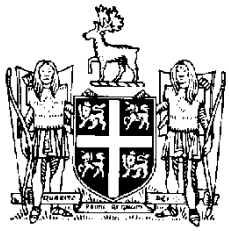

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Department of Health and Community Services

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Honourable Derek Bennett, MHA

SOCIAL SERVICES COMMITTEE

Department of Health and Community Services

Chair: Sherry Gambin-Walsh, MHA

Vice-Chair: Chris Tibbs, MHA

Members: Perry Trimper, MHA
Lucy Stoyles, MHA
Jamie Korab, MHA
James Dinn, MHA
Paul Dinn, MHA

Clerk of the Committee: Mark Jerrett (A)

Appearing:

Department of Health and Community Services
Hon. Sarah Stoodley, Minister
Hon. John Haggie, Minister
John McGrath, Deputy Minister
Chad Antle, Departmental Controller
Alicia Chenard, Executive Assistant
Greg Clarke, Assistant Deputy Minister, Professional Services and Workforce Planning
Bradley George, Executive Assistant
Jeannine Herritt, Assistant Deputy Minister, Regional Services
Patrick Morrissey, Assistant Deputy Minister, Corporate Services
Dr. Pat Parfrey, Deputy Minister, Health Transformation
Brian Scott, Director of Communications
Gillian Sweeney, Assistant Deputy Minister

Also Present
Hon. Gerry Byrne, MHA, Minister
Hon. Pam Parsons, MHA, Minister
Hon. Scott Reid, MHA, Minister
Barry Petten, MHA
Jim Locke, Government Members' Caucus
Darrell Hynes, Official Opposition Caucus
Steven Kent, Third Party Caucus

Pursuant to Standing Order 68, Barry Petten, MHA for Conception Bay South, substitutes for Paul Dinn, MHA for Topsail - Paradise.

Pursuant to Standing Order 68, Minister Byrne, MHA for Corner Brook, substitutes for Perry Trimper, MHA for Lake Melville.

Pursuant to Standing Order 68, Pam Parsons, MHA for Harbour Grace - Port de Grave, substitutes for Lucy Stoyles, MHA for Mount Pearl North.

Pursuant to Standing Order 68, Scott Reid, MHA for St. George's - Humber, substitutes for Jamie Korab, MHA for Waterford Valley.

CHAIR (Gambin-Walsh): Okay, we'll call the meeting to order and I'll just announce the substitutes first.

Substituting for Lake Melville, Minister Byrne will be here. He's not here yet. Substituting for Mount Pearl North is Harbour Grace - Port de Grave, substituting for Topsail - Paradise is Conception Bay South and substituting for Waterford Valley is St. George's - Humber.

So, typically, we take a break about halfway through. We'll see where we are to with the subheads around 7:30. I just want to remind you that sometimes they leave the lights on upstairs and that's okay so that we can go back and forth but if they don't have your light on and if you say your name, just wave also so that they can see who is speaking.

Please don't make any adjustments to the chairs. We have water coolers in the ends of the room. I know there are glasses over here on this side if you want some water.

I will first ask the Committee Members and the substitutes to introduce themselves, then I will go over to departmental officials.

We will start here with Conception Bay South.

B. PETTEN: Barry Petten, MHA for Conception Bay South.

D. HYNES: Darrell Hynes, Director of Research and Legislative Affairs for the Opposition Office.

C. TIBBS: Chris Tibbs, MHA for Grand Falls-Windsor - Buchans.

J. DINN: Jim Dinn, MHA for St. John's Centre.

S. KENT: Steven Kent, Research Assistant for the Third Party Office.

P. PARSONS: Pam Parsons, MHA for Harbour Grace - Port de Grave.

S. REID: Scott Reid, MHA, St. George's - Humber.

G. BYRNE: Gerry Byrne from the beautiful and historic District of Corner Brook.

J. LOCKE: Jim Locke, Research Coordinator for Government Members' Office.

CHAIR: Minister Stoodley.

S. STOODLEY: Thank you.

Sarah Stoodley, Acting Minister of Mental Health and Addictions.

J. HAGGIE: John Haggie, Acting Minister of Health and Community Services.

J. MCGRATH: John McGrath, Deputy Minister.

C. ANTLE: Chad Antle, Departmental Controller.

A. CHENARD: Alicia Chenard, Executive Assistant to Minister Haggie.

B. GEORGE: Bradley George, Executive Assistant, Mental Health and Addictions.

P. MORRISSEY: Patrick Morrissey, ADM, Corporate Services.

J. HERRITT: Jeannine Herritt, ADM, Regional Services.

B. SCOTT: Brian Scott, Director of Communications.

CHAIR: I don't think the lights are coming on.

G. SWEENEY: Gillian Sweeney, Assistant Deputy Minister, Population Health and Well-Being.

G. CLARKE: Greg Clarke, ADM Professional Services and Workforce Planning.

CHAIR: Okay, thank you very much.

The Committee has a copy of the minutes from the previous meeting, and I now ask for a mover to the minutes.

P. PARSONS: So moved.

CHAIR: The Member for Harbour Grace - Port de Grave.

Thank you very much.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, minutes adopted as circulated.

CHAIR: We will now proceed with the Estimates review process. Once I ask the Clerk to call the first subhead grouping for the head of expenditures, I will then ask each minister to proceed. Each minister gets 15 minutes, if they so desire, for opening remarks.

I ask the Clerk to call the first subhead.

CLERK (Jerrett): 1.1.01 to 1.2.02 inclusive.

CHAIR: 1.1.01 to 1.2.02 inclusive, Executive and Support Services.

Minister Stoodley, would you like to start?

S. STOODLEY: Thank you very much, Chair.

I do have a few opening remarks.

Budget 2025-2026 continues to strengthen commitments made under *Towards Recovery* and our two provincial action plans, the Alcohol Action Plan and Our Path of Resilience. This includes a special focus on the opening of the new adult Mental Health and Addictions Centre and furthering support for the treatment of substance use disorder for residents of Newfoundland and Labrador.

One of the recommendations achieved during *Towards Recovery* was an increase in provincial mental health and addiction spending from approximately 5.7 per cent of the total annual health care budget to 9 per cent to better align with the recommended national average. This increase was sustained in 2023-2024, when 9.4 per cent of the mental health and addictions spending came from the overall health care budget for Newfoundland and Labrador. This is higher than the Canadian average, which is 6.3 per cent and the highest percentage in the Atlantic region, which is from the Canadian Mental Health Association in 2024.

Spending on mental health and addiction services and supports is having positive results. *Budget 2025* will continue to build on this through the following investments: $1.8 million to expand rapid access to substance use treatment and withdrawal management services within the existing opioid-dependence treatments hubs in all Newfoundland and Labrador Health

Services zones, as well as to establish a new treatment hub in the Eastern-Rural zone; over $600,000 to enhance access to naloxone kits province wide, with the goal of reducing opioid-related overdose deaths; nearly $10 million for community-based, step-down facilities to support individuals who do not require hospitalization but need specialized supports to successfully transition to community; $1.17 million to establish a 10-bed substance use adult treatment centre in Labrador, supporting access to substance use and addictions in-patient treatment closer to home; $1.2 million to increase access to medical withdrawal management services at the recovery centre in St. John's, the only dedicated withdrawal management facility in the province; $566,500 to expand access to in-patient treatment beds at Humberwood, building on a highly successful model; and $2 million to plan and implement sober-living recovery homes as an intermediary step between substance use in-patient treatment and the transition to home.

Other highlights of *Budget 2025* include continuing support for the two provincial action plans, the Alcohol Action Plan and Our Path of Resilience; ongoing access to a suite of free e-mental health programs available on Bridge the gapp; supporting operations at the new adult Mental Health and Addictions Centre, which opened yesterday, and represents a new era in mental health and addictions service delivery in Newfoundland and Labrador; implementing a customized public awareness campaign to improve awareness of the mental health and addictions services available in Newfoundland and Labrador and how to access them.

We're very pleased with the progress to date in transforming the provincial mental health and addictions system to one that is person-centred and recovery-focused and will continue to work with our many partners in government, Newfoundland and Labrador Health Services, the community, and people with lived and living experience to develop innovative solutions to enhance access to appropriate, timely and compassionate support for all Newfoundlanders and Labradorians.

I do want to add that I think it's a super privilege to be Acting Minister of Mental Health and Addictions for the opening of the adult Mental Health and Addictions Centre. I've had a tour of it. I know some others here have. It's an incredible facility. I also toured the former Waterford Hospital, which is no longer seeing new patients now, and all of the patients have been successfully transferred to the new adult Mental Health and Addictions Centre, and it was a very stark contrast to see the old and the new.

The old was dingy, grungy. There was a patient in kind of an outdoor area, as I was going through, and I just can't even fathom the experience from a mental health perspective getting treatment in that former facility and now contrasted with the experience in the new facility. There is a virtual tour online now, which, if you're curious, I'd recommend everyone check out, will give you a sense of what – I do think that, in this instance, the physical infrastructure will have a significant impact on patient outcomes and the mental health of Newfoundlanders and Labradorians.

So, saying that, thank you very much. I'd like to pass it over to Minister Haggie.

CHAIR: Minister Haggie.

J. HAGGIE: Thank you very much, Chair.

Great to be here for what is my eighth budget for Health and Community Services. I hadn't quite anticipated number eight, but things happen.

This year our budget, comparing like with like, in the Estimates book the vote will be $4.7 billion. Last year it was $4.5 billion. If you look at that, compared with the budget from 2020, you're looking at a 42 per cent increase. That shows a commitment on

behalf of this government, particularly with the emphasis after COVID and the Health Accord. We've made record investments in health care and we're actually seeing real and measurable results. These don't appear in the lines of dry numbers that you see in the heads of Estimate book, but I think there's a story to be told of what last year's money has bought.

There are 75,000 people now in the province connected to Family Care Teams – structures that didn't exist a couple of years ago. Of the people who are not yet connected but are listed with Patient Connect, there are 18,000 people in there that have access to care virtually. For those listeners at home, if you haven't got a family doctor and are not registered, I would encourage you to do so because that will enable you then to access virtual care through Teladoc, which is a quantum improvement over other virtual methods of care.

Recruitment and retention has been highlighted in this Chamber and it's the major challenge for everybody. I would argue it's a major challenge across the globe and it's certainly a major challenge in Canada. In the last two years, however, we've recruited over 140 doctors with our endeavours and incentives and more than 1,100 – I think it's 1,133 nurses, of whom 760 were RNs.

In October 2022, there were 752 RN vacancies. Today, that number is 300. That's a huge progress in just two years. In terms of access to surgeries, there has been emphasis on improving and increasing access to surgical procedures. The ones that are measured nationally, our figures are showing a significant benefit. We've got travelling orthopedic programs for surgery for joint replacements in St. Anthony and Carbonear. We've got same-day hip replacements and knee replacements in St. Clare's and Corner Brook, and a short-stay orthopedic pilot in Gander working on developing those short-stay beds there too. And we've expanded surgical capacity across the province.

There were 2,200 or more orthopedic surgeries in '23 to '24, which is a 29 per cent increase, and that's from prepandemic levels, not just picking up after the pandemic. This is prepandemic comparison. And we continue to build on that process.

With our approach to cataracts, between April of '24 and January of '25, 10,834 cataract procedures. That's an increase of just under 16 per cent. Again, showing the success of the programs.

So building on that, budget '25 has further investment. Another $35 million to bolster, enlarge the Family Care Teams that exist and also to open new ones; continued investment of $10 million again for recruitment and retention, bearing in mind the successes of the last two years of investment; $4.2 million to expand undergraduate medical education seats for Newfoundland and Labrador students here in Memorial; and $10 million in digital health.

So that includes both virtual care and access for patients to their own record and information through MyHealthNL. I think there are around 115,000 to 120,000 people using that service to access their own information. We're trying and I think we're continuing to succeed in making it easier for people to access their services and this can be done from home.

We heard about IVF. We had a program that was put in place as a bridging manoeuvre. We've increased that level of support, and now we're on the cusp of having a larger fertility servicing clinic in the province. There was one already, and that's going to be enlarged and built upon.

In terms of other elements within health care, pharmaceuticals are always a pressure point. This year, the extra on the budget is $17 million. That is the highest

increase I've ever seen in all my time in Health version one and two. And 18 new drug therapies will be bought for the provincial drug program, a mix of cancer and non-cancer drugs.

We're investing in ambulance services, urgent care centres and a new ambulatory care hub in St. John's. In Corner Brook, there's $13.6 million for a new community care centre, which is transitioning available space to 15 transitional care beds and 30 long-term care beds, to ease their challenge with alternate level of care patients in Western.

Other initiatives in the Budget Speech include expanding cardiac catheterization services with a fourth lab, a new CT service for the Dr. Charles L. LeGrow Health Centre in Port aux Basques which is not there at the moment, the CT that is, and continued investment in stroke care, building on the provincial stroke program and Dr. Browne's pioneering work in this province in bringing EVT as a real and tangible treatment which will be of significant benefit to an important group of individuals who would otherwise end up permanently disabled and continuous glucose monitoring for our type 1 diabetics in the Insulin Pump Program.

Other concerns we hear are around wait times and backlogs. There's $10 million in *Budget 2025* to reduce delays, that is expanding MR and CT services – details include extra machines, extra hours and faster software that will enable more scans to be done in a working day – increasing capacity again for more joint replacements, a dedicated hip fracture unit for St. Clare's for rehabilitation for a significant burden on the acute health services and this will help ease that and move these patients through in a more appropriate way. We are adding five orthopedic surgery beds and, across the province, both here in St. John's and on the West Coast, expanding PET-CT services.

In addition to that, the focus, again from Health Accord, has been around preventative cancer care, there is $4 million more this year, HPV testing for cervical cancer and the like, a new lung cancer screening program and expanding the lower age limit of breast cancer screening to women between 40 and 49.

Mental health and addictions, my colleague here has alluded to, but they remain an integral part of health care in line with *Towards Recovery* and, any suggestion of a separation or some kind of difference between mental versus physical health, keeping them welded together. I think that's important from a stigma point of view. I think some of the successes we're seeing in mental health in terms of demand, paradoxically come from this destigmatization which has been a focus of government for some years.

One of the key background pieces, which everyone I think takes for granted but nobody really acknowledges in many respects, is health information. Our health information systems are outdated and there are multiple legacy systems that not only don't talk to each other but were deliberately designed not to talk to each other. We're fixing that.

There's another $140 million allocated in this year's budget to roll out better information management, which will benefit patients and it will benefit administrators of the system, it will help the department in its prioritization and it will enable patients to directly access their own information without gatekeepers; because, after all, these are the patients' charts. We, the system, are simply custodians and overall will improve the front end of health care in a way I think people really don't realize yet.

Seniors are a significant portion of this province. We have one of the most rapidly aging and significantly aged provinces. We've got $10 million for seniors' health and well-being through a variety of grants.

The other piece, and I can get into this in some detail because I see my time is running low, is financial responsibility and accountability. It is important that this money, which is a huge portion of the provincial budget, is spent efficiently, effectively, accountably and responsibly, and need to build tools to do that because, again, we have legacy systems out of back office, as well.

I'll go quiet.

CHAIR: Thank you, Minister.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

On those sections, I haven't got questions per se but I've got general questions. I hope that's fine to start with.

Minister, the Topsail Road urgent care centre, where are we with that? What's the time frame and staffing? What's the status with that, I guess?

CHAIR: Minister Haggie.

J. HAGGIE: Thank you very much.

I will defer to Mr. McGrath here about the Topsail Road health centre.

CHAIR: Deputy Minister McGrath.

J. MCGRATH: The deputy minister is trying not to choke.

There is money appropriated in this year's budget for the urgent care centre. For an exact date on when it's going to open, I'm going to look at Patrick to see if he can get that.

There is money for operations, as you alluded to, for hiring staff. That did come in through *Budget 2025* and, like I said, there is an appropriation this year for it for a date for when we're going to –

P. MORRISSEY: The fall.

J. MCGRATH: The fall?

CHAIR: Patrick Morrissey – oh, go ahead.

J. MCGRATH: Oh, sorry. The fall is what we're projecting.

B. PETTEN: The fall to open, is that what you're saying?

J. MCGRATH: I think that's what –

P. MORRISSEY: Yes.

B. PETTEN: Do you anticipate any problem with staffing, because I know that's an issue?

CHAIR: Minister Haggie.

J. HAGGIE: The short answer is we are working on staffing and, in terms of problems, we'll know when we go out and put the posts out there.

We have a wealth of incentives, they have, by and large, been very successful. The challenge for recruitment now is much more rural than it ever was. The urban areas here are relatively well looked after and relatively attractive because of their other surrounding appeals. As I've said in other fora, you may recruit a doctor, but you attract a family.

B. PETTEN: Minister, Change Healthcare, the integrated capacity management system, that was a $35-million deal; whatever became of that?

J. HAGGIE: It's alive and well. It's fully implemented in Eastern-Rural. It is implemented at the Janeway. I think there's a rollout in place in the remaining areas of the Health Sciences Centre.

It is delayed in Western for reasons which I can't quite remember but I'm sure my colleague to my left would be able to explain that, and it's being rolled out across Central. This is going to be a key piece in matching acuity of patients to staff and using our staff responsibly and appropriately.

So it's alive and well and it's there. I would have liked to have seen it go out a bit quicker, but there's always a little stumble here and there.

B. PETTEN: How much savings has been found to date?

J. HAGGIE: Sorry from ICM?

B. PETTEN: Yes.

J. HAGGIE: I don't have that figure. We can look and see if we can find it for you.

B. PETTEN: Is this a US-based company?

J. HAGGIE: My recollection is it has US affiliations, yes. This was awarded some years ago.

B. PETTEN: How long is that contract for?

CHAIR: Deputy Minister McGrath.

J. MCGRATH: I can certainly get that information for you.

B. PETTEN: Thank you, Chair.

Respectfully, Mr. McGrath, we had a list of questions from last year's Estimates and we never did get any answers, not one.

That was something that was highlighted along the way and, actually, I spoke about this issue last year at Estimates and we were supposed to get an update that we never received. I guess we'll – what is it – live in hope and die in despair. Anyway, hopefully this time I'll get some information.

Minister, this is a question that come up in the House of Assembly recently between myself and you on the US contracts: Has there been any contracts cancelled with US-based companies?

J. HAGGIE: The direction was given to look at all our contracts and how these might be effected by US companies. The challenge is that a lot of our sourcing is done through a group called HealthPRO, which we're a member of, so we actually benefit from group purchase prices. So it's not quite as simple as that.

To disentangle that is a work in progress. I am not aware of any contracts that have been cancelled; I am aware of one that has not been awarded because of the possibility of it going to a US company. Having said that, the health care market is troubled – if you want to use that word – by the fact that it is very, very dependent on the US suppliers.

There are things that you can only get from the US. I think if you were to cancel all US contracts, for example, we would have no masks, we would have an inability to do TAVI and a lot of interventional radiology would cease completely, because there are no readily available alternatives. At the moment, you either deal with the devil or you don't deal at all.

B. PETTEN: Minister, Teladoc, isn't that an American company?

J. HAGGIE: Our contract is with Teladoc Canada; it is incorporated internationally in Spain.

B. PETTEN: But there are US doctors employed by Teladoc to deal with residents of Newfoundland, correct?

J. HAGGIE: No, they're all Canadian licensed.

B. PETTEN: They're all Canadian licensed?

J. HAGGIE: All Canadian licensed.

B. PETTEN: So what's the status? What are the numbers with that? Do you have any data on how many people they see or what their –?

J. HAGGIE: We can certainly get that for you.

B. PETTEN: The usage data, do you have the usage? How many people are using Teladoc? Do you have any numbers or figures?

J. HAGGIE: The only number I've got at the moment is 18,000 had virtual consultations. Whether those were all Teladoc or whether those were virtual in a different way, because virtual encompasses services provided through the NLHS as well, we can certainly get that breakdown of data for you.

B. PETTEN: The same thing applies with the cost per call versus your MCP, you should be able to get a quick breakdown through MCP the cost for Teladoc, through MCP billing.

J. HAGGIE: Well, Teladoc is contracted, and MCP is fee-for-service and the claims are remitted on a fortnightly basis.

B. PETTEN: But there has to be some way to figure out the cost per call –

J. HAGGIE: Oh yeah, we can do it. I'm just saying that they go through different mechanisms. You said it was all MCP. That's not strictly accurate.

B. PETTEN: Fair enough. That's fine.

Minister, why haven't we signed on to the national pharmacare program yet?

J. HAGGIE: There is no federal government to sign on with, and the money ran out before the election. So as soon as the government is out of caretaker and the money is restored, we're ready to roll.

B. PETTEN: So it's just a matter of timing with the federal election?

J. HAGGIE: It's out of our control. This is a federal issue.

B. PETTEN: Okay.

The national dental program, has there been any savings seen provincially for that program?

J. HAGGIE: There has been a reduction under the heads when we get to Dental Services. It would be easier for me to do that as a head.

If you want to do it now, I can look. Which would you prefer?

B. PETTEN: That's fine, we can do it then. That's no problem.

Corner Brook cancer centre, what's the update on that one?

J. HAGGIE: There is recruitment underway. Pending the recruitment of doctors dedicated to that unit, there are discussions with the oncology team through what was eastern health and what is now NLHS to see if there can be some kind of provision of service, either remotely or on a visiting basis, until such time we can get the service off the ground and get it provided.

B. PETTEN: So what positions are not filled out there right now? What's the biggest gap?

J. HAGGIE: I do believe they've got a medical physicist; I think they're shy of one and there are some radiation techs that need to be hired.

As to the exact complement of physicians that are out there, maybe ADM Clarke would be in a position to answer that better than I.

CHAIR: ADM Clarke.

G. CLARKE: Minister, I can't put my finger on the number of physicians that are required right now at cancer care Western, but I can say that we're hiring a dosimetrist and radiation therapists as the Minister pointed out.

CHAIR: The hon. the Member for Conception Bay South.

B. PETTEN: This one's probably directed more to Minister Stoodley: The new Mental Health and Addictions Centre, the 10 community beds that are supposed to be located around the outside of the hospital, where are they or are they in the works – I guess, what's the status of those?

CHAIR: Minister Stoodley.

S. STOODLEY: Thank you for the question. I'll pass it to John or Gillian to best – okay.

CHAIR: Gillian Sweeney.

G. SWEENEY: Currently, there are a number of initiatives in place to support patients with mental health and addictions issues in the community. For example, the patients that were in more of the longer-term care beds at the Waterford, they were all placed prior to the move. We are scaling up community resources to support people that are in the community in advance of the downtown centre that will be built in the coming years.

B. PETTEN: So what precisely does that mean though? You're scaling up – I mean, it sounds like it's in the works but, right now, today, are there any physical places where they are or like those beds or are they just deal with it when the need arises?

CHAIR: Minister Stoodley.

S. STOODLEY: Thank you.

I can give an answer and, Gillian, you can supplement, please.

I've heard a lot about how the team were finding creative solutions for long-term residents who don't need to be in the new adult mental health facility but, for many reasons unfortunately, historically, have been institutionalized and cannot live on their own. I heard of one very innovative solution where four individuals were accommodated in a residence. They have staff supporting them, but they are living independently and sharing cooking, cleaning and those types of life skills, whereas before they were living in the Waterford Hospital.

Gillian, I don't know if you wanted to add anything. Those were before now, currently, living independently. If Gillian wants to add –

CHAIR: Gillian Sweeney.

G. SWEENEY: Thank you.

Yes, there are patients that would be located in a number of different settings throughout the community.

B. PETTEN: I mean, basically what you're referring to, I guess, there are group homes throughout the province or throughout St. John's. There are a lot of them in St. John's, actually, I deal with a lot of those individuals. From my mental health counsellor days, I'm well-aware of where a lot of them are located, so what Minister Stoodley just mentioned, I mean, that's not a new thing. That's been going on for a long time and it's going to continue on, I guess, for eternity.

Basically, I guess what I'm asking: that doesn't appear, as was in the original plan, that those 10 beds are actually, physically there now. It's just a matter of as-needed basis trying to find solutions as they arise.

From responses, that's my assertation from that one. Would that be correct?

CHAIR: Minister Stoodley.

S. STOODLEY: I guess if you're looking for a breakdown of the beds in the new adult mental health facility, I'd ask Gillian to give us a breakdown of that, please.

CHAIR: Gillian Sweeney.

G. SWEENEY: We currently have a total of 102 acute-care beds that are located in the new MHAC that opened yesterday. There are also 14 beds for acute care that are in the Health Sciences Centre that remain open as well.

B. PETTEN: Minister, if you put four residents in a home, staffed and supplied quality of life to them – which I think is wonderful – what's the associated cost figure with that? Do you have an idea of what the cost of that is?

CHAIR: Minister Stoodley.

S. STOODLEY: We can certainly get that.

Those individuals were full-time, long-term residents of the former Waterford Hospital. They did not need to be in the Waterford Hospital, so I just want the kudos to the staff for thinking about how they can really give more life to these individuals.

I think that was the spirit in which that was derived from. Rather than having these people be institutionalized and continuing to do that, I think they tried an innovative option which so far has really worked out for those individuals.

We can certainly get the cost, but I think it's cost plus the quality of life for those individuals. Then, that's four beds in the new adult mental health facility that they're not living in unnecessarily.

CHAIR: The Member's time has expired.

The Member for St. John's Centre.

J. DINN: Thank you, Chair.

The national pharmacare legislation was introduced in February 2024 and it was proclaimed on October 10, 2024. That's about six months ago, I'm just wondering what were the, I guess, negotiations or the discussions with the federal government from then until now to get onto the plan prior to the election? What discussions were taking place?

CHAIR: Minister Haggie.

J. HAGGIE: Thank you.

Yes, the detail around those plans would be how it is that the federal government either wished to take over the funding of things we already fund through our own drug programs or whether they wish to introduce something that was simply complementary and kind of reconcile it at the end.

That was also then around the range of products that would be covered. The general discussion was around the concept of diabetes medications, of which there are numerous, and also around family planning, again of which there are numerous. Those details, we're trying to align what the federal government's desires were with what the practicalities of our drug plan would be and how that would affect the use of money, basically. We were at a stage where we had reached some level of agreement and were not very far from finalizing it. Then, the feds announced there was no more money and they would come back later, and then went to the electorate instead, so we're in caretaker mode.

That's where we're up to at the moment. We're ready to resume those and the feeling from the actual individuals who were involved in the negotiations was that we were very near to being able to have documents that we could present to the provincial minister and the federal minister.

J. DINN: Thank you.

I know Manitoba, BC, PEI and Yukon have signed on. There's some indication that those who signed on, well, they made it in, and those who hadn't signed on, basically the door's shut.

So is that your understanding or is your understanding that discussions will continue once the election is finished?

J. HAGGIE: My understanding is the door is currently ajar, and depending on who wins and what happens.

If, according to what you hear in the media, one party were to be successful, this would continue. According to the interpretation of what's been said by the other, this is nowhere near as clear should they win. So, I mean, I wait to see what happens on the 28th just like everybody else.

J. DINN: Thank you.

I ask with regard to the old Waterford Hospital, the facility and the site: What are the plans for the site?

CHAIR: Minister Stoodley.

S. STOODLEY: I'm going to boldly – anyway.

My understanding is that there are teams currently in there and they will be moving out over the summer. Let's say by August or September, all staff should be out of the Waterford. Then, my personal preference is that it is decommissioned.

J. DINN: Once it's decommissioned, what happens then?

S. STOODLEY: I think that's above my pay grade, but that's an excellent question. I don't have an answer right now – no, we don't have an answer now.

CHAIR: Minister Haggie.

J. HAGGIE: I have experience with one decommissioned hospital building which was tortuous, time consuming and stressful. I don't know that under normal circumstances buildings like that would fall under the remit of TI. They are responsible for that kind of thing unless there was a decision and some proposal came forward prior to that, but that's all in the future.

I think it's a matter of speculation as to what would happen if normal situation applies and the Waterford is decommissioned. That building then becomes the responsibility of TI to manage as an empty/derelict property.

J. DINN: The reason I ask is, when I was first elected, one of the suggestions made with regard to the old Grace Hospital was, at that time, to use it as some form of deeply affordable housing that would be operated by a not-for-profit board of directors.

You could have a shelter, dwellings or you could even rent some of the spaces to not-for-profits. At the time, speaking to the Minister of Transportation and Infrastructure, he said that would have been an idea 10 years ago but it has gotten to the point where the only thing that you could do was tear it down.

I don't know what the state of the Waterford Hospital is but there is an opportunity here because I assume this land and facility is owned by the province. There's an opportunity here to see (a) if indeed this can be converted into something along those lines and (b) if it's going to be demolished because it's beyond reclamation. Then, I would assume too, there's the opportunity here to establish either a land trust or land-lease community which then could be used by not-for profit organizations to build deeply affordable housing or co-operative housing, along those lines.

I guess what I would hope, and I would have hoped that in your recommendations, that this building not sit derelict and if it's to

be sold, that maybe not-for-profits could be given first right of refusal to purchase that land or lease that over a length of time rather than sell it off to a private developer or retain part of it for such things if that helps.

Anyway that's just my thoughts there.

CHAIR: Minister Stoodley.

S. STOODLEY: Thank you.

I just want to say, personally, I agree and, as Acting Minister of Housing, I will push for us to look at how we could best use that land. I agree with your suggestions.

Thank you.

J. DINN: Thank you.

Is it possible to have an update on the *Personal Health Information Act* and when might we expect to see amendments presented in the House?

CHAIR: Minister Haggie.

J. HAGGIE: Thank you.

I kind of anticipated that this might have happened after I left because we had commissioned some work on that. I think the general view in the department is that time has slipped by and that there is a new process of consultation under way, and the results of that will inform a revision of PHIA.

There are several areas there that really kind of didn't exist when the original bill was drafted, and now do. How you best deal with those in that legislation, I think, will be an interesting discussion, and it may actually be that we're required to modify the bill and split it in some way.

Those are questions that are active with our legislative team, and the answer is, stay tuned, but don't hold your breath just yet.

J. DINN: Thank you.

The Long-Term Care and Personal Care Home Review was released in February. Can the department provide any details on plans to implement any of the 23 recommendations?

CHAIR: Minister Haggie.

J. HAGGIE: Certainly, from my point of view, I know that those recommendations have been taken to heart, and staff in the department are working on them. There are impacts from the Auditor General's report on personal care homes as well. And what we'd like to do is mix those in, as it were, and then start to act immediately on those that are pressing.

There is, in relation to personal care homes, an action plan that is being developed as we speak, and I hope to have something of a draft to see within the next few weeks, with the aim of implementing that in the very near future.

Obviously, we'll continue to work with the personal care home operators. We've been in discussions with them, and they have issues that they would like addressed. We're happy to chat with them about it, and we'll work together to make things better.

J. DINN: Thank you.

Will the department provide an update specifically on Recommendation #7 of the long-term care review, which asks for support for allowing couples to remain living together in care?

J. HAGGIE: That is work that is under way. We are trying to craft a policy that is both humane and fair, and we hope to have something in the not-too-distant future.

J. DINN: Thank you.

What is the ratio, I guess, of caregivers to patients in long-term care and personal care homes?

J. HAGGIE: I have to get those details for you. They are going to be the subject of a core staffing review. It's one of the sites that has been chosen. If you recall, there was discussions before COVID in actual fact, with then president of the RNU, Debbie Forward. Since then, the new president wanted some amendments made to that and, as a result of that, the process is really only just started with going out to the market.

In terms of specific ratios, care hours are calculated on a need's basis by patient assessments, usually prior to admission, and then staffing is built up to accommodate those care hours. In terms of how that is managed, the ICM, the Member opposite was talking about earlier on, allows not only to do that in a responsive and proactive way, but also to engage in some predictive modeling for clients to better utilize staff, that will ensure their needs are met.

If you're looking for current specific care ratios, it would be very much case dependent, but I can try and get you some breakdown if you can narrow it a little bit for me.

CHAIR: The Member's time has expired.

The Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

I'd like to just go back where we finished off before the break, before my time expired, on the mental health, the new facility.

Back in 2016, I sat in on the tail end – actually, I was late joining – on the *Towards Recovery* All-Party Committee and one of the recommendations in that report – and Minister Haggie was chair of the Committee – was to replace the Waterford Hospital. If I'm not mistaken – I don't think I am – but prior to that report was less beds but bring it more to the communities. Because we all agreed after we went around the province that people with mental health illnesses out in rural Newfoundland, far away from St. John's, out in the middle of the city is not the place for them. They should be getting mentally well in their own communities, but it appears that those community beds are not in place everywhere.

I know the Nurses' Union said it wasn't big enough and not enough in-patient beds, but I've even said it to my own colleagues is that is part of *Towards Recovery* plan. The part that seems to be missing – and you can correct me if I'm wrong – is the community beds. Throughout the province, really – I mentioned in the city – that was the whole intention. I think one example at the time we may have heard – I don't know if you recall or not – it was someone up in the remote areas of Labrador. I believe we were up in Nain together, the Northern Peninsula. That is a real issue with mental illness. It's not like a broken hip or a medical illness where you go the hospital and get well and you're out in two weeks. As we know, mental health is much more complex than that.

I guess, where are those beds to or what ever became of that recommendation? Are there that we're unaware of, because we don't seem to be able to get any tracking on that?

CHAIR: Minister Haggie.

J. HAGGIE: I think part of the problem is – and you're right, I remember those conversations and that was and still remains the thrust of *Towards Recovery*. I can speak only by example, but some of those beds, they do exist. They're just not called community mental health beds; they're called something else.

We have facilities in Gander, for example, where we have individuals with mental health and addiction issues in the community in supportive living. I think

supportive housing has become the phrase instead of community beds as such. I think it's just a change in semantics.

So you can see these there. The community supports for these individuals have been put in place. There are ACT teams and FACT teams that weren't there before. There's a regional mental health and addictions team, for example, in Central which wasn't there three years ago.

The supports are there, and the beds have been relabeled as something else. Maybe this is a change in language on the advice of recovery council and these kinds of individuals. So I take your point. I think your better number to look at might be people receiving community care rather than where they actually sleep, because the facts of the case are that may change from week to week or month to month. The idea is, at the end of the day, if you were entirely successful, you get people living as independently as they possibly can and that could be like you and me, and we wouldn't appear as living in supportive housing or community beds.

But you're right, the whole premise of the mental health reframing was a hub-and-spoke system, with care in the community, nearest to home or a home-like environment.

B. PETTEN: Thank you for that.

I guess that goes a bit towards the stigma, which is another big issue from *Towards Recovery*.

I guess Minister Stoodley or whatever may be able to answer this one. It's still related. Are there any beds in the new hostel being used now for overflow for the Mental Health and Addictions Centre?

J. HAGGIE: Sorry, I do apologize. I missed that, so I'm not actually sure what the question was, whether it was directed to me or Minister Stoodley. I do apologize.

B. PETTEN: No problem.

Are there any beds at the new hostel being used now for overflow for the new Mental Health and Addictions Centre, which used to be the Agnes Cowan, it was redone to be the new hostel –

J. HAGGIE: Agnes Cowan doesn't exist anymore.

B. PETTEN: No, it was previous, now it's been converted to a hostel.

CHAIR: Minister Stoodley.

S. STOODLEY: No.

B. PETTEN: That was a quick one.

Travel nurses: Minister, what are our numbers on travel nurses now?

S. STOODLEY: Travel nurses, travel nurses.

J. HAGGIE: Oh, travel nurses.

B. PETTEN: My God, Estimates don't end until 9.

J. HAGGIE: We were trying to answer your previous question.

B. PETTEN: But she said no, so I just moved on.

J. HAGGIE: No, it's all right. I do apologize. This is the difficulty. I'm not used to having –

B. PETTEN: Having to share.

J. HAGGIE: Being a wingman.

B. PETTEN: I know.

J. HAGGIE: So our reliance on travel nurses still exists. The issue is that until we get rid of those 300 vacancies for RNs, we will always be reliant on locums or casual nurses to some degree.

Again, I caution that in Labrador, travel nurses have existed for 50 years. They have become an integral and integrated part of health care on the coast, and I wouldn't like them to be tarred with some inappropriate feelings or sentiment because of the term "travel nurses." They have served a valuable role for years.

We are down in our usage of travel nurses by 42 per cent, and I would anticipate that as our recruitment and retention efforts continue, that percentage will gradually drop. What it will end up as, depending on the Labrador piece, I couldn't quite say yet, but we could certainly model that for you with time.

B. PETTEN: Thank you.

Minister, the Nurses' Union want all the nurse graduates hired in the floater pool. What's the problem with that idea?

J. HAGGIE: We have a class of 246. Two hundred and twenty-two have signed on for full-time employment within the province. We're working on the other 24.

B. PETTEN: I'm trying to rationalize a question. It's an issue that we spoke about last week. It's the nurse vacancies. I know that Miss Coffey has not been on the same page with you, and I guess I probably agreed with her because I think I clearly stated that I trust the union and that they have a membership base that they have a better track record than me or you or anyone else, or they should anyway.

We had 700 vacancies last year, apparently recruited 1,100, but we still have vacancies. So are they leaving the province? We should be a surplus if that's the case. So what's going on? We're losing that percentage of nurses, which is like probably 30 per cent or more of the nurses. Are they leaving the province, retiring or what's the issue?

J. HAGGIE: So that 1,133 is nurses, generically. It's not specifically RNs. If you want to look at RNs and be a bit more focused, over a six-month period – I think that should be maybe a nine-month period. I'd have to check the dates, again, now because I'm working from memory. We recruited 399 RNs. We lost 199.

The average age of retirement for an RN is 58 and if you look at the demographics of our workforce, there's a bulge around that age. So we know we're going to have retirements. On the basis of that nine-month aliquot, we are 50 per cent ahead in terms of reducing the vacancy rate – 399 in, 199 out.

B. PETTEN: Another issue – I guess these are all coming back to me. I've talked about it many times and this is probably a great opportunity to bring it up again. Health Human Resources Plan: Is there any updated time frame? I know I, personally, asked for it more times that I can remember or recall and I'm sure others have asked for it as well. Are there any time frames associated with that?

J. HAGGIE: Yes, a very short one. Watch this face.

B. PETTEN: Watch this face – I've been watching this face, Minister, so do you have any idea though or any reasonable – like it's not hours.

J. HAGGIE: Before the end of the school year.

B PETTEN: Okay. So we'll wait until June,

Are there any long-term care beds closed in the province now due to the shortage of staff?

J. HAGGIE: I'm not aware of any but – Mr. McGrath?

CHAIR: Deputy Minister McGrath.

J. MCGRATH: None are closed right now, I'm told, because of staffing.

B. PETTEN: None?

J. MCGRATH: None.

B. PETTEN: And with all the beds in acute care that are filled with our alternate level of care patients, I mean what's the plan? I know that out in Corner Brook there are some beds being – I know Dr. Parfrey actually made reference to that in that the old Corner Brook hospital have been utilized. What is the overall plan to deal with that issue?

CHAIR: Minister Haggie.

J. HAGGIE: It is an issue that is not common to one particular location. Health Sciences Centre have done remarkably well. Their ALC rate was in the 40 per cent two years ago. It is now 9 per cent. The challenge is to try and replicate some of that in other areas. Corner Brook, there is an opportunity to rebadge, repurpose the old Western Memorial, now the Corner Brook Community Centre.

So there are, what are called, 15 transitional beds. These are very important part of the system because they take frail, elderly people who need a little bit more time and rehabilitate them so that they don't actually have to go to long-term care and that they can be accommodated in maybe personal care homes or in the community, which is preferable, in line with the sort of philosophy of aging at home and aging in place.

In Central, for example, they were pioneers in rehabilitating people in long-term care itself and actually rehabilitating them to the point where they could go either to personal care homes or back into the community.

So it was, in part, part philosophy change that long-term care is not where you actually have to go and die, you can go and progress in that sense and go home. But it is a challenge, and our aim is to have as many people in the community looked after at home as possible.

CHAIR: The Member's time has expired.

The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

With regard to ratios, I guess I'm looking at, if you look at the different levels of care, one, two, three, whether it's at the long-term care facility, Pleasant View Towers, on a typical floor, what would be the ratio right now for let's say, I don't know, a level three facility or what would be – I'm just trying to get an idea how many people would be staffed both daytime and at night.

I've heard at Pleasant View Towers, at one time, that there is basically three people per floor and one nurse who would go between two floors, so I'm just trying to get an idea of what is the ratio.

CHAIR: Minister Haggie.

J. HAGGIE: Thank you.

I mean, I think the reason it's hard to answer sometimes is simply because patient's level of care in terms of where they end up is actually determined by the care they need. So number of care hours provided, I think, the average for a level three patient in this province is around 3.9 hours of actual nursing care.

In terms of the actual ratio, this, in some respects, will be informed going forward as to whether we got it right with the core staffing review I alluded to before. In terms of what the typical staffing for a long-term care unit would be, again, it depends. I mean, if you go to Lakeside, there's a special care unit, there's a protective care unit and then there is kind of the regular floor and each of those are staffed differently. If I generalize for one, I'm wrong

for the others because it is somewhat more particular.

If you want, I mean, maybe Dr. Parfrey could produce an average figure for what the staffing complement by day would be, for example, for a long-term care facility. I know the newer long-term care facilities such as Pleasant View Towers, and particularly Corner Brook, are staffed slightly differently. There are 15 bedded pods, as it were, of seniors, and the staffing is done on the basis of that.

Dr. Parfrey, I don't know if you have any numbers?

P. PARFREY: I could not answer that question, but I'm sure we can get the information going. Do you have information, Jeannine?

CHAIR: Jeannine Herritt.

J. HERRITT: The number of hours required per resident per day is outlined based on levels of care, as has been described. For level one and level two, which is a resident who would receive care in a personal care home, the hours of care are two hours per day, and that would be two hours of direct care being provided.

For level two enhanced care, which also occurs within a personal care home, the total number of hours per day is 3.5 and for level three, the total number of hours of care for direct care per day is 3.9 as the minister stated.

J. DINN: Okay. I guess, here's where I'm going with it and the question, is it enough? I'm assuming level three, two hours a day, that's not a lot in some ways, depending how in need the patient is. But I know we met many years ago, when I was first elected, with the group and they were promoting Lillian's Law which was basically establishing a ratio. At that time, I think it was 1-3 or something like that, especially of having enough – we can talk about hours, but I guess it comes down to how many people would be on the floor at that time. They were advocating for a ratio, similar to what I'd be advocating for in the school system, that reflects the needs of the patients.

That's where I'm going with it. I know from talking to relatives who've had their loved ones, their mother or mother-in-law, in long-term care facilities, that they would be there every day. They saw that there were many patients who didn't have family to come in to see them, that there wasn't enough staffing. People would be left in their beds, sometimes wearing a diaper for quite a few hours. They weren't gotten up and dressed for breakfast, and so on and so forth.

I guess what I'm looking for is, what does the number of hours look like? If a patient gets two hours per day, how many people are we talking about? If you've got to get people up in the morning, to get dressed, get down to breakfast, maybe to get a shower, that's a very human-intensive operation.

In light of, I guess, when you look at the AG's report on personal care homes, there is a significant concern on the part of many people, and certainly I've heard it since, about whether apprehension and fear about even the thought of going into a long-term care facility. Because they are afraid, very much so, that they will not be looked after. I would say for many families who have aging relatives, that would be a significant concern as well.

So that's what I'm after is what is the ratio and if you're looking at the stat, how will that work out as opposed to – so on a floor where each patient is getting two hours a day, I'm assuming that's during the daytime hours, how many staff are we looking at? How many on that floor? How many would that be in staff?

So that's where I was going with it and if, indeed, we can start looking at a staffing in

the way so that the ratio is much lower. Are there any particular items from the Health Accord blueprint that we can expect to see rolled out in the coming year?

CHAIR: Minister Haggie.

J. HAGGIE: I think the answer is there are items. Certainly, if you go through the Health Accord – and the author is very close to me, so I almost feel as if I'm getting it from both sides now – there is a lot of preventative stuff that tends not to be regarded in quite the same light as some of the more obvious bricks and mortar and staffing hires.

I mean, if you look at the health and well-being elements, they're out there and they will continue to roll out. Wearing my other hat, we have well communities or community wellness grants which we put out there. There are parts of the Health Accord blueprint. They wouldn't appear here and you won't see them under any head of expenditure here, necessarily.

So there are those. There are initiatives that go through Minister Stoodley's other portfolio in Housing. There are initiatives that go for nutritional supplements, increase in Child Benefit. We've had a massive reduction in child poverty in this province as a consequence of budgets before. So there are incremental progress of those.

If you want to look at something more tangible, there's the ground ambulance integration, which was part and parcel of Health Accord. There's the air ambulance piece which is coming out. There are the beginnings of a helicopter emergency medical service, starting out from the East Coast which we will begin to roll out. Each of these initiatives will have tangible landmarks, as it were, over the course of the next year.

We've talked about hip fracture units, the focus on provincial delivery of health care, the Family Care Teams, the integration of primary care and the integration of secondary care programs. So there's a common general surgical program, a common internal medicine program across the province rather than silos here, there and everywhere. Each of those, while it is not necessarily a huge media announcement, is a tangible from the Health Accord.

J. DINN: Thank you.

Has the department considered incentivizing entry into the nursing profession by paying nursing students for their work terms? Where are we on that?

CHAIR: Minister Haggie.

J. HAGGIE: I think that question was addressed by Minister Howell in the House the other day, looking at the fact that they have these work terms and receive not only no recognition for it, but actually have to pay tuition, and I would defer to her in that way.

If you're looking at incentives for recruitment for nurses, we have got satellite campuses which enable them to have education closer to home. We've got incentive bonuses for signing and for returns in service. We have a bursary program.

I would argue that there are incentives, the specific one about work terms falls under Minister Howell and I know, as she said to the House here, she's looking at it.

J. DINN: Thank you.

How much money will the integrated road and air ambulance service cost once completed? How does that compare to previous spending?

J. HAGGIE: I can't give you a figure from when it is completed because we don't exactly have a firm end date yet. We actually haven't signed a contract with Medavie. We've signed an MOU and there is money allocated in the budget here,

which is under a head of expenditure again and it's scattered across salaries in the department. It's also, in one of the heads of expenditure – had we gone through these in an order, I have my binder all nicely, neatly laid out and would have been able to tell you as we went through. I'm sorry I don't want to delay you by rummaging wildly.

CHAIR: The Member's time has expired.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

Minister, while we're on the topic of beds, are all the beds open in the Placentia Lions Manor?

J. HAGGIE: That's a good question.

I will defer to Ms. Herritt, maybe, or Pat.

MS. HERRITT: We will have to take it away as well.

J. HAGGIE: We'll find out for you. I mean, we kind of came here expecting heads of expenditure and money questions, so we were prepared for that. But we'll find out for you.

B. PETTEN: That's fair enough, thanks.

Minister, wait times, how are we doing with their benchmarks?

J. HAGGIE: Our wait times are longer than I would like them to be, there's no doubt about it. I think the only benchmarks that are national – we have challenges with joint replacements, but we have improved that. I think the wait times for cataracts have come down significantly and, I think, you'll find they are within the national benchmark. Our wait time for radiotherapy has been a little bit suspect, shall we say, but our wait time for other cancer treatments is within the benchmarks as well.

So in terms of exactly where they are within those benchmarks, I would have to go away and bring the data back. What I can tell you is that for our treatment results in the cancer field, we are either first or second in Canada and where we're second, we're going to be first next year.

B. PETTEN: Good.

MRI wait times, is there any improvement? I know that's been a much talked about issue. Are we making any strides to improve and shorten those times?

J. HAGGIE: Yes, particularly for Eastern-Urban currently, they're down by 13 per cent, the wait times.

B. PETTEN: Psychiatric wait times, has there been any movement on that, because that's been a fairly lengthy –

CHAIR: Minister Stoodley.

S. STOODLEY: Thank you.

I will defer to Gillian, please.

CHAIR: Gillian Sweeney.

G. SWEENEY: We continue to work on reducing wait times in each of the zones of NL Health Services. There continue to be differences between each of the zones based on the availability of psychiatry in each of the zones, so I can't provide a standard wait time because we don't have that figure, given the differences between the zones.

B. PETTEN: Okay.

This is another issue that's come up and there's been some media about it. I know me and you had questions about it as well, but the issue is still outstanding. Pediatric specialists diagnosing with ADHD, we have speech pathologists in there, and we also have autism of course. The wait times for that, children usually are in the two-to-four

range, three-to-five age, and that's where I focused at the time. There's been stories done on it, and parents have spoken out. There is a wait time. There's a two- to 2½-year wait time.

I do know that in one exchange, I think it might have been with you, I spoke to the media, but I've spoken to pediatric specialists about this actually, and we discussed, is there another way of speeding this up because you've got a short window. It's not something that you really should be delaying because, you know, if they don't get that in their early ages, it could have a detrimental impact on them down life's road as they get older.

So has there been any discussions on that? I know that you alluded that you didn't think it was an issue, but, at the time, you didn't think it was a serious issue as we were saying. I can't remember your exact words, but it wasn't what I said. We weren't on the same page, but that shouldn't shock anyone around here.

I still believe, on a serious note, that it is a very serious issue facing a lot of young families, and I know I've spoken to them throughout the province but especially in my own district. I have numerous families who have run into the 2½-year period of wait times. So has there been any discussion or plans on trying to address that? Is there any other medical profession that could assist with the backlog?

CHAIR: Minister Haggie.

J. HAGGIE: I would never accuse you of putting words in my mouth.

B. PETTEN: Well, *Hansard* never lies, Minister.

J. HAGGIE: Look, the short answer is yes. We've provided some money to NLHS, and they are working on an implementation plan to add staff for the assessment for ADHD, autism kind of issues. We're also looking at the possibility of taking the long-waiters, or the worrisome waiters, and seeing if we could work with the psychologists of the province to maybe find an initiative that we could fund through them to help address some of that backlog.

A lot of our psychologists are actually not in the NLHS employ. They are independent contractors, so there is a potential there for access to skills.

B. PETTEN: I appreciate that. That is an important issue, no doubt.

Minister, the old Costco building, I guess, leases for the urgent care and ambulatory care, any update on time frame, staffing or where we're to with that building? Because I know there's a lot of things going in down there, most recently IVF, I believe, are using part of the building for providing an IVF clinic. So any updates on staffing or leasing or time frames?

J. HAGGIE: It's a popular spot.

I don't have an update. I'm not sure whether it would be Ms. Herritt or Dr. Parfrey who be best to answer that.

CHAIR: Jeannine Herritt.

J. HERRITT: So the timeline is anticipated for fall of 2025 and plans are under way for staffing.

B. PETTEN: I guess the staffing is self-explanatory. That's a challenge we face right across the province, so I guess you can't really answer that question until you actually go looking for staff, correct?

CHAIR: Minister Haggie.

J. HAGGIE: I think my answer to that would be the same as the one before. We have significant bonuses to attract new staff. We would really rather have new staff go in there, rather than pouch old staff. We do have, over the summer, a new graduating

class of residents, some of whom are currently looking for jobs and, by and large, our recruitment incentives do work. They do work better for metro than they do for rural and that is a challenge for us in managing service delivery in rural areas.

I would anticipate that once it is clear as to what magnitude of staff we want and need and what that skill set would be, and I don't see that as being something that would take necessarily a long time to generate, then once that goes out, I would imagine a fairly robust response. Certainly, before I left, the last time round, jobs in St. John's were having between 20 and 40 physicians applying for them. There was no shortage of applicants.

B. PETTEN: Thank you.

So, Minister, basically my question, I suppose, summarized it. My point is it can be opened and finished and all fully furnished but operational, I guess – so your hope is, based on your past advertisements, you're hoping that it would be also operational this fall?

J. HAGGIE: I would hope that it's operational by the fall and I don't know that there is any concern that that would not be the case. Now, whether it wants seven doctors and by the fall we have five, you can still go and you've seen that with some of our other Family Care Teams.

We've got the colonel of a Family Care Team and then we got it operational to provide a level of service and then we've worked to boost that. Indeed, some of the comments at the beginning about the $35 million for Family Care Teams referenced teams that already exist being bolstered and enlarged rather than just simply trying to create new ones.

B. PETTEN: Thanks.

Minister, it's been a lot of debate over this one as well, the personal care home issue, but something that I know my colleague from the Third Party has spoke out about it a lot, but I changed course with that, and it was about the evictions. I do have a lot of personal care homes and community care homes in my district and they're one stream to the next, but I have some very, very impressive facilities too.

I had discussions with various homes, a couple in particular, and I asked them directly the question about the evictions. Surprisingly, the answer came back it was that, yes, I do. I asked why you do it. Because they feel the system is failing them because they have problem residents there – and these could vary from not being able to provide the care to personality changes, a whole variety of things that we all know happens within the personal care homes.

They feel they're being left with no other option. Now, this person in particular, I had to do it two or three times over a long period of time. So it changes the focus on – and I think I heard your public commentary was, they're not being dropped off in the parking lot. I get that piece. When you read the reports, you could make that connection.

Any public record will show I've not mentioned that topic because I had a different view on it. But, I guess, my question on their behalf to you and your officials is, what's being done to help – we have a lot of good operators out there, as we both agreed upon and how they're presented. Some were unfortunately grouped in with everyone else, the not-so-good ones.

What's in place to assist those homeowners who are trying their best to try to provide care to those people and they throw their hands up and they have no other choice but to go to emerg or call an ambulance and refuse to take the resident back – which is quite sad in itself, but there are two sides to that story. I'm sure you're aware of the other side as well.

Is there any commentary you have on that issue?

J. HAGGIE: I mean, it is a difficult situation. You have to remember that personal care homes are essentially private businesses. They're landlords. There is a relationship of a landlord and a tenant, albeit modified by the fact that these are individuals who do need care.

We're moving very clearly to a case management system for individuals in personal care homes. I would like to think that with some of the changes we're making to the personal care home standards around evictions that this would be a communications issue, so that a care operator didn't feel that their level of care for their client was such that they had to drop them off at emergency department at 5 on a Friday night. That is totally the wrong time to do it.

I'm not saying they all do it. I am aware of some that that do, because I've been on the other end at the door at 5 on a Friday afternoon.

I think I would do two things. One, I would encourage them as individuals to use that case management to talk to the individuals concerned. Reassessments are straightforward to organize, and we put 17 FTEs into the system across the health system last year to enable assessments to be done more rapidly and monitoring to be done more closely.

At the same time, I would listen to the commentary of our staff as they speak to personal care home operators who live this. I think the numbers are actually small. When you look, there's 4,500 people in personal care homes, and over the period of the AG's discussion or monitoring there were 91 that were dropped off at an emergency department. That's actually a very tiny percentage.

Again, like with the other incidents, it's a number I'd like to see at zero, but I think we need to be careful about crafting a blanket policy to deal with a very small percentage of individuals because that's not good policy making. But you and I walk the same set of lines because of both sides of that issue.

CHAIR: The Member's time is expired.

The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

With regard to personal care homes, I know one owner reached out to me, and the comment was, with regard to equipment, that even if they wanted to, like a chairlift, it would not be supported by Newfoundland and Labrador Health Services. If they use a chairlift to take a person off the floor who's fallen, to do otherwise I guess would risk injuring workers, but I'm just trying to get an idea of what is it then that personal care homes, when it comes to equipment, are permitted to use or not use.

It was put to me that if they could access – in this case, the owner said I would pay for the equipment myself, do the training with the staff, and make sure that it was used properly. That would be a huge help in keeping people in their personal care homes. So I'm just trying to get an idea of what is the policy, or is there one, from the Health Services or from the department.

CHAIR: Minister Haggie.

J. HAGGIE: The only specifics around that that I'm aware of is if a home wants a piece of equipment, NLHS will supply it if it is clinically indicated for that patient, but I'm not aware of anybody telling anybody that they can't use something that they have already.

J. DINN: So if they wanted to go out and purchase it, themselves – in other words, it would have to go through Health Services and it would have to be, I guess, identified

that the patient would need it. Someone falls and you need to get them up off the floor, they can't get up on their own but a chairlift or some sort of a device would help them.

I'm just trying to get an idea, would it have to be approved by Health Services first or it's up to them what equipment they use, if they want to train people themselves properly and if they want to purchase it, are they able to do that if they wish?

J. HAGGIE: I will defer to Ms. Herritt, but I'm not aware. The only thing I said was if they wanted a piece of equipment for an individual and wanted us to pay for it, we would only do so if it was necessary for that patient's clinical care, but that's what I said.

CHAIR: Jeannine Herritt.

J. HERRITT: In a personal care home, the use of equipment again ties back to the levels of care that we spoke about earlier. Based on a clinical assessment of the client, as the minister has noted, the health authority can work with personal care homes to implement appropriate equipment in the personal care home setting. It is an individual assessment based on the client and the factors within the home as well and ensuring that staff have appropriate training and are able to use the equipment effectively.

I think there's not a one-size-fits-all answer but more of an individualized assessment depending on the home, the particular needs of the client and the ability of staff and the knowledge around the equipment use in the personal care home setting.

J. DINN: So if I may, then it would have to be approved by Health. Like, if I own a home, I need my chair lifts or whatever else, we have a patient there, we'll buy it and we'll train the staff according to standards, would I be able to do that, or does it have to go through the Health Services?

J. HERRITT: That would be a discussion with the health authority to determine the appropriateness of the equipment and, again, to discuss things such as training needs which the health authority would have a role in with the personal care home depending upon the decision at hand.

So it's not an individual personal care home decision. It would be a decision made in collaboration with the health authority and, of course, in line with the operational standards.

J. DINN: I guess, even if the personal care home was saying look, we'll pay for it ourselves. I'm just trying to clarify what I was told versus – so if I said, look, I don't want the health authority to pay for, we'll pay for the training, you certify them and we're happy to go with that. So I'm just trying to say, in that case, they would still have to get the approval of the health authority?

CHAIR: Minister Haggie.

J. HAGGIE: I think the concern from the other point is, is this an appropriate piece of equipment to do the job you wish to do, and it's knowing whether or not there is the skill set there to make that decision. Because there are different types of lifts available; there are different types of sit-to-stand devices. I think the caveat from our point of view as a department is to make sure that the staff in the home know which to use and how to use it.

It's decision-making and training, not the actual equipment, that is the cause of what anxiety may appear in this process. It's not a desire to deprive the home of anything. It's a desire to make sure both the people who are operating that equipment are safeguarded, as well as the individual they're using it on.

J. DINN: Okay, that makes sense.

In other words, you can't have one piece of equipment then they decide, well, I'm going to use it in another – or another patient who may have something similar but not quite.

I would like you, if possible, to take me through the consultation process with Janeway pediatricians with regard to the integration of the gynecological services into the Janeway. I'm trying to get an idea. It was said today that the process has now begun. I'm just trying to understand the timeline of this process.

CHAIR: Minister Haggie.

J. HAGGIE: As I said in the House today and on previous occasions, there are a multitude of possibilities about how best to use the resources that are present on the Health Sciences site and the Janeway. At some point, those consultations have to begin. I think that equally well – and Dr. Parfrey can probably speak to this with more granular detail – at some point somebody feels that someone else knows something they don't. The minute that happens people start to get worried and defensive and reactive.

So, having said that, and acknowledging that we are at the beginnings of this, I think it would be sensible just to ask Dr. Parfrey if he wanted to add anything to that analysis.

CHAIR: Dr. Parfrey.

P. PARFREY: Sure. Maybe I might be a little bit long-winded here now.

The Health Accord mentioned three things in relationship to children's health. It mentioned the issue Mr. Petten brought up about wait times for certain outpatient stuff, like autism and developmental delay and mental health and addictions, et cetera. The response currently is to develop a child health model that integrates the health side with the social workers at CSSD and the educational system, and I'm optimistic that that solution will roll out over the next short period of time.

The second one was around the Children and Youth in Alternate Care clinic, which is a community-based clinic that provides wraparound services to children in care and recommended that be increased. That service is currently in a bed part of the fourth floor of the Janeway, occupying a patient bed area.

Then the third part was around developing the Janeway as a children and women's hospital for two reasons. One was that the number of children has dropped by half since 1990 and the sustainability of the Janeway would be enhanced by having services that were targeted for women. In particular, it was also considered that targeting services for women was dealing with a neglected area, and this would be able to enhance women's health, particularly around menopausal therapy, prevention of cancer, access to cardiac disease where they're underdiagnosed and undertreated.

So that proposal has been made and, as a consequence of that, obstetric services have been planned to be transferred from the Health Sciences Centre to the Janeway and a new 28-bedded obstetrics unit has been approved and is meant to go forward over the next number of years. The renovations are substantial. The other thing that's happened is that gynecological surgery has started in the operating rooms of the Janeway.

So in the last period of time, we've had large problems with adult patients being in the corridors of the Health Sciences because there's no beds available to them, and we've investigated a number of different ways of being able to identify acute-care beds for those people. One of the potential areas was the area that the CAYAC clinic occupied in a bed area of the Janeway hospital. That potential solution would have no effect on the pediatric beds.

The thought process around how to solve our problem involved meeting with the pediatrics group, the Janeway group, in March. Dr. Greg Browne, who is the clinical lead for infrastructure and clinical transition, was the person who had that initial discussion with them and what their opinions were. I subsequently then met with the pediatric group separately last week and spent an hour and a half with them probably and then met with the gynecological group a few days later, all within the last period of time.

It was agreed that we would continue to engage about what the solutions could be and what the problem would be, and then we'd also examine what other hospitals are intending to do when it comes to the role of gynecology in children and women's hospital.

The reality, I think, is that the pediatrics group of the Janeway believe that this should be a children's alone institution and we, as an executive, are concerned about how we can deal with a bigger risk which is that we have people in corridors, adults in corridors that could get beds if the gynecology unit went to the space that's occupied by the CAYAC clinic and we were able to use those beds for acute care.

That's just a long-winded background to what's happening. There has been no plan delivered to the Department of Health and Community Services and we have not finalized a plan in terms of how we would deal with the problems that we've currently got.

Engagement will continue. For example, the Izaak Walton Killam has a children and women's hospital and Dr. Browne is going to visit there with the principles that are involved in pediatrics and gynecology and we will continue to engage.

CHAIR: Thank you, very much.

The Member's time has expired.

We're going to take a break now and come back at 7:50 p.m.

Recess

CHAIR: Okay, we are going to start up again.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

Minister, the Extended Stay on Lemarchant Road has been used as a hostel for a nice number of years. Is this still presently being used as a hostel?

CHAIR: Minister Haggie.

J. HAGGIE: Yes.

B. PETTEN: It is?

Do you have any idea of the cost per year?

J. HAGGIE: Not offhand. But maybe Mr. McGrath might be able to get it for us.

CHAIR: Deputy Minister McGrath.

J. MCGRATH: I will get it.

B. PETTEN: Don't forget this time, though.

J. MCGRATH: Oh, sorry, we do have it. Patrick has it.

CHAIR: Patrick Morrissey.

P. MORRISSEY: Yes, so it's $258,500 a month.

B. PETTEN: $250,000 per month?

P. MORRISSEY: $258,500 per month.

B. PETTEN: Not a bad gig.

Has there been any plans of purchasing this, or just continue on with the monthly rentals?

CHAIR: Minister Haggie.

J. HAGGIE: At the moment, until we know exactly what's going to happen with hostel accommodation and the need for it, this seemed to be a reasonable short- to medium-term measure while the rest of the requirements for the Health Sciences and Mental Health and Addictions Centre were determined.

B. PETTEN: The downtown clinic timelines and staff, I think I asked this during Transportation Estimates, if I'm not mistaken, and I was told that this was under Health. So any update on that? That's the downtown wellness – is it the wellness centre? Is that what it is called?

J. HAGGIE: Hang on a second, the downtown wellness?

B. PETTEN: The downtown wellness clinic, yes.

J. HAGGIE: Okay, hang on a second. I will defer to Dr. Parfrey.

CHAIR: Dr. Parfrey.

P. PARFREY: That's the proposed site for the Downtown Health and Well-Being Centre at the Grace Hospital. It's got four elements to it. One is as a step-down unit for psychiatric care, in which there would be 20 beds that would be created for people who've been started on their drugs, but they need to be stabilized on their drugs. So it would also house the community-based programs like ACT and FACT and, et cetera, those other community-based endeavours. And would include a transfer of the Pleasantville detox centre to that same site.

Then the other part of the site would contain a Family Care Team for the downtown, and eventually would have an urgent care team to replace the emergency room at St. Clare's when St. Clare's was finished.

So that's just been planned and hasn't yet had an approved budget from the current government.

B. PETTEN: Thank you for that.

I guess that's to do with the void that's going to be in that area where it's the downtown core and St. Clare's will no longer be there. Okay, it makes sense.

P. PARFREY: So the Family Care Team would be particular to the downtown. It would function as a hub for resources that would go to places like The Gathering Place and Choices for Youth, et cetera.

B. PETTEN: Okay, makes sense.

Minister, Heart Force One, any data on the usage of trips and the cost?

J. HAGGIE: My understanding is that it's moved 241 patients, as of the end of last calendar year. I'm not sure exactly how many flights that would've been over. As to the cost, I would defer to either the comptroller or John.

CHAIR: Chad Antle.

C. ANTLE: I don't have that on me now, but we can certainly get it.

B. PETTEN: Cardiac wait-lists: We've had new labs announced and we've been sending people to Ottawa, but we still have 200 on our wait-list. What's the reason we can't seem to get that number down? Are cardiac issues increasing that much, or are there other issues within the system that's causing that number to stay at 200?

J. HAGGIE: It's a victim of success temporarily, as it were, in another area. The cardiac cath lab is working more efficiently and processing more patients. The vast

majority of people who go for a cath will have – where possible – an interventional procedure like a stent or an angioplasty. But there's a fixed percentage of those individuals for whom that doesn't work and who require cardiac surgery. So what you've done is you have increased the volume, but because it's a fixed percentage, that number increases at the other end.

So that is what's driving the demand for cardiac surgery at the moment. We have an arrangement with the Ottawa Heart Institute. There is discussion with the cardiac surgeons about adding another FTE, another full-time equivalent cardiac surgeon, to our roster. And those discussions are well under way and that should raise the opportunity of increasing throughput at the cardiac surgery end. And those discussions are well advanced.

B. PETTEN: Okay.

Minister, missed appointments, does the department have any stats this year? It seems like we send appointment reminders for everything, but a lot of things we don't. Is there anything in place or anything being worked on to try to decrease that number? Because we all know that's a big issue within the health care system and it's driving everything from costs, you name it, to efficiencies, to access to services, obviously, delays in getting with this issue.

But it's a big issue and it probably doesn't get talked about enough. So is there anything internally being worked on to try to eliminate or lower that missed appointment rate?

J. HAGGIE: Yes, it is an issue. If someone can't make an appointment and we know about it, with enough notice, we can use that for somebody else. Obviously, at the very last minute if some prep is required like for a colonoscopy, where you need a couple of days' notice, that isn't always as easy.

Basically, it's a notification system and depending on where you are, it's either automated or it's manual. We have an automatic notification system, for example, for certain areas in Central for ambulatory non-evasive cardiology. You get a little thing on your phone. You have an appointment. Are you going to go? Press one if you are and press two if you're not. For others, it's clerical calling to try and reduce it.

Where we've had those in place, even 10 years ago, we could reduce the no-show rate for endoscopy lists – mine particularly. I know it's 10 years ago, but it worked then. We could reduce that to 2 per cent or 3 per cent from anywhere from 20 per cent to 30 per cent sometimes.

B. PETTEN: Minister, any update on the geriatric health care centres that's been talked about?

J. HAGGIE: That was based on initially, really, a hub-and-spoke model. There are the makings of one at the Miller Centre. I think the discussion then is how best to put these in other locations. One of the challenges really is whilst you could maybe find a geriatrician, a solo practitioner, without support in that area particularly is a very difficult proposition.

What you need to look at is space, what you need to look at is rehabilitation services, physio, OT, that kind of thing. For example, the transitional beds in Corner Brook will be an excellent addition to that, kind of, armamentarium. We've had discussions with NLHS about how to kind of clone that and get it out there.

One of the challenges as a country, Canada's training system for residents – which is a system that is so bizarre and archaic some days I wonder whoever designed it – does not train many geriatricians. The last figure I saw was 18 a year. It just doesn't match our demographics, yet it's been very difficult to change that because of the hold of

universities and others in maintaining the status quo.

B. PETTEN: Thank you.

Minister, the health system information update – I know you spoke about it in your opening remarks – it's a large budget item. As we all know, it's $600 million. Do you feel that's a good value for money? I know we've gone through cyberattacks and we've gone through the most recent ones in education and throughout. It's become a more important issue than just – some people would glaze over it not so long ago when you'd mention it. Some still do because they don't really understand it or appreciate it.

I guess with that amount of money being invested, it's quite a large sum of money. What are the outcomes you're hoping for when this gets implemented?

J. HAGGIE: Well, just for an update for the House, we are on time and on budget, and it's not always you can say that, so I'm really pleased about that.

This is a gamechanger for clinical care in this province. Both for the clinicians, for the administration, who can use it for real-time decision support, and for the patient because it interfaces with all of those areas in a way that allows access to information. So you would be able to ultimately read your own chart in the comfort of your own room at home. You can integrate clinical decision with lab test and these kinds of things.

Essentially, it takes Meditech and a lot of the legacy systems from the clinical frontend and plugs them all in together. We have a separate approach for the backend, which will really be around facilities management and payroll and administration, but that's rolling out in parallel as well, and will yield huge dividends. But the health information system is a clinical, front-facing thing, and I think it will be a huge improvement.

There will be a change management piece, because everyone's used to pressing button A and button B to get where they're going. When you change that, they'll not be happy in the early days, so we need to learn from the challenges we've experienced in the past and do a good job of that change management. That's been a big part of our discussions with OCIO and with other folk who are project managers on this.

CHAIR: The Member's time is expired.

The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

I'll go back to the consultation process, but I do have a few questions in the meantime before I do that.

Right now, as I understand it, there are more patients than beds at the Health Sciences Centre, so why is that? I know last time I was at St. Clare's there were an awful lot of elderly people in the emergency ward. I would assume, for some of them, they have no other beds to go to. Maybe they should be in long-term care facilities, and I've heard that from doctors at St. Clare's that you could free up space if there were long-term care beds available.

So I'm just trying to get an idea, what is the issue at the Health Sciences?

CHAIR: Minister Haggie.

J. HAGGIE: Now it's as much demand as anything. There are no opportunities yet, although we're working on it and have some steps in place already for going right to the frontend. So treat and leave options, using advanced care paramedics and community supports, all the way through to the rapid discharge of patients to an appropriate environment – be it the one we've all heard about is long-term care. But there are

opportunities for early discharge after surgery. Health Sciences Centre has a program that's been rolled out, to some extent, in other centres. The ALC problem at the Health Sciences Centre is actually a lot less than in other areas now because of some of the maneuvers that have been possible in town.

It's an issue of demand management and flow that is the problem in the Health Sciences Centre at the moment.

J. DINN: Would it be possible to have a breakdown of the number of either alternative level of care or long-term care patients who are in St. Clare's and in the Health Sciences Centre?

J. HAGGIE: Yes, just specify a date or a day because it does change by day, but currently the average for the Health Sciences Centre site alone is around 9 per cent. As to St. Clare's, I don't have that figure on the tip of my tongue.

J. DINN: Okay.

I would certainly look over the last few months. I can send you the specific months or the dates and you can give that to me in a snapshot.

J. HAGGIE: Yes, that's fine.

J. DINN: Perfect.

As I understand it right now, would be able to confirm if indeed Janeway diagnostic equipment, MRIs and so on and so forth are being used for adults? Is that the case?

J. HAGGIE: I would defer to either Jeannine or Pat. My understanding is that, in the past, the CT Scanner has been used in that regard but that was back in some years ago. So I would defer Jeannine or Pat.

CHAIR: Dr. Pat Parfrey.

P. PARFREY: My wife was a pediatric radiologist and to be able to sustain pediatric radiology, get an MRI and get a CT scan, they decided that they needed to extend the service to adults, in particular cancer. To be able to provide that sustained pediatric radiology, they needed to increase their volume in other arenas. Those radiology services have been used for adults for over a decade, both MRI, CT scan, et cetera.

J. DINN: Have any children been bumped or have their services cancelled as a result of this?

P. PARFREY: I doubt it very much.

There's a very strong connection between pediatric radiology and the pediatricians and the pediatric surgeons in the Janeway. I mean, I can't give you chapter and verse but I think that they run a collegial service that includes pediatric radiology and then it would include services to adults as well.

J. DINN: Have there been any diversions of children to other hospitals from the Janeway for the pediatric intensive care?

CHAIR: Minister Haggie.

J. HAGGIE: The last ones I was aware of were during COVID. Again, Dr. Parfrey may have a more up-to-date figure. I'm not aware of any currently.

CHAIR: Dr. Pat Parfrey.

P. PARFREY: I'm not aware. You're talking about pediatric ICU? Is that what you're talking about Mr. Dinn?

J. DINN: Yeah.

P. PARFREY: Yeah, so there are six beds staffed for pediatric ICU. They have on a number of occasions in the last year and a half hit four, and then they have an extra two that they can use in addition for pediatric ICU if there's a surge.

The occupancy for the medicine and surgery for pediatrics they have 33 beds, and they haven't gone up above 80 per cent any time in the last year and a half.

J. DINN: Have there been any children who've had to spend overnight in the emergency ward because there was no bed available?

CHAIR: Minister Haggie.

J. HAGGIE: I'm sure Dr. Parfrey would be able to tell you, but if there is always 20 per cent beds empty, it seems unlikely.

Pat?

CHAIR: Dr. Parfrey.

P. PARFREY: I can't give chapter and verse, but it's a very unlikely event in the fact because, as Dr. Haggie said, the occupancy has never been over 80 per cent for the pediatrics medicine and surgery.

J. DINN: With regard to the Janeway, I think you had said that doctors believe that the Janeway should be a children's only hospital. I would ask, why shouldn't it be?

CHAIR: Minister Haggie.

J. HAGGIE: Are you asking me? If you're asking me –

J. DINN: I'm asking whoever wishes –

J. HAGGIE: Well, I'll tell you.

It is a pediatric tertiary service for the children of this province.

J. DINN: So I'm looking here, and maybe you can correct me if I'm wrong, but I suspect not in this case since the doctors are putting it forward, of the 11 hospitals including the Janeway, which are tertiary or quaternary care pediatric health care centres across Canada, none of them offer adult gynecological services and only two offer obstetric services, which would be in separate buildings. That's the CHU Sainte-Justine in Montreal, Quebec, and the IWK Health Centre, Halifax, Nova Scotia. I think you talked about taking doctors or something on a tour of some places to show how it works.

So none of them, I guess, have actually taken over space in the children's hospital to accommodate this. As a person who has brought his children to the Janeway when it was in the old building and someone who has had to bring his grandchildren there in the new building, it is a purpose-built hospital so, again, I guess why shouldn't it be when no other jurisdiction is attempting to do what we're doing?

Here it seems we're trying to solve an adult acute-care problem by taking from the Janeway. I'm just trying to get an idea here, why wouldn't we build on the space we need to the Health Sciences or find a way to move those who might be in long-term care into another setting. I'd like an answer to that please.

CHAIR: Minister Haggie.

J. HAGGIE: These three issues there that you raise or three topics, I think the first thing, and I've said this repeatedly, no diminution of the services available to the children of this province. The second thing is this is part of the consultation process to do jurisdictional scans. You have presented some information there, and that will be very helpful. Finally, the issue about building only comes at the very end. If there is unused and empty space in a facility, it is beholden on all of us to use what is the province's most expensive real estate in a way that makes sense for the most benefit.

We're not taking anything away from anyone. We are hoping to add to the services that are generally available with whatever we do, but this is a consultation process and we're at the beginning of it.

CHAIR: The Member's time has expired.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

Minister, an update on the fertility services clinic, proposed a new clinic, I guess, what are we looking at? What's that going to look like when it comes to fruition, is what I'm asking.

CHAIR: Minister Haggie.

J. HAGGIE: It will be an expansion of services currently. We've increased the supplement as the Member opposite is aware. Across Canada, some of these services are insured by provincial health plans and some are not.

The discussions at the moment with the two physicians who want to offer this service as part of a clinic that's already run through Eastern Health are under way about what it is they would need and what it is that's needed to fill the gap. The desire from our point of view was to have something in place by the beginning of 2026. It would appear that some of their announcements now are quite optimistic in terms of a timeline, so exactly what it will look like will depend on those discussions. Essentially, the desire is to offer a package that minimizes the need for residents of this province to travel.

B. PETTEN: Thank you for that.

This question came up last year; several of my questions are repeats and I was supposed to get the information after we had Estimates, but that never came. The final cost of the cyberattack…?

CHAIR: Minister Haggie.

J. HAGGIE: The bill I've seen so far is $16 million. The investment going forward – I mean we talked about the health information system, that is cyber security.

In addition to that there's some implementation money for the Gartner report, which I think is another $1.5 million for this year, specifically for the budget.

B. PETTEN: Minister, I know this is an issue that's been asked many times, was there any ransom paid?

J. HAGGIE: I don't know that I'm actually at liberty to disclose anything about that. I'm afraid I'm not up-to-date with what the public pronouncements have been. The last I heard was that we were neither to confirm or deny that that was the case.

B. PETTEN: I know there have been high numbers on Family Care Teams, but what is the status of Family Care Teams? How many are presently open or on the verge of opening?

J. HAGGIE: Twenty.

B. PETTEN: Twenty.

I know last year during Estimates, the former minister made reference that there were plans to have something in Conception Bay South, which, by no accident, is my district, and we severely lack health care services. We don't have any public transit.

I'm smirking because Dr. Parfrey, when he was doing the Health Accord, a couple of times, my colleague and I actually had a couple of meetings with himself and Sister Davis on this same issue. At the time, we were an ideal location for collaborative care, now it's gone to urgent family care, but of some form of health service. The former minister as much as alluded that we were in line, there was something coming our way. But again, I wait.

Are there any proposed plans or discussions to address that?

CHAIR: Minister Haggie.

J. HAGGIE: I'd be happy to look at the Member's concerns for his district.

B. PETTEN: I've been around a long time to know what that answer means, okay.

J. HAGGIE: You could be surprised.

B. PETTEN: Listen, nothing surprises me anymore, but you never know.

Minister, with those urgent Family Care Teams, this issue has been talked about a lot, it's been confused, it's been complicated, the rostering. We hear rostering and its overuse or misuse. If you're rostered, as opposed to being able to see a doctor, there are two distinct differences there. If you're rostered, where does that put you on a line of being able to see a family doctor?

J. HAGGIE: The idea of rostering is you have a family care home. You know where to go if you have a problem. You would go to the much-hoped-for CBS Family Care Team, for example. That's where you'd go. What happens to you when you get in there depends on what your problem is at the time and it also depends on the resources in the clinic.

For example, if you have a fairly routine prescription refill, if the Family Care Team has a pharmacist on staff and that pharmacist is there that day, you might actually see the pharmacist, or, if not, the nurse practitioner. Eighty per cent of primary care can be done by nurse practitioners, unsupervised. And that was the whole idea of altering the medical care act to make sure they were autonomous practitioners.

The role of a family practitioner is to deal with those complicated cases where a kind of arbitration needs to happen. You have five comorbid conditions – which is not unusual in this province – each of them is treated with what's called an algorithm, a recommended set of treatments followed by a physician or a nurse practitioner,

Once you get more than three of those, they fight each other. Then what happens is it becomes an arbitration between the patient and their primary care provider, their physician. Which of these is more important to you? Is it the fact that you can't get these nice shoes on and your ankles swell when you want to look good when you go out, or is it the fact that your eyesight is a problem or you've got numb hands? How do we best treat those when the drugs for one will make the other worse? Which matters most to you?

That's the role of a primary care provider. It is for the complicated cases that are not easily managed simply. So the answer to your question is you go to your medical home, your family care home, primary care home and it depends, what do you need, we got what you need.

B. PETTEN: But there's no guarantee you're getting to see a family doctor. Say if those people can't help you and you have something more serious you end up, most times, going to emerg; am I correct?

J. HAGGIE: At the moment, there is a gap. That's what the urgent care centres are for. Because again, there's another matrix to be looked at. If you go to your primary care home with an urgent complaint, how urgent is it? And you can quantify that. There's a Canadian triage score, CTAS, one to five.

Four and five are straightforward, elective, daytime stuff. Unfortunately, because of a lack of access to primary care in the past, the only place they could go was emergency rooms. That's why they sit there because they're triaged from clinical need to the lower end of the list. If you're a three, maybe you should have called an ambulance. If you're a two, you shouldn't be at a family doctor's clinic; you should be in an emergency room.

So that matrix has to be dealt with as well. Most family doctors will have an ability to fit in a walk-in, someone who is ill, couldn't make an appointment because of sudden onset and they would normally fall at a kind of CTAS three. Maybe they're ill; maybe they could be managed by a primary care provider.

An urgent care clinic is different again because if you've cut yourself and you need stiches, currently the only place you can go is an emergency room. If you have an urgent care clinic, there are care providers who can do that for you. It could even be an ACP.

So they're slightly different but they're related. Because if you've got a really bad chest infection, you could be urgent and therefore need to go to urgent care rather than try and fit into your primary care home. The answer is there will be options and it depends and if you're out of town, you could even ring 811 or Teladoc and get that determination.

B. PETTEN: Minister, the Lionel Kelland Hospice, that bridge funding, last year – and I guess they're wondering why this funding wasn't increased as more funds have been needed and its successes in the operation of this facility. I know the funding wasn't increased this year, even though they wanted the funds increased. Is there any rationale or reasoning for that?

J. HAGGIE: They did get an injection of funds last year. The discussions at the moment are around what their operational needs are. That negotiation is actually still ongoing and hasn't concluded, so there's been no conclusion as to what money they would require for this year yet.

B. PETTEN: Final wrap up – not final, it'll never be final. What are your numbers on the people without a family doctor in the province right now? Because it's not the same numbers as NLMA and, I guess, we've been using. What are your numbers on the family doctor shortage?

J. HAGGIE: You and I have butted heads over what that number is. The fact is, one without a family doctor is the wrong number. You and I can argue, black and white. The NLMA have a very, very strict set of questions they ask on their surveys to decide whether or not you have a family doctor. Most of us who actually think they have a family doctor would not actually get that on there.

I'm not going to argue numbers. It's pointless because anybody who hasn't got one is a concern to my department.

CHAIR: The Member's time is expired.

The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

Minister, is the Janeway staffed appropriately?

I guess where I'm going with this, if there are beds empty, is that because we have a very healthy population of healthy children, or is it just that staff has not been provided to keep the beds open?

J. HAGGIE: The empty beds that I've been referencing at the Janeway are staffed beds. The problem that we have is demographic. As, I think, Dr. Parfrey alluded to, and I have certainly said, if you look 10 years ago, our pediatric population was probably double what it is now. The planning for that new Janeway facility, which is no longer new, was made at a time when the pediatric population was even larger.

Our birthrate is 3,400 or 3,500 a year. We have 67,000 children in the school system. We do not have the children we used to have. Even with immigration, all that does is it holds the decline to zero.

J. DINN: I know last year there were extra units added into the school system basically to accommodate – I think it was, roughly, in the metro area – a full school of population of children that came into the metro area. That's a significant number of students and of children.

I know that based on this, what pediatricians said, from January 20 to March 2025, 15 patients were delayed transfers out of PICU due to a lack of beds, three critically-ill children were transferred out of province, 24 sleep studies were cancelled and numerous surgeries and oncology admissions were delayed. I guess that's my concern.

Also, with the immigration of newcomers, there is probably a whole host of conditions, diseases, such as sickle-cell anemia, that we probably didn't experience before in Newfoundland and Labrador. While the model, you referenced the declining birth rate, and I would agree with you on that, but even if I'm looking at some of the people in my district, newcomers have a larger than normal family and it's good to see more children that's for sure.

I have a question then related to the consultation piece. On March 11, there was a presentation given and it was very clear, I think, that doctors understood that that wasn't about asking what do you think, but here's what's going to happen. I think then Dr. Parfrey said he met with doctors on the 7th or so, the early part, of April and made it very clear at the time that no decisions had been made and this was more or less about consultation.

Again, I guess what really threw the monkey wrench into it was that, on April 9, two days later, the budget comes out and it has a very clear line there, "$3 million for the Redevelopment of the Janeway Children's Hospital and to relocate women's health services…."

The doctors, I think they would accept that when it came to obstetrics. That's a natural continuation, hand in glove when it comes to maternal care and to the children's care, but obviously all those assurances went out the window when we saw in the budget that there was now a budget line of money allocated for it. It sort of the belied the whole notion that this was consultation.

So here's what I'm looking for: I would love to have a copy of the presentation that was given to see if indeed it was about a proposal or the research. We've seen what the doctors have put out; it would be interesting to see what was presented to the doctors and what caused the consternation.

Secondly, I guess the key thing for me is that Dr. Parfrey had said engagement will continue. The question I have written down is how and what is the timeline now? In this report, doctors made it very clear not only about doing further consultation with them, and I'm assuming that this document, that they presented to you, Minister, and to Dr. Parfrey and I think to Dr. Greg Browne, will be the basis of further discussions and consultations. I'm just wondering then, if this is the beginning of the consultation process, how will this look going forward? What are the plans, because if indeed the consultation and the conversation has started, where does it go from here and when will we see public consultation with families and with the stakeholders, the people who have been donating to the Janeway?

J. HAGGIE: Yeah, thank you very much.

These presentations that you allude to, I have not seen. They were maybe the ones that Dr. Parfrey alluded to that Dr. Browne made. There is no line item in the budget for this as such. The reference to the money for the Janeway, my understanding was it was to deal with the changes required around the obstetric piece, which, as you've said, it would appear the Janeway pediatricians have little aversion to.

I would probably get Dr. Parfrey to allude and describe his views of what's next and what the timeline is. I can't really shed any light on that having not been directly involved and, just for clarity, I have received no communication as of coming to the House today from anybody about this particular issue.

J. DINN: Thank you.

CHAIR: Dr. Pat Parfrey.

P. PARFREY: I do think there's a bit of a misunderstanding about the $3 million that is in the budget. The only plan that's gone to the Department of Health and Community Services has been around obstetrics.

Health and Community Services received nothing around gynecology, and the engagement process that we've discussed has been on that basis. We intend to take people to the Izaak Walton Killam and we intend to take account of the objections of the pediatricians, in terms of the fact that they want it to be a child-only hospital, as against the other needs that are there as well.

The timeline – there's no given timeline to coming forward with a recommendation that could be made to the Department of Health and Community Services.

J. DINN: Okay, thank you.

So the hospital then, the one that you refer, where is that one located?

J. HAGGIE: Halifax.

J. DINN: Halifax. So this is the IWK Health Centre? I've seen the map, the layout of it and, again, it's two separate buildings, correct?

CHAIR: Dr. Pat Parfrey.

P. PARFREY: I assume so. I'm not an expert in what's going on there. That's why people are going up to visit it and to discuss the issues that they have to deal with and how they solve them.

J. DINN: If you look at a diagram, it is indeed two separate buildings joined by an intermediate building. They are two separate buildings for gynecological services and the obstetrics.

Okay, thank you for that lease.

Is there a plan then, I guess the consultation process from Newfoundland and Labrador Health Services' point of view, where we go from here with regard to this?

CHAIR: Minister Haggie.

J. HAGGIE: From my point of view, once Dr. Parfrey and his team have done their work then the discussion will revert to what to do with the empty space and the problem of over occupancy in the other facilities, because those problems do need to be addressed.

I think Dr. Parfrey has done his best on the fly to describe a consultation process. It is obvious from the Member opposite that he has some detailed knowledge of one view of this problem. So I'm quite happy to take that into consideration and, indeed, this is the whole point of having a consultation process. There is no idea that can't be improved by listening to other people. We found that out over the years so that's the value of consultation, and we're right at the beginning of this so I think it would be rash to make any commitments to anything one way or anything, except we're here to talk.

J. DINN: Thank you.

What work is this department responsible for in administering the Aging Well at Home Grant and what is the budget for the program in the coming year?

CHAIR: Minister Haggie.

J. HAGGIE: If the Member opposite will indulge me, I will endeavour to try and find that, because I'm still at 1.1.01 and I think that's a long way down in the book.

Have you got it there? Are you going to find it faster?

CHAIR: Deputy Minister McGrath.

J. MCGRATH: So that's part of the Seniors' Health and Well-Being Plan. The total budget for that is $10 million. The grant itself, I believe it's the Aging Well at Home Grant, that's administered by Newfoundland and Labrador Health Services.

CHAIR: Okay, the Member's time is expired.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

Minister, what's the status of the expansion of the Fogo Island Health Centre? What's the status of that expansion?

CHAIR: Minister Haggie.

J. HAGGIE: My understanding is that the RFP is out, but I would not know any greater detail than that. Maybe Jeannine might be – no?

CHAIR: Deputy Minister McGrath.

J. MCGRATH: Yeah, I believe the RFP is out. I will confirm that just to make sure, and that work is ongoing.

CHAIR: Okay.

B. PETTEN: Are there, Minister, any plans to expand the schedevac flights to the North Coast?

CHAIR: Minister Haggie.

J. HAGGIE: That's usually a discussion between Labrador zone and Air Borealis based on demand. I know that there is always a discussion and there's always some back and to about what should go on those flights.

So I would defer that to them in detail. But my understanding is that is a regularly discussed issue.

B. PETTEN: Thanks, Minister.

Minister, in the financial statements for the health authority, there was an operating deficit for '23-'24 of $640 million. That's the most recent documents we have, up-to-date documents. Would this amount have been approved by the minister?

CHAIR: Minister Haggie.

J. HAGGIE: That is, in large part, made up of an operating line of credit, and that is a cash flow issue over the course of the year. That is the prime aim from the department's point of view of the line of credit. There has been some discussion with NLHS about the magnitude of that line of credit, and those discussions are ongoing.

B. PETTEN: What's the projected operating deficit for '24-'25, Minister?

J. HAGGIE: If someone could point me toward the line item, I would be grateful because we're kind of dancing around a little bit here, but just bear with me and I'll dig it out.

It's not in the Estimates, but Mr. McGrath will enlighten us.

J. MCGRATH: For this fiscal year, I don't believe that NLHS, Newfoundland and Labrador Health Services, would have their last quarter or number of months closed off yet. I know at the end of the year, certainly, I think, everyone can appreciate, there is money transferred around to try to pay down that deficit. I wouldn't be able to speak

to right now what that would be without going through the Auditor General or seeing all of their financial statements at this time.

B. PETTEN: Thank you for that.

Any directives to deal with this deficit?

CHAIR: Minister Haggie.

J. HAGGIE: There have been significant discussions about how best to deal with this deficit. There have been several initiatives, not least of which was combining the four RHAs into a provincial health authority to try and cut down on back-office duplication and expense.

We're at a stage at the moment with the health authority that we are investing to save. That is the paradox of this. The issue around the health information system, the issue around the ambulance integration, the issue around the back-office functions are all part and parcel of a broader strategy to get fiscal tracking of things that currently, at the moment, are actually a lot harder to do because they are on pencil and paper and they're not easily done in real time.

So in terms of real-time decision support, that's where we see over the time, supply and inventory management and these kind of things paying off. There are a variety of strategies in place and evolving to deal with that.

B. PETTEN: In '23-'24 the line of credit was $693 million, with $648 million used. I know Mr. McGrath just said they haven't had the most recent numbers, but does the department have any idea the current amount used as of today or approximate? Any figures?

J. HAGGIE: I don't, but maybe Patrick?

CHAIR: Patrick Morrissey.

P. MORRISSEY: The current line of credit being used right now is $665 million.

B. PETTEN: Thank you.

Minister, supply inventories 2023-2024 there was $9 million in the pandemic inventories. As of today, are these supplies still useable? I know, back during COVID time, that there was an awful lot for – I'm at a loss for that outbreak. It's leaving me, but I think you know where I'm going – that had to be destroyed, they were outdated.

Is there any idea in that amount, that $9 million since the pandemic inventories, is all that still useable and is their expiry date getting close or where are we to with that?

J. HAGGIE: If you recall the idea was that the pandemic inventory, unless it was specifically in the NESS supplies, which were kind of not solely provincial responsibility, those would be used by filtering them through the supply chain, if they were items that would be used on a regular basis.PPA and masks would be useable during the winter months when those kind of precautions were much more common.

There is a process in mind, as far as I'm aware, to rightsizing that so it will go to a lower level. We do need to keep some pandemic supplies in readiness but the question is what that rightsizing should be.

B. PETTEN: Okay, thank you.

I'm actually getting through a lot of this stuff in those first two headings. I'd be remiss if I never asked my favourite topic of nurse practitioners. I know we touch on it but in Question Period sometimes you never get the real opportunity to ask; it's more of a frank discussion.

The federal government has it possible to have nurse practitioners do billing, bill directly to government. I'm at a loss to why – and we've talked to lots of nurse practitioners out there and, to me, it makes sense, it's a low-hanging fruit to try to deal with our family doctor shortage, our delivery

of health care and you know all the concerns that come out with seniors having to pay fees to nurse practitioners and what have you.

What is the real reason that the government are hesitant on letting nurse practitioners bill directly to government? Forget about MCP; they can have their own billing mechanism. Leave it clear of MCP. What's the hesitation that nurse practitioners can't bill government directly?

J. HAGGIE: The federal requirement or the federal sort of deal was that public funds would be used to pay nurse practitioners who are in private practice; 95 per cent, 90 per cent of our nurse practitioners are in a salaried model in this province. We are working with the nurse practitioners' group and the RNU who are kind of their bargaining unit, to work on a way that they can access public funds if they are privately employed. It is not a fee-for-service model in the sense of you provide a specific service and you bill, it is on maybe a mode similar to Alberta. I don't want to negotiate in public but Alberta has a system that works for nurse practitioners who are in private practice. We've looked at that.

Again, we've asked the RNU and the Nurse Practitioner Association actually to come forward with a model that they would like for nurse practitioner led clinics, which is kind of part of the driver for this. The first time I asked the RNU, Debbie Forward was president. I still haven't heard back from them, so there must be some debate internally as to what they would like, too. I'm quite happy to arrange for them, in private practice, to be paid out of public funds, but fee-for-service failed for physicians, so I'm not going to go down the same road again for nurse practitioners because it will fail for them too.

B. PETTEN: I think it's something that should be explored, as we both agree to disagree, but I appreciate your remarks.

Minister, your last question for this round, cleaning the Health Sciences complex – this issue has come up, again. It's another issue, and I know Dr. Parfrey is there. We've seen some alarming pictures and commentary and, quite frankly, I've seen it myself. My sister is in there now going on three months. She's been slowly recovering but she had a very serious illness, and it leaves a lot to be desired. It's something that I know I've spoke about and there's been public commentary on it.

I know the authority or NLHS has tried to address it but I have to question the overall bigger plan. It's fine to fix that room or that floor or those two or three rooms, but you're only putting out fires. Do you know what I'm saying?

I do believe, as a whole, there's a major problem somewhere in that whole operation. It's something that irritates me to a degree – well, for a good reason, actually – and I think it should irritate any of us. It's not acceptable really, in our main acute-care hospital, but it's an issue and it's not being addressed, in my opinion, the way it should be addressed. You can put out fires all day long. When I go on the media and then someone goes up and closes off a bathroom or closes off a room and fixes it, you're not fixing the problem. You're putting on a Band-aid and you're putting out a fire.

I say that with all due respect to those involved but these issues are real. I think you can agree that you see where I'm coming from. Has there been a plan, a bigger plan, to deal with this issue? I likened it at the time I spoke about it as an issue that's like the preventative maintenance for the infrastructure issue at MUN. Now we're face with – it's well, well documented – some of those buildings are in pretty hard shape.

I guess I'm questioning it, and the same thing happens to a lot of government buildings and we're seeing it happen at the Health Sciences Centre. Is there any plan,

planning or talks of planning in place to deal with that issue?

J. HAGGIE: There is significant money for renovations for the Health Sciences site. That may or may not deal with some of the issues depending on whether they're actually directly impacted by those specific renovations. In the process of doing that, you actually allow the repairs and reno budget to be used on those other areas.

I think, you know, you make a good point. The challenge is we have a huge amount of infrastructure and the Health Sciences Centre is now 50 years old. It's an aging building and, because of that, it is sometimes difficult to walk the line between maintaining operations and having the repairs and renos done. I think NLHS over the years has done a very good job in walking that line in such a way that services are maintained.

CHAIR: The Member's time has expired.

The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

How has work progressed on creating the new MCP codes required for blended capitation?

CHAIR: Minister Haggie.

J. HAGGIE: I can't address the exact detail of that.

My understanding is that that work continues. Maybe ADM Clarke would be able to shed a little bit more light on that specific aspect.

CHAIR: Greg Clarke.

G. CLARKE: I'm unable to do that, but I'll certainly look into the progress on the capitation codes.

J. DINN: Thank you for that first section.

That's it. I had one or two others from other sections, but I can wait.

CHAIR: Okay.

Any further questions?

Seeing no further questions, I ask the Clerk to recall the subheads.

CLERK: 1.1.01 to 1.2.02 inclusive.

CHAIR: Shall 1.1.01 to 1.2.02 inclusive, Executive and Support Services carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 1.1.01 through 1.2.02 carried.

CHAIR: I ask the Clerk to call the next subheads.

CLERK: 2.1.01 to 2.3.01 inclusive.

CHAIR: 2.1.01 to 2.3.01 inclusive, Client Services and Support.

The Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

I have a few line-by-line questions. I don't have a lot more actually, but I have a few.

Under 2.1.01, Provincial Drug Programs, under 09, Allowances and Assistance, what is the nature of the extra $20 million?

CHAIR: Minister Haggie.

J. HAGGIE: I presume the Member is referring to 2025-26, less 2024.

The extra $20 million is related to $17.28 million related to new drug therapies; $384,000 for new oncology therapies; $16 million for non-oncology therapies; and $3.1 million for new drug therapies that are coming out in 2024-2025.

B. PETTEN: Thank you.

Under Medical Care Plan, 2.2.01, Physician Services, under Professional Services, there's an extra $35 million last year but now it's back down to $416 million. Why the extra $35 million last year?

J. HAGGIE: Sorry could the Member read the head again, please?

B. PETTEN: 2.2.01, Physician Services and under Professional Services.

J. HAGGIE: This is the difference between projected, revised and the Estimates this year? Is that what you're asking about?

B. PETTEN: Yes, an extra $35 million was actually spent.

J. HAGGIE: There's a deficit because of increased utilization.

The fee codes have increased and the activity in emergency departments has increased, so that's why we're projected with more than the budget. We've allowed some extra in the 2025-26 based on what we think the utilization will be next year and a smaller amount for annualization of driver's medicals.

B. PETTEN: Under Medical Care Plan, 2.2.02, Dental Services, Professional Services, what was the nature of the $3 million dropped balance under Professional Services?

J. HAGGIE: Sorry, was that 2.2.02?

B. PETTEN: Yes. Dental Services, under Professional Services, there was a $3 million dropped balance under Revised.

J. HAGGIE: That was due to lower utilization in the children's dental plan.

B. PETTEN: Oh, okay. Interesting.

Under 2.3.01, Memorial University Faculty of Medicine, how many seats do we have now, Minister?

J. HAGGIE: Eighty-four this year.

B. PETTEN: How many?

J. HAGGIE: For Newfoundland and Labrador students, 84.

B. PETTEN: Eighty-four, okay.

And that's the Newfoundland's allotment for Newfoundland students?

J. HAGGIE: We have one extra because an MOTP candidate from out of province dropped out, so we filled it with a Newfoundland student.

B. PETTEN: So how many Newfoundland students are there, then? How many of them are Newfoundland students?

J. HAGGIE: There are 82 –

B. PETTEN: Newfoundland students.

J. HAGGIE: Sorry, there are 84 students. Let me just check. The 84, they're all Newfoundlanders?

J. MCGRATH: There are 84 seats.

J. HAGGIE: There are 84 seats, there's one MOTP from out of province, and then there's some from New Brunswick.

CHAIR: Deputy Minister McGrath.

J. MCGRATH: So 84 seats for Newfoundlanders and Labradorians through that.

B. PETTEN: Okay.

Is that the total number of seats?

J. HAGGIE: I think it's 85 (inaudible).

B. PETTEN: Okay, so there's one extra.

J. MCGRATH: It's actually 90.

CHAIR: Minister Haggie.

J. HAGGIE: Sorry, it's getting late. There's 84 Newfoundlanders and Labradorians. There's 90 –

B. PETTEN: In total.

J. HAGGIE: – in total. The others are a mix of out of province and MOTP.

B. PETTEN: Got you.

Minister, the MUN infrastructure issue, is there any action that's been taken by your department in dealing with that, or is that something that's passed over to TI?

J. HAGGIE: The infrastructure related to the medical school, we simply give them a grant and a subsidy. I think the bulk of their infrastructure debt is managed by Education.

B. PETTEN: Well, Minister, deferred maintenance money on chairs and landscaping – so is this something hat's supported?. It seems like we've got bigger issues than landscaping and chairs.

J. HAGGIE: Can you point me to where that item appears?

B. PETTEN: That was under the AG's report, Minister, on faculty of medicine. There's maintenance money being deferred for use on chairs and landscaping.

J. HAGGIE: Okay, I would be interested to look into that. I've not been aware of that particular issue.

B. PETTEN: Okay, that's fair enough.

That's all I have on this section, if we want to wait to do three, I know we're running late on time.

CHAIR: The hon. the Member for St. John's Centre.

J. DINN: Thank you, Chair.

Has there been a review of the income eligibility thresholds for the provincial drug card program under the Access Plan?

CHAIR: Minister Haggie.

J. HAGGIE: My understanding is that eligibility thresholds are actually determined by Income Support. I'm just making sure, though, there are two plans that fall outside that. I'm just looking for the appropriate one.

I know that outside of the department, there is a cross-government review on thresholds, but I think that is across CSSD and Finance.

J. DINN: Okay, thank you.

Have any new treatments been added to the list of those covered under the NLPDP?

J. HAGGIE: Yes, we have $17 million worth of new drugs, and I think there are 18 new drugs included in that.

J. DINN: Okay, thank you.

Would it be possible to have a list – you don't have to go through it now, but have a list of what those new drugs –

J. HAGGIE: There is one. I've seen it, but it isn't in the binder.

J. DINN: Okay, thank you.

Under 2.2.02, Dental Services, has rollout of the federal dental program affected funding here? Has money been reprofiled for others in need of dental care, or has money been allocated elsewhere in the department?

J. HAGGIE: We haven't seen anything. There's only been the drop in the lower utilization of the children's dental plan. Other than that, there's been no impact that we've seen yet.

J. DINN: Thank you.

That's it.

CHAIR: That's it?

Any additional questions on section 2.1.01?

Seeing no further questions, I ask the Clerk to recall the subhead.

CLERK: 2.1.01 to 2.3.01 inclusive.

CHAIR: Shall 2.1.01 to 2.3.01 inclusive, Client Services and Support, carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 2.1.01 through 2.3.01 carried.

CHAIR: I ask the Clerk to call the next subhead.

CLERK: 3.1.01 to 3.2.03 inclusive.

CHAIR: 3.1.01 to 3.2.03 inclusive, Health and Community Service Delivery.

The hon. the Member for Conception Bay South.

B. PETTEN: Thank you, Chair.

Under 3.1.01, Provincial Health Authority and Related Services, Supplies went from $6.5 million budgeted to almost $11.9 million spent, to now $22 million requested. Why such a variation?

J. HAGGIE: Vaccines – shingles and RSV.

B. PETTEN: That would have been a lot higher if you'd listened to me.

J. HAGGIE: I'm sorry, that means that –

B. PETTEN: I couldn't resist.

J. HAGGIE: – your bids fallen out.

B. PETTEN: I couldn't resist.

3.1.02, Support to Community Agencies: Can we get a list of those?

J. HAGGIE: Yes.

B. PETTEN: How many groups apply and don't get anything; don't we have a listing of those too?

J. HAGGIE: What listing?

B. PETTEN: The unsuccessful groups that applied. Are there any people that applied and never got anything?

J. HAGGIE: I would have to check. This is the group that we fund and, in actual fact looking at them, apart from the small grants program and unallocated funding, these are all regulars.

B. PETTEN: So it is more than likely there was no one that got denied.

J. HAGGIE: Well, I'm not aware of any.

B. PETTEN: Could you just check, though?

J. HAGGIE: Oh, we'll do that certainly and you can have the list.

It's things like the Alliance for the Control of Tobacco, Canadian Red Cross, Hope Air, the HUB, SPANL, the Spinal Cord Injury, Association of the Deaf and these kinds of things. They feature regularly.

B. PETTEN: Okay.

Under 3.2.03, Building Improvements, Furnishings, and Equipment, what's the reason for the increase from $144 million now back up to $192 million? What are the fluctuations, I should say?

J. HAGGIE: That's building projects that have been paid out and been put back in again for building improvements, purchasing medical equipment and that kind of thing. The amounts fluctuate, usually because of emergent and urgent medical equipment replacements and that's kind of our best guess for this year.

B. PETTEN: That's all the questions I have on that section, Chair.

CHAIR: Okay.

The hon. the Member for St. John's Centre.

J. DINN: Thank you.

One question: What improvements or renovations are slated to be completed this year on health care facilities and which ones will be the highest priority on that list? That's under 3.2.03.

CHAIR: Deputy Minister McGrath.

J. MCGRATH: That's a process where Newfoundland and Labrador Health Services would identify those priority pieces of equipment. It's typically block funded throughout the appropriated, so that process has started. They will submit the listing by zone, by region, and then it will go through an approval process. I just don't have it here right now, but there is an established process by need from the health authority.

J. DINN: Perfect. Thank you.

That's it.

CHAIR: Okay.

Seeing no further questions, I ask the Clerk to call the subheads.

CLERK: 3.1.01 to 3.2.03 inclusive.

CHAIR: Shall 3.1.01 to 3.2.03 inclusive, Health and Community Services, carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

On motion, subheads 3.1.01 through 3.2.03 carried.

CLERK: Total.

CHAIR: Shall the total carry?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Motion 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?

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

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

CHAIR: Okay. I thank the ministers, the departmental staff and the Committee for attending.

The next meeting is Wednesday, April 16, 2025, at 5:30 to consider the Estimates of the Department of Municipal and Provincial Affairs.

I'll ask for a mover for adjournment.

P. PARSONS: So moved.

CHAIR: Moved by the Member for Harbour Grace - Port de Grave.

CHAIR: All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Carried.

The meeting is now adjourned.

On motion, the Committee adjourned.