



New Brunswick
Health Council

Engage. Evaluate. Inform. Recommend.



Our Health. Our Perspectives. Our Solutions.

FIRST ENGAGEMENT INITIATIVE WITH NEW BRUNSWICK CITIZENS

*Summary of Participants'
Primary Care Priorities*



For more information:

New Brunswick Health Council

Pavillon J.-Raymond-Frenette
100 des Aboiteaux Street, Suite 2200
Moncton, New Brunswick
E1A 7R1

Telephone: 506.869.6870

Fax: 506.869.6282

Toll-Free: 1.877.225.2521

www.nbhc.ca

How to cite this document:

New Brunswick Health Council, *Our Health. Our Perspectives. Our Solutions. Results of Our First Engagement Initiative with New Brunswick Citizens . Summary of Participants Primary Care Priorities*

The *Our Health. Our Perspectives. Our Solutions.* complete report is available at:

http://www.nbhc.ca/citizen_engagement.cfm



Our Health. Our Perspectives. Our Solutions.

Our Health. Our Perspectives. Our Solutions. was the first large-scale citizen engagement initiative undertaken by the New Brunswick Health Council (NBHC). Its purpose was to help the NBHC develop recommendations to health system partners on what citizens believe is required to achieve a citizen-centered health system. This three-phase process was designed to involve New Brunswick citizens and health stakeholders (see **Figure 1**) in a dialogue on what people value most with regard to the provincial health system, how the system can be strengthened and what can be done to improve provincial health outcomes.

Figure 1: Citizens/Stakeholder Target Groups

Participants (Target Groups)	
Citizens-50%	Stakeholders-50%
<ul style="list-style-type: none"> • Age groups • First Nations • Gender • Official language of choice • Rural/Urban regions • Socioeconomic groups 	<ul style="list-style-type: none"> • Academics • Community Groups • Government Representatives • Health Professionals • Health & Wellness Managers • Municipal Officials • Public interest Groups

In the third and final phase of the process, participants were challenged to undertake the difficult task of setting priorities among the numerous ideas and suggestions they developed during Phase I and Phase II. In order to help structure this work, the most salient and frequently occurring ideas were grouped thematically as a series of possible areas for action.

Participants were then asked to imagine that they were *Minister of Health* for one day as they assessed each option first through personal reflection, then in discussion with their tablemates and finally in plenary. Their assigned task was to choose which two primary care options they would elect to proceed with *first* in order to ensure that the health system:

- meets the needs and expectations of New Brunswickers (as articulated throughout Phase I and Phase II of this process)
- is sustainable over the long term.

In addition, participants were reminded that as Minister of Health, they also needed to balance an array of competing needs and interests, including:

- balancing the province’s response to current needs and the pursuit of future goals
- recognizing and addressing the unique needs and expectations of various populations (e.g., children and youth, seniors, persons living with disabilities or mental health issues)
- allocating resources to both “upstream” (promotion/prevention) and “downstream” (curative) care and services
- allocating resources across health care sectors (primary, acute, supportive/specialty, palliative)
- optimizing investments in centres of excellence and local care
- determining if system-wide or targeted interventions are required.

1 Primary Care Priorities

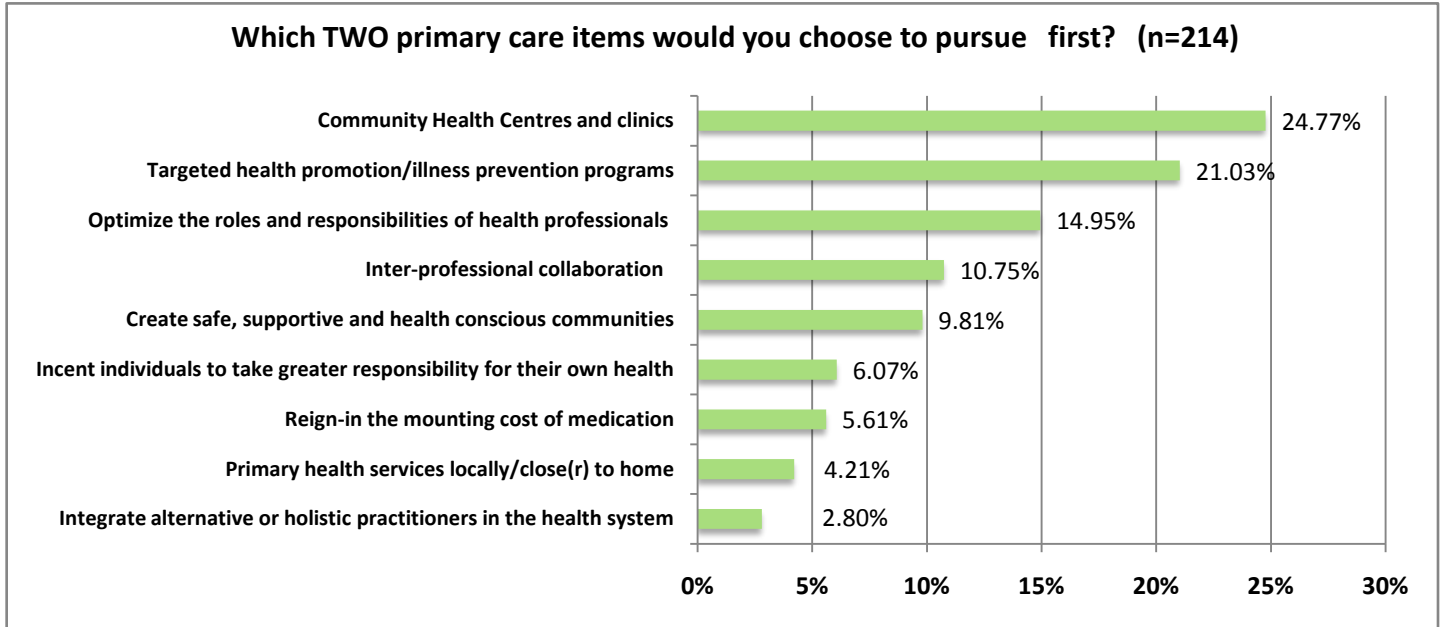
Phase III participants began by exploring nine possible areas for action relating to primary care. They identified the two items they would elect to pursue *first* if they were Minister of Health for a day and then shared and discussed these choices at their tables. Each group then discussed the benefits, drawbacks and tradeoffs associated with their top choices and shared these in plenary.

After hearing the arguments in favour of each proposed area for action, participants were then called upon to vote (using the voting keypads) for the two primary care items they would choose to pursue first.

As illustrated in **Figure 2**, “Make community health centres (CHCs) and clinics the centrepiece of primary care” and “Develop targeted health promotion/illness prevention programs” emerged as clear favourites, respectively obtaining 25% and 21% of participants’ votes. “Optimize the roles and responsibilities of health professionals” ranked third, with 15% of votes. The following chart summarizes the reasons provided by participants for selecting particular areas for action.¹ Each section begins with a description of the area for action as presented on the participant worksheet used for this exercise.

¹ **The uneven distribution of detail in the following section reflects the fact that participants spent more time discussing those items that were of greatest importance to them.**

Figure 2: Primary Care – Priority Areas for Action²



1.1 Make Community Health Centres (CHCs) and Clinics the Centrepiece of Primary Care

To reduce the burden on hospitals and facilitate access, particularly in rural areas, move as many primary health services and programs as possible into CHCs and/or clinics (e.g., walk-in clinics, after-hours clinics and specialized clinics, such as those for chronic disease management or maternal/women’s health).

As demonstrated by the keypad voting results – and participants’ comments throughout the three phases of this initiative – the community health centre model, combined with clinics (including mobile clinics) works well and is greatly valued by participants. They repeatedly stated that they believe

“We need to transfer more powers to CHCs so that they can respond to the needs of the community rather than delivering services that do not reflect local needs.” (Translated)

“More CHC access [in] rural areas. Have mobile clinics, like in the TB clinic days, transport trucks for MRIs. Avoid overuse of hospitals.”

Phase III participants

² Participants were asked to respond with two choices. Some may have opted not to respond or responded with only one choice. Therefore, although 111 participants were in attendance at the Phase III dialogue, there were 214 responses to this question.

this approach holds great promise for improving access to health care. Participants' suggestions on the CHC model follow:

- **Enables more equitable access to care** by bringing services to citizens in their communities. CHCs offer greater access to health care locally, which was felt to be particularly important in rural regions where citizens are often required to travel some distance to access services in larger centres. Beyond being a matter of convenience, participants felt that this was a key strategy for ensuring more equitable access to services across the province. They also saw this as a way to improve access to care for those who do not have a family doctor.
- **Maximizes flexibility.** Participants believed that CHCs are more apt to deliver services that are tailored to the specific needs of the community and/or have particular focuses, e.g., prevention and education, health and wellness, mental health and chronic disease clinics. Because of their smaller size and local administration, they felt CHCs may offer greater flexibility with respect to hours of operation and the manner/location in which they deliver their services.
- **Enables more individualized and personalized care.** Participants underscored that the "local" nature of CHCs and their ability to offer issue-specific clinics means that the medical staff and patients can establish ongoing relationships, which in turn improves quality of care. This includes, for example, more effective early detection and management of chronic diseases.
- **Is more efficient and cost-effective.** Participants felt that CHCs can play a key role in decreasing the stress on the health care system in general and hospitals in particular by freeing hospital beds, decongesting and reducing wait times in emergency rooms and moving clinics outside of the hospital setting (e.g., walk-in clinics, diabetic clinics, physiotherapy services). Other examples of efficiencies cited include an opportunity for better record-keeping (charting practices) and making greater use of local volunteers.
- **Maximizes the contribution of various health professionals.** Participants saw great value in the ability of CHCs to bring together multidisciplinary health teams that allow patients to benefit from a broad range of skills and services in a single location. They also felt that this enabled a more collaborative approach to care which provides greater efficiencies, for example, with nurses taking on some tasks traditionally performed by physicians (e.g., running diagnostic tests) and by allowing more effective sharing of information among members of the health team.
- **Places health and health care at the heart of the community.** Participants felt that CHCs are often one of their community's most important institutions and that they can create a clear "connection" between the community, the health care system and individual patients – particularly when the community can play an active role in the life of the CHC.

Some participants also explored the potential drawbacks and tradeoffs associated with prioritizing CHCs.

- **Health human resource challenges.** Participants acknowledged that historically, it has been difficult to recruit and retain qualified health care professionals (particularly specialists) in rural areas.
- **Balancing investment in CHCs and regional hospitals.** Participants recognized that greater investment in CHCs might require drawing resources away from regional hospitals. They warned not to duplicate services between the two types of institutions nor to put the quality of hospital services at risk. They also highlighted that closing down a regional hospital can have serious negative effects on the local community and region: *“The community might not perceive the transition of a hospital into a centre as a positive.” (Translated)*
- **Risks to continuity of care.** While participants greatly valued CHCs and clinics as a way to improve access to care, they noted that this does not in any way diminish the need to ensure that patients are adequately followed by the same health professional(s) over time. As one participant put it, *“There is no continuity of care if you don’t get the same health professional every visit.”*

1.2 Develop Targeted Health Promotion/Illness Prevention Programs

Promote wellness and healthy living (e.g., proper diet, exercise, mental health, safe sex, reducing drug and alcohol addiction); invest in early education, assessment and intervention with children and youth; and create workplace-based health promotion strategies (e.g., tax credits for employers who provide sustainable wellness programs in the workplace).

Participants felt strongly that a shift in thinking was required to refocus the health system away from the curative towards the preventive – from “sick care” to “health care.” Investing now in health promotion and early intervention, they said, will help to prevent greater costs (money, time, pain and suffering) and lessen the strain on the health system over the long term.

They also felt strongly that prevention wasn’t the exclusive purview of the health care system, stating that *“health promotion can happen anywhere, anytime”* (at school, in the workplace, through public health programs, etc.).

Participants stressed that citizens have to assume personal responsibility for their own health. In this regard, they saw education as paramount.

“An ounce of prevention is worth a pound of cure.”

“We are our own primary health care provider.”

“Change in mindset to how can I be well instead of how do I keep from being sick.”

In particular, they spoke time and again of the importance of educating children and youth about health, wellness and fitness through the education system and of encouraging healthy behaviours in schools (e.g., encouraging sufficient water consumption, offering more hours of physical education, eliminating junk food). They also noted that while parents must set a good example for their children, children who learn about healthy living at school can also positively influence their parents. Finally, some participants cautioned that it is equally important to invest in the health education of adults and seniors, given the province's aging population.

Participants also recognized some of the drawbacks associated with health promotion. These include challenges relating to measuring the return on promotion/prevention investment (*"the benefits are long-term and costs are immediate"*) and reaching some of the most vulnerable or higher-risk populations (e.g., the homeless, seniors). One group also cautioned against developing new prevention and promotion programs and suggested that efforts should instead be directed to strengthening initiatives that are already in place.

1.3 Optimize the Roles and Responsibilities of Health Professionals

Ensure physicians are focused on diagnosing and treating illnesses; expand the role of nurses/nurse practitioners and pharmacists to alleviate the pressure on physicians and allow them to spend more time with patients; and do a better job of integrating other health professionals (e.g., dieticians, paramedics) into multidisciplinary health teams.

Participants noted that the health care system relies heavily on doctors – too much so, according to some. They highlighted that not every condition required consultation with a physician and that recognizing this would allow the health system to make better use of available health human resources.

"We must focus our attention on providing or ensuring that the Right Patient receives the Right Care at the Right Time in the Right Place by the Right Health Care Professional."

Phase III participant

In particular, participants mentioned expanding the roles and responsibilities of specialists, nurses, pharmacists, midwives and naturopaths. While participants recognized that physicians are the cornerstone of the health system, some also felt that doctors wielded too much control (over patients and over the health system) and that they needed to better collaborate with, and support, other health care professionals.

A few participants also stressed that in order for health professionals to perform well, they needed to be healthy and have good working conditions. One participant, who self-identified as “*someone who has been working in the system too long,*” asked, “*Do medical professionals have regular reviews to see how they are dealing with the health system and if they are able to deal with the stress... of this system?*”

Ultimately, participants stated, the goal must be to improve accessibility, make better use of resources and ensure that each health professional is working to his or her full potential in support of the patient and the rest of the medical team.

1.4 Promote and Support Interprofessional Collaboration

To reduce duplication of efforts and ensure better continuity of care, invest in well-integrated, multidisciplinary teams that are, ideally, co-located and have access to the tools they need to work together (e.g., One Patient, One Record, electronic health records); and ensure that privacy rules don't interfere with the ability to deliver timely services to patients.

Participants felt that a team-based approach to care was both more efficient and more effective. They suggested that, if properly organized and supported, collaboration should translate into a team of professionals delivering higher quality of care than if they were operating as separate entities. More specifically, they felt that interprofessional collaboration can achieve a number of objectives.

“Multidisciplinary teams can take a ‘wellness focus’ rather than a ‘sickness focus.’”

Phase III participant

- **Foster the optimization of each health professional's role and responsibilities.** Participants suggested that in a well-integrated multidisciplinary team, each health professional could work to the full scope of his or her expertise and thus alleviate the burden on other team members while also ensuring the patient receives the best possible care.
- **Improve patients' care experience.** Participants underscored that interprofessional collaboration (e.g., doctors communicating with specialists) and a team-based approach (e.g., a single point of access to a multidisciplinary team) to care can mean quicker access, seamless delivery of services and less stress on the patient. They also believed that it offers greater chances of accurate diagnosis, more efficient treatment of serious illnesses and a greater ability to treat the patient as a whole rather than as a series of individual symptoms.

- **Help break down barriers between professional groups.** Participants felt that interprofessional collaboration is required to break down territorial boundaries between departments. However, they suggested that this may need to be mandated. As one participant noted: *“[There are] turf issues: not all professionals welcome interdisciplinary work or have been trained to work in these team environments.”*

Participants also noted that the *One Patient, One Record* (OPOR) initiative is a key foundational element for effective interprofessional collaboration. They highlighted that effective implementation of OPOR could help reduce wasteful duplication (e.g., of records, charts or tests), simplify visits with the doctor and improve the coordination of treatments. They also saw great value in having all of one’s health information on a single electronic card.

However, participants highlighted the potential barriers to an effective OPOR strategy, namely the challenge of achieving standardization across the province and overcoming resistance to change by health professionals. A few participants also cautioned that privacy issues would need to be carefully considered and managed.

1.5 Create Safe, Supportive and Health-Conscious Communities

More community-based wellness initiatives, such as programs and resources to encourage the population to be more active (green spaces, cycling paths); address harmful environmental issues (e.g., use of pesticides and other harmful chemicals); and consider the unique health needs of those facing specific challenges (e.g., homeless population, those suffering from mental illness or addictions).

Participants believed that achieving optimum population health and wellness requires the active involvement of communities – from providing access to green spaces to offering a range of social services. They stressed the importance of understanding the needs and strengths of each community with a view to addressing the former by building on the latter. This includes recognizing the unique health needs of those facing specific challenges, such as people living with mental health or addiction issues and the homeless.

“Health, education, social development, housing, transportation: all need to be at the table for creating both physically and mentally well communities. Social-economic situation can dictate a person’s physical and mental well-being. By spending on housing and proper food for [the chronically ill and the poor], you will be saving in the long term.”

Phase III participant

More broadly, some participants noted that achieving the goal of creating safe, supportive and health-conscious communities requires addressing the social determinants of health (such as access to employment and working conditions, education and housing).

One participant provided a concrete example of community-based wellness measures taken from a British Columbia community faced with high obesity rates: *“All who wanted were encouraged to share and cook meals together at a community centre. Results: weight loss, healthy meals. Participants learned that [this] made them feel better. Children learned what they should be eating.”*

1.6 Incent Individuals to Take Greater Responsibility for Their Own Health, to Make Healthier Choices

Create deterrents (taxes, regulations) to making unhealthy choices (junk food, smoking); provide yearly “health status report cards”; and provide more information on the true costs of health care.

Participants echoed many of the ideas expressed in Phase II with respect to providing incentives for healthier choices and behaviours by New Brunswickers (see section 5.4 of this report), stressing the importance of adopting *“a wellness approach, assisting people to make healthy choices and making it financially feasible [to do so].”*

However, they also cautioned that government had a responsibility for curtailing the power and influence of those industries that promote unhealthy lifestyle choices.

“Big business spends billions in marketing unhealthy lifestyles. Government and health care providers need to consider how to compete with big business. Can the tools used to draw people into unhealthy lifestyles also be used to draw them towards healthy ones? And how?”

Phase III participant

As one participant suggested, *“don’t tax the individual for making unhealthy choices, tax the businesses that sell the unhealthy choices. (Make these businesses less lucrative!)”*

Others suggested that grocery stores should be mandated to make unhealthy food less prominent and accessible on their shelves: *“Stores: get to the healthy stuff first, chips in the back!”*

1.7 Rein In the Mounting Cost of Medication

Encourage physicians to be more judicious in prescribing medication (and ordering tests) that are costly to the system and to patients. Ensure that cost does not become a barrier to accessing medication when medication is necessary (e.g., catastrophic drug plan). Limit pharmaceutical company influence on physicians and prescriptions. Encourage greater use of generic drugs. Also, seek alternatives to drug-based therapies if other options are available and fund preventive interventions (e.g., quit-smoking aids).

As highlighted in Phase II, participants felt strongly that pharmaceutical companies should have less involvement in the health care system and less influence on/direct relationships with doctors. They also felt that whenever possible, generic drugs should be used instead of promoting expensive brands and that these cost savings should be passed on to consumers.

“Why do doctors give you a prescription for one month instead of three when you take the medication year-round?” (Translated)

Phase III participant

Some participants also questioned the need for repeat physician visits to renew regular prescriptions, suggesting that consideration should be given to longer prescription periods or more flexible renewal methods (e.g., by a pharmacist).

Finally, participants expressed concern that many people without private health insurance coverage cannot afford the prescription medications they need.

1.8 Make Maximum (and Innovative) Use of Available Infrastructure to Deliver Primary Health Services Locally/Close(r) to Home

Co-locating CHCs in schools; delivering prevention/promotion programs in schools and workplaces; and making greater use of community pharmacists and pharmacies.

Participants felt that this option was closely tied to the first one, “Make community health centres (CHCs) and clinics the Centrepiece of primary care”. Again, they saw this as an opportunity for improving accessibility and efficiency.

“The infrastructure is already in place... We must use it to its full potential.” (Translated)

Phase III participant

The idea of locating CHCs in community buildings (co-locating), such as schools or government buildings, was particularly resonant for participants, who felt that this would help improve awareness and use of services as well as facilitate a focus on prevention and education.

1.9 Integrate Alternative or Holistic Practitioners into the Health System

Chiropractors, naturopaths, massage therapists, etc.

Numerous participants spoke in support of holistic practitioners such as naturopaths, massage therapists and osteopaths, highlighting that they draw from a long tradition and wisdom of healing practices. They also felt that holistic remedies can be a legitimate alternative to drug-based treatments, citing, for example, the health benefits of vitamins and fish oils (neither of which they felt should be taxed, to facilitate access).

They also believed that many holistic practices had a strong prevention focus and, as such, could prove more cost-effective over the long term (at least one participant stressed that any decision to move in this direction should be evidence-based). Some participants recognized, however, the tensions that often exist between holistic approaches and traditional medicine, noting that *“doctors do not often support this type of practice or research.”*

