PROVINCE OF NEWFOUNDLAND AND LABRADOR
HOUSE OF ASSEMBLY

Third Session
Forty-Eighth General Assembly

Proceedings of the Standing Committee on Social Services

April 30, 2018 - Issue 5

Department of Health and Community Services

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

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Carol Anne Haley, MHA

Members: David Brazil, MHA
Jerry Dean, MHA
Betty Parsley, MHA
Kevin Parsons, MHA
Scott Reid, MHA
Gerry Rogers, MHA
Brian Warr, MHA

Clerk of the Committee: Kim Hawley George

Appearing:

Department of Health and Community Services
Hon. John Haggie, MHA, Minister
Carol Ann Haley, MHA, Parliamentary Secretary
John Abbott, Deputy Minister
Heather Hanrahan, Assistant Deputy Minister (A), Regional Services
Paul Greene, Manager of Infrastructure
Mike Tizzard, Departmental Controller
Alicia Anderson, Executive Assistant
Tina Williams, Director of Communications

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

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

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

The Committee met at 6:05 p.m. in the Assembly Chamber.

CHAIR (Warr): Good evening and welcome to the Estimates of Health and Community Services.

My name is Brian Warr and I'm the MHA for Baie Verte – Green Bay. It's my pleasure to chair your meeting tonight. I'll be taking MHA Carol Anne Haley's place, who sits as the parliamentary assistant to the minister. I will take her place and chair the meeting.

Thank you, Carol Anne.

Before we get started, I'd like to have the Committee introduce themselves, starting with Mr. Brazil.

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

MR. COLLINS: Sandy Collins, Office of the Opposition.

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

MS. WILLIAMS: Susan Williams, Researcher for the NDP.

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

MR. DEAN: Jerry Dean, MHA, Exploits.

CHAIR: Okay, thank you.

We'll get started and I'll ask the Clerk to call the first subhead, please.

CLERK (Hawley George): 1.1.01.

CHAIR: Shall 1.1.01 carry?

Minister Haggie, we have 15 minutes for you for some introductory remarks and if you would have your department introduce themselves as well.

MR. HAGGIE: Certainly. We'll start with the introductions, I think, if you don't mind, Mr. Chair.

CHAIR: Okay.

MR. HAGGIE: To my right …

MR. TIZZARD: Mike Tizzard, Departmental Controller.

MR. HAGGIE: To my left …

MR. ABBOTT: John Abbott, Deputy Minister.

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

MS. HALEY: Carol Anne Haley, MHA, Burin – Grand Bank and parliamentary secretary to the Minister of Health and Community Services.

MS. WILLIAMS: Tina Williams, Director of Communications.

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

MR. GREENE: Paul Greene, Manager of Capital Infrastructure with the Department of Health.

MR. HAGGIE: Thank you.

John Haggie, MHA for the beautiful District of Gander, where it was really sunny the weekend.

I'm not going to spend an awful lot of time on introductory remarks. I know some people tend to do that and burn time, but I think in the interest of efficiency we can simply say that this department represents the single largest outlay of expenditure by government on any program and set of services. Our task really has been to try and make that sustainable. This is my third time presenting to the Social Services Committee for the Estimates and the vote.

I think one of the things of which I'm very pleased and must give the staff credit for is that we have kept the health care budget pretty stable at approximately the $3 billion mark over that entire period of time. Having said that, our per capita health expenditure in this province is still the highest in Canada. And whilst other jurisdictions are set to rise, so is ours. It's difficult at the moment to see how that will change, unless we keep our expenditure level.

Our specific approach, really, is to extract more value from the dollars that we do spend. We've seen in previous years in line with general government policy about producing more efficiency, reducing waste and then looking at sustainability and value for money. So we have tried to balance that, looking at investing in prevention; we are very much focused on moving more of our efforts and more of our care to focus it in the home and in the community. My mantra has been that the centre of excellence now shouldn't really be a building on a hill somewhere. It should equally be the home or the community.

By moving that change in emphasis nearer to the individual's home where at all possible, not only do they get better access but we get better value; particularly with our aging demographic, we support the concept of people staying in their own homes for as long as is safe and feasible. Set against that, we still have responsibilities for managing acute care; we have challenges in the public health and preventative arena, and those are going to be addressed in policy changes that are really outside the scope of the financial piece here today.

So with that, I really don't want to beat the preamble and the rhetoric to death too much and I will be happy to begin the process of working through the heads of expenditure.

CHAIR: Thank you, Minister.

And I just want to announce as well that Mr. Browne is substituting for Ms. Parsley tonight, and the MHA for St. George's – Humber has joined us as well. We will get under way.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

Thank you, Minister, and welcome to all the staff from the department. I won't go line for line unless I think there's a real dramatic difference here to have a discussion around, but I do have some general concepts or some general discussions to get some clarification.

Can I request that we get a copy of your binder down the road, which is the normal standard?

MR. HAGGIE: Certainly.

MR. BRAZIL: I appreciate that.

I just want to clarify, because I know last year – it wasn't your line department but other line departments where I was critic, we did discover after that when the Estimates were printed, there were some errors that were identified. And if they happen to be, just to note those, so we're not coming back trying to get clarification on why there's $40 million difference or $10 million difference if it's already been identified and clarified.

MR. HAGGIE: Okay. I mean certainly if there are any discrepancies that we identify here tonight, we'll deal with those as we go.

MR. BRAZIL: Perfect.

I'm going to ask a general question here, and I know the $3 billion and you have stated the line there, and again, taking into account additional costing in salary basis, infrastructure costs, costs that may be out of your control as part of that – has there been any identified cuts to programs and services, in a major level?

MR. HAGGIE: The short answer is no, we did realign some services after last year's budget where we felt that they weren't performing, but essentially the money was reinvested in other areas. We had challenges, for example, in Central Health and across province with the Community Rapid Response Team, which didn't serve its purpose, for example, of keeping people out of the emergency room.

So we removed that program, but we have moved those resources into other areas. So, net across, there's been a change – we've removed a redundant program effectively, or an ineffective one, shall we say, that wasn't producing the

outcomes clinically that were warranted for the expenditure, but in terms of financially, that money has been reinvested back into the RHA.

MR. BRAZIL: What costing would that be? Was that $100,000, $1 million, $3 million?

MR. HAGGIE: It was, I think – and we'd have to go back to be absolutely sure, but ballpark was around a million, million-and-a-half mark across the province.

MR. BRAZIL: So would that money then go back into the amounts in each particular region (inaudible)?

MR. HAGGIE: Yeah, they were staffing costs basically within the RHAs. For example, there were nurse practitioners allocated in there. They're still employed, but they are now working in long-term care in Gander in Carmelite, for example, as a local example.

MR. BRAZIL: Have you had a reduction in staffing across the board?

MR. HAGGIE: There has been a change in staffing in the department which, in actual fact, has reflected the investment for Mental Health and Addictions money. So our departmental footprint is 10 people – sorry, nine people –

OFFICIAL: (Inaudible.)

MR. HAGGIE: Sorry, we have gone from 189 to 197 in the department, but that reflects seven Mental Health and Addictions individuals and some admin support for that.

MR. BRAZIL: And that funding is that cost shared with the federal government? Is that part of the –?

MR. HAGGIE: The money from Mental Health and Addictions has gone into these consultants for the implementation teams for the all-party committee *Towards Recovery* plan from last June.

MR. BRAZIL: Okay, fair enough.

I'm just curious, because I'm staying at the first heading here, the severance that's going to be paid out now, is that built into your budget, the $3 billion? I would think Health and Community Services has the largest (inaudible) –

MR. HAGGIE: Are you talking about the NAPE agreement?

MR. BRAZIL: Agreements, yeah.

MR. HAGGIE: I would defer to staff but I'm thinking that that isn't forecast in our budget; it appears under HRS.

MR. BRAZIL: Okay, fair enough. I'm just trying to get my head around what the real number is in the way of how we equate that to services within the health profession.

The only other new hires were just those ones for the addictions. Other than that, it was just people in and out in the same categories –?

MR. HAGGIE: In actual fact, if you look under the Minister's Office, you'll find there is a slight increase in salary. I took one of your predecessor's advice. The first budget we were here, we reduced the department staff to the minister and an executive assistant. Previous incumbent ministers of Health have had a ministerial liaison and I remember the MHA for Topsail – Paradise said well, good luck with that. And he was right, so we now have a ministerial liaison, and that's reflected in the salary budget.

MR. BRAZIL: Fair enough.

Do you have any vacancies in the department there now, or are they full complement?

MR. HAGGIE: Fifteen, yes.

MR. BRAZIL: How many?

MR. HAGGIE: Fifteen, that's within the Department of Health proper.

MR. BRAZIL: Are they being advertised or they being held for a period of time? Is there temporary? Are they contracted positions? Are they full time?

MR. HAGGIE: I would have to defer to the staff, but I think they're contract.

MR. ABBOTT: (Inaudible) for a minute.

MR. HAGGIE: Yes.

MR. ABBOTT: Mr. Brazil, we're recruiting for permanent. We will be doing some contracts. And if all else fails, we would then do any of the remaining on temporary assignment.

MR. BRAZIL: They're all expected to be done in this fiscal, obviously, as part of that?

MR. ABBOTT: Yes.

MR. BRAZIL: A couple of quick – these could be ones at the end but while I still have some time and there are not a lot of issues in this first heading, I want to throw out some general things. I'm trying to get my head around – talking to some people – the electronic X-ray program where each health authority would be able to do. You know, instead of carrying your X-rays when you're coming in for specialists here in St. John's, that the electronics would be done. How far are we that other jurisdictions can have that, other parts of the province?

MR. HAGGIE: Within the province, it's total integrated. If you are a specialist in St. John's and want to look at some X-rays from Nain – Nain is an example because we actually put the machine in with the TB issue. Previously it would have been Goose Bay. They're available in real time online.

MR. BRAZIL: Okay. And all regions have access to that now?

MR. HAGGIE: Yeah, wherever you are in the province. So you can have a radiologist in actual fact called out of bed in the middle of the night and the lucky devil can go downstairs and log in to his computer and look at the X-rays in his sitting room. It's that good.

MR. BRAZIL: Okay. Good, that's a positive.

Has that recently come online fully implemented?

MR. HAGGIE: It's been a slow progress in some areas, but we've been up and running it with PACS – it's called, provincial archiving service – that's been online, probably fully integrated for at least three years.

MR. BRAZIL: Okay.

The medical records recording, I'm hearing there are still some doctors that are not on the system yet. Are we getting closer to completing that?

MR. HAGGIE: The EHR initiative with the Medical Association, with the TELUS one, there were an original tranche of 300 licences and the last time I looked we had nearly all of those committed, if not actually installed. There had been some delays with capacity through NLCHI at one stage in terms of getting them in earlier under the year, but I think those have been remedied now.

We have actually also gone out for an enterprise solution for salaried physicians working in RHA, so they can be put on the same platform. That is not quite as advanced.

MR. BRAZIL: What are your time frames on that do you think?

MR. HAGGIE: The enterprise solution I would imagine we will see some progress over the course of this year, but that has not moved a lot in the last six months.

MR. BRAZIL: Okay, fair enough.

The pharmacies, their system, is that fully integrated at this point?

MR. HAGGIE: The Pharmacy Network went live at the beginning of last year and all the pharmacies are compliant on it, as far as the Pharmacy Network is concerned.

The next step, the Prescription Monitoring Program, as you're aware, will roll out and there will be full implementation of the prescriber requirements within the next month or so.

MR. BRAZIL: Okay.

Not only in your capacity as the minister but as a former physician, is it meeting the needs that you expected?

MR. HAGGIE: I think really the acid test, as far as the Prescription Monitoring Program will come, will only be 'evaluatable' – if that's a word – once we've had some time with it running fully implemented.

In terms of the prescribing profiles and the data that is generated, we're still getting our heads around how to collate that and make it into a usable package. Because one of my aspirational aims is to make that into a prescriber profile, so that everybody who prescribes in family medicine can see where they are against other GPs, not just in their own district, but maybe across the province and similarly with specialists ultimately.

MR. BRAZIL: So will this be live time or it's uploaded every so often versus if somebody puts it in, it now can be accessible by everybody who goes in on that system?

MR. HAGGIE: At the moment, the pharmacy information goes in real time. So if you go with a prescription, which is handwritten, take it to a pharmacy, the software will immediately update the patient profile and the pharmacist dispensing profile across the province. So that you could go from one pharmacy to another literally within the space of five minutes and the person would say, well, I'm sorry you've already filled that prescription, which is its utility in terms of opioid diversion and potential misuse.

Indeed, the first two pharmacies that were connected ever, that actually happened the day they were connected up – the afternoon they were connected up – they were both in the same Bay Roberts-Carbonear area. And they rang each other because that was before the system was up and running. Its utility is well demonstrated.

In term of the data, I don't think that physicians really have given us a clear idea of how'd they like it. In other jurisdictions, it's done on a periodic basis. Here's what you did for the last six months or the last year. It becomes a signal-to-noise issue. If you give it to them every week, it goes in a big pile in a round filing basket but if you give it to them in a way that they would like, regular intervals that suit them – and ideally online. But there are several steps in that process that's ultimate and aspirational. We're not there yet.

MR. BRAZIL: Okay, perfect.

But you're having a dialogue with the Medical Association, I'm assuming?

MR. HAGGIE: Yeah.

MR. BRAZIL: Fair enough, good on that.

I think I'm good on that heading. I will pass it on to my colleagues there on that heading.

CHAIR: Thank you.

The Chair recognizes Ms. Michael.

MS. MICHAEL: Thank you, Mr. Chair.

I really have no questions about 1.1.01, but a question, Minister, as we go through, I will be interested in seeing how the new Health Accord money is being used, where it fits in. Is that something you want to talk about in general or can we can identify it in line items?

MR. HAGGIE: It becomes more apparent as you go through the heads of expenditure and would pop out more under a kind of programmatic approach.

MS. MICHAEL: Well, let's do it that way then, okay.

MR. HAGGIE: It may be more interesting (inaudible).

MS. MICHAEL: Okay, good enough. Thank you very much.

I will go on to 1.2.01, Executive Support. I am interested in the salary line because there was quite an increase between the budget of last year and the revision. Then this year's budget is below last year's budget. So just an explanation, Minister, of what's happening there.

MR. HAGGIE: The paid leave and severance was the spike and that salary continuance ended 2017-18.

MS. MICHAEL: Okay.

So how many positions resulted in the $458,500 in paid leave and – well, not the paid leave so much – well, I guess they were part of the people leaving also, were they? (Inaudible) lump sum payments.

MR. HAGGIE: My note just says it's paid leave and severance to the former deputy.

MS. MICHAEL: Okay, so that was part of lump sum payment?

MR. HAGGIE: Yes.

MS. MICHAEL: And how many individuals would that have been?

MR. HAGGIE: It was the former deputy.

MS. MICHAEL: The former deputy, okay. So the $458,500?

MR. HAGGIE: It was carryover from the RHA, because she had been employed there before.

MS. MICHAEL: Right, okay.

Coming to 1.2.02, Departmental Operations, once again if we could start with Salaries. The budget was $11,706,000, approximately; the revision was $12,391,800. So there's quite an increase in the revision, if we could have the explanation of that.

MR. HAGGIE: So that's the difference between 2017 budget and 2017-18 revised, which is this one here. That's, again, severance and paid leave cost to those folk that retired or left during 2017-18.

MS. MICHAEL: And how many people were involved in that?

MR. HAGGIE: We could get that number for you.

MS. MICHAEL: Please.

MR. HAGGIE: I couldn't tell you offhand.

MS. MICHAEL: And this year the estimate is eleven – oh no, it's not that much more. This is not written the way I was reading it. But there is an increase in this year's estimate. So could we have an explanation for the increase over last year's budget?

MR. HAGGIE: That's a netting effect of the loss of the spike, the addition of seven Mental Health staff, and we're also taking 17 folk from Advanced Education, Skills and Labour to run the Medical Transportation and Assistance Program for Income Support clients.

MS. MICHAEL: And where exactly are the new, the seven Mental Health positions? Where are they going?

MR. HAGGIE: They are in the department. Do you happen to know which teams they go into?

OFFICIAL: (Inaudible.)

MR. HAGGIE: They under the direction of Mental Health, but I just wondered – do you want to know which Mental Health teams they're going to?

MS. MICHAEL: Yes, please.

MR. HAGGIE: Okay, hang on.

One for each of the seven teams.

MS. MICHAEL: Okay, thank you very much.

And is that new money? Is that part of the new funding there?

MR. HAGGIE: I believe so.

MS. MICHAEL: Yes, it's part of the new Health Accord money.

Okay, thank you very much.

If we come down – it's not a big difference but in Transportation and Communications, in the same head, it was under by $8,000 last year and this year it's going to be $15,000 more than last year's budget. So if we could just have an explanation.

MR. HAGGIE: That relates to the 17 additional employees for the consolidation of medical transportation and Income Support medical expenditure, so there will be some travel involved for those there.

MS. MICHAEL: Right, thank you very much.

I won't ask about things that are rather inconsequential but if we come down to Revenue – Provincial, we have a difference of $85,000 between this year's estimate and last year's budget.

MR. HAGGIE: That is funding associated with the pan-Canadian Pharmaceutical Alliance, giving us money to the pharmaceutical division for the hiring of a contractual position to fulfill our obligations under the pCPA for generics and purchases.

MS. MICHAEL: Okay, thank you very much.

If we come on to 2.1 – just hold on one second, I do have some questions here that may have been answered already. No, they aren't, so I'm going to ask some general questions now.

What is the status of home care action plan?

MR. HAGGIE: Good question. I may be getting confused about the main clincher. Do you mean the Home Support Program?

MS. MICHAEL: Yes.

MR. HAGGIE: Yes, okay.

The changes to the Home Support Program fall under several heads. One is around a common source of financial assessment; the other is around the issue of coming to service level agreements and putting standardization and verification in for home care needs.

We have projects afoot that are progressing well to deal with both of those. We have proposals that are ready to submit to look at a streamline financial assessment. We have negotiations with, for example, private personal care home operators. The other piece is around technology, to look at trying to make the self-managed care option easier and more straightforward for verification purposes.

I think I've mentioned them all. No, the other one was around standardizing the assessment piece for clinicians because there has been significant variation, both within and across the health authorities in how the standardized assessment tool is actually interpreted. We've gone back to work on that to make it more uniform.

This all fits in with the Deloitte report and basically their 24-point action plan and the matrix with the time frames is what we've been following. I think we're making progress in those areas.

MS. MICHAEL: What is the plan for assessing those changes?

MR. HAGGIE: We have internal project management on that but, in terms of assessing them going forward, there is an evaluation component built into it so when it hits the ground, we'll be able to measure some of these – particularly with relationship to the move from an emphasis on hours of care to items of care and care needs and outcomes.

One of our challenges has been verification of care delivery and the outcome base. One of the technology issues that we're working with is to try and get a tool that will allow us to do that in an easy way for both self-managed and agency-managed care. There is not onerous for people who have self-managed option and is not hideously expensive for the people or the care agencies.

Once we've got that sorted out, I think we'll be in a position to measure both process and outcome far better.

MS. MICHAEL: Thank you.

With regard to the Home First program – and you speak about it a lot, et cetera – can you give us an idea of progress?

MR. HAGGIE: The Home First plan is more of a home-first philosophy. It involves a variety of approaches. It's very difficult to call it a plan in the sense that you would look at a series of bullets and want to see where you were on this scheme. But the idea underlying it is that the default for a person – where at all possible – should be they stay home first. So what is it we need to keep that person in that environment, and what is it that an individual needs?

We're trying an approach whereby the assessment will be done to produce an individualized care plan. The individualized care plan will then be handed off to either a managed care provider or for self-managed care. So the two are integral; but the other piece then is around what levels of additional support somebody might need in terms of OT or PT at home, and what other care needs they may have, because at some point the needs of the person will exceed what can be safely delivered at home. But it's a philosophy rather than an action plan, in the sense of the Deloitte report where it has 24 pieces to it.

MS. MICHAEL: To what degree do you see it actually starting to be in practice, that philosophy?

MR. HAGGIE: It's out there already. I think one of the things is trying to change people's approaches, and I think the education piece around standardizing the assessment tools that we use and standardizing the quality of care will go a long way towards dealing with them.

CHAIR: Thank you, Ms. Michael.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

I had some questions about the operational structure here. How much did you spend on consultants last year?

MR. HAGGIE: Which heading are we under, Mr. Brazil?

MR. BRAZIL: Well, it's still under Operations, General Administration.

MR. HAGGIE: Operations, okay.

$1.105 million for policy, planning and performance monitoring and, on the back page, I've got a shopping list of things here; it's in the binder. So it would fall under Audit Services. For example, there was a total of $27,000 paid there for audit appeals; $15,000, pharmaceutical audit; $6,000, Medical Consultants' Committee. We have pharmaceutical services which include Atlantic Common Drug Review, pCODR, Drug Information Centre at Memorial and the interchangeable drug projects, which would total $169,000.

The whole thing grosses out at $1.1 million. There are some under RHAs for long-term care, provincial blood coordination. There's some mental health money; evaluation of new primary health care teams, for example; and then some federal contributions that we make for caPER and CADTH, these kind of things.

Again, we can provide that.

MR. BRAZIL: That's all in the binder?

MR. HAGGIE: We can provide that breakdown for you.

MR. BRAZIL: Perfect, that will save us a lot of time.

MR. HAGGIE: You'd get fed up with listening to me read out an accounting spreadsheet.

MR. BRAZIL: No, that's perfect.

Just get a comparison how many are employed – I know you said in the department today – versus this time last year?

MR. HAGGIE: I had that figure at the beginning and I think I gave it to you.

MR. BRAZIL: Yeah, 189 but –

MR. HAGGIE: We had 189 this time last year and we have 197 as of – I think that was March 31, was it?

OFFICIAL: Yeah.

MR. HAGGIE: Yeah, March 31.

MR. BRAZIL: Okay, perfect.

MR. HAGGIE: That doesn't include 17 positions that will come over from AESL.

MR. BRAZIL: Okay. That's to do the medical transportation, obviously.

MR. HAGGIE: Yes.

MR. BRAZIL: So the money comes –

MR. HAGGIE: So you could have a common entry for all medical transportation, whether it's for Income Support clients or whether it's the universal MTAP.

MR. BRAZIL: Just refresh my memory, before it used to be a bit more complicated because both departments were sort of conflicting with each other on what would be policy and what would be acceptable.

MR. HAGGIE: Income Support clients were managed through AESL. They had a needs-tested eligibility but their travel costs would be covered, if necessary, upfront and completely – as long as it was medically necessary and supported with appropriate documentation.

The medical necessary piece became something of a problem because, as they pointed out, and we acknowledged they did not have always the expertise in-house to make that determination.

The MTAP, Medical Transportation Assistance Program, is the other piece of it which was run through Health which is universal, it's not means tested. It's reimbursement and there are criteria, but you don't get the full cost reimbursed.

MR. BRAZIL: Is there any anticipated changes to that program when you mesh the two?

MR. HAGGIE: At the moment, we're simply having a common location for all claims to be dealt with. The idea at some point is that these two programs would merge, but it's a matter of figuring out how to do that in an equitable fashion for those people – you don't want to disadvantage people and you don't want big gains simply because you don't want to pay for transportation that you don't have to pay for, for legitimate medical reasons.

MR. BRAZIL: Fair enough.

So logistically, you're actually moving the positions – people lock, stock and barrel?

MR. HAGGIE: Yeah, they're going from one floor to the next floor. There's no –

MR. BRAZIL: One part of the floor to the other, okay (inaudible).

They'll administer the same program as you just outlined?

MR. HAGGIE: Yes.

MR. BRAZIL: They'll each do that until it meshes together.

MR. HAGGIE: It will simply be one common location. The advantage of doing that is that you can get the people who are familiar with the system running it to start to compare notes and see areas of similarity and areas where there's a problem but it also allows AESL staff or what would have been AESL staff access to clinical expertise. The issue of medical necessity should be done.

MR. BRAZIL: There'll be a bridge there, perfect.

Is there any anticipated additional dollars going into the program as you (inaudible)?

MR. HAGGIE: At the moment, this is cost neutral. We're just simply moving bodies from one place to another.

MR. BRAZIL: One place to the other.

So there's no change in the program itself?

MR. HAGGIE: No.

MR. BRAZIL: Okay, fair enough, avoid costing.

Question here, you looked at last year and there were some discussions about the removing of the IQ70 threshold for access to programs. Where are we with that?

MR. HAGGIE: That is a part of a piece of work with CSSD and the disability community. I think everybody wants to do it; it's just simply a question of putting it into the context of a bigger picture for care and assistance for persons with disabilities.

The general philosophy has been around, again, individualized funding models and individualized care plans. There are pieces of that looking at funding, for example, for long-term and community care for persons with

disabilities, which we're in the process of working through which falls in the Deloitte area, which I've alluded to already, as well as the IQ70 – it's also an educational piece as well because of entitlements and possibilities within the K to 12 system.

MR. BRAZIL: What outside entities would be engaged in that discussion on how to implement this and make it policy?

MR. HAGGIE: At the moment, I think we're trying to get the inside entities sorted out and then each of those constituencies will come up with what outside entities they feel would be appropriate within their own sphere of expertise or influence.

MR. BRAZIL: Okay, fair enough.

Any particular time frame? Do you have a target date in your mind?

MR. HAGGIE: It's been one of those things where if you have 25 priorities, it's very hard to have a priority. This is something that Minister Dempster and I have discussed working on fairly closely over the course of the coming year.

MR. BRAZIL: Would it be an idea to try it in one region and then see how it unfolds, or is it all at once?

MR. HAGGIE: Again, it's a question of what model you come up with and it may well be that a phased rollout would be the way to go. The question would be whether it would be easier to roll out in a more densely populated area or one where the system is already near what we want, as it is currently.

So if we've got one area that has a slightly different emphasis – because there are differences between the RHAs in terms of the way they approach things. If we have one RHA that's nearly there already, we might as well roll it out there first and got less kinks to work out.

MR. BRAZIL: Makes sense, fair enough.

Can you give me an update on the diabetic registry, the diabetes?

MR. HAGGIE: The diabetic registry has had some challenges with getting, what I call – not trying to be mocking, but the geekery sorted out. We got the regulatory framework in place. It is there where – I gather there was some discussion about difficulties with entry and access. Was that right, John, or am I confusing that?

MR. ABBOTT: (Inaudible.)

MR. HAGGIE: No, okay.

The other piece was we're trying to use it in a way that makes sense to look at the Choosing Wisely element, how many people have had their HbA1c's done in the last three months and these kinds of things. We're still at the stage of trying to scope out its potential. There are some suggestions about how that can be done, but we've not got it to a place yet where we've actually, as far as I'm aware, been able to start to use it to its full potential.

MR. BRAZIL: How do we track now the money we spend on diabetes and the issues relevant to that, the health issues?

MR. HAGGIE: The expenditure we can track through the NLPDP for those people who have the appropriate cards and eligibility. For people who use private insurance, we have to rely on clinical audits, so you would go to the local clinical support systems like MEDITECH or when we get the EHR out there, it would allow us better access into the community piece.

The central locus is really the diabetic clinics, the diabetic educators in particular facilities or regions, and they are probably the single most reliable source of data.

MR. BRAZIL: Would the plan be, once the registry is up and running, you would be able to collect all the different components of the diabetes interventions?

MR. HAGGIE: Yes. What we would do then is compare it with the guidelines from the Canadian Diabetes Association, or Diabetes Canada, and see how we could get a lineup between what is current best practice and then an idea of how our population fits in there, to see where the gaps are and then work to fill them.

Some patients out there may be getting tested more frequently than they need. One of the things we found when we altered the diabetic test strips was that we had a significant education problem because people who were on diet alone were testing their sugars seven times a day and getting the strips to do it. That was unnecessary, painful and expensive.

That may turn out to be a challenge in terms of aligning caregivers and guidelines and patients' expectation guidelines and caregivers – it's getting everybody on the same page.

MR. BRAZIL: Fair enough (inaudible).

CHAIR: Thank you, Mr. Brazil.

Ms. Michael.

MS. MICHAEL: Thank you.

Just a couple of questions, again, tied with Operations. Where are things, Minister – is the department working on the provincial autism strategy that has been promised?

MR. HAGGIE: I think that is a question I really can't answer in the way that it could be. It really has fallen to other departments in some respects. We have our own approach to the pre-school children. We have invested significantly in JASPER, which is an acronym which I can never remember exactly what it stands for, but is generally regarded on evidence-base as the best way to go for children with that diagnosis.

Some of the community supports come through us. Some of the educational piece is obviously founded in the K-12 system, and then also there is the issue around how to tie all of those together. From the health point of view, we have really concentrated our efforts on the early end, the early intervention and early diagnosis and reducing wait-times for that.

We have had the plan and we're hoping that we will be able to unveil something later on this year.

MS. MICHAEL: Would what you're doing right now, would that be lodged both within the health care system in terms of the infrastructure as well as in the community?

MR. HAGGIE: To be perfectly honest, I think ideally I'd like to see this defused out through health into the community, but the big piece as well is how it integrates with the outcomes from the Premier's taskforce on educational outcomes, because the people that we're focusing on are on the younger end of the spectrum, currently, and we're trying to get that right so that they get the best opportunity at school and then they get better outcomes when they come out t'other end, as it were.

That's where we are with our approach.

MS. MICHAEL: Since you've mentioned the taskforce – I can't remember it off the top of my head now because I don't have that in front of me, but there are a number of places where the recommendations do talk about the Department of Health and Community Services engaging with the Department of Education and Early Childhood Development.

I know that things are being rolled out with the recommendations; but, at this point in time, have those doors been opened wider between the two departments?

MR. HAGGIE: We have one of the teams under the Mental Health *Towards Recovery* plan concerned with youth mental health and I can't, for the life of me, remember exactly what it's called. But in fact, the team lead actually comes from Education and Early Childhood Development, although the group is supported by the Mental Health division within Health.

One of the things we're moving to is kind of a one-stop shop for youth and children in the school system with health issues. So that rather than them trying to figure out whether it goes to a school counsellor or whether it should go to an RHA person, or whether it should go a school board individual, we're trying to get the idea of a one-stop shop.

I think mental health is the place we're starting with that because (a) it's a pressure point, and (b) we have the infrastructure there currently through these teams to address that better and then we can see how that works.

MS. MICHAEL: I'm trying to get a handle now on that structure. You have these teams and you

have maybe one person from your department on a team. What is the line of communication back from that person in terms of accountability to your department?

MR. HAGGIE: There should eight teams under the Mental Health *Towards Recovery*. The Indigenous team is one – we're still working with the First Nations to get a handle on how they would like to run that. We have seven other teams and one of them, for example, is service redesign.

In terms of the teams that are led by another department – in this case, Education – it still involves Health staff. So someone from the Mental Health directorate will go and the discussion will then feed straight back into the director of Mental Health, which then feeds straight to the deputy, and then it feeds straight back to myself.

From a health perspective, I couldn't speak in any detail to how that would work within Education because I'm not sure where in, if you like, the chain of command (inaudible) –

MS. MICHAEL: No, it's health I'm interested in.

MR. HAGGIE: That's our bit, so it's one step down from the director of Mental Health.

MS. MICHAEL: Okay.

Keeping with autism just one direct question, is there a move towards the elimination of the IQ70 assessment and replacing it with a functional based assessment?

MR. HAGGIE: The short answer is yes, and I think MHA Brazil referenced that a little bit earlier on and my answer was a little roundabout.

MS. MICHAEL: I hope we got the note on it and if we don't, I'll be back to you, how's that?

MR. HAGGIE: Fair enough.

MS. MICHAEL: Thank you.

Okay, now I'll come back to line 2.1.01, which is Drug Subsidization. Under Professional Services there was a very slight reduction last year from the budget line to the revised line, and this year the estimate is back up to the budget line of last year. So what was the under spend under Professional Services?

MR. HAGGIE: That's the Bell Aliant online system. There were fewer enhancements in the system than anticipated last year, so that's why it went down from what was budgeted. We've simply put it back to where it was on the basis that was just a temporary depression of cost.

MS. MICHAEL: Okay.

Would you explain what exactly that means, fewer enhancements?

MR. HAGGIE: The detail of that, I could not actually give you. We can find that out for you. It's software enhancements.

MS. MICHAEL: Okay. Thank you very much, that helps.

Under Allowances and Assistance, last year the budget – and these are payments directly to clients, I understand, so under the budget last year it was $142,824,700 and the revision was $5 million upward to $147 million. This year it's not quite as high as the revision last year, but it's over last year's budget. So if we could just have an explanation of what's happening there?

MR. HAGGIE: Okay.
The $5 million rise was utilization but it was basically around Methadone biologics, anti-depressants and cancer drugs. Those were the four groups that went up. The reason it's gone down is a netting effect because of changes through the pan-Canadian Pharmaceutical Alliance, which has yielded us some savings.

MS. MICHAEL: Well, that's good to hear. The usage was the main reason for the $5 million, not the rise in cost of the pharmaceuticals.

MR. HAGGIE: No. Well, I mean Methadone biologics are a significant pressure, as are cancer drugs and I think principally it was a numbers issue in terms of the volume.

MS. MICHAEL: Right, thank you.

Under Revenue – Provincial, last year $7 million was the budget and the revenue was under by $600,000. The revision was $6,400,000 and this year the estimate is $7,250,000. So an explanation of what that's about.

MR. HAGGIE: Well, the drop was due to lower billings because of better product listing agreements in place and some of them were finalized later, so it produced a drop. The other change is, again, revenue from the product listing agreements with pharmaceutical companies going in the opposite direction.

MS. MICHAEL: Right.

Minister, with regard to pharmaceuticals and the usages, is there a way – I'll see if I can get this out, see what's in my own mind – of doing analysis to show a connection between the diseases that are being treated and the cost of money that's going into pharmaceuticals related to a particular disease?

MR. HAGGIE: It's actually easier to track the use of specific drugs in terms of their changes year over year by class.

MS. MICHAEL: Okay.

MR. HAGGIE: So biologic agents tend to be disease modifiers and they would fall under one of two or three categories, but it's not quite as easy to tie the disease to the drug to the cost. It's easier to try the drugs and classes which give you a broader picture. You lose a little bit of detail, but you gain a bigger appreciation of where your cost drivers are.

MS. MICHAEL: Right.

And you named the four classes that caused the rise?

MR. HAGGIE: Yes.

MS. MICHAEL: Okay, thank you.

CHAIR: Thank you, Mr. Michael.

With leave from the Committee, I'd just like to bring in MHA Lane.

MHA Lane.

MR. LANE: Thank you, Mr. Chair.

Thank you to my colleagues for the leave. Minister, I have general questions. I'm not going to get into line to line; I'm going to let my colleagues continue on with that.

My first question relates to the persons who have been prescribed opioids and their inability to get a family physician. I've come across a number of people in that category where even though a physician might have had openings to take new patients, they ask the question have you ever taken opioids, or are you on a prescription. If the answer is yes, then I'm sorry, we're not going to take you.

I know Dr. Bruce – I think it's Bruce Hollett. Dr. Hollett anyway, I'll call him, at the Waterford –

MR. HAGGIE: It is Bruce, yes.

MR. LANE: – has a program. I've spoken to him and it seems like he is doing some good work there, but I am just wondering about an update as to what the plan is or what's being done to address this issue of persons who have a prescription for opioids obtaining family physicians to prescribe what they need and to deal with their addiction, if they have one.

MR. HAGGIE: The challenge, quite simply, is that there are 1,200 physicians or prescribers in the province who are able to write opioid prescriptions, but we have 22 who are prepared to prescribe opioid dependence treatment, if that's the particular action there.

If you're looking at people who are taking opioids and need to continue them for therapeutic purposes, then I think you're into the realms of professional practice and cherry-picking issue, and the discussion, that question, would be better asked of maybe the College of Physicians and Surgeons of the NLMA as to how they would like to approach that.

We've got a plan to try and have a hub-and-spoke system. We're looking to encourage physicians to take on opioid dependence treatment as part of their normal primary care activities, and we're trying to support them in doing this.

The federal government have announced that they will remove the requirement for an exemption for the prescription for methadone in the not-too-distant future. We are looking at what provincial regulations are in place that was put in when we brought in Suboxone on open access to make sure that we haven't inadvertently got any barriers there, so there are no process issues.

The challenge then is to try and create a degree of clinical interest amongst physicians. We now have, however, the first nurse practitioner in the province who has completed the Suboxone training program that the ARNNL have put in place. There is one closely behind her and there are another five going through that program. Now the ARNNL, their members, as nurse practitioners, have the authority to prescribe opioids and opioid dependence treatment. That's going to help enlarge the pool of prescribers.

The final piece is that most people start on therapeutic opioids for pain and our other strategy, which is in the works, is a pain management – chronic pain – system for the province. We are looking at bringing in someone to provide a little bit of a jurisdictional scan and some expert advice. We have a couple of pockets of pain management and we, in actual fact, had some proposals to increase funding to those, quite frankly. But it didn't make sense to do it without a framework in which to do it because we need a province-wide system.

In the back of my mind I was thinking that if you have a hub-and-spoke method of prescribing for – or managing – opioid dependence, where you have front-line prescribers who can then call in and consult with a more knowledgeable prescriber with more experience who, in turn, would then happen to be a provincial resource, you could do the same thing for pain management.

That's just my view from 30,000 feet and we are going to get some expertise in over the course of the summer to tell us whether that's right and, if not, what to do instead.

MR. LANE: Thank you, Minister.

Just to clarify in my mind – you said a mouthful; I appreciate that. Just to get it down to the bare bones, so I am perfectly clear, what you're saying is that currently – and I assume Newfoundland would be no different than any other province – if every doctor in the province decided I'm not going to prescribe opioids, I'm not going to take patients who use opioids, then the people who are on opioids now, who were prescribed them by a doctor, they would have nowhere to go? I know it's an extreme example, but I'm trying to make it so I understand.

MR. HAGGIE: It is an extreme example, but you're quite right. I cannot force a care provider currently to prescribe, or work – particularly if they turn around and say this is outside my area of expertise. Even though they may be fully trained primary care practitioners. There is no leave I have as minister to make them do that.

MR. LANE: And would that be the same in every province? Would it be in the same boat or …?

MR. HAGGIE: I would defer to the wisdom of the staff, but I think the answer to that is yes.

MR. LANE: Okay.

MR. HAGGIE: There are no levers. There is no compulsion.

MR. LANE: Okay. Well, it is a serious issue. I'm sure you've heard it and I've heard it from a number of people and, like I said, I've had discussions with Dr. Hollett and I know it's a problem.

MR. HAGGIE: I don't think my email in-basket is any different than yours actually (inaudible).

MR. LANE: Yeah. All right, I appreciate that.

Minister, I'm just wondering the whole concept of people cancelling appointments and specialist appointments and stuff like that and the cost that would have to the system. Do you have any stats on – any idea how much of that is happening, what it's costing us and any potential thoughts on remedies so that wouldn't be happening, particularly when we're talking specialists?

MR. HAGGIE: No, all I can do is really speak to my own experiences from pre-politics days

and, in actual fact, since, because I've seen it from a different angle. There are strategies you can use to reduce what are called no-show rates. There are several and they're proven and, in actual fact, we have from a departmental and a RHA level put some of those practices into place.

For example, as an automated phone reminder system for endoscopy appointments, that can ultimately, I hope, take the form of text rather than simple automated voice calls reminding people, sending them letters that say should you not confirm, then by so-and-so ring in this number. If you don't confirm, then we'll hand your appointment off to somebody else. Those kinds of strategies work.

There is never a zero no-show rate. Well, there's rarely one but the best, if you look at it averaged out over a six- to 12-month period, is around 3 per cent. I think that would be an aspirational goal for some and for others – the endoscopy unit I left, for example, was down at that level back in 2015.

MR. LANE: Minister, when you say that these are strategies that can be used, for example, phoning saying if you don't confirm that you'll be here then we're going to give your appointment to someone else, was an example you used – is that strategy being employed across all specialists now?

MR. HAGGIE: Well, I mean I think one of the challenges we have is that a significant number of specialist consultations are actually done through private offices, so I have no insight into how they may choose to do that because they're run as private businesses and that is what it is.

I would have thought, from a business perspective, they have far more to gain from reducing their no-show rates than they do by not doing something about it. How a private business chooses to do that is up to them. I know the telephone and the messaging system has been put in place, and I know some of the RHAs have used the approach that if we do not get a confirmation back from you, your appointment will be offered to somebody else. Now, whether or not that's still in place, because that latter is my own personal experience, I would defer to staff.

MR. LANE: Okay, thank you, Minister.

I'm running out of time quickly so I'm going to ask one final question for now. I'm just wondering if you can comment on emergencies and, in particular, I'm thinking of – St. Clare's comes to mind certainly. We've all heard stories, whether we've gotten emails or listen to *Open Line* or whatever the case might be – and there has been a lot of, I'll say, negative experiences.

I know there are good experiences as well. Primarily for people who, perhaps, are not in an emergency situation. I understand there's a triage and so on, but is there a thought or any way that could be looked into – I'm going to call it a navigator, for lack of better terminology, that if people go in and staff know you're going to be waiting for eight hours, and someone says you realize you could be here for eight hours, or even someone who – like I had a person who was a lady, she was a senior citizen and she was a cancer patient.

She thought she broke her ankle. She went for an X-ray. She had the X-ray within 15 or 20 minutes, she was sent up, and then she proceeded to wait eight to 10 hours in the emergency to get the results of that X-ray. I understand there is triage. It would seem to me if they got an X-ray and it turned out it was sprained in the end – she left on her own because she couldn't wait any longer; she was getting sick. Somebody could have easily, you would think, be able to say it's not broken; you can go home and see a doctor on Monday and saved her an eight- or 10-hour wait.

But someone to navigate people in emergency or whatever, so that they're not waiting as long or maybe they're told that there's no point in waiting, you could be here all night or whatever, I don't know – I'm just wondering what's being done in emergency, if anything.

MR. HAGGIE: I think it's difficult to pick specific examples because you really rapidly go down into the weeds and it's very difficult to generalize and make a system out of it. The facts of the case are that well north of 65, even 70 per cent of people who attend the emergency department are categorized as Canadian triage Levels 3, 4 and 5.

Four and 5 are essentially those that are regarded as minor; they could be easily managed by a walk-in clinic. The challenge is that walk-in clinics are still not quite as common as I would think that they would be from a demand perspective. The vast bulk of patients, particularly in areas with good levels of employment, actually attend their doctors after 5 o'clock, not between 9 and 5.

One of the strategies from a system's point of view, which is really the best vantage point I have currently, is to try and provide options for them, whether it's self-managed through 811 – and we've had some considerable success with 811. A significant proportion of those people ringing 811 who intended to go to the emergency department are diverted and that's well over 50 per cent, probably even over 60 per cent from my last recollection of those figures.

So that's one strategy. The idea of triage is okay but I mean if you have an ailment and still require treatment, if you can't walk on your ankle because it's sprained, you still have a problem, whether it's broken or not; it's just you need a different kind of treatment. The challenge there is to try and find capacity to deal with those lesser injuries without – because emergency departments traditionally are disease focused, disease-centric and acutely ill; that's what they're there for. That's what they work best at and, indeed, that's what the clinical interest of a lot of the clinicians in that area went into that area to do.

How do you reduce the need for patients to go there? You offer them options: walk-in clinics, phone line clinics, 811, that kind of thing, I think, are really good places to start. It's getting people to use them and there is a degree of expectation management that needs to take place.

Again, this question always comes up with this process and this process always takes place usually in the middle or the end of flu season where the emergency departments in this province are traditionally under some considerable strain because of surge. We've had what is the worst flu season in five years with basically an issue with one component of the vaccine, quite frankly.

CHAIR: Thank you, Mr. Lane. Thank you, Minister.

Mr. Brazil.

MR. BRAZIL: Thank you, Sir.

You got me intrigued with the nurse practitioners training around the Suboxone intervention or support program.

Hypothetically, I've spoken in the House about some of the challenges that I have in my own district and if you have a community that has a very active hospital and you've got more than the norm average of opioid dependency, how would I go about or that particular health institution being able to get a nurse practitioner to be able to offer Suboxone support treatments or interventions in a community like Bell Island?

MR. HAGGIE: There are a couple of routes. One is through the RHA because they are nominally and, de facto, the administrators/managers of the facility if that is actually the case, unless it's a private clinic you're talking about. The other is you can write – because Mental Health and Addictions is now a provincial program, even though it's administered, in a sense, by each RHA. Its direction, policy and coordination is driven through the department itself, so you can write to the director of Mental Health and Addictions services in the department, Ms. Colleen Simms.

MR. BRAZIL: And make a request that it be reviewed, looked into, see what –

MR. HAGGIE: State your case, make your case. And if you have some numbers, or you can put them in contact with people who can provide that data, then certainly – data is what will make the decision easier, shall we say.

MR. BRAZIL: The nurse practitioner, is that individual offering it in a clinic, or in a particular hospital? Are there any restrictions on it? I know the training is only happening now.

MR. HAGGIE: Well, the requirements for nurse practitioner are actually fairly liberal. They need the appropriate training and qualification and, in the case of Suboxone, they need the extra course. But they also have to

practice with a therapeutic clinical liaison with a physician. There may be the rub, in a sense, if they want to do addictions work, they're going to need somebody to whom they can refer. And the comments from MHA Lane are that not all primary care practitioners are comfortable doing addictions work. That may be the practical rub there.

We only have the one and I'm not honestly quite sure where she went to work. I have the sneaky feeling it was in Central somewhere. Was it Hope Valley? I can't remember. I did meet her at an event and I can't for the life remember – she is from Central, so it may well be she's gone back up that way.

MR. BRAZIL: Is there any way – I don't know because of privacy – being able to track down that individual? I would like to have a conversation because of the challenge that we have.

MR. HAGGIE: I would suggest you contact the executive director of the ARNNL and she might facilitate a connection. She's the first, but she won't be the only one.

MR. BRAZIL: Fair enough.

And the time frames for doing that, the length of this course, what are we talking?

MR. HAGGIE: I can't honestly remember. It's months, not years.

MR. BRAZIL: Okay, perfect.

I want to go down to some of the drug programs there. How many drugs have been added to the provincial drug formulary this past year? Any addition – what new ones? Not the particular ones but how many of them?

MR. HAGGIE: I couldn't easily give you a number. I could give you a cost of the new cancer drugs and the new non-cancer drugs that we've put in. But if you want actually the number of new medications in total, there are eight in the new drug therapies that we have funded out of an increase. Whatever else is in there, I would actually have to check with our director of Pharmaceutical Services, because there may be some very low cost items for which we didn't really need new money.

MR. BRAZIL: But you do have the number there on what the additional cost –?

MR. HAGGIE: Yeah, the eight new ones net out at $6 million extra.

MR. BRAZIL: Any drugs removed from the program?

MR. HAGGIE: I wouldn't know what drugs would come off the formulary. I can find that out for you too. I would imagine that, by and large, by the time they get to being removed off the formulary they're not a fiscal problem.

MR. BRAZIL: They're not the ones being used?

MR. HAGGIE: They're low-ticket items.

MR. BRAZIL: Yeah, fair enough.

MR. HAGGIE: They go down the cost chain very rapidly, or the cost ladder.

MR. BRAZIL: I just want to get my head around – and I know you've talked earlier about the centres of excellence and these types of things, and I know there was some discussion with Dr. French on the West Coast.

Can you just fill me in if that's gotten any further or the general concept? It doesn't have to specifically be Dr. French's proposal. But the concept of particular areas where physicians, who have a specialty in a certain area, can provide a service that through their proposal would appear to be more financially viable and provide the service in a more equitable manner.

MR. HAGGIE: I think the jury is still out on that from a fiscal point of view and a needs-demand point of view. The one centre of excellence I would point to, which very much flies under the radar, is Botwood. It has a protective care unit; it has interested family physicians who actually are the only place in the province that train for an extra year for family medicine residents to gain skills in looking after patients with neurocognitive disorders.

Building on that, we've committed to put another 20 beds on to the Hugh Twomey centre to double the capacity of that. Because our pressure point in Central, whilst it is for long-term care, is actually more acutely for long-term protective care units. That's a perfect example of how you can find something almost serendipitously.

The other – and it's not really regarded as a centre of excellence, but I think it's a misnomer or a mischaracterization – are the primary health care teams. And we'll roll those out over the course of this here. I mean, if you want to be impressed with high-quality, excellent primary care, go to the downtown collaborative. They are excellent at what they do; they really are. I think one of the challenges the medical profession has had, is that it has never given primary care the recognition it deserved.

We have proposals – and some of them are very, very near delivery – for primary health care centres. Again, not necessarily in big urban areas, but certainly in places like Burin. There is one proposed for Corner Brook. Both of those are relatively well advanced and I would except certainly one of those could be announced in the not-too-distant future. We have looked at Botwood. There are other places as well. We have a plan in the department under the primary health care action plan, the Family Practice Renewal Program, to roll these out, as time and opportunity presents itself.

MR. BRAZIL: So are there different hybrids here – are the ones that would be in Dr. Hugh Twomey facility, and would there be ones that could be driven and owned and operated by the private sector process?

MR. HAGGIE: I mean, it's an interesting comment, and the word "private" is always loaded; but if you look at it, the vast majority of physicians in this service are private businesses.

MR. BRAZIL: Private anyways, yes.

MR. HAGGIE: They are stand alone. There's quite a discussion, for example, about the cardiology and having a cardiac centre of excellence here. That's something that we've said we would be interested in. It is, however, at the moment, kind of on the backburner until we've sorted out some of the issues that were highlighted in the CIHI report around cardiac care.

I think the answer is that we'll look at anything that will reasonably improve outcomes, but it has to be driven by data. It's either got to be driven because you're getting better value for your dollar or, alternatively, because your outcomes are vastly superior by doing it that way. I think one of the things I've discovered over the last three years is that we collect a lot of information, but it's trying to synthesize that in a way that makes it into usable data, and it's not always quite as easy as it sounds.

MR. BRAZIL: Okay, so we're open for business to look at alternatives and partnerships that provide the best quality of service.

MR. HAGGIE: I'm open to anything that can be demonstrated to make sense in terms of improving outcomes.

MR. BRAZIL: And you mention that there are a number in the works, and some that are very close?

MR. HAGGIE: Well, the primary health care teams are what I was talking about from very much a clinical point of view. We've talked about those and, indeed, the Medical Association have been keen on the concept. The implementation of those is very nigh ready for some.

MR. BRAZIL: Would that be across the province or here –?

MR. HAGGIE: Anywhere where there are a critical mass and an interest. You can't have a primary health care team unless you have a team, basically. And in Corner Brook, for example, one of the challenges at the beginning was to identify what those needs were. The downtown collaborative identified its main needs around mental health and addictions and those kinds of things, so that was how it was built up.

It may not be that that kind of composition is needed in Corner Brook. They may have more important challenges with chronic disease and

maybe diabetes, for example. So you would structure their team differently.

MR. BRAZIL: And the regional health authority would make those decisions, or make that proposal?

MR. HAGGIE: The needs assessment comes through the regional health authority.

MR. BRAZIL: The health authority, yeah.

MR. HAGGIE: It then gets fed into a mechanism between ourselves and the primary care action plan. I can't remember what it's called now. What's that group that Cameron holds?

OFFICIAL: It would be the regional Advisory Committee.

MR. BRAZIL: Okay.

So just one quickly – the decision-making process would go through there. Who or what group would finally make the decision that we're going to pilot this, or this is what we are going to implement?

MR. HAGGIE: It's a joint decision between the regional Advisory Committee and the Department of Health. Because, obviously, we need to remove resources around to make it work, and there may be funding implications – well, there will be funding implications; the question is whether it nets out or whether we need new money.

MR. BRAZIL: Exactly.

Thank you.

CHAIR: Thank you, Mr. Brazil.

Ms. Michael.

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

Minister, a couple of general – well, specific questions, rather than line items. Does your binder include and, if not, could we have the amount of the expenditures and the number of clients in each of the drug plans?

MR. HAGGIE: I don't think it includes it, but we could find that –

OFFICIAL: Yeah, it's in there.

MR. HAGGIE: Is it? It's there. It's in one of the annexes.

MS. MICHAEL: Great. Okay, thank you very much –

MR. HAGGIE: I must have skimmed over it – my apologies.

MS. MICHAEL: We look forward to seeing that; that's okay.

MR. HAGGIE: But there's no difficulty to find it for you.

MS. MICHAEL: Right, thank you.

With regard to the Smoking Cessation Program, are numbers going up, going down? How many clients do we have in that?

MR. HAGGIE: There is an increase in the budget for the Smoking Cessation Program, because we have, actually – what was it? We did make a change to that.

OFFICIAL: We did an evaluation (inaudible).

MR. HAGGIE: Yeah, we did an evaluation of it, because there was a talk about exactly what form of nicotine replacement therapies should be available, and we had planned to enhance the scope of those.

MS. MICHAEL: Right, so the budget has gone up?

MR. HAGGIE: Ten thousand dollars.

MS. MICHAEL: Okay, thank you very much.

Do you have the numbers of how many clients are in the program?

MR. HAGGIE: No, but we can get them for you.

MS. MICHAEL: Okay, thank you.

I'm going to move on now to 2.2.01. Well, this is very simple because this is the Physicians' Services, but just a brief explanation of figures. The budget last year, '17-'18, was $367,487,500 and it went up by $5 million in the revision up to – I won't do the math, not necessary, but it went up by $5 million.

Then the estimate for this year is $360,000 under what was budgeted last year. So could we have an explanation of what's happening there, especially the spike in '17-'18?

MR. HAGGIE: That was retroactive payments for physicians after the signing of the MOU. The MOU runs from October 2015 to September 30, 2017.

MS. MICHAEL: Of course, right. Thank you very much.

The $360,000 less for this year in comparison to last year's budget …?

MR. HAGGIE: That was a transfer to the vaccine budget.

MS. MICHAEL: Okay, thank you very much.

Under Allowances and Assistance – which is out-of-province billing I think – we have an increase of $500,000 this year over last year's budget. What is that based on?

MR. HAGGIE: Mainly cost of service increase outside and allowance for increased utilization.

MS. MICHAEL: Because there was no change last year between the budget and the revision, so what are the indicators to you that that's needed?

MR. HAGGIE: Because it's the cost from the MOUs in other provinces, as the fee codes in other provinces elevate.

MS. MICHAEL: There has been a change in some of those codes.

MR. HAGGIE: Yeah, it costs more to get what we got already.

MS. MICHAEL: Okay, thank you very much.

Under Grants and Subsidies last year the budget line and the revision – there's no revision; they're the same. This year it's $6,521,400 less than last year's figure. That seems a lot.

MR. HAGGIE: Yes, it's a combination of three things. We have developed a hiring process for new salaried physicians and currently that has reduced the number of salaried physicians. We've actually looked at reducing the locum budget by encouraging people not to all go on holiday at the same time and specifying that there will be some criteria around locums. You're not going to get one for one day but if you're going away for three days and there's no cover, then we'll provide them, and saved us $1.8 million.

The other piece was there were some salaried physicians who were getting inadvertently two sets of benefits.

MS. MICHAEL: Oh really?

MR. HAGGIE: Yes. So that's 1.7 million.

MS. MICHAEL: May I ask how that happened?

MR. HAGGIE: That was because they were getting benefits from their salary through the university and they were getting benefits from their salary through the RHA.

MS. MICHAEL: Oh yes, I heard about that, now that you say it that way, we did.

MR. HAGGIE: So we corrected that.

MS. MICHAEL: Right, thank you.

Are all locums paid under the Grants and Subsidies?

MR. HAGGIE: Yes.

MS. MICHAEL: They are, okay.

MR. HAGGIE: If they're salaried – some physicians in private practice will arrange their own locum and pay them out of their own billing.

MS. MICHAEL: Okay, that's what I was trying to get at.

MR. HAGGIE: That comes out of the fee-for-service pot. We wouldn't necessarily have insights into that, unless the physician came to an arrangement with MCP to pay the locum directly rather than himself.

MS. MICHAEL: Okay, you were talking about locums for salaried –

MR. HAGGIE: But this is for salaried physicians. But there will be some locums for fee-for-service physicians in there where, for example, there's a salaried physician and a fee-for-service physician and the fee-for-service physician goes on vacation, then you would get a salaried physician to replace them – or a salaried locum to replace them.

MS. MICHAEL: Right.

And does your binder include – if not, could we have a breakdown of the numbers of fee-for-service and salaried in each RHA?

MR. HAGGIE: It's included in the page I am looking at now. And yes, by all means.

MS. MICHAEL: Great, thank you. We'll find it.

MR. HAGGIE: It is a snapshot and it's dated. It was right on that day. And the date is on it.

MS. MICHAEL: Right, okay. Great, thank you very much.

I have a couple of more questions related to that. Could we have – and maybe it's in the binder – the number of family physicians and of specialists?

MR. HAGGIE: Yes, you can; it is listed. We have 595 specialists on the day in count and 619 specialists – so 595 general practitioners; 619 specialists. And, in addition to that, we probably have somewhere of the order of 158 nurse practitioners, predominantly practicing in primary care.

MS. MICHAEL: Okay, the number is really going up.

MR. HAGGIE: But not exclusively.

MS. MICHAEL: Good.

MR. HAGGIE: If you add primary care providers together, it actually comes up to more than specialists, which is really what a lot of jurisdictions would suggest you should have.

MS. MICHAEL: Right, okay. Thank you very much.

I'm going to move on to Dental Services, 2.2.02. Last year between the budget and the revision, we have a revision upwards of $1.9 million. And then this year we seem to be more in the ballpark of – well, it's slightly less, $400,000 less. But what's happening along that line? Obviously there seems to be more money going in to dentists.

MR. HAGGIE: It's principally the children's dental program. There's been significant cost pressure there and the changes you see are a netting effect of that. There was a $400,000 deficit which we considered to be one time. There was $1.9 million that drove the budget and we put in an extra $1.5 million.

MS. MICHAEL: What drove the $1.9 million increase?

MR. HAGGIE: Principally, outreach pediatric clinics and extractions. There's a lot of surfacing, coating of pediatric teeth being done – an awful lot compared with previous years, and it's gone up year over year. In addition to that, there's been an increase in the number of extractions which are insured services – covered by the program, rather.

MS. MICHAEL: Covered by the program, right.

With regard to the Allowances and Assistance which is reimbursements to individuals, the budget has come down from $700,000 last year to $200,000 this year. That's quite a decrease.

MR. HAGGIE: That's due to a change in opting-in and opting-out payments. We have more people opted in and less opted out, so that the $500,000 off the bottom is gone to the top to Professional Services.

MS. MICHAEL: Oh, I see. Okay.

MR. HAGGIE: Because under Allowances and Assistance, we pay the patient reimbursement.

MS. MICHAEL: Right.

MR. HAGGIE: Then more have opted in, so we pay the dentist instead of the patient, so it appears under all the Professional Services.

MS. MICHAEL: You meant more dentists have opted in.

MR. HAGGIE: Yes.

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

MR. HAGGIE: The money hasn't left the pot; it's just been moved from one line to another.

MS. MICHAEL: Okay, that explains it.

Again, I'm assuming in your binder we'll probably find the number of clients in the Adult Dental Program and in the children's dental program.

MR. HAGGIE: No, but we can get them for you.

MS. MICHAEL: Okay, thank you very much.

CHAIR: Thank you, Ms. Michael.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

(Inaudible) the first one on the line, under the 2.3.01, Memorial University Faculty of Medicine, the line under Grants and Subsidies was cut by $1.7 million. Can you explain how we'll save and how the faculty will be impacted?

MR. HAGGIE: The first bit was the downward change. Is that what you're referring to? I'm sorry, I missed the beginning of your question.

MR. BRAZIL: 2.3.01, Memorial University, Grants and Subsidies, they're downward.

MR. HAGGIE: Yeah, that is right. It was $56,595,000 budgeted and revised and it's now down to $54,858 million – that's the question. The reduction there is twofold. There is an end to a five-year commitment for the TPMI, genetic research, that was $1 million, and the annualized Faculty of Medicine reduction plan takes out another $735,700. So that would be made up of things like elimination of rental space, increase use of teleconferencing, reduction in charges for offsite storage, VoIP for phones, reduction in office supplies and equipment, reduce professional development and reorganization of the Office of Professional Development, and the elimination of two positions through attrition over six years.

MR. BRAZIL: Okay.

The $1 million that was cut out of the genetics research, was there a rationale? Was there an assessment? Did it reach its end?

MR. HAGGIE: It was a five-year program that ended. It was a five-year block of funding that was ended while – that was the agreement that was set out.

MR. BRAZIL: There's no lobbying to continue it. There wasn't another proposal to go for another lot?

MR. HAGGIE: No.

MR. BRAZIL: Okay, fair enough. I was just curious to see what it was, perfect.

Talk a little bit more about that, also – how many graduates last year versus the previous year in medical school?

MR. HAGGIE: It was the same; I think it was 80 for both years, isn't it?

OFFICIAL: Each class.

MR. HAGGIE: Yeah, each class is 80. The size was increased – or the intake was increased in around 2014, and it's been static since.

MR. BRAZIL: Okay, so it's status quo through the process?

MR. HAGGIE: Yeah.

MR. BRAZIL: Okay, fair enough.

Talk a little bit about the Adult Dental Program – any analysis done with regard to increasing ER visits, due to the cuts to the Dental Program?

MR. HAGGIE: ER visits?

MR. BRAZIL: Yes.

MR. HAGGIE: We haven't looked at any data from ER.

MR. BRAZIL: That would be relevant to issues around things that would've been covered under the Dental Program.

MR. HAGGIE: I mean, that's one way of looking at consequences and side effects of changes (inaudible) if there has been any change in ER visits.

MR. BRAZIL: Are there any anticipated changes in the program this year?

MR. HAGGIE: No.

MR. BRAZIL: Status quo, as is.

MR. HAGGIE: Yes.

MR. BRAZIL: Have you had a lot of complaints or inquiries from regional health authorities or GPs, or social workers or the general public?

MR. HAGGIE: I haven't seen any. The commonest comment – and it's probably only two in the last year – has been dentures that were misplaced in an RHA. I would say that's probably the commonest. As I say, I've only had two of those now. If staff have dealt with them and not passed them up, I'm not aware of any more, no.

MR. BRAZIL: I've had a few from a consistency point of view, and particularly one that you had intervened with, from a mental health point of view and from a logistics point of view of their physical health, not being about to eat properly and this type of thing that there had to be some interventions. It was fairly costly. I do realize there's a cost associated with it.

Has there been any thought given to going back and looking at are there particular specialty programs that could be put in play, that instead of having to go through the whole encompassing thing of engaging five or six different senior bureaucrats or specialists and these type of things – I had one psychiatrist who had to get involved for us to be able to get the intervening supports necessary.

MR. HAGGIE: I think one of the challenges is there isn't awareness about the dental appeals committee and that kind of mechanism for those situations, and maybe that's something that could be publicized more. We've certainly been in discussion with the Dental Association. We have not received any specific recommendations that I can recall that would change the Adult Dental Program in any major way.

MR. BRAZIL: I've had some inquiries from the Denturist Association about could we lobby, is there a way of – and I do know there was an extreme, seven, eight years ago when there was an extra $20 million basically put in the program. I agree that it wasn't necessarily put there – the uptake was so dramatic at the time that's what it ended up having to be budgeted for, as part of it.

But we did see for the out-years a real improvement, so I've been told, from a health point of view, from an ER point of view that would have been the comparables. That's why I say that there may be a small trend in the people who are going there because, at the end of the day, the impact that it has. I'd be curious to see if there's a way of tracking any of that data like you'd mentioned at the beginning.

MR. HAGGIE: It is certainly something we could look at. We haven't specifically put that in place at the moment.

MR. BRAZIL: Is there any other type of special programs from a dental service that we don't do here in Newfoundland and Labrador because it's not the trend that could be addressed?

MR. HAGGIE: Not specifically, I mean we did have some challenges a few years ago, maybe 2016, with the maxillofacial program but that's sorted itself out and we haven't had any concerns brought up from that direction.

I think, realistically speaking, there will always be a small percentage of cases that are so uncommon that they need to go to a bigger centre, a super-regional centre, if you like. I mean that happens – the classic example I give is always pediatric cardiac surgery where we just simply don't have the volume –

MR. BRAZIL: Don't have the expertise.

MR. HAGGIE: – even for the most basic of routine – if open-heart surgery can ever be called routine – pediatric cases, and I think there's always going to be complex maxillofacial work that really has to be done in a craniofacial unit, and Toronto is the place for us to send them.

MR. BRAZIL: Fair enough.

Are you seeing any trends of having issues around attracting dentists to some of the rural areas or the more suburban areas?

MR. HAGGIE: We have had changes in the way dental services are run, but in actual fact, when Labrador-Grenfell had challenges with their salaried dental program the private dental groups were quite happy to come in and take up that. And I believe there's quite a satisfactory, well-received arrangement now back on the Northern Peninsula. Certainly the remaining salaried dentists that we do have both practise in southeast Labrador. I'm not aware of any service delivery challenges, other than from geography, that are causing any issues there that I'm aware of. The dental world actually – touch wood – seemed to be fairly quiet this last year.

MR. BRAZIL: The medical transportation, is that accessible for dental transportation also?

MR. HAGGIE: It's medically necessary. There is a grey area there. If the services aren't present in a community – I would have to go back and check what the criteria are, but I do know that people have gone out for dental work and had it covered. I don't know what level of criteria is there. I think if the service is not available locally, then that's the trigger for Medical Transportation Assistance Program – which is the reimbursement program.

MR. BRAZIL: Yes.

There are some challenges – again, I go back to the part of my district that is the remote, isolated – Bell Island – which doesn't have dental services, as such. And people are trying to access the transportation to get the services here. It may not seem as encompassing, but it is if it's a financial burden for somebody to get. It may be nowhere near what it would be to come in out of Labrador or the Northern Peninsula but it does have – and there are a few nuances there where we're going to try to challenge it to see if it can work. And I wasn't sure if it does fit under that. The local GP says (inaudible).

MR. HAGGIE: That would be regarded, I think, as local because of the proximity to the city, unfortunately for your residents.

MR. BRAZIL: No appeals process for that?

MR. HAGGIE: I'm not aware that we've had any that have appealed successfully.

MR. BRAZIL: We'll have one next week. That will be the test case to see the rationale. It does go through – the GP has looked at it; it's very severe, at a senior citizens' level, the financial ability – you would have to come, stay overnight, things like this that would be part and parcel of the expense. And I'm just curious to see – before I start lobbying for people before I know them, rather than waste my time, their time and your time if we could look at something immediately.

MR. HAGGIE: It might be worth checking with the dental consultant before. I think a preliminary discussion would give you a discussion about the (inaudible) possible. Because there is a surgical dental program, rather than simply an ordinary dental program, and it might be worth having a chat with Dr. Williams about that, from the department.

MR. BRAZIL: And if it falls there it might be covered, as such?

MR. HAGGIE: I'm sorry?

MR. BRAZIL: If it falls under that category?

MR. HAGGIE: He would be able to tell you the answer to that question with confidence.

MR. BRAZIL: Perfect, thank you, Mr. Chair.

CHAIR: Thank you, Mr. Brazil.

Before I pass it to Ms. Michael, is there a desire for the Committee or the department to have a washroom break?

MR. HAGGIE: I'm good.

CHAIR: We only have one person down at the Broadcast Centre tonight, so let's take five to seven minutes or so and we'll reconvene at maybe 7:45.

Recess

CHAIR: Okay, thank you all again.

We will turn the floor over to Ms. Michael.

MS. MICHAEL: Thank you, Mr. Chair.

Just to get my thoughts together here now. Looking at 3.1.01, Regional Health Authorities and Related Services, some line item questions first – Minister, the Supplies, I think that's the immunization program is going up by $360,000 for '18-'19 over what was expended last year. What's the basis for that decision?

MR. HAGGIE: Our gender-neutral HPV program.

MS. MICHAEL: I'm sorry, I've got to put this on. Go ahead.

MR. HAGGIE: Gender-neutral HPV. It was basically the boys getting the HPV vaccine.

MS. MICHAEL: Right, okay. Great, thank you very much.

Then under Purchased Services we also have an increase, but first of all the revision from the budget last year was upward by $672,000 and this year the estimate is $322,300 more than last year's budget. So could we have an explanation of that as well?

MR. HAGGIE: There's a built-in increase to the HealthLine contract (inaudible) which is just over $65,000 of that, and then we re-profiled some funds to the air ambulance budget because of increased utilization of contract aircraft. That's at just over $256,000.

MS. MICHAEL: Okay. So it's basically those two expenditures. Great, thank you very much.

Under Allowances and Assistance last year it was $13,530,600 and the revision was quite a lot lower, it was $1,260,200 and this year it's back up to what was estimated last year. What happened last year that there was such a decrease, $1.2 million?

MR. HAGGIE: It's a one-time savings from workforce planning bursaries due to funding remaining from 2016-17 which hadn't been spent which we used in '17-'18.

MS. MICHAEL: Okay.

And then under these Allowances and Assistance, I understand you have MTAP and the bursaries.

MR. HAGGIE: Yes.

MS. MICHAEL: Okay, very good. Thank you.

Then the Grants and Subsidies, which is basically the RHA operating grants, there is a decrease – well, first of all there was a decrease last year in the revision from the budget and then this year there's a decrease from the estimate from last year's budget.

First of all, why such a decrease? Last year in the revision it was over $23 million.

MR. HAGGIE: The revision savings were due to three things. Some of the mental health programs and primary health care programs were funded but didn't get used; they'd been delayed. The cancer care strategy, the colorectal cancer screening program, the implementation of that was pushed back, so money wasn't spent. The minimum wage increase for home support agencies and personal care homes wasn't required because we'd gone to contracts instead for those, so the payments weren't required. So that was the loss of about $23 million from that.

MS. MICHAEL: Since you mentioned the contracts for a lot of the home care services, is

there information on what number or what percentage of companies is now unionized?

MR. HAGGIE: I don't have at hand. Mike, can we find it?

OFFICIAL: (Inaudible.)

MR. HAGGIE: We can find it.

MS. MICHAEL: I'd be interested in that, yes. Mr. Abbott might know.

Okay, we look forward to getting that information.

MR. HAGGIE: You might have to go around to companies and ask them; that might be the only way of finding it.

MS. MICHAEL: Well, it might be, but you might have some information there.

Okay, so that was the drop there. This year it's $2.1 million lower than last year's budget, the estimate this year.

MR. HAGGIE: It's a netting effect. We've got addition of Health Canada agreement money going in, offset by transfer of Transition House funding to NLHC.

MS. MICHAEL: Oh yes, I see the addition of the money going in.

MR. HAGGIE: And transfer of repairs and renovations to the capital.

MS. MICHAEL: Okay, thank you.

So this is one place where we have a big piece of the new money coming in, because we're up to $13 million here.

MR. HAGGIE: Yes.

MS. MICHAEL: Okay, thank you very much.

That's all I have in terms of the line but a couple of questions – well, maybe more than a couple. Some of them have been answered in one form or another. Could we have – and maybe it's in the binder – the number of subsidized home support clients?

MR. HAGGIE: If we haven't got it in the binder, I can certainly find it for you.

MS. MICHAEL: Okay, thank you.

OFFICIAL: That would not be here.

MR. HAGGIE: No, we can get it.

MS. MICHAEL: You can get it?

MR. HAGGIE: I've seen it recently and in actual fact I can't, for the life of me, remember what it is.

MS. MICHAEL: Okay.

Do you have numbers on those who are in the Paid Family Caregiving Option?

MR. HAGGIE: We can get those, too?

OFFICIAL: That is not here.

MR. HAGGIE: Yes, same answer. We've got it, but we haven't brought them.

MS. MICHAEL: Okay, thanks a lot. We don't need them now as long as we can get them.

Could we have an update on the enhanced care in personal care homes program?

MR. HAGGIE: It was originally a pilot, but it isn't any more. In terms of how many are utilizing it currently, it's on a case-by-case basis. That's another figure we could find for you. I couldn't give you exactly –

OFFICIAL: (Inaudible.)

MR. HAGGIE: Okay, here we go. Enhanced care as of December 2017, 107 personal care home residents are receiving enhanced care.

MS. MICHAEL: Okay.

Do you know if that's going up? Of course it's not that long in place so –

MR. HAGGIE: It is going up, but I couldn't tell you what previous years (inaudible).

MS. MICHAEL: Okay, thank you.

The Public Accounts Committee on Health had some discussion, because of the AG's recommendations, with regard to standards for personal care homes. Has the department begun working on new personal home care operating and monitoring standards?

MR. HAGGIE: Yes, we've actually had a series of meetings and I've been involved in some of them with the personal care home associations. They're a work in progress but they're quite well advanced, because we would want to put those in as a backstop for a new round of service-level agreements, so not very far off from being finished.

MS. MICHAEL: Oh good, I'm glad to hear that.

Could we have an up-to-date list – this may be in your binder actually; we've never had trouble getting this information – the number of people on wait-lists for nursing homes by region and also the number waiting in acute care beds?

MR. HAGGIE: That would be alternate level of care numbers and those within that category waiting for long-term care placement?

MS. MICHAEL: Yes, that's right.

MR. HAGGIE: Okay, we can.

The answer currently is on a placement waiting list between communities, personal care home and acute for long-term care, the total is 227. But some of those are located, as you say, currently in personal care homes or acute care. We got a breakdown by region: 71 for Eastern; 65, Central; 70, Western; and 21, Labrador-Grenfell.

MS. MICHAEL: Right, okay.

That's all the information we need, I think, on that one. The next question you've answered; I will not ask that again.

Could we have the number of recipients who have used MTAP and out-of-province travel by region, the number of recipients and the amount of money?

MR. HAGGIE: I don't think we have that with us, but we can get it.

MS. MICHAEL: Okay, thank you very much.

How are things going with the ambulance central dispatch centre?

MR. HAGGIE: The proposal to move that to a unified CMDC, Central Medical Dispatch Centre, is pretty well ready to go out for approval, and I would expect that would happen sometime within the next month or so.

MS. MICHAEL: Okay.

With regard to the RHAs, I know that there are some areas in which they have gotten into sharing services. What steps forward are being made by them in that whole area?

MR. HAGGIE: There are three areas that are either in play or are about to be in play. The longest established was the shared services for purchasing and inventory and the infrastructure – the governance structure, rather, is in place for that. We are looking to now craft – or they are looking to craft a platform on which to run that from a software point of view and the lines of reporting have been realigned, but the actual rollout of it is it's still at that stage.

I think that's fairly accurate?

OFFICIAL: (Inaudible.)

MR. HAGGIE: They're also into vender management and contract management, so they started running that through the central system.

MS. MICHAEL: Okay.

MR. HAGGIE: The second one is IT. The governance structure for that is still being worked out and it's a lot further behind, but it's a different nature of the beast. That's being run through Newfoundland and Labrador Centre for Health Information, if you remember there were some legislative changes around that. So that's at a lot of an earlier stage.

The next piece, which is still at more of a conceptual stage but nearly ready to be put into a formal proposal, is laboratory services and that

would probably be run through Eastern Health, given their capacity, and it would be tiered approach for labs. But that's not quite ready yet.

MS. MICHAEL: Okay, right.

Is there any discussion going on in terms of – I'll use a concrete example and I've used this before because it helps me conceptualize what I want to say – the sharing of services? For example, we know that somebody could get a knee replacement or hip replacement in Gander done much more quickly than in St. John's and they are from the Burin Peninsula, you get up to the main road – that kind of sharing, is that being discussed yet?

MR. HAGGIE: It is. Certainly, it's still done on a more regionalized basis. One of the best iterations that I'm personally familiar with has been the endoscopy program in central where there is free discussion between the two endoscopy centres as to who may have the shorter wait time, if you're screening positive or if you're an urgent for some reason.

MS. MICHAEL: Right. But that's under the same RHA?

MR. HAGGIE: It's under the same RHA but there are discussions through the department wait-time office in how to run that more provincially. Certainly there is collaboration in radiology and diagnostic imaging between central and Clarenville, for example. There's also that kind of to and fro where people are offered the option of going one way or another depending on the wait time.

Again, it's further behind in terms of a provincial-wide thing. Some areas have still not yet got to the idea of central intake within their own region but that's, again, a work in progress in the individual RHAs.

MS. MICHAEL: Okay, thank you.

CHAIR: Thank you, Ms. Michael.

Thank you, Minister.

Mr. Brazil.

MR. BRAZIL: Thank you, Mr. Chair.

A couple of quick questions here: Is there any plan to fund in vitro fertilization in this budget in any way, shape or form?

MR. HAGGIE: There's nothing specific in this budget. There are discussions about, if you like, a critical mass approach. We do fund some of the workup and preparation work, but there are concerns about the ability to provide critical mass, do we have enough patients in-house, as it were, or are we better arranging for folks to go out of the province.

At the moment, we have not gone beyond the prep work, as it were, the workup, as part of the insured services. Really, it's budgetary constraints that have stopped us.

MR. BRAZIL: Okay.

There will be discussion. It's still on the radar.

MR. HAGGIE: It's not gone away. It's one of those things that cycles around from time to time.

MR. BRAZIL: Fair enough.

Are there any discussions – I know there are always discussions, but is there any real concrete plan of cutting programs in rural Newfoundland in some of our health centres, clinics and that, or realigning the jurisdictional makeup, or closing a clinic and moving people to a bigger subunit?

MR. HAGGIE: I think it depends on really how you phrase things. One of the ways it could be put is a rationalization of services. You have some clinics that are really underutilized, where the cost per case, the value to the patient, it's difficult to justify when compared with other areas.

What we're looking at is trying to look at access, so that one of things we've talked about – and indeed we've just introduced some new fee codes for physicians – is to allow consultation to take place between a physician and a patient over the phone or electronically, without the patient having to leave their home. So rather than wondering about whether the patient's going to go to a clinic that's underutilized or having staffing challenges, you've got a

situation whereby the service can go to the patient.

That's been our approach, currently. We're always looking to see what the level of utilization of facilities are and if there's any need to consider delivering them in a different way, but I think that's just a fiscal reality. When your community gets down to having 24 people in it, and only in the winter, what is reasonable and what is sustainable, both for them and for the service?

MR. BRAZIL: What would be the difference in costing from a financial point of view, if a physician does it over the phone, or electronic consultation costs versus in-clinic, where there's additional overhead and all this?

MR. HAGGIE: We've had a fee schedule, and I don't know whether it's actually public yet for telephone code for physicians. Certainly it went through the NLMA approval process. It did not require a regulatory change because up until then the physician could only bill face to face.

MR. BRAZIL: Based on in-house.

MR. HAGGIE: The telephone piece, the electronic piece have kind of been an omission. So it's certainly cheaper for the system and it's easier for the patient. The question then will be in terms of efficacy. We've heard from the HealthLine, for example, a significant proportion of patients who ring up the HealthLine with a stated intent of going to the emergency department and no longer need to. We have not even got the system up and running yet, in terms of anyone actually billing it, but it would be interesting to see over the first year if the availability of the phone consult will drive or change the physical utilization of clinics.

The other piece is there is what's called an eConsult program, which also goes with the new phone code in parallel – they're separate, but they're related – which is to allow discussion between a referring physician and a specialist to see whether or not the person actually needs to be referred.

One of the interesting things that has been found in – there was a CBC article very recently about gastroenterology. It suggested that 85 per cent of patients referred to gastroenterologists in Edmonton, I think it was, didn't actually need to go and see the gastroenterologist; they could have been managed differently, had sufficient information been exchanged between the referring physician and the specialist in advance.

And I've see that in other jurisdictions as well, in Saskatoon with urology, for example. I know that Eastern Health and I think it's the eConsult group – and I can't remember which physician groups are involved with that in detail. That's a parallel process here we're trying to get underway. Basically, it's a sharing of information electronically to see what is the most appropriate way of managing a problem for a referring practitioner.

MR. BRAZIL: Will that be set up as a pilot first to see if it's workable?

MR. HAGGIE: It's actually in place.

MR. BRAZIL: It's in place now? Across the province or –

OFFICIAL: Apparently Eastern Health.

MR. HAGGIE: Eastern Health. And I think it's for oncology, but I'm not 100 per cent sure.

MR. BRAZIL: Okay.

So you will study the data over a period of time and then see if it's expandable?

MR. HAGGIE: Yes. This is a test bed and if it works, then we will get the kinks out of it and it will become a phase thing. I hate to call them pilots because it's not really; it works elsewhere –

MR. BRAZIL: It's going to happen; it's just a matter of making it work.

MR. HAGGIE: We are just test running it on a small area, geographically and numerically, and then once we've debugged it you can roll it by beta testing.

MR. BRAZIL: I think it has merits. I've done a little bit of research into some of the other jurisdictions that made that work and the cost effectiveness is tenfold. Not counting it's less

intrusive for patients in the sense of having to travel to areas.

MR. HAGGIE: And when they do travel – particularly the urology example with which I'm familiar – the referring doctor knows what the patient is going for, the patient knows what they're going for and the arrangements are made for that to happen at that visit rather than saying, oh, we'll come back next week and we'll scope you or whatever it is. Yeah, it's a win all around.

MR. BRAZIL: Perfect.

Any idea what the methadone program cost last year, and what it's expected to be costing this year?

MR. HAGGIE: We can get that for you. I've certainly seen it. It has increased in numbers. I think there has been an increase of about 30 per cent in the number of people on the methadone program, or opioid dependence treatment program because the Suboxone figures are in there too. We can get that for you. I'm not sure it's in the binder.

MR. BRAZIL: Okay, that's good. And I know Ms. Michael has asked for some information. Whatever you share with her, can you share with me and vice versa when you do it –

MR. HAGGIE: I would never treat you differently.

MR. BRAZIL: I appreciate that.

I'm just going to move on to the Building Improvements, Furnishings and Equipment because I'm down to the last few questions that I have. Can you provide a list of the Capital infrastructure expenditure for last year and, as well, what is planned for this year?

MR. HAGGIE: The Capital infrastructure spends, I think, might actually be in here. There's certainly a list of projects for Capital. I can read them out if you're interested, but they're all listed here. They're all in different stages. For example, there's a Health Sciences Centre electrical substation which has some cash flow alterations. There's money there for the Western Regional Memorial –

MR. BRAZIL: They're all outlined there, and the breakdowns.

MR. HAGGIE: They're outlined. Green Bay Health Centre, Waterford, the redevelopments of CNRHC, Hugh Twomey, long-term care in Central and so on and so forth. It's all there.

MR. BRAZIL: Okay, that's perfect (inaudible).

Can you give us an update on the P3 long-term care homes?

MR. HAGGIE: Okay, I actually have a table here which may be an eye test. Sorry, what specifically would you like to know about it? Would you like to know –?

MR. BRAZIL: Just at what stage we're at now. I know you've gone through the consultation (inaudible).

MR. HAGGIE: The RFP closed for the long-term care in Corner Brook. They had some preliminary site work done just at the very end of last year. Once the snow goes, they should start then full swing in Corner Brook, on the site, whenever the snow goes.

The Central piece, Botwood is done in a different way, the protective care units I alluded to before. The two centres there, there will be a qualification process cluing up shortly for people who will then bid on the work for Gander-Grand Falls.

MR. BRAZIL: Where are those two sites now?

MR. HAGGIE: The two sites, there's one in each community. They haven't actually been announced. I think they'll be announced as part of the RFQ-RFP announcement. They're still doing some geotechnical work on one possible site.

MR. BRAZIL: On the Waterford project, I know it's newly announced. What stage are we moving in there?

MR. HAGGIE: Well the value-for-money piece is underway. Eastern Health has an RFP nearly ready to go for the hostel piece, because that has to go first. Once that's done then the value-for-

money piece will inform whether it's an RFQ-RFP or some other process.

MR. BRAZIL: Any plans for the existing Waterford (inaudible)?

MR. HAGGIE: The existing Waterford will stay providing services until they can all be transitioned, either into the community or into the new site. Once the building is no longer needed by Health, then traditionally what's happened is it's gone to Transportation and Works and they've looked at it as an asset to be managed appropriately.

MR. BRAZIL: Fair enough.

MR. HAGGIE: As far as I know, that's the plan at the moment.

MR. BRAZIL: Good. I think I'm good, unless something else surfaces.

CHAIR: Thank you, Mr. Brazil, right on time.

Ms. Michael.

MS. MICHAEL: Thank you Mr. Chair.

I just have some line items under the same section, under the Infrastructure and Equipment. So in 3.2.01 under Grants and Subsidies, the budget was $31,900,000, but it was revised up to $34,196,000. What caused the revision upward? Because I would think that the budget is pretty tight around the infrastructure expenditures.

MR. HAGGIE: Yes – sorry, you're looking to find where the extra $3.8 million went?

MS. MICHAEL: Well, $2.2 million between the budget and the revision, first of all.

MR. HAGGIE: We moved money in from Current to Capital to accommodate requests from the regional health authorities, so that was what the boost was.

MS. MICHAEL: Okay.

And now going up $3,800,000 over last year.

MR. HAGGIE: Yeah, that's this one, is it?

OFFICIAL: Yes.

MR. HAGGIE: So basically, that breaks out into electronic medical record, building improvements, furnishings and equipment. The electronic medical record was the big change; it was $1.9 million.

MS. MICHAEL: Right.

I'm assuming that in the binder you have a breakdown of those categories.

MR. HAGGIE: Yes.

MS. MICHAEL: Okay, that's fine; we don't need to go any further then. We can see that.

MR. HAGGIE: I'm getting cross-eyed looking at the numbers, I apologize. I need a ruler.

MS. MICHAEL: That's okay.

Down under 3.2.02, again under Salaries, the budget was $1,585,000, but it was underspent by $1,100,000.

MR. HAGGIE: That was basically due to delays in projects, weather and the like, and delays in project design. The awards and issuing of tenders was delayed, so that money was not consumed simply because – these reflect salaries for staff moved from Transportation and Works who were used in project management.

MS. MICHAEL: Right.

Are there projects then that are sort of a bit behind in the timeline? Which ones?

MR. HAGGIE: Yeah, and the list that MHA Brazil asked for, there's a cash flow adjustment there that'll explain some of that for you. Rather than trying to go through it now, it's probably easier to see in a tabula form.

MS. MICHAEL: Great. If it's there, that's fine. The Salaries this year are under by $100,000 based on the budget last year. Anybody let go, or did you need fewer people?

MR. HAGGIE: It's basically trying to divide TW's time between health projects and non-health related projects. That's a guestimate of

what their time would be required towards health projects is lower, the number of hours, than non-health from previous years.

MS. MICHAEL: Okay, thank you.

The other one where there's a big change, the Professional Services, which I think is engineering and design mainly in this line. This may be related to your other answer, but I'll let you tell me that. Because the budget was $21.700 million but the revision was down to $4,810,500.

MR. HAGGIE: Same answer.

MS. MICHAEL: Same answer, that's what I thought. And same answer for this as well; I would think it might be different.

MR. HAGGIE: The cash flow varies with the timing of the projects and if the timing of some is disturbed, then the cash flow alters year by year. And that's what you're seeing there.

MS. MICHAEL: The minus $11 million is related to that.

MR. HAGGIE: Yes.

MS. MICHAEL: Okay, thank you.

Under Purchased Services, do we have the same answer for this line as well?

MR. HAGGIE: Yes, in actual fact, the first two paragraphs are exactly the same wording about anticipated delays.

MS. MICHAEL: Okay, good enough.

That finishes my questions.

CHAIR: Thank you.

MR. BRAZIL: I've got one last question (inaudible).

CHAIR: Mr. Brazil.

MR. BRAZIL: We've been, as a caucus, asking this to other line departments –

MR. HAGGIE: Oh right, you've got trick question for the last one.

MR. BRAZIL: Yeah, it's a trick question. I doubt if you know the answer but I want to throw this out there, unless you're really ahead of the game on this one and I wouldn't think – but as we talk about facilities, has there been any analysis on what the new carbon tax will have on your budget lines? With all the facilities, from an emissions point of view, a heating point of view.

MR. HAGGIE: The honest answer is I haven't seen any. There is talk for the newer buildings of whether or not low carbon emission heating sources would be geothermal. I know there was talk of biofuels for example and this kind of thing. But in terms of the existing plant, no is the short answer. I haven't seen any.

MR. BRAZIL: Okay, fair enough.

CHAIR: Thank you, Mr. Brazil.

Mr. Lane.

MR. LANE: Thank you.

Minister, I'm just wondering if you can comment on what your plans are, what's being done, from the perspective of scope of practice. I know it's a touchy issue. Certainly there was, I guess, an issue out there in the public a while ago. Mr. Abbott would know, of course; took a little bit of heat, I think, from Ms. Forward on it. I do support, in principle, basically what Mr. Abbott was saying about scope of practice and other things he was saying, actually.

I am just wondering: What is the process going forward on that? Bearing in mind, I realize there are collective agreements and there are sensitive issues, but it would seem to me that we should be getting the highest value out of the employees that we have for the best costs. Is there a strategy or is it just sort of piecemeal, when opportunities arise, type of thing?

MR. HAGGIE: I think the low-hanging fruit from that I would refer, really, to the new long-term care facilities. Because as people are moved into those, they are staffed according to the newer, best-practice models. So the

distribution of staff and workload to match the patients' needs is different than has been the case in some of the more, longer established things. It's certainly the case that that happened in Pleasantview Towers. The intent is to look at making sure we've got best-practice staffing models for the new ones coming out.

I think one of the challenges is, over time, how you move from where we are now to where you need to be. Whilst attrition is a fairly straightforward way of doing that, given the fact that there's a significant bulge in our workforce, as a lot of the health care providers are in that band where they're going to retire in the next five to eight years, we'll want to do this on a gradual, roll-in basis.

It would really cause minimal disruption. I think the challenge will come when you have a unit that's staffed by one particular kind of provider with a collective agreement, and you want to bring in people whose skill set has broadened, and has broadened legitimately and generally accepted to be, there will be a discussion to be had about who replaces whom. I think that's going to be a challenge going forward, and there's no way of getting around that.

MR. LANE: Yeah. I tend to agree, and I thank you for the answer. I do tend to agree that that's going to be problematic where it exists and certainly, as you say, the opportunities will be with new facilities and so on to make those changes upfront. I do encourage you to continue down that road wherever opportunities do exist because it makes perfect sense. At least as far as I'm concerned, it does.

I also just wanted to say, just as a statement, more or less, that I did want to acknowledge the investment that was made for the inpatient clinic for eating disorders. I think that was a good move. I've had conversations with Mr. Withers and the folks with the Eating Disorder Foundation, and I know it's something they had lobbied for, for a long time, and they're very appreciative of it. Again, I just wanted to acknowledge that.

Minister, just wondering, this whole concept of Home First, I think, is what it's referred to when you said it's not really a strategy in terms of picking off bullet points or if we are going to do this, this and this; more of a concept, if you will, than anything else. Is the Home First – is this the same – we just named the program or the concept that was brought forward prior to the last provincial election, at the time, was this whole concept of keeping seniors in their homes. Someone would go into their home, do an assessment, make sure that the home was safe. If they had needs for making their homes more accessible, that would be pointed out. Someone would look at their medications, make sure they're eating properly and then try to connect them up with all the appropriate services so that they would stay at home.

That whole thing that was discussed in the election, is that what this Home – what's it called, Home –?

MR. HAGGIE: Home First.

MR. LANE: – Home First strategy is? Is that what that is?

MR. HAGGIE: It's part of it. The healthy living assessment, which is what I think you're referring to, is proactively going out and picking a demographic and, if you like, screening them for needs –

MR. LANE: Correct.

MR. HAGGIE: – is something that has bounced back a little bit between the CSSD, who have responsibility for seniors and Health who have responsibility for health care delivery, as well as home support. We see this as being something we'll be moving on this year.

In actual fact, there may be a way of incorporating this into the home care assessment. In the sense you can have a screening test and if it turns out that you don't need anything, then everyone goes on their way. But if you then turn out to find identified needs, then you can start to work through the more formal assessment process.

That is still one of those things which I think we will probably end of running as a test bed – a beta test somewhere. We'll start somewhere with it and roll it out. Again, it might even speak to housing and subsidy things. If you need a rail in someone's bathroom to keep them safely in

their home, then, currently, that funding comes from somewhere other than in Health.

It's still very much out there. It is more of a philosophy – this idea – and it may be confusing because there are lots of initiatives out there that have home in it, or something first. Even I get confused something about which labels we've put on it. But I think if you work on the idea that it's proactive, you're screening, when you find something, it's a question of an individualized care plan and an individualized funding model, where appropriate, to try and put the right things in the right place at the right time.

MR. LANE: Thank you, Minister.

That's the one I was referring to, all right. I would see it involving a number of departments, maybe AES, maybe CSSD and perhaps Department of Health and so on. It would be looking at the whole picture of that individual, particularly a senior, I think is how it was framed, to make sure they had all the – and like you say, some of the funding for accessibility would come from Newfoundland and Labrador Housing; some stuff would come through AES; some things would be related to community health and so on.

This program that was a plank in the platform, if you will, in the last election of the governing party; you would have a piece in that. That program itself has not been rolled out to my knowledge, has it? And who would lead it? Would it be you or would it be a different department?

MR. HAGGIE: Rather than having the program, you've got the bits being built from – it's like building a house from the foundation up. You put some blocks in here and you put some blocks in there. I think the bit I recall from the last election was the healthy living assessment, the idea that you would proactively screen seniors early on. And that's something that we have repatriated a little bit into Health and we'll be moving on that over the course of this year.

MR. LANE: Okay. It will be your department taking the lead to proactively screen seniors?

MR. HAGGIE: Now, I would hate to cause trouble with Executive Council, but I think it is. That was the understanding I had as of very recently.

MR. LANE: Okay, I appreciate that. That's good; I think that's a good idea, if it happens.

Minister, the other thing I'm wondering about, and this is around trying to deal with the realities of our fiscal situation. Of course, we know the Department of Health is the largest budget item there, $3 billion (inaudible) at, next to our debt – or it's the highest and then it's our debt.

Minister, just wondering, in terms of looking at the big picture and service delivery and so on, is there a strategy in place that would look at it from the perspective of at what level is an accepted of subsidy. At what level, what distance, is an accepted level of travel for services and so on? Is there a strategy around that? And then in areas that fall outside that, are there opportunities for technology?

I've heard you talk about those things, I've heard members of government and the Premier talk about those things, but is there an actual strategy that looks that at sort of that bigger picture of health care delivery in terms of the realities of geography and cost and, like I said, what's acceptable subsidies, what's acceptable distances and all this kind of stuff.

MR. HAGGIE: Well, I think there are two parallel threads there, and one of my phrases, I've used recently, is using technology to defeat geography. I think we've started that. We have fee codes in place now for addictions-based counselling that will allow that to be done by kind of video conferencing. And it's not the Telehealth that we used; this can use GPs in their office, desktop software, this kind of thing.

So that's one stream of trying to manage that. I alluded earlier on to HealthLine and 811 and this kind of thing. In terms of subsidies and what is reasonable from a financial point of view, one of the things that we have looked at are the costs that we have rise steadily, and we've never even allowed for CPI in any of these things; but, equally well, there is some kind of assessment that needs to be done about what is a reasonable threshold for income.

We can set in place processes which are fairly straightforward for doing a financial assessment, based on CRA data, if you wanted to, for example. But I think there's a bigger, broader discussion across government as to where those thresholds should be. I'm not sure that it's reasonable to have one threshold for health where you get subsidies and one threshold for general living if you're, for example, on income support.

How to align those and how to align that with seniors' benefits is big across government discussion, and there are discussions that happen around that. They're going to be with us forever.

MR. LANE: Yeah, it's challenging; there's no doubt. I don't deny that. I was just wondering what your thoughts were on that because geography is a challenge, and the cost of delivering services is, without doubt, a challenge. We also, I think, realize that there has to be a reasonable distance; the people can't be expected to travel too far.

I don't know what that distance is but, by the same token, you can't have a clinic in every community either. So there has to be a balance and I'm just wondering if there's been any sort of big picture visioning of how things maybe could be aligned, realigned, utilizing technology and so on to make the system more efficient and cost effective while still delivering needed services.

MR. HAGGIE: I mean we certainly looked at distances to travel for primary care, for example. I think that's probably the easiest one to deal with. Over the years, I've seen various times and various distances quoted and it does seem to change and then, of course, in winter it changes even more.

I think there is no generally agreed distance; there's just a kind of reasonable man test. Again, that's something we examine and re-examine and it's going to be one of those dynamics. You can't write a policy and then walk away from it for 10 years because it won't make sense at the end of 10 years.

MR. LANE: That's right – particularly with young people's health.

Thank you, Mr. Chair.

Thank you to my colleagues for allowing me the leave to ask the questions.

CHAIR: Thank you, Mr. Lane.

I will ask the Clerk to recall the first subhead.

CLERK: 1.1.01.

CHAIR: 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 3.2.02 inclusive.

CHAIR: 1.2.01 to 3.2.02 inclusive.

Shall those subheads carry?

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, subheads 1.2.01 through 3.2.02 carried.

CLERK: The total.

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 the Department 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: There are a couple of housekeeping notes.

I need a mover for the minutes of the meeting of April 25, which was with the Department of Children, Seniors and Social Development?

CHAIR: So moved by MHA Dean.

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: All those against?

Carried.

On motion, minutes adopted as circulated.

CHAIR: This will conclude our Estimates on the Social Committee and the next meeting will be at the call of the Chair.

Minister Haggie?

MR. HAGGIE: It was remiss of me and probably it's the best time to say it now, I just want to say thank you to the staff here. This would not have come together in five minutes over a cup of coffee, as anyone can tell. What you see here is a result of – as everybody who's been through this process before knows – a very, very long process.

I would just like to call out and thank Mr. Tizzard. It's his last of nine Estimates as he moves tomorrow to Newfoundland and Labrador Housing to a promotion, and I would like to go on record and thank him.

SOME HON. MEMBERS: Hear, hear!

MR. TIZZARD: Thank you as well, Minister, and everybody else for all your support over the years.

Thank you.

CHAIR: Ms. Michael.

MS. MICHAEL: Thank you, Mr. Chair.

Just to thank the minister and the staff for being here with us. Our researchers don't get to say anything publicly but I'm going to quote our researcher who said that probably one of the best binders that she gets is the binder from the Department of Health and Community Services.

MR. HAGGIE: I would second that. I was a great fan of this binder; I still am. Thank you, Mike.

MS. MICHAEL: Thank you all very much.

CHAIR: Thank you, Ms. Michael.

The Chair recognizes Mr. Brazil for any closing remarks.

MR. BRAZIL: I want to echo what Ms. Michael has said here. It's been a pleasure. Very detailed information and I look forward to – this is my first kick at the cat, but I know that the information will be very relevant and we'll have an opportunity to have some follow-up discussions in the House, no doubt.

Thank you to the staff and good luck on your promotion.

CHAIR: Thank you, Minister, to you and your department, on behalf of the Committee and our chairperson, Ms. Haley. I want to say thank you as well to the Committee. Having said that, obviously we would like to thank the personnel in the Broadcast Centre, and to Kim Hawley George for her services here this evening.

I look for a motion to adjourn.

So moved by MHA Jerry Dean.

All those in favour?

SOME HON. MEMBERS: Aye.

CHAIR: Meeting adjourned.

On motion, the Committee adjourned *sine die*.