HEALTH AND LONG-TERM CARE REFORM IN NEW BRUNSWICK: A PRESCRIPTION FOR CHANGE

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In 1959 the *Hospital Insurance and Diagnostic Services Act* was passed by the government of Canada following ten years of debate kicked off by Tommy Douglas and the government of Saskatchewan who had introduced government regulation and financing of hospitals in Saskatchewan in 1949. Tommy Douglas is viewed by many as the politician who helped to pave the way for the Canadian health system as we now know it.

Economists of the day were divided on the potential impact of the new federal legislation on Canada. The legislation provided for a 50/50 cost sharing between the federal and provincial governments in the provision of "medically necessary hospital and emergency care and diagnostic services that accompanied such care." Out-patient care was generally not included.

Malcolm Taylor was a health economist in the department of economics at York University and it was his candid view that eventually the costs of care would grow to the extent that it would place enormous pressure on federal and provincial resources. He made the observation because as a health economist he had a better-than-average understanding of how the health system actually functions. Analysts like him had the impression that many people had been delaying medical treatment and surgical intervention because they just could not afford the costs associated with hospitalization.

An illustration of this was the presence of inguinal hernias in men, common particularly with men who did farm and other outdoor, strenuous labour. The use of "trusses" was common, a device worn by men to "hold the hernia in, preventing its expansion." In the early years of the hospital insurance system, people came forward, or so physicians of the day claimed, to have bunions and hernias repaired and club feet fixed. Without the financial barrier to care, suddenly hospital beds filled up with people while hospitals were able to charge the province for their care.

By 1965 the provincial health ministers were worried about the growth in hospital costs and wanted to meet with then–federal Minister of Health, Judy LaMarsh. The 50/50 arrangement worked as long as annual cost increases did not outstrip inflation, but they were finding that the cost increases, year over year, represented much more than inflation, something like two to three times the inflationary rate. Then in 1969 the *Medicare Act* was passed federally, which provided for 50/50 cost sharing of remuneration for physicians. This added much stress to provincial budgets already stretched with hospital services. Medical schools started increasing class sizes and trained more physicians who were needed to provide the service now demanded by the public for whom financial barriers to care had disappeared. With more doctors providing more services, performing more procedures, and admitting more patients, the pressure was on and the negotiations between the provinces and federal government started to heat up.

Added to the cost pressures was the explosive growth of technology that had not really been factored into the planning in the 1950s. In those days, orthopedics consisted of some basic reconstruction, but fractures and spinal surgery exploded. Then in the 1980s the area of joint replacement surgery expanded, starting with hips and knees, and then some hand structures. There was

transformation in the surgical procedures in the hand, the ankle, the spine, and cervical area. And that same level of transformation took place with organ transplantation, neurosurgery, reproductive organs, and eyes. When many of these highly expensive procedures were developed, the thought was that most of these procedures would probably not be performed on people over sixty-five years of age.

Then as time and expertise advanced, joint replacement, lens replacement, and heart procedures were regularly performed on persons in their late seventies and older. As the population aged and as more and more Canadians reached their elder years in relatively good health, there seemed to be more justification to perform joint replacement procedures, for instance, to improve mobility. But economists and health planners have long pointed to the large costs incurred in the latter years of life, attributable to drugs and surgical interventions.

In 1971, the Hospital Research and Educational Trust published a landmark book by Professor Anne Somers, *Healthcare in Transition: Directions for the Future*. This was important reading for those in leadership in the health care system in North America for it called for hospitals to be the hub of comprehensive health care services for the communities they served. Regrettably, in Canada Somers's book received little attention and debate except in academic circles. Her argument was that typically the hospital has a robust organization and governance model that could serve as the platform around which to organize primary health care, a wide array of diagnostic and therapeutic services, long-term care, home care, and day surgery. Had that concept been developed, it is entirely likely that many of the issues of coordination and gaps in service might have been prevented.

Instead, in Canada, and New Brunswick in particular, the system is known for program silos that prevent collaboration and integration, much of which has been discussed for years in the media in New Brunswick. Throughout the evolution of care services in New Brunswick, the power and influence of unions and professional bodies has become unprecedented. One of the concerns expressed by new nurses seeking jobs is that the hospital can only offer casual employment. The hospital takes the blame, but the reason for that is the way the collective agreements are written. Unions protect their members' seniority and if the employer was able to open up some full-time positions, people with seniority, not always with the best performance evaluations, get the job, which leaves a superb graduate who may have excelled in clinical training, to wait while working perhaps two shifts per week for months. One of the common complaints of nursing graduates in New Brunswick, as reported in the media, has been that after graduating, they were not able to secure full-time work.

In 1974 the Lalonde Report found great favour around the world. "A New Perspective on the Health of Canadians," authored by Hon. Marc Lalonde, Minister of National Health and Welfare, was an innovative way to try to redirect the thinking of the public and health professionals. Twelve years later, in 1986, many people from around the world convened at den Haag at the International Hospital Federation and extolled the virtues of this report and outlined how it influenced thinking in their countries. In Canada, however, this was not the case. Why?

The power structures that drive health services are insidious, with drug companies and manufacturers of major diagnostic equipment and supplies playing a key role in how services are developed. These are companies with world-wide influence who have traditionally played a major role in the education of physicians at various levels. Their power and influence have been significant. On the other hand, the products and services they bring to the system are life-changing and life-saving. For instance, not many years ago, there were no CT, MRI, and PET scanners; now these are essential tools

of medical practice and have revolutionized not only practice but the cost to the system. Similarly, with endoscopic surgery, many major surgical procedures previously requiring huge incisions and weeks of hospitalization and recuperation are now reduced to tiny incisions requiring only days of recovery.

In each clinical discipline there are illustrations of how tools developed by large multinational companies have transformed health care. One health minister told me that there were several hundreds of companies and interest groups lining up to meet with senior health officials to engage in fruitful discussions about how their organization can help to shape health services. So in making decisions about programs and expenditures, many of these groups have much to offer by way of advice and counsel that may not come through normal decision-making channels.

Unions also have much influence on the activities and duties of persons appointed to supervisory positions, and that has been a challenge in cost management as well as workplace culture. Staff absenteeism in health care is, for instance, an incredibly expensive budget item in which the rule of thumb is that not more than thirty percent of all sick days claimed are attributable to specific illness. Unions negotiate the sick time benefits into collective agreements yet are engaged by management in discussions, sometimes not pleasant, when use of sick time exceeds budgetary allocations. With the right relationships, unions and management can, and sometimes do, work together to take steps to avoid conflict on this delicate but costly topic.

In the daily management of health care, admissions, investigations, therapies, and most medications are ordered largely by physicians. Variations in practice exist amongst doctors, often dependent on the training facility from which the physician graduated. In a group of three urologists, for instance, each may have different approaches to routine surgical procedures that requires the hospital to have three different surgery tray set-ups, which adds to the cost of the procedure.

The health care system has been described by some internationally known academics as the most complex organization in our society. The reason for that largely stems from the convoluted lines of accountability. Physicians conventionally function as independent practitioners with “privileges” granted by the hospital for the performance of a range of diagnostic and therapeutic procedures. But there is no accountability to a supervisor or manager as would be the case, for instance, in a major commercial enterprise. To a lesser extent, a similar principle applies to other professions in which the regulatory authorities and unions play a major role in duties and workplace practices. Adding to that complexity is the observation that those appointed to positions of leadership and authority often may not have had first-hand experience in health care or training in health care leadership.

Complicating the entire health care story is that in a socialized environment such as Canada, and specifically in smaller provinces, everything is political. People have been appointed to key positions of leadership in health care who had good intentions but little experience and training in health care leadership. Completing the circle is the observation that those who regulate health care should have had some relevant experience in a senior role in directing such a complex institution as a health authority. Ideally, those in regulatory roles should have had specific education in health care management or a closely related field. The reason for that is simple: those who practice in the system come to understand how the public behaves, how physicians practice, how unions work, and how to work both with unions and professional bodies. In the absence of that level of experience, those who deal with issues in those regulatory roles often tend to view the world in impractical ways.

During the Covid-19 pandemic, for instance, there were numerous bulletins sent to those health care managers that were intended to direct workplace practice and behaviour. But often they are written in a language and form that is scarcely understood by those receiving them, resulting in the service provider defaulting to other established practices or simply calling a friend for counsel. For instance, during the pandemic, bulletins were regularly created by the public health department and written in language familiar to them based on the science of public health. The language was clear to those with public health training but required interpretation for use in most long-term care facilities.

In New Brunswick we have wrestled with reforming or modernizing the health care system for decades. Following nearly thirty years of studies by such internationally recognized consultants as Llwellyn Davies Weeks and Dr. Fraser Mustard, the Department of Health, in 1991, developed a plan to commence the regionalization of hospitals as had been previously recommended. At that point there were fifty-five hospitals in New Brunswick ranging from twelve beds to seven hundred beds, depending on location and history. Most hospitals were struggling to balance budgets and the statistics showed that many beds were being used by patients whose illness could easily be treated at home. There was little coordination between hospitals, and signs of duplication and competition were serious.

In February 1992, the minister rose in the legislature and dismissed all hospital boards and replaced them with seven regional hospital boards as well as the Extramural Hospital Board. It came as a shock to rural New Brunswick, in particular, as suddenly control of health care was transferred, staff were rearranged, some staff positions were eliminated, and some hospitals were downsized. Those who were involved in its implementation vividly recall widespread community unrest and resistance.

New Brunswick was the first province to embark on an aggressive restructuring and, frankly, it would not have happened if the government in power was not visionary and if they did not have an overwhelming legislative majority. They knew that dissolving local hospital boards would be very contentious. That is why it took thirty years of consulting studies for it to happen. Similar mergers and restructurings were already happening in other countries and as close as the state of Maine. Health care has been described as the "third rail of Canadian politics" by Jeffrey Simpson, noted *Globe and Mail* journalist and author, in his book *Chronic Condition*. The seven persons chosen to lead the new regional hospital corporations were people who already had demonstrated leadership skills in operating the largest hospitals in the province. The media become involved immediately and the issue of how health boards conducted their meetings (in public or in camera) arose as an issue. The boards were new to this difficult role as were the CEOs, and since New Brunswick was the first province to initiate major reform, there was no "playbook."

The media had the impression that somehow there was a detailed set of directions that boards had to follow so they immediately placed pressure on boards and CEOs. The press coverage was stifled, of course, by the unrest in the rural communities. The CEOs were appointed initially for three-year terms, and it took all that time to get systems in place, get people accustomed to working together in different ways, and to rearranging jobs. By 1995, government was now facing another election in September. As always happens, political planners sought to "quiet the troubled waters" in order to avoid the wrath of voters. They knew that some seats in rural areas were at risk, so government made the bold promise of "no further cuts to health care." Those who understood the system, and how its costs are generated, understood that to be simply election talk, that there had to be a series of adjustments that now would be deferred until after the election.

The CEO of the largest hospital corporation moved on, with the "encouragement of government," prior to the election campaign getting underway, which planners thought would defuse some of the rural anger caused by regionalization. After the election, the corporations got back to some semblance of normal and continued the process of integrating services in their regions. Then the premier resigned in 1997. Successive governments no doubt saw the distress caused by the regionalization of hospitals, so they avoided the contentious issues still to be resolved such as service integration, centres of excellence, defining the roles of small rural hospitals, and coming to terms with long-term care planning.

In 2008, the Shawn Graham government, seeing the stumbling of the seven regional corporations, took the bold step of once again dissolving regional boards and restructured them under two health authorities, Vitalité and Horizon. This was a move that was intended to provide direction for problems left over from the 1992 reform, the thinking being that further consolidation would yield efficiencies and standardization. This was good in theory, but whenever large complex organizations are created—and these two health authorities were now huge—you need to ensure a whole new level of executive leadership, not just at the CEO level but at several levels in what now is a complex enterprise. The new board structure was a hybrid of persons elected (in municipal elections) and appointed by the government (i.e., political appointments). What was created was a nightmare situation in which the boards were hybrid and political while the CEOs were appointed at the pleasure of the premier (Executive Council Office).

Students of health care governance have been highly critical of this form of governance for years. In brief, competent hospital governance emphasizes a strong skills-based board, engagement of best practices, board selection of its CEO together with a structured performance management policy with clear lines of accountability throughout the organization. What the public has seen has been a mixed array of things. On the one hand, they have witnessed the development of professional cardiac services anchored at the Saint John Regional Hospital, along with a network to related services in other key regional hospitals in the province. It is indeed a centre of excellence of which the public should be proud.

They also have some world class orthopedic surgery, but some skilled surgeons are frustrated by the lack of access to operating room time. Cancer diagnostic and treatment services, much of which is centred at the George Dumont Hospital, are wonderful and receive high ratings, but were compromised recently when four oncologists resigned and left the province.

Overflowing hospital emergency departments, not uncommon in the mid-1990s, have now become legendary in the province. When the hospital has to post a notice that wait times may extend to twelve or fourteen hours, that is a serious problem. It is a worse problem when the patient is either a child with breathing problems and a mother desperate for answers or a frail senior who really needs to be lying down with someone paying attention.

Much has been written about the cause of these long wait times and there is no one single answer; simplistic solutions do not apply. What is aggravating to the public is that this phenomenon has been seen in New Brunswick's hospitals, along with many other related problems, for nearly thirty years, and they are not seeing a strategy to deal with it. In the last two decades, the public has heard repeatedly, at election time, the promise to hire more nurses or hire more doctors, but this has been merely election talk.

Government and the health authorities have repeatedly tried to assure the public that all provinces have the same problems and that when we hire more doctors everything will be fine. The reason these problems are not being resolved is that they are not simple; it is not a simple matter of hiring more of anything. The practice of medicine has changed dramatically in the last twenty-five years; similarly, nursing has changed dramatically. Finding a solution to such complex issues requires first that the issues be clearly stated and understood. That is a step that has been overlooked in the public discourse in New Brunswick. The sources of power and influence within the health and long-term care systems are many and need to be brought to the table for serious talk and commitment to charting a new course for primary health care.

This is not for the faint of heart, for it requires someone with knowledge and courage sitting across the table with some very powerful people, all of whom represent organizations with a good deal of public and political influence. The medical society, for instance, is responsible for protecting the interests of practising physicians. While they try to move in new directions, the membership may not always agree with the new directions that really need to be initiated. Similarly, the nurses association and the nurses union, along with the licensed practical nurses (LPN) association, must be involved in these conversations. There is a fair amount of political influence that can be mobilized when you have thousands of RNs and LPNs agreeing or not agreeing on a course of action. The academic institutions who educate nurses, LPNs, physicians, and diagnostic services personnel all have influence.

In moving these forces in new directions there is also a great need, expressed by many, to bridge the gap between the academic world and the service providers world. Many years ago, the training of nurses, physicians, and diagnostic services personnel was based in hospitals. Students knew when they showed up for their first class what they were signing up for. Long hours, challenging patients, discipline, rigour, and professional pride.

Much of the inherent pride of performance seems to be at risk as nurses move to retire "at the earliest possible moment," while other nurses leave the profession for a variety of reasons, ranging from irregular hours to workplace toxicity. While the media would like to report that somehow the system can be fixed with some specific action, it just will not happen in the absence of a strategy that brings the various groups who have vested interests to the same table, committed to the same goals, and agreeing to allow things thought sacred to be on the table for debate.

In 2019, Blaine Higgs was elected with promises of reform at many levels: education, municipal structures, health and long-term care all were in his sights, and he used the reform language that was encouraging to those looking for serious improvement, specifically in health and long-term care. In February 2020, the government called a press conference and announced their health reforms: the closure of rural hospital emergency departments was the resounding theme heard across the province and it generated the backlash that was predictable. Suddenly, there was the real spectre of losing many rural seats in the next election because rural people have long memories. They saw this move as a further erosion of health care services in rural New Brunswick and the promise of the replacement service did not inspire confidence. The replacement was that during the night the people in rural communities would call an ambulance that would take them, if necessary, to the nearest regional hospital. People in the greater Sussex area, for instance, had mental images of an hour to wait for the ambulance, then another hour or more to get to the regional hospital where they may have to wait another six to eight hours to receive treatment.

For government, this was a messaging disaster and it backfired. Government had to backpedal and promised community consultation by the minister of health. Those consultations took place in large groups by Zoom, not in person. The outcomes of the consultations prompted the government to announce a new wave of reforms. This time they would appoint a two-person Task Force on Health Reform whose job it was to oversee the implementation of corrective strategies in seniors' issues, primary care, access to surgery, and mental health.

The co-chairs, good and respected people, commenced their work in fall 2021 and have invested countless hours in collaboration with people in various sectors across the province. Government also appointed new CEOs of the two health authorities, both seasoned physicians. During the time since those actions were initiated, emergency department performance did not appear to have changed and the waiting list for access to a family doctor keeps getting longer.

The co-chairs have expressed hope, but the public is not seeing hope measured in anything they can see and feel. Nurses are retiring with too few new nurses to replace them. Doctors arrive in New Brunswick but there seem to be fewer of them accepting the responsibility of a practice, finding that their economic and professional goals can be met by doing emergency department and after-hours clinic shifts.

The public mood took an abrupt turn for the worse when a frail elder passed away in July 2022 while sitting in the Emergency Department at the Dr. Everett Chalmers Regional Hospital in Fredericton waiting to be assessed. The premier's response was swift: a new minister of health was appointed, deputy ministers were shuffled, the two health authority boards were replaced with trustees, and the Horizon CEO, who had only been in the job six months, was fired.

Since mid-July the two Task Force Co-Chairs have served as Trustees, one for the Vitalité Network and the other for Horizon. In these roles, they serve essentially as one-person boards of directors with all the powers and influence of the full board. How that will translate into a more permanent governance structure is yet to be seen. So, when informed people call for reform in health and long-term care, those initiating the reforms need to be keenly aware of the history and lessons from history; they also need to know that reform takes many forms and is needed at many levels. They also need to understand that this is no time for finger pointing and ascribing blame. The system is where it is because of many factors and not the failure of one or two people or one political party; both major parties have had opportunities to implement reforms and many opportunities have been squandered.

Will these actions alleviate the public's anxiety about the current state, and the future, of the province's health care system? No; unless there is a much-improved communication strategy with the public, combined with strong and visible leadership that can work through some very choppy waters with organizations that do not have a history of rapid response!

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