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SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Lisa Dempster, MHA

Vice-Chair: Gerry Rogers, MHA

Members: Paul Davis, MHA
Carol Anne Haley, MHA
Betty Parsley, MHA
Scott Reid, MHA
Brian Warr, MHA

Clerk of the Committee: Elizabeth Murphy

Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
John G. Abbott, Deputy Minister
Alicia Anderson, Executive Assistant
Bernard Davis, Parliamentary Assistant to Minister
Michelle Jewer, Assistant Deputy Minister, Corporate Services
Mike Tizzard, Departmental Controller
Denise Tubrett, Assistant Deputy Minister, Regional Services
Tina Williams, Director, Communications

Also Present
Mark Browne, MHA
Steve Kent, MHA
Lorraine Michael, MHA
Sandy Collins, Researcher, Official Opposition Office
Susan Williams, Researcher, Third Party Office

Pursuant to Standing Order 68, Mark Browne, MHA for Placentia West – Bellevue, substitutes for Betty Parsley, MHA for Harbour Main.

Pursuant to Standing Order 68, Steve Kent, MHA for Mount Pearl North, substitutes for Tracey Perry, MHA for Fortune Bay – Cape La Hune.

Pursuant to Standing Order 68, Lorraine Michael, MHA for St. John's East – Quidi Vidi, substitutes for Gerry Rogers, MHA for St. John's Centre.

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

CHAIR (Dempster): Good morning everyone.

We'll get started. Welcome to the Estimates for Health and Community Services

I want to make note of three substitutions: Mr. Kevin Parsons will be sitting in for Mr. Petten today; Mr. Hutchings will be sitting in for Mr. Kent. I'm not sure if that's correct.

MR. KENT: No, I'm sitting in for Mr. Hutchings, I think.

CHAIR: Okay. I've got the reverse – as long as someone is there.

Mr. Finn will be sitting in for Ms. Parsley. Some people may be en route, so I guess there are no minutes to –

CLERK (Murphy): Yes, there are.

CHAIR: There are minutes. Okay.

Mr. Browne is sitting in for Ms. Parsley. Okay.

We have a set of minutes from Social Services Committee, May 1, Department of Education and Early Childhood Development.

I'll just ask for a motion to accept those.

MR. WARR: So moved.

CHAIR: So moved by Mr. Warr.

Thank you.

On motion, minutes adopted as circulated.

CHAIR: We'll give the minister a few minutes to introduce his staff and make a few opening remarks. I would just remind people, for the purposes of Hansard downstairs, say your name at the beginning each time you speak for the record.

Thanks very much.

MR. HAGGIE: Okay.

John Haggie, Minister of Health and Community Services. To my immediate right is Ms. Michelle Jewer, Assistant Deputy Minister, whose title may have changed in the reorganization but essentially used to be corporate services.

To my left, Mr. John Abbott, who is the Deputy Minister of Health. To his left is Ms. Denise Tubrett who is the Assistant Deputy Minister for Regional Health Services-ish.

Behind Mr. Abbott is Ms. Tina Williams, Director of Communications for the Department of Health and Community Services. Behind me is Ms. Alicia Anderson, Executive Assistant to the minister. Behind Ms. Jewer is Mike Tizzard, the Controller general of the department. Is that right, Mike?

OFFICIAL: Departmental Controller.

MR. HAGGIE: Departmental Controller. No generals. Okay.

I don't really have a lot of opening comments. Just to put it in perspective, the Department of Health and Community Services is the biggest expense in government. Over the period 2002 to 2017, health care spending has effectively doubled from about $1.5 billion to $3 billion projected for 2017-'18. Our focus has really been on trying to change the value we get for the dollars we spend rather than focusing on absolute amounts. We've been talking about cost-effective measures, innovative solutions in the short and long term.

In the documents you'll see a number of variances for the department that can be essentially explained with common themes. There's a decrease from the 2016-'17 budget to

the 2016-'17 projected revised in the majority of the department's Operating Accounts, things like Transportation and Communications, Supplies and Purchased Services. This is really building on two things; one is the expenditure management plan which was introduced 2011-'12 to reduce discretionary spending. Then building on that is a zero-based approach that was taken looking forward for 2017-'18. That cumulatively, those two measures, account for a reduction of $510,700 over the course of that period.

The department has also reduced its Operating Accounts by over $2.9 million, 57 per cent compared with a baseline of 2011-'12. That is, again, a cumulative effect from several initiatives. It was the first department to introduce a managed print strategy. We have a very effective – one might even say rigid – inventory control for office supplies. We've developed a policy regarding the purchase of food and refreshments for meetings and we've increased significantly the use of teleconferencing and video conferencing solutions.

I think with that, it would probably be best use of the Committee's time if we were to go through the *Estimates* book rather than me to say anything else. Between us, I'll take the easy questions and the really hard ones will go further back to the staff.

CHAIR: Thank you, Minister.

So, first responder, Mr. Kent, will have 15 minutes, and then for the remainder of the morning it'll be 10 minutes back and forth. About mid-morning we will have a five, 10 minute break, if that's okay with everyone.

Ms. Michael?

MS. MICHAEL: Madam Chair, I think you were notified that I'm replacing Gerry Rogers for today.

CHAIR: Okay. I don't have that on my list, but for the record, Ms. Michael is sitting in for Ms. Rogers.

MS. MICHAEL: Thank you.

CHAIR: Mr. Kent.

MR. KENT: You noted that Mr. Hutchings will be sitting in for me. I'd be quite happy if he did, but I haven't been able to find him yet this morning, so here I am.

Good morning everybody. It's great to see some familiar faces. I said about two and a half years ago that I never, ever aspired to be Health Minister, and I can assure you I'm equally honest in saying that I never, ever aspired to be Health critic. I avoided it for a year or so, but unfortunately have been saddled with those responsibilities in the last number of months.

I remain very passionate about health care. I learned an incredible amount during the year I spent in the department, and I can honestly say the most talented and passionate and committed people that I ever worked with in my time in public service over the last 20 years were in the Department of Health and Community Services. Some of them are sitting over with you this morning, Minister.

I've got great respect for the work the department does. I didn't spend my career in health care as you did, but even in the year I spent working in health care I gained a real appreciation for the complexity and for the opportunity to impact a lot of lives.

I know we often focus on lots of the negative things that are going on in politics and in government, and even in the health care system, but we don't focus enough on the fact that the vast majority of people who have contact with the system have positive experiences and their lives are improved as a result. So I won't go on for too long with opening remarks, Madam Chair, but I did want to try and set the tone for this morning.

Often in this Chamber we get 45 seconds each to go at each other, and it's not necessarily the most productive or informative. So I'm honestly hoping that this morning we can have a more informed, productive dialogue, and I'll frame my comments accordingly.

Anyway, I continue to have great appreciation for the work the department does and that the RHAs do as well.

CHAIR: Mr. Kent, pardon me for a moment. We just need to call the first – I let you start without calling the first clause.

MR. KENT: No problem.

CHAIR: It's a slow start here this morning.

CLERK: 1.1.01.

CHAIR: Shall 1.1.01 carry?

We're going to move through this – if it's acceptable to everybody, we'll just do it by subheadings.

Mr. Kent, go ahead.

MR. KENT: Thank you.

Now I'll speak to 1.1.01. Minister, if it's okay with you some of my questions are sort of broad and impact multiple subheads, so I'll try and cover some of them upfront. If you're comfortable and it makes sense to answer them that way, then it may save us a bunch of time as the morning goes on but I'm comfortable with whatever way you want to proceed.

One of my initial questions related to 1.1.01 relates to some of the restructuring that's going on in the department which I feel fairly confident in saying couldn't have been easy. There are some sections of Estimates that have significantly changed over last year. They're the ones I would have been familiar with during my brief time in the department and ones that would have been reviewed in last year's Estimates, even though I wasn't part of that process.

For example, some sections that are no longer identified separately include Corporate Services, there are five: Corporate Services, Professional Services, Regional Services, Population Health, and Policy and Planning. Now, just anecdotally and just based on some of the discussion that has happened publicly over the last month or so, I have some sense of how the restructuring has happened but those five sections totalled about $30 million last year. I know some of those responsibilities may now fall under the new departmental operations heading but I'm having a little bit of trouble following the dollars.

I was wondering if you might be able to begin by giving me some sense of where those five sections are now included and identify where they could now be found.

MR. HAGGIE: Sure. The departmental reorganization essentially was phased and has resulted in the deputy minister having three direct assistant deputy minister reports. What you will see in 1.2.02, under Departmental Operations, is a lot of those common functions that you would have seen across Corporate Services, Population Health and the like have been subsumed under that specific head there. Not all of them, because some of the actual Grants and Subsidies dollars will still remain under, for example, the provincial drug program. So there has been a homogenizing of those there.

It's difficult to give you a categorical list simply because of the fact they've been moved probably effectively twice over the course of the time. So it will pop up from time to time, and I think the easiest thing to do is to highlight that maybe as we go through and pick them up there.

MR. KENT: Okay. Thank you.

Another couple of upfront questions, I guess. In one of the other Estimates meetings that occurred, we discovered there had been some technical or just mathematical errors that had been discovered post-printing where some calculations had been found that were incorrect and there are now adjustments being made or there will be adjustments needed.

To your knowledge at this point, are there any calculation errors that we should be aware of? Or to the best of your knowledge, are the Estimates accurate as they presently are presented?

MR. HAGGIE: My understanding, and staff will correct me, there are monies moved around from different heads as we've alluded to.

MR. KENT: Yeah.

MR. HAGGIE: In actual fact, a bit later on there's money moved in from outside, but I'm not aware of any mathematical errors.

MR. KENT: Okay.

MR. HAGGIE: There may have been the odd accounting adjustment but I don't think there's any –

OFFICIAL: (Inaudible.)

MR. HAGGIE: Yeah. I'm receiving assurances that we're good on both counts, no mathematical or accounting issues identified between last year's budget and this.

MR. KENT: I'm not surprised to hear that.

Thank you.

Also, related to your opening comments and zero-based budgeting, we've heard lots about zero-based budgeting in recent weeks. Some of our caucus members had an opportunity to be briefed by finance officials in the last week or so. Through that process, we became aware of the $510,700 number that you referenced this morning.

I have the line-by-line breakdown of where the savings came from through the Minister's Office, through Executive Support, through Departmental Operations. We can go through the details, certainly, but I guess what I wanted to ask you upfront is can you tell us a little bit about what that process looked like.

I understand the principle of zero-based budgeting. That, I get. But I'm just curious, practically, as you went through the department's budget, what did that exercise look like? I've heard multiple ministers say it will have little impact on operations. I suspect when I look at the line items that are impacted, in the case of Health and Community Services that's probably true, but I'd just like to – if you could give me a sense of how you went through that process, how you tackled it and found the $500,000 successfully.

MR. HAGGIE: Okay.

Yeah, I mean, it was actually quite an interesting exercise because it got you down to the level of operation in the department which was really – how many telephone landlines do you need? We identified quite a number that were effectively redundant, so we removed those.

We then looked at the new organizational structure and said, well, how many people do we need to be able to contact out of normal working hours? If the answer was yes we did, they were the folk who got the Blackberries. We shed 11 Blackberries over the department because of that approach to that issue alone. Each of those generates a certain cost per month. So that wasn't factored in.

We started with a blank slate and said, well, we need X-Blackberries where X was 11 less than last year, but we didn't look at last year's as a point of reference. We looked at the new org chart and said how many do we need. Similarly, voice mail, you pay for that service. How many people do you need voice mail on those lines?

For example, as well, in Transportation and Communications, we looked at travel for the minister for FPT meetings. For example, we know for a fact there are two. The minister will travel only with one person. So that's two tickets, no more. That's your baseline. How much is that reasonably likely to cost? Then, bear in mind, we have still some face-to-face meetings in association with the details of the Accord money, for example, or the opioid strategy. Factor in maybe one meeting each for those.

That's the minister's travel, and the deputy will have two deputy meetings for Health at PT level. The deputy will not take more than one person. How many tickets? So you build up the budget for Transportation and Communications based on that.

That was the kind of exercise we went through. I don't know whether that's specific enough for you but I think that gives you a flavour of how it was done.

MR. KENT: No, that is helpful.

Thank you.

I'll move to some more of the typical questions. I probably won't finish, Madam Chair, in my two minutes, so I'll turn the floor over to Ms. Michael.

One upfront question, would it be possible to obtain a copy of your Estimates notes following this session?

MR. HAGGIE: Yes, sure. I mean would this binder be the sort of thing you're looking for?

MR. KENT: That will be great. I think it will feel familiar but I still welcome it, as I'm sure my colleague would as well.

MR. HAGGIE: Not a problem.

MR. KENT: Regarding the Salaries in 1.1.01, the variance is minor. I'm sorry, I've mixed up subheads. It's exactly the same for 1.1.01.

Given the time, I'll pause there, Madam Chair, and let my colleague ask her questions.

CHAIR: Thank you.

Ms. Michael.

MS. MICHAEL: Thank you very much, Madam Chair.

Just to put upfront so we don't have to say that at the end; obviously, whatever is asked by either Party comes to everybody, that includes the binders.

Thank you very much, Minister. I know you'll co-operate with that. We got it last year quite well.

I will be asking line by line and then at the end of each section I may have some general questions. I'll put them in there as I go through.

MR. HAGGIE: Okay.

MS. MICHAEL: Thank you.

With regard to 1.2.01, Minister –

CHAIR: Ms. Michael, we haven't called that one yet.

MS. MICHAEL: Oh, just on 1.1.01. I have no questions on 1.1.01.

CHAIR: Okay. No questions on the Minister's Office.

Well, if it's okay we'll call – do you have more questions?

MS. MICHAEL: It's too minor; the amounts are very minor.

CHAIR: Okay.

Ms. Michael, do you want us to – we'll just go back to Mr. Kent.

MS. MICHAEL: Sure, that's fine.

CHAIR: Okay.

Mr. Kent.

MR. KENT: Thank you.

Some of these questions, again, cross over subheads but I feel it's probably more productive to ask them upfront.

Minister, given the changes that have happened in the department, I was wondering if we could obtain copies of the revised organizational charts including your branches and divisions and their responsibilities.

MR. HAGGIE: It's in the binder.

MR. KENT: Great.

I was wondering if you could tell us how many people are employed in the department today, I guess 2017 versus 2016.

MR. HAGGIE: 189.

MR. KENT: And how would that compare to last year? It would be slightly smaller I think.

MR. HAGGIE: My recollection is it's not much different, but we can get that number for you for sure. I don't actually have it with me.

OFFICIAL: I think it's 212.

MR. HAGGIE: 212, okay.

MR. KENT: Okay. Thank you.

In that total number, Minister, the 189, are all contractual positions included?

MR. HAGGIE: Yes, there are three.

MR. KENT: Would any temporary positions, 13-plus week positions, would they be included as well?

MR. HAGGIE: Yes. There's a table in the binder for your perusal later.

MR. KENT: Okay, excellent. It will give me something to read this evening.

Positions eliminated, would it be possible to get the list of what positions were in fact eliminated?

MR. HAGGIE: Yes.

MR. KENT: Is that in the binder as well?

MR. HAGGIE: It isn't. No, that was part of the reorganization. What there is, is a list of positions and position numbers that are there.

MR. KENT: Okay.

So related to the position numbers, as you went through your restructuring, I'm guessing there were some PCNs that were eliminated. Could you confirm that was in fact the case?

MR. HAGGIE: I think there were. Yes, the exact number we can provide you with. There was a net because there was a couple created.

MR. KENT: Right. So the new hires would be assigned new PCNs or were they assigned to existing PCNs?

MR. HAGGIE: A combination.

MR. KENT: Okay. Thank you.

I recall we had a 2015 attrition plan. I'm just curious, is that still being followed by the department?

MR. HAGGIE: No.

MR. KENT: No.

MR. HAGGIE: We've reorganized.

MR. KENT: Okay.

MR. HAGGIE: We feel we're as lean as we can reasonably be within the department.

MR. KENT: I would tend to share that view.

Madam Chair, that's all I have on 1.1.01.

CHAIR: Okay, we'll call that one.

Shall 1.1.01 carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, subhead 1.1.01 carried.

CLERK: 1.2.01 to 1.2.02.

CHAIR: Shall 1.2.01 to 1.2.02 carry?

Shall I go to Ms. Michael now? We'll let you start here.

MS. MICHAEL: Okay. Thank you very much.

Minister, under 1.2.01, obviously the big question does relate to the Salaries. I don't know how complicated it is because I assume there has to be complication with the changes that have happened, but maybe not so much in Executive Support. If you could explain to us the variance between last year's budget and revision and now this year's budget, please.

MR. HAGGIE: Okay.

Essentially, the Salaries there include deputy, three ADMs, secretary to the deputy, three secretaries to the assistant deputies, director of communications and a media relations manager. The difference between that structure and the previous year is a result of removing two ADM positions and the retirement of the medical consultant. There were some moves to consolidate the support salaries in there as well. So it's a net.

MS. MICHAEL: Okay. So right now you have three ADMs and before this you had five ADMs. Is that correct?

MR. HAGGIE: And a medical consultant, yeah.

MS. MICHAEL: Okay.

MR. HAGGIE: There will be a copy of the new org chart.

MS. MICHAEL: Okay.

MR. HAGGIE: Which I think is far easier to see rather than for me to try and describe it.

MS. MICHAEL: Yes, exactly. That is why getting the briefing book is good.

We do have your salary report as well here.

MR. HAGGIE: Right.

MS. MICHAEL: Under that there are two contractual positions: one at $144,000 and one at $78,500. That's probably in your briefing book also.

MR. HAGGIE: It is. Yes, along with the PCNs.

MS. MICHAEL: But could we get an idea of what the contractual work is?

MR. HAGGIE: They are the legal counsel for the department.

MS. MICHAEL: Okay. Thank you very much.

Transportation and Communications, some variance. Now this usually does happen, but maybe you can give us an idea. I think you have explained maybe why it's gone down with regard to Transportation and Communications in terms of decisions around travel, Minister, travelling only with one person, et cetera.

MR. HAGGIE: It was really those two items I referenced –

MS. MICHAEL: Right.

MR. HAGGIE: – in the more generic answer, but specifically it was how many meetings would the deputy go to, who would go with him, how many blackberries we need for what staff. So that's a net, starting with a blank slate and working upwards.

MS. MICHAEL: Right, thank you very much.

Moving on to 1.2.02, you have given us an idea of the reorganization that's gone on. So it's a bit hard here to get at differences in Salaries, et cetera. But again, last year there was a variance of $120,000 difference between budget and revision, and this year there's quite a drop: $414,200. If you can explain that, please.

MR. HAGGIE: The over expenditure between '16-'17 revised and the budget is due to severance and paid leave costs, folk that retired.

MS. MICHAEL: Right.

MR. HAGGIE: The projection for 2017 compared with the revised is a result of one-time termination costs in '16-'17 not being required in '17-'18, as well as changes from the management restructuring, because the salaries that are included there are, for example, we've got the departmental controller, we've got director of audit and claims, pharmaceutical services, director of physician services, and there's a list there which we can share with you when you get the binder. It's fairly well laid out there.

MS. MICHAEL: So basically I just want to name this, because it's what our analysis tells us, and I think that's what you're telling us, that the salary that was budgeted last year was basically the salaries for corporate services, professional services, population health professional services twice, regional services and policy and planning. Okay, and that's still what's reflected in this year's budget.

MR. HAGGIE: They've just been moved under this one head instead of scattered across five.

MS. MICHAEL: Okay, thank you very much. That's helpful to get all that straight.

Under Transportation and Communications last year underspent by $111,000, and this year we'll still be below what was budgeted last year. Could we have an explanation, please?

MR. HAGGIE: Yes, sure.

We have removed 36 land lines, 26 blackberries and 55 voicemails. So there's the communications piece. The transportation piece, again, is an attempt to stipulate upfront what the likely meetings are and specify numbers who will or won't go.

There was also money added to the travel budget from salaries and operating moved into the department for Canadian Blood Services and mental health. They had been previously posts that were under Eastern Health and were brought into the department to reflect the provincial responsibilities.

MS. MICHAEL: Okay, thank you very much.

Moving on to Supplies, again, a reduction – what would that cover, that line?

MR. HAGGIE: Again, a zero-based budget, so we have essentially removed any discretion as far as is possible and practical. Some of it was based on historical estimates simply because we didn't have any accurate way of tracking it; but if you look at the expenditure, for example, on office supplies: paper and envelopes: $36,000; printer cartridges: $13,000; nutritional items were for meetings and the like worked out to $20,500; and general office supplies: $24,200.

Again, we've got those broken down for you in the book, but that's the general flavour of what that went to.

MS. MICHAEL: Right, thank you.

I assume this will be broken down in the book too, but I would like to ask a question around Professional Services. Last year it was underspent by $516,000. This coming year, it is budgeted at $348,000 less than the budget last year.

MR. HAGGIE: Yes. The reason for the reduction was there was basically less audit review and appeals. We didn't spend as much on mental health review board fees, and some of those items were budgeted as a contingency and we've removed those, so it's a net.

MS. MICHAEL: Okay, right, so no more contingency.

MR. HAGGIE: Well, it was a contingency for consultant help and we completed a lot of that work in-house and we think we can probably continue to do that.

MS. MICHAEL: Okay, thank you.

Under Purchased Services, again, underspent last year by approximately $150,000 and going up by $56,000 this year.

MR. HAGGIE: Yes. We've actually transferred some funds from the regional health authority to cover a lease cost on Topsail Road. We've moving one of the mental health walk-in facilities. We've saved money on the lease by taking over a lease from a different government department, but to do that we transferred the money in from Eastern Health because if we reassigned the lease, we would have had to renegotiate it. This way it's still under a government department, so it is a cost-saving measure on the lease. We also had some reductions from a zero base and there's some federal money for drug treatment which ended which we don't see recognized.

MS. MICHAEL: Okay, thank you very much.

Under federal revenue you anticipate $60,000 federal revenue. What would that be?

MR. HAGGIE: The agreement is for transfusion safety initiatives.

MS. MICHAEL: Oh, and that's the result of taking the blood services into this department?

MR. HAGGIE: Yes.

MS. MICHAEL: Oh.

MR. HAGGIE: Sorry?

MS. MICHAEL: Is that correct?

MR. HAGGIE: It's a new one.

MS. MICHAEL: It's a new one.

MR. HAGGIE: It's a new agreement.

MS. MICHAEL: Right.

MR. HAGGIE: It's officially called the Canadian Blood Safety Contribution Program agreement.

MS. MICHAEL: Okay, which would have been covered by Eastern Health before and now it's here.

Okay, thank you.

The provincial revenue is down by $75,000. Can you explain that?

MR. HAGGIE: It was based on a review of actual revenues received. The budget was adjusted by that amount.

MS. MICHAEL: And what are those revenues?

MR. HAGGIE: Defaults on bursaries, MCP overpayments and refunds from vendors, those are the three categories.

MS. MICHAEL: So basically the same as other years we've gotten that answer as well.

MR. HAGGIE: Yeah.

MS. MICHAEL: I'll ask one general question: In your booklet or in the briefing notes, will you have information on things like the average call volume for the HealthLine and those specific kinds of questions or should we put those to you directly?

MR. HAGGIE: I think those are not covered directly in here. We can provide that information, but I'm not sure that we'd be actually be able to answer specific questions accurately. I can give you ballparks, but if you want the actual, the real numbers as it were, that's not a problem.

MS. MICHAEL: Right. Okay, well, we'll decide what we'll ask here and what we might put in the letter and just request directly.

Thank you. I may want to come back after Mr. Kent.

CHAIR: Okay. That's fine.

Thank you, Ms. Michael.

Mr. Kent.

MR. KENT: Thank you.

I have a number of questions that are a little broader. I appreciate Ms. Michael's questions which saved me from asking them.

Minister, I was wondering if you could give us an update on the status of the restructuring of the Medical Transportation Assistance Program and just give us an idea of where we are with rollout of that.

MR. HAGGIE: Yeah, there are some specifics further down in line items relating to that.

MR. KENT: Okay. I thought it was here. Sorry.

MR. HAGGIE: But essentially we're looking at a common point of entry across both our department and Advanced Education, Skills and Labour.

MR. KENT: Yeah.

MR. HAGGIE: It will be a phased process, but further on you will see there has been some money transferred into Health from AESL to cover parts of that transition. It's a work in progress and it's started.

MR. KENT: I definitely support the concept of bringing the two programs together, as some of the folks here are aware. Have there been any impacts – I understand the budget shift has happened, but have there been any impacts on staffing at this point? Have any personnel moved from one department to the other, or have any jobs been eliminated on the other department side to deal with the restructuring?

MR. HAGGIE: At the moment, we've got one person coming into the department from AESL but they're still on AESL's payroll. They kind of come over and work with the MTAP folk.

MR. KENT: Are there more staff working in AESL dedicated to the program that are not coming over?

MR. HAGGIE: Well, at the moment, as I say, it's a phased approach.

MR. KENT: Okay.

MR. HAGGIE: We started with dialysis patients in the first instance because they're a fairly stable, predictable population.

MR. KENT: Yeah.

MR. HAGGIE: We have some software challenges, as well as the actual nuts and bolts of having a common financial entry. So we want to take it in bite-size chunks. At the moment, as I say, there's just one individual, staff member from AESL who's familiar with their program, who's working with our staff.

MR. KENT: Thank you.

Do you anticipate changes to eligibility criteria for the program, and have any changes happened so far?

MR. HAGGIE: Well, the answer to the second question is no. At the moment it's up in the air because there are some discussions about financial eligibility issues in general because between us, our department for our programs and between AESLs, we've certainly got two, if not three different sets of criteria.

MR. KENT: Thank you.

Would this be the appropriate time to ask about the Deloitte home support review? Does that fit here or does it better fit elsewhere?

MR. HAGGIE: It would probably fit further down under the RHA really because the money for home support is included by and large – it flows through the RHA and is managed by each regional health authority.

MR. KENT: Okay.

MR. HAGGIE: In practical terms, it doesn't really matter when you want to ask it because it's not specifically in the book.

MR. KENT: I appreciate your co-operation. If you don't mind, then, I'll ask my couple of questions while we're on the topic and not have to ask them again later.

MR. HAGGIE: Fill your boots, as they say back home.

MR. KENT: Thank you.

I'm just curious if you could comment on the overall cost of the home support review and where you are with implementation at this point?

MR. HAGGIE: Okay. The second part of the question is that there is an update coming shortly about where we are with the implementation, but the review actually had 24 or 25 points and it was presented in such a way, they were grouped in terms of an implementation plan. So, really, the kind of implementation plan was there. Currently, we have a staff member engaged in consultation with stakeholders and the RHAs to get their feedback on the nuts and bolts of actually running through that program.

So we're in the beginning phases of setting the plan out in the sense of announcing it. We're at that kind of final feedback stage. The report really contained an implementation plan.

In terms of the cost of that review, I would have to look around for someone to give me the actual dollar figure.

OFFICIAL: $250,000.

MR. HAGGIE: $250,000.

MR. KENT: Okay. Thank you.

Related to that, in the government's *Way Forward* document there was a commitment to implement a home support action plan. Can I assume then that's the update that's coming shortly?

MR. HAGGIE: Yeah, they're all together. The Deloitte report contained an action/implementation approach. That action plan that you've just referenced specifically is going to be essentially that as the foundation.

MR. KENT: Thank you.

Switching to personal care homes, are you continuing with plans to expand the Enhanced Care pilot?

MR. HAGGIE: Yes. That was a little bit delayed rolling out because of some logistical factors basically in terms of paperwork and implementing it through the RHA. My understanding is there are 40 individuals in 24 homes who have already taken advantage of that. I think there were somewhere in the region of eight new hires because of the money put into the program. Yes, I'm receiving nods.

It's been a slower uptake than we'd thought, but I think some of that was essentially because of the delay in getting it rolled out in the first place. It really probably didn't pick up steam until fall of last year.

MR. KENT: Sorry, Minister, I didn't quite catch the numbers. Can you give those again?

MR. HAGGIE: Twenty-four homes with 40 individuals out of 100 places that were available in the first run.

MR. KENT: Okay.

Well, 24 homes is considerably larger. I believe we started with like four.

MR. HAGGIE: Three.

MR. KENT: Three, so that's good to hear.

How did you select the homes, or was there an opportunity for all homes to apply?

MR. HAGGIE: It was the latter. Any home that was interested and – it was usually client driven. If they had someone, it was up to them to go to the local RHA to do that. I think there were some challenges around initially communicating that, maybe. That may have led to a bit of a slow uptake but we seem to have fixed those now.

MR. KENT: What's the rate structure for personal care homes that are participating? They would be paid a higher rate for the enhanced care residents. I'm just curious what that rate structure looks like.

MR. HAGGIE: I could give you a ballpark but we can get the exact figure for you.

MR. KENT: Okay. That would be great.

Thank you.

This is another one where you may have to get the detail for me, but Chancellor Park, which is familiar to some of the folks here I'm sure. I'm wondering what is currently paid at Chancellor Park for a Level 3 bed.

MR. HAGGIE: Again, I could give you a ballpark but the exact figure we can find for you.

MR. KENT: I appreciate that.

Thank you.

Given that this subhead covers NLPDP as well, I'm just curious if there are any changes at all happening within the drug program in 2017-2018.

MR. HAGGIE: The program itself, the main thrust of it is to continue with efforts to use the national and regional purchasing bodies to try and increase the proportion of generics, particularly. Although, I think really we've got the low hanging fruit there at the moment. It is, again, to try and use bulk purchasing to reduce the cost where possible, or at least slow the rate of rise of cost through the drug program.

MR. KENT: In doing so, as you work through those processes at the Atlantic level and at the federal level, do you anticipate making changes to our formularies as a result?

MR. HAGGIE: I think the issue of a provincial formulary; we effectively have that through the NLPDP because of the listing process. I think from the point of view of the discussions at the national level, we've seen the issue of the 117 essential drugs that World Health Organization put out. One of the challenges, actually, is to Canadianize that because of those 117 drugs. I think 40 or more of them are actually specific for tropical diseases we would not see here but on a global scale affect significant percentages of the population.

We haven't engaged in any discussions along those lines specifically in any granularity but it is part of the Pan-Canadian Purchasing Alliance discussions of which we are a member.

MR. KENT: Are there any plans to consolidate the drug formularies? I understand and I appreciate your comments related to the NLPDP formulary but there are still regional formularies. I'm just curious, is it your intention to see those consolidated or are you satisfied with the current structure?

MR. HAGGIE: I think it may actually occur de facto, because if you look at another piece, which is the shared services concept, if you have a provincial purchasing system for the institutions, which is a presumed, what I'm reading from your use of the word regional formulary, then I think ultimately that would probably come to pass by default.

MR. KENT: Okay, and seeing as – oh, I'm out of time. I have a couple more questions, but I'll hold them for now.

CHAIR: On 1.2.02?

MR. KENT: Yes.

CHAIR: Yes, okay.

Ms. Michael.

MS. MICHAEL: Minister, I'll try to not ask questions that are so statistical that we'll put in writing, but I have questions that aren't. I'm interested in knowing what the status of the midwifery implementation is. We have the regs in place, et cetera, but what's happening with regard to implementing?

MR. HAGGIE: The first piece was to find a consultant whose responsibility would be two-fold, which would be to help craft the professional end of things, in terms of regulations, educational requirement, then to work on a policy level. Once that framework had been done – and we anticipate that would be done by maybe mid to fall of next year, then they would be responsible for helping recruit three midwives to the initial pilot site, which will be located in a rural setting, probably Central.

They would act as clinical lead and then move their policy development regulatory piece to look at an urban site in the St. John's area somewhere. So the interview process has been completed, and I think we'll be in a position to make an announcement about the consultant in the not-too-distant future.

MS. MICHAEL: So the implementation coordinator is not in place yet, but you're in the process?

MR. HAGGIE: I will hopefully be able to make an announcement about that in the near future.

MS. MICHAEL: Okay, thank you.

I'm also interested in the rapid response team pilot project for seniors coming to emergency rooms and wondering at this point in time what the outcomes have been. I, just on a personal basis, know many friends actually – four or five – who've really benefited from it. I'm just wondering how you've looked at it, how you've evaluated how things are at the moment. Are the teams going to continue? Will there be an expansion?

MR. HAGGIE: There have been some significant challenges on my initial read of the data in terms of making those effective in terms of their stated goals. I'm pleased that you've had some people who have had a successful result from those encounters. The report, the jury isn't quite in, but I am pessimistic about their efficacy. On that basis, given my other comments, then I think we'd have to look at a different way of achieving the same ends.

MS. MICHAEL: Can you give me some sense of why you have that pessimism?

MR. HAGGIE: Well, the figures I've seen would suggest that each team sees less than four patients a week.

MS. MICHAEL: Okay.

What would cause that? Is that the nature of what gets presented to them (inaudible) –?

MR. HAGGIE: I think they're in the wrong place, quite frankly. They're in emergency department; they need to be outside.

MS. MICHAEL: Right, okay.

MR. HAGGIE: By the time people get to the emergency department, the ship has sailed.

MS. MICHAEL: Right, okay.

So it's not doing away with the teams but looking at where they're located and how it might –

MR. HAGGIE: I think they need to be revamped as a minimum but, as I say, the jury is not quite in yet in terms of what the data really show and what we're going to do with it. So I would reserve final comment, but that's where my head is at the moment.

MS. MICHAEL: Okay, thank you.

Because the people I know for whom it's been effective, it's people who have had accidents; friends who've fallen, sometimes in their homes, sometimes on the street.

MR. HAGGIE: And maybe that's a subgroup for who that kind of approach would work but, by and large, it hasn't achieved what we had hoped –

MS. MICHAEL: Right. I think that is –

MR. HAGGIE: Had been hoped when it was set up.

MS. MICHAEL: That's the group I'm aware of because all the friends I'm talking about, that's their situation. So getting through the service, being sent home, getting the home care immediately, being able to do the physiotherapy, et cetera, at home has been extremely effective for those people.

Thank you. I am interested in a few other things that we've been waiting on for a while, not just from your government, prior to you. The electronic medical record, is this still being looked at? Is implementation being worked on?

MR. HAGGIE: Yes, there are several thrusts; NLCHI has the kind of electronic health record brief with regard to the NLMA and their joint venture. There were 300 licences initially allocated. My understanding is – 60?

OFFICIAL: Fifty.

MR. HAGGIE: We have the early adoption of 50. At the moment we've had some discussions with Telus about the requirements under PHIA to be able to link all those and, hopefully, those will be settled very shortly, but there are 50 licenses up and running currently as stand-alone. There is a connection issue.

MS. MICHAEL: And the goal is 300?

MR. HAGGIE: There were 300 initially allocated. There are 200 expressions of interest, but I think the rollout has been a little bit slower. Some of it, I think, relates to network issues around PHIA and who is the custodian and who the company have to have agreements with. Rather than just NLCHI, it should probably be under the PHIA, the individual practitioner who's using the licence because, technically, they are a custodian under the law.

There is a PHIA review ongoing at the moment. We haven't received that report yet.

MS. MICHAEL: Okay.

MR. HAGGIE: That was that five-year assessment mandated or written into the original act.

MS. MICHAEL: When do you hope to get that report?

MR. HAGGIE: The commission is up and running. Dr. Morgan is its chair. I don't have a timeline yet, but I was led to believe it wouldn't be a lengthy process.

MS. MICHAEL: It would be or wouldn't be?

MR. HAGGIE: It wouldn't be a lengthy process.

MS. MICHAEL: Wouldn't be.

Thank you.

With regard to the ambulance central dispatch centre, what's happening with that?

MR. HAGGIE: Internally we are at the stage of trying to craft some specific requirements, but

we feel that is the next step in terms of the improvement and stabilization of the ambulance service in general across the province. It's very much on our radar, but there's been a little pause because of this process here which has seized the department's activities for the last little while.

MS. MICHAEL: Okay, I'm glad to know it's still on the radar.

MR. HAGGIE: Oh, very much so.

MS. MICHAEL: I think it's absolutely essential.

MR. HAGGIE: In actual fact, I had a meeting about it yesterday.

MS. MICHAEL: Okay.

MR. HAGGIE: It's very active.

MS. MICHAEL: Thank you.

I'm also interested in and have great concerns with regard to our chronic disease situation and needing a province-wide diabetes database. If you can bring me up to date on the chronic disease and diabetes prevention and management programs in the province.

MR. HAGGIE: That really falls into a strategy, a plan to deal with chronic disease in general as an umbrella. Whilst diabetes has been very much a talking point simply because of its numerical size, I mean we would envisage a stream for COPD, congestive heart failure; we have the kidney program and also then diabetes.

In terms of the specifics of a registry, we currently have a database. One of the challenges has essentially been to get that converted from a database into a registry. That had never been done with anything. Recently, we did that with the Cancer Care Registry. That's become the database. Well, there were five, in actual fact, which were amalgamated under the Newfoundland and Labrador Cancer Care Registry.

That process has been completed and now will act as a template for the other diseases. Diabetes is the next one in the stream currently waiting for privacy impact analysis, which the regulations, the legislation, stipulate has to happen. That's been completed and I'm waiting to get that on the diabetes piece. That's the final piece before then we put the package together and submit that through the same process that we did with the Cancer Care Registry. So it's in train, but it's one of those pieces where there's some crafting of regulations and legislation needed.

MS. MICHAEL: Okay, thank you

Could we have an update on the chief medical officer review?

MR. HAGGIE: I have no role in that, directly; that's done through JPS. My understanding is the Office of the Chief Medical Examiner was reviewed. I met Dr. Bowes, when he came over. My understanding from comments from the Minister of Justice is that he expects that report to be delivered to him in the near future.

MS. MICHAEL: Okay, thank you.

A real concern that I have: Government did commit to eliminating the IQ 70 threshold for services to individuals with autism and create a provincial autism strategy. Where are things with that? Because we all know autism is a growing issue here in the province

MR. HAGGIE: I think there's been a shift in the way we've approached that in the sense that certainly in discussions with Children, Seniors and Social Development, who have a significant role in this, the idea is to look at functional capability and capacity for folk with disability rather than diagnose these specific groups.

That would roll into a more functioned-based assessment of people's exceptionalities and abilities to cope in the community or with life in general. It has certain implications that we are still trying to unravel between the two departments. Again, it's an active file; it hasn't gone away. I think it's just a question of there are more nuances to it than we'd anticipated.

MS. MICHAEL: Well, certainly the evaluation of functionality is the key thing. We all have enough knowledge of autism to know that IQ is not the factor here –

MR. HAGGIE: No.

MS. MICHAEL: – but it's still there on the books and we're still operating under it.

MR. HAGGIE: The difficulty is – the temptation to blow it up is enormous, but you really have to have something in place for when you do. You can't just leave a vacuum. The challenge is how to craft assessments that are evidence based and tested and makes sense to both the disability community, CSSD, ourselves and community services, and also education because there's a piece in that there as well.

MS. MICHAEL: And I do understand that it will require more resources from an HR perspective. I think it will require much more time doing an analysis if you're looking at functionality and social interaction than just looking at IQ.

Thank you.

CHAIR: Ms. Michael, are you finished with that section?

MS. MICHAEL: Yes, I am, actually.

MR. HAGGIE: Just maybe to help the process; a lot of the questions that you've referenced, both Mr. Kent and Ms. Michael, they are actually covered under other heads as well because of the way this structure has changed slightly. So there's an opportunity to beat these to death a bit more, if you want to.

CHAIR: Mr. Kent.

MR. KENT: No, I appreciate that and I appreciate the minister's willingness to be flexible because I think we'll be able to whiz through a lot of the other subheads by allowing us to cover some of these topics. Ms. Michael covered a number of topics that I had intended to ask you about.

While we're still under this subhead, I had a few others noted that I'll ask and then we'll perhaps move on to other subheads, but I think they'll be much quicker, given your co-operative approach to the process this morning.

Minister, in response to one of Ms. Michael's questions, you mentioned moving a mental health clinic and you referenced Topsail Road, which I have a keen interest in. I'm just curious if you could tell us a little bit more about where the clinic is moving and what's the impact on the Topsail Road site.

MR. HAGGIE: My recollection is that the clinic is on Ropewalk Lane and is going to Topsail Road because the lease has expired. We could take over a TW lease with a property that was suitable at a lower cost – have I got that the right way around?

OFFICIAL: Yes.

MR. HAGGIE: Sorry, people are talking behind me and I'm wondering if I'm digging myself a hole here.

OFFICIAL: (Inaudible.)

MR. HAGGIE: Carry on digging, yes.

MR. KENT: They used to cut me off when I'd do that.

MR. HAGGIE: They obviously don't like me as much.

MR. KENT: I doubt that. I think they probably like you more.

MR. HAGGIE: To resume – the lease was up, the space on Topsail Road was already in a longer lease, is suitable and was underutilized.

MR. KENT: Are we talking Mount Pearl Square or are we talking another site on Topsail Road?

OFFICIAL: (Inaudible.)

MR. KENT: Oh, west end, next to Jungle Jim's.

MR. HAGGIE: They're virtually adjacent to each other because that was one of the reasons why the move from Ropewalk Lane was potentially difficult because it services a clientele who have significant transportation/mobility challenges.

MR. KENT: Right.

MR. HAGGIE: So we kept them there. The lease would have been held by TW and was still in its early stages. So rather than reassign the lease to Eastern Health, we took the money from Eastern Health into the department and reassigned the lease between departments in government.

So effectively, TW still takes the lease; we pay TW on behalf of Eastern Health.

MR. KENT: Okay.

MR. HAGGIE: That's how the money flows, and it's open, by the way.

MR. KENT: Sorry?

MR. HAGGIE: It's open. The move has taken place.

MR. KENT: Okay. So the clinic has moved but there's been no change in services, other than the location?

MR. HAGGIE: No, nothing. It's just a cheaper lease and a suitable space in the same area.

MR. KENT: That makes sense.

OFFICIAL: (Inaudible.)

MR. HAGGIE: Oh yes, we did combine Ropewalk with another facility. What was that one?

OFFICIAL: Again, it was mental health.

MR. HAGGIE: Yes, we put two mental health clinics, one from Ropewalk Lane and another one in the same building.

MR. KENT: Where was the other one coming from?

OFFICIAL: (Inaudible.)

MR. KENT: It was on that stay, okay. So it's a consolidation but the clients are still being served. So staffing is moved together; there are no cuts.

MR. HAGGIE: The constraint was the clientele that we served were not able to travel at significant distances.

MR. KENT: Right.

MR. HAGGIE: We have not altered any of the staff or any of the reporting structures.

MR. KENT: Okay, thank you for the explanation.

You mentioned shared services earlier. I was just wondering if you'd give us an update on where you are with implantation of the shared services organization.

MR. HAGGIE: There are documents in the system going up to Cabinet in the not-too-distant future about initiating the first block of shared services, which would be the block that was being worked on at the transition, which was inventory and supply chain.

MR. KENT: So inventory and supply chain hasn't been implemented at this point, but there's a Cabinet Paper pending?

MR. HAGGIE: Yes.

MR. KENT: And the reason for the delay would be the fact that we got kicked out of government?

MR. HAGGIE: Well, the reason for the delay was reworking some of the organizational structure and there are some software challenges around IT. The question was the affordability of some of the options, quite frankly, given the fiscal situation, but we think we have a way to examine that, which will allow us to proceed with setting up the organization.

MR. KENT: I'm pleased to hear you are moving forward with supply chain and purchasing and all that goes with it. I'm wondering, are you still committed to the consolidation that was envisioned in the original plan? Are you still moving forward with the rest of the shared services approach in other areas?

MR. HAGGIE: There are, as far as I can recall, four or maybe five areas that were discreet entities where there was duplication in each of

the RHAs and kind of a low hanging fruit that had been worked up the most was supply chain and inventory –

MR. KENT: Correct.

MR. HAGGIE: So that's why we started with that. The others are in different degrees of preparation and there are also different views as to their practicality in terms of bang for your buck by moving to that kind of model. So we would see moving ahead with certainly one or two of the others, whether number five would ever be doable – and I think that was the IT piece, but I couldn't swear to that. But they were at different levels of practicality, and some of that may be down to the fiscal challenges of the up-front investment if you wanted to move to a common IT platform, for example.

MR. KENT: Yes, and that was actually the next thing I was going to ask you about, because I recognize the significant costs of consolidating a whole bunch of independently functioning IT platforms that exist within the health care system. Meditech alone is quite complicated, as I'm sure you've gained an appreciation for, if you didn't have one already.

I'm just curious – well, first of all, I'd respectfully encourage you to keep pushing on the IT front because I think there are potential efficiencies and savings that can be realized, even if it takes a number of years to get there by consolidating those systems and processes.

Could you give me an update on where you are with Meditech consolidation and dealing with the technology challenges in the system overall?

MR. HAGGIE: At the moment, the Meditech piece, the last bit, was the amalgamation of Lab-Grenfell with Eastern Health. Immediately prior, or probably around the same time, there'd been an amalgamation of the Central-East and Central-West as they had been systems. That was moved to Grand Falls-Windsor on the basis that their hardware was newer than Eastern Health's, even though their software iteration in Central-East was newer – because Meditech, as you know, is a hardware and a software platform. It can't be run on any machine; it has to be run on dedicated hardware.

At the moment, that piece is paused essentially. There hasn't been any more amalgamation of Meditech across the province. What has happened in the last little while is the completion of the telepathology. That runs through a different system analogous to PAX. The challenges there have been quality of images, because the resolution there requires colour.

That's rolled out, and I'm told in recent conversations with a couple of pathologists that that's working very well, certainly on an intra-provincial basis. There are some challenges in hooking up with outside jurisdictions directly on an electronic basis because of the deficiencies in their hardware, not ours. They're not up to date. Manitoba is the only other iteration that's got the telepathology.

We're looking again in a slightly different direction with a similar process for non-invasive cardio respiratory data, so the Epiphany system. But in terms of Meditech specifically, that's kind of paused at the moment.

MR. KENT: Okay. I appreciate the explanation.

My final question related to this subhead – well, not related to this subhead but I'll ask it anyways – is just to pick up on your commentary with Ms. Michael related to EMR. Did you say there have been 200 applicants? There were 300 spots. There have only been 200 applicants from fee-for-service physicians? Is that what I heard you say?

MR. HAGGIE: There are 200 expressions of interest and 50 of that subset actually have the hardware up and running, software.

MR. KENT: Two follow-up points. That surprises me. I'd welcome your thoughts on why only 200 because my thought was the 300 would be snapped up really quickly and there would be a demand for more. So it's interesting that hasn't happened. I'll ask you one question at a time. Can you share your thoughts on why that is?

MR. HAGGIE: Wearing a hat I used to have, I would suggest that given the demographic of a lot of fee-for-service practitioners in this province, a significant number of them are at that: I've only got five years; I'm not going to

learn new tricks. I've got a system that works for me, whoever takes over can look at that.

I think there's an element of that because certainly we do have the same demographic bulge in the fee-for-service physician population as we have in the population in general. There's a significant predominance of practitioners in that 55-65 age group.

MR. KENT: Okay.

MR. HAGGIE: I think that's part of it. I think to be honest the others are probably waiting to see the results from the first 50. Word of mouth is going to be your best advertisement in that group.

MR. KENT: Yeah.

MR. HAGGIE: I think the full functionality of the system hasn't actually become apparent yet because of the discussions between Telus and the individuals concerned over this PHIA element. But we think we've got that resolved and hopefully, once they get online and see the connectivity piece – which really is like night and day when you compare the two systems, stand-alone versus connected – I think the buzz that will generate will be the next kick to get the other 150 onboard and then the next 100 may be interested.

I think probably the number 300 is about the right place to be for fee-for-service physicians currently. We have only 589-odd primary care physicians in the province and the 300 will probably take care of the fee-for-service ones.

MR. KENT: Oh, okay.

Madam Chair, can I ask for leave to just ask my final follow-up question related to this?

CHAIR: Are you okay with him –?

MS. MICHAEL: (Inaudible.)

MR. KENT: Can I just ask one more question, Lorraine, if you don't mind, just quickly?

MS. MICHAEL: Oh, sure, yes.

CHAIR: Mr. Kent.

MR. KENT: Thank you, Madam Chair.

Just a final question on that issue – I was receiving a small amount of pressure from a number of salaried physicians who also saw value in accessing the system. So given that there are only 200 fee for service have applied at this point, has there been any consideration in places like Labrador West, for instance, just to use a random example, to allow salaried physicians who might have an interest to access EMR and be part of the initial 300?

MR. HAGGIE: It's funny you should mention that. Yes, we have some discussions with Telus around what enterprise solutions may be available, for example, rather than steal from the NLMA's pot of licences.

MR. KENT: So you would use a different system?

MR. HAGGIE: No, same system, but they call it an enterprise solution for some reason.

MR. KENT: Okay.

MR. HAGGIE: It's a different licensing arrangement.

MR. KENT: So it's just about licensing?

MR. HAGGIE: Yeah.

MR. KENT: It would be the same platform?

MR. HAGGIE: Same stuff.

MR. KENT: Okay, that's –

MR. HAGGIE: It's just how it gets the money back to Telus.

MR. KENT: That's good to hear. I'm glad you're continuing to solve some problems that were lingering.

That's it for me on this subhead, thanks.

CHAIR: Okay.

Ms. Michael.

MS. MICHAEL: Thank you, Madam Chair.

Just some questions, Minister, with regard to mental health and relating of course to the report of the All-Party Committee, and just to say, just of interest to you, last night I did attend the public forum that was held by the coalition on mental health at city hall, and there were about 50 people. There were six tables with eight at each table and then you had the committee and some others there.

There was a general, very positive reaction of the 50 people who were at the tables to the report and I think had some good comments to make to the coalition, and they were also members of your provincial advisory committee there as well.

So I thought it was a very good session and we all encouraged the coalition to have more of these sessions, but it was a very positive response, just to put that out.

MR. HAGGIE: Good.

MS. MICHAEL: Having said that, the province has committed to spending 9 per cent of the health budget on mental health and addictions by 2022. How is that going to happen? What is your plan or do you have it in place yet?

MR. HAGGIE: No, the undertaking from government's side was that there would be an implementation plan in place by the end of June, and we're on track to deliver that. The budget did actually allocate $5 million specifically for actions that would fall out of that plan.

In addition to that, whilst we haven't finished our discussions with the federal government, they have suggested that they would give us $2.5 million of the mental health money pot for use on a fairly liberal basis outside of whatever we agree subsequently in terms of mental health. Their emphasis is very much on access for youth as a subset of mental health in general.

I think at the moment we've made steps on that journey, but in terms of an exact plan, I think we need to wait for the implementation plan to come out.

MS. MICHAEL: Is the department working with the RHAs in creating that plan?

MR. HAGGIE: Yes. Not only have we done that, as you will see from the new organizational chart, the director of Mental Health now reports directly to the deputy minister.

MS. MICHAEL: Right.

MR. HAGGIE: We've tried to streamline internally in the department to make sure that there is a ready route for mental health issues to get the level of attention they need to get fixed.

MS. MICHAEL: In the spirit of a lot of the recommendations, but one in particular from the All-Party Committee, are you engaging the community in this discussion as well?

MR. HAGGIE: Yeah. I mean one of our ports of call, really, is the provincial advisory committee which is really a very large table of groups and coalitions.

MS. MICHAEL: Right.

MR. HAGGIE: I think it's a fairly Catholic with a small "c" church as it were. I think, in addition to that, we have our usual meetings with a variety of groups like CMHA, the coalition and others. So I don't think there's any shortage of voices eager to have some say or some commentary on what we've proposed even to date.

MS. MICHAEL: Thank you.

Separate from that, are you – well, I know you're still working on it, but when can we expect to see the new methadone treatment policy?

MR. HAGGIE: Again, that's a specific subset. One of our challenges that's highlighted in the All-Party Committee report is really a grounding in addictions medicine within the province, and I use that really with a small "m" as much as a large "M."

One of the recommendations is that there be some kind of academic lead within the university to help build a body of expertise. To be honest, I think methadone as a title may be outdated. I think I would much prefer to refer to opioid dependency treatment as an umbrella term.

One of the challenges is the potential for Suboxone and removing barriers to access for that and making sure it is the – really for youth, particularly. The evidence would suggest, I'm told, that should be the first-line treatment rather than methadone. I think rather than get hooked on the labels of methadone and the baggage that that carries, I'd much prefer to see a more widespread availability of opioid dependence treatment, not otherwise specified, and leave that to the individual practitioners. As I say, I think the fundamental to underpin that would be some kind of educational/academic base for addictions medicine.

MS. MICHAEL: Okay.

Thank you. I think that's the end of my questions at this point.

CHAIR: Okay.

Mr. Kent, you were finished with that subhead as well?

MR. KENT: I was.

CHAIR: So we'll call that, okay.

Shall 1.2.01 and 1.2.02 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 1.2.01 and 1.2.02 carried.

CHAIR: We'll do one more subhead and we'll take a brief break.

CLERK: 2.1.01 to 2.3.01.

CHAIR: Shall 2.1.01 to 2.3.01 carry?

Ms. Michael had four minutes on the clock. Do you want me to just start clean with Mr. Kent?

MS. MICHAEL: Sorry, I wasn't listening.

CHAIR: Okay.

MS. MICHAEL: I was concentrating on (inaudible).

CHAIR: You did have three or four minutes on the clock. Do you want me to start with Mr. Kent and we just go 10 and 10 again or –?

MS. MICHAEL: Yes, and we're going all the way through to 2.3.01 without a break?

CHAIR: Yes.

MS. MICHAEL: Is it possible to have the break earlier than that?

CHAIR: We can have a break right now if it's okay with everybody. We're about midway through the morning; take six or seven minutes.

MS. MICHAEL: If we could, that would be helpful.

CHAIR: Okay. Is that okay with you guys?

Okay.

All right, so we'll resume at 10:25.

Recess

CHAIR: (Inaudible) are starting with Mr. Kent, I do believe. Was that how –? Yes, Ms. Michael is okay with – because she did have four minutes on the clock but we'll start with Mr. Kent on the 10 and go.

Okay, Mr. Kent, 2.1.01.

MR. KENT: Thank you.

For the record, in the spirit of co-operation and openness, the Opposition currently controls the majority of the Estimates meeting and would be able to vote down the Estimates if we wish to do so, but in the spirit of co-operation, and given the minister's tone and approach this morning, I'm not going to make a motion to vote down the Estimates even though I have technically the ability to do so. I hope that that's duly noted for the record.

CHAIR: I'm noting that there is some good in you.

MR. KENT: There's more good in me than the minister probably realizes, but that's understandable.

OFFICIAL: (Inaudible.)

MR. KENT: Yeah, right.

Let's move on to 2.1.01; Minister, I don't have a lot of questions on 2.1.01 because I already asked you this morning about NLPDP, but could you make a general comment on the increase of, it is roughly $6.2 million in the Allowances and Assistance line.

MR. HAGGIE: The change is basically a net. On the book here we'll give you the details of what that net is, but essentially you have an annualization of the Smoking Cessation Program which is a plus of $12,000. You have some annualization of budget deficit reduction initiatives from last year which is a negative of $1.75 million. GRI initiatives, the NLPDP reform around over-the-counter medications and changes to the foundation in 65Plus, that's a negative of $552,000.

There was funding back from the 2015-16 budget. There was $5 million taken out for pharmacists for compensation and we did not achieve that so we put that back. We haven't renegotiated that.

Projected revenues have increased due to an increase in expenditure for therapies, PLAs. The average increase in expenditures coincides with this trend and it's offset by an increase in revenue of $3.5 million. So there's a net there, and that's explained in the booklet in a bit more detail.

MR. KENT: Thank you.

MR. HAGGIE: Rather than trying to remember those numbers, if you're anything like me.

MR. KENT: Yeah, no problem. I'll review them in the booklet then.

I have no further questions on 2.1.01.

CHAIR: Mr. Kent, it's been called up to and including 2.3.01.

MR. KENT: Oh, okay. Well then I'll carry on.

Minister, related to Physicians' Services, I recall the annual increases that occur in that area even if you stand still, so to speak. Do you want to briefly comment on the $12.7 million increase under Physicians' Services under Professional Services?

MR. HAGGIE: Yeah.

That is an accommodation of a forecast provision for fee-for-service utilization and manpower increases, and funding for the new agreement within the LMNA itself. So that breaks out at $5.5 million for utilization and increases, and $7.259 million for the new agreement with the LMNA, the MOA.

MR. KENT: So moving on to 2.2.02, there's been a slight decrease in the Professional Services related to dentistry. I was just wondering why that would be. We saw significant changes to dental services last year, I've commented on that in the past. I'm just curious, what changes are occurring to dental services in this year's budget, and is the decline in Professional Services related to last year's decisions?

MR. HAGGIE: There's no change to the dental plan this year. The changes were as a result of an annualization of the initiative from the previous year.

MR. KENT: Okay, thank you.

Madam Chair, you said to go as far as 2.3.01, is that correct?

CHAIR: Correct.

MR. KENT: I guess a general question then on 2.2 and 2.3, the ones we just talked about. We had some back and forth publicly around the budget process and anticipated cuts. While we have an opportunity to actually have a conversation – and I really appreciate your directness and openness this morning. What I recall from going through this process, when I sat in your chair, is that before we started the process we faced a 3 per cent to 5 per cent increase just based on things like the issues we just talked about: the contracts with physicians,

demands on the system due to aging demographics, other contractual obligations related to other health professions and inflation. So based on that, to have what's effectively a status quo budget overall, there would have had to have been some savings.

Now, I tried to add up the numbers. We talked about, for instance, the savings related to zero-based budgeting; we talked about the restructuring that's happened in the department. That accounts for some of that savings, but there would still have to be significant – and I know we're not in the RHA budget yet, so I can ask the same question then, but my question is: Overall in the system, how did you find the savings, because the zero-based budgeting and the restructuring wouldn't produce that 3 per cent to 5 per cent, based on my quick math.

Are the RHAs simply going to run larger deficits, or have there been other savings realized to get you to what's effectively a status quo budget overall?

MR. HAGGIE: Well, I mean if you look back at the trend for the Health budget over the last five years, in actual fact the flattening started the end of 2012 really, and plus or minus 1 per cent seems to have been where you've landed pretty well with every budget from 2013 right up to today.

I think in general there has been within the department a very conscious decision to say, what is the value of any dollar that we spend? We have done a very thorough job, I think, within the department itself of looking at the dollars. I think zero-base is a useful epithet. It's a useful label for it, but the concept of actually examining what you're spending and avoiding spending things that you don't need to you. What's your core business? So I think that's part of it.

I think in terms of the drivers, quite frankly, the federal government may have had some justification for saying that simply putting 6 per cent escalator per year hasn't produced any increase in value.

MR. KENT: I agree.

MR. HAGGIE: I would flip that around to say that in terms of the dollars spent, having a fairly static budget since 2013 has not produced any reduction in value from the consumer's point of view.

I think really what we're doing is by an approach between the department and the RHAs is to say where is the money going and is that a wise use of the money? When you look and stand back globally, it's actually very difficult to pinpoint any one thing in all those moving parts that's made the difference. I think the difference is cumulative on lots of little moving parts where you have managed to not spend more than last year.

MR. KENT: Okay. I appreciate that explanation. While I definitely don't have your experience, and you've been in the portfolio for already much longer than I was, I do have some appreciation of the challenges you face and, obviously, a unique perspective as a result.

When I look at the overall challenges around system sustainability and the drive toward system transformation, which is not easily achieved, when I see a request from the NLMA – which we've also talked about publicly, so I don't intend to rehash that, but when I see a request like that that says, okay, why don't we step back and do sort of an independent review of services, locations and do it in an objective, independent way that would potentially make some of the really difficult challenges we face maybe easier to deal with, I just wonder why government wouldn't embrace that kind of approach.

So to me – and I'm saying this sincerely, it seems like a reasonable approach. I'm just curious, is there an alternative approach you're taking that is the reason why you wouldn't be open to pursuing the route that LMNA is proposing in terms of that review?

MR. HAGGIE: The LMNA and I, and the department have been in discussions about their rebuilding NL, rebuilding Health NL – forgive me if I've butchered their title. The eight points or nine points they bring out are policies that have been extent in the department from your time and even before.

MR. KENT: I agree to a degree.

MR. HAGGIE: It's not anything new. There's no magic bullet in there.

One of the things that has been going on, and it probably predates my time, is a realization again of looking, for example, in mental health or in primary care, or whatever, looking at each of those areas as a piece, recognizing it's a piece of a bigger puzzle, a bigger machine but saying, well, what are we doing here? What is best practice and how do we line up with that?

I think what you've actually effectively had is multiple internal reviews as a way of life. Certainly in the department now it is not unusual for people to come to me and say, we went back and looked at that and we found a, b and c, what should we do about it/

So I think on one level the machine has become much more self-examining in the way it deals with itself. I think by providing some overview and some strategic guidance in terms of where things go the machine will by and large do that.

Stepping back, if you look from Lalonde in '74 all the way through the more recent iterations of Kirby and Romano and those kinds of things, they're all sitting on a self somewhere saying exactly the same thing having gathered dust. People have cherry-picked a bit here or a bit there and run with what they fancied.

The biggest example of that was the Barer-Stoddart fiasco of the early '90s where, suddenly, we were going to have way too many docs, they put the screws on and then we have a huge gap in primary care. That was an example of a report that didn't do what it was supposed to because people cherry-picked the bits they want and ignored the rest.

My view, in general, is that big reports, by and large, have tended not to add to the discussion in terms of moving things along – sorry, they've added to the discussion; they've not added to the action. Also, by and large, the bulk of those have gathered dust, after delaying everything for 18 months or two years, because people say we're not going to do anything now because we got this report on the go.

In a sense, we have colluded, in actual fact, perfectly legitimately I think, because that's the other end of the argument on the issue around the All-Party Committee. In a sense, you started that on a recommendation from the Third Party and the consent of the House and ran with it. I think, on that situation, it was perfectly justified because mental health, with the exception of Kirby, has been ignored for 20 years, and that's your big review there that we've done.

You can see, in a sense, that the discussion around mental health, all parties have said let's wait for the report; let's wait for the implementation plan. There's been a degree of, from the outside, community groups would argue paralysis; but, in this particular case, I'd argue useful reflection and data gathering. But I think out of mental health, a lot of that work has been done and done repeatedly.

CHAIR: Mr. Kent, I've been a little bit lenient with the clock, and I know it's flowing good but I don't know if you just want to hold that thought and go back to Ms. Michael.

MR. KENT: With Ms. Michael's permission, I'd like to ask one follow-up question, if that's okay.

MS. MICHAEL: Fine with me.

CHAIR: Okay, Mr. Kent.

MR. KENT: I appreciate those comments, Minister. The only thing I'd say in response is more an offer. I agree with you on the mental health example. When I look at the challenges you face, when I look at the challenges we face, I wonder if there are other issues.

What I'd extend to you this morning is a sincere offer that if there's another issue within health care related to the sustainability of the system or the kind of transformation that's required, or even a more specific issue, if that kind of collaborative approach would work to solve some of those challenges or to help get us to a point where we've gotten with mental health, then that's something I believe our caucus would be open to and I, personally, would be very open to.

Let's face it, politics and party stripes aside, we all have a vested interest in making the system better. When you talk about health care and when I talk about health care, we're often saying much the same things about the general direction and vision for where the system needs to go.

So if those opportunities present themselves – in light of your comments a couple of minutes ago – then I'd be open to a non-political discussion about that and would rather be part of the solution than simply highlighting some of the problems we know exist.

I have no further questions up to 2.3.01, Madam Chair.

MR. HAGGIE: Thank you.

CHAIR: Thank you, Mr. Kent.

Ms. Michael.

MS. MICHAEL: Thank you very much, Madam Chair.

Just coming back to 2.1.01, Minister, a specific line item question: The provincial revenue, could you explain what that's about and why there's been such a jump in that?

MR. HAGGIE: 2.1.01, one moment and I will find that for you. I can't turn the pages fast enough.

Provincial revenues: Projected revenues have increased due to an unanticipated increase in expenditures for therapies that have PLAs. Does that answer your question?

MS. MICHAEL: No. Could you explain that, please?

MR. HAGGIE: Okay. The revenues from the product licensed agreements are a slightly complicated issue, which I would suggest somebody else would be able to answer better than I; it's a more technical question.

MS. JEWER: I can answer it.

MR. HAGGIE: You can answer it? Fire away, Michelle.

MS. JEWER: What happened is when we sign PLA, product listing agreements, we get rebates for revenue but we also have a corresponding expenditure because a new drug is coming on. So what's happened, we're finding we're getting more rebates for those drugs coming on, so revenue has increased. But there's a corresponding increase in expenditure as well.

MS. MICHAEL: Right, thank you very much; that helps.

One more question under 2.1.01; you gave information with regard to the smoking cessation program in terms of the cost being annualized throughout the budget, but could you just let us know what is happening with the program. Is it continuing, is it doing well and could we have the figures for 2016 of the numbers of people who went through it?

MR. HAGGIE: The short answer is yes, we can get you the figures. They're only globalized as a number in the booklet here. But if you want the figures of people who have accessed the program, those are fairly readily available and we can supply them for you.

MS. MICHAEL: Okay, thank you very much. I'll expect those, then.

2.2.01; again, the only thing I'd like to ask here is something you will have to get to us, I'm sure you don't have it there, but the number of family physicians and the number of specialists in the province.

MR. HAGGIE: It's in the binder.

MS. MICHAEL: It's in the binder? That's fine.

MR. HAGGIE: There are 589 family docs and 629 specialists.

MS. MICHAEL: Great.

Thank you very much.

MR. HAGGIE: But the numbers are broken down by region and by discipline for you.

MS. MICHAEL: And are they broken down by salaried and fee-for-service and alternate fee payments as well?

MR. HAGGIE: They are, yes.

MS. MICHAEL: That's great.

MR. HAGGIE: There's a matrix and it's in the book.

MS. MICHAEL: Okay, that's great. We don't need to go through that. We'll get that.

Thank you very much.

MR. HAGGIE: The global number is 1,209 as of the day that was done because they do tend to move around a bit.

MS. MICHAEL: Right.

Thank you very much.

Dental Services; here it's just a question, again, with regard to statistics. Could we have – this may be in your book as well, it probably is – the expenditures and number of clients in the Adult Dental Program in 2016 and the same thing in the Children's Dental Program for 2016.

MR. HAGGIE: We can get those. I don't think it's actually in the book.

MS. MICHAEL: Okay.

Under 2.3.01, is that included?

MR. HAGGIE: Yes.

MS. MICHAEL: Yes, it is. That's part of what we're discussing.

There is a big reduction in the grant to the School of Medicine, $924,600. Obviously, the School of Medicine had to deal with that cut. Do you know how they've dealt with it and how they've been able to make this adjustment?

MR. HAGGIE: This was a *Budget 2016* announcement. If you remember, the grant to faculty went down by 3 per cent that year to this year, one and one. It was predicted, there is a net because of the MUNFA collective agreement which adds to that and the annualization of a Faculty of Medicine reduction plan which was in place already beforehand. The GRI piece from last year is the bigger chunk of that.

There is a breakdown in the book. Essentially, the Faculty of Medicine reduction plan talked about things like elimination of rental space. They had a team in place to oversee the expansion of the seats from 65 to 80. That team is now being dismantled because that expansion is complete, use of teleconferencing and a variety of other issues there. They're in the binder in a bit more detail, but that explains it for you.

MS. MICHAEL: Thank you.

That's it, Madam Chair, for me.

CHAIR: Okay.

Mr. Kent, did you have anything else up to –? Okay.

Shall 2.1.01 to 2.3.01 carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, 2.1.01 through 2.3.01 carried.

CLERK: 3.1.01 to 3.2.02.

CHAIR: Shall 3.1.01 to 3.2.02 carry?

I don't know – Ms. Michael, do you want to use your remaining four minutes and start?

MS. MICHAEL: Yes, I can start off and use that time.

CHAIR: Okay.

MS. MICHAEL: Okay, this one gets a bit more complicated.

First of all, just to ask this question then. Minister, I think the operating funding for the Newfoundland and Labrador Centre for Health Information is not here. That's new is it, coming in under this head?

MR. HAGGIE: It's always been there.

MS. MICHAEL: It's always been there?

MR. HAGGIE: Yes.

MS. MICHAEL: Okay.

Thank you.

Coming down, the Allowances and Assistance has gone up significantly, by $6,400,000, I think – yes. Could we have an explanation?

MR. HAGGIE: That's a net effect. The bulk of that is the transfer in from AES, which I mentioned earlier on for the medical transportation.

MS. MICHAEL: Okay.

MR. HAGGIE: That's actually $7.4 million.

MS. MICHAEL: Right.

MR. HAGGIE: There is a reduction of that, of workforce planning bursaries, which haven't flowed through the RHAs in the time that we'd expected. So they've been credited against that. The bulk of it relates to MTAP.

MS. MICHAEL: Okay.

Under the Grants and Subsidies, there is a variance between the budget and the revision last year. This year it's going up by $14.7 million approximately.

MR. HAGGIE: Yes, it's a net result.

I've got a detailed annex in the booklet for the RHAs, but essentially it boils down to increases from minimum wage and JES. For example, new initiatives in primary care, mental health and addictions in the Home First Program. Some of the repairs and renos were re-profiled to capital, and there were new contracts in place for home support personal care and the private road ambulances. Some management reduction set against that and some annualization from previous budget decisions, but there's a full sheet breakdown in the back of the book that tops up to $14.69 million.

MS. MICHAEL: That's great.

Thank you very much.

Under the Federal revenue, where does this fit with regard to the agreement with the federal government with regard to funding, because we have a major decrease of a million dollars?

MR. HAGGIE: Yes, this relates to changes with relationships with Health Canada, Workforce Planning Canada and an agreement entitled the Project for Enhanced Rural and Remote Training, PERRT. Again, there's a summary in the book and a detailed breakdown in the annex of where those monies come from. So there are some increases in revenue from the transfusion surveillance project, which would not have been budgeted, and the breakdown is all there for you.

MS. MICHAEL: Okay.

MR. HAGGIE: Rather than me read it out –

MS. MICHAEL: No, that's fine. Just so we know it's there, we can find it.

Minister, where do we find the $2.5 million to expand the primary health care teams? Where does that show up?

MR. HAGGIE: It's in the Grants and Subsidies.

MS. MICHAEL: Pardon?

MR. HAGGIE: It's in the Grants and Subsidies. I was just looking to my right, sorry, I wasn't pointing (inaudible).

MS. MICHAEL: Okay, so under number 10 there?

MR. HAGGIE: Yes.

MS. MICHAEL: Yes, okay.

Thank you very much.

Do you have a plan yet in how that's going to work?

MR. HAGGIE: For the primary care?

MS. MICHAEL: Yes.

MR. HAGGIE: We are discussing locations for primary health care teams. You remember, we did announce in *The Way Forward* one for Burin and one for Corner Brook.

MS. MICHAEL: Right.

MR. HAGGIE: The emphasis on those, really, is because of gaps. It's to put something where currently very little exists.

I think in addition to that there are, however, some lower hanging fruit, if you might call them that, of primary health care clinics, which are really functioning almost at the level of primary care teams. With a little bit of money and a little bit of extra support, maybe an addictions counsellor here or a housing support worker there, or some alteration of the technology to include the EHR, they could become primary health care centres as well.

So I envisage over the next little while two streams. The difficult problem areas where obviously there's a challenge but also those areas – and they exist around the province – where there's very high quality primary care delivered by pretty well the team that we would have envisaged on the basis of a needs assessment doing cutting-edge primary care.

It would be very straightforward to be able to support them just a little bit further and to put primary care teams there and label them as such. Not just as a labelling exercise, but really to encourage the development of the teams in more challenging areas so they can see areas where it's succeeded because I think the best marketing tool for those kinds of primary care teams is examples where they work well somewhere else.

It's not all doom and gloom. We have some really good, primary health care team environments, even though they're not called teams. I point you to Central and Twillingate, for example, Botwood just down the road. I'm not trying to create problems by leaving others out. I know of those simply from a geographical perspective, but they're not the only ones.

MS. MICHAEL: Right.

MR. HAGGIE: I think it's very important from time to time not to focus on all the problems but to enhance some of the potential solutions that are already working.

MS. MICHAEL: With co-operation from Mr. Kent, could I just ask one more thing, directly related?

MR. KENT: Go right ahead.

MS. MICHAEL: I thought of this before, but also as a point that was brought up last night at the forum. Is there a plan to have on the primary health care teams or primary health care centres – I prefer to use that term – to have mental health included directly in the primary health care?

MR. HAGGIE: Personally, I see no difference, philosophically or practically, between good mental health and good physical health. I would regard the primary care centre as a single point of entry to the health care system or the wellness system – however you want to put it. So if you go there with an addictions issue, a mental health issue, an obstetric issue, the system works.

MS. MICHAEL: Well, I mean that's what exactly I'm looking for, and that would mean that part of the team then is somebody to deal with – there are people to deal with all aspects of health. I totally agree with you philosophically on that.

MR. HAGGIE: I would see that as being an integral part of a primary health centre or however you'd like to label it.

MS. MICHAEL: Is that in place at this moment or do we have a lot of improvements to make even with the centres that are working well?

MR. HAGGIE: Well, I think if you look at the downtown collaborative, their emphasis is probably as much on mental health and wellness and addictions as it is on physical health. They're virtually equal workloads and inseparable.

You go to Botwood, for example, they have recognized that their challenge there is they would need someone with an addictions background to help them out, and then they would have the complete suite. You go further

west and Springdale or the clinics there, which are very – there's a great emphasis on addictions and mental health as part of primary care. It's not ignored, and certainly the newer practitioners that are coming out are very conscious of tilting the balance to make sure that mental health and addictions is included in every location where they practice.

MS. MICHAEL: Right.

What I would hope is that the work that's been done through the All-Party Committee and through the recommendations would move us in that direction for a more holistic approach to our health care, recognizing there are no compartments. You don't put cancer over here and mental health over there, and something else somewhere else.

MR. HAGGIE: And that was clear from the recommendations of the committee.

MS. MICHAEL: Right.

MR. HAGGIE: That was emphasized pretty well on every page in some way or another.

MS. MICHAEL: Right.

Thank you very much.

CHAIR: Mr. Kent.

MR. KENT: Thank you.

Minister, the first specific question to budget lines that I'd like to ask you relates to Allowances and Assistance. I suspect it has something to do with the restructuring, but the amount budgeted this year is more than twice the revised budget of last year. I am just wondering if you can explain why that would be.

MR. HAGGIE: This is 3.1.01, line 09 is it?

MR. KENT: Correct, yes.

MR. HAGGIE: That's the MTAP.

MR. KENT: Oh, that's MTAP, sorry.

MR. HAGGIE: Yes, that's the MTAP piece.

MR. KENT: Okay, thanks.

Federal Revenue, I presume, has fallen related to the expiration of a previous agreement?

MR. HAGGIE: Again, the binder has the details, but it references a decrease in the net from workforce planning agreement ending.

MR. KENT: Okay.

MR. HAGGIE: So that's a loss of revenue of just under $500,000. Mental health drug treatment, two-year agreement offset by federal funding ended, and that PERT program was just shy of $200,000 as well.

Again, there are some increases in revenue from the transfusion system. Revenue was not budgeted, family medicine training, revenue higher than anticipated. There is a page in the binder which explains all those net shifts for you there.

MR. KENT: Okay, great.

Thank you.

Moving on to more interesting topics then; has the healthy living assessments for seniors, have they begun at this point?

MR. HAGGIE: The short answer is not yet.

MR. KENT: When would you anticipate that happening, and who would be responsible for doing it?

MR. HAGGIE: One of the desires in the department was to make it as easily usable as possible. So we would try and have an assessment that could be used by a broad variety of folk who would interact with that population and not just, say, an RN or a nurse practitioner or anything like that. My anticipation is this will roll out over late summer and fall.

MR. KENT: Okay.

How about the child health risk –

MR. HAGGIE: Oh, sorry, I misspoke. It will be next spring.

MR. KENT: Next spring. So we're about a year away.

MR. HAGGIE: Yeah.

MR. KENT: Okay.

What about the child health risk assessments for school-aged children, can you give us an update on that?

MR. HAGGIE: The same, next spring.

MR. KENT: And who would be responsible for doing them?

MR. HAGGIE: We are looking at community level personnel but, again, we're trying to make that as user friendly as possible so we don't restrict it to one particular kind of practitioner, given the rural challenges we have with personnel sometimes.

MR. KENT: What kind of deficits do you anticipate the regional health authorities running this year compared to last year?

MR. HAGGIE: I'm hoping it will be zero.

MR. KENT: I'll shake your hand if it's zero.

MR. HAGGIE: We have encouraged them to do that.

MR. KENT: I'd encourage my friends in Gander to vote for you if it's zero.

MR. HAGGIE: You have friends in Gander?

MR. KENT: I don't have many friends anywhere after the length of time I've been doing this work.

MR. HAGGIE: I mean realistically speaking, we have made the health authorities aware that they have a budget and they're expected to live with it.

MR. KENT: I don't want to put words in your mouth, so I'll just ask a follow-up question. Do you anticipate the deficits to be reduced?

MR. HAGGIE: I would anticipate that as a minimum.

MR. KENT: Okay, that's good.

I don't think that will be easy for the RHAs to achieve but I think it's a good goal, and we'll see how that goes. Hopefully, I don't have to make phone calls to people in Gander.

MR. HAGGIE: I can give you some numbers.

MR. KENT: I have a few, not many. It's a lovely place, though.

I want to talk about homes first, it's an initiative that I very much supported and tried to find money for. I'm encouraged to hear recently that there has been some money found for it. I feel like it fits very much with our previous close to home strategy, and I know Eastern Health had a keen interest in pursuing Homes First.

Can you comment on what's envisioned as a result of the recent announcement? What will that look like this year? Will it be specific to this region or will it be province wide? What will that look like overall?

MR. HAGGIE: Well, I think it's going to look different in detail between an urban area and a rural area for sure. Some of it, the challenge is to actually identify folk at a stage before they decompensate. We had a discussion a little earlier about the rapid response teams which, I think, were in the wrong place and a bit late.

MR. KENT: Yeah.

MR. HAGGIE: Essentially, my vision ties in with the healthy living assessment in a sense that that's your screening tool. What that would then do is allow you to identify those people who had challenges and see if there are resources locally that can be employed to deal with those.

It's a very nebulous answer, but I think the answer is going to be very contextual in terms of (a) where you live and (b) who you are. So something in the Member's district in Cartwright – L'Anse au Clair is going to have to look something different than Nain or in Gander or, in turn, in urban St. John's.

I think there are elements there in terms of the Home Support Program; there are elements there in terms of social inclusion. We don't really

have a mechanism identified, for example, to deal with social inclusion; yet, that's one of the biggest determinants of certainly mental, psychological well-being in the elderly.

One of the challenges I see with the Home Support Program is that a lot of the time the hours equate to company and not necessarily care. We don't have a way of dealing with that. I think there's a huge opportunity there for not-for-profits and community groups to become involved.

MR. KENT: I agree.

MR. HAGGIE: I know in some areas there have been small pilot schemes with the community hours, for example, from high school students. What they've done is they've introduced them to personal care homes, long-term care homes to put a link between the elderly and the young. Whether that would work in downtown St. John's or Gander is very much dependent on the environment there as well.

So it's an approach and I think it also feeds into another element really, which is the Health-in-all-Policies approach. These things aren't so much purely fiscal as they're policy, they're social issues. It's sometimes very difficult to finance and certainly almost impossible to legislate.

MR. KENT: Agreed.

You had previously committed to streamlining the financial assessment process for community support services and long-term care services, which is a goal that I do support. Can you give me an update on where you are in that process?

MR. HAGGIE: That feeds into the home support action plan –

MR. KENT: Okay.

MR. HAGGIE: – and that work is in progress. I'm not sure whether that will be one of the first parts of an update or whether it will be an announcement of a work in progress because, as you commented on earlier on, there are sensitives around that.

MR. KENT: I'd like to ask you a few questions about long-term care but I suspect we'll run out of time. So I'm going to let Ms. Michael continue with her questions and then I'll pick up where I left off.

CHAIR: Thank you.

Ms. Michael.

MS. MICHAEL: Thank you very much.

Continuing along with these types of questions; I do have some statistical ones but I'll hold those. What we'll do is if the answers are in the briefing book we'll look for them; if not, then we can go seek them rather than name them all here. Some are general ones.

With regard to the private paying of long-term care in 2017, will there be a fee increase?

MR. HAGGIE: There isn't one in the budget.

MS. MICHAEL: There isn't?

MR. HAGGIE: No.

MS. MICHAEL: Okay, because currently it's $2,990 a month, I think.

MR. HAGGIE: Yes.

MS. MICHAEL: Yeah, so that's going to stay.

MR. HAGGIE: Off the top of my head, that number is accurate and there's no plan to change it.

MS. MICHAEL: Okay, great.

Thank you very much.

A lot of my questions, Mr. Kent has asked. That's why I sort of have to go into my notes here. I'm sorry for the slight delay.

I'm not sure this is something that the government could actually get a handle on, but we would like to ask the question. Do we know the number of private paying home care clients in the province, or is that something that's too difficult to ascertain?

MR. HAGGIE: A good question. I think we can make a stab at finding out for you. It may be difficult but we'll make a try and see.

MS. MICHAEL: That would be good. It would be very helpful actually.

Thank you very much.

MR. HAGGIE: It may be we can't determine that, and if that's the case then so be it.

MS. MICHAEL: That's right, because I suspect a lot of it would be if people are getting home care and they're using the agencies. The agencies know who is paying privately and who is subsidized, I would imagine.

MR. HAGGIE: Yes.

MS. MICHAEL: Do they have to report that to you at this moment?

MR. HAGGIE: No.

MS. MICHAEL: Or if you seek the information they would give it to you, or not?

MR. HAGGIE: Presumably, we would only be involved with those people for whom we provide some financial assistance.

MS. MICHAEL: Right.

MR. HAGGIE: We don't know what we don't know beyond that.

MS. MICHAEL: Right.

Well, you're going to make a stab at this –

MR. HAGGIE: We'll see. As I say, on behalf of the staff, I honestly would have to make no promises there because that may simply not exist.

MS. MICHAEL: Right.

Okay, thank you.

Again, as I said, we have some statistical ones but we'll hold up on that.

In that case, let's go to 3.2.01, the Grants and Subsidies, Building Improvements, Furnishings, and Equipment underspent by $17 million last year and going up by $2 million this year.

MR. HAGGIE: The under spend was – in actual fact, was that the deferred revenues piece? Yeah, there was – cash flowed through to the RHAs which was used to offset those. So the budget piece from 2016 appears to be underspent. The work was done but the difference was made up with deferred revenue from the RHAs.

MS. MICHAEL: I'm not sure I'm clear on what you mean.

MR. HAGGIE: Okay. There was money flowed through to the RHAs which was –

MS. MICHAEL: In 2016?

MR. HAGGIE: In previous years.

MS. MICHAEL: Okay.

MR. HAGGIE: – which was not utilized. So the work was done but the RHAs were instructed to use what cash they had in deferred revenue –

MS. MICHAEL: Got it.

MR. HAGGIE: – before they drew down on the department's grant.

MS. MICHAEL: Okay, that makes it clearer.

Thank you.

Then this year, what is the anticipation which has you putting an extra $2 million over what you budgeted last year?

MR. HAGGIE: The breakdown is in the book, but essentially it's $20 million for Furnishings and Equipment, $10 million for Building Improvements, and $1.9 million for the EMR, which totals up to $31.9 million.

MS. MICHAEL: Okay, so all of that is in the book.

Thank you very much.

3.2.02, could we have an explanation of the salary line there, please? It was underspent by $573,600 and going back up by $505,000.

MR. HAGGIE: We use staff from TW to perform duties related to health care facilities. It was underspent last year and the budget is an estimate of what is likely to be needed for the coming year.

MS. MICHAEL: Okay, thank you.

Under Professional Services, again, there was a big under spend there and this year going up radically. What –?

MR. HAGGIE: The decrease essentially is because some of the projects didn't go ahead. Weather, manpower shortage and delays in project design. So it's a cash flow issue.

MS. MICHAEL: Do you have that list of which projects in particular?

MR. HAGGIE: We have a listing of those budgeted for next year. Do we –?

OFFICIAL: (Inaudible.)

MR. HAGGIE: It's in the book. Okay, we've got a listing at the back of those that are on the go. There's a projected revised budget for 2016-2017 on the current infrastructure builds, and that explains the flow over 2016-2017 projected and revised variances and the 2017-2018 Estimates.

MS. MICHAEL: Okay, and so you have –

MR. HAGGIE: It's in the book, and if it's something that isn't self-explanatory, then let us know.

MS. MICHAEL: Okay, thank you very much.

Then under Purchased Services, again, underspent by almost $20 million and down by $7 million, approximately, this year.

MR. HAGGIE: Yes, similar cash flow issues with projects. Again, it's probably better seen in a graphical display –

MS. MICHAEL: It's all explained.

MR. HAGGIE: – on the table at the back. Again, if there's something that isn't self-explanatory we'd be happy to provide some feedback.

MS. MICHAEL: Thank you very much.

That's it for the moment, Madam Chair. I may have a couple of more afterwards, but we'll see what happens in further discussion here.

CHAIR: Okay.

MS. MICHAEL: Thank you.

CHAIR: Mr. Kent.

MR. KENT: Thank you.

I'll start with long-term care. I would appreciate getting some current statistics on the wait-lists, but also the current wait times. I know that varies based on the client, but would we be able to get some updated, fairly recent statistics on both length of wait and also the size of the current wait-list?

MR. HAGGIE: Yes.

MR. KENT: Thank you.

I know some of these things wouldn't logically be in the binder, so I appreciate that you'll provide them as soon as you can. In term of the binder content, do you anticipate providing that to us today?

MR. HAGGIE: I can leave you mine if you want.

MS. MICHAEL: You need two copies.

MR. KENT: Well, yeah, so –

MR. HAGGIE: Well, what we'll do is –

MR. KENT: I don't want to share with Lorraine.

MR. HAGGIE: – we'll get two suitably bound documents for you and your colleague as soon as we can.

MR. KENT: Excellent. Okay.

I wouldn't mind sharing temporarily, but two copies are probably more practical. We've gotten a little more friendly since I've been over on this side but we don't want to get carried away.

Has there been any long-term care beds created in the past year?

MR. HAGGIE: I'm not sure whether you could say in the past year. I know Central Health repurposed 11 beds across its region in the recent past from respite beds to permanent, long-term care beds.

In terms of new builds; the new builds that you'd be aware of are the ones that are (inaudible) the Corner Brook issue, and there is planning ahead for Central.

MR. KENT: Can you tell us a little bit more about the planning for Central? Will it be a similar model to what is proposed for Corner Brook? Would it be the 120 beds that was previously envisioned, or are you looking at something different?

MR. HAGGIE: Well, there were two reports for Central.

MR. KENT: That's right.

MR. HAGGIE: One of them predated the other, and I think there was some debate or differences between the two. So at the moment, staff have gone back and kind of asked them to update the numbers.

The challenge in Central is it's physically the largest geographical region on the Island. So the question then becomes one of distribution, because the big debate of late has been about proximity to their community and travel for family as much as actually accommodation itself.

So there's always going to be a point where it's difficult to reconcile those two competing – economy of scale versus an economy of operation versus geography. I think we would look to see what those numbers break down by community, and we haven't got those finalized yet. It's coming in the near future.

MR. KENT: Okay, thank you.

What about Eastern Region? I suspect the wait-list in Eastern is – I don't know if it's still the longest, but I suspect it is. Is there a plan to expand the number of long-term care beds in the Eastern Region?

MR. HAGGIE: I think the short answer at the moment is we've worked our way – or between us – from East to Labrador, to West and back to Central. I think the issue of distribution of beds on the Avalon is, again, something we would need to keep monitoring because, you're right, the wait-list does fluctuate.

Our current pressure points in terms of numbers – in actual fact – is currently still Central.

MR. KENT: Okay.

Switching topics completely, the PET scanner: Is there a new provider or is there a new contract? I understand there was some time lapse with the original proposal. I believe there was something new awarded in the last 12 months. Is there anything to that? Has there been any change, or was there simply an extension or renewal of the existing contract, or was there a renegotiation? Is that something you can comment on?

MR. HAGGIE: I don't have those details quite honestly. I mean my understanding was that the scanner would be up and running by May and that the cyclotron and isotope production would be online by the fall. In terms of the contracts, I think I'd have to take a rain check on that. I couldn't answer it off the top of my head, no. We're not aware of anything.

MR. KENT: Okay.

So if you could get back to us on that I'd appreciate it, because we understand there might be a new provider involved. It's not problematic; we're just interested in getting an update and getting the information. I'm wondering if there are additional costs associated with that. If you can get back to us, that would be great.

MR. HAGGIE: At the department level, currently we're not aware of any changes or any changing cost.

MR. KENT: Okay, so we'll see.

I recognize that this next issue spans multiple departments and it's related to mandatory reporting of critical incidents. I know that while the issues related to the Child and Youth Advocate are being led by another minister, I recall significant discussions within the Department of Health around addressing the issues as they pertain to the regional health authorities and the health system.

I'm just wondering, given that it felt like we were close to a solution, I'm just wondering if you can comment on any progress from the health system's perspective?

MR. HAGGIE: The only bit I would have any real insight into is around the regulation crafting for the new *Patient Safety Act* and quality assurance framework. As yet, we haven't crafted the level at which those mandatory reports would occur, if you use a five-point scale for severity of incidents, you take three or two or four. I think we're still looking at guidelines and jurisdictional scans about that at the regulatory level.

MR. KENT: Okay.

I'm now going to ask you a question that I was previously asked when I sat where you now sit. Is there any update on the whole issue of HPV vaccinations for males?

MR. HAGGIE: Currently, no, but we're still working on that.

MR. KENT: Okay.

Well, that's good to hear. I'm glad it hasn't fallen off the radar because I believe there's – I sense that over the last couple of years there's been growing evidence to support making a change, but I do understand the reason for the current state quite well.

Another issue I was asked about in the past that I'll now ask you about: Any plans to change coverage or services in the province related to IVF?

MR. HAGGIE: Again, that's something we're looking at. One of the challenges around IVF is critical mass in terms of patient volumes and skill. We are not sure we'll ever be in a position to fix that, simply because of our population size. That's a big factor, and the question then is at what point you're and how you hand off that to another jurisdiction, if that's the way you have to go.

MR. KENT: Okay.

Minister, I'm aware of the ongoing and historic challenges around staffing the obstetrics unit in Gander. Given your love for Gander, I'm sure it's an issue you've spent some time dealing with. While it's a regional issue, I know it's an issue you'd be familiar with. I'm just curious, what's the current situation and has there been any progress made to create some more stability there?

MR. HAGGIE: My understanding is that Central Health has five physicians in the pipeline currently for recruitment with various stages. Most of them, my understanding is – and I don't know what most means in this context – have signed some kind of paperwork. One of them is a Canadian trained obstetrician.

The current obstetrician there is unavailable, certainly, for the next month or so. In regard to other pieces of that puzzle, we have the midwifery project that we mentioned earlier on, and Central Health would be part of that.

My understanding at the moment is there are actually currently only two obstetricians in Grand Falls. So it's important to be able to stabilize this service across the Central district. My position has always been that we should have vibrant antibaryon post-partum care in both sides.

MR. KENT: Thank you.

I probably need, Madam Chair, another 10 minutes. The clock has run out. I'll pause to see if Ms. Michael has some additional questions.

CHAIR: Ms. Michael.

MS. MICHAEL: Thank you, Madam Chair.

Yes, I do have one, in spite of what I said about statistics. You might have this one because it is a

bit of a crucial question. It has to do with people waiting in acute care to get into long-term care. Do we have the numbers on those and the percentage of acute care beds that are still being occupied by people waiting for alternate care?

MR. HAGGIE: I can provide you with a snapshot set of data. I actually have one being passed to me currently. We have – those down at the bottom. Yes, okay.

We have alternate-level-of-care patients here, but I don't have the percentage of those that are waiting for long-term care beds. My experience is that as of March 31, there are 285 people who are ALC, which represents 19 per cent of acute care beds. Of those, traditionally – and it varies by day and by jurisdiction, but anything up to 50 per cent of those could actually be waiting for care in the community. They may be waiting for a shower rail to be put in or a ramp to be put to their front door rather than waiting for a long-term care bed.

MS. MICHAEL: Right.

MR. HAGGIE: It's unlikely they'll be waiting for a personal care bed.

MS. MICHAEL: Do we have any idea – you may not – of that breakdown so that we can get a better idea of the ones who are there for a much longer period because they're waiting for long-term care?

MR. HAGGIE: We can certainly provide, I think, a breakdown of those people who are ALC and waiting for long-term care.

MS. MICHAEL: Okay.

MR. HAGGIE: I think that would be easier than trying to specify all the reasons.

MS. MICHAEL: Yes.

MR. HAGGIE: Because the other pot would be a group of people who had other issues which weren't going to be necessarily reflective of the health care system.

MS. MICHAEL: Right.

No, and we're interested in the long-term care because, obviously, it still remains a problem. I don't have to tell you what's just happened in Gander with somebody having to travel quite a long distance because of beds being needed in the hospital for acute care. It still remains a big issue, as we know.

I think I'll pause there.

CHAIR: Mr. Kent.

MR. KENT: Thank you.

Hopefully we'll cover it in the next 10-minute interval. I'll try and keep my preamble short just like Question Period, although they don't let me up often enough in Question Period. That's a whole other story.

Mr. Speaker – I'm practicing. Maybe I'll ask you something this afternoon, although I don't think there will be anything left.

Minister –

CHAIR: You're in the wrong profession, Mr. Kent.

MR. KENT: Am I? My wife tells me the same thing. We just don't have a good answer as to what the right profession is, although I do need some professional help probably.

Air ambulance, any new developments? I know the challenges. I know there's been some controversy in the past year. I'm just curious if there's anything new on the air ambulance file that you're willing to share with us at this point.

MR. HAGGIE: Well, only that there is in the binder an explanation of some variances in costs. Transportation and Works have been challenged to keep one of their planes going and sometimes they've had some crewing issues. So we've been outside and used the contracted alternative.

MR. KENT: Yes, I'm aware of the ongoing challenges with Transportation and Works and I believe there's a new service delivery model required. Is that something that's still being explored?

MR. HAGGIE: I think you'd have to ask Minister Hawkins that in detail. We're simply the consumer of the product in some respects. Certainly, from my point of view, I've made it plain that really the Department of Health requires a one-number fix where you can ring and use it in the instances where it is determined that air is the best form of transportation.

The gap in our service is nighttime and IFR rotary operations. We, in actual fact, are very fortunate in having 103 in Gander because they fill that gap and they actually do it at no cost to the province. So, in a sense, that may be an opportunity rather than a cost.

We have had discussions – Transportation and Works and myself, our department – about how to ensure a reliable 24-7 service for fixed wing.

MR. KENT: Okay. I'm glad to hear there are still discussions happening on that.

Switching gears once again – actually, let's stay on ambulances. I know there were some previous questions by Ms. Michael related to Central dispatch and the provincial ambulance service overall. It's another area where we've got a challenging model and one that's not easily solved.

I'm just curious if there any updates in terms of provincial ambulance service overall, any changes coming this year, anything happening on that front?

MR. HAGGIE: I think you're probably aware that the contract with the ambulance operators I think expires this year and we'll be starting negotiations again around that.

I think if you look at the business model outside, it's tending to be a clumping of the private providers. There have been some buyouts and changes over the last five years which have consolidated the management structure of the bulk of the private ambulances into two or three principal players as it were.

I think really and honestly beyond that, I would see sorting out a provincial central medical dispatch either in conjunction with the current 911 mechanism or through some alternate would be the first brick, the first foundation in any changes to the ambulance service. I think given discussions on a jurisdictional scan, there is a feeling we could get better value for our dollar by looking at slightly different ways of doing it.

MR. KENT: I would agree with that.

Now, switching gears completely, Steamplicity. I regularly get photos sent to me from various people in various places in the health care system and some of them are familiar situations that don't require any follow-up and others may require a little more investigation. It's evident from some recent photos that Steamplicity hasn't yet been fully implemented at the Health Sciences Centre. I'm just curious what the status is and when you would anticipate a change in food services at the Health Sciences?

MR. HAGGIE: The problem with Steamplicity, if I recall correctly – and I'm sure there'll be people whispering vigorously if I get it wrong – was the challenges in getting the building sorted out for the accommodation for the new equipment which, if I believe correctly, is Mount Pearl, if I'm not ….

MR. KENT: I think it's Donovans, yes.

MR. HAGGIE: Yes. So that's delayed its implementation, but other than that the project is funded and is due to roll out when those kinks have been ironed out.

MR. KENT: Okay.

So probably this year, certainly.

MR. HAGGIE: Well, my understanding is, yes, it will be over the course of this year that it will get up and running properly.

MR. KENT: Yeah, and I recognize there are some impacts on the location of people in the system as a result but I think we're both committed to trying to improve food quality in our health care facilities, which is desperately needed.

MR. HAGGIE: Well, certainly Steamplicity got a very good sort of write up as part of the evaluation process for going in that direction in the first place.

MR. KENT: Yeah. No, I'm a believer, based on what information I had anyway.

MR. HAGGIE: One of the things we were trying to do was make sure that local ingredients could be sourced.

MR. KENT: That's a great idea.

MR. HAGGIE: I mean some of it has to be partly prepared.

MR. KENT: Yeah.

MR. HAGGIE: I'm thinking of the beef, the meat and that kind of thing, but we have had some tentative discussions with the health authorities about local source of produce for example.

MR. KENT: Excellent.

Opioid Action Plan, there have been some recent deaths. I know the Action Plan is in place. I'm just wondering have there been any issues with implementation and any gaps you've identified, any changes coming that we should be aware of.

MR. HAGGIE: No, I mean it was kind of inevitable. I think to flip the statistics around, out of the 16 overdoses, 14 survived. So that's a testament to the fact that there's been some benefit from the plan.

In terms of the kits, there are still some left that haven't been deployed. The final piece was rolling out the nasal spray to the EMRs, the emergency medical responders. The paramedics have the injectable, but we've sourced nasal spray now for the EMRs who have a different skill set.

MR. KENT: They now have it?

MR. HAGGIE: It's being rolled out. Some have, some not yet. It's not quite – the rollout is not complete.

MR. KENT: Is that for all EMRs in the province?

MR. HAGGIE: My understanding is, yes, it was done through PMO.

MR. KENT: Okay.

Any plans to make the naloxone kits available anywhere else?

MR. HAGGIE: Well, they're available through 811 or through the numbers that we published on the government website in the news release.

MR. KENT: To individuals.

MR. HAGGIE: Yeah. All we ask is that you give us a contact number and we number the kit. We do that because they have a two-year shelf life and we also would like to know when they're used and how to replace them.

MR. KENT: If somebody in the community wanted to have a kit who's not a drug addict or not somebody who, because of their medication, would necessarily require a kit, but if there's somebody in the community who works with affected populations who wanted a kit, can they call 811 and get one as well?

MR. HAGGIE: Yeah.

I mean, in actual fact, those are the people you want to have them because by and large they're not likely to be incapacitated. So 811 is the generic catch-all from my memory, which is not good with multiple telephone numbers. But there are a whole variety of RHA sites that have stock to give out as well as the SWAP program and some of the community groups. In actual fact, the launch took place at the SWAP program.

MR. KENT: Okay.

Madam Chair, I see I'm going to run out of time. I don't have many questions left but I still have a few more. I'll pause and see if Ms. Michael has anything additional and then I'll continue.

CHAIR: Thank you.

Ms. Michael.

MS. MICHAEL: I'll just ask one question as part of the discussion that Mr. Kent was just having with the minister. I know this is more informational than anything, but last night at the town hall on mental health, an issue was brought up with regard to the experience of some people,

here in St. John's it's happened, where a pharmacist has refused – some pharmacies, it's not general – to sell needles to someone whom they are treating. Is that the pharmacist's call?

MR. HAGGIE: You would probably be better directing that to either the Pharmacists' Association of Newfoundland and Labrador or the Pharmacy Board because I don't really have enough knowledge, quite frankly, to answer that question.

MS. MICHAEL: Because if somebody is being treated at that pharmacy, that person still is in control of his or her own addiction. I just question what right the pharmacist would have to make that call, to say I'm not selling you needles.

MR. HAGGIE: No, and I don't have the answer to that question.

MS. MICHAEL: Okay.

MR. HAGGIE: I think you would be best asking either one of those two groups or the pharmacist concerned.

MS. MICHAEL: Right. Thank you.

That's all.

CHAIR: Okay.

Mr. Kent.

MR. KENT: Thank you.

Just an offer of support once again before I move on to other topics, on the mental health implementation plan that we know is coming over the next month, if there's anything we can do to be of assistance with any of that work. Despite the fact the committee has concluded, there's a lot of work to be done over the next number of years and there are a number of us who remain willing to support your efforts to implement those 54 bold and broad recommendations. That's a standing offer.

I have a couple of questions for you related to the overall RHA budget, and this comes from the briefing we received from Finance officials. Through, I guess, the zero-based budgeting exercise, there was a reduction in salary and benefits of $30.8 million. From the comments that Finance officials made, we think about $20 million of that probably relates directly to the RHAs.

The Department of Finance assures us that between $20 million and $30 million that's coming out of the RHAs will have no impact on front-line services. Is that all related to the management changes that recently happened at the regional health authorities, or is there more to that story?

MR. HAGGIE: You're talking about $20 million that was saved over last year?

MR. KENT: Yes.

MR. HAGGIE: Yeah.

Okay, that comes from three areas, essentially. One is, for example, Steamplicity, which was budgeted but the cash didn't all flow because of the delays –

MR. KENT: Right.

MR. HAGGIE: – and that accounts for part of it. The other piece is around changes to the way capital and current accounts are being registered, and the other piece was about accrual versus cash. There was no change. It's to line up with an accrual accounting mechanism.

You've reached the limits of my financial competence there. Was that right?

OFFICIAL: That's good, yes.

MR. HAGGIE: Oh, it's good. Okay, yes. It's just not said with enough confidence.

MR. KENT: Your accent inspires confidence, so that helps a lot.

When it comes to the zero-based budgeting and the RHAs, what will the impact really be then? There has been funds taken out, we've been told by another department that won't have any impact on services, but can you just tell us what the impact of zero-based budgeting on the RHAs actually is, in practical terms?

MR. HAGGIE: Well, what we have done with the RHAs is directed them to use a zero-based budgeting approach. They didn't do it in any great and determined way in the terms of this year's budget process. Essentially, it is a very granular approach to the way they do business.

Do you really need to have half a dozen boxes of 24 ballpoint pens on every ward clerk's desk? Do you need to have BlackBerrys for automatically anybody who's above a certain level on the org chart? Because there are some people, quite frankly, who are never going to get called. We have whittled away in our department at the number of BlackBerrys, the number of voicemails. Can you amalgamate some voicemails? It really does get down to simple things like that.

Print management, for example; there is talk now of discussion through Service NL of some of Eastern Health's printing, for example, being done on this huge, new machine that they're going to acquire for Service NL. It'll have capacity, and it doesn't just have to run for the benefit of GNL.

I think it's more of an approach, and you can see how that is not going to have any impact, should not have any impact on front-line services.

MR. KENT: Right.

MR. HAGGIE: How many vehicles does a hospital or an RHA need to purchase? It will vary. You may need a lot more in Central because it's so big. You may need a different vehicle in Labrador because the winter conditions are what they are.

It's very difficult to be specific, but they've certainly been told that when they go through a zero-based approach, it is not to be directed at front-line workers and programs. I think you could probably manage with maybe 50 per cent of the ballpoint pens that you have at the moment, paper stocks, these kinds of things. I think there is a lot of room there.

I think on the other side, what will make that a whole lot easier, is the shared-services approach for inventory control. Not only are you going to look at purchasing across the RHAs, but you will actually have some kind of inventory management system.

There are some across the province. Western has quite an interesting one whereby stock levels of needles for the emergency department are kept at an optimum level. Instead of having boxes and boxes, which people trip over and get tucked in corners, they have their stock levels determined by level of utilization. It's very, very apparent if you don't have enough needles in the tray. Someone will find out about that and that will be fixed very, very rapidly. On the other hand, nobody ever did anything about the 16 extra boxes of green needles tucked in the corner; yet, that was money that had been spent that was actually not benefitting patients. It's that approach.

There is no one person or no one group that's going to make a difference of the whole system. It's going to be lots of people adopting that approach that will make the difference.

MR. KENT: Okay. Thank you.

Moving on to 3.2.02, Ms. Michael asked some questions about the change in the salary line. There was some comment by the minister related to what's anticipated broadly.

I'm just wondering if that relates to some of the planning that's ongoing for facilities like the Waterford and a new West Coast hospital. Is that the anticipation you referred to?

The salary increase in under Health Care Infrastructure – well, it's up more than $1 million from revised, but it's about $500,000 from last year's budget. Is that in anticipation of further planning work related to those projects?

MR. HAGGIE: Yes is the short answer.

MR. KENT: Okay

I just ask for a little bit more clarity then. I know there's some money budgeted for planning related to the Waterford Hospital for this year. I think we're in agreement that – I know we're in agreement that simply replacing the existing infrastructure would be a mistake, which is part of why the project hasn't proceeded sooner, and I know you'd be aware of all of that history. I'm

just curious, can you comment on what that planning work looks like and how far we will get during this fiscal year and whether there's active consideration being given to a P3 build for the portion that will be built?

I know there will be some services that will come out and be located elsewhere in the community and in the province, hopefully, which is I believe the right approach but for whatever will be built to replace the Waterford, can you just give us a sense of how far that will get this year?

MR. HAGGIE: The process of devising a kind of functional plan and a master plan, you know the shopping list of things you need in a facility, that had been done for, if you like, the old Waterford concept.

MR. KENT: Correct.

MR. HAGGIE: And really that has been put on one side given the deliberations of the All-Party Committee. What has happened is it's been taken out now and there are discussions in the department about what the new Waterford project would look like, and I would anticipate that document will get fleshed out over the course of the next couple of months.

In terms of what and how that will be built, generated, I think there has been a patent apparent of looking at value for money and then seeing what the role of a P3 might be. I would envisage that between Health and TW, we would probably go down that road again with any new infrastructure build whether it's the Waterford or long-term care in Central.

MR. KENT: Thank you for that.

I think doing that exploration makes sense. I know I may differ with my colleague on that particular point but I think doing the value for money analysis and being as transparent as possible about it will allow the right decision to be made. Given the challenges that surround the Waterford, it's one of those areas where I'd say if we can be helpful and be collaborative then there's certainly a willingness on my part to do so.

Are there any consultants engaged in all of that planning work at this point? Do you have somebody engaged who's doing a value-for-money analysis related to the Waterford, or who is doing the design work at this point?

MR. HAGGIE: We have no one engaged on design work. We're still at the in-house stage of kind of a shopping list.

As regards to the value-for-money pieces, those have all been done through TW and I don't have any visibility into that at the moment. I would suspect however, that until we've got the master plan, the functional plan sorted out that there're wouldn't be anything on which you could base a value-for-money assessment because you wouldn't have your plan.

MR. KENT: So in terms of the functional plan – and I'm nearly done, Madam Chair. I know the clock has run out but can I ask for leave to just finish up?

CHAIR: (Inaudible.)

MR. KENT: Thank you.

I would have anticipated that you won't be able to complete the full functional plan in house. So is it the intention during this fiscal year to engage somebody to help with that work?

MR. HAGGIE: That's what the planning money is. One of the reasons the planning money is set aside.

MR. KENT: Okay.

MR. HAGGIE: Yes, sorry, I may have misled slightly and I didn't mean to. We have not gotten to the stage where what we've done in house yet is ready to hand out to a designer/planner to convert into a functional plan.

MR. KENT: Okay.

So there will be some kind of RFP, I would presume.

MR. HAGGIE: It will go through the usual channels kind of thing –

MR. KENT: The usual procurement channels.

MR. HAGGIE: – until we get to the stage of having something to take to the market to flesh out. We're not quite ready yet.

MR. KENT: Ms. Michael and I have both asked for a number of pieces of information that are outside of the binder that we're going to be provided with. I trust you'll ensure that whatever we've asked for, we both will receive.

MR. HAGGIE: You'll get handwritten, if need be – hand autographed letters with the same content.

MR. KENT: Okay, great.

Thank you.

I just want to conclude by expressing my thanks to you in particular for your approach this morning and for your openness. It's well received, it's helpful and I appreciate your flexibility in answering all the questions. It's an approach that I believe worked well and I'm glad to see you continuing in that tradition. I think it makes this process more useful for everybody.

I want to thank the staff who support you in that work. I won't repeat what I said at the beginning. I've got great respect for the folks that work in our health care system, particularly the ones I've worked directly with in your office.

So thank you for your approach and for your answers. I'll look forward to more sensible conversations like the one we've had over the last three hours.

MR. HAGGIE: Thank you.

CHAIR: Thank you.

Ms. Michael.

MS. MICHAEL: Thank you, Madam Chair.

Just again to thank the minister, his deputy and all his staff for being here with us today, for giving us all the information that we're looking for. I appreciate the fact that we can get the binders and that you will give us information we're looking for.

I've chosen, Minister, deliberately not to put out my differences of opinion with you with regard to some of the directions government is taking. I do that when I have to do it, do it in the House of Assembly. I don't think this is the place for me to do it, but you know where we stand on P3.

I think the one thing I would urge is when you talk value for money, that there are many, many aspects to that when looking at P3. That's all I want to say, just to put that on the record.

Thank you very much. I really do thank you sincerely for today.

CHAIR: Thank you, Ms. Michael.

I don't know if the minister has some closing remarks.

MR. HAGGIE: Really only to reiterate what others have said. I mean this process has been as smooth, apparently, as it has been is entirely due to the people around me, not me. I would just like to go on record again as thanking them and, Chad, who is not here and all those other people who labour on behind the scenes. That's really all I have to say.

Thank you.

CHAIR: Thank you.

3.1.01 to 3.2.02, shall it carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, subheads 3.1.01 through 3.2.02 carried.

CHAIR: Shall the total carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

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?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

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

CHAIR: A couple of notes, the next Estimates of the Social Services Committee will take place here in the Chamber at 6 tonight. I can't wait again. That will be Municipal Affairs and Environment. If substitutions are required for this evening's meeting just a reminder to notify the Government House Leader in writing.

With that, I'll thank all Members for their co-operation this morning. I wish them a fantastic rest of the day.

I will call for a motion to adjourn.

MR. KENT: So moved.

CHAIR: So moved by Mr. Kent.

Have a great day everyone.

On motion, the Committee adjourned.