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SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Glenn Littlejohn, MHA

Vice-Chair: Tony Cornect, MHA

Members:

Lisa Dempster, MHA
Gerry Rogers, MHA
Glen Little, MHA
Dale Kirby, MHA
Kevin Pollard, MHA

Clerk of the Committee: Kimberley Hammond

Appearing:

Department of Health and Community Services
Hon. Paul Davis, MHA, Minister
Chad Antle, Manager of Budgeting
Dr. Cathi Bradbury, Associate Deputy Minister
Elaine Chatigny, Assistant Deputy Minister, Population Health
Bruce Cooper, Deputy Minister
Veronica Hayden, Executive Assistant
Michelle Jewer, Assistant Deputy Minister
Heather MacLean, Director of Communications
Keith Sheppard, Director, Pharmaceutical Services Division (A)
Karen Stone, Assistant Deputy Minister, Policy and Planning
Mike Tizzard, Departmental Controller
Denise Tubrett, Assistant Deputy Minister

Also Present
Andrew Parsons, MHA
Joy Buckle, Director of Research, Official Opposition Office
Susan Williams, Researcher, NDP Office

Pursuant to Standing Order 68, Andrew Parsons, MHA for Burgeo – La Poile, substitutes for Lisa Dempster, MHA for Cartwright – L'Anse au Clair.

The Committee met at 9:00 a.m. in the Assembly Chamber.

CHAIR (Littlejohn): Good morning, everyone.

Minister, I would like to welcome you and your officials this morning to the Social Services Estimates Committee.

Before we start, Minister, I am going to ask our Committee members and representatives to introduce themselves. Then I will ask you to introduce your staff or they can introduce themselves individually. Then we will call the first subhead. You will have fifteen minutes, if you want, for opening remarks, and we will move on from there.

Okay, Andrew.

MR. A. PARSONS: Andrew Parsons, MHA for Burgeo – La Poile.

MS BUCKLE: Joy Buckle, Researcher.

MS ROGERS: Gerry Rogers, MHA for St. John's Centre.

MS WILLIAMS: Susan Williams, Researcher.

MR. LITTLE: Glen Little, representing the beautiful historic District of Bonavista South.

MR. CORNECT: Tony Cornect, the great cultural District of Port au Port.

MR. POLLARD: Kevin Pollard, MHA for Baie Verte – Springdale.

CHAIR: Thank you.

Minister, if you wish to introduce yourself and your staff. I guess I should introduce myself. I am Glenn Littlejohn, MHA for Port de Grave.

MR. DAVIS: Thank you, Mr. Chair.

We will do that. I will ask the staff each to introduce themselves. I just remind them that there is a red light in front of them. When the red light comes on they know that all systems are a go, and it is a good time to introduce themselves.

We will start with Michelle.

MS JEWER: ADM, Corporate Services, Michelle Jewer.

MR. COOPER: Bruce Cooper, Deputy Minister of Health and Community Services.

MS TUBRETT: Denise Tubrett, ADM, Regional Services.

MS CHATIGNY: Elaine Chatigny, ADM, Population Health.

MS STONE: Karen Stone, ADM, Policy and Planning.

DR. BRADBURY: Cathi Bradbury, Associate Deputy Minister.

MR. TIZZARD: Mike Tizzard, Departmental Controller.

MR. ANTLE: Chad Antle, Manager of Budgeting.

MS HAYDEN: Veronica Hayden, Executive Assistant to the minister.

MR. SHEPPARD: Keith Sheppard, Director of Pharmaceutical Services.

MS MACLEAN: Heather MacLean, Director of Communications.

CHAIR: Thank you.

As the minister already indicated, wait for your red light. Please, when the red light is on, state your name for Hansard and the record. I shall ask the Clerk to call the first subhead.

CLERK (Ms Hammond): Subhead 1.1.01.

CHAIR: Shall 1.1.01 carry?

Minister.

MR. DAVIS: Thank you, Mr. Chair.

Good morning ladies and gentlemen. I am pleased to be here today and to give opportunity to have further discussion on items contained in the 2014-2015 budget for the Department of Health and Community Services, and more specifically to review and answer your inquiries regarding the Estimates.

Our budget in this department is just shy of $3 billion. It represents approximately 40 per cent of the overall provincial Budget. It is a significant portion of the Budget. We focused on making investments that balanced our commitments to health and safety issues while keeping the health care system sustainable for the people of Newfoundland and Labrador. I believe that our investments this year reached that balance, which was the goal through the budgetary process and operational process.

Our responsibility in the Department of Health and Community Services focuses on prevention and treatment in many ways. We all know too well the serious illnesses, such as cancer, and other illnesses, and required services such as dialysis services; we know the importance of infrastructure in order to deliver these services throughout Newfoundland and Labrador. We also recognize the importance of long-term care and community support.

Then there are other programs that are close to home, if I may use those terms, Mr. Chair, for the people of Newfoundland and Labrador, especially those who have to travel frequently to obtain necessary health services. Programs such as the Medical Transportation Assistance Program we know is important to people and we have made some changes on that this year.

Mental health and addictions is a topic that is being talked about nationally this week. I know Mr. Parsons joined me in an announcement on Monday morning on a program and project to reduce the stigma that sometimes quite often people with mental illness or addictions have to face. We are making great strides in that area as well.

We are making investments in two new treatment centres for youth; one in Paradise for youth with complex mental health needs, one in Grand Falls-Windsor for youth with addictions, and also an adult addiction centre not too far from your home, Mr. Chair, in Carbonear – Harbour Grace. Also, we have work underway as well on the Waterford Hospital replacement. They are all very important pieces of work and progress that we make in regard to mental health and addictions.

Very close to our department and important to the operations and the delivery of services are the very broad variety of stakeholders, private organizations, and non-government organizations that provide support and assistance to the department, to the delivery of services, and also to the people of Newfoundland and Labrador. Significant to the quality of our health care system is people. I can tell you as the minister, and as a citizen of the Province, that I value and respect the variety of backgrounds, the variety of training and expertise that exists within our health care system and health care providers throughout the Province.

I know that members opposite are quite aware that I quite often will address and talk about – and they share the views. I know the members opposite share the views on the dedicated, hardworking public service that exists in Newfoundland and Labrador. They are hardworking people who have desire, I know, for best outcomes. In Health and Community Services in the department, as well as throughout the regional health authorities, that holds true.

There are 179 health care centres, clinics, hospitals, and long-term care facilities in Newfoundland and Labrador. We share in the delivery of those services, as I mentioned, through stakeholder groups, through regional health authorities, and also the employees of the department. That includes the people who have joined me here today.

I can tell you in my long tenure of six days in the Department of Health and Community Services we have had a bit of a round-the-clock marathon since I came in last week. These people around me have not questioned the number of hours that we have worked to ensure that I am, as quickly as possible, prepared as I transition into this new department. They have been providing me with a significant amount of information. I call it an education. These are

my teachers and I am their student at this point in time. I thank them for that as I transition into this new department.

I encourage all members this morning to ask questions. I have asked hundreds of questions of these people in the last six days, and we have had some very interesting and insightful discussions. I ask you as well to consider the value that they provide. I know they will, and they will maintain the respect that these people deserve, and that we have a respectful and engaging exchange this morning.

Thank you, Mr. Chair.

CHAIR: Thank you, Minister.

Just for the Committee members, the Estimates for Health and Community Services are found and begin on page 16.3. I will turn it over to Mr. Parsons.

Andrew.

MR. A. PARSONS: Thank you, Mr. Chair.

I want to thank the minister and his staff for making themselves available here this morning, it is much appreciated. I know the minister is new in his job, but I believe he is up to the task. I look forward to working with him and asking questions. If there is anything we do not get today, I am sure that we will get it at some point. I very much appreciate it.

I am going to dig right in here. I am going to go to 1.2.02, Corporate Services.

CHAIR: Subhead 1.2.02 Corporate Services.

MR. A. PARSONS: My first question under Corporate Services would be the Professional Services line. There was $1.133 million budgeted, but only $54,500 spent. There is a significant under spend in that particular line item. What would be the reasoning behind that?

MR. DAVIS: Under Professional Services, Mr. Parsons, there is a $1 million contingency fund that relates to federal-provincial funding agreements which may arise throughout the year. This year there had not been a use for those resources. When it does occur, there is an in and out effect that occurs to the budget process. We have to budget for that potential of that expenditure and that is where it is budgeted but was not utilized.

MR. A. PARSONS: Okay. I see this year it is $1.1 million so there is a possibility next year it could be the same thing. There is $1.1 million budgeted.

MR. DAVIS: Correct.

MR. A. PARSONS: Okay.

MR. DAVIS: There was an additional $78,000 besides the $1 million that was not utilized. That pertains to our Audit Services Division for audit appeals. There is a budget there for physician appeals and pharmaceutical appeals and none occurred in the past year as well.

MR. A. PARSONS: Okay, thank you.

Under Purchased Services it was under spent by roughly $430,000. What was not purchased that was intended to be?

MR. DAVIS: There is a new building for MCP on Major's Path. It was forecasted or intended to open in April 2013. We did not actually engage in the lease until February of 2014.

MR. A. PARSONS: Okay.

I noticed under there it says the revenue, that is the $1 million – would that be tied in? Okay, I just want to make sure.

I am going to move forward to 1.2.03, Professional Services. Under this there is roughly just over $670,000 extra in Salaries for this year. I am just wondering what new positions are being added or are there new programs being developed.

MR. DAVIS: There was also a small increase – I will mention both of them now, Mr. Parsons; you will see these throughout the Estimates. This year there was a $10,200 increase over last year's Estimates. The revised was $10,200 increase. That was primarily referenced to the $1,400 signing bonus for employees.

The $688,000 deals with a couple of matters: one is a 2 per cent increase in a new collective agreement; and as well, there was a transfer from the NLPDP, the Prescription Drug Program Assessment Office from Corporate Services, Professional Services. There are a number of areas here where there has been some restructuring done in a department from last year to this year. If it was not enough for me to learn already, I had to learn what it was last year and what has changed in the last year. This is one of those as well when there was a change in the structure.

There is a reduction from doctors and staff subject to an MOU with physicians through that particular branch. There was also, I think, a one-time retention bonus there as well for four physicians.

MR. A. PARSONS: So there are no new positions, it is the bonuses, et cetera?

MR. DAVIS: Yes, and that piece of restructuring.

MR. A. PARSONS: Okay.

In the Professional Services there is an additional $85,000 or so increase this year in the Estimates. What is the plan there?

MR. DAVIS: The $19,500, $20,000 increase for 2014 you are referring too?

MR. A. PARSONS: Well, we spent $332,000 last year and this year it is up to $416,000. I guess it is up almost $20,000 but we only spent $332,000 last year.

MR. DAVIS: There was a reallocation of funds from the department to increase the budget for the Atlantic Common Drug Review. That is an independent advisory group that is composed of physicians, pharmacists, and other persons who have expertise in drugs. There was a reallocation of those funds from last year to this year. There is a drug evaluation fee or participation that we pay annually.

MR. A. PARSONS: Under the Purchased Services, I noticed last year there was $62,300 budgeted, $62,300 spent exactly and this year it is $39,600. So what is the decrease accounting for?

MR. DAVIS: There is a reduction because of the Queen's Printer change in how they operate. I do not know if you have heard that from other departments. They still operate but how they do their billings, their interdepartmental billings, have changed so that had an impact there.

MR. A. PARSONS: Okay.

MR. DAVIS: There was a transfer again of the NLPDP Assessment Office –

CHAIR: Excuse me, Minister. Can I ask staff members to move their cellphones away from the mikes?

Thank you, Minister; I appreciate that.

MR. DAVIS: Is that mine doing that? Sorry, Mr. Chair.

CHAIR: Sorry, Andrew.

MR. DAVIS: I am sorry, Mr. Parsons.

So that was $17,700 on the interdepartmental billing process that has changed. The transfer of the NLPDP Assessment Office from Corporate to Professional, as I talked about before, played an impact there as well. There was also a transfer of the Office of the Chief Nurse in Professional Services to Regional Services. So the Chief Nurse position has been restructured as well. So you will hear that in a few other line items as well.

MR. A. PARSONS: Okay.

Regional Services, 1.2.04, under the Professional Services we saw last year there was $1.4 million budgeted, $992,000 spent, and this year it is down to $843,000 estimated. I am just wondering what the rationale is.

MR. DAVIS: Sure. Well, first of all, the difference in the revised, approximately $430,000 – in 2013-2014 there was a focus on wait times and there was work done on completing emergency room reviews for the Janeway, Western Memorial, and also Central Newfoundland regional health centres. That

work has now been completed. There is also a review at the James Paton Memorial Regional Health Centre in Gander, which has now begun. We are also addressing wait times for endoscopy services and also continuing to reduce wait times for hip and knee surgeries.

The piece of work on the emergency rooms, as I mentioned, has been completed, so that required less funding than was anticipated. Also, funding for these items is budgeted in the regional health authority grants, and that comes under section 3, page 16.9 is where you find that. So funds for those services are coming under grants to the regional health authorities.

MR. A. PARSONS: Okay.

Under the Purchased Services –

MR. DAVIS: If I may just cut you off, was there anything else there, pertinent, Bruce, that I should explain on that one?

MR. COOPER: No, I think that is fine.

MR. A. PARSONS: Okay, thank you.

MR. DAVIS: I just want to make sure you get all of it.

MR. A. PARSONS: Under Purchased Services, $262,000 budgeted and $77,000 spent. What was anticipated that was not necessary?

MR. DAVIS: There was a promotional campaign that had been anticipated regarding the HealthLine that did not go ahead. It did not occur in 2013-2014, as previously had been anticipated. What has been happening is there has been work ongoing to expand the use of the HealthLine. So the department did not feel it was prudent to begin a promotional campaign on the HealthLine when the concept and the use of the HealthLine were looking at being expanded. We wanted to carry out that piece of work to do the expansion on the HealthLine first before we actually carry out that promotional campaign. That is why those funds were not used.

MR. A. PARSONS: This year we still have roughly the same estimate –

MR. DAVIS: Yes. That work on expanding the HealthLine is nearing completion, and then the plan is to roll out a promotional campaign on the use of the HealthLine once that work is completed. So it will still be used.

MR. A. PARSONS: Would that be this year?

MR. DAVIS: Yes.

MR. A. PARSONS: Are we talking summer, fall?

MR. DAVIS: You know I hate to give –

MR. A. PARSONS: I know you do not want to be put down on a timeline, but –

MR. DAVIS: I can see you standing in your place here come the fall: Where is it?

What I can tell you is the expanded scope work is nearing completion. I have not had an opportunity yet to go through it.

MR. A. PARSONS: Okay.

MR. DAVIS: It would be really premature for me to try to give you a better indication than that. I am sure some of these folks might like to, but I would rather wait until I have a look at it first myself.

MR. A. PARSONS: Not a problem. I understand.

I am going to move forward here to 1.2.05, Population Health. Under Transportation and Communications $90,000 was not spent. I am just wondering was there any travel planned that did not happen or any communications that did not go ahead.

MR. DAVIS: Yes, that is exactly it. There was lower than anticipated travel. Specifically – I do not have more details that I can provide you with.

CHAIR: Bruce.

MR. COOPER: Yes, there was less travel than expected in the Population Health area, Mental Health and Addictions, and Healthy Living Division. We generally used past years'

experience to base future years' experience on. Just this year, the travel that we would have seen to build up our budgets did not occur.

MR. A. PARSONS: I am just wondering because under Population Health we see the promotion of wellness and prevention, so I did not know if this would be something that we would do more travel on, given that it is probably cheaper than the end result. I did not know if there were any plans. I see that I guess the reduction for this year is based on the past experience, so there are no plans on increasing that, to get out more.

MR. COOPER: We find now, particularly in the area of Population Health, we do a lot of work with our colleagues across the country and at the FPT table through the Public Health Agency. Every province wants to move more into telemeetings or webinars. We are seeing a bit of a shift occur in the way staff are doing their work.

We have been trying to strike that balance because it is not everything you can do by distance. Certainly, that is a question we always ask when people come forward looking for travel: Is there value we are going to get from that trip? Is it something where people are going to bring something back to the department?

We have been certainly not missing out on doing anything that needs to be done. We are just finding new ways of engaging and asking good questions at the management level.

MR. A. PARSONS: Okay. Thank you.

Under the budget for the Professional Services line, there was less spent than estimated last year. I am just wondering what the rationale there was.

MR. DAVIS: In this $175,000 from budget to revised are delays in implementing an e-mental health Web site. There was a delay in implementation of an e-mental health Web site, and also the mental health and addictions team were working on the anti-stigma awareness campaign. There were investments as well made in that area, but now we just rolled that one out, as you know.

We supported RHAs in acquiring technology that will help them – as Bruce just referred to – in increasing the use of telemedicine as well. So, when you factor all those together, we did not spend what originally had been anticipated.

MR. A. PARSONS: Okay.

Under the Purchased Services, there was about $25,000 less spent than what was budgeted, but I notice that there is a significant reduction estimated for this year. So what would that be for?

MR. DAVIS: The $25,000 revised was lower than anticipated expenditures that were related to advertising for the seniors' initiative, and for the decrease this year of $247,000 it relates to the ending of a drug treatment funding with Health Canada. Health Canada offsets the revenues. It is a program that is coming to an end.

There was also a reduction in the budget for a transfer of the Queen's Printer again under this area that was impacted by that. That actually, under this area, the Queen's Printer, elimination of their interdepartmental billing, is about $220,000 difference. So, essentially what happens, it comes out of our line item here. That line item now goes into the Queen's Printer.

MR. A. PARSONS: Okay.

MR. DAVIS: So it used to be that they would do the work for us, they would bill us, and we would take it out of ours and pay them for the service. Now they are paying the services out of their own line items is what is going to happen.

MR. A. PARSONS: Okay.

Thank you, Mr. Chair.

CHAIR: Ms Rogers.

MS ROGERS: Thank you very much, and thank you very for coming this morning.

I know the huge mountain of work that you all have, and the wonderful work that everyone is doing. Congratulations to the minister on this new portfolio –

MR. DAVIS: Thank you.

MS ROGERS: – and I look forward to working with you. Mind you, I am substituting for our leader, Lorraine Michael, who is with the All-Party Fisheries Committee – which is a great thing, I think, to have an all-party committee.

I just want to go back to 1.2.05, Population Health, and the Purchased Services reduction. I did not quite understand the Health Canada offsetting. Could you just explain that to me again?

MR. DAVIS: Yes, certainly. Bruce, do you want to explain that in some further detail?

CHAIR: Bruce.

MR. COOPER: There was a drug treatment funding agreement that we had with Health Canada that ended. We had to recognize that any agreement with the federal government comes in as revenue and then we need space in our budget, appropriation space, to spend the money. So we have had an end of an agreement, thus a corresponding decrease in appropriation requirement.

MS ROGERS: So that was money for drug treatment programming?

MR. COOPER: There are a number of projects that we initiate with the federal government under the drug treatment funding envelope. If you would like some details on the particular projects, I could have Elaine Chatigny answer that for you.

MS ROGERS: Great.

CHAIR: Elaine.

MS CHATIGNY: Thank you very much.

This was a time-limited national fund that provinces and territories could avail of under the National Anti-Drug Strategy. It was a five-year program that sunsetted. This program allowed jurisdictions to work on very specific initiatives. It was not meant to provide drug treatment programming – that is provincial jurisdiction, if you will – but it was meant to help top up, in terms of knowledge generation, knowledge transfer and to pilot certain initiatives. So, for example, we were able to develop standards and guidelines on addictions withdrawal and concurrent disorders. By developing those standards through an evidence base, we were able then to share that with the regional health authorities who then used that in their treatment programs on the ground, on the frontlines.

So that is the kind of example of what that fund allowed us to do, and it is work that is sustainable now throughout the department and with the RHAs.

MS ROGERS: How much money was that that had come in for that yearly, over the five years?

MS CHATIGNY: Over the course of the life of the programming, it was just over $1 million.

MS ROGERS: Per year?

MS CHATIGNY: No, over the life course of the program. So this past year would have been $600,000, I think.

MS ROGERS: Is there any way that the money will be made up any other way? These are activities that appear to be very important.

MS CHATIGNY: Indeed. Health Canada has not re-profiled but re-engineered its anti-drug strategy. There is a new fund available and we, as other jurisdictions, have made proposals. We are hoping to get some word soon from Health Canada on whether our proposal has been successful.

MS ROGERS: Would that be for this fiscal year?

MS CHATIGNY: Yes.

MS ROGERS: What would be entailed in that proposal?

MS CHATIGNY: We would like to continue some work on what we call outcome monitoring. When we work through RHAs in their addictions treatment programs and they follow a client who has successfully terminated a treatment program, we do some monitoring for a period of time after they have left their program,

regardless of the type of treatment that they received.

The outcome monitoring is important because it allows for an ongoing connection with the client, a check in if you will, in terms of how they are doing post-treatment while they are in recovery. It allows us as well through the conversation, the tracking of how they are doing, to feed back to the treatment program to help adjust the treatment program.

MS ROGERS: Great.

MS CHATIGNY: Yes.

MS ROGERS: Fantastic.

MS CHATIGNY: We would like to continue that work.

MS ROGERS: Yes. That kind of work would be for people who went to what particular types of programs, within the Province?

MS CHATIGNY: Any type of addiction in the Province.

MS ROGERS: Yes.

MS CHATIGNY: In Newfoundland and Labrador, any type of addiction treatment program. When they enter the program we were asking them if they would be willing to be part of a post-treatment recovery monitoring program. Then we would establish a protocol with the client in which we would do that monitoring.

An important component of that program is that because it would be trained psychologists who would have the interaction with the client, if we felt that there were issues that this individual was experiencing as part of recovery, we could help direct them back to appropriate treatment facilities. It was a very supportive program.

MS ROGERS: It would also then monitor whether or not there are gaps in services, what kind of gaps in services depending on the needs.

MS CHATIGNY: Not in services so much as in the type of treatment. It was really focused on treatment.

MS ROGERS: Okay. Would your application be a five-year application, like a five-year plan, or is that just…?

MS CHATIGNY: I am not sure if the fund is for three years or five years. I would have to find that out.

MS ROGERS: Okay, great. Thank you very much.

If we could move on to Policy and Planning, 1.2.06 and under Salaries, Professional Services, what kind of professional services were you looking at here under Policy and Planning?

MR. DAVIS: For the entire budget item you mean? What kind of professional services is there?

MS ROGERS: Yes.

MR. DAVIS: Bruce.

MR. COOPER: We from time to time require consulting services to support the various divisions in the branch and also to support the contributions we make on a per capita basis to FPT initiatives.

MS ROGERS: Were there any particular initiatives or policy areas that you were looking at?

MR. COOPER: I will probably turn to Michelle for the specific details.

MS JEWER: Probably the largest part of this budget is our contribution to Canada Institute for Health Information. All provinces would contribute to that, so this is our piece of it. That is almost $350,000 of this budget.

There is also money in here for National Common Drug Review and those parties that we use with the drug program.

MS ROGERS: Thank you.

Then under Revenue – Provincial, 02, we see that there increase of $50,000.

CHAIR: Minister.

MR. DAVIS: The increase of $50,000 was added during the budget for a consultant to complete the National Ambulatory Care Reporting System. It is a provincial readiness assessment review based on the readiness review completed in 2008. We can provide you with more information on that. I cannot give you much more detail, but we certainly can.

CHAIR: Bruce.

MR. COOPER: This is a reporting system that we participate in and we are preparing to do a readiness assessment to complement a piece of work that was done in 2008. In terms of the particular data that is collected through the National Ambulatory Care Reporting System that is something we would have to get for you.

MS ROGERS: Okay, thank you very much.

Moving on to Memorial University Faculty of Medicine, we see that there was a variance of $750,000 from the budget of 2013-2014 to the revision that was not spent.

CHAIR: Minister.

MR. DAVIS: In Budget 2011 there was an announcement regarding improving accommodations for medical students in rural Newfoundland and Labrador. There was funding available for that and there were delays in implementing that initiative as announced previously.

The department works with the faculty and the regional health authorities on gathering an inventory of provincial properties. We are working on that piece of work to determine what is available and what exists throughout Newfoundland and Labrador. That has now been completed. A list has been developed for accommodation needs in 2014-2015. That work has been carried out and it will move forward into this year.

MS ROGERS: Okay, thank you.

CHAIR: Gerry, a follow-up question to that?

MS ROGERS: Just for this particular line, we see an increase in 2014-2015 of $3.144 million.

MR. DAVIS: About $1.5 million of that are the salary increases for MUN, as well as increases to the health and dental plan. There are some increases for energy costs, inflation adjustments, insurance premiums, medical school expansion, and accommodations for medical students as well. As you know, we have increased the number of seats at the medical school.

MS ROGERS: That is great.

MR. DAVIS: Some of that funding is for some of those increasing costs. There is also the 2 per cent in the salary adjustments that we have talked about before. Also, just shy of $1 million is associated to the operating costs with the MUN genetics centre, which is anticipated to open later this year.

MS ROGERS: Great, thank you.

CHAIR: Andrew.

MR. A. PARSONS: Thank you.

I am going to move forward to the Drug Subsidization, 2.2.01, Provincial Drug Programs. We see that the Allowances and Assistance has been increased by just under $1 million. What are the details?

MR. DAVIS: There are a number of them there, Mr. Parsons – just a moment now. You said $1 million. It is a little bit more than that. That is where you threw me off. It is $9 million.

MR. A. PARSONS: Oh sorry, I had the zero in the wrong spot. Sorry, my bad.

MR. DAVIS: Yes, that is why you threw me off. I said: Am I on the right line?

MR. A. PARSONS: Wrong zero.

MR. DAVIS: Yes, so it is $9,350,000 roughly.

MR. A. PARSONS: Yes.

MR. DAVIS: Seven million dollars is the increase in the result for new funding for drug therapies which was announced during the Budget, just over $7 million for that. A little less than $500,000 which was re-profiled from Professional Services for a Fabry agreement –

that is Fabry disease – for an agreement to add to the base funding for that disease.

Are you familiar with that? Let me see how good my memory is now. The Fabry disease is an absence of an enzyme that causes a fatty buildup in cells. It could be painful, very difficult to treat, very expensive to treat, very painful for patients, and it is very expensive. There are a very small number of patients in Newfoundland and Labrador. A small number in Canada but a very small number in Newfoundland and Labrador, but that is an increase in cost for treatments of those individuals.

There is also just over $700,000 for the smoking cessation program that we announced in the budget; $7,000 for increasing drug card coverage from six months to one year for individuals who are coming off Income Support. It used to be you would stay on the drug program when you are coming off Income Support for six months, and we have extended that to a year. Also, $300,000 is for growth and the needs of the department, or the branch.

MR. A. PARSONS: Excellent.

The revenue, it says there is $2.25 million anticipated for this year and there was none last year. What is the source?

MR. DAVIS: Yes, that relates to anticipated rebates from product listing agreements with pharmaceutical companies.

MR. A. PARSONS: Okay.

MR. DAVIS: It was not there last year but that is the estimate for this year under Provincial Drug Program.

MR. A. PARSONS: I am just wondering – again, in the budget there were a number of new drugs that were being covered but at that time the names were not provided. Are they available now?

MR. DAVIS: There is a process – a good question, and I have had a bit of discussion about this in the department because there was a process that was undertaken when there is the approval of new drugs. In some new drugs there is an approval process. Much of it, I know, is cancer drugs, but Bruce –

CHAIR: Bruce.

MR. COOPER: The reason we do not release a listing of drugs at the time of budgeted, when we build the budget we have a sense of the drugs that are in the review pipeline that are soon to come to market. We build the budget on the basis of what is going through one of the Common Drug Review processes. Before we will list a drug and cover it through our formulary, it has to be recommended from a clinical point of view and an economic point of view through one of the Common Drug Review processes, through CADTH, pCODR, or the Atlantic Common Drug Review.

We build up the budget on the basis of what we see as the needs and coming down the pipe, but it has to pass through that decision-making gate around the Common Drug Review before we would list. There is also another step that we would – working with the Pan-Canadian Pricing Alliance with other provinces, we would work to try to secure the best value for that product.

Once we get a positive recommendation from one of the review processes and then negotiate, we are in a position where we can announce that the drug has been added. Sometimes there are drugs that we think are coming, they are going to be online, and they do not get a positive recommendation. Then another drug that we did not know was going to be available, becomes available to the list. So that is how we manage that.

MR. A. PARSONS: What was the dollar amount put on that in the budget?

MR. COOPER: It is $7.1 million.

MR. A. PARSONS: There is a possibility that the $7.1 million does not get used?

MR. COOPER: I do not think we have been in a position where we have not used our new drug expenditures. There is a huge growth and demand for new drugs. It would be theoretical, I think.

MR. A. PARSONS: Okay. Basically, you plan for this, and depending on what comes out that is when you figure it out. Next year at some point we can get an idea of how the $7.1 million was allocated, which drugs, what did each one cost?

MR. COOPER: As a drug gets added, it is known to people. It is on the formulary. I am trying to think – I will look to Keith Sheppard – whether in fact we do, I do not believe we do releases but certainly it is publicly available.

MR. A. PARSONS: Yes, okay.

MR. COOPER: Yes, as it ticks along.

MR. A. PARSONS: I am just wondering now, this is a general question. How do you decide as a department which new drugs get added to the formulary?

CHAIR: Bruce.

MR. COOPER: Well, I described in a cursory way the Common Drug Review processes. To get inside the full mechanics of how a drug gets added, perhaps I could ask Keith Sheppard to give you a more in-depth brief on that.

Keith.

CHAIR: Keith.

MR. SHEPPARD: There are several ways the drugs can get added as a benefit. If a new drug comes in, if it basically has no budget impact, it replaces an existing therapy, if it is sort of a (inaudible) therapy it would just be added as we get the submission, as it is approved by the review agency.

As Bruce had mentioned, many drugs go through the Common Drug Review, through the pan-Canadian Oncology Drug Review, or the Atlantic Common Drug Review, they would come to us. We would look at the list of what was expected to go through the committee in the coming year. We would also meet with drug manufacturers to find out what they expect to be putting through the drug reviews in the coming year, and we would build that up as the list that we would bring forward in the Budget process.

As the year goes on, as the various drugs go through the review processes, their recommendations come out. If the recommendation has no cost implications, then it will be added as a benefit. In many cases the drugs will come out with what is called a conditional recommendation, whereby they would say we recommend this drug for inclusion on the formulary, but at increased cost effectiveness. At that point, as Bruce had mentioned, we would go to the Pan-Canadian Pricing Alliance process on a national basis to negotiate a better price with that manufacturer. Once that agreement was in place, the drug would be listed as a benefit.

MR. A. PARSONS: The cost implication has a big role to play here?

MR. SHEPPARD: For many of the new therapies, yes.

MR. A. PARSONS: I am just going to ask – and I know my time has run out. Some of this may have to get held to the next one. What were the actual savings last year from the generic pricings? What did we actually realize?

MR. DAVIS: Michelle.

CHAIR: Michelle.

MS JEWER: It is probably best to go to Bruce on that one.

MR. COOPER: We have that here; I just have to take it out.

CHAIR: Okay, Bruce.

MR. COOPER: For last year we did, as of July 1, reduce the generic rate to 25 per cent of brand, which we projected $4.8 million savings from last year and annualizing out to $6.4 million savings thereafter. I know what our projected savings were. I do not have the actual budget items. We do not have that here in terms of what the actual experience was.

MR. A. PARSONS: Can the minister undertake to provide me with the – because there may have been a difference between projections and actual, so if I could get the actual.

MR. COOPER: I was just advised that we do not actually have that level of data with us.

MR. A. PARSONS: You do not have it here.

CHAIR: Minister.

MR. DAVIS: Thank you, Mr. Chair.

We will gather what we can and put it together for you.

MR. A. PARSONS: There is somewhere in the department an actual savings figure, it is just not here. If it is not here that is fine.

MR. DAVIS: Right.

MR. A. PARSONS: Okay.

CHAIR: Bruce.

MR. COOPER: Yes, we will go back and look through finance and find the savings for you.

MR. A. PARSONS: Thank you very much.

Thank you, Mr. Chair.

CHAIR: Gerry.

MS ROGERS: Okay, thank you.

Also, I would just like to state that whatever we each ask for, if we could –

MR. COOPER: Of course.

MS ROGERS: Yes, and that was one of my questions as well.

Staying here on this area, Lucentis; we get calls from doctors, from patients, about increasing the number of doses of Lucentis for macular degeneration. Is there anything in the budget to allow for that? Is there a plan for that?

CHAIR: Bruce.

MR. COOPER: We did provide funding since 2009-2010 for Lucentis for the treatment of macular degeneration, and there is a lifetime maximum of fifteen treatments.

MS ROGERS: Yes.

MR. COOPER: In Budget 2013, we received funding to use Lucentis for two additional indications. Visual impairment due to diabetic macular edema, where there is a limit of eight, and macular edema secondary to retinal vein occlusion, which there is a limit of ten to twelve. Last year we spent more than $2 million for 330 beneficiaries.

We have had ophthalmologists, we have had some people questioning the criteria. We are currently in the process of reviewing the drugs we use for these particular conditions, and, in fact, for engaging the ophthalmology community in that review to help us try to ensure we are moving in the right direction. We have a committee established, an ad hoc committee with the LMNA that is going to start work on this issue early this month.

MS ROGERS: I am really glad to hear that because it has been a real burning issue for many of our constituents and for people in the ophthalmology community. I am very, very glad to hear that. So, that is starting this month?

MR. COOPER: The committee work is starting this month and the product of their work will be a review of what is available to treat these conditions and further advice to us.

MS ROGERS: Okay. Thank you very much.

The smoking cessation therapy coverage, how will that program work? Who will get the actual smoking cessation therapy, and what will that entail?

MR. COOPER: The smoking cessation program, the eligibility criteria will be individuals who are eighteen and up who meet the criteria for one of our NLPDP programs. It will provide for three months of treatment of either CHAMPIX or Zyban. We are going to be working very closely with the physicians who prescribe to also ensure that as part of the process of prescribing that the individual is linked with some of the peer support and the Smokers' Helpline so that in tandem with – obviously we want the program to set people up for success.

Success happens with the pharmaceutical intervention if there are also other supports that they take advantage of. We have certainly focused it in that way, and the people who will be eligible for this will be around 28,000 NLPDP clients. That is the eligibility criteria right now.

MS ROGERS: Around 30,000.

Will there be, in the budget, extra resources for the Smokers' Helpline so that they can deal with this? Hopefully their use will increase with this.

CHAIR: Bruce.

MR. COOPER: The budget does not contain any increase for the Smokers' Helpline but our assessment is they should be able to accommodate any increase within their budget. This will be starting in October, and if it turns out they have any experience we deal with, utilization issues as part of our normal budget process, we know we would hear from them.

MS ROGERS: Bruce, do you know at this point whether or not they feel they have enough resources to be able to do this extra work?

MR. COOPER: I am not entirely sure.

MS ROGERS: Okay.

MR. COOPER: I have not had a conversation specifically about the October roll out with them.

Elaine, are you able to comment on that?

CHAIR: Elaine.

MS CHATIGNY: We know that the helpline has some capacity currently. For example, last year they took in an additional 1,024 calls, first-time callers to the Smokers' Helpline. We know that year over year they see increases and it has not been a problem for them.

As the Deputy has mentioned, we are working with them. We are tracking with them, and if they feel the additional calls exceed their capacity, we will be dealing with that.

MS ROGERS: Okay.

Also, if somebody does their Zyban or their CHAMPIX and they fall off the wagon, can they go back?

CHAIR: Bruce.

MR. COOPER: The program provides for three different allotments of –

MS ROGERS: Three times?

MR. COOPER: Yes, three times.

MS ROGERS: Okay, great. We all know that the first time is often just practice.

MR. COOPER: Yes.

MS ROGERS: Okay, thank you very much.

What is the status of the initiative on pharmacists' expanded scope of practice?

CHAIR: Bruce.

MR. COOPER: We have had ongoing discussions with the Pharmacists' Association of Newfoundland and Labrador. As you are no doubt aware, I think it was August of last year, I believe that is the correct date, they submitted a paper called The Pharmacist Option outlining six areas where they believe that pharmacy scope of practice could expand; things like medication reviews, involvement in immunization programs, and there are a cluster of other areas.

We have had ongoing discussions. We have a proposal that we have discussed with them around making progress on five of the six areas. I think the conversations are being very productive. We certainly hope that we are in a position very soon to have a mutual agreement about how we can better utilize our resources.

MS ROGERS: It is very exciting. It is good news. That is good news.

How many rural and remote pharmacies availed of the subsidy last year?

CHAIR: Bruce.

MR. COOPER: I do not know the answer to that question. I will ask Keith if he has that.

CHAIR: Keith.

MR. SHEPPARD: I do not have that data with me but it can be provided.

MS ROGERS: Okay, thank you very much.

If we can go on to Medical Care Plan, 2.3.01, Physicians' Services, in Professional Services we see an increase of $7.5 million.

CHAIR: Minister.

MR. DAVIS: Thank you, Mr. Chair.

About $5.5 million of that $7.5 million increase is anticipated for utilization increases in the fee-for-service budget. Two million dollars is a reallocation from Grants and Subsidies budgeted in the same activity. So it is a reallocation of the $2 million to move the budget for amounts paid to salaried physicians who provide after-hour services.

MS ROGERS: So there are no new positions in this amount of money?

MR. DAVIS: You mean new as additional positions?

MS ROGERS: Yes.

MR. DAVIS: Bruce.

MR. COOPER: This is not how this budget works, this particular budget line. We have provision here for increased utilization. Some of that utilization may well occur because we have new fee-for-service physicians recruited.

MS ROGERS: I understand.

MR. COOPER: We do not have a plan for some many positions.

MS ROGERS: It is not bodies; it is use.

MR. COOPER: Yes, right; it is utilization.

MS ROGERS: Okay, great, I understand. Thank you very much.

CHAIR: Gerry, last question.

MS ROGERS: I am ready to hand it up to –

CHAIR: Okay.

Andrew.

MR. A. PARSONS: Thank you, Mr. Chair.

I am just going to go back – I had some more questions under the Provincial Drug Programs. I had asked a question about the anticipated savings and actual savings. Is there an anticipated savings for this year?

CHAIR: Bruce.

MR. COOPER: Yes, we do anticipate annual savings of $6.4 million associated with the movement to 25 per cent as of last year.

MR. A. PARSONS: Thank you.

You may not have this. Can we get a breakdown on the number of people currently covered under each category of the NLPDP? I guess we will put that on the list.

MR. DAVIS: I might be able to give you that.

MR. A. PARSONS: Okay, perfect, thank you.

MR. DAVIS: I think I might have it here, actually.

CHAIR: Minister.

MR. DAVIS: Under the five plans – Foundation Plan: 56,550; under the 65Plus Plan there is just under 44,000; under the Access Plan there is 27,800; the Select Needs Plan is a small, very specific plan with a relatively small number, sixty-three individuals is the information I have listed; and under the Assurance Plan: 8,000.

MR. A. PARSONS: I believe my colleague asked some questions about the smoking cessation. I had to step outside there. I am just wondering: Is there going to be a co-pay charged to low-income individuals for them to avail?

CHAIR: Bruce.

MR. COOPER: Yes, there will be a co-pay. The total co-pay over the period of the three months treatment course will amount to $75.

MR. A. PARSONS: Okay.

I am just wondering – and this is sort of more theoretical – we are treating low-income people, and again this is a hard thing when we are talking about smoking cessation, to get people to do this. Isn't a co-pay another barrier for a low income – I guess it is a barrier for anybody, but when we take low-income people and then they have to pay $75, this is a significant sum of money when you think about. We are trying to get people to quit smoking.

MR. COOPER: Minister, do you want me to speak to that?

MR. DAVIS: Yes, go ahead.

MR. COOPER: I can speak to the intent. Certainly, we have heard the pharmacists – in our discussions with the Pharmacists Association, they have expressed some concern around the idea of particularly a front-loaded program and wondered whether if we split it up into three equal allotments of $25 a month, if that might be a disincentive to people. So we are looking at actually trying to change the – still achieve the objective of a co-pay, which is a symbol of intent on the part of an individual, and also we want them to be successful, and with success will come – I do not know how much a pack of cigarettes costs today, but there is a significant –

MR. A. PARSONS: It keeps going up.

MR. COOPER: Yes, I do not know – but obviously there are a lot of savings. So the balance that we as a department tried to strike in the design was to find that right balance between a cluster of supports and at the same time as having the individual come forward with a show of some stake.

MR. A. PARSONS: I am just wondering – and you may have already answered this, and if you did, my apologies – is there an idea of how many people you expect to take in?

MR. COOPER: Yes.

MR. DAVIS: Sometimes that is hard to anticipate.

MR. A. PARSONS: Very.

CHAIR: Bruce.

MR. COOPER: Actually, I will have to shuffle to find that number. Elaine, you probably know it off the top of your head?

CHAIR: Elaine.

MS CHATIGNY: Yes, we expect that as of October 1, this calendar year, we would be looking at approximately about 1,900 people. The metrics are based on similar programs in other jurisdictions. As the deputy says, it is hard to anticipate accurately how many people will avail. Certainly we expect there will be increases over time.

MR. A. PARSONS: Okay, thank you.

MS CHATIGNY: You're welcome.

MR. A. PARSONS: Still under this, this is a very specific question – I actually have a letter drafted that I meant to send to the minister, but we are here so hopefully I can bring it up. It relates to certain drugs: Olmetec and Teveten. Again, I have it laid out here so nice.

January 2, the public was notified that these would be delisted effective April 1. I guess the long and short of it is that there is a fair bit of information that says that I am not sure if this makes sense from a medical perspective. So I am just wondering when it comes to these drugs – and I do not know who would answer, who makes the decisions, because there is going to be an increased workload for physicians, there is patient impact, there are people who may have to go into the hospital. I am just wondering what the rationale was.

CHAIR: Minister.

MR. DAVIS: Thank you, Mr. Chair.

I am not familiar with it, but I think Mr. Cooper can provide some information.

CHAIR: Bruce.

MR. COOPER: Originally, we had planned to remove Teveten and Olmetec from the scheduled benefits, under an NLPDP, as of April 1. There are five alternatives that review as effective, because that is obviously a primary consideration for us: to make sure that people receive their required treatment.

As you say, there was notification provided to physicians and pharmacists regarding the coverage status on January 2. We wanted to provide people with sufficient lead time to be able to manage this, to discuss alternative therapies, and to be switched to an alternative.

We did hear some concerns from physicians regarding this change and, as a result, we decided to change the status of the drug to special authorization. So it is still available. As of April 1, it is still available. It has not been removed from the benefit list. We do ask that it come through the special authorization process.

MR. A. PARSONS: In that case, though, don't they have to visit their family physician and in this case maybe try five different drugs before they can go back?

MR. COOPER: That is not how the special authorization process works. Yes, they do have to visit their physician. In terms of the criteria used for special authorization, that process, I will ask Keith to give you a description of that.

CHAIR: Keith.

MR. SHEPPARD: The criterion that was set up for Teveten and Olmetec was basically if they could not tolerate or the treatment was not effective on the five generics that were available. The physician does have the option, if they feel strongly that they need to retain the patient on one of those two drugs, they can make that request in special authorization as well.

MR. A. PARSONS: Okay, so if a physician contacts you or the department and says look, let's not fool with this, it is working, it is superior, and then you guys will accept it –

MR. SHEPPARD: No, that is something we would take under consideration as part of the assessment that we would do on the special authorization.

MR. A. PARSONS: I am just wondering now because you look at something – like when it was cholesterol, there was Crestor. I think, if I am right, there is no generic for that.

MR. SHEPPARD: I believe –

MR. A. PARSONS: For Olmetec there is no generic pill, right? The research I have seen – again, it has been pointed out to me and I have obviously had people come to me, this is a very specific issue; Olmetec is superior from what I have been told. So why would we ask someone to go their doctor and try different, inferior medications when we know this one is superior and it works, and they may have been on it. I just do not know why we would put a person through that.

MR. SHEPPARD: I guess the research that was available to us indicated that the generics were as effective as the two brand name products, the Teveten and the Olmetec.

MR. A. PARSONS: Are we privy to that? Are we able to get that research?

MR. SHEPPARD: I would have to check and see what is available with the pharmacists. I could look at a background file on that particular issue.

MR. A. PARSONS: Do you have a list of patients that were stable on this medication?

MR. SHEPPARD: No, we would just have the number of people who are actually taking Teveten and Olmetec.

MR. A. PARSONS: Okay.

Can we get that?

MR. SHEPPARD: Yes.

MR. A. PARSONS: Was there any consideration given to grandfathering this particular medication?

MR. SHEPPARD: At the time no, there was no consideration given to grandfathering it.

CHAIR: Andrew, you time has expired, but I will let you finish. Are you just about through

this line of questions and answers? Do you want to come back at your next round?

MR. A. PARSONS: I think I am done for now. I may come back.

Thank you.

CHAIR: Okay.

Minister.

MR. DAVIS: Just if I may for Mr. Parsons, maybe what I could suggest, if you wanted to submit your letter as you previously intended to do, then we can respond to you and get that information. If there is additional information that you have asked for and not contained in the letter, we will try and include that in the response and we will get that back to you. That is just as a suggestion to you.

MR. A. PARSONS: Yes, I think I will still send it off just to get it on the record.

MR. DAVIS: Yes.

CHAIR: Gerry.

MS ROGERS: Just to continue a few questions on the drug subsidization. Diabetes, the pump: Is there anything at all, any movement at all towards looking at extending assistance for the insulin pump beyond the age of twenty-five?

CHAIR: Bruce.

MR. COOPER: No, the insulin pump program criteria have remained unchanged for this year.

MS ROGERS: Is there any discussion, any research, or any movement at all looking at that policy?

MR. COOPER; Certainly we always try to stay current with the research to ensure we understand trends, but it is not something that we have budgeted for this year.

MS ROGERS: Okay, thank you.

Glucose strips: Is there anything in the budget at all looking at the expansion of covering glucose strips for folks?

MR. COOPER: There are no new investments in blood glucose strips. We do have significant expenditures on blood glucose strips annually. We have had discussions with our – because our current program we spend $6.6 million a year through NLPDP on glucose test strips, so that provides individuals 2,500 strips automatically to the beneficiaries who require insulin or oral diabetes medication. For people who require more than 2,500 there is a special authorization process they can come through.

MS ROGERS: Can you remind me again exactly who qualifies for them now under which programs?

MR. COOPER: This would be under the beneficiaries under the NLPDP program. It would be one of our five NLPDP programs.

MS ROGERS: Okay, thank you very much.

If we then can go back to the Medical Care Plan, 2.3.01, under 09, Allowances and Assistance, we see an increase in 2014-2015 of $500,000. We did not get to that point, did we?

CHAIR: Minister.

MR. DAVIS: That is an anticipated increase in the MCP out-of-Province program.

MS ROGERS: Okay. That is our folks who are travelling?

MR. DAVIS: Yes.

MS ROGERS: Okay, great, thank you very much.

Grants and Subsidies, we saw that we spent $8 million less last year.

MR. DAVIS: Expenditures, as you know, are always on anticipated uptake quite often. This is lower than anticipated expenditures associated with the bonuses for physicians. There was a one-time bonus that was originally calculated and budgeted based on all salaried positions being filled for the full duration of the agreement. There are a number of reasons why all of those bonuses did not realize. That is such as physicians transferring, retiring, changing

their own status, or left positions before the end of the agreement.

MS ROGERS: Then for 2014-2015 we see a decrease in $14 million.

MR. DAVIS: Yes, and again that results to the one-time retention bonuses under the MOA.

MS ROGERS: Last year there would have been more one-time retention bonuses we see.

MR. DAVIS: Yes.

MS ROGERS: Okay, great, thank you.

Then the Revenue – Provincial, there was an increase. What is that revenue there?

MR. DAVIS: The revenues received from other provinces for residents of other provinces who receive health care here in Newfoundland and Labrador.

MS ROGERS: Okay.

MR. DAVIS: Except Quebec.

MS ROGERS: Okay, except Quebec. What happens in that case?

MR. DAVIS: They do not have the same reciprocal agreement. What happens in those cases?

CHAIR: Bruce.

MR. COOPER: Quebec residents would pay out of pocket and then be reimbursed by their province.

MS ROGERS: Okay, thank you very much.

Dental Services –

MR. DAVIS: Sorry?

CHAIR: Dental Services, 2.3.02, Minister.

MS ROGERS: Sorry, before we go there, can we have the latest figures on the number of family physicians that we have and the number of specialists?

MR. DAVIS: We have that.

MS ROGERS: Great.

CHAIR: Bruce.

MR. COOPER: In terms of the number of physicians practicing in the Province, as of March 31, 2013, we have 1,055; 576 are general practitioners and 579 are specialists. In terms of the breakdown between fee-for-service versus salaried, approximately 70 per cent are fee-for-service and 30 per cent salaried – Cathi, correct me if I am wrong on that.

DR. BRADBURY: Sixty-three per cent are fee-for-service, 33 per cent are salaried, and 4 per cent of specialists are on alternate payment plans.

MS ROGERS: When you say 576 general and 579 specialists, would a family practice doctor be considered a specialist?

CHAIR: Bruce.

MR. COOPER: No

MS ROGERS: Or is that general?

MR. COOPER: That is GP, yes.

MS ROGERS: Okay, thank you very much.

Are the bonuses and higher fees helping to retain physicians, and are there any other new measures in this year to attract and retain?

MR. COOPER: We have had a number of initiatives to improve recruitment and retention of physicians and we have seen a net increase of 166 physicians since 2008. This is the highest number of physicians we ever had in our history in the Province and it is an increase of 18 per cent since that time. Just as a comparator, the Province's population has increased 1.8 per cent in the same time frame.

MS ROGERS: Wow. So we are good with recruitment, how are we doing then with the retaining of those?

MR. COOPER: For retention, I am going to have Dr. Bradbury answer that question for you, please.

MS ROGERS: Okay, thank you very much.

CHAIR: Doctor.

DR. BRADBURY: We have several initiatives with regard to the retention of physicians. We spend over $5 million a year in retention bonuses for salaried physicians. With our last agreement in 2009, we introduced a retention bonus for fee-for-service physicians in rural Newfoundland, and that was costed out at approximately $3.1 million.

Retention varies depending on the site of the Province and the type of physician that is recruited. For example, we know if we recruit a Newfoundland graduate, there is an 80 per cent chance that they will be here after five years. If we recruit a Canadian graduate, that percentage reduces to 60 per cent to 65 per cent and if we recruit an international medical graduate, that percentage goes as low as 50 per cent.

There is no doubt that there is turnover in some of our smaller, more rural, more isolated sites. We continue to look for ways to improve retention based on geographic considerations.

MS ROGERS: Thank you.

Twenty-two new positions were announced in the Budget, were there, physician positions? No?

CHAIR: Bruce.

MR. COOPER: Okay, sorry for the confusion. I apologize for the confusion. We did not announce new physicians.

MS ROGERS: It may be over here too.

MR. COOPER: Sorry?

MS ROGERS: The confusion may be over here too, Bruce. We can share that.

MR. COOPER: Okay. I think you may be referring to other positions we announced in the Budget.

MS ROGERS: Yes.

MR. COOPER: Yes, okay.

CHAIR: Minister.

MR. DAVIS: There were new positions surrounding investments in autism.

MS ROGERS: Yes.

MR. DAVIS: Is that maybe what you are referring to?

MS ROGERS: Susan, just let me check.

MS WILLIAMS: Yes, probably.

MR. DAVIS: Because the number matches.

MS ROGERS: Okay, what are the new physician positions included in the twenty-two new positions announced in the Budget?

CHAIR: Bruce.

MR. COOPER: We have a developmental pediatrician as being added to the assessment team at the Janeway to support diagnosis.

CHAIR: Gerry, do you have a follow-up or I will go back to Andrew.

MS ROGERS: I am good, thank you very much.

CHAIR: Thank you.

Andrew.

MR. A. PARSONS: Thank you, Mr. Chair.

Just a question, this comes to something Dr. Bradbury said. I have always wondered it and it just hit me, now is the opportunity to ask. Is there a technical definition on what is considered rural for the Department of Health?

CHAIR: Dr. Bradbury.

DR. BRADBURY: When we established the retention bonuses for salaried positions, we negotiated with the NLMA a three-tiered retention bonus based on geography with the

concept being that the more rural you are, the higher the retention bonus. There is no set definition of rurality. If you look at the rest of Canada, Newfoundland is rural because rurality can be defined both by geography as well as professional isolation.

MR. A. PARSONS: I am just wondering, I have heard this and I do not know if it is true or not. I represent Ramea, an island to the south. They are obviously extremely rural, I would say isolated. I have also heard that Corner Brook is considered rural. I am just wondering if they would be treated the same.

DR. BRADBURY: As it relates to retention bonuses for salaried physicians, they are broken out between GPs and specialists and they are broken out into three tiers so that the tiers even, say, for specialists that might be in the same site, might be in a different tier than the GPs. It considers, as I said, both geography as well as professional isolation.

Does Corner Brook qualify for a retention bonus? Yes. St. John's does as well, but for a significantly lower retention bonus than other parts of the Province.

MR. A. PARSONS: I am just wondering, again Ramea would not qualify for a GP or a specialist, but the big issue down there is a nurse practitioner which we had meetings with the minister on it and we have had a lot of discussions with Western Health. Would the retention bonus for a nurse practitioner in Ramea be the same as a retention bonus for a nurse practitioner in Corner Brook? I do not know if that is available now, but I think it is a good question.

CHAIR: Bruce.

MR. COOPER: The fact that there is a retention bonus and we have an approach to try to retain people and attract people is the same. There is obviously a different setup for each profession in terms of the value and the approach, but government has a policy that supports departments like ours in trying to recruit and retain hard-to-recruit positions and also dealing with issues of rural and isolated practitioners.

We do get permission to be able to put in place different retention and recruitment bonuses for people and benefits to be able to attract them to stay or to work in rural Newfoundland, places like Ramea.

MR. A. PARSONS: Before I continue on I want to go back to Olmetec – and I am going to put a letter in, but I have a copy here of the bulletin that was put out on April 4. I will just take Olmetec and it says: Effective April 1, 2014 the brand names will be moved from open benefit to special authorization, the updated criteria are as follows. So for Olmetec it says: For use in patients who have failed or had intolerable side effects to treatment with Candesartan –and I might pronounce these wrong – Irbesartan, Lorsartan, Telmisartan, and Valsartan. So, it is five different ones.

I am just wondering: Do they have to try all five? You are saying that there will be consideration given to what a doctor says, so can we stop after one?

MR. COOPER: Again, inside the special authorization process there is an assessment that is undertaken by the pharmacy staff in the department. In interaction with the physician, they assess each case on the merits of the case and they make a clinical judgement about what the right approach is.

MR. A. PARSONS: Obviously, I am a layperson, but if I am the treating physician and I have this person's blood pressure issue controlled with Olmetec, they have been on it, it works, now all of a sudden we are saying no, we are going to switch you off – even it if it worked – for budgetary reasons, because that can be the only consideration to change somebody. You would not change them to a less effective drug unless there was a cost factor, I am assuming.

If that is the case, we are saying: do you know what? You are going to try this first one. I am just wondering at what point the patient benefit is factored in with the cost benefit. That is sort of where I am going with this.

MR. COOPER: I think the core issue here is at a higher level. The fact is that with the evolution of generic drugs we do not introduce or support the inclusion of generic drugs on our

formulary, unless there is strong evidence to suggest that it is clinically effective.

We do go through a process with drugs from time to time of delisting them because there is a reasonable alternative available from the generic approach. Certainly, that is the core issue we deal with in trying to – it is not just an issue for these drugs. There is a policy approach we have in the department of trying to strike a reasonable balance between the – of course, clinical effectiveness of a drug is primary consideration. We would not bring a generic drug unto our formulary, and to be trying to move people in that direction, unless we had strong evidence and advice from professionals that in fact it is equivalent.

MR. A. PARSONS: Okay. For Olmetec specifically, my understanding is that it is superior. Again, you are suggesting that your evidence and research shows that it is not. I guess that is a matter of comparing the evidence to see which one is right and then what the professionals are saying.

What I am saying is we have a personal doctor who has a history with this individual. They have him on this, it is working well, and it is controlled. Now all of a sudden we have to possibly change this drug. I am not talking about on an ongoing basis, I am talking about people who were already on it. I understand that ongoing is different, but if you have somebody who is on a drug and their situation is controlled, and you are possibly going to put a kink into that, this person could end up in an acute care facility which there is a cost implication there.

I am just wondering, it does not say anywhere on the bulletin that we can stop after one. I am just saying the patients that I talked to and the doctors, I am just wondering: should I tell them to call in and say, do you know what? My professional opinion is that they should stay on this. We have tried it on one. Will they be given the consideration they deserve to stay where they are?

That is just what I am wondering here. Because at the end of the day I would assume that the patient benefits here and everything else comes under that. That is just what I am tossing out there.

CHAIR: Bruce.

MR. COOPER: In terms of the evidence, we are certainly not proposing that evidence the physician has, that you have been speaking to, is inferior to ours. I am just trying to answer factually, that the process we use is one that is evidence based and that the approach we use as a department in making a decision in what drugs to move to special authorization is one that is certainly focused on the best use of that evidence.

It is hard in the context of this kind of Estimates review to get into a significant policy discussion around this particular drug. I find myself, without the pharmacists at my back here today, to be able to get into some of the more nuance discussion that I think you want to have on this. Certainly, when we get your letter we will dig into this.

MR. A. PARSONS: How much did this particular delisting save government?

MR. COOPER: I will have to turn to Keith Sheppard to answer that.

CHAIR: Keith.

MR. SHEPPARD: I do not have that data with me right now.

MR. A. PARSONS: Do you have a ballpark here today?

MR. SHEPPARD: No, I actually prefer to go back and get the correct number.

MR. A. PARSONS: Okay, because I am going to need that information and see what is saved here versus the cost if somebody goes off this drug and ends up in the hospital. That is just putting that out there today.

Thank you.

CHAIR: Okay.

I think this will be an appropriate time to say let's take five and stretch our legs and do whatever else we may need to do.

We will reconvene here at 10:32 o'clock, which is six minutes.

Thank you.

Recess

CHAIR: We are ready to continue. Thanks, Minister.

I believe, Gerry, you are up.

MS ROGERS: Thank you very much.

I just have one question before we go on to the Dental Services. For the smoking cessation program, what kind of a rollout ad campaign budget for that is there?

MR. DAVIS: It is in development.

MS ROGERS: The program starts in October, is it?

MR. DAVIS: That is the plan.

MS ROGERS: Okay.

MR. DAVIS: I always say, Ms Rogers, that I am always sensitive to hard lines this far out because you might be two weeks away from a planned announcement and something may push you back for a week or two weeks or push you into the next month or something like that, so I am always sensitive to that.

MS ROGERS: I understand that.

The Dental Services, we see that there was $5,200,000 in Professional Services not used – the revision there.

MR. DAVIS: If you look at the entire section, there is a $4.7 million revision. The overall dental program had savings of $4.7 million in 2013-2014, and that included Professional Services and Allowances and Assistance.

In March of 2013 the department introduced measures to ensure that the program operated within its allotted budget, and we remember those discussions back in March –

MS ROGERS: We sure do.

MR. DAVIS: It was $6.7 million that had been allotted for the dental program in 2013-2014. In the last fiscal year 2013-2014 there was a $150 cap that had been added and also $750 for dentures. There was prior approval process that was also implemented.

We have reviewed and we have continued to monitor how that happened. We have had a fair bit of interest in this one, knowing that there has been interest in the past and it is a new program, so I have had some discussions since I have come in the department on this particular area, a fair bit actually, because one of the implications of having a program that has significant uptake and has these increases and decreases is the impact it also has on the industry and also the capacity of the industry to adjust to the demand for service.

The cap was put in this past year of $150 for dental services and the $750 on the dentures. This coming budget year, we have increased that to $200 knowing that we can do that because we wanted to make sure that we managed the budget in an appropriate way while still providing the services to the people.

That is essentially where this has taken place. You see that we still have essentially the same budget this year for dental services as we had last year. An increase in the cap will result in an increase in the usage and uptake is the anticipation.

MS ROGERS: Can we just go back to the $4.7 million savings? What did you save on?

MR. DAVIS: There were a number of areas – and Bruce, did you want itemize them more specifically?

MR. COOPER: Okay.
We had a $2.5 million variance in the Adult Dental Program and a $2 million variance in the Children's Dental Health Program. We had lower anticipated uptake for the children's program.

As you are probably aware, the Children's Dental Health Program provides universal access to dental services for children twelve years and under. We cover exams every six months, cleanings every year, and fluoride for

children between six and twelve, routine fillings and extractions, and sealants. That is the nature of the universal program, of course, available to all children in the Province.

We did see a savings. Over the last number of years, we are seeing some savings in that area that we have been able to use to offset expenses in other parts of the dental program.

MS ROGERS: I find it a little concerning that we know that there are a number of adults who need more dental care and with the cutbacks in the dental program, with the imposition of the caps, what would those savings be in the adult program? How did you save money?

MR. COOPER: The fundamental reason is that we had lower than anticipated uptake for the dental program for the actual access to dental services on the part of eligible individuals as well as the denture program. Fewer people accessed the program than we anticipated last year.

MS ROGERS: Why do you think that is?

MR. COOPER: It would be speculative for me to –

MS ROGERS: Sure.

MR. COOPER: In the first year, we saw a significant demand in the service. This was the first year the program was offered and we had 20,000 people come forward and receive service. This program is certainly one of the leading edge programs in Canada. Government designs it under the Poverty Reduction Strategy to meet a need and I guess the first year showed us there is a need. There was a lot of work done that year. I do not know if there may be some role that the ebb and flow has played. Naturally, the department introducing a cap would also play a factor in changing people's behaviour.

MS ROGERS: That is what I am wondering as well. I think that we had all talked about there would have been a huge increase in uptake when there wasn't a cap, because we are getting calls from people who have severe dental issues who need help and they cannot because of the cap. We are also hearing from dentists who find it difficult to get the authorization and it is time consuming.

Has there been any research done at all to look at the impact of the cap on people accessing preventative and maintenance type of dental work, not just emergency?

CHAIR: Minister.

MR. DAVIS: As Bruce mentioned it is somewhat speculative because you try to anticipate and manage demands for services, especially new programs as this one was. As I mentioned earlier – and I should probably elaborate a little bit. For many, many years there is a certain level of demand for a certain industry or a certain service and all of a sudden there is a significant uptake, it has an impact on those services, those operators as well and services that are available. Then they have to measure how they are going to respond to that increased demand.

I remember when I first heard of the program, I would of expected a big pocket of uptake and then over the period of time, probably a very short period of time, relatively speaking, things would calm down, if you like, because people would have their major issues sorted out.

I was at my own dentist not that long ago and I was having that discussion with some of the staff. I said well, you must see a variety of patients of different areas and so on. One of the professional staff said she essentially has her client base and she said no, I am getting them now to an area where I like. She said it takes a few years for people who come in with significant issues and over time, you begin to deal with those issues and the person reaches a state or grows to a state where they have better dental health and then it becomes that maintenance piece. That was the discussion I was having.

I would expect the same type of thing to have happened with a program like this and what the cap does, the intention of the cap was to not create a circumstance where the demand was so great that industry could not keep up with the demand and had to figure out a way but it was to level that out but also we know that it may take a person who has complex dental needs, it may

take them more than a year, it might take them two, three, four years doing pieces of work but I do not think and I would defer to the people in the department who would know much more about this, I would not think that would be different from an individual who may need a lot of work and they may go in and get a piece of work done.

They have their period of time, they get more work done and so on and I know people personally who have gone through the same kind of thing. As Bruce mentioned there is about 20,000 people in the first year uptake on this program and last year with the cap it was much less than that. So increasing the cap we know is going to make an adjustment on that. We would anticipate making an adjustment but it is an important program. It is important to people who really need the benefit of these types of services and we intend to continue on it and make it as available as we can for both the dental work and for dentures.

MS ROGERS: Well I think the fact that 20,000 people took advantage or used the service that was provided was an indication that there was a need for it and the fact that there is a drop is not an indication, we cannot speculate and say that that is an indication that there fewer people who need this service. It is that the cap makes it inaccessible for a lot of people and I think we are not talking about cosmetic work where you might get something done one year and something else done another year we are talking about I think very, very basic dental work that has to do with health.

MR. DAVIS: We have increased the cap and you still can get work done.

MS ROGERS: Two hundred bucks.

MR. DAVIS: Right you can still get work done but if you need $400 worth of work done instead of doing it in a single year you do it over two years. Bruce I do not know if you wanted to discuss that further.

MS ROGERS: That is a little bit hard if you are in pain.

CHAIR: Bruce.

MR. COOPER: Yes there is a possibility the individuals are eligible for a service

So yes, there is the possibility – I mean individuals are eligible for service every year. The only eligibility rule around the access to the adult basic program is you can only have the same service on the same tooth done every three years. So a person actually every year can access the basic dental services.

CHAIR: Gerry, I am going to hold you there because I have been fairly –

MS ROGERS: Sure, yes, go ahead.

CHAIR: Andrew.

MS ROGERS: I will continue on (inaudible) after.

CHAIR: Because I am sure you are going down a similar path.

MR. A. PARSONS: Alright, you are using up my time, Mr. Chair.

CHAIR: Okay.

MR. A. PARSONS: Just on the dental plan, how many people availed of it in the last fiscal year?

MR. DAVIS: About 10,000 I believe is the number. That is just the dental. That does not include dentures, that is just dental, I believe, is it not, Bruce? Or is that both?

CHAIR: Bruce.

MR. COOPER: Cathy?

CHAIR: Dr. Bradbury.

DR. BRADBURY: I know in the first fiscal year there were 20,000 who accessed the basic dental program, and 10,900 accessed dentures. In fiscal 2013-2014, the number for the basic dental was approximately 10,000, and I do not have the denture number here today, I am afraid.

MR. A. PARSONS: So can we get the denture number when it is available?

DR. BRADBURY: Sure.

MR. A. PARSONS: I am just wondering now, so the cap for dentures is $750. Is there an estimate on what the cost of dentures is?

MR. DAVIS: Yes.

MR. A. PARSONS: What is the understanding that the cost of dentures is?

MR. DAVIS: I know it does vary, but maybe Dr. Bradbury could (inaudible) as well.

CHAIR: Dr. Bradbury.

DR. BRADBURY: The cost of a basic denture, and there are twenty or thirty different sort of bells and whistles and adjustments – as I understand it – that you can do to a denture – a basic denture costs $750. We know based on the first fiscal year of the program when there were no caps that the average denture was $1,042.

MR. A. PARSONS: Okay.

So I am just wondering – say it is $1,042 – and again, the number I was given was $1,200, but I know what you are saying, it could go up, it could be down – so I am just wondering, if you are given $750 in a year and the cost is a $1,000, what does the person do?

MR. DAVIS: So normally it would be $750? You used two numbers, I want some clarification here too, Andrew, because there were a couple of numbers that Dr. Bradbury referred to. She referred to an average of $750, and also the $1,000. Maybe she could explain that a little bit further as well.

CHAIR: Dr. Bradbury.

DR. BRADBURY: I have been informed that the cost of a single, standard denture is approximately $750, and that in the first year of our Adult Dental Program the average cost was $1,042. This I assume would indicate that a number of clients received upper and lower dentures as opposed to just a denture.

MR. A. PARSONS: Okay, so the denture means singular and dentures means plural obviously. If somebody needs both dentures and the cost is over the $750, do they get both or do they get one?

CHAIR: Minister.

MR. DAVIS: Mr. Chair, they can get one this year.

MR. A. PARSONS: Yes.

MR. DAVIS: They can get another one next year. Each one can be replaced then I think every number of years.

MR. A. PARSONS: You are not going to take the blame for this, but every time I have stood up in the House and mentioned it, I have everybody on that side saying you do not know what you are talking about. I have said you get one set per year.

The problem I have – and again I am a layperson, but I have denturists and dentists say you should get them both the same time just due to the fact of the changes in size, et cetera. I am just wondering does it make sense to get two at the same time or get one this year and one next year? That is what I am wondering.

MR. DAVIS: You said you have been told and I do not know because I have not been told. I do not know if Dr. Bradbury would like to comment on that further for us.

CHAIR: Dr. Bradbury.

DR. BRADBURY: I have not had a conversation about the most appropriate timing for dentures.

MR. A. PARSONS: I have had a conversation because I do not know. I have not availed of that service personally so I have talked to the people who do it. They say quite clearly, get them both at the same time.

I am just wondering is this something that needs to be looked at if it makes sense to do it at the same time. If they get them one year then obviously they do not get it the second year. Would it cost the same? I am just wondering.

CHAIR: Minister.

MR. DAVIS: I do not know the answer to your inquiry there now, Mr. Parsons. I tell you I will have that discussion and I will get some further information. I understand what you are saying and what you are asking. We will inquire to get that and I will get a response to you.

MR. A. PARSONS: Yes, I guess the basic point I am making is that I think people should get the full set of dentures if they need it at the same time rather than making them get one per year and having that gap there, which makes no sense whatsoever. That is the basic point.

MR. DAVIS: Only to add that I know people who have availed of the program and have done one in a year, one at a time. Not to say it does not exist, but I have not heard the same type of criticism or concern that you are raising. We will have a discussion about it and we will get back to you.

MR. A. PARSONS: How long does it take for you to get the prior approval? What is the time period these days? What are we averaging?

MR. DAVIS: About five to six months. That is for dentures, right?

MR. A. PARSONS: Yes.

MR. DAVIS: Yes. That is from application approval until the time you get right through, it is about five to six months.

MR. A. PARSONS: If it is an emergency it is quicker than that.

MR. DAVIS: It could be.

MR. A. PARSONS: I am just wondering, is an emergency application quicker than that?

MR. DAVIS: I will let Bruce –

CHAIR: Bruce.

MR. COOPER: I am not certain about the emergency dentures. I know about emergency dental services.

MR. A. PARSONS: Yes.

MR. COOPER: At the beginning of the program, we had a prior approval process in place and that ended.

MR. A. PARSONS: Okay.

MR. COOPER: We do not have people wait for emergency services.

MR. A. PARSONS: For regular dental, what is the approval timeline?

MR. COOPER: Individuals go to their dentists and if there are dentists who are set-up with us, they would bill us for the portion that we pay. We would not manage that. The access to dental service is between the patient and their dentist.

MR. A. PARSONS: Okay. What I am going to do, if it is okay by the minister, we have an hour left and my general experience doing these Estimates is that there is never enough time. We were lucky to get three hours of everybody together and I appreciate that.

I have a bunch of topics I want to hit. If it is okay, can I put them out there and you answer them if you want to?

MR. DAVIS: It is kind of like the speed round, is it?

MR. A. PARSONS: Unfortunately, we have learned not to look for extra time.

I am just wondering about the family caregiver program. Is there an update that can be provided on that?

MR. DAVIS: The family caregiver program is being operated, I believe, as a pilot initially.

OFFICIAL: Phased in.

MR. DAVIS: It is a phased-in approach we are taking. I am just trying to remember, we have it set up this year to carry out – how many?

OFFICIAL: Two hundred and fifty.

MR. DAVIS: Two hundred and fifty and the program is working its way through the process, but 250 is the target for this year to phase it in.

MR. A. PARSONS: I know that it started in March, I believe, people started calling in. Has the approval been made of the people who are allowed? Do you have a breakdown per RHA?

CHAIR: Bruce.

MR. COOPER: We do not have the breakdown by RHA.

MR. A. PARSONS: Okay.

MR. COOPER: The RHAs are collecting data on the people who apply for the program. We are monitoring the approvals. At this point, I think, as of last week, we had eighteen approved and fourteen almost ready for approval. There are 123 individuals who have come forward and are in the queue for assessment.

MR. A. PARSONS: That is all the applications? There were 123 plus the numbers you listed?

MR. COOPER: So far, but this is an evolving program as all home support is. We have significant growth every month. In the Home Support Program we see growth numbers up to thirty-six new cases a month, new.

MR. A. PARSONS: Would it be fair to say that the number per regional health authority will be determined by how many applications come in and where they are? Or was each RHA given a-

MR. COOPER: We did start off with an allocation to each regional health authority and I cannot conjure it at this moment. What we are doing with this program because it is new – and we are wanting to ensure that there is provincial consistency in how it rolls out, and where it is new – there is learning taking place about making sure that the policy is working the way it is intended.

Every week we get together with the regional health authorities and have discussions. There is an opportunity as a provincial system for people to be working together on what the need is. As time goes on – and this is not uncommon with initiatives that are new and that we are leading rollout through the Province – if there are needs that develop in a particular area there may have to be some rethinking of the allocations but it will really be following the need.

MR. A. PARSONS: My last question just on this topic so I can clue up, I believe the original timeline for an update was September 2015. I think that was the plan. You would do the pilot and that is when you would tell us the results. Is that still the intention or will there be any changes?

MR. DAVIS: The year 2015 is a long way out. One of the processes that we have had discussions on since I have come into the department is about how do we evaluate, how do we measure those types of things. It will be part of it but we have not had a specific discussion about a hard date of September 2015. I can tell you from my perspective as minister, it is important that we do evaluations on these types of programs.

MR. A. PARSONS: Okay, so it may not be fall 2015?

MR. DAVIS: We might decide that we need to do it earlier than that. If we have a small number in uptake, for example, we may say well lets revisit this. Are we capturing the need? Is there a modification we need to make and so on? Do we need to change or alter something we are doing? As we just talked about with the dental program we moved a cap this year. We moved it, measured it. We may move it again next year. We will see how it rolls.

MR. A. PARSONS: Okay.

MR. DAVIS: The same kind of thing with this.

MR. A. PARSONS: Thank you.

CHAIR: Okay, Gerry.

MS ROGERS: Continuing on the paid family caregiver program, Bruce, when you say eighteen have been approved, so then are they now happening?

MR. COOPER: I presume they are happening. I presume they have been put in place, but I do not –

MS ROGERS: Okay.

MR. COOPER: That is delivered by the RHA. Once the approval is done they implement.

Once approval occurs for regular home support, normally, that happens very seamlessly.

MS ROGERS: Yes, okay. The fourteen pending approval or ready for approval, how long is the approval process, do we know? How long has it been taking?

MR. COOPER: The assessment process that we are using for this is fundamentally the same assessment model that we are using for the regular Home Support Program. I do not have the particular numbers for you in terms of what the time frame is in terms of the application.

MS ROGERS: Would it be possible to get that information?

MR. DAVIS: Mr. Chair, if I may.

CHAIR: Minister.

MR. DAVIS: We can just do a quick review. We started to receive applications in March. We began the approval process then after. On March 13 we started to accept applications, and on March 24 we began the approval process.

MS ROGERS: Okay.

MR. DAVIS: It is a very short snapshot in time relatively speaking. Over the last six weeks there were eighteen approved, fourteen in the approval process.

MS ROGERS: Okay, thank you. Back to the dental services, the savings, I do know that I have a number of constituents who have one set of dentures, just upper or lower, in their drawer because you cannot use your dentures unless you have both sets. If you need both and you only have one you cannot use it. They may put their dentures in the drawer for a year and then there are problems with fittings.

There is a savings you say of $2.2 million in the children's program. What was saved there? Also, how many children should be availing of dental services? How many are availing of dental services?

CHAIR: Bruce.

MR. COOPER: I do not know the answer to your second question.

MS ROGERS: Okay.

MR. COOPER: I do not have the population of children numbers in the Province with me, the age bands. In terms of what was saved, money was saved because there were fewer dental services offered than anticipated in our budget. That is the short answer to the question. The utilization was not what we anticipated.

MS ROGERS: Maybe it is not so much a savings –

MR. COOPER: Oh, it is not. It is not savings in the sense that there is nothing occurred to alter access or anything like that. This is just simply utilization.

MS ROGERS: Yes.

CHAIR: Minister.

MR. DAVIS: Thank you, Mr. Chair.

It is an important point to bring up because it is one of the things that I want to know if there was less – where did we measure our anticipated uptake, where was it, and is there something we need to do to increase the uptake? Are there not enough children or fewer children availing of it that could be or should be availing of it? It is an important piece of health and how do we increase that utilization.

Another discussion we have had – I think that one was around 11:00 on Saturday night, but it was another discussion we have had in the last week.

MS ROGERS: I would wonder if that would be a discussion as well to be had around the adult program.

MR. DAVIS: Absolutely. There is ongoing monitoring on the adult program, and that is why there was a change made this year in the cap that will be measured and we watch that as the year goes through. If there is opportunity for making an improvement in the next budget year, then we will look at doing that as well.

MS ROGERS: I would imagine that when there was not a cap and there was such an uptake it is because people needed it, because who wants to go to the dentist if you do not have to. I do not imagine it would have anything to do with frivolity or abuse, but probably necessity.

Subhead 3.1.01, Regional Health Authorities and Related Services, Allowances and Assistance, we see that there is an increase there of $2 million.

MR. DAVIS: Oh yes, $2 million.

There are a number of changes. You are talking about the increase of $2 million in the 2014-2015, correct?

MS ROGERS: Yes.

MR. DAVIS: Approval had been granted for enhancements to the Medical Transportation Assistance Program or MTAP as we call it.

MS ROGERS: Yes.

MR. DAVIS: You know what that program is and what that is about I am sure. Also there is a correction in the forecast error between Allowances and Assistance and Grants and Subsidies. Essentially, it is a fund that was previously put in a different category, not an error on its estimation, but it was put in the wrong category and the guidelines require us to move that so that was moved to this category. So there was twofold there.

MS ROGERS: Then in Grants and Subsidies we see an increase of $104 million.

MR. DAVIS: The breakdown on those, I can run through for you. Salary increases for the regional health authorities was the most significant amount, more than $37 million; funding for increases, inflation and utilization pressures on the regional health authorities was $26 million; operational budget for funding for the St. John's long-term care facility was just over $10 million; annualized home support growth from the budget of 2013-2014 to this year and also new funding for home support is $8.6 million or closer to $8.7 million; family-based care program was $8.2 million; there was also increased funding for intervention services for autism and new cancer drugs for Eastern Health.

MS ROGERS: Thank you.

Can we have a breakdown by health authority of allocations of grants and subsidies? Is this also the area where community groups who doing health related work – is this where they would get their grants or subsidies as well?

MR. DAVIS: I am sorry, what was the…?

MS ROGERS: Is this also the line item where community groups who are doing…?

MR. DAVIS: No, that is on 3.1.02.

MS ROGERS: Oh, there it is down that. Great, I will get back to that.

MR. DAVIS: For the regional health authorities, I think I have that here –

MS ROGERS: Even, Minister, if you want to send that to us.

MR. DAVIS: I think I have it actually. Eastern Health for 2014-2015 was $1,142,000,000; Central Health was $297 million; Western Health was $282 million – of course, I am rounding all of these, Ms Rogers – and Labrador-Grenfell was $124 million.

MS ROGERS: Great, thank you.

Revenue from the federal government, we see an increase in 2013-2014 of $517,000 and a decrease in this coming year of $800,000. What would that be?

MR. DAVIS: The federal revenue increase in the revised budget was the final claim for various Health Canada agreements in 2012-2013 that were received in 2013-2014, and the public health agency of Newfoundland and Labrador transfusion injuries surveillance system project. I am told that does not mean they are sitting in parking lots secretly watching people; that is not what that is.

MS ROGERS: Transfusing?

MR. DAVIS: It was a new agreement that was not in place for the budget and that was $125,000. So for this year, $801,000 is drug treatment program funding that was discussed earlier, that Elaine had talked about earlier, and that was a program that was sunsetting, but we are waiting on the federal government for new funding opportunities. The second part of that was the Health Services Integration Fund that has ended.

MS ROGERS: Okay. Then for provincial revenue we see an increase of $3 million.

MR. DAVIS: An increase of $3 million for this year?

MS ROGERS: Yes.

MR. DAVIS: There was a combination –

OFFICIAL: That is the cars.

MR. DAVIS: Oh, really? It is an increase anticipated in a vehicle levee program. It is received from insurance companies for motor vehicle accidents. So when there are more cars and more accidents, then we recover those costs from the insurance companies.

MS ROGERS: Oh, I did not know that. Did you know that, Andrew?

MR. DAVIS: So we get the third party for the medical expenses.

CHAIR: We learn something new every day.

MS ROGERS: Great. It looks like my time is up.

CHAIR: Gerry, I am going to hold you there. I am going to go to Andrew because that was a good spot to stop, I think.

MR. A. PARSONS: I am going to go into 3.2.02 and specifically Corner Brook hospital, which I do not think is a big shocker.

I just have a number of questions on it. What is the status of the new hospital as it stands? Where are we?

MR. DAVIS: As you know, there was a master plan process that went through; there was a draft functional plan that was developed. Then there are a number of processes that occur with the draft plan, reviews, adjustments, modification, inputs, and considerations that take place. The goal is to have the finalized functional plan by the end of this month or early June. I just set a date, didn't I? Darn.

MR. A. PARSONS: You did it.

Have the plans for radiation and PET scanner been incorporated into the design yet?

MR. DAVIS: If you consider the functional plan, it is more about the physical facility itself. From that perspective it is. That is included there.

We are also going to go through a process; we still have to determine the best practice and safest way to deliver radiation therapy. That is kind of a separate piece of work that we are doing as well. In the process and development of the functional plan, yes, it is included in that.

MR. A. PARSONS: What is the latest status on the number of beds in the new hospital? Can you break them down to acute care, long-term care? Do we have those numbers?

MR. DAVIS: Yes, we do.

CHAIR: Bruce.

MR. COOPER: Actually I will pass this question to Cathi Bradbury please.

CHAIR: Dr. Bradbury.

DR. BRADBURY: The numbers are not finalized and will not be finalized until the functional plan is completed. Following the completion of the master program there were 160 acute care beds and 100 long-term care beds.

MR. A. PARSONS: Are there any mental health care beds or hostel beds?

DR. BRADBURY: Mental health care beds would be included in the acute care bed count of 160. There is a hostel also planned for the

campus. The bed number I believe for the hostel is twenty-four.

MR. A. PARSONS: Twenty-four; so 160, 100 and twenty-four. No other beds that I am missing headings on?

DR. BRADBURY: Not from the master program.

MR. A. PARSONS: I guess that is the latest we have which is the information you have. This is the number, okay.

CHAIR: Minister.

MR. DAVIS: Yes, the functional plan will give us a better idea on that. I have to stress, because it has been stressed with me a number of times, the functional plan or drafts of the functional plan are snapshots in time. Numerous changes, modifications take place with those plans as they are being developed.

MR. A. PARSONS: How many addendums have been made to the functional plan in the last two months?

MR. DAVIS: I do not know if we would know that. Bruce?

CHAIR: Bruce.

MR. COOPER: The draft functional plan I guess you are referring to is the December draft functional plan?

MR. A. PARSONS: Yes, my understanding is that there have been addendums that come in and get added.

MR. COOPER: Yes, right. I think to call them addendums would be not really representing the process properly. The process with the draft plan that was produced, the purpose of the draft was to support the further planning and validation of the assumptions that were being made.

There have been multiple meetings. I could not speculate the number of changes from editorial changes to changes in thinking about proximities of services, what is going to be required. We, through the direction on radiation therapy, have made changes.

To try to count the number of addendums, there are a significant number of changes that have been made. It is a living document as you would expect. We fully expect that in the final draft, that will be the product of countless changes.

MR. A. PARSONS: How many ultrasounds are scheduled to be placed in the new hospital, or spaces?

MR. COOPER: That will be known when we have the final functional plan.

MR. A. PARSONS: Okay, because the Stantec report says three and the hospital currently has six. That is one of the concerns that are going around. I am not going to just say Corner Brook, I am going to say the West Coast because we are all affected by it. I did not know if there was an intention to cut that.

MR. COOPER: Yes, I think what you are perhaps referring to is the draft document point in time. The final document will contain the final number. I know that there are more than three ultrasound rooms in that draft as well, there are actually four, but it is just a labelling issue, so again one of those issues that you pick up. That is the work that is occurring right now is to finalize what the program should be.

MR. A. PARSONS: Do you anticipate cuts to ultrasound in the new hospital from what is currently there?

MR. COOPER: There is a lot of discussion, consultation, and work of the planning committee ongoing. It is speculative to talk about cuts. There will be no cut in the service. The whole purpose of the hospital is being designed in such a manner as to respond to projected future need. We will get a functional plan that will show us how to deliver the service to the people of the West Coast in the best way possible.

CHAIR: Minister.

MR. DAVIS: Mr. Parsons, in the discussions I have had, in some of the learning I have had in the last five or six days, the way things are done

in hospitals today is not necessarily how it is envisioned and how it would take place in the future. The same things are done differently.

As an example, there is a new generation of dialysis equipment that needs a different level of maintenance than the older equipment. It takes up a different amount of space. It is more portable. It has more options than the older. Dialysis in its early days was very large and cumbersome and a highly maintained type piece of equipment. It has become so much better than they were then. It opens the opportunity to do different things with dialysis. When we talk about home dialysis, it is not something that would be considered not that many years ago.

Some radiation services, not the radiation bunkers that we are talking about, but for ultrasound equipment it is the same kind of way. It is much more portable, it has more features, and it has more options now. You have to consider, through this, I am told that we have to – I was asking the same kind of questions. I am kind of like well we have to wait now because we know what some of the evolving technologies are. We have expectations where technologies are moving, and what opportunities exist today with equipment that could not be utilized. That same equipment five, ten, fifteen, twenty years ago could not be used for the same thing as it can today.

As they go through the functional plan those are some of the considerations that are taking place. If you see things like four rooms instead of five or four rooms instead of six and why is that, it should be wait now, let's get the full information first and understand because those types of services will have to be provided.

MR. A. PARSONS: That is certainly fair.

MR. DAVIS: There may be other ways to do it. I am just saying this for you generally. I am just speaking very generally.

MR. A. PARSONS: No, no. As long as there is no cut in service from what is currently there, then that is all the people of the West Coast expect, that there will be no cut from what they are already getting.

Can you tell us if you will be installing your own water tank for this hospital or will you be relying on the city's water supply?

CHAIR: Bruce.

MR. COOPER: The issue of site preparations, water tanks, electrical, sewer, water issues, that is really within the purview of Transportation and Works. Our focus as the Department of Health and Community Services is the functional planning for the programs and services that are required in the hospital. We are focusing on what are the services that are going to be needed in the hospital, so I cannot answer your question.

MR. A. PARSONS: Okay. What is the status of the $500,000 radiation report? We know things have changed since it was announced; we know radiation is going to Corner Brook. I am just wondering will the $500,000 still be spent. How have the developments in the last couple of weeks affected this?

CHAIR: Minister.

MR. DAVIS: It will be spent. What needs to happen there, and I referred to it earlier, we have to find what is the best model. If it be single machine or a double machine, how do we make that work, what is the best model for us to follow.

That is a little bit outside of what you would expect to have from Stantec, so we need to go to another source for that consultation. That process is getting underway. I know that the documentation is being prepared to seek out the proper consultant to do that piece of work for us.

MR. A. PARSONS: Perfect.

Thank you, Mr. Chair.

CHAIR: Gerry.

MS ROGERS: Okay, thank you.

Subhead 3.1.02, Support to Community Agencies.

MR. DAVIS: Subhead 3.1.02?

MS ROGERS: Yes.

Can we have a list of the community agencies that are receiving support, the work that they are doing, and the amount of money?

MR. DAVIS: I am sorry, I could not –

MS ROGERS: Can we have a list of the community agencies that will be receiving funding, the work that they are doing, and the amount of money that they are receiving?

MR. DAVIS: Yes.

MS ROGERS: Can we also have a list of those who applied and then those who were successful?

MR. DAVIS: I know we can give you a list of who was successful. Do we have all that?

MR. COOPER: We can certainly provide you with a listing of the agencies that receive funding. The funding we are talking about here is core funding for agencies.

MS ROGERS: Yes.

MR. COOPER: With core funding, these are longstanding relationships that the department has with the community sector.

MS ROGERS: Right.

MR. COOPER: There is an application process, but we do not have a process for – it is not like some of our grant programs under Population Health where we have a competition for wellness grants, age-friendly grants, and those sorts of things. It is not the same.

MS ROGERS: That would be under Population Health then?

MR. COOPER: Yes, that is right.

MS ROGERS: Okay, all right. If we could have a list of those though, the core funding, that would be great, Bruce.

Thank you.

MR. COOPER: Yes.

MS ROGERS: The amounts of money – where the amounts.

The Corner Brook Committee on Family Violence asked the department in February to fund a feasibility study to look at options for addressing the fact that the transition house is falling down. Is that proposal being considered?

MR. COOPER: I am sorry; I cannot speak to that proposal. I just do not have the knowledge about where that would be in our process.

MS ROGERS: I guess that would be in Western Health. It is with the regional health authorities.

MR. COOPER: Yes, so that would be with Western Health. That would not be something that would have come to the department then if that is the case.

MS ROGERS: In Western Health, have there been any additional monies for a project such as a transition house?

MR. COOPER: Western Health makes their own decisions about funding community organizations through their own board-delivered grant program. We do not have any knowledge of what decisions Western Health would make – not to say that we are not all gathered together under the same kind of strategic direction, but I cannot answer your question. I am sorry.

MS ROGERS: At this point there has been no extra funding made available for Western Health for a special project like that? That would be a significant ticket there.

MR. COOPER: We provide a global budget to the regional health authorities and we have increased the budgets for the RHAs, but that sort of level of granularity would not show up at our level.

MS ROGERS: Okay.

Do you know by how much for instance Western Health's budget would have been increased?

MR. COOPER: Michelle.

MS ROGERS: I cannot remember; have we already asked for a breakdown of budgets for each of the health authorities?

MR. DAVIS: Yes, I gave you them.

MS ROGERS: Okay, that is right.

MR. COOPER: In terms of the increase in Western Health's budget this year, it is gone from last year $274 million to $281 million this year; it is a $7 million increase.

MS ROGERS: Thank you very much.

I just have a few general questions. The ambulance program, the Budget announced funding to plan for a central medical dispatch centre. What are the details on that? Is that happening? Where is that?

MR. DAVIS: Yes, it is an important piece of work that is underway. It is a review that has taken place. There is still some work to be done on that before we reach the final plan or direction that we are going to take, but that work is still underway.

MS ROGERS: So do we have any idea of the time frame? I am not going to hold you to a date.

MR. DAVIS: We do – you know how I am with time frames.

MR. COOPER: During this year we will be scoping out the requirements for central dispatch with planning money.

MR. DAVIS: Did you catch that?

MS ROGERS: No.

MR. DAVIS: The work is underway. There is funding allotted this year to carry out that planning process. That is the plan for this year, or the intention this year is to utilize that funding for the planning of a central dispatch.

MS ROGERS: We will not see a central dispatch centre this year, we are seeing planning?

MR. DAVIS: You will see planning. It appears to be a much bigger piece of work than I would have anticipated. It is a fairly intensive piece of work considering the variety of service providers throughout the Province and the geography that exists. All of that has to be a part of that planning process.

MS ROGERS: Okay, thank you.

The status of reviews of Central, Western, and Labrador-Grenfell health authorities, those were all under review?

MR. DAVIS: Bruce.

MR. COOPER: The health authorities you mentioned did engage in operational improvement reviews. This is the process where they benchmarked their performance against other reasonable comparable organizations in other parts of Canada.

They determined how they performed in key areas. They found areas where they were good performers and other areas where they could do better. The regional health authorities developed plans using that information. It was not a prescriptive approach; it was really a ground-up approach where with the data in hand the regional health authority looked at what the opportunities would be to try to bring their performance closer to the higher performing organizations.

As you may be aware, the regional health authorities announced their plans in the fall, I think it was October they came out with their plans. Those plans are unfolding. In fact, when you look at the cumulative progress on the operational improvement plans between all the health authorities, including Eastern Health, 56 per cent of the anticipated efficiency and savings has already been achieved through these plans. There is good progress being made within all health authorities with respect to making better use of their resources, without compromising the quality of clinical services to people.

MS ROGERS: Okay, thank you very much.

How many personal care home residents now have portable subsidies? I am jumping around a little bit here. I am aware of the time.

MR. COOPER: Minister, is that okay?

MR. DAVIS: Yes, go ahead.

MR. COOPER: All right.

In terms of the number of subsidized residences, we have 2,357 subsidized residents within personal care homes and that represents about 76 per cent of people in personal care homes. So 76 per cent of our residents at personal care homes receive a subsidy.

To your specific questions around the number of subsidies that are portable, I do not have that information. I do know that we, every year, have been increasing the balance of portable subsidies. I do not have that number and I can certainly get that for you.

MS ROGERS: Okay, that would be great. Thank you very much.

I turn it over to you now, Andrew.

CHAIR: Okay.

Andrew.

MR. A. PARSONS: Thank you.

Just a couple of questions on behalf of my colleague, the Member for The Straits – White Bay North. The echocardiogram, there are apparently two ultrasound machines in St. Anthony but they no longer do echocardiograms. He was wondering why the service is no longer offered.

CHAIR: Bruce.

MR. COOPER: Actually, I am going to ask Denise Tubrett to answer the question.

MS TUBRETT: You are talking about St. Anthony, right?

MR. A. PARSONS: Yes.

MS TUBRETT: It is my understanding that Lab-Grenfell is looking at establishing that – is it echocardiogram you are talking about?

MR. A. PARSONS: Yes.

MS TUBRETT: They are looking at establishing that service. They have been looking for some data and they may in fact – they are going to be looking at establishing it in this fiscal year.

MR. A. PARSONS: Reinstating it?

MS TUBRETT: They are looking at it.

MR. A. PARSONS: Okay.

MS TUBRETT: Because they need to look at utilization and they need to figure out – I understand there is somebody there who is trained who can do that, but needing to look at what the utilization would be in St. Anthony as well as across the rest of the regional health authority.

MR. A. PARSONS: Would the numbers be available for us to get, perhaps, from Lab-Grenfell about how many people are utilizing it, the referrals outside?

MS TUBRETT: I do not have it with me.

MR. A. PARSONS: No, I would not expect you to. Would we be able to get them through you from Lab-Grenfell?

MS TUBRETT: Yes, they are looking at that now, so they have been monitoring it for a while.

MR. A. PARSONS: Okay.

CHAIR: Minister.

MR. DAVIS: That is the type of information, I understand, that they are trying to gather so they can assess –

MR. A. PARSONS: Okay.

MR. DAVIS: They do not have all of that brought together yet for the full assessment.

MR. A. PARSONS: All right, perfect. Thank you.

I have some questions on a different topic that was brought to my attention, if I can just find it. I have been talking to optometrists. I understand

they are not a service covered by MCP, but they are doing medical procedures in certain cases, especially in rural areas.

Again, a lot of times these matters are being sent to them because an ophthalmologist is not available. I believe there are four ophthalmologists on the West Coast particularly. There was one point this winter where all four were gone at the same time, and optometrists have had to perform medically necessary procedures, but they are not compensated. I understand there may have been correspondence to the department at some point to discuss this. I am just wondering about the status.

CHAIR: Minister.

MR. DAVIS: I do not have the information.

CHAIR: Bruce.

MR. COOPER: I know that the profession of optometry have a view that suggests that optometry services should be insured in the same way that other medical services are insured. Is that the kind of correspondence you are referring to?

MR. A. PARSONS: No, not optometry in general, but when optometrists do medical procedures because they cannot be done by MCP-covered physicians such as ophthalmologists, or even a general practitioner. For instance, I have a very specific example of where somebody had something stuck in their eye and the optometrist had to do the procedure. He is not covered for that, he is not going to turn the person away, and I think they may have inquired about shouldn't they be covered if they are doing the medically necessary procedure. The cost would not actually be different if – I would assume that if it is done under MCP by a physician, it would be the same cost. That is what they are sort of wondering about.

MR. COOPER: Thank you for the clarification.

In that instance the question goes to the matter of MCP coverage, and so I would ask Dr. Bradbury if she has had any engagement on the issue.

DR. BRADBURY: I am not aware of those examples. Having said that, under the Canada Health Act it clearly defines what services are insured and not, and you have to be either a licensed physician or an oral surgeon to provide insured services. So, it is the provider as much as it is the type of services that they are providing.

MR. A. PARSONS: Okay. So these optometrists who are doing medical procedures not covered by our doctors, I should tell them to probably stop? I am sort of relaying the information here. I am just passing along what I have been told by optometrists.

CHAIR: Minister.

MR. DAVIS: My understanding, as Dr. Bradbury referred to, is the Canada Health Act outlines what services would be considered to be insured. I think if I was somebody outside of the purview of a physician or a surgeon, then I would probably want to be making sure that anything I am doing I am not exposing myself or outside the bounds of what I am licensed to do or intended to do.

Maybe Mr. Cooper will –

MR. COOPER: Just in addition, so as Dr. Bradbury said the Canada Health Act covers insurance. I think the issue you are speaking to is really is one of a professional scope of practice and what is advisable. Again that is an issue that is covered by colleges. As you know, they are self-regulated profession. Given that responsibility under legislation, they are responsible as a college to be able to provide practice guidance to their members to determine what is reasonable within the protected scope of practice.

I would ask Karen Stone, our ADM of Policy who works in this area, if she has anything to add in regard to the regulation of optometry.

MS STONE: I have not heard from optometrists on this issue, and we hear from them fairly regularly with respect to other issues so I am surprised that that one has not been brought to our attention.

MR. A. PARSONS: I will certainly go back to the individuals I talked to and get some clarification which I will bring forward. It sounds like there have been no negotiations or discussions in the past about that?

MS STONE: It is not an issue that I am aware of.

MR. A. PARSONS: Okay.

They have not come to you on scope of practice?

MS STONE: No, they have not.

MR. A. PARSONS: Oh, perfect. Well, that is it. If they have not asked, they have not asked.

I am going to move forward to ambulances and ambulance service. Can you tell us – and again I know you will not get into it – the status of current negotiations? How is that going?

CHAIR: Bruce.

MR. COOPER: Certainly as a Department of Health and Community Services while we participate in negotiations, we are not the group that actually leads them. It is Minister Johnson's department that leads that area. I know that we have been participating in ongoing discussions, but in terms of the status of negotiations I think that is really for a different department to answer.

MR. A. PARSONS: My understanding from talking to operators is that they have been in discussion with the department. I understand Minister Johnson handles the finance, but we are talking about the model and the different model; I understand the Health Department deals with that. Is there any idea – I will put it out there: My understanding is that there is going to be cuts in emergency service to rural areas and it has already started. Is that the case or is that not the case?

MR. COOPER: Certainly what is under discussion with ambulance operators is a new model. I think it is precipitous to suggest that the outcome is going to be cuts and I am a little surprised to hear that it is already started because we do not have an agreement.

MR. A. PARSONS: My understanding is that – and maybe I am wrong, I am only saying what I have heard and you will tell me if I am wrong for sure – there have been negotiations and a new model has been suggested. In some cases I know there have been layoffs. There has been a layoff out in my area I know that. This new model will lead to less emergency ambulances in certain areas.

MR. COOPER: Yes. You are familiar with the significant growth that has taken place in the ambulance program. It is a very significant amount of budget growth. What we learned from the ambulance review is that there is a significant number, I think it is 48 per cent or 49 per cent, of the utilization of ambulances relates to routine transfers of people who are healthy.

There is a whole cluster as you saw I am sure, of other inefficiencies. We have been advised we could make better use of resources and better serve people if we could squeeze those inefficiencies out of the existing system. It would be no surprise that the intention is to preserve service, while at the same time making sure the service matches the need. That is the fundamental approach. That is the objective that we have.

MR. A. PARSONS: No doubt. We know the issues when it comes to routines and there are issues there. I am more worried about the emergency service. How many emergency ambulances are available in a certain area at a certain time when a call comes in? That is where the fear is coming. I have been contacted by paramedics and operators.

I am just wondering; we are talking about changing the model, do we have solid numbers to go on right now? I think that was one of the things in the review, that we need to put in the technology so that we would have a better understanding on how our system is being utilized.

CHAIR: Bruce.

MR. COOPER: If I understand your question, you are wondering what data we have?

MR. A. PARSONS: Yes. One of the things the operators tell me is that they are unable to track;

they are unable to give you the information on routines, emergencies, et cetera. There is technology out there that has been tendered in the past but pulled back, for electronic equipment so that they can better document this. That documentation can then be used to determine the model, but that has not been done. I am just wondering, what is the basis for changing if we do not have the solid numbers over a period of time?

MR. COOPER: Yes. We are at a little bit of a disadvantage here talking about the dynamics of discussions that are ongoing. I have articulated from the department's perspective what our objective is in terms of the ongoing dynamics of negotiations.

I think it is most prudent for us just to let those discussions conclude and then we would be in a position to more appropriately convey the basis of an agreement. We are certainly hopeful that government will forge an agreement and we will be in a better place then, to speak to the particulars.

MR. A. PARSONS: Thank you.

Thank you, Mr. Chair.

CHAIR: Gerry.

MS ROGERS: Thank you.

Were there any Home Support Program reviews done last year? Reviews of how home support is working?

MR. DAVIS: Home Support Program reviews done last year? Bruce will speak to that.

MS ROGERS: Thank you.

MR. COOPER: There has been a significant amount of work done within the home support area. We did have planned to do a review during last year. We had a significant amount of engagement with the regional health authorities in terms of a round table with VPs and directors, and dialogue sessions with front line staff and management. We have been working very closely with the regional health authorities on the introduction of the paid family caregiver option.

We had to reprioritize some of our work this year to focus on these areas. We do have planned to engage in a fulsome review of the Home Support Program. In fact, we are currently drafting an RFP for hiring of an external consultant to do that work.

We have certainly been intensely involved in reviewing elements of the Home Support Program and it was evidenced by the launch of family-based care. As well, the department also worked with home support agencies over the summer to work on some issues they were having.

We are going to build on reviews that were done. There were two financial reviews done in previous years in Central and Western. I am sorry, there was a clinical review done in Eastern, and two other reviews done –

MS ROGERS: Bruce, is that this past year?

MR. COOPER: No, this was previously. This was the previous years.

MS ROGERS: Okay.

MR. COOPER: Sorry, we had an internal clinical audit at Western Health and a financial audit at Central Health. I apologize, I misspoke on Eastern.

Our plan is to build on that. We are finalizing that RFP to get a consultant to help us with a fulsome review of the home support during this year.

MS ROGERS: When do you think you will release the RFP?

MR. COOPER: I am going to take the minister's lead and not give a date because we have not fully briefed him on it yet.

MS ROGERS: Maybe before the turnips are harvested. Okay, but you are hoping to do the review this year, within this fiscal year.

MR. COOPER: That is our plan.

MS ROGERS: It will be a comprehensive review, fiscal and clinical, Province-wide?

MR. COOPER: We have not finalized the terms of reference for the review. That is ongoing. We are considering that in terms of how we get what we need from it.

MS ROGERS: Okay, thank you. What is happening with the rapid response pilot projects, the mobile emergency team to help seniors?

CHAIR: Bruce.

MR. COOPER: The rapid response teams, I think you probably know we plan for four teams. There is going to be a team in Grand Falls-Windsor, the Central Newfoundland Regional Health Centre, Health Sciences, St. Clare's and Western Memorial Regional Hospital in Corner Brook. The recruitment process for all four teams is underway and we expect that teams will be operational by the fall.

MS ROGERS: In all four locations?

MR. COOPER: That is our plan. That is the RHA plan I should say.

MS ROGERS: Great.

MR. COOPER: Yes and the other dimension of this is that there are two really critical components to the program. There are the professional staff who will operate essentially connected to the emergency department to make sure that services can be provided and wrapped around somebody to divert them from emergency and provide the appropriate care in their home. That professional team, that is the group that is being recruited.

Then of course, there is a twenty-four hour home care provision that may be required for some people for a period of time. We are going to market to seek agencies that would be willing to work with us to provide those services for clients. That is in the process of being concluded as well.

MS ROGERS: Okay. What is the budget for this program?

MR. COOPER: We have $3.1 million.

MS ROGERS: For the entire Province?

MR. COOPER: Yes, for four teams.

MS ROGERS: It is not per health authority?

MR. COOPER: No, that is the total cost of the initiation of the program.

MS ROGERS: Is it a pilot, Bruce?

MR. COOPER: Yes, this is a two-year pilot. There are many things that we are doing in long-term care that are new. Evaluation to see either how we scale it up or improve it or change it is a really important part of a lot of what we are doing. That is included here as well.

MS ROGERS: Yes. If it is a two-year pilot and you are going to evaluate it, then is the plan for it to be operational for two years and then stop, sort of like the Family Violence Intervention Court?

MR. COOPER: What we will be testing over the term is the difference it is making. If it makes a difference, that is something that the department would bring forward.

MS ROGERS: There will be sort of an ongoing impact, process, evaluation throughout it?

MR. COOPER: Yes, that is right; exactly.

MS ROGERS: Okay, all right, thank you. I have three minutes.

Population Health –

MR. DAVIS: Just if I may, Mr. Chair.

CHAIR: Minister.

MR. DAVIS: I am sorry; I do not mean to cut you off, Ms Rogers. As we talked about a little bit earlier, part of when you do new projects, new programs, new initiatives or new efforts, you try to assess what the need is and how you best deal with that. I am a firm believer in that evaluation process so that we can go so far in are we addressing a need, is there actually a benefit, and how much of a benefit to how many people is being achieved through it.

It is really hard to say and that is part of the reason why you sometimes call it a phased-in

approach or a pilot project to see, so you can adjudicate it and judge it as time goes on.

MS ROGERS: Right. It is great to be able to do that process and impact evaluation while it is going on rather than having to stop. Yes, that is great.

Population Health, 1.2.05.10, Grants and Subsidies; is this where there are grants and subsidies to community groups?

CHAIR: Subhead 1.2.05, Population Health, 10, Grants and Subsidies.

MS ROGERS: Yes.

CHAIR: Is it $1.3 million, roughly?

MS ROGERS: Yes.

MR. DAVIS: Yes.

MS ROGERS: Have I already asked for a list of grants and subsidies to different community groups?

MR. DAVIS: No, I do not believe you did.

MS ROGERS: I will ask now. Could we have that?

MR. DAVIS: Yes.

MS ROGERS: I see that there was a cut there as well or a reduction of $150,000.

MR. DAVIS: Yes. That is transferring funds from one of the former programs being breastfeeding promotion support and it has been transferred to the regional health authorities.

MS ROGERS: Okay, so that is a direct transfer to there?

MR. DAVIS: Yes.

MS ROGERS: Okay, great, because we would not want to cut that.

If we could have a list of all the organizations – is it possible as well to have a list of those who applied because I imagine then that this is not all just core funding, these are groups that have applied for funding, for project funding, for special initiatives?

MR. DAVIS: I know there are a couple of different grant programs that come under that. Do we have all that data available, Bruce?

MR. COOPER: We certainly have all the data on who has been approved. I was just conferring around the question of would there be any issues with us disclosing who applied for a grant. We would certainly go back and look at it. I just want to make sure that we are not doing anything untoward for these groups that applied by releasing that information. I just want to make sure that we are by the book with that.

MS ROGERS: Okay.

If, in fact, there is a problem what I would like then is even numbers of applications under the different programs; for instance, if there were $500,000 worth of requests under mental health but only $200,000 received. As much detailed information as we could possibly have would be great.

MR. COOPER: If I could, I am just checking to see – do we have any of those stats now in terms of the applications received, applications approved, or is that something we would have to put together?

CHAIR: Elaine.

MS CHATIGNY: Thank you –

MS ROGERS: Elaine, before that, just one quick question of clarification. Do the individual health authorities also have special monies allocated for community groups?

CHAIR: Bruce, a quick answer.

MR. COOPER: Yes, they do.

MS ROGERS: Okay.

CHAIR: I am going to pass it back – Elaine, do you want to answer the previous question?

MS CHATIGNY: Specific to the provincial wellness grants, we received 150 applications.

We had a total fund of $500,000 and seventy groups were approved.

MS ROGERS: Sorry, $500,000?

MS CHATIGNY: That is correct. That is envelope for the provincial wellness grants.

MS ROGERS: Elaine, with 150 applications, do you know how much money was involved – what was the value of the applications?

MS CHATIGNY: The total value was over $1 million.

CHAIR: Okay, Gerry, to be fair to Andrew, I am going to give Andrew the last five minutes.

Andrew.

MR. A. PARSONS: Thank you, Mr. Chair.

I will try to keep this quick. First topic: mental health – the Mobile Crisis Treatment Unit; it came out last week that they only operated Wednesday to Sunday and we have since been told that it is not a budgetary issue. So are there any plans to make it seven days a week?

CHAIR: Minister.

MR. DAVIS: Thank you.

There are no immediate plans to make it seven days a week, but the mobile response unit for Eastern Health metropolitan greater St. John's area, the way I see it is it is another tool in the chest of opportunities for a response. When it was set up, it was determined that the greatest need for response is during those time periods.

I would have thought that Saturday night would probably be your busy time for such a response. If you had to pick a day, I would say maybe that would be a Saturday night would be the most – and it is not. It turns out that it is not in some cases. The days that are picked or the five days were the ones that were the most needed response.

I think it is important to point out that there seems to be some confusion publicly in the difference in the mobile response versus the crisis line. The crisis line is available twenty-four hours a day, seven days a week; but publicly there seemed to be some confusion that some people believed that if you call on certain times, there is no one available on the crisis line to provide service to you, and that is not the case.

MR. A. PARSONS: No, I think I got it straight where I am. So the mobile unit, though, is available five days a week?

MR. DAVIS: Right.

MR. A. PARSONS: It is not budgetary. So the question then becomes, you have it as a tool in the chest, why wouldn't you use it seven days a week? Why wouldn't we provide this service to people who need it all the time?

MR. DAVIS: Yes, and I did not say it was or was not budgetary, but what I did say –

MR. A. PARSONS: No, the lady – sorry to cut you off, Minister. The person in the news said it was not a budgetary issue.

MR. DAVIS: Okay, my mistake, Mr. Parsons; I thought you were suggesting that was part of my comment and it was not.

MR. A. PARSONS: No.

MR. DAVIS: Again, like many things in the department, it is a new discussion for me; but I do not mind deferring to Mr. Cooper to see if he wanted to add some value to this discussion for you as well.

MR. COOPER: This is a matter, obviously, within the purview of the regional health authority at Eastern Health in the St. John's and greater environs region, and this is something I know that they are reviewing to take a look at utilization of the program. So, it is really within their mandate to operate this and to ensure that it is resourced appropriately.

MR. A. PARSONS: The regional health authorities fall under the department. Am I correct?

MR. COOPER: Absolutely.

MR. A. PARSONS: I do not have enough time to get into the debate here that could be had, but I think the point we are making is valid. Obviously it is not a budgetary issue according to what they are saying. We have people who need the service on Monday. I would have thought Monday would have been the worst day, but they need it on Monday.

MR. DAVIS: So…?

MR. A. PARSONS: So I am just putting it out there. Anyway I do not have enough time for us to get into it, but I think I have made my point.

MR. DAVIS: I will just make one quick comment for you, Mr. Parsons, if I may. There are many topics of which I hope to receive some further information and have further discussion on. That is one of them.

MR. A. PARSONS: Thank you. The last question I have really concerns long-term care and it is about the new facility out in Pleasantville. Is there a date on when this is going to open?

MR. DAVIS: It will open in 2014. We anticipate the fall.

MR. A. PARSONS: The fall. Okay.

When you anticipate opening, do you anticipate all the wings will open at the same time?

MR. DAVIS: Good question. I would think. I think so, unless there is something that has changed recently. No, there is not, so we do anticipate that the full facility will be open in the fall.

MR. A. PARSONS: Okay.

MR. DAVIS: Just to clarify, during these processes, it is a large facility so it is not something that will happen with a flip of a switch overnight. There will be a phased approach of transition.

MR. A. PARSONS: Okay. Unfortunately, Mr. Chair, I still have questions on that because there are staffing issues in long-term care in general. I am pretty sure if I put it in a letter to the minister and staff that we can –

MR. DAVIS: Absolutely.

MR. A. PARSONS: Thank you, Mr. Chair.

CHAIR: Thank you. Minister, if there are any outstanding questions that the members want answered, they can certainly put it in a letter and staff would look forward to that.

MR. DAVIS: Absolutely. I know there are some matters that we said we would get some further information on. I am confident that the officials surrounding me and behind me here have duly noted those requests. We will get to those as well in due course.

CHAIR: Okay. I want to thank the Committee members. It has been an interesting number of sessions. I want to thank you for your questions.

Minister, I want to thank you and your staff for your openness in the discussion this morning and the answering of the many questions that our Committee did have. Again on behalf of all our Committee I want to thank you and your staff for taking the time this morning to come and sit in front of our Committee.

MR. DAVIS: Thank you, Mr. Chair.

CHAIR: Just a couple of housekeeping things we need to do. I will ask the Clerk to call the first subhead please.

CLERK: Subhead 1.1.01.

CHAIR: Shall 1.1.01 carry?

All those in favour, 'aye'.

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay'.

Carried.

On motion, subhead 1.1.01 carried.

CLERK: Subheads 1.2.01 to 3.2.02 inclusive.

CHAIR: Shall 1.2.01 to 3.2.02 inclusive carry?

All those in favour, 'aye'.

SOME HON. MEMBERS: Aye.

On motion, subheads 1.2.01 through 3.2.02 carried.

CLERK: The total.

CHAIR: Shall the total carry?

All those in favour, 'aye'.

SOME HON. MEMBERS: Aye.

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.

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

CHAIR: One last piece, we need the approval of the minutes of May 6 for the Department of Justice and the Labour Relations Agency.

Can I have a mover?

MR. LITTLE: So moved.

CHAIR: Moved by Mr. Little.

MR. POLLARD: Seconded.

CHAIR: Seconded by Mr. Pollard.

All those in favour, 'aye'.

SOME HON. MEMBERS: Aye.

CHAIR: Carried.

On motion, minutes adopted as circulated.

CHAIR: I ask for an adjournment to the call of the Chair of the Committee. Once again ladies and gentlemen thank you very much and have a wonderful day.

Could I have a motion to adjourn?

MR. LITTLE: So moved.

CHAIR: Moved by Mr. Little.

We are adjourned.

On motion, the Committee adjourned.