair, I'll come back again on my next round (inaudible).

CHAIR: All right, thank you.

Ms. Coffin.

MS. COFFIN: Thank you very much.

Let's start with Revenue - Provincial. Can you give me some sense of – are we giving ourselves money? How is this working?

MR. HAGGIE: Revenue - Provincial.

MS. COFFIN: That's 3.1.01, Amount to be Voted, 02, Revenue - Provincial, $31 million this year. It's exactly the same as last year, although actuals are less than budget.

MR. HAGGIE: It's a vehicle levy program, third-party liability and reciprocal billings. So the vehicle levy program is what the insurance industry cough up, based on a formula, a sum of money to cover health care costs related to accidents.

MS. COFFIN: Oh.

MR. HAGGIE: The third-party liability and the reciprocal billings are those that we would get from say, Alberta, if an Alberta health care recipient was taken ill here.

MS. COFFIN: Yeah.

MR. HAGGIE: We reimburse the physician at our rate and then Alberta will reimburse us. That's where it would show up here. So the amounts up to March 31 and the accounts receivable were actually in Public Accounts.

MS. COFFIN: Oh, okay, that's enlightening.

Can we have a number of the subsidized home support clients and how many are using the paid family caregiver option?

MR. HAGGIE: Home support clients, let me just find out. Here we go. My binder is falling to pieces under the stress. Sorry, what again was the question?

MS. COFFIN: Number of subsidized home support program clients and how many are using the paid family caregiver option?

MR. HAGGIE: Okay. Of all the information I have here, those two statistics don't actually figure out. We can look for those and provide them for you.

MS. COFFIN: That's fine, okay, lovely. Thank you.

Can we have a list of the number of people on the wait-list for long-term care indicating the number waiting in hospital?

MR. HAGGIE: Yes, sure.

The number I couldn't give you with any accuracy but we can find that for you.

MS. COFFIN: Sure, excellent.

What's the percentage of hospital beds occupied by people waiting for long-term care or home care?

MR. HAGGIE: That fluctuates, and in actual fact during COVID it went down dramatically, which was quite interesting because I would have expected that not to be the case. Just intuitively I would have thought they would have been the hardest to get out but, in actual fact, that wasn't the case.

The percentage varies day to day, but we'll pick a date, snapshot and give that to you.

MS. COFFIN: Lovely, thank you.

Let's see, can we have the expenditures of the number of clients in the medical transportation program and out-of-province travel by region?

MR. HAGGIE: Yes, sure, we don't have the breakdown (inaudible.)

MS. COFFIN: Okay. I'm just wondering if I have a question lofted in on the text there.

This one, it's even noted for me that it might belong to Transportation and Infrastructure: Has the cost of air ambulance been affected by EVAS's loss of routes due to Air Canada's cancellations?

MR. HAGGIE: We're not aware of any changes in our contract with them that could be ascribed to that.

MS. COFFIN: Good.

How many new primary health care teams were established in RHA sites in 2019-20? I'm not sure if I asked exactly that same question –

MR. HAGGIE: You asked a very similar one before and I'll give you exactly the same answer. We'll go find out.

MS. COFFIN: Okay.

MR. HAGGIE: The answer is there are 291 patients awaiting long-term care in the province

and 115 – I think it's 115 – of those are currently in hospital or in a facility somewhere.

MS. COFFIN: Thank you.

Let's see: How many people have accessed services under the Home First philosophy and avoided hospital admission?

MR. HAGGIE: Good question. I gave you the number of home supports that was the 3,700.

MS. COFFIN: Yes.

MR. HAGGIE: But I don't know of them how many have avoided hospitalization. That might be a harder answer.

MS. COFFIN: Yes, I imagine because you don't know –

MR. HAGGIE: You don't know what you wouldn't have done, kind of thing.

MS. COFFIN: That makes sense, of course.

Where are you with the new personal care home standards?

MR. HAGGIE: They are in process. Again, a lot of our policy capacity got kind of usurped over the course of the last six months. One of the things is now we have issued a whole series of COVID-related guidelines around infection prevention and control and COVID-related measures such as cleaning and extras and things like that.

I think there needs to be a look at the standards in the light of that to see if they should be amalgamated in some way. They're still on the drawing board as it were. I'm reluctant to delay the process any longer but really and honestly I think we are in a post-COVID world and it would be daft to do it twice.

MS. COFFIN: Good to hear. I've certainly heard – well, we've all heard – about some of the privatized facilities for seniors and some of the devastating effects COVID has had on those. I knew there were going to be some new federal guidelines come down, but of course we have all public care home – below Level I. I'm not sure if I have the levels right. I'm sorry.

MR. HAGGIE: No, the levels are, again, a part of the personal care home review.

MS. COFFIN: Right.

MR. HAGGIE: We've talked about levels of care related to need, we've talked about standards of care to meet those needs at particular levels and then we've talked about a funding model that will allow money to flow related to those levels of care. That's kind of been like the three-legged stool.

You're right; other jurisdictions do seniors' care differently. Our current levels of care are III and IV for long-term care which are run by regional health authority facilities, with the exception of one historically grandfathered facility. Levels I and II have traditionally been done through the private sector here.

I think just to straighten the record here we have a very good relationship with personal care home operators. I wouldn't like the comment you made about private operators in other jurisdictions to reflect on the private operators here. That's apples and oranges.

MS. COFFIN: That's my understanding as well and I did not want to conflate those. I know I've received numerous calls about: What are we doing about personal home care? I usually respond with: We are very different than other provinces. What you're seeing there, you shouldn't try and transpose that onto our province. Good, we are aligned. I'm happy to hear that.

How many personal care homes are signed up for the Enhanced Care arrangement for people who are at Level II-plus or III?

MR. HAGGIE: I do have that somewhere and I will endeavour to find it.

We have 87 personal care homes. I don't have the number of homes that have signed up for Enhanced Care. I know it had grown over the first year of the program for sure. It started with the trial of 10 and I think it rapidly travelled in the first year, but I'll get you that number.

MS. COFFIN: I appreciate that. Thank you.

Can I have an update on the autism strategy with respect to access to support services for children and expanding the ABA in education?

MR. HAGGIE: Yes, there is some outstanding work to be done there and, again, some of this was down to the issue of COVID. We have 19 of the short-term actions completed as of March 2020. There are 22 medium-term actions: 17 are in progress and five completed. They're all on track for the March 2021 deadline.

Five long-term are in the report. Three are not yet begun but all are still within the timelines for March 2022. In terms of provincial services supporting children beyond Grade 3 with ABA, $750,000 in funding will be required to do that by March of 2021 and $250,000 needed for professional development for new assessment tools by 2020.

The eligibility for IQ 70 is now based on functional assessment; it's not based on IQ. The new tools for that are needed. That's a $300,000 price tag. The RHAs are telling us that they can't absorb the full cost of making the adult community supports more widely available. That's a discussion we need to have about sources of funding for that, either by reprofiling or by going back to Finance.

MS. COFFIN: That's some good news for folks with children with autism.

MR. HAGGIE: Again, it's been a bit delayed but I would draw your attention to comments I made at the beginning. It's not an excuse; it's a fact of life. The staff who have been involved in policy were rapidly redrafted to do other things because of the needs of COVID.

MS. COFFIN: I completely understand and am quite sympathetic.

Again, thank you for all the hard work.

CHAIR: Thank you, Ms. Coffin.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

A number of questions here, just for some clarification. Minister, could you just explain what's in the stabilization fund. Has any of that been used at this point?

MR. HAGGIE: I have several stabilization funds in my mind. Which one specifically did you reference? (Inaudible) Clinical Stabilization Fund –

MR. BRAZIL: For the regional health authorities.

MR. HAGGIE: Sorry?

MR. HAGGIE: The deficit for the regional health authorities.

MR. HAGGIE: Okay, one moment.

MR. BRAZIL: While you're at it, just to move along, the deficits. Would you have the deficits for the health authorities last year and projected for this year?

MR. HAGGIE: I think they might be on the same page I'm looking for.

MR. BRAZIL: Okay, perfect.

MR. HAGGIE: I will see what I can find for you, Sir.

The 2019-20 expenditure limits, actuals and the variance: Eastern Health, the original expense limit was $1,536,288,053 and the actual was $59,673,947 over.

MR. BRAZIL: Over.

MR. HAGGIE: That's the overage. I've given you the original expense limit and the variance. It's over.

Central Health: $395,090,309.

MR. BRAZIL: Yeah, you can round that off to $395 million or $400 million.

MR. HAGGIE: I can get you this –

MR. BRAZIL: I'm good.

MR. HAGGIE: I can get you this table. Maybe that would be easier.

MR. BRAZIL: Okay.

MR. HAGGIE: The bottom line is the only one that didn't go over. It was Labrador-Grenfell which had a positive variance of $3 million.

MR. BRAZIL: Fair enough.

MR. HAGGIE: Just over.

MR. BRAZIL: Did I hear you earlier say that the deficits then are deferred to the Minister of Finance?

MR. HAGGIE: There is a discussion to be had. They have an operating line of credit and, then, in terms of what happens next, that goes through the Treasury Board process.

MR. BRAZIL: Okay, so you're part of Treasury Board and you'd have that discussion.

MR. HAGGIE: Yeah.

MR. BRAZIL: I was going to say, I was a bit wary that if the Minister of Health is not engaged in that process it would worry me that just Finance officials would be determining whether or not the money's being spent in an equitable way, or pushing to make sure they have enough money to be able to cover their debts. Fair enough on that. Thank you for that.

The hundred million dollars that was announced for the COVID, can you give me a bit of a breakdown on where that may go?

MR. HAGGIE: It's $108.826 million in total. There are two equal parts based on per capita of $41.118 million. There are two of those identical figures: the first one is for testing, contact tracing and data management; the second one is for PPE.

In addition to that there's a health care capacity box. These are federal terms. Mental health and substance use is included in there and that's $16.447 million. Then there's a final pot which is shared with CSSD and Housing for vulnerable populations, which includes seniors in long-term care facilities. That's at $10.143 million. If you add that up, please tell it does actually equal $108.826 million.

MR. BRAZIL: I'm assuming the formula is based on population?

MR. HAGGIE: Yeah, it's a per capita bases.

MR. BRAZIL: Yeah.

MR. HAGGIE: That's about as much as I can tell you about the details of the formula.

MR. BRAZIL: No, fair enough. That breaks that down for me.

I want to have a little discussion on the task force that you've been instructed to put in play, the health task force. Give us some details on the configuration of that, is there any money attached to it for its operation?

MR. HAGGIE: It's still at a very nascent stage. The discussions are around how it should look, who should chair and/or co-chair it. The framework that's envisaged is likely you would have a small modest-sized steering group and then you would break it out into areas of interest. Some of those have already been defined by work that, for example, Quality of Care NL and the Centre for Health Information have come up with.

In terms of support and how it would be administratively composed and configured, that's a discussion at the moment we're having with Cabinet Secretariat. The general mandate I think is in my mandate letter. I'm not sure yet that we're at a stage where you can flesh that out into too much detail.

MR. BRAZIL: Okay, thank you for that.

I noticed reading the papers recently that two of the regional health authorities, their CEOs are no longer in play, have retired or moved on. Is there any discussion around one regional health authority for the whole of the province? Or are two of those positions going to be refilled?

MR. HAGGIE: Certainly, we've had this discussion about the idea of one regional health authority. The thrust of the department, which really started before I got there but we have continued, is actually to take those functions that can be done well across the province by a single entity and kind of pull those out. Because there

is a concern about the significant differences and local input and local flavour of areas such as Labrador being, say, run from St. John's or the decisions appearing to come from there and how to generate proper community input.

My other concern, quite frankly, is very practical. The last time somebody amalgamated health authorities it cost us $54 million, caused chaos that we haven't quite recovered from yet and made no difference to outcomes.

MR. BRAZIL: Fair enough.

We had a discussion a bit earlier just around the capital budget being moved to TI and I realize that and I do support it. There were discussions in a previous administration about how to move that there. What impact will that have for your department? Are there staff moving with that or is it all being encompassed in TI itself?

MR. HAGGIE: We actually had a very, very lean staff in terms of capital, it was basically based around infrastructure and maintenance and repair. We are in discussions with TI now to repatriate that budget. I don't think TI have any interest at all in wanting to get involved in re-roofing the health care centre in Forteau, for example.

Those kind of repairs, renovations, maintenance, that kind of thing, there is a discussion now to see what element of that capital money should really be rebadged under those titles and brought back in for operational reasons into Health.

MR. BRAZIL: Okay.

No staff are directly engaged or going to be affected with TI?

MR. HAGGIE: No staff are moving.

MR. BRAZIL: There won't be any moving?

MR. HAGGIE: No, not from our department anyway. I can't speak for other amalgamations of capital money into TI.

MR. BRAZIL: Okay, fair enough.

Fill me in on where we are on the road ambulance review.

MR. HAGGIE: The road ambulance review, there's been several in actual fact. There's Fitch's and Pomax and various others. We have been negotiating with the ambulance operators to get some stability in the system. We have yet to arrive at a long-term plan for road ambulance. The pressure is now coming around ambulances and aging infrastructure. We wanted to try and get some stability into the system now to enable the private ambulance operators to have some confidence about investing in vehicles and this kind of thing for the foreseeable little while.

Again, a lot of the policy and staff were actually directly involved with the emergency operation centre, which was running until the latter part of COVID. A lot of policy work in that area has been on hold.

MR. BRAZIL: Okay, thank you.

One last question under that heading. Federal revenue is up by $12.3 million, can you outline what that's for under 3.1.01 01?

MR. HAGGIE: Federal revenue, okay.

We've got First Nations Inuit Health Branch, which is for transportation. There is a quantum but some goes to TI, we get $432, 900. We've got $10,400,000 in COVID cash flow. There is $835,000 for Vera Perlin and CHT home care, which is now the home care and mental health funding which was from the 2016-17 accord, $17,428,300, for a total of $29,096,200.

MR. BRAZIL: Thank you, clarifies that.

Thank you.

CHAIR: Okay, thank you.

Ms. Coffin.

MS. COFFIN: Thank you very much.

I'm going to look at 3.1.02. I understand that's a new transfer over from CSSD. I understand it is the Healthy Living grants. Can I have a list of these organizations and the amount of funding for each in 2019-20 and 2020-21, please?

MR. HAGGIE: We can give you the budget for 2020-21, it's in the binder, but which other years did you want?

MS. COFFIN: The previous year.

MR. HAGGIE: Okay.

MS. COFFIN: That would've come from CSSD or …?

MR. HAGGIE: It would. I'm sure they might let us see it.

MS. COFFIN: Okay, I appreciate that.

MR. HAGGIE: If not, you can always ask the relevant minister when they come to Estimates.

MS. COFFIN: I do believe, or I'll pass it along to my colleague. I'm not sure if that's my critic area.

The other thing is some very good news, I still have lots of energy and no more questions, so there you go.

MR. HAGGIE: Excellent.

CHAIR: Okay.

Before I turn it over to Mr. Lane, and sensing we're going to be somewhat on time, we are approaching, I think, 9:20 is what I recognized as three hours?

CLERK: 6:19.

CHAIR: Okay, yeah.

So I'm sensing we're going be able to finish somewhat on time and I don't need to put a question to the floor. We'll carry on, as we're running out of questions, that's good.

Mr. Lane, Sir.

MR. LANE: Thank you. I have a couple of questions.

Minister, I think what I heard you say in response to one of the questions – and if you did, I'm glad you said it. I, too, have seen what happened, for example, with the school boards when they decided to put it all under one big massive school board and it was going to save us a pile of money. In fact, it cost us more money, and a whole lot of confusion as well. So I agree, in general, of not necessarily having one big giant beast that is hard to control. But I think what I heard you say is that you are looking at taking certain aspects of the authorities that could be done by just one.

I think there was something done maybe last year or there was talks about doing something with maybe payroll or whatever; payroll, HR, different things. So is that kind of what the thinking is, that we're going to look at things that are happening in the four health authorities and say, yeah, we're still going to have their own boards managing them, but there are aspects of this that could all be done by one and, hopefully, save us some money and efficiency by doing that. Is that what I heard you say or …?

MR. HAGGIE: No, that's correct. In actual fact, we have taken steps in that direction. We – you may remember – brought the Newfoundland and Labrador Centre for Health Information Act back to the House, amended it.

MR. LANE: Yes.

MR. HAGGIE: What that allowed NLCHI to do was to take over management of clinical registries; it made them custodians under PHIA. The Cancer Care Registry, the screening registry, the survival cancer and these kinds of things were all run and administered – administratively supported, tech support through NLCHI, but it also means they do the bulk of the heavy lifting with networking and IT for all of the regional health authorities. That's run out of NLCHI.

Shared services was a move which brought purchasing and inventory control into a centrally located body that took that out of the RHAs. There are obviously people in the RHAs but staff have been hired, realigned. That service is currently up and running. It was quite active during COVID as a provincial source of tendering for PPE and these things. It was actually one of several because of the global situation. We had a federal stream, we had that and you remember there was TaskforceNL, as

well, looking at local industry and generating some new sources of PPE locally which is great.

Those were kind of the low-hanging fruit. There has been discussion around payroll and HR. HR is a little bit more nuanced because of shift management and these kinds of things. There is now a workforce management software package which is going into Eastern Health and then being rolled out across the province, which allows staffing to acuity and a much more dynamic management of scheduling. It does it electronically and does away with the need for time cards and written little sheets on a two-week basis, that kind of thing.

Yes, that's happened and will continue to happen. Again, the pace has been altered a little bit over the last six months because of COVID and just really sucking the oxygen out of some of these things, but in terms of purchasing, that's well underway.

MR. LANE: Maybe things like training and stuff like that is another opportunity, for example.

Anyway, thank you for that, Minister. I'm glad to see that we're heading in that direction to try to get some of the costs under control hopefully.

This is probably not going to be a popular one with a lot of people; it depends on where you're from. I've had a number of people raise this with me, I'm sure you've heard it as well. When we look at the number of actual facilities that are around the province – hospitals, clinics and so on – is there anybody looking at how many we have comparative to the population, travel distances and all that kind of stuff to examine if that's all required?

Again, I'm sure there are people in the province in certain areas that don't want to hear that, but it's a question that I hear all the time about those things. I'm just wondering – I'm asking on behalf of the people who have asked me – is there any plan to look at rightsizing that? That's the term government likes to use.

MR. HAGGIE: That's a very good comment and it's a question that tends to come from – again, without prejudging or being pejorative – people in the metropolitan areas.

MR. LANE: Yeah.

MR. HAGGIE: Once you get past either the overpass or Fair Haven, depending on where you want to draw the line, we're a territory. We actually have a population density less than that of Nunavut in part of our province. One of our prides is that we're the newest province, but one of the realities is that we are actually a territory with a kind of populace pimple on one eastern end. So the distribution of facilities to deal with the issues you describe around travel are only really resolved by actually having scattered facilities.

The issue of viability, clinical load and these kind of things, obviously, will be important. I mean, at some point you may find there are very few people left in a community and yet it has a clinic that sees very few people a day. That's going to be when those kinds of decisions will really stare us in the face. I think a lot of the roles in some of these clinics change over time.

You've seen how some of the centres, where surgery used to be performed, were reduced over the course of a couple of decades ago. It was done on the basis of volume, and I referenced earlier on about how you need to have a certain throughput to maintain not just competence, but to get good at it. Those kinds of changes are reflected in the number of acute admissions in certain smaller rural hospitals versus the number of people there with chronic long-term medical problems, and that redistribution is occurring naturally.

I would suggest that it's likely to be a redistribution of roles by the nature of the clientele they serve, rather than necessarily closing buildings. Certainly, from our point of view, we're just in the process of, and not far off, commissioning a new building in Springdale to replace Green Bay Health Care Centre. There will never be any thought of cutting that service, for example.

MR. LANE: No, I understand that.

MR. HAGGIE: I think there are opportunities for improving access in the really small communities using some of the things we've talked about here with virtual care and that kind of thing. I understand where people come from,

but I think we have a significant issue with geography that unless you actually spend a little bit of time thinking or maybe a lot of time travelling, you really don't appreciate.

MR. LANE: No, I get it.

Again, this is feedback I get quite often actually. You're right, it's probably because there are people in the metro area – they have the Health Sciences and St. Clare's and they're saying: My god, look at all these hospitals in certain areas, three hospitals on the West Coast or whatever, do we really need that many? That's the commentary you hear. I'm asking on behalf of those people who asked me to do so.

Long-term care: I know you talked about this 10-year plan. I do also know you've talked about NAPE, but I'm going to refer you to a petition which I presented in this House, I don't know how many times, on behalf of Advocates for Senior Citizens' Rights. In particular, their concern is around long-term care and the housing of people with dementia and Alzheimer's and having appropriate staffing at all times.

Not just to make sure there's certain staff there but also that if people – it's fine to say I gave someone their supper, but if that person is not capable of feeding themselves and there is nobody to actually feed them, then that is a problem. Then if you have people with dementia and they're on a ward or whatever, and there is not someone there in that room to watch them to make sure that they're not going to hurt themselves or hurt another person in that day room or whatever, then that causes problems. We've talked about this many times.

On behalf of that group, Advocates for Senior Citizens' Rights, is there any move towards what they're asking for, to have those minimum staffing to cover those types of issues in long-term care, particularly for those who are the most vulnerable of all?

MR. HAGGIE: I'd answer in a couple of ways. Firstly, I think it's worth pointing out that care in long-term care facilities is provided on the basis of need; it's built up patient by patient, resident by resident. Each resident has a regular care needs assessment and on that assessment the type of care, the hours of care and this kind of thing that they need is specified. Then, the unit is staffed to that and the care delivered.

Now, we've highlighted some challenges with COVID because we went to a one-worker one-facility policy. That introduced some staffing challenges and the staff in long-term care did extremely well with that. The other gap was that there's informal care provided by family and visitors. Obviously, that wasn't available and that became apparent too.

Several things, one is we are moving to a more nimble staffing system in terms of workforce management software and scheduling. To check that we are actually doing what we think we're doing, there is the discussion with NAPE around long-term care staffing at a provincial level. There's also a very detailed sampling going to occur of core staffing, which will include two very typical long-term care facilities, one metro and one on the South Coast of Labrador, as well as a regional referral centre.

I think we are working on validating what we're doing at the moment. We'll see if there's a mismatch and if there is, we'll fix it.

MR. LANE: Thank you.

CHAIR: Mr. Lane, your time has expired. Our allotted time has expired.

I'm seeking from you a signal. Are you completed in your questions?

MR. LANE: I have one question left.

CHAIR: You have one question left.

MR. LANE: (Inaudible.)

CHAIR: I'll just make sure I don't see strong disagreement; otherwise, I'll let you finish your final question, Sir.

MR. LANE: Thank you.

My final question – maybe it's more of a comment than a question, Minister. I realize that we go through this budget area exercise every year; it's in a standard format and so on. An observation I make – and this year is no different

than last year – when you think about it, $3 billion of our budget or whatever is health care, and the vast majority of that is going out to health authorities. It's a huge expenditure; it's funded totally by the taxpayer.

We'll go through the budgetary process in different departments and we'll ask questions about how come there's $5,000 spent on paper here that wasn't spent last year or photocopying or whatever, which is still important to do. But when we look at all the money that's going to the health authorities, ambulance services and all that, that's all captured under one big, huge paragraph; in this case, $2.982 billion, with a B.

In terms of public transparency and being able to compare this year to last year, and how much money the health authorities spent specifically to each one – you've been really good in answering the questions that my colleagues have asked and I appreciate that. In terms of transparency and to have this here, it would be really nice – maybe it's a take-away – if in the future we could consider instead of having this one big item, Grants and Subsidies, we could have this broken down a little bit more in terms of some more of the detail.

I'm not saying now let's start counting the bedpans that are being used at each hospital, but we can certainly break it down a little more so that the public knows how their money is being spent and so that we're able to ask some more informed questions about money that's being spent on some of these services. You can comment on it. It's more of a commentary, I suppose, than a question, but I just wanted to throw it in there.

MR. HAGGIE: The only comment I would offer is I came to this structure. It was given to me.

MR. LANE: No, I understand that.

MR. HAGGIE: I'm not sure were one would want to change it, how one would go about doing that. I would defer to the expertise of others. I take your comments.

CHAIR: I thank everyone for their good questions and excellent answers.

Madam Clerk, let's carry this one forward, our final section of the Estimates.

CLERK: Health and Community Service Delivery, 3.1.01 and 3.1.02.

CHAIR: Shall 3.1.01 through to 3.1.02 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

This section of the Estimates is completed.

On motion, subheads 3.1.01 through 3.1.02 carried.

CLERK: The department totals.

CHAIR: Let's go to the totals of the Department of Health and Community Services.

Shall the total carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

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

CHAIR: Shall I report the Estimates of the Department of Health and Community Services carried without amendment?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

This is carried.

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

CHAIR: The Clerk has distributed the meeting minutes from last evening, the last time that this Committee met. I need someone to move that these minutes be accepted.

MS. COFFIN: So moved.

CHAIR: Madam Coffin has done so.

All those in favour of the minutes, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Thank you very much.

On motion, minutes adopted as circulated.

CHAIR: I'd like to now announce that our next meeting of this Committee is …

CLERK: Tuesday, October 6 at 9 o'clock. It's the Estimates for the Department of Education.

CHAIR: We'll see you all then.

I turn to the minister, perhaps for a final remark, if you'd like, Sir, before we have a motion to adjourn.

MR. HAGGIE: I won't keep anybody. I thank everyone for their interest. They were good questions and it was an interesting exchange.

I'm sorry if I couldn't get some of the numbers out. My brain seemed to cease working sometime around half an hour ago. I apologize for any inconvenience that may have caused, but thanks for your time and indulgence.

CHAIR: I'd like to thank you all very much. I'd like to thank the Clerk, everyone who has prepared and kept us clean here this evening, the Broadcast group as well.

Now I would need a motion to adjourn.

MR. BRAZIL: So moved.

CHAIR: Mr. Brazil has done that. I thank you very much.

We'll see you next Tuesday at 0900 hours here and we'll talk about all things Education.

On motion, the Committee adjourned.