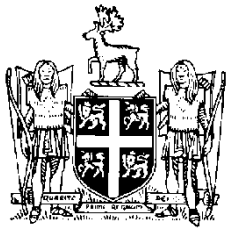

PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

First Session
Forty-Eighth General Assembly

Proceedings of the Standing Committee on
Social Services

May 11, 2016 - Issue 7

Department of Health and Community Services

Published under the authority of the Speaker of the House of Assembly
Honourable Tom Osborne, MHA

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Lisa Dempster, MHA

Vice-Chair: Tracey Perry, MHA

Members: Paul Davis, MHA
Carol Anne Haley, MHA
Paul Lane, MHA
Betty Parsley, MHA
Scott Reid, MHA
Gerry Rogers, MHA

Clerk of the Committee: Elizabeth Murphy

Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
Dr. Larry Alteen, Medical Consultant
Alicia Anderson, Executive Assistant
Angie Batstone, Executive Director
Beverley Clarke, Deputy Minister
Bernard Davis, Parliamentary Secretary to Minister
Heather Hanrahan, Assistant Deputy Minister, Professional Services
Michael Harvey, Assistant Deputy Minister, Policy, Planning & Performance Monitoring
Michelle Jewer, Assistant Deputy Minister, Corporate Services
Karen Stone, Assistant Deputy Minister, Population Health
Mike Tizzard, Departmental Controller
Denise Tubrett, Assistant Deputy Minister, Regional Services
Tina Williams, Director, Communications

Also Present
Lorraine Michael, MHA
Brian Warr, MHA
Sandy Collins, Researcher, Official Opposition Office
Susan Williams, Researcher, NDP Office

The Committee met at 9:03 a.m. in the Assembly Chamber.

CHAIR (Dempster): Good morning, everyone. We'll get started.

Good morning, Minister. I trust everyone is good on this beautiful spring day. I am; it's the last Estimates for me. After chairing eight departments –

MR. HAGGIE Well, it's the first and last for me for this season as well, hopefully.

CHAIR: – I'm especially good.

So we'll start with the minister saying a few words, if he would like. Maybe we'll preface that by having your staff introduce themselves, and then we'll have people on this side introduce themselves. I don't think we have anyone subbing in today.

AN HON. MEMBER: Yes.

CHAIR: Okay. Baie Verte – Green Bay, Mr. Warr – for the record – is subbing in for Carol Anne Haley for Burin – Grand Bank.

Minister.

MR. HAGGIE Thank you very much, Madam Chair.

I think it would appropriate, as I seem to have a large number of bodies behind me, to introduce them. On my right is Deputy Minister, Beverley Clarke; on my left – actually I keep forgetting your title – off you go.

MS. JEWER: Michelle Jewer, ADM, Corporate Services.

DR. ALTEEN: Larry Alteen, Medical Consultant.

MS. TUBRETT: Denise Tubrett, Assistant Deputy Minister, Regional Services.

MR. TIZZARD: Mike Tizzard, Departmental Controller.

MS. HANRAHAN: Heather Hanrahan, ADM, Professional Services.

MS. BATSTONE: Angie Batstone, Executive Director, Regional Services.

MR. HARVEY: Michael Harvey, ADM, Policy, Planning & Performance Monitoring.

MS. STONE: Karen Stone, ADM, Population Health.

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

MS. WILLIAMS: Tina Williams, Director of Communications.

MR. DAVIS: Bernard Davis, Parliamentary Secretary to minister.

MR. COLLINS: Sandy Collins with the Office of the Opposition, and Paul will be by in five minutes. He is caught in traffic on the Outer Ring.

MR. REID: Scott Reid, MHA for St. George's – Humber.

MS. MICHAEL: Lorraine Michael, MHA, St. John's East – Quidi Vidi.

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

MR. WARR: Brian Warr, MHA for Baie Verte – Green Bay, and I'm just about to leave.

MS. HALEY: Carol Anne Haley, MHA, Burin – Grand Bank.

MS. PARSLEY: Betty Parsley, MHA, Harbour Main.

MR. LANE: Paul Lane, MHA, Mount Pearl – Southlands.

CHAIR: Okay. So we'll hear a few words from the minister and following that, I just want to remind people that if your staff speaks, just start with your name for the purpose of the Broadcast Centre downstairs.

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

Essentially, the health care system is the largest and most important – at least I would argue – of the systems we do manage as a government. Over the last 15 years, health care expenditure has gone from $1.5 billion a year to $3 billion – so it's doubled. That $3 billion budget for the Department of Health and Community Services represents 35 per cent of the entire provincial budget currently.

So from our point of view, we are very conscious that we need to try and improve efficiency, contain expenditures, yet manage to provide quality services at the same time. So finding cost-effective and innovative solutions is important, both in the short and the long term. That includes evaluations of what we do based on outcomes so that we are doing things that make clinical and fiscal sense.

Through the GRI, the Government Renewal Initiative, and budget 2016-17 processes, the department, along with its four regional health authorities and the Newfoundland and Labrador Centre for Health Information, as well as the Faculty of Medicine at Memorial, have identified a number of potential saving opportunities that will help improve the efficiency of how we do business, how we deliver health care in the province.

To preface the *Estimates* document, a number of the variances contained in the *Estimates* document can be explained with the same explanation under the items on decrease in revenue from 2015-16 budget to the 2015-16 projected revised. In the majority of the department's operating accounts, such as Transportation and Communications, Supplies, and Purchased Services, there's a decrease. This decrease is due to the department's expenditure management plan. This was introduced initially in 2011-12 in an effort to reduce discretionary spending.

The department has successfully reduced its operating accounts by over 55 per cent, or $2.3 million, since 2011-12. The following are some examples of the steps that have been taken in the department to reduce those operating accounts. It was the first department to implement a management print strategy, it's got an established inventory control system for office supplies, we have a policy regarding the purchase of food and refreshments for meetings and we've increased the use of teleconferencing and video conferencing services to reduce travel. Through these steps the department has become more efficient, but it hasn't produced any impact on the services we provide as a department.

The second item and second explanation that you'll find common to several pages is you'll notice a decrease from the 2015-16 budget to the 2016-17 budget in the department's operating accounts and the salary account. The main reason from this decrease is due to the detailed line-by-line review that was completed during this budget 2016-17 process. Through the review, the budget in a number of areas was reduced to bring the budget in line with historical expenditures.

In the case of salaries, the department has had a history of drop balances due to vacancies and delays in recruitment. As a result, the salary budget was adjusted through the line-by-line review. We'll continue to manage the department's salary budget through those vacancies and delayed recruitment. In total, the department has identified savings of $12.7 million in the line-by-line review. I think those two explanations will pop up on a lot of areas. I thought it was easier to introduce them at the beginning as a kind of theme.

Having said that, Madam Chair, I think the time has come to hand it back to the members of the Committee and yourself. We'll be more than happy to deal with the questions as they come.

CHAIR: Thank you, Minister, for those opening comments.

I think we'll go through each section; meander through, it's fairly long.

I'll ask the Clerk to call the first subhead.

CLERK (Ms. Murphy): 1.1.01 to 1.2.06.

CHAIR: Shall 1.1.01 to 1.2.06 inclusive carry?

Mr. Davis.

MR. P. DAVIS: Thank you.

Good morning, Minister, staff, officials. There are a few familiar faces over there from days gone by. Good morning, colleagues, and staff that join us on this side of the House as well.

Thank you, Madam Chair. I apologize for being a few minutes late. I had intended to be here in lots of time before it started this morning but the Outer Ring Road is the Outer Ring Road and when four cars pile into each other, that's what happens. There's no getting out of it.

Minister, I apologize, again, for missing some of your introduction, but I did catch your latter comments in regard to salaries. The very first item is your own office. There is a fairly substantial reduction in the budget for Salaries in your own office. Could you explain that one to us?

MR. HAGGIE: Certainly.

We have removed, effectively, three positions from the budget. The salary for the parliamentary secretary no longer exists. The CA to the parliamentary assistant was inappropriately charged to the department, whereas it should be under the House expenditures. There was a ministerial liaison position which had been vacant since December 2015 which we have not refilled.

MR. P. DAVIS: So your intention is not to fill the liaison? That used to be a really busy office.

MR. HAGGIE: It still is, we're just working –

MR. P. DAVIS: But there's nobody there.

MR. HAGGIE: We're just working longer days for less money.

MR. P. DAVIS: That was a real busy office. And by the way – and I meant to mention this, and I will – your department, obviously, is by far the most complex of any department and Estimates, therefore, would be similarly complex. There are a number of areas that I wanted to discuss in more detail with you today. My fear is that I may ask a question that may not be in the right area or right category or the right subheading.

MR. HAGGIE: Okay.

MR. P. DAVIS: So instead of me asking you every area for every subheading as we go along, if I miss one and there's a go back to, I would trust you wouldn't have any difficulty with that. If we go through a subheading and later ask about something and say, well, that was already carried out in or that was already part of a –

MR. HAGGIE: I'll certainly do my best to accommodate that, yes.

MR. P. DAVIS: Thank you, Minister. I appreciate that. I suspected you would.

As well, under 1.2.01, under Executive Support, under Salaries again, a similar circumstance there, about $150,000 change. Was that a position or positions there?

MR. HAGGIE: Let me just make sure I got the right page. The salary budget in this area was decreased by year two of the attrition plan and reallocation of funding to the new structure. So we have lost $154,100 from the budget for that year.

MR. P. DAVIS: Was that a position, then, or positions? Under attrition plan then it would be –

MR. HAGGIE: I think it was – I would bow to, Michelle. Would that be you?

MS. JEWER: It's not a position. The Department of Finance, through the attrition plan, would have keyed savings from attrition in certain areas. But we don't know what positions we're actually going to target until people retire. So we'll reallocate salaries throughout the department when attrition becomes available.

MR. P. DAVIS: So that's an expected retirement I can refer to it as?

MS. JEWER: Yes.

MR. P. DAVIS: Okay.

What level of eligibility for retirement exists under that salary heading? I don't know how many positions there are. I'm assuming there are people who are eligible to retire that you're expecting to retire?

MS. JEWER: Pardon?

MR. P. DAVIS: I would expect, then, that there are people who are eligible to retire that you are expecting will retire this year.

MS. JEWER: Right.

In the department – I don't have the breakdown by division –we have 26 employees that are eligible to retire in '16-'17, and there are 12 positions underneath Executive.

MR. P. DAVIS: Okay, so 26 in the entire department.

What is the staff complement of the whole department?

MR. HAGGIE: The total count is 208.

MR. P. DAVIS: Is that pretty much where it's been in recent years or is there no significant change?

MR. HAGGIE: I would bow to people who have been in the department longer than I, but I'm told not the past couple of years.

MR. P. DAVIS: Okay, and 26 eligible to retire. How many did you say in Executive Support? Did you give a number?

MR. HAGGIE: Twelve.

MR. P. DAVIS: Twelve. Okay.

MS. JEWER: Actually, it's 15. Sorry.

MR. HAGGIE: Sorry, 15. I misspoke.

MR. P. DAVIS: Okay. And, of course, the Employee Benefits and so on go on with that.

What's Purchased Services under Executive Support?

MR. HAGGIE: This area provides advertising- and communications-related activities for the department. It also provides for meeting room rentals and taxis. That's really what that head is. Some of it is regarded by us as somewhat discretionary. We haven't got an advertising want at the moment but we weren't sure what the year would hold.

MR. P. DAVIS: Something may come up. Get your flu shot or something.

Can we move over to 1.2.02? Corporate Services is obviously a larger operation and also a salary change there. It is more in line with what was revised for '15-'16. Would that be more in line with vacant positions that haven't been filled or is that – what would I expect there?

MR. HAGGIE: The revised decrease was down to vacancies in Financial Services, IM and the MCP division in Grand Falls-Windsor. Some of those have been filled.

MR. P. DAVIS: So what's the change in MCP in Grand Falls-Windsor?

MR. HAGGIE: Three positions net loss. The reasoning behind that was because they were essentially counter staff and there's a very low walk-in volume in Grand Falls. Most of the staff there deals with mail. The walk-in numbers were higher in St. John's. The alternatives for folks there are call-in or online now.

MR. P. DAVIS: So there's still staff in Grand Falls-Windsor.

MR. HAGGIE: Oh yes. Ninety per cent of the mail for MCP goes through Grand Falls-Windsor and that's still a big part of the work there.

MR. P. DAVIS: Minister, my thought on it when I heard this that the walk-in service, there was very little uptake and very little usage of it, was if there are other staff there and there's very little usage, is that a function that other staff could do and just blend it into existing staff?

MR. HAGGIE: We looked at that. I think the difficultly is in workload. The staff who are there in the mailroom, my understanding is with the volume of mail, there really isn't discretionary time to have them do a walk-in service as well. That was the rationale provided when the discussion was had.

MR. P. DAVIS: When you say there was low usage, what kind of numbers would we be

talking about? I don't know how long it takes to process someone who walks into a counter or anything.

MR. HAGGIE: My information was 10 a day or less.

MR. P. DAVIS: Okay.

When I thought about it, I just thought, well, maybe someone else is doing work there, and if it's only a small number of times during a day that someone walks in, rings a buzzer, you stop what you're doing and you go out and serve the counter. You're saying that wouldn't be possible.

MR. HAGGIE: Well, it's a drop-box service for folks who do want to walk in and leave material. There is a 1-800 number, there's an online number.

The comparative really was the walk-in numbers in St. John's where, obviously, the population is bigger but it was an order of magnitude greater. It was over a hundred a day.

MR. P. DAVIS: Okay.

I see under Corporate Services the revised on Transportation and Communications was about $100,000 higher and a similar Estimate, a little bit less, for this year.

What does Transportation and Communications include under Corporate Services?

MR. HAGGIE: We have significant costs for telephone lines, teleconferences and postage.

MR. P. DAVIS: Can the department explain why it was higher last year than what was anticipated?

MR. HAGGIE: Higher cost of postage.

Sorry, I'm trying to work down the page here. I have some explanations.

MR. P. DAVIS: That's fine. I understand.

MR. HAGGIE: Higher cost of postage. Volume and the costs have gone up over prior years.

MR. P. DAVIS: When I went into Health as the minister, it was five days before Estimates.

MR. HAGGIE: You have my sympathy.

MR. P. DAVIS: I relied heavily on the people around you and the notes in front of you.

Minister, I see a reduction in Supplies, Professional Services and Purchased Services. I just mentioned three of them; maybe you could just highlight those for us as well.

MR. HAGGIE: The cost of special office supplies are funded out of this. We have tried to do our best through inventory management to keep those costs down.

MR. P. DAVIS: Professional Services, what would that include? That's a significant reduction. There was little usage of it last year but still a significant reduction budgeted for this year.

MR. HAGGIE: The reduction, essentially, is Professional Services within the Audit Services Division for appeals and in Information Management for IT consulting services, both of which we don't anticipate needing as much as in the previous year.

MR. P. DAVIS: What kind of appeals would that be?

MR. HAGGIE: That is appeals for MCP payments and also NLPDP adjudications.

MR. P. DAVIS: Okay.

So MCP payments for practitioners, or would that be for billings?

MR. HAGGIE: Practitioners.

There is a contingency fund that was for federal-provincial-territorial agreement that might arise during that year. There's $250,000 taken out of that because we have felt there were no unbudgeted federal agreements, so we didn't budget the money. So that's $250,000 of it.

MR. P. DAVIS: Right.

So that's the federal revenue. Is that the one you're referring to under the revenue line below? There's $250,000 revenue from the federal government in '15-'16 that didn't occur. It was budgeted and didn't occur, and not under '16-'17.

MR. HAGGIE: I think it might be wiser if Michelle explained this.

MS. JEWER: Under Professional Services, there was $250,000 budgeted for federal-provincial-territorial agreements that would come up during the year. That's offset below by the $250,000 in revenue. So the net impact was zero. We weren't using that budget, so we reduced Professional Services by $250,000 and then reduced revenue by $250,000.

MR. P. DAVIS: Got it.

Thank you.

Under Professional Services, the category of 1.2.03, there's about $175,000 change in Salaries there. NLPDP doesn't come under this, right? Is this departmental support or for NLPDP?

MR. HAGGIE: Yes. This is the in-house support for the program, the administration of the program, not the actual cost of the product it produces.

MR. P. DAVIS: Yes, right.

My NLPDP question should probably stay for 2.2.01, right?

MR. HAGGIE: Right.

MR. P. DAVIS: Salaries here under 01, can you explain the change from budgeted to revised and also the new estimate?

MR. HAGGIE: There are vacancies in Physicians' Services and the NLPDP office division. Some of them have been filled and some of them haven't. So it's staff vacancies.

MR. P. DAVIS: No staff reductions in the area?

MR. HAGGIE: No, recruitment is underway. Some of them are filled and some of them have not yet been filled.

MR. P. DAVIS: Okay. Thank you.

Professional Services under this category, can you explain that one? This year $183,500, was $394,500 last year. It wasn't all utilized.

MR. HAGGIE: There was $170,000 saved because it was funding that wasn't required for a business analyst for the NLPDP. There was a management relationship with Bell Canada for the Claims Adjudication System and these duties were handed over to the director of pharmaceutical services for 2015-16.

MR. P. DAVIS: Thank you.

Madam Chair, it might be a good time to switch over to my colleagues, if you like.

CHAIR: You're good with the ones?

MR. P. DAVIS: Yes, I think, depending on what they ask. I anticipate they might cover off the rest of it.

CHAIR: Okay, all right.

Thank you.

Ms. Michael.

MS. MICHAEL: Thank you very much.

Thank you, Minister, and your staff for being here this morning. I look forward to the rest of the time.

In the interest of what you said in your opening statements, I'll be doing as my colleague has done. I'm not going to be asking about small variations under operations, unless there's a substantial one that looks like I'd want a response to, both in the interest of time and knowing a lot of the answers are exactly the same. So thank you for saying that in the beginning.

There is nothing from the past ones that I need to add to. I think I have all the answers. There just may be one in 1.2.03. I didn't quite hear the

answer with regard to the Professional Services and the variation there. So if you wouldn't mind just repeating your answer. This is under 1.2.03.

MR. HAGGIE: There was $170,000 which was saved. The duties of a senior business analyst were absorbed by the director of pharmaceutical services. The senior business analyst managed the contract with Bell Canada for the real-time adjudication system, and the director of pharmaceutical services took that role on this year in-house.

MS. MICHAEL: Okay, great. That maintains itself then.

Thank you very much.

MR. HAGGIE: You're welcome.

MS. MICHAEL: On to 1.2.04 then; once again, could we have an explanation of the Salaries first and indicting if there's been a loss in positions through vacancies or attrition or whatever. I'd like those details.

MR. HAGGIE: There's a combination. There were savings from the vote because of vacancies in the Acute Health Services and Infrastructure divisions. The line-by-line would explain the decrease of 2016-17 from 2015-16. There are dropped balances in Salaries due to vacancies and delays in recruitment.

MS. MICHAEL: Again, in the interest of time, I'm assuming – because it's happened with all the other Estimates – we will receive your briefing notes for the Estimates?

MR. HAGGIE: Yes.

MS. MICHAEL: If that's the case, then we'll get the details on how many vacancies and that would be in the briefing notes.

MR. HAGGIE: There are tables in here that we're happy to supply.

MS. MICHAEL: That's right. So I won't bother to ask you that because if we're going to get the notes they'll be in the notes.

MR. HAGGIE: Yes.

MS. MICHAEL: Great. Thank you very much.

Under 1.2.04, coming down to the Professional Services, a big drop there, $590,000 unspent under the revision and then this year only half of what was budgeted last year; if we could have an explanation of that.

MR. HAGGIE: They were less than budgeted because we didn't avail of consulting work for acute care and long-term care. The money that was spent relates to a shared services strategy and a supply chain assessment, in addition to a HealthLine awareness campaign for the 811 number. The decrease is down to match historical expenditure.

MS. MICHAEL: What was the impact of not requiring the consultations that you had thought you would do?

MR. HAGGIE: I think that was money that simply was put there in case and wasn't spent. I couldn't speak to that because I wasn't involved in the 2015 budget.

MS. MICHAEL: Okay, thank you very much.

Under Purchased Services, we have quite a drop there from what was budgeted last year. Was there something special that was in last year's budget that was a one-off, or –?

MR. HAGGIE: There were reductions because of the HealthLine advertising campaign, which we're not repeating. The rest of it was down to the departmental expenditure management plan to remove discretionary spending.

MS. MICHAEL: Okay.

So nothing to do with the HealthLine itself, but the advertising for the HealthLine?

MR. HAGGIE: Just the advertising. There was a budgeted amount last year which was spent, which we haven't allocated this year.

MS. MICHAEL: Could we have a bit of an update then on the HealthLine and the demand for it. Are you seeing that it's being used well in the province?

MR. HAGGIE: The utilization of the HealthLine varies, but the average call volume is around 3,000 calls a month. I visited Fonemed in actual fact when I was out on the West Coast. They have a very impressive operation. They have successfully – if you look at the calls they receive, people who state that they need to see a physician or a primary health care provider at the beginning of the conversation, 60 per cent of those folks are manageable in other ways, usually self-care.

Some of them then go on to have a recommendation that they seek advice from their health care provider within a time period depending on the algorithm and the problem, and about 10 per cent of them end up being recommended to go to emergency. So it has actually had a significant impact amongst that population on emergency room attendance (inaudible).

MS. MICHAEL: Well, that's good to hear.

If you're not going to be having an aggressive advertising program, will you be monitoring the impact to see if there's a drop off of phone calls, et cetera?

MR. HAGGIE: Part of the new contract with Fonemed includes cost per call and performance-related issues like that. So, yes, the department will be keeping an eye on that.

I see, on a longer term basis, a much greater potential for using the line. I've become quite a fan in the last little while.

MS. MICHAEL: Right.

When my mother was alive and I lived in the home with somebody who required a lot of care, I had to use that a couple of times. That's a few years ago, but even at the very beginning I found it was really excellent, actually.

MR. HAGGIE: I mean it's very impressive from the point of view of the fact it's put a significant number of jobs in rural areas. I didn't realize it, as a total aside, but they're actually triaging patients for Alaska and Oregon from St. Anthony.

MS. MICHAEL: Right. Minister, last year we had some discussion with regard to the Health Workforce Plan and there was work going into that. Is that still happening?

MR. HAGGIE: Yes.

MS. MICHAEL: Could we have some details on that in terms of the process?

MR. HAGGIE: Maybe Ms. Hanrahan could give you the details from an operational perspective.

MS. MICHAEL: Thank you.

MS. HANRAHAN: The Health Workforce Plan was launched in July of last year. We have a provincial committee involving the health authorities, MUN, CNA, NLMA; a provincial, I guess, outlook. We've established 10 priority items that we're working towards accomplishing. And those things look at leadership in the health system, looking at our supply issues and where there are gaps, looking at our attendance issues in the health system.

So that's just a flavour. I won't go through all 10, but that's just a flavour of the kinds of – and we will provide a first-year update later in the spring.

MS. MICHAEL: Okay. Thank you very much.

Moving on then – I just have to see where I am here. I have quite a number of questions here; one in particular that I'm interested in. What is the timeline for the implementation of the midwifery profession?

MR. HAGGIE: The implementation working group has been struck. I don't have a firm timeline on that. There're looking at best practices across jurisdictional scan and trying to see what models would be most suitable for this province. I really don't have a firm timeline. I anticipate something, hopefully, this year.

MS. MICHAEL: Great.

I'm just going to ask a question of clarification because you and I have both said something different in public. This is not confrontation; I do want to get clarification. I do have a decision

direction note from the department that was given to us when we asked for documentation. It's dated December 10, 2015, so it was after the provincial election.

On the last page of this note, on page 4, it says: The proclamation of the *Health Professions Act* into force for midwifery administerial approval of the regulations will not result in the introduction of midwifery into the public health care system at this time. And then there's a major redaction so I have no idea of what that sentence, the implications. It implies a lot, but there's a redaction so I don't know. Then, after that it says: Midwifery should be understood to be an add-on service that would increase patient choice.

That was the basis for my comment with regard to midwifery not being under the regional authorities. Can you give me any update or any explanation of what's in this note of the department?

MR. HAGGIE: The delay in implementation was to allow expectant mothers and people who were practising as midwives – with a small m – to make alternative arrangements. Thereafter, the place of midwifery and how it's implemented across this jurisdiction would really rather depend on the recommendations of the implementation group, and then a funding model based on those recommendations. So it's a multi-step process and that's probably the best answer I can give to that just at the moment.

MS. MICHAEL: Okay. Thank you.

I have a lot of general questions, but I think what I'll do is I'm going to leave those and just continue with the line by line for –

MR. HAGGIE: Okay.

MS. MICHAEL: Oh, I don't have any more time left right now.

Thank you.

CHAIR: We can come back to you, Ms. Michael.

MS. MICHAEL: We'll come back, yes. Thank you.

CHAIR: There are no more questions on that section.

MR. P. DAVIS: It's up to 1.2.06.

CHAIR: To the end of the ones, 1.2.06, I believe.

MR. P. DAVIS: I'm fine, if Ms. Michael –

CHAIR: Are you okay if Ms. Michael finishes up that section? Then we call the vote on that.

MR. P. DAVIS: Yes, absolutely.

CHAIR: Okay. You can continue on the ones.

MS. MICHAEL: Let's see. I think what I'll do is I'll wait. I may decide not to ask some of these so I'll wait. We can continue on. When we get to the end of the 1.2 section – oh, we're almost there, are we?

Let's do 1.2.05 first, okay?

CHAIR: Do you have any more questions up to 1.2.06 or can we call that?

MS. MICHAEL: No, I do have. Yes, I didn't realize you didn't have any more at all. Okay.

Under 1.2.05 then, which is Population Health – I think the document, when I get it, will show me the answer to my questions about Salaries. I guess there it's attrition and vacancies also, so I won't bother.

OFFICIAL: Yes.

MS. MICHAEL: Under Professional Services in 1.2.05, last year there was $655,000 budgeted, the projected revision was $508,500 and now it's down to $120,000. So that's quite a drop.

Could we have an explanation of what was required last year under Professional Services that isn't required this year?

MR. HAGGIE: The issue there was several. There was a reduction in the budget as a result of the end of the contract for the mental health anti-stigma campaign. That accounts for $300,000 of that reduction. There's also been the environmental health strategy which didn't

occur, the methadone treatment policy and monitoring system has been delayed and the secure treatment reviews in 2015-16 didn't take place.

That legislation is under review for drafting. The all-party committee didn't spend as much of its money as anticipated last year. I think because of the hiatus around the election, quite frankly.

MS. MICHAEL: Right. Well, the two things you mentioned, in particular the environmental health strategy and the methadone; are these not going to be done or are they part of the $120,000 that's budgeted for this year?

MR. HAGGIE: They are part of the ongoing budget. Those are still priority. Certainly, the methadone treatment program and maintenance program is part of the ongoing work.

MS. MICHAEL: Okay. Thank you very much.

I think I have answers to some of the questions that are here in front of me.

Coming back to 1.2.04, I will then ask a couple of my general questions. One is the diabetes database pilot project at Western Health; what is the status of that pilot project?

MR. HAGGIE: I would defer to a member of the staff for a more accurate update than my kind of 30,000-foot overview.

MS. MICHAEL: Okay, thank you.

MR. HAGGIE: Karen?

MS. STONE: So that's no longer just a Western Health project; it's now a provincial project. All the data has been validated, and we expect to be able to release our first reports this spring.

MS. MICHAEL: Right, thank you very much.

Minister, would your briefing notes include the following, and if not, could we get these statistics – I don't expect you to get them to now – of the number of personal care homes and beds by region in terms of the four health authorities; the numbers of community care homes and beds as well; the number of nursing home beds by region; and the number of people on the wait-list for long-term care bed by region?

MR. HAGGIE: There are some statistics in your binder. There are the personal care home statistics; there are the long-term facility beds and wait times. The others are not in the binder.

MS. MICHAEL: Okay, but we could receive them as well?

MR. HAGGIE: I think it would not be too difficult to find those for you.

MS. MICHAEL: Okay, thank you. There's a head nodding behind you, so –

MR. HAGGIE: Okay, so long as they're nodding, I'm happy.

MS. MICHAEL: You've got staff support for your answer.

The enhanced care in personal care homes pilot project, could we have an update on that, please?

MR. HAGGIE: The three pilot sites were successful according to the evaluations I've seen. Patient satisfaction was high. They dealt with – and I better just check from memory exactly how many it was, I think it was 24 – 24 clients, and basically we were pleased enough with it to put money in the budget this year going forward to increase the number of sites.

The main limitation in the uptake was actually the geographical location of the pilot sites. People were happy to avail of the idea, but they didn't particularly want to go to those locations for family reasons.

MS. MICHAEL: Okay, and will the notes include the homes that are actually involved in this project?

MR. HAGGIE: I think they're –

OFFICIAL: It's 100 subsidies.

MR. HAGGIE: Sorry?

OFFICIAL: It's 100 subsidies.

MR. HAGGIE: Oh, the new homes, or the existing homes in the pilot –

MS. MICHAEL: The existing and the new.

MR. HAGGIE: Well, the existing ones are in there. The new ones, we will have to wait, roll out, see what the uptake is because it is discretionary and it's up to the care home operator to apply and, as yet, that hasn't occurred.

MS. MICHAEL: Okay.

I'll have one more general question then. I could not let Estimates go without asking for an update with regard to electronic medical patient records.

MR. HAGGIE: There is uptake initially from the work through the Medical Association. I think the first one certainly went on stream in the fall, if I'm not much mistaken. I think it was in the late fall. There are five more that I'm aware of who are in the pipeline. We're trying to encourage uptake, but that's an issue for the NLMA and us. So it's rolling out slower than I would like, but it's rolling out.

MS. MICHAEL: Is the department and NLMA working together on this?

MR. HAGGIE: Oh yes.

MS. MICHAEL: Right.

MR. HAGGIE: And NLCHI.

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

CHAIR: Okay, that's good; we're all good on that section.

So I'll ask the Clerk to call that.

CLERK: 1.2.01 to 1.2.06 inclusive.

CHAIR: Shall 1.2.01 to 1.2.06 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 1.2.01 through 1.2.06 carried.

CHAIR: Shall 2.1.01 to 2.3.02 carry?

Mr. Davis.

MR. P. DAVIS: Thank you, Madam Chair.

Minister, is there any change in the seating allotments anticipated at the Faculty of Medicine this year or in coming years in regard to its overall seats, or any change in the ratio of Newfoundland and Labrador seats versus international students?

MR. HAGGIE: No.

MR. P. DAVIS: No changes, okay.

There is a change in fellowships and awards, a decrease. Can you explain that to me and how that came about?

MR. HAGGIE: Could I just get a little bit of clarification? Are you referring to Memorial fellowship and other awards?

MR. P. DAVIS: Well, I know they're under the Faculty of – maybe it doesn't come under this head. If it doesn't come under this head, fine, we can park it, but I know there was a change in awards and fellowships for students.

MR. HAGGIE: That was a recommendation from Memorial Faculty of Medicine if it refers to this particular budget. There are some other bursaries and awards which come in later on, and I don't know whether you are referring to that.

MR. P. DAVIS: Is there a change in bursaries and awards for students?

MR. HAGGIE: For students for returning service and recruitment initiatives, there is a change.

DR. ALTEEN: There is a change in the bursary program that we instituted back in 2014 that reflects more on increasing the award to students who are going to more rural locations in the

province and for a three-year return of service commitments. That's to students and residents.

In that change in 2014, that's been implemented over the last couple of years, we certainly have a fully utilized program this year. We just went through the applicants recently, so those have been awarded this year. That's for students who are going to wish to return to service in this province in various locations and commit to being in that location for three years.

MR. P. DAVIS: For two years?

DR. ALTEEN: Three years.

MR. P. DAVIS: Three years.

Dr. Alteen, how far along in a student's progression in their studies would these return to service agreements be put in place?

DR. ALTEEN: We have two. We have one that we put for the undergraduate medical education. So prior to your MD degree, and I think there's about 30 of those that we have available each year. That's for students who wish to, while they are doing their undergraduate medical education, commit to staying in the province. It's not location specific.

When you get into your post-graduate education, during your residency training, the awards then occur in the last two years of your training, which is really when most people are ready to make a decision as to where they might want to stay in this province. That's where we focus the money in the program on.

MR. P. DAVIS: It's full uptake as you said?

DR. ALTEEN: Pardon?

MR. P. DAVIS: There's a full uptake in utilization?

DR. ALTEEN: Yeah.

MR. P. DAVIS: I believe, if I remember correctly, the NLMA partner assist in the –

DR. ALTEEN: There's another signing bonus program where we utilize money that would normally go to physicians for payment for providing services. We took some of the unused money out of the 2009-2013 agreement and did the signing bonus program. That's a separate program.

That's more to attract people once you finished your training and are interested in coming to work in Newfoundland, and there are some requirements for that. That's based on hard-to-recruit positions in the province, so where they've been vacant for a period of time and the rural location.

MR. P. DAVIS: While it's a little bit off topic, but you raised it, what is the prevalence of hard-to-recruit areas in the province today? Would you have that?

DR. ALTEEN: It varies because a lot of times it's based on geography and it's also based on the specialty. So there's some specialties because of the subspecialization that's gone on in medicine that have made it difficult, and I could take the example of general internal medicine where we would need a number of those physicians in the province, but training programs have geared more towards subspecialization in cardiology, nephrology and so on. We've tried to encourage – and this is occurring at a national level as well – to focus people more on the generalist approach to this is what we probably need more in this province, and less subspecialization.

So there are areas that are difficult to recruit but it varies from time to time. It may be one location today and another location tomorrow. But the RHAs are certainly trying to do a better job at focusing on our own grads. We've increased our class size, and our first enhanced or enlarged class size will come out in 2017 – an extra 20 students a year –and focusing on those and trying to have those willing to go to various places in the province.

MR. P. DAVIS: I believe that was the focus and the intention, wasn't it?

DR. ALTEEN: Yes.

MR. P. DAVIS: When do they start to graduate?

DR. ALTEEN: 2017 is the first graduating class. Then they'll have two to five, six, seven years of post-graduate training after that.

MR. P. DAVIS: We still hear, from time to time, issues and complaints about some areas that I'm sometimes a little surprised to hear, where people have trouble in engaging with a family doctor. In Corner Brook, for example, not too long ago I heard concerns from Corner Brook itself.

Are there still urban areas like that which have the same challenges?

DR. ALTEEN: There are still some urban areas, and Corner Brook is a prime example, where we've done some work. But one of the challenges in some of these areas is physical space for them to set up an office.

Most physicians nowadays are not interested, necessarily, in the business of practising medicine. They would like to go somewhere where they can hang out their shingle, do their work and have somebody else look after the business side. So we're doing some work and this is where primary care really comes into play; some work in primary care where you may enhance that.

I think that places like Corner Brook, Carbonear – there's a few of them around the province that we can do a better job of that. So I think primary care is the real catalyst for making those changes. And most people want to work in a collaborative practice with other disciplines. The day of the solo practitioner, I think, has passed.

MR. P. DAVIS: I know in rural parts of the province we have clinics where the regional health authority would operate and run a clinic and have doctors on staff to run those family practice-types of clinics. So would that type of set-up be a potential future for somewhere like Corner Brook?

DR. ALTEEN: That's the challenge. Yes, in rural Newfoundland we do have those facilities where we have the RHAs manage clinics and the physicians, be they salaried, they would work in our facilities. But sometimes they're fee for service and also work out of our facilities. The challenge is in urban centres it's not necessarily been set up that way, but that's where I think primary care will get us into a model where that type of thinking will occur.

MR. P. DAVIS: Thank you.

Minister, if I can go to 2.2.01, which I think we're going to have a fairly extensive discussion on because there are many concerns around drug programs. I have a number of areas that I want to get some further information on.

I think I'll start with seniors and over-the-counter drugs which we're hearing a lot about. Can you give me a description or what changes are being made on coverage for seniors who rely heavily on over-the-counter drugs?

MR. HAGGIE: The change to the drug plan under the NLPDP is essentially a withdrawal of over-the-counter drugs. It is based on aligning the drug plan in this province with that of the majority of our neighbours. We have been quite generous in the past.

MR. P. DAVIS: What plan would that be under, that the over-the-counter drugs are now available? Which of the prescription drug plans?

MR. HAGGIE: The only plan that remains is a select plan where they're covered.

MR. P. DAVIS: What plans did they have before?

MR. HAGGIE: It was available to all of the plans under the NLPDP.

MR. P. DAVIS: Do you know the total savings anticipated on this, the total dollar amount?

MR. HAGGIE: It's $2.6 million.

MR. P. DAVIS: Are you able to tell me how many patients and how many seniors were utilizing over-the-counter drugs under the NLPDP or accessing over-the-counter drugs?

MR. HAGGIE: One moment.

We don't have that data with us.

MR. P. DAVIS: You don't have that?

MR. HAGGIE: No.

MR. P. DAVIS: Would it be accessible? Would you be able to get it, do you think?

MR. HAGGIE: Yes.

MR. P. DAVIS: I see the chain going –

MR. HAGGIE: Sometimes I have to refer –

MR. P. DAVIS: Absolutely.

MR. HAGGIE: – because sometimes it's difficult to figure out whether you can get that information.

MR. P. DAVIS: I get the answer before you because I can see behind you.

OFFICIAL: You see the nodding heads.

MR. HAGGIE: My children have left home so the eyes in the back of my head have faded.

MR. P. DAVIS: I don't want to make light of it because we're hearing this a fair bit. We're getting response from people throughout the province who are concerned about this that have been receiving drugs. Some of them have, what they describe to them to be, fairly significant drug costs.

What do we tell them? What do we tell seniors who are saying I can't afford to purchase these over-the-counter drugs which I've been told I need and should have and have been approved under that plan. What do we tell those people?

MR. HAGGIE: If, in the opinion of a prescriber, a drug which is not funded – i.e. over-the-counter now – is necessary, then there is a process under the NLPDP by which that request can be assessed by a clinical panel.

MR. P. DAVIS: I'm sorry, assessed by whom?

MR. HAGGIE A panel for the NLPDP process. It's a special authorization program – process. I always get that last word wrong.

MR. P. DAVIS: So things like a doctor prescribes vitamins, which we see commonly prescribed for, especially our aging population, vitamins and other items that are prescribed regularly for ailments that are quite common to our aging population. So those type of needed drugs – and I know from my own experiences with private insurance and special authorizations, quite often they'll say, well, show us that you have this prescribed and have been using this for a period of time and we'll approve it.

I know I went through this recently when the provincial drug program changed. They said, well, if you are looking for a drug that requires special authorization, establish that it's been approved by the prior provider and we'll approve it as well. So is that the type of circumstance that would happen here?

MR. HAGGIE No, I think the test that I understand would be somewhat more stringent. It would have to be related to a diagnosis. So if you were looking for an iron prescription, for example, you would have to have a clinical condition for which iron would be the therapy, rather than simply a dietary supplement because you thought you'd have some iron or vitamins, whatever it might be.

MR. P. DAVIS: I always find these special authorization processes – and I'm talking about a private provider now. I always find these special authorization processes to be time consuming and frustrating from my own personal perspective, but I don't know how the NLPDP does that. What would a senior who relies on these drugs – how difficult would that process be for that?

MR. HAGGIE Well, simply it would be a matter of discussing this at their next visit with their primary care provider, whether it's a nurse practitioner or a physician, and going through on maybe a drug-by-drug basis, if it's over-the-counter medication. This doesn't affect other medications available under the plan; it's simply that category of drug that is called over the counter. If, in the opinion of the prescriber, there was a medical condition that required this prescribing, then a request could be submitted through the special authorization program.

MR. P. DAVIS: Okay. Thank you.

One of the areas that we've heard from is personal care home operators who have contacted us and said what's the change, what's being covered and what's not being covered, and not wanting to get caught up in saying all of a sudden they're stuck with bills or in a process that they can't get out of. We asked for a list and got a listing that was fairly complicated. It didn't actually provide a list of drugs. It was a lot of references look here and look here and so on.

Is there a list available of what's no longer going to be provided under the program or what would have to go through a special authorization program to get approval? Is there a specific list of those drugs?

MR. HAGGIE: Yes. In actual fact, the Member for Conception Bay South had it in the House yesterday.

MR. P. DAVIS: Yes, it's 64 pages of references and material that: go here, look at this –

MR. HAGGIE: There is a list. It comes out as a couple of pages.

MR. P. DAVIS: Okay.

MR. HAGGIE: We can provide you with the link. It is just a pdf to download.

MR. P. DAVIS: Yes, 64 pages of links I think. I saw a lot of links that are on there. If you could have a look at it just to see if there's a way to get it simplified, because what we had really wasn't going to be much benefit to an operator or someone who's trying to make these decisions because there was a lot of –

MR. HAGGIE: And that's a useful comment, if there's a problem with the links to the website we'll fix that.

MR. P. DAVIS: Okay, thank you.

My time is up.

CHAIR: Are you okay if I move to Ms. Michael?

MR. P. DAVIS: Yes, certainly.

CHAIR: I gave you a couple of minute's leeway because I did the same for her just now.

MR. P. DAVIS: Yes, I just missed the clock but I'm sure we're going to be on for a little while.

CHAIR: Balancing out – yes, no problem at all. Then we can come back to section two again, Mr. Davis?

MR. P. DAVIS: Yes, absolutely.

CHAIR: Okay, all right.

Ms. Michael.

MS. MICHAEL: Okay, thank you.

Just for clarification, staying where we are with regard to the over-the-counter drugs, I think most of what I wanted to ask has been covered.

For example, I'm using an example here now, if somebody has been diagnosed with osteoporosis and the supplement that you get – supplements advise with regard to calcium compounds – that could be covered if a doctor shows there's been a diagnosis of osteoporosis and the supplements are advised.

MR. HAGGIE: The form can be submitted and if the criteria are met, yes.

MS. MICHAEL: Right.

I'll just make one comment to say I understand the special authorizations and it's really great, but when I look at the people who are affected by this change, seniors, low-income people, sometimes people with low literacy levels, there's a lot involved here that I think can become an impediment for some of them. I do find this disappointing that this change was made.

Coming on to one other thing – well, actually it's the dental program. I'll save that. It's the dental program I'm thinking about.

With regard to the Smoking Cessation Program, Minister, is that program continuing in 2016?

MR. HAGGIE: Yes.

MS. MICHAEL: What's the uptake like in that program in terms of numbers?

MR. HAGGIE: That falls with Seniors, Wellness and Social Development, the Smoking Cessation Program.

MS. MICHAEL: Okay.

MR. HAGGIE: The numbers, the minister there would be able to provide that for you more accurately.

MS. MICHAEL: Right.

I don't know about you, and I don't know about Paul Davis either, but I am, on a fairly regular basis, even having people stop me on the street and talking about vaping. We're getting a lot of – actually, I think this morning on CBC there may have been a story about the whole thing of vaping as well.

MR. HAGGIE: Sorry, I –

MS. MICHAEL: Oh, vaping, it's the –

MR. HAGGIE: Vaping. Sorry, I'm with you, yes.

MS. MICHAEL: Okay, sorry about that.

MR. HAGGIE: Yes.

MS. MICHAEL: Okay. Yes, don't be afraid to say. My voice drops. Usually it doesn't, but sometimes it does when I'm thinking through something.

Are you having any discussion in the department at all about it? There aren't any health authorities anywhere, I don't think, in the country who are really dealing with it. I don't know even what to think about it, because I have no idea – and maybe this is where research is happening right now. I don't think we have any definitive word on what the impact of the nicotine is in another form. We know the smoke, that's the one we've been used to dealing with, but is any discussion going on in the profession or inside the department around the whole issue of vaping?

MR. HAGGIE: Yes, there is. Again, that's being led by Seniors, Wellness and Social Development. I know they're very active in this, and the minister and I have had conversations about it. So I think there may be some developments in that line in the not too distant future.

MS. MICHAEL: Okay, thank you.

That's all I have for those two sections. So moving on, unless – does Paul want to go back to –?

CHAIR: Well, it would be best, and then we'll call that vote in the twos.

MS. MICHAEL: Okay.

CHAIR: Mr. Davis, did you have more questions under this subhead of the twos?

MR. P. DAVIS: (Inaudible.)

CHAIR: Okay.

Are you okay, Ms. Michael?

MS. MICHAEL: Oh, no, I just realized I have one question back to 2.1.01.

CHAIR: Okay.

MS. MICHAEL: Minister, you may be able to give me the answer to this or not. It's not sort of a discrepancy, just on paper we have very small change, as we've already noted, in the Grants and Subsidies to the faculty; yet, in other budget documents outside of our Estimates, in what we're calling the budget savings document, the 10 pages of all the different initiatives under the budget and the savings. That document identifies $1,778,900 with regard to savings in the operating grants under the School of Medicine. So I'm wondering, those are savings, but the grant has remained the same.

MR. HAGGIE: Yes. They're offset.

It's a question of funds in and funds out from different sources. So to offset those savings, for example, the faculty collective agreement cut some of those savings by over $900,000; accommodations for medical students and

forecast for provision of salary increases, then again offset by some current service level adjustments. What you've got really is a shift of money, and the net effect is what you see on that top line.

MS. MICHAEL: Okay. Thank you.

For the record, for anybody from the School of Medicine who may find out I asked that question, I wasn't recommending the money to the Grants and Subsidies should be lower. I just wanted to get an explanation of the discrepancy that seemed to be there.

Thank you very much. That's helpful.

That's it now, yes.

CHAIR: Mr. Reid, did you have a question before we move out of that section?

MR. REID: Yes, just in relation to the allocation for Memorial University Faculty of Medicine. To go back to the recruitment issues and the incentives being offered to medical students there, just for my own information, could you explain the incentives that are being offered.

Also, in terms of nurse practitioners, are incentives offered to nurse practitioners as well? Because I know in several circumstances in my own district, nurse practitioners have provided a very good alternative to doctors.

MR. HAGGIE: You're quite right. I think the recruitment of health care providers across the spectrum is important. We need a full suite of them.

I think the department has something like 22 different bursary programs. They are aimed at a wide variety of primary health care providers, and certainly nurse practitioners are part of that suite.

There are some for undergraduates prior to the end of their degree. In the case of physicians, there are those for residents prior to the end of their post-graduate training. The aim is to try and spread those incentives so we end up with a balanced suite of health care providers.

In addition to that, as Dr. Alteen referenced earlier on, there are signing bonuses for, not just physicians, but other health care providers based on localized, hard to recruit positions.

So the short answer to your question is yes, we have a range of them.

MR. REID: Thank you.

CHAIR: Okay.

Can we call two, or you're still in two?

MR. P. DAVIS: I'm still up for questions on two, yes.

CHAIR: My apologies.

You continue.

MR. P. DAVIS: I think there might be some questions back here, too, behind me actually.

If I can go back to over-the-counter drugs for a few minutes; Minister, in personal care homes, residents who are subsidized – I would assume there are hundreds throughout the province – they're allowed to keep $150 a month for their own personal expenses, clothing, hygiene products. Their grandchild may come to visit and they want a gift for them. Their entire life expenses have to be made under $150 a month.

Now many of them, of course, if they need aspirin or if they use iron, because they're trying to regulate their diet – of course, they don't have a lot of control over their diet in a personal care home because they essentially have to rely on what's available to them. I know personal care homes try to cater to the best they can, but in many cases we'll have seniors in personal care homes who use iron, and laxatives they need to go with iron and so on.

It's kind of hanging with me a little bit because I know lots of people in personal care homes don't have any money left over at the end of the month and now they're going to have this additional cost, for some may be a fairly big cost for these over-the-counter drugs. I'm just wondering, what is your analysis or determination been on what the impacts are going to be on these people?

MR. HAGGIE: From a point of view of data, it would appear on average that the cost of drugs under this plan to the patient was around – the cost of the medications themselves would be around $15 a month.

We are aware of the issue of the comfort allowance. It's one of the things that as part of a review of long-term care and the income and means testing for residents for personal care homes and long-term care homes that the department is starting to do some work on to see if there needs to be some adjustments, in the light of the fact that a lot of those haven't been adjusted in some time.

MR. P. DAVIS: Okay.

I would expect we're probably going to hear that fairly quickly once the loss in drugs and those extra expenses come. I hope that government is going to be well positioned to adjust because a lot of them concern me. I have personal care homes where I visit residents of my own. As you can probably appreciate, I'm sure you do from your own history, sometimes when you visit them and they call you aside and whisper in your ear and they talk to you about how tough their circumstances really are. That's the ones we worry about.

I want to talk a little bit about the Adult Dental Program. I know I asked you in the House a little while ago about how many people utilized the dental program last year. Are you able to give me that information today?

MR. HAGGIE: Yes, 12,611 people accessed the Adult Dental Program last year.

MR. P. DAVIS: How many would have been eligible last year but not eligible this year? Of those 12,000, how many of them now are no longer eligible under the change in the program?

MR. HAGGIE: We have 44,000-and-some who are eligible under the new arrangements for the adult dental plan. If you compare that with other jurisdictions, we're better than three and the same as five more. So the exact number of which of those 12,600 are eligible under the old rules and which would be eligible under the new rules, I couldn't give you that figure.

The utilization, in terms of numbers of the adult dental plan, has been pretty consistent over the last three years, somewhere between high 11,000 and 13,000.

MR. P. DAVIS: There have been comments in the past that oral health and dental health is important to a person's overall health. I know we had a short exchange in Question Period on it, but it's a discussion that has come up to me a number of times by people who've either utilized the program and now they feel different in their own lives, that they're more willing to leave their home and go outside for a variety of reasons, but it's added to the quality of life for them.

I'm just wondering, do you agree with that, that adult or dental health, oral health is important to a person's overall health and complements that. I expect you would, but then what would be the impacts of people who are no longer eligible and how will that impact them?

MR. HAGGIE I think you can argue of what level you decide to augment someone's plans, be it dental plan or drug plan, and you have to bear in mind your ability to fund those.

The facts of the case are we look after 44,000-and-some of the most vulnerable of our population with a plan that is as good as, or better than, eight other jurisdictions. I think, given the situation we find ourselves in financially at the moment, whilst one might wish to do things differently, you have to live within your means.

MR. P. DAVIS: Yes, there's no doubt, you have to live within your means. I appreciate that. I don't disagree with that. It's the choices we make to live within our means are the ones that are worthy of further discussion and any impacts on the people of the province.

Under the 65Plus Plan, obviously, there would be benefits to seniors who have great difficulties in making ends meet. People who rely on the GIS and the OAS, obviously, they have to have both in order to be eligible for the 65Plus Plan. These are our most challenging seniors who are trying to make ends meet. So under the new policy – and I'm seeking clarification, Minister. My understanding is under the new policy

people who have coverage under the 65Plus Plan would not be eligible for dental care. Am I reading wrong?

MR. HAGGIE The coverage is the Foundation Plan only. There are some in long-term care who would also fall into that plan who are outliers on the other plans, but it's a small number.

MR. P. DAVIS: Okay.

So people who are covered under 65Plus, the OAS and GIS won't be eligible for dental care?

MR. HAGGIE: Foundation, plus these outliers only.

MR. P. DAVIS: Okay.

The same with the Access Plan, which are low-income families, they won't be eligible for coverage either.

MR. HAGGIE: Children are not affected by these changes. The children's dental plan remains unchanged.

MR. P. DAVIS: Remains the same, yes, okay. So it's just adults and seniors.

I know a couple of cases – and I've heard the Premier speak about this publicly – where people have already begun the process. I'm told by people in the business in dental care that this whole process can sometimes take many months, six months, in some cases maybe up to a year to complete the process.

I've heard the Premier make comments that people who've already had extractions and so on, that they would cover them. Is that generally the policy overall now or is that being done on an individual basis, or can someone who's already had teeth extracted assume they're going to finish the program?

MR. HAGGIE: Anybody who has begun treatment prior to April will be eligible to have this completed under the old criteria.

MR. P. DAVIS: Good.

Thank you.

I want to move to prescription drugs, if I may. I know every year there are a number of drugs that are removed from the formulary for one reason or another. Do you know how many overall have been removed this year?

MR. HAGGIE: I couldn't answer that question offhand as to how many drugs – we don't have it?

OFFICIAL: (Inaudible.)

MR. HAGGIE: No, we don't have the exact number. I mean one of the challenges with pharmaceuticals is we budgeted $2.6 million for new drugs for this year. I think there's been much more enthusiasm about trying to put drugs on, than take them off. There's a whole body of work within the profession currently going on about what advantages new drugs may have over old, and that's a professional discussion. I think it has to feed in, and so we take advice from the Atlantic Common Drug Review, as I'm sure you know, and the various national agencies that advise on cancer medications, and medications in general, as to what to put on.

The exact number that's come off, I couldn't give you at the moment but I'm sure we could try and find that for you.

MR. P. DAVIS: I know from my own experience as well, that sometimes you'll find that with the one drug or a drug taken off it's going to impact somebody somewhere or they say the new drug doesn't fit their needs. Because quite often when drugs come off the formulary, it's because something newer or better has come along or –

MR. HAGGIE: And the big debate there, to go back to some debates I've had in the past, is that 80 per cent of new medications are what are described by the pharmacists and the clinical pharmacologists as me-too drugs. They are the same in terms of their therapeutic abilities as older ones, it's just that because they're patented medicines they cost a hell of a lot more than the older ones which have become generic. The question, then, is: What is the science and what is the marketing behind the new drug?

MR. P. DAVIS: Right. Sometimes it's just a better, more cost-effective especially.

MR. HAGGIE: It's certainly more expensive.

Now, there is a big change in cancer chemotherapy, which our money, I think, will probably end up going more towards this year, in that they're changing to oral treatments for cancer medications.

The advantage of that is that the current medications are given with a very labour-intensive treatment with intravenous injections or infusions or ports or extensive hands-on involvement. Now, if you can substitute those for oral medications – and pCODR, which is an acronym I can never remember, which is the national body looking at this – we may have more expensive drugs on the face of it coming forward, but the service costs will be significantly lower because these patients can take the pill at home rather than go to a clinic and have an IV and this kind of thing.

MR. P. DAVIS: Right.

MR. HAGGIE: That's going to be a challenge over the next year or so.

MR. P. DAVIS: Thank you.

Can I just add maybe one more and I think I might be finished on the Newfoundland and Labrador Prescription Drug Program, if I may, Madam Chair.

The other one is on catastrophic drugs. I know it's a very low number; very high cost at times. Are there any changes in any of those circumstances?

MR. HAGGIE: There are none. No.

MR. P. DAVIS: Okay. Thank you.

That was an easy one.

MR. HAGGIE: Yes.

MR. P. DAVIS: I think that's all I have.

MR. HAGGIE: I just look for reassurance. That was why I was slow speaking.

MR. P. DAVIS: I was going to go on to diabetic test strips and so on, but I don't want to use our time for that. There are other items I want to get to instead.

CHAIR: Would that be still in section 2?

MR. P. DAVIS: It would be, but I think we can move on. Maybe if we have a half an hour or something leftover, which I doubt –

CHAIR: Ask the generic ones then.

MR. P. DAVIS: – we can go back after, but I'm fine.

CHAIR: Ms. Michael, are you still in section 2?

MS. MICHAEL: Yes, I have a couple of questions.

CHAIR: Okay.

So we'll switch now to Ms. Michael.

MS. MICHAEL: Continuing on with the Dental Services. I was glad to hear you say that those who have begun the process of getting dentures prior to April, that will be accommodated.

Has that information been given to the providers? Because I am having people coming to me saying – I've had, very particularly, three different children of seniors who have come to let me know they had gone through the process of having the teeth removed because the dentures were going to be put in.

I've had people – this happened recently, over the last 24 hours, I think, on Facebook, examples coming to me saying the provider has told them the funding is not there. Have the providers, has the association been notified that this is the case?

MR. HAGGIE: Yes, is the short answer. They've actually been notified several times. The folks on the end of the 1-800 line for any clients who might ring up have had that message for some time now.

I've seen several mail shots, faxes, emails that have gone out to denturists and dentists explaining what I explained to the Member opposite about how anybody who was in the

process of having work – extractions or whatever that would then lead on to denturists – would be dealt with and they have. The old criteria applied as long as it was done up to April of this year.

MS. MICHAEL: That process had started. Right.

I'm really glad to hear that. Now I will start saying that officially as well.

MR. HAGGIE: Thank you.

MS. MICHAEL: From the minister.

As we all know communications – we think we've said it and said it and said it, but we know that communications is complicated. So we have to continue finding all the ways to get that message out. Thank you very much.

This is just pretty straightforward. With regard to physicians, will your notes have an update on currently the number of family physicians and specialists broken down by salaried, fee for service and alternate payment arrangements?

MR. HAGGIE: Yes, that is, in actual fact, on page 45 and 74 of my briefing book.

MS. MICHAEL: Wonderful. Thank you very much.

How many oral surgeons do we now have within MCP?

MR. HAGGIE: Oral and maxillofacial surgeons; we have four. Five – sorry, I misspeak.

MS. MICHAEL: Has that number gone up?

MR. HAGGIE: Yes, we did have four. And we've gone up incrementally over the last couple of years.

MS. MICHAEL: Okay.

Thank you. That's all I have for those two sections, Chair.

CHAIR: Okay.

Mr. Lane has a question.

MR. LANE: Actually, I did have a question, but I think Mr. Davis pretty much answered it. I was wondering about the over-the-counter medications and some examples of what would be covered now that won't be covered in the future. I'm assuming it's things like Tylenol, perhaps laxatives, stool softeners, things like that. Is that basically what we're talking about?

MR. HAGGIE: There are a variety of compounds or medications on that list usually bought over the counter for minor self-limiting issues. It includes things like the medications you've referenced, yes. That list, there seems to be some difficulty getting it, but we can make sure that you have that.

MR. LANE: Okay.

I would just say I'm glad to hear that there is going to be review in the department over the issue, because I do share the concern that Mr. Davis raised about the seniors in a nursing home with only $150. I have a senior in my life in that exact circumstance; I know how tough it is. Quite frankly, in her particular case, she's lucky that she has me to supplement what she has to make sure that she's never without, but I do think about seniors who don't have family members that could do that.

MR. HAGGIE: That was our thinking too.

MR. LANE: Thank you. That's all.

CHAIR: Okay, are we okay if we call the headings now for section 2? Yes?

CLERK: 2.1.01 to2.3.02 inclusive.

CHAIR: Shall 2.1.02 to 2.3.02 inclusive carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, subheads 2.1.01 through 2.3.02 carried.

CLERK: 3.1.01 to 3.2.02 inclusive.

CHAIR: Shall 3.1.01 to 3.2.02 carry?

Mr. Davis, Ms. Michael had left about seven minutes on the clock. Are you okay if I start there or do you want –

MR. P. DAVIS: (Inaudible.)

CHAIR: You're okay with that? Okay.

Go ahead.

MS. MICHAEL: I'm starting, am I?

CHAIR: Well, I was going to give you your seven minutes that you had left on the clock and come back to Mr. Davis.

MS. MICHAEL: Very good. Okay, thank you very much.

3.1.01, starting with Professional Services; we have an increase of $300,000 in this year's budget over last year's budget and revision. Could we have an explanation?

MR. HAGGIE: Yes, of course you can.

The changes here are a contract for Institute for Quality Management in Health Care for lab accreditation. It's been transferred from the Grants and Subsidies line to the Professional Services line. The contract is per a Cameron recommendation. The move was done as a result of an internal audit in government to show that it should be accounted for in a different line.

MS. MICHAEL: What was the contract, Minister?

MR. HAGGIE: It's for lab accreditation for the Institute for Quality Management in Health Care. It's a $300,000 contract to ensure that national standards across the RHA labs are met and that they are accredited. And this was a recommendation from the Cameron inquiry.

MS. MICHAEL: Mentioning Cameron, it may be a good time just to ask, we haven't had an update in recent times on the various recommendations. I don't have it in front of me because there were different times when some reports were going to be due, and I really haven't looked at that document lately. So where are we with regard to the recommendations?

MR. HAGGIE: We can provide you with that; that's no problem. The current one that's still being worked through is to get all three hormone receptors done at the Health Sciences Centre. And the view of the laboratory physicians there is until all three can be done there, they all go out to one accredited laboratory. So they're all done in the same place.

They're nearly there with the third one, but it's not quite ready to go operational yet.

MS. MICHAEL: Okay.

Any timeline for that, Minister?

MR. HAGGIE: This year.

MS. MICHAEL: This year. Okay, great, because we do continue to get questions on that also. Thank you.

Under Purchased Services there's an expenditure line now that wasn't there before, so could we have an explanation of what this is, the $5,075,000?

MR. HAGGIE: Okay.

Again, Professional Services and Internal Audit have suggested moving line items into here from other areas. So the air ambulance contract with PAL, which is $1.85 million; the HealthLine contract with FONEMED, which is $2.89 million-and-change; and interpreting services for visual sign language is for persons with hearing or visual impairments for the RHAs – those have been moved in as an accounting change on the recommendations of the Internal Audit.

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

Mentioning the ambulances, I'll ask this question now. When will the central medical dispatch centre for ambulances be set up?

MR. HAGGIE: There is a report being generated by a consultant on what central medical dispatch should look like, or could look

like in the province with some options. We have not yet received that in the department. It is expected that we will receive that in the near future. Once we've done that, then we can look at what the recommendations are, how that would fit, and how we move forward with that. So we're still at the stage of waiting for that report to be delivered.

MS. MICHAEL: Okay, thank you very much.

Moving down then to 09, Allowances and Assistance, there was a big drop from the budget to the revised estimate of $993,600 and now in this year's budget we are $379,000 under what was budgeted last year. So just an explanation, please.

MR. HAGGIE: There is a list of savings under there. The medical resident bursary incentive program uptake was lower than anticipated and we saved $312,500 there. There was a lower than anticipated use of signing bonuses for difficult-to-fill RN positions. That saved us $281,100. The Medical Transportation Assistance Program didn't use $400,000. That's a total of $993,600.

MS. MICHAEL: Okay.

What is the impact of this year's budget being $379,000 less than last year's?

MR. HAGGIE: We have reduced the bursaries in line with utilization, so there have been reductions in the Bachelor of Nursing Bursary Program, the Signing Bonus Program and the Provincial Physician Bursary Program.

MS. MICHAEL: What do you see as the impact of having fewer bursaries?

MR. HAGGIE: Well, these were underutilized so we've matched our budget ask or vote to the previous year's expenditure. Obviously it's something we're going to have look at over the course of the year and see how that rolls out; but again, given the financial circumstances, money that was left as it were or dropped, it seemed sensible to budget as prudently as we could and then go forward to see. The answer is it's unknown.

MS. MICHAEL: Okay, but you will be monitoring, that is what is important.

MR. HAGGIE: Oh yes.

MS. MICHAEL: Thank you.

I'm almost down to – I only have 23 seconds left and I suspect Paul may be picking up on some of my questions. If not, I can come back to them.

Thank you.

CHAIR: I was going to suggest a five-minute break. Is that the wishes of the committee –

MS. MICHAEL: Good idea.

MR. HAGGIE: That's fine with me.

Thank you.

CHAIR: – and then we will come back and start with Mr. Davis.

Recess

CHAIR: All right.

Minister.

MR. HAGGIE: Oh right, thank you. Sorry about that.

I misspoke earlier on. The savings from the over-the-counter changes is $3.3 million, not $2.6 million.

CHAIR: It's $3.3 million, not $2.6 million.

MR. HAGGIE: My apologies.

CHAIR: Okay.

So we'll start with Mr. Davis. We'll start the clock.

MR. P. DAVIS: Thank you.

A number of areas under this heading, Minister, I'm sure you appreciate I want to go, but I just heard your discussion before the break regarding bursaries for RNs. It was underutilized as I understand. Would that be right?

MR. HAGGIE: Yes, it was.

The Bachelor of Nursing Bursary Program was underutilized in previous years by $281,000.

MR. P. DAVIS: So is that a bursary program for hard-to-fill positions?

MR. HAGGIE: No. The Signing Bonus Program was underutilized by $281,000. I don't have a figure about the Bachelor of Nursing Bursary Program in terms of how underutilized that was, but it's been reduced by $74,000 in the coming year.

MR. P. DAVIS: So the signing bonus would be for hard-to-fill positions.

MR. HAGGIE: The signing bonus is for hard-to-fill positions.

MR. P. DAVIS: Am I to take it, then, those are positions that still remain unfilled?

MR. HAGGIE: Good question. There are some vacancies still within the RHAs for RNs. The exact number I think is in one of the tables in the binder.

Okay. No, we'll have to provide you with that number. It's not in the staffing table, my apologies.

MR. P. DAVIS: My point, I guess – and you can comment if you're in a position to. If you're not, I understand. My thought on the Signing Bonus Program, this is about hard-to-fill positions, similar to physicians, trying to go fill those vacancies. Instead of reducing the budget, I would have thought you would give consideration to increasing the signing bonus or find a way to incentivize nurses to go to those hard-to-fill positions instead of leaving them vacant. But to eliminate it seems like we're not making any strides to help fill those difficult positions.

MR. HAGGIE: We haven't eliminated it, we've simply reduced it.

MR. P. DAVIS: Well, reduced it.

MR. HAGGIE: I think the issue of a bonus from a philosophical point of view for signing is a moot one. It may help with recruitment but it doesn't often help with retention, and therein lays your challenge.

I think if you go back to the whole concept of workforce planning, there are some adjustments that probably need to be done in the light of that report, when it's available. It may be wise to revisit these programs once that workforce plan has been generated.

MR. P. DAVIS: Your comment on recruitment and retention is interesting, because I always felt that if you're able to recruit somebody, then you have an opportunity to retain them. I remember a Newfoundland movie not that long ago that dealt with that very thing.

I know, personally – and as you said it I'm thinking of a teacher who I know as a young graduate from Memorial went to Black Tickle teaching. Not because she wanted to live in Labrador, but because she wanted to gain employment as a teacher and start her career. And 15, 16, 17 years later she's still teaching in Labrador, not because she has to, but because she wants to. That's part of the recruitment and retention process.

So I'm just obviously interested. Any time there's a vacancy, I know it's a lot of work to try and recruit for those, but I believe that sometimes recruitment turns into retention as well.

I wanted to move to another area. I know you received an email from a gentleman – and he's told me I could, he's been talking publicly as well – Stephen Chard. He got a response back from your office that at least your office has received the email.

He lives in Bonavista. I don't know if you're familiar with the case offhand but a complex case. An 11-year-old son who has complex health needs: cerebral palsy, epilepsy disorder, infantile spasms he references, which you likely know more about than I do. He has a G-tube. He says he's had pneumonia maybe twice a year his entire life and in his email to you he outlines he's had probably 80 to a hundred X-rays since birth.

He has explained – I've spoken to the man and in the interest of full disclosure I know him before now. He's a man who feels that the change in the X-rays, in his particular case and others potentially as well, is going to have a significant impact on his family and the potential health of his child.

My question to you about this is that when you have a case like this in Bonavista, is it really worthwhile from a health perspective for patients and also from the cost perspective, not to keep the X-ray services there and those extended hours?

MR. HAGGIE: The challenge – and one of your colleagues opposite brought it up in a rather general way during one of his comments on the budget – was that we accept, he said, that you can't have everything everywhere. The problem is and the question is how you have that line, if you like, or that delineation of services.

It's been a difficult exercise going through the budget. I think the honest answer is these changes are based on recommendations that have come from the operational end of the RHAs and they're based on utilization statistics, basically. They are based on, among other things, location, they're based on the busyness factor and they're based on the proximity of alternative sources of care.

I think you will always find, as you referenced earlier, there's someone who is going to be impacted. That is an unfortunate fact with health care.

MR. P. DAVIS: I know the X-ray changes that are, I think, in Whitbourne, Old Perlican, Placentia, St. Lawrence, Grand Bank and Bonavista – I suppose it could be that in Grand Bank there's not that great a distance, I don't think, to access X-ray services. But, in particular, Bonavista and this family, one of the questions that he was asked is: Are you willing to move. This is a man who, within the last five years, built a home specific for his son's needs. They have their family supports around them which, of course, alleviates pressures on the health care system.

One of the points he made to me when I spoke to him was that in likelihood now, when his child has been transported by ambulance before, a nurse has attended with him. Now that the X-ray services are not in Bonavista, this could fairly frequently occur where he has to be transported by ambulance from Bonavista to Clarenville and, at times, he's been moved on to the Janeway. It's going to mean extra resources for ambulance transfers, RN to travel with his son and so on. He's questioning even if the savings will be realized because of his personal circumstance.

Now, they may not exist in any of those others areas, but at very least, Minister, what I would ask of you is: Would you review this person's personal circumstances, apply it to the change and then reconsider that change if the case meets the needs or makes the case that yes, this is not a good reduction of service for this particular area?

MR. HAGGIE: I recall reading the gentleman's letter and passing it over to staff for some comment so I could respond to him, and, of course, we will do that. It's not like there will be no X-ray services in Bonavista. What you're looking at is a reduction in hours.

The evidence from the operational review, as I understand it, is that there are actually very few urgent X-rays that have to be done outside the hours that are scheduled; and, by and large, under those circumstances, the patients have a clinical problem that is such that they would need a higher level of care anyway. So that transport, that move would have taken place anyway.

Yes, I will certainly undertake to look at the gentleman's correspondence and respond to him. The facts of the case are whatever changes – as you alluded to before in the provision of health care – you make will impact somebody.

MR. P. DAVIS: I know you appreciate as well that sometimes one size doesn't fit all. There may be modifications needed to larger plans because there are those individual circumstances that should be addressed. I appreciate that. Thank you, Minister.

Minister, if I can go to home care. There are some changes in home care this year. Can you

give me just an overview of what changes are taking place?

MR. HAGGIE: I'm trying to find the appropriate page here. I'll be with you shortly.

MR. P. DAVIS: Yes, certainly.

MR. HAGGIE: The home care programs that we referenced in the budget were three. There was the enhanced home care project, which the previous minister of Health had run as a pilot in three sites: Golden Meadows, Gander and one other, which escapes me. They had been very successful.

There is money in the budget now to clone that and offer that service to other sites to accommodate an extra 100 clients who would fall into the so-called level two-plus, which would keep them hopefully from needing long-term care.

There is a home first strategy, which is a more comprehensive one, which will roll out over the course of the coming months and year which is designed to allow people to age as near to home as possible. Then there are also some enhancements to OT and PT services in the community to allow for folk who need those services to stay at home rather than necessarily going into a personal care home.

So those are the changes from a kind of strategic level that we have proposed.

MR. P. DAVIS: I would think that the paid family caregiver program would be part of that.

MR. HAGGIE: The paid family caregiver program is in there and has not changed.

MR. P. DAVIS: Okay.

So based on what you're saying then I would think that there is a possibility there could be some expansion or continuation or extension of the paid family caregiver program.

MR. HAGGIE: That has not been on our radar currently. It is there and I actually haven't seen an evaluation in terms of the uptake of it, the benefits of it or the cost as yet.

MR. P. DAVIS: Okay.

Any changes on budget on the paid family caregiver program, do you know?

MR. HAGGIE: No, there wasn't in this year's budget. I was confused about some changes to minimum wage or is there a consequence of minimum wage in home care, but no.

CHAIR: Mr. Davis, seeing the time on the clock, are you okay if we shift over?

MR. P. DAVIS: Yes, absolutely.

CHAIR: Ms. Michael.

MS. MICHAEL: Thank you very much.

Minister, with regard to the Grants and Subsidies, basically the operating money that the regional authorities receive, obviously pressure was put on them to come up a variety of measures to save money because government wanted money saved within the health care. There's no doubt that some of the measures they came up with are efficiencies and efficiencies that may or may not directly affect people's lives. Those are good. There are things I look at and I say, well, that's a good idea.

When the efficiencies come down to changing of services, the shutting down of some services or lessening services, whatever, which do affect people's lives, I have a problem. I'm wondering, in doing the exercise they had to do as the regional authorities, did they sit with the department during that process and were the discussions around, well, is that measure a good one in terms of impact on people, or did the authorities just do this on their own without any consultation back and forth between them and the department?

MR. HAGGIE: It was a bilateral discussion. We, in broad-brush terms, went to the RHAs as operational deliverers of health care and said where would you see reasonable, reasoned economies to be found. They brought back a suite of options and suggestions. Some of which were fleshed out and some of which weren't. Some of which were feasible in the short term and some of which required more implementation and mitigation planning.

What you saw in the budget was those that had a combination of being accessible and utilizable in the short term with mitigation or alternative strategies, which really focused on trying to realign services where possible. There are ongoing discussions about how and what should be done next, but essentially the key message was to find efficiencies in operations, savings where you could, in terms of the purchasing and the kind of backroom activities.

But as far as the front end, front-line services, my instructions and my request was that you looked at programs critically and said what is it that works, what is it that you need, and what is it that you can't afford and that won't work and is more of a want than a need. That was the hierarchy that was suggested to them.

MS. MICHAEL: One of the areas, and you've just made an allusion to it, where I think money must have been saved would be with regard to shared services between the authorities. Could you give us an idea of how things are going, what exactly right now are the services that are being share and where money is being saved in the sharing of services?

MR. HAGGIE: Well, on a general level, things that have been implemented revolve around buying groups. We have those in place for, if you like, consumables such as dressings and the like. And also there is a second buying group nationally, CAPsource, which is aimed at more capital equipment. Currently, we're looking at ultrasound machines and anaesthesia machines. We estimate for each anaesthesia machine, purchasing through CAPsource will save us $50,000 per machine approximately. For each ultrasound machine, we could save probably somewhere in the order of maybe $30,000. Those are ballpark and I may be out a little bit.

As far as a shared services organization or a shared services structure within the RHAs, what has happened is the feasibility of this has been looked at. It was felt that there were certainly four areas that were worthy of consideration. Each of those four areas is a little bit more advanced. What has happened is an implementation group looking at how to put in place a shared services model, and the furthest advanced is that of purchasing and reconciliation of accounts in that line.

The other areas of interest which are a lot less fleshed out rely around payroll and HR. They run around issues of IT. Those are not as well developed; they're still in a concept stage. There is work being done in the department with some inside resources to address these as well as a small body who've been tasked to become a shared services team with a view to moving that forward.

MS. MICHAEL: Right.

Do you have a dollar figure for the savings that have happened with regard to the shared services around the buying of consumables, for example?

MR. HAGGIE: Denise, do you have the number?

MS. TUBRETT: We've saved significant money through Health*PRO* and CAPsource. The minister has referenced the money that we've recently saved per anaesthetic machine. I think the cumulative savings on Health*PRO* is in the order of $20-odd million. That's fairly substantial when you consider that's savings that we get just by purchasing –

MS. MICHAEL: Could you repeat the amount again?

MS. TUBRETT: It's over $20 million.

MS. MICHAEL: Okay, over $20 million.

MS. TUBRETT: I don't have the exact number with us.

With respect to a shared services model, the work that we're doing with respect to the shared services organization is based on work that Deloitte had done. They estimated it's in the order of about $25 million once fully implemented, but that's the work that we're currently doing trying to validate the savings that can be achieved, actually achieved.

The bulk of that $25 million is about another $12 million to $14 million associated with buying differently. That's an overview of that.

MS. MICHAEL: Great. Thank you very much.

It's probably in your notes, and if so, then we'll get it when we see it, but I'm just interested in what was the number of recipients by region of the MTAP, the Medical Transportation.

MR. HAGGIE: We have a number in the binder but we don't have it by region. We could – 2,993 unique patients in '15-'16 went through MTAP, but we don't have that broken down by region. We can find out for you.

MS. MICHAEL: We should we able to get that though, the regional, can we? Yes.

MR. HAGGIE: Certainly by Island versus Labrador.

MS. MICHAEL: Right. Okay, that will give us an idea.

MR. HAGGIE: Because it's administered provincially. I don't know whether that granularity would exist easily in terms of which region within the Island.

MS. MICHAEL: Right. Thank you.

And, Minister, which clinics are closing because of the budget?

MR. HAGGIE: There are a couple of clinics that are only open on a part-time basis. There was the one-day-a-week clinic in Hare Bay. They have two other clinics in very close proximity. There's one in Carmanville which again, is not far from Gander or the Gander Bay clinic and there's one which was only open two days a week in Hermitage. The patients there would go on to Connaigre in Harbour Breton.

MS. MICHAEL: Okay. None of these would have been a diabetes centre.

MR. HAGGIE: These were rural primary care sites with visiting services.

MS. MICHAEL: Right.

Okay. Still under 3.1.01 – just give me one second, please.

I think I can move on to 3.2.0.1.

CHAIR: Maybe given the clock, if you want to just go back to Mr. Davis and then we'll start first with you.

MS. MICHAEL: Yes, that will be fine.

CHAIR: Okay. Thanks.

MR. P. DAVIS: Thank you, Madam Chair.

I wanted to talk about Medical Transportation Assistance Program. We know it's a valuable program used by many in the province. What changes are taking place this year? My understanding is part of it is being moved from Health to AES.

MR. HAGGIE: No.

MR. P. DAVIS: It's not?

MR. HAGGIE: It's staying in the department.

There is a desire to look at cost of transportation across both departments. But that is, at the moment, a desire rather than anything that translates into action.

MR. P. DAVIS: Okay, so any changes to the program overall?

MR. HAGGIE: No.

MR. P. DAVIS: Funding, or design and delivery?

MR. HAGGIE: No, it runs exactly as it has in previous years.

MR. P. DAVIS: Are there any systematic issues that have come up on – we hear stuff all the time about one size doesn't fit all. But, overall, are there any issues that have been raised that are ongoing or need a review that you're aware of? I guess there's not. I'm sure you probably would have reviewed it if there was.

MR. HAGGIE: Well, yes. I mean the concept of transportation and the cost to both AES and Health and Community Services has been raised. I think at some point the cost and the method of delivery will be a subject for review, but that's not something that's on our short-term radar at moment. I'm not aware of any significant issues

that have arisen lately with the program that haven't been the kind of background activity that's gone on perhaps when you were in office, or your predecessors.

MR. P. DAVIS: I've always known to be a fairly strong uptake in utilization. The numbers are still high, there's still good utilization of the program. Do you know how many people utilize it?

MR. HAGGIE: It was 2,993 unique patients in '15-'16.

MR. P. DAVIS: Two thousand – sorry?

MR. HAGGIE: Two thousand and nine hundred and ninety-three.

MR. P. DAVIS: Two thousand and nine hundred and ninety-three. Okay.

MR. HAGGIE: In '15-'16. That's unique patients, rather than trips.

MR. P. DAVIS: Yes, I understand.

MR. HAGGIE: Yes.

MR. P. DAVIS: Minister, I understand there's a lot of pressure on OBGYN services in Central. What's the status on that now?

MR. HAGGIE: There are active recruitment efforts for both locations, in actual fact. The challenge is, as Dr. Alteen referenced earlier on, a combination of critical mass and generalism.

One of the things that the profession is not good at is encouraging and maintaining generalism. From my previous roles I can wax lyrical about that. But, essentially, it can be difficult for rural sites to attract specialists and these are, both in Grand Falls and in Gander, areas that are having some issues. We're working hard to try and fix them.

The problem is, again, as was alluded to by Dr. Alteen, you have four or five years of medical school and then you have five years as a residency program. So there's a lead time to try and find individuals. We do have people who are from Central who would be interested in coming back, but they're at stages in their career that you've still got a lag.

MR. P. DAVIS: That's also partially because of the lack of critical mass?

MR. HAGGIE: Well, it's far easier to recruit a third physician for a group of two, than it is to recruit one when there's nobody there – speaking from personal experience.

MR. P. DAVIS: OBGYN is now provided in both Gander and Grand Falls-Windsor, is that right?

MR. HAGGIE: Yes.

MR. P. DAVIS: Has been any discussion or plans or consideration on amalgamating to one location?

MR. HAGGIE: There are rumours abound, of course, but in actual fact, having spoken to Central Health, there is not only no plan to amalgamate them, they're actively trying to maintain both of them.

MR. P. DAVIS: Okay.

I'd like to have a discussion about autism and any changes in funding or services for individuals and their families and caretakers.

MR. HAGGIE: I had a discussion actually last week with Scott Crocker and Tess Hemeon from the Autism Society. What we have in mind are some short-term discussions around, for example, IQ 70 as a threshold for services. That has proven to be a significant barrier. The issues they've highlighted about access to ABA, we are working through those.

There have been significant reductions in the wait times between assessment and treatment for children identified as being autistic. We're working to try and further reduce those.

At a more strategic level, there is a need and a desire to build a provincial strategy. The discussion has been whether or not we should focus solely on autism initially or try and build a more umbrella approach for all children who are differently abled, and autism would simply be a

part of that bigger picture. There are pros and cons to that.

MR. P. DAVIS: I'm sure Mr. Crocker was more than happy to discuss all of that with you.

MR. HAGGIE: Oh, we had a very interesting chat. I learnt a lot and I think it was a very useful hour we spent.

MR. P. DAVIS: I have a tremendous amount of respect for him and the organization. I think they do fabulous work. They're very dedicated, and of course their funding is always an issue for them.

Were there any chances to their funding this year?

MR. HAGGIE: Not that I'm aware of. They get the bulk of their funding through SWSD. I'm not aware of any challenges there.

MR. P. DAVIS: Okay.

The IQ 70 is still a matter being considered?

MR. HAGGIE: Oh, actively. Yes, it is a problem.

MR. P. DAVIS: Yes.

What would be the alternate?

MR. HAGGIE: Our approach is to step back a little and say, what are the challenges any individual child has? This isn't my field of expertise, but autism, I'm told, is a complete spectrum from children who are just a little bit quiet and bright, to those who are very, very difficult to manage and all point in between.

I remember going to an Autism Society meeting in Gander, for example, and we had some very heartfelt discussions with some parents there, particularly of those children at that end of the spectrum. The challenge in the get-go is sometimes you can't actually assess a child's IQ because of their autism; therefore, this categorical approach doesn't work. So to step back and say well what are these children's needs, kind of a performance/disability approach to any given particular child and a wraparound of services that both start before school, kindergarten and through the school and then transitioning into adult life, because it's those transitions that children with autism seem particularly challenged with.

MR. P. DAVIS: Minister, is the number of children being diagnosed with autism continuing to increase?

MR. HAGGIE: Over time, there certainly has been an increase in the diagnosis. Mr. Crocker and I discussed whether or not this was an increase in awareness. Certainly, the numbers are growing.

MR. P. DAVIS: Is that the number – I think to the point that probably you had a discussion on. Does that mean the actual number of children with autism is growing or just the numbers that are being diagnosed are growing, they existed before, just weren't diagnosed or picked up?

MR. HAGGIE: There's a mix. I think we agreed there was a mix.

I think people in education and in health care are more sensitive to the possibility of that diagnosis now. That will always generate an increase in incidents but there is certainly some suggestion from multiple sources that the actual number of diagnoses is increasing because the incidents are increasing.

MR. P. DAVIS: I know SWSD probably has more input or AES from an adult perspective. What involvement does your department or the funding from your department have with adults with autism?

MR. HAGGIE: I think the involvement has been traditionally in well children screening. There is some doubt as to the efficacy of that. It certainly picks up some children, but Mr. Crocker and I also discussed the fact that there are a significant number that are actually picked up when they enter the education system. Having teachers, kindergarten and early childhood educators aware of the possibility of autism is certainly a key part of any strategy going forward because the earlier these children are identified, then it would appear from the data the better their prospects are with early treatment.

MR. P. DAVIS: Even if they're picked up prior to the education –?

MR. HAGGIE: Yes. Again, what modalities of treatment are available, whatever they are – and there are debates within the autism community, as well as the scientific community, about what treatments are best. There is no magic bullet, seems to be the main theme, but the general consensus for all of them is that if they are picked up earlier they do better.

MR. P. DAVIS: I don't know if you have it with you, or maybe you can provide it to us in your materials after Estimates today, about the numbers of diagnosis annually, or overall, the number of children in the province who are living with autism?

MR. HAGGIE: We could probably provide you with those children who are referred for autism services under our auspices in terms of psychology behavioural therapy, those kinds of things. I don't think that would be too difficult to find. I think I've seen that table somewhere. We didn't bring that with us today.

MR. P. DAVIS: NLCHI, Newfoundland and Labrador Centre for Health Information would probably have a better idea.

MR. HAGGIE: We can certainly produce some information for you.

MR. P. DAVIS: Thank you.

CHAIR: Are you good?

MR. P. DAVIS: Time to change, yes.

CHAIR: Ms. Michael.

MS. MICHAEL: I'd like to come back to the regional authorities. This is just shocking for me. I should have realized this before.

The federal revenue for this year is $2,009,600. Is that correct?

MR. HAGGIE: Yes.

MS. MICHAEL: Yes.

And that's the total federal revenue for our health care? Where else does federal money show up? Under no other estimates line is there any federal money.

MR. HAGGIE: Federal revenue, it is in the binder here and it's broken down. The money there relates to cost-shared agreements with federal agencies. So the revenue from the feds, from a health transfer doesn't appear in here.

MS. MICHAEL: That's it?

MR. HAGGIE: No, it doesn't appear in here.

MS. MICHAEL: It doesn't appear.

MR. HAGGIE: No.

MS. MICHAEL: Okay.

MR. HAGGIE: It's not our department. It goes through Finance.

MS. MICHAEL: Do we know what that share – well, I guess it's in the consolidated funds, in that whole booklet where we can find out.

MR. HAGGIE: My impression is, as of 2017 that will be approximately 18 cents on every dollar we expend in health care.

MS. MICHAEL: Are they going to be using the per capita system that the former federal government said was going to happen?

MR. HAGGIE: At the moment, there has been no talk of changing that. There have been discussions at the federal-provincial-territorial Health Ministers' meetings, and it's certainly the position of this province and the Atlantic provinces, that formulary does not serve our interests at all.

The whole question of the federal government share of health care expenditure in the province, if you look back historically, it was 50 cents on every dollar.

MS. MICHAEL: That's right.

MR. HAGGIE: It's gone down progressively, certainly in the last – I call it an agreement, it wasn't really. It was kind of diktat in 2012, I

think it was, essentially puts us on a trajectory where the feds will supply 17 cents of every health care dollar.

The position of the Atlantic health ministers – I think it was supported generally – was that they should go back to 25 cents forthwith, with the aim of trying to restore some further equity.

The difficultly outside of Atlantic Canada, is there are jurisdictions who are quite happy with the per capita. There are some who would like age and complexity of chronic disease – certainly, we're in that group to be considered – and there are others who don't want age but would prefer complexity.

I think those different positions reflect the demographics of that population because when the changes were made in 2012 – accumulatively, I think it takes somewhere over $200 million out of our revenue from the feds for the CHT – there was only one province that actually benefitted, and that was Alberta to the tune of $918 million positive. That was a source of some irritation, shall we say, at the time.

MS. MICHAEL: Right.

Allowing for the variations of positions of the provinces, is there, though, at least an agreement that we need a new Health Accord?

MR. HAGGIE: There is an agreement that we need more money or a greater percentage of the health care dollars from the feds. That's unanimous. Once you get beyond that, it would be difficult to say there's a national consensus or a pan-Canadian consensus. There's certainly an agreement in the Atlantic provinces that we're very much aligned, because our problems are not that different –

MS. MICHAEL: That's right.

MR. HAGGIE: – looked at from outside. So it would be a weighted formula. It would involve age and it would involve chronic disease.

MS. MICHAEL: Right.

Mentioning chronic disease, could we have an update on the chronic disease policy framework?

MR. HAGGIE: Ms. Stone, can you –

MS. STONE: The Department of Seniors, Wellness and Social Development are working on a healthy living strategy which will complement our current chronic disease framework that we have.

MS. MICHAEL: Do you have any timeline for that work?

MS. STONE: I'm not comfortable speaking for Seniors, Wellness and Social Development, but they've just finished a significant consultation process. I'm not entirely sure what their next steps are.

MS. MICHAEL: Okay, thank you very much.

I'm finished with 01, and if Paul is as well, we could move on to 3.2.01.

CHAIR: You can continue on.

MS. MICHAEL: Okay, good enough.

CHAIR: Use your time on the clock, and then we'll go back to Mr. Davis.

MS. MICHAEL: Great.

Under 3.2.01, it's pretty straightforward. We have a big drop in the budget line for Property, Furnishings and Equipment. Could we have a justification for that, please?

MR. HAGGIE: Yes; $13 million was removed from the capital equipment block and the communicable disease surveillance management system project, which was $2.5 million, was removed. There was dissatisfaction with that, and I think from a provincial and a federal point of view, because we were trying to tie in the two.

There's a forecast adjustment for the Electronic Medical Record project, which is a cash flow adjustment. So the communicable diseases has been removed, the GRI removed $3 million, and there was a budget decision from 2015 to remove $10 million.

MS. MICHAEL: So when you say removed, you mean completely gone or moved somewhere else?

MR. HAGGIE: Just gone.

MS. MICHAEL: Just gone, okay.

Under the Health Care Facilities, 3.2.02, could we have a breakdown with regard to the Salaries, if there are vacancies or retirements, et cetera, the number of physicians involved in the drop of $570,000?

MR. HAGGIE: The salary allocation was for T&W staff who acted as project managers in Health. They oversaw the infrastructure projects that were on the go. In 2016-17 there are fewer projects, and we have reduced the estimate of the time that they would be involved in the coming year.

MS. MICHAEL: Right.

So I'm assuming the drop in Professional Services and Purchased Services all have to do with the projects that have been put on hold?

MR. HAGGIE: One moment, I'll just get there and have that.

The revised was an allocation error in the 2015-16 Estimates. The further decrease is simply due to the fact that the projects have shifted in terms of their various stages. Some are in planning, site preparation, tendering or construction. They lead different levels of funding as the project goes through. I think 80 per cent of a project's funding goes through in the first 18 months, and then it tails off fairly rapidly.

The design funding for '16-'17 is for the Health Sciences Centre substation, and project work for the water for the Corner Brook hospitals.

MS. MICHAEL: Okay.

And the Purchased Services, because there's a large drop there, too, of $25,724,000?

MR. HAGGIE: Again, that's down to a reduction in the number of projects and the fact that a lot of projects are nearing completion. The PET scanner is on its last phase. It only requires $2.6 million this year, and that's basically to put the thing in and plug it in and switch it on, as far as I can tell.

MS. MICHAEL: That's the second one in St. John's is it, or –?

MR. HAGGIE: It's the first one.

MS. MICHAEL: The first one.

MR. HAGGIE: We don't have one. This will be the first (inaudible).

MS. MICHAEL: Oh, that's right, yes.

MR. HAGGIE: Yes, and there's a cyclotron built into that as well, isn't there?

OFFICIAL: Yes.

MR. HAGGIE: So that will enable home-grown production of isotopes, which is probably the most sensible.

MS. MICHAEL: Right.

MR. HAGGIE: The Carbonear and Happy Valley-Goose Bay long-term care projects are nearly finished. So the bulk of their expenditure is gone, and there are fewer projects going forward.

MS. MICHAEL: Right.

And you may or may not want to answer this question. If you don't, that's fine. I know there'll be some people in some part of the province who won't be happy with me for asking it.

It seems to me the information that I have, the research we've done, is basically with a population our size and with the demands the PET scanner would have, that it really isn't – I don't think we need more than one in the province. Does the department have a position on that, or –?

MR. HAGGIE: I don't really think I'm equipped to answer that question.

MS. MICHAEL: Right.

MR. HAGGIE: It's not my field of expertise and I haven't done the research to do it justice by giving you an off-the-cuff answer.

MS. MICHAEL: Okay.

MR. HAGGIE: You don't want a surgeon talking about radiological matters.

MS. MICHAEL: Right.

CHAIR: Ms. Michael, I'll go back to Mr. Davis.

MS. MICHAEL: Yes, I actually have no more at this point, I don't think.

CHAIR: We've moved totally away from the Estimates, I think, and the minister's been great with answering the other policy questions.

Mr. Davis.

MR. P. DAVIS: Thank you.

I think it's actually part of Estimates, but – it comes up. If it costs money, it's part of Estimates.

AN HON. MEMBER: You didn't think that when you were on the other side.

MR. P. DAVIS: I did, yeah. Well, when I sat over there, much like the minister's doing today, I was willing to talk about anything that the department – that there was a dollar sign to it or should have been a dollar sign to it or wasn't, then in Estimates I was quite willing to discuss it then. Much like the minister's doing today, and I appreciate it.

CHAIR: You have the choice to ask whatever question you wish and then the minister chooses whether he answers.

MR. P. DAVIS: Right. Yes, he's been very gracious today so far and his staff as well.

Minister, now that we have that over, I have a minute gone.

CHAIR: Would you like me to restart the clock? The Chair maybe hasn't been fair.

MR. P. DAVIS: No, that's fine.

Minister, we know that eating disorders and treatment and care are an increasing concern in society today. What's the recommended treatment and care for persons with eating disorders? I know it's (inaudible) it would be individual, it would be very individualized circumstances and so on. What's the standard of care across the province available for people with eating disorders and what's the recommended care?

MR. HAGGIE: Again, not delving into the clinical world because it wasn't particularly my specialty, but these folk need a variety of modalities of treatment depending on the nature and severity, because within eating disorders there is a constellation of different types. In general and kind of without prejudice, they would need access to psychological services, social work and counselling, psychiatry possibly, may even need internal medicine or gastroenterology.

It's kind of a tiered response. I know the Eating Disorder Foundation is looking for a specialist unit which would deal with the most complex of the complex. There are, however, two beds in the Health Sciences complex allocated on the psychiatric unit with access to the full support of the Health Sciences Centre's internal medicine and investigative capabilities which currently deal with those.

The ideal I think, in the view of the Eating Disorder Foundation, would be to make that into a full bedded, dedicated area. That is probably a goal that we should work towards but, again, given the fiscal situation we are kind of moving in baby steps.

We have a bare-bones system which is dealing with the bulk of patients. There will always be the odd patient in any discipline whose needs exceed that of the provincial system to deal with whatever the discipline, and eating disorders are no different. There we have the options that we have through MTAP and various other things for people to go and get that. So that's kind of like a 30,000-foot overview.

MR. P. DAVIS: Eating disorders itself – I shouldn't say always troubled me, but in recent

years – is one of these areas that as discussions increase, knowledge base increases. PTSD is another example that I wanted to talk to you about.

Eating disorders is one of those that we seem to have a better understanding today. I think we understand better today that if treatments are in place it could shorten treatment, benefit the patient, quality of life. And long-term, the cost of those treatments could ultimately be less if the intervention happens earlier. Autism is similar in some ways to that, but a little bit different.

So, Minister, when they make a case, I know it's a really difficult one, but I suppose I'm looking for what – if you look at what best practices happen in other jurisdictions, how the patient outcome is improved by having those services upfront versus later, is there a way to do that under what resources you just mentioned, how those resources are available to the Health Sciences. Is there a way to do that, having those resources around you?

MR. HAGGIE: I think the skeleton is there, the embryo is there of what are generally accepted as best practices elsewhere. There are some areas that need strengthening, there's no doubt about it, and I've alluded to some of them.

I think the difference in some respects is an awareness now that people with mental health are best regarded as being managed with a recovery model rather than a cure model. What you have is you have individuals who will have to manage and cope over a lifetime.

You're right, the early psychological supports and interventions are going to be key in starting them down that road. The challenge is always the resources locally, rather than necessarily the resources in one particular area geographically.

It's the old analogy around the Waterford in a sense. You don't want just to have a building there and say you fixed mental health. It's all the stuff that you put in it and put around it. It's the same with mental health in general and eating disorders, specifically.

The challenge is to try and find the resources as close to home and there's certainly work to be done there. It goes back to sometimes we have made some significant strides in access; it comes back to resources on the ground and the demand versus the supply. That's a challenge, certainly, in a fiscal constraint.

MR. P. DAVIS: Can you give me any sense of numbers of patients either diagnosed or that receive services that would be classified as eating disorders?

MR. HAGGIE: I can get that for you. I didn't bring that with me. It's the same kind of discussion, in a sense, as we had with autism. The numbers are there and they are increasing.

MR. P. DAVIS: They are increasing? That was my next question.

MR. HAGGIE: Well, there is – again, it's the same discussion with autism. Is it an increase in awareness and diagnosis of milder conditions? Is it an actual rise in the true incidence of a condition? And again, I think it's a mix of two. Having spoken to the eating disorders folks, I think they would probably agree with that statement. Not that I should put words in their mouth, but I think that's basically the agreement we came to. We'll find you those figures.

MR. P. DAVIS: Yes, I appreciate that. I think it's just worthy of acknowledging as well, similar to autism and a society that does good work, the eating disorders group as well. I know they're very dedicated and looking for those reliefs and benefits. I'm sure we all know of cases personally where a patient wasn't successful in battling the disorder. Maybe the outcome would have been changed if there was an improvement to the services or earlier intervention available to them.

MR. HAGGIE: I think in actual fact the peer groups themselves provide a service that nobody else can because what a lot of the discussion is around with the peer groups is that they serve two functions. We've talked about this in the context of autism as well with the society. They can serve the role as navigators to what can be a complex system for people who are challenged and frightened, but also, they can provide a peer support that nobody else can.

There is a general acknowledgement that if you have a problem and you can sit with a group of people who have walked that walk and gone down that path before you, that you will get far more out of it than sitting in a room with a clinician, necessarily, depending on the nature of your problem. They're there often in the evening when you're just having a low moment. Those are the kinds of things that really are supports that can't be provided and probably shouldn't be provided any other way.

MR. P. DAVIS: Yes, I appreciate that. I appreciate as well that your department, while you're not on the front line of the delivery of service and so on, you're quite often the catalyst for expanding or changing how those deliveries take place. The staff around you have a variety of skills and backgrounds that can help lead those types of changes, if it be autism or with eating disorders. So I appreciate that and I appreciate your interest. Of course, your background brings a unique perspective, somewhat unique from a ministerial perspective as well.

The other one I want to talk to you about that's different, but I expect the conversation may be similar, is around PTSD and recognizing that many people inflicted with PTSD are government employees or provide services, either at arm's length or in contract with or as part of their role in first responders. I believe PTSD likely goes beyond first responders and even moves into the events that, quite often, occur in emergency rooms where chaotic type of circumstances happen from time to time.

I'm wondering if you or your department have or would be willing to give some consideration to PTSD from government perspective and front-line employees who are – again, we're gaining a better understanding. I'm personally gaining a better understanding in recent months on PTSD. I know that globally there's a growing understanding of PTSD.

So from a health department, government being the employer, is or would your department give consideration to interventions for government employees?

MR. HAGGIE: We have started in several ways, sort of simultaneously, because this has kind of grown up in a variety of ways. You're right; there is an increasing awareness. It isn't just confined to necessarily what would be traditionally regarded as first responders: police, fire, ambulance crews. It does happen to staff within health care.

I know that each of the health authorities has kind of grown their own solutions in terms of one will do critical incident stress debriefing, another one has the access through the employee and family assistance program.

I think trying to legislate a common approach across the RHAs like that may actually be counterproductive because these build on existing resources with systems that are working. So rather than have a prescription for – so the health authorities, I think, are on board with that.

In terms of within government itself, I think there has not been that much of a recognition maybe yet about the arrival of PTSD. Although some of my staff may say working with me has been too stressful. You may want to have a word with them quietly, but joking aside, I think that's a very valid point. I think you make a good point.

CHAIR: Mr. Davis, are you okay if we move to Ms. Michael?

MR. P. DAVIS: If I could just have another minute or two on this topic and then we can move off it, if that's okay with Ms. Michael or I can come back to it if she prefers?

MS. MICHAEL: I don't have any more questions.

CHAIR: Oh, you don't have any more. So continue.

MR. P. DAVIS: I do. Maybe you will after I ask more questions.

One of the issues – and it's not specific to your department, I just raise it for your own awareness and your department and it may be something you might want to discuss further with your own colleagues.

One of the problems that I'm understanding with PTSD is the very rigid requirements under WorkplaceNL or workers' comp, as it's known as, for employees because workers' comp right now requires an employee diagnosed or a worker diagnosed with PTSD to identify the event that caused the PTSD.

As you're probably aware now, it's becoming a greater understanding the PTSD quite often is a cumulative disorder, not just a single event. So I just raise it with you and just put it in your mind because you may have opportunity to influence change in that. I know it's a significant barrier for front-line workers that I've spoken to in medical or health care related, fire and police. I've talked to some in all areas and also internally in health care that have said that this is a major stumbling block for them when they can't identify an event that has caused PTSD, then they're declined for coverage. Then, of course, they're put in turmoil.

MR. HAGGIE: You make a good point. I think the use of current diagnostic best practices is something that anybody who is making decisions about treatment should employ. I can raise it with the minister responsible, for sure.

MR. P. DAVIS: Thank you, I appreciate that.

And while we're on the topic in mental health, I know there was some discussion on it, I'm just wondering what changes in funding – and very global, you're 30,000 foot on mental health for programs. And, much like your comment a few minutes ago, I think it's very important to focus on programming and services, not just bricks and mortar. But what funding has been earmarked for the development of new programs in relation to the all-party committee, or has there been any funding separate for that or is it just part of the general fund?

MR. HAGGIE: I think, specific to the all-party issue, the feeling was that until we knew what shook out and came out of that process, it wasn't really possible to allocate any funding on a speculative basis given the fact that we'd really been lean with what funding had been put in, in a kind of discretionary way, to the budget for any department.

I think, in terms of on the ground, the practical things, there were some changes around delivery of programs at the Rowan Centre, which despite it being labelled a centre, it was really more of a program. The logic behind that was it was geared up for the tweens and teens, 12 to 16; and that the utilization, it saw 65 patients through that program in a calendar year 2015-16. And it was a program whose staff could be better utilized and absorbed to provide services elsewhere in the system.

I think some of the developments with the opening of the Hope Valley and the Grace Centre may have an impact on that as well. So that was the change. There was no reduction in terms of personnel or skill sets; they were simply moved elsewhere. The addictions library had less than one request a day, and that has simply been merged with the Mental Health and Addictions Library. There's a feeling that most of the access was not for written, printed material but could be managed electronically as well. It was a very low utilization.

Those were the two principal changes in community-based care.

MR. P. DAVIS: You mentioned Hope Valley and Grace Centre. Which ones are they?

MR. HAGGIE: I'll get this right. Hope Valley is in Grand Falls-Windsor and that's the addictions centre. Tuckamore was mental health and then the Grace Centre is addictions.

OFFICIAL: Adult.

MR. HAGGIE: Adult addictions, that's right. Tuckamore –

MR. P. DAVIS: Is that the new one in Harbour Grace?

MR. HAGGIE: Yes. That was the one that was opened in Harbour Grace recently. That's for adults. I misspoke; it's the Tuckamore and the Hope Valley which are the children's and adolescents.

MR. P. DAVIS: So there's movement of their own services more so than a centre. Programs are going to be run from Tuckamore in Paradise.

MR. HAGGIE: They have a central intake. It's provincially done. So a client can self-refer or be referred by social workers, psychiatry to a central location and then the team there will prioritize and decide on the best access, whether or not they need in-patient or whether or not they need community based. The Rowan Centre, I wouldn't be able to tell you exactly where the bulk of those 65 referrals came from geographically, whether they were all Avalon-based –

OFFICIAL: (Inaudible.)

MR. HAGGIE: Okay. It's a day program; they would have been Avalon based.

MR. P. DAVIS: It would be a long drive from –

MR. HAGGIE: A long drive indeed.

MR. P. DAVIS: I was going to ask about actually Tuckamore and Hope Valley and Humberwood and Grace. Am I right to think that they are probably all full, at maximum capacity, or is that not the case?

MR. HAGGIE: I would have to check to be sure. I know there was some sort of lead time with the Hope Valley Centre. They had several units and I think because of staffing they were – the same with Grace when it opened, they were going to admit in groups as it were to allow the place to spool up, but I don't have any current figures. I'm sure we could find them with not too much difficulty.

That was Tuckamore?

MR. P. DAVIS: Tuckamore, Hope Valley, Grace Centre and Humberwood.

MR. HAGGIE: Okay, we'll find those for you.

MR. P. DAVIS: Humberwood is still in operation as well.

MR. HAGGIE: Oh yes –

MR. P. DAVIS: Grace Centre and Humberwood, essentially the same programming for both? They are both addiction centres.

MR. HAGGIE: The deputy has detailed knowledge of that.

MS. CLARKE: Yes, they are similar. The Humberwood program and the Grace Centre will work together. They do also have a central intake. They will look to see where the most appropriate places are for clients and patients. The Harbour Grace facility, Grace Centre, is a bit longer in the program itself. So depending on the needs of the client, it is at least a week longer, maybe more. It's also medically based. So it has nurse practitioners and full-time nurses on staff, as well as physician consultation.

So because of that, it's taking some of the more complex, high-level needs people with additions but they will work together, between the two facilities, to ensure people get what is the most appropriate in-patient treatment that they need.

MR. P. DAVIS: I've been in all four centres. I think they're fabulous centres. It would be great if we had 50 more of them. I'm sure they'd all be utilized, but we don't and we can't. They're great centres.

MR. HAGGIE: I hope there will be a day when we can actually start closing them, really.

MR. P. DAVIS: Really, yes.

MR. HAGGIE: That's another discussion for other policies.

MR. P. DAVIS: I'm sure we won't see that any time soon.

Minister, I want to talk to you a little bit about long-term care beds. How many beds are actually being taken out of the system?

MR. HAGGIE: Sorry, how many beds –

MR. P. DAVIS: Long-term care beds being taken out of the system.

MR. HAGGIE: None.

MR. P. DAVIS: None?

MR. HAGGIE: None.

MR. P. DAVIS: Can you explain that to me?

MR. HAGGIE: Of course I can.

MR. P. DAVIS: You're closing Masonic Park and there are 40 beds at Masonic Park.

MR. HAGGIE: Masonic Park has 40 residents. The new arrangement at the Memorial Veterans Pavilion creates 31. Veterans Affairs Canada are alternating the criteria for admission to other beds in Memorial Veterans which will allow 10 currently ineligible veterans or their spouses housed in long-term care in St. John's to move into Veterans Pavilion. So you will have 31 new beds and 10 reallocated beds out in long-term care, for a net of 41, having closed 40 beds.

MR. P. DAVIS: So these are new beds being created at Veterans Pavilion? They're under construction?

MR. HAGGIE: They're a newer agreement between Eastern Health and Veterans Affairs Canada.

MR. P. DAVIS: If they're under construction, what's the expected time before they're –

MR. HAGGIE: The Pavilion is being painted. The stuff's there. I think the only thing they need to do is to install some equipment for Occupational Health and Safety at Veterans Pavilion because that isn't current. It's not anticipated to take very long.

My understanding is that once discussions with the families are complete, the last number I had was, I think, 23 out of the 40 had made a decision, 10 of them didn't want to go to Memorial Veterans and they will be accommodated elsewhere. The move would start around October 1.

MR. P. DAVIS: So the beds at Veterans Pavilion, they were existing beds, but used for veterans?

MR. HAGGIE: They were unused beds that veterans had, that they had capacity.

MR. P. DAVIS: I guess they were used one time but they haven't been – I know numbers have been decreasing.

MR. HAGGIE: Well, I mean the criteria for the Caribou Memorial were very strict. You actually had to be a World War II or a Korean War vet. Nature has taken its toll on those individuals. I mean the Korean War has been over for 60-odd years.

MR. P. DAVIS: Yes.

Was there a change in the funding model for that as well? One time there was block funding for veterans or for the Caribou Memorial and now that's being changed to per bed. Is that what's taking place here?

MR. HAGGIE: My understanding is that is still being negotiated. I couldn't, for the life of me, tell you whether it was resolved.

OFFICIAL: (Inaudible.)

MR. HAGGIE: No, it hasn't been resolved yet, whether it's going to be block funding or a per diem. I think Veterans Affairs would look for a per diem, but I'm not sure of the details of the negotiation yet.

MR. P. DAVIS: They've created 31 new beds. There are 40 at Masonic. They're all full at Masonic Park?

MR. HAGGIE: As far as I'm aware, there were 40 clients in Masonic Park who were subject to the move, as it were.

MR. P. DAVIS: So there are 23 out of 40 who made their decision. There are 31 of them. So the other nine would go where?

MR. HAGGIE: The same day I got the figure of 23 out of 40, I was informed that 10 had opted to go elsewhere. The elsewhere wasn't specified by Eastern Health at the time. My understanding is they would be given priority for their first choice.

MR. P. DAVIS: Okay.

What about the beds at the Waterford. The Waterford has a residential wing that's being closed.

MR. HAGGIE: That is a unique population and –

MR. P. DAVIS: It is, yes.

MR. HAGGIE: – has a group of patients, clients who need care for life. They're not your typical long-term care population.

My understanding from information I've received from Eastern Health is that each of those 10 remaining clients are having an individual-care plan worked out to see where they'd be best placed. They are not sure yet where they would need to go, simply because those care plans haven't taken place. They may be re-accommodated elsewhere in the Waterford, they may be appropriate for other facilities or possibly, but not clear, community care.

MR. P. DAVIS: That's 10 beds out of the count of – what do you classify those beds as? They are not acute care beds. I always considered them to be long-term care type because most of them now, I think, are all probably 65 and over. I know some of them, they've been there probably their entire lives or adult lives anyway.

MR. HAGGIE: Good question. I couldn't answer what the technical classification for those beds is, to be quite frank.

MR. P. DAVIS: But either way, it's 10 beds out of the system.

I'm glad to hear – I think what I heard you say was individual plans are being made for them.

MR. HAGGIE: Yes.

MR. P. DAVIS: So their own circumstances – because, again, I'm not an expert in the field, but I would imagine that for some of these patients who've spent essentially their entire lives living on this unit in this hospital, there might by some – I can anticipate, I would think or expect – challenges in trying to close them. I know there are a much smaller number of them today than there ever was.

MR. HAGGIE: Yes.

MR. P. DAVIS: I'm trying to remember the term you used earlier, but as time passes, those numbers are going to decrease.

MR. HAGGIE: Nature.

MR. P. DAVIS: Nature, yes, that's the term you used. Nature will take its course. Not that we want that to hurry along or anything, it's just that's what happens. It's going to happen to us all, right?

Thank you, Minister.

With long-term care, do you have a target or a goal for bed numbers into the future? I know we've got changes happening in Carbonear, but I think essentially there are two homes that are closing. The new home then would take the patients from those two older homes.

If there's any change in the numbers, it's very, very small for Harbour Grace, would that be right?

MR. HAGGIE: Yes, I think you're correct. The amalgamation or the move is analogous to Hoyles going into Pleasant View Towers, as it's now called.

MR. P. DAVIS: Yes.

MR. HAGGIE: The needs assessment for beds is as much of an archaic science, as it is evidence based. What we have tried to do with modelling is to predict long-term care bed need and then make an estimate as to stages to get to that.

One of the challenges is that if you are actually successful with the home-first strategy, the enhanced care in the community and the enhanced personal care home project, and others that have been tried elsewhere, which we haven't looked at yet, you may actually have demand management working in your favour. So that people who, five or eight years ago, would have been classified as in need of long-term care, may actually be able to be managed in – I don't say a lower level of care in any derogatory way, but a less intensive way of looking after them, kind of nearer the home.

There is a needs assessment that was specific for Central. That was done by EY at the end of 2014 or early 2015. For example, in that particular locale, I would suggest that would be where some of the planning money for long-term care

in Central Health would start, would use as a building block rather than take it out.

The advantage of that particular proposal, firstly, is Central is actually the area with the highest demand in terms of folk waiting for long-term care. Also, the EY recommendations, although they were high level, was very much an integrated approach because it also looked at rehabilitation beds and respite beds for the needs of that community and those communities in Central.

Western, the work is less well formulated. There was a plan originally to put some many beds – I think 100 in the original iteration of the new Western Memorial. That has been changed at least four times that I know of. Currently, we're working through the design schematics that came back from the previous – not the last iteration – and then I think the question there is to see what the bed numbers are, get a revised figure if we can.

The 120 is a ball park and it's as good as any guess at the moment, unless we can come up with some better way of estimating beds.

MR. P. DAVIS: You said that's for Central?

MR. HAGGIE: That was Western.

MR. P. DAVIS: That's Western.

MR. HAGGIE: Because if you remember, there was talk of, I think, 360 beds across the province. Then there was talk of a total need of 660. So there are various numbers bandied around and I think that's part of the problem. It's crystal-ball gazing to some extent.

MR. P. DAVIS: It is.

Does the number of ALC patients in acute care beds continue to increase or is it pretty stable?

MR. HAGGIE: Well, the number of ALC beds has fluctuated in Eastern because they have had an initiative to reduce it. I think at one point they actually hit somewhere in the order of 6 per cent ALC.

I think the other thing that's important is you mustn't confuse or one shouldn't confuse alternate level of care patients with long-term care patients because they're not a contiguous group. Within alternative level of care is a subset of patients who require long-term care.

There are a proportion of alternate levels of care patients who are actually waiting for community supports, maybe even something like getting a contactor to put a ramp in the house and a rail by the toilet. They can then be managed at home with appropriate home care and supports. The two numbers aren't the same and I think there has been a little bit of confusion about that.

MR. P. DAVIS: Do you have the current numbers that are in acute care beds?

MR. HAGGIE: I have numbers, but they were done on the day the *Estimates* document was drawn up. As a working rule of thumb for Western and Central, you're looking at anywhere between 20 and 27 per cent of the hospital acute care beds on any given day. I don't have an accurate figure or a guesstimate for Lab-Grenfell or Eastern.

We can provide you with a snapshot on a given day, that's no problem, but I think you have to be aware it is a snapshot.

MR. P. DAVIS: Absolutely, numbers go up and down.

How many acute care beds were in total in Western and Central?

MR. HAGGIE: The number of acute care beds in Eastern Health is 936 – this is April 2016. Central has 202, Western has 261 and Labrador-Grenfell has 89. That's in the hospital beds, those are acute care beds.

MR. P. DAVIS: Right, okay.

MR. HAGGIE: Now there are a smaller number of acute care beds in community health centres, which would be places like Twillingate or Fogo.

MR. P. DAVIS: They wouldn't be included in those numbers?

MR. HAGGIE: They're not.

Would you like them separately – do they get this binder?

OFFICIAL: (Inaudible.)

MR. HAGGIE: This is a nice little table here; we can provide it for you, rather than me chanting numbers and you writing furiously.

MR. P. DAVIS: And trying to get them straight, what represents what and so on.

MR. HAGGIE: No, that's fine.

MR. P. DAVIS: Okay. I appreciate that. Just give me a quick second, Minister, if you wouldn't mind.

I was going to ask on the Waterford, and I know that my colleague for CBS referenced 13 or 17 personal care homes in his district. I don't know if you're familiar with the history on it, but many years ago a lot patients in the Waterford were considered to be residential patients. They were moved into what I think were initially called community care homes, but they are really personal care homes today. They seem to have all developed in Conception Bay South or a strong number of them.

While those numbers are decreasing, those homes are decreasing by the same nature, a process that seems to be happening. These patients that are at the Waterford in that particular wing, my understanding was, are patients who had these complex needs to a level whereby they couldn't come out of the hospital. You mentioned they could stay at the Waterford at a different unit. What other options would exist for them? Of course, it would depend on the individual needs, but what other options besides staying at the Waterford would be considered for them?

MR. HAGGIE: You kind of half given yourself the answer I'm going to give you, which is it really depends on their level of need.

I think the idea has been to look at these people, kind of without prejudice and a blank sheet of paper, and see what it is their challenges are and what their needs would be. More specifically than that, I couldn't say. I would have to leave that to the folk who know at Eastern Health.

MR. P. DAVIS: Yes, and the only reason I go back to it is because these are patients, as I understand, that when patients were moved out of the Waterford back in probably the late '80s or early '90s – I think is about when it occurred – it was determined they couldn't be taken out of the Waterford. Their individual needs were great enough that they had to maintain their lives within the hospital.

So now that we're going to revisit what sounds like it might be a similar kind of process but they'll obviously need a higher level of care. It seems to me, that's 10 beds coming out of the system and 10 that are going to be injected somewhere else, either in beds at the Waterford – are they considered to be acute care beds?

MR. HAGGIE: Some of them are. In the Waterford, some are forensic, some are acute psychiatric.

MR. P. DAVIS: Yes, or long-term care or some other aspect.

MR. HAGGIE: Yes.

MR. P. DAVIS: That's why I just throw it out to see what other options, depending on their needs, but what other options? Long-term care would be an option?

MR. HAGGIE: Well, long-term care, enhanced personal care or community are generically the options, or a bed at the Waterford.

I think what may or may not have been regarded as feasible and practical in the '80s when the sort of deinstitutionalization phase arrived, and that happened in Europe as well in the UK, what would be a standard then and available in the community, I think may be significantly different now.

Again, it's down to the individual detail of these 10 individuals and the assessment that Eastern Health will do.

MR. P. DAVIS: Very good.

Well, thank you. I want to thank you, Minister, and thank your staff as well. My time is up. I think we pretty much used up our clock. If our

Chair lasts that long with us, we'll get to the end and get to the vote. Anyway, I do want to thank you and the Members in the House on this side as well.

Thank you, Madam Chair.

CHAIR: Ms. Michael.

MS. MICHAEL: Madam Chair, I'd just like to ask one question. I know we don't have time to get into detail but perhaps I'll ask the question in a way to say maybe we could have an ongoing conversation about it.

I want clarity with regard to the response around the chronic disease strategy. Is it that Health and Community Services are no longer going to be involved in the development of a strategy? To me, this is preventative health care we're talking about in an area that is so serious for our health care system. So I really need some clarification around that.

MR. HAGGIE: There are pieces of chronic disease management strategies in place currently. We've referenced the diabetes database. I think there's a desire to look at the regulatory framework around that and turn it into a registry, which would have implications in terms of how it could be used for the benefit of everybody.

There are pilot schemes around management of common chronic conditions such as chronic obstructive pulmonary disease, congestive heart failure. There's a remote monitoring program coming out from Eastern Health which is well advanced as a pilot, and we're hoping to move that out. So the pieces are there.

What we as a department want to do is try and integrate all of those bits into a more holistic approach across chronic diseases, not only to give it a home and a place in the hierarchy of things within the Health and Community Services Department – because chronic disease management is – we need to integrate it with a wellness approach from Seniors, Wellness and Social Development as well, from a preventative end. But it needs to have a home.

The other piece as well, is that a lot of people – a significant proportion of older patients will actually fit into more than one group. They won't just be diabetic, have heart failure or COPD. They may have renal disease as well.

So the answer is, no, we haven't forgotten about a chronic disease strategy and management plan. The question is: what is the best way to put together the pieces that have already grown up around the diabetes pressure point, the heart failure pressure point, the COPD pressure point. And the mental health point, because I think one of the things that has not served everyone's interest well is the idea of hiding mental health and addictions off as some kind of box on its own; because at the end of the day, ultimately, it is a chronic disease for a lot of people and that has to fit in somehow under the umbrella. It may well be that that's going to take a little bit of work to try and find a good policy framework for that, but certainly it is well on our radar.

MS. MICHAEL: Okay.

Thank you very much.

CHAIR: Okay, just a couple of things here to run through.

We'll call the subheads first.

CLERK: 3.1.01 to 3.2.02 inclusive.

CHAIR: Shall 3.1.01 to 3.2.02 inclusive carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 3.1.01 through 3.2.02 carried.

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

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

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

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

CHAIR: Minutes from the last Estimates have been circulated, Social Services Committee, May 3, Labour Relations.

Could I have someone move to adopt those minutes?

I'm not sure who was first there. I'll say the MHA for Harbour Main, Betty Parsley.

On motion, minutes adopted as circulated.

CHAIR: That's the final Estimates for 2016.

Thanks, Minister, for your co-operation. Thank you to the Opposition and Third Party.

Now we'll have a motion to adjourn.

MR. KENT: So moved.

CHAIR: So moved by the MHA for Mount Pearl North.

Have a good rest of the day, everybody.

On motion, Committee adjourned *sine die*.