New Brunswick Health Council

Engage. Evaluate. Inform. Recommend.

Our Health. Our Perspectives. Our Solutions.

RESULTS OF OUR FIRST ENGAGEMENT INITIATIVE WITH NEW BRUNSWICK CITIZENS

OCTOBER 2010

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for the New Brunswick Health Council

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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 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.

- **Phase I** focused on exploring the perspectives and concerns of citizens with respect to the current state of New Brunswick's health system with a view to identifying what they see as the system's greatest strengths and most important challenges.
- **Phase II** looked to the future to envision the kind of health care system New Brunswickers want to have and to identify possible solutions to the challenges identified in Phase I.
- **Phase III** allowed participants to identify shared priorities and elements of a common vision to inform and guide decision and policy-making.

> **In total, 479 qualified participants confirmed their participation in the Phase I dialogues, and 310 ultimately attended. Of these, 223 returned to participate in Phase II, and roughly half of this number (111) took part in the third and final phase.**

This report presents an overview of the engagement methodology adopted for this initiative, a profile of participants and a summary of "what participants said" during the three phases of the process. The views contained herein reflect those of the participants and are not the NBHC official recommendations to the health system partner.

Please note: All Phase I findings were later validated by Phase II participants, while Phase II findings were later validated by Phase III participants.

Key Findings

Participants in the three phases of this initiative provided rich feedback to the New Brunswick Health Council. While a great variety of perspectives were provided, the degree of consistency in participants' comments across dialogue sites and across Phases I, II and III highlights a powerful province-wide consensus on a number of key elements which together lay the foundation for a common vision for health care in New Brunswick:

- A firm belief in the importance of addressing barriers relating to distance, language, socio-economic status and cost to ensure equitable access to health care services province-wide.
- Strong endorsement of community health centres, clinics, home-based care (i.e., Extra-Mural Program), Tele-Care and tele-health as strategies for bringing health care closer to citizens and for ensuring that hospitals remain focused on their primary purpose: acute and supportive care, including emergency services.
- A call for a fundamental paradigm shift towards wellness, health promotion, health literacy and illness prevention ("health care" versus "sick care") with a particular focus on reducing the incidence of chronic diseases and fostering a "culture of health" early on in childhood.
- The belief that more must be done to optimize the roles and responsibilities of health care professionals in order to ensure that all available health human resources are used to their full capacity within the framework of the province's public health system.
- Recognition that the rising costs of health care must be better communicated to citizens and reined in through improved systems and processes, promotion and prevention, more creative use of available public infrastructure and reducing the cost of drugs.
- A strong sentiment that health care is a valued public good in which citizens and communities alike have a high stake.
- Strong support for strategies that encourage and empower citizens to take responsibility for their own health.
- Deep appreciation for the commitment and generosity of the people who make the health system work – front-line health care workers.

The following pages provide additional details on participants' perspectives and conclusions throughout the three phases of this process.

Phase I: Values

Participants were tasked with articulating what they would value most in an "ideal" health system. Their work led to the identification of five core values:

- ensuring the accessibility of health care services
- providing equitable care and services for all
- investing in education (health literacy), health promotion and illness prevention
- focusing on quality (effectiveness, efficiency, accountability and safety)
- making the health system truly centered on the needs of citizens.

When asked to validate these core values (through keypad voting), 90% either "strongly agreed" or "agreed" that these values taken together accurately reflect what they would expect from an "ideal" health system.

> **Key Finding:**
> **A firm belief in the importance of addressing barriers relating to distance, language, socio-economic status and cost to ensure equitable access to health care services province-wide.**

Participants were then asked to vote for which of these five core values would be *most important* to them as citizens of New Brunswick. Accessibility was selected by 29% of participants, while health promotion and illness prevention was chosen by 28%; equity ranked third (20%) but was considered by many as a value which is complementary and closely intertwined with the notion of accessibility.

Phase I: Issues

Participants identified what they saw as the priority issues that should be addressed in order to create the kind of health system they want for New Brunswick. Their concerns were grouped in the following broad categories:

- accessibility of health care services
- cost/funding of the health care system
- promotion of health and prevention of illness
- optimization of health care services
- systemic changes required for a citizen-centered system.

During the validation exercise, 91% of participants either "strongly agreed" or "agreed" that these issues taken together reflect the key challenges faced by New Brunswick's health system. Participants were then asked which categories of issues they felt the New Brunswick health system needed to focus on first. Consistent with what they valued most, they prioritized addressing the lack of promotion of health/prevention of illness (32%) and increasing the accessibility of health care services (27%).

Phase I: Strengths and Opportunities

Participants were keen to recognize and celebrate New Brunswick's strengths and successes, enthusiastically noting that the system's biggest strength was the *"people who make the system work."* They also strongly valued the province's Medicare program (and universal access to health care) as well as several state-of-the-art services such as the Extra-Mural Program and Tele-Care. They also highlighted what they saw as key opportunities to drive change and improvements to the New Brunswick health system: the province's (and health system's) small size as a source of nimbleness; citizen and stakeholder commitment to change; and increased focus on and investment in health promotion and illness prevention to reduce the burden on the health system.

> **Key Finding:**
> **Strong endorsement of community health centres, clinics, home-based care (i.e., Extra-Mural Program), Tele-Care and tele-health as strategies for bringing health care closer to citizens and for ensuring that hospitals remain focused on their primary purpose: acute and supportive care, including emergency services.**

When later asked to validate whether these strengths and opportunities taken together reflected the best aspects of New Brunswick's health system, 91% either "strongly agreed" or "agreed" that they did.

Phase II: Where Health Care, Services and Supports Should Be Delivered

Participants underscored the fact that the answer to this question is in large measure dictated by the patient's needs. For example, they felt that elder care should be delivered at home if possible or in a nursing home if specialized care or supports are required. They believed that hospital emergency departments should be available and accessible to treat emergencies. They suggested creating specialized clinics to support chronic disease management outside of a hospital setting.

In more general terms, participants suggested that the following guiding principles help determine where health services and supports should be delivered: deliver services locally, as close to home as possible or at home, when possible; make greater use of community health centres staffed by effectively integrated multidisciplinary teams and providing a range of services that include education/health promotion and preventive care; maintain the primary role of hospitals as providers of acute care, supportive care and emergency services; make greater use of clinics and community pharmacies to offer services that do not need to be delivered in a hospital setting and/or to increase the availability of services in rural areas; and offer services where people live, work and study (e.g., use available space in schools to deliver services locally).

In the follow-up validation exercise, 98% of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflect *where* health care, services and supports should be delivered.

Phase II: By Whom Health Care, Services and Supports Should Be Delivered

Participants expect to receive the health services and supports they need from health care workers that are competent; properly educated, trained and qualified; available and accessible; and able to communicate with them in the official language of their choice (particularly in the case of first responders, such as paramedics and nurses). They also expect to be cared for by health professionals who have the time to dedicate and listen to their patients.

> **Key Finding:**
> **A call for a fundamental paradigm shift towards wellness, health promotion, health literacy and illness prevention ("health care" versus "sick care") with a particular focus on reducing the incidence of chronic diseases and fostering a "culture of health" early on in childhood.**

Moreover, participants felt that teamwork and collaboration among health care workers are critical and must be encouraged and adequately supported. Nurses and other allied health professionals (e.g., pharmacists, paramedics, nutritionists, dietitians) should be given more responsibility and decision-making power in order to alleviate the demands placed on physicians. Mental health and holistic/alternative health practitioners should be made an integral part of the health system. Finally, greater use should be made of volunteers and community organizations, particularly in the realm of health promotion/illness prevention.

Participants also saw a great need for greater access to professionals and resources that could help patients navigate the health system more effectively (e.g., care maps, health system navigators). They valued services that allow people to better care for themselves or their loved ones at home but stressed the importance of providing adequate supports to family caregivers. They noted that the media have an important role to play in raising awareness about health (e.g., chronic disease prevention) and health system issues (e.g., costs) and stressed that each New Brunswicker also has to assume responsibility for his or her own health.

Again, 98% of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflect *by whom* health care, services and supports should be delivered.

Phase II: What the Health System Should Be Doing More of

Participants thought that more ought to be done to improve access to health care, particularly with respect to facilitating access to specialists (e.g., without referrals); allowing physicians to spend more time with patients; ensuring a more equitable distribution of clinics and health care professionals across the province; providing greater access to holistic or alternative care (e.g., chiropractors and naturopaths); and providing more facilities and resources to care for the province's aging population.

Participants also felt that greater investment should be made in health promotion and illness prevention, including education on the prevention and management of chronic diseases; creating a "culture of health" early in childhood (particularly through the education system); creating more community-based initiatives to encourage the population to be active (e.g., green spaces, cycling paths, community gardens); implementing more deterrents (e.g., taxes, regulations) to making unhealthy choices (e.g., smoking, junk food); and doing more to encourage people to take responsibility for their own health, (e.g. "health status report card" for each citizen).

Participants believed that making greater use of information technology (e.g., *One Patient, One Record*; tele-health; videoconferencing) is key to reducing costs and increasing efficiency, as is consulting with and learning from the experiences of front-line workers.

> **Key Finding:**
> **The belief that more must be done to optimize the roles and responsibilities of health care professionals in order to ensure that all available health human resources are used to their full capacity within the framework of the province's public health system.**

Participants identified a number of specific services they felt ought to be strengthened, including obstetrical/maternal/women's health services and mental health services. They also felt that greater investment in home care supports and the province's network of community health centres would be key to making the health system more "citizen-centered." Finally, participants stressed the importance of supporting the role of communities and local decision-making in health and of paying attention to the needs of the most vulnerable and disenfranchised citizens (e.g., the poor, the homeless).

When later asked to validate these findings, 96% of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflect what the health system should be doing *more* of.

Phase II: What the Health System Should Be Doing Less of

While participants had fewer suggestions to make on this topic, they nonetheless offered three clear messages: fewer barriers to care, less costly drugs and less bureaucratic and political interference.

Reducing barriers to access includes not only addressing wait times but also eliminating some of the "red tape" in the health system (e.g., clerical work required of nurses, bureaucratic hurdles to accessing specialized or alternative care) and accommodating factors such as language and distance/inability to travel so that they are not barriers to access.

Reining in the cost of the health system was also identified as a priority, for example, by addressing waste and inefficiencies in health care delivery and making greater use of available facilities and infrastructures (e.g., schools). Participants also felt that the cost of drugs should be addressed (e.g., by limiting the influence of pharmaceutical companies) and that it was imperative to ensure that costs (e.g., of drugs, services) do not prevent people from receiving necessary care and treatments.

Finally, participants called for less bureaucratic and political interference with health care delivery and decision-making, stating that "we need to take the politics out of health care." They argued for less political interference and influence in decisions about the health care system; fewer costly studies and reforms; and greater collaboration across government departments.

> **Key Finding:**
> **Recognition that the rising costs of health care must be better communicated to citizens and reined in through improved systems and processes, promotion and prevention, more creative use of available public infrastructure and reducing the cost of drugs.**

In the validation phase, 87% of participants either "strongly agreed" or "agreed" that these ideas taken together reflect what the health system should be doing *less* of.

Phase II: Encouraging Healthier Choices and Behaviours

Participants identified a variety of incentives and supports that could be put in place to encourage New Brunswickers to adopt healthier behaviours. Their suggestions focused largely on measures that would promote exercising regularly (e.g., community-based programs and infrastructure) and healthy eating (e.g., subsidizing locally grown, organic produce; community gardens or kitchens). They also sought measures that would create safe and health-conscious communities (e.g., safe home and work environments and reduction of environmental pollution) and actively promote healthy lifestyles (e.g., more physical education and nutrition classes in school, school or community-based healthy eating classes).

Key Finding:
A strong sentiment that health care is a valued public good in which citizens and communities alike have a high stake.

They also valued supports that would help people practise self-care, take responsibility for their own health and stay informed (e.g., addiction counselling services; regular access to a doctor; mental health supports; rewards for being/staying healthy).

Finally, they argued in favour of measures that would help lessen the use/consumption of harmful substances, for example, higher taxes on unhealthy substances to discourage use (e.g., of tobacco, alcohol, energy drinks) and more needle exchange programs, methadone clinics, etc.

When asked to validate these findings, 97% of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflect the kinds of *incentives* and *supports* required to encourage healthy choices and behaviours by New Brunswickers.

Phase III: Priority Setting

In the third and final phase of this 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. To provide a framework in this regard, the most salient and frequently occurring ideas were grouped thematically as a series of possible areas for action in two broad categories – Primary Care and Acute/Supportive Care – and presented to participants for their consideration and priority setting.

It is important to note that some of the ideas put forth by participants fell outside of Primary Care and Acute/Supportive Care; however, for the purpose of this exercise, all ideas were grouped in one or the other category based on wherever they fit best.

Making community health centres (CHCs) and clinics the centrepiece of primary care emerged as a clear primary care priority, reflecting participants' strong belief in the benefits of this model, including more equitable access to care, more flexibility in the range and mode of delivery of services, efficiency gains and cost savings, more individualized and personalized care, and closer ties to the community.

Key Finding:
Strong support for strategies that encourage and empower citizens to take responsibility for their own health.

Prevention and promotion were also recurring themes throughout this process and a clear primary-care priority. Participants fervently argued that a shift in this direction was required if New Brunswickers were to rein in health care costs and stem the tide of chronic illnesses. As one participant stated, *"We must change the system from 'sick care' to 'health care.'"* Participants also reiterated that

incenting individuals to take greater responsibility for their own health was a critical underpinning of long-term population health and health system sustainability.

Optimizing the roles and responsibilities of health professionals was also seen as critical to ensuring that patients receive *"the right care, at the right time, in the right place, by the right health care professional."* Participants felt that making better use of available traditional *and* alternative or holistic health professionals (i.e., allowing nurses, paramedics, pharmacists, mental health professionals, midwives, naturopaths, chiropractors and others to play a greater role within the health care system, funded by Medicare) would give patients more choices and easier access to care as well as help to alleviate the burden on the health system in general and on physicians in particular.

With respect to acute/supportive care, participants prioritized strengthening supports for home-based care, followed by integrating the mental health and physical health systems, augmenting our capacity for care for the province's aging population and developing chronic disease prevention and management strategies or programs.

> **Key Finding:**
> **Deep appreciation for the commitment and generosity of the people who make the health system work – front-line health care workers.**

Citizen Engagement

Participants were asked to reflect on their experience over the course of this process and to consider what "citizen engagement" meant to them now. They were then asked to think about:

- the issues or decisions they would expect citizens to have a say in when it comes to health and health care in New Brunswick
- how and by whom they would expect to be engaged.

Participants felt that citizens should be consulted on current or emerging issues that may affect citizens directly; the cost and funding of the health system; major infrastructure decisions; and programs and services.

Participants expressed a clear desire to see the New Brunswick Health Council continue to deliver on its mandate of citizen engagement, but they felt that the Government of New Brunswick must also engage citizens on issues that affect them.

Participants offered a variety of suggestions on *how* and *by whom* citizens should be engaged: through the creation of citizen committees; online; in person; by working with community partners; through public opinion research; and through referenda on strategic issues during elections.

Participants also outlined the following conditions for meaningful citizen engagement: engagement should not be limited to validating decisions that have already been made; citizens should be consulted regularly and regionally; "citizen" engagement needs to include communities, as

communities are closest to citizens and are key partners in the delivery of health and social services; meaningful engagement requires informed participation, that is, not only providing citizens with an opportunity to provide input but also ensuring they are equipped to do so in a meaningful way; and citizen engagement should be open and transparent.

Finally, while participants greatly valued citizen engagement, they also cautioned that citizen engagement decisions needed to include a cost-benefit analysis to ensure resources are used as judiciously and effectively as possible.

Conclusion

Participants saw health and health care as a shared responsibility. They were ready to assume responsibility for their own health but expected health system partners to work together and *"take the politics out of health care."* As one participant stated during the final dialogue in Fredericton, *"As Health Minister of the day, I would call a meeting with the Departments of Education, Public Safety and Health [in order to collaborate on] proposed initiatives. [...] The Department of Health cannot and should not do it alone. We must bring the money forward to kick off these initiatives. We need accountability from all departments and we will save in the long run. […] Let's push the bar a little further."*

The participants' message was clear and simple: citizens, communities and health system partners all have a role to play in ensuring the best possible health outcomes for New Brunswickers.

The New Brunswick Health Council wishes to thank all participants for their time and energy, for the depth of their commitment and for the thoughtfulness of their contribution.

1. INTRODUCTION

Created during the 2008 health reform as an independent and objective organization, the New Brunswick Health Council (NBHC) is mandated to measure, monitor and evaluate population health and health service delivery in the province of New Brunswick. This involves an obligation to provide regular and accurate updates on the province's state of health and on the health care system's performance and to formulate recommendations to the Minister of Health. The creation of the NBHC was also driven by the recognition that citizens are the health care system's most important stakeholders. As such, the organization was also mandated to make citizen engagement a core part of its work with a view to engaging New Brunswickers in a meaningful dialogue for the purpose of improving health services in the province.

Figure 1: Mandate of the New Brunswick Health Council

New Brunswickers have the right to be aware of the decisions being made, to be part of the decision-making process and to be aware of the outcomes delivered by the health system and its cost. The NBHC will foster transparency, engagement and accountability by:

- **Engaging citizens in a meaningful dialogue**
- **Measuring, monitoring and evaluating population health and health service quality**
- **Informing citizens on the health system's performance**
- **Recommending improvements to health system partners.**

A citizen-centered philosophy and approach

Citizen engagement is a way for people to have a say in how public policy is shaped. This requires that citizens be well-informed about issues and that they be provided with meaningful opportunities to share their views. It also requires that governments be open and attentive to the voices of citizens.

For the NBHC, this means reporting to New Brunswickers on the performance of the health system and seeking their informed input on the policies that guide the health system and affect the health of the province's population.

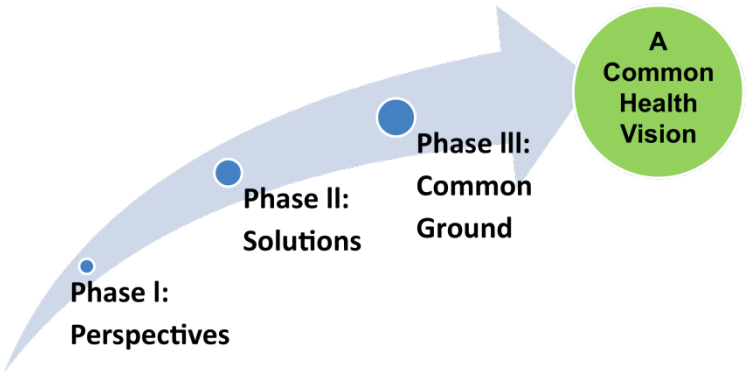
1.1 *Our Health. Our Perspectives. Our Solutions.*

In 2008, the Government of New Brunswick published the Provincial Health Plan 2008-2012, in which it clearly expressed the view that the province's health system needed to become a "citizen-centered health system," that is to say:

> **"A system that meets the needs and preferences of individuals and communities, rather than expecting people to adapt to what the system has to offer."**[1]

Our Health. Our Perspectives. Our Solutions. was the NBHC's first large-scale citizen engagement initiative, and its purpose was to help the NBHC develop recommendations to health system partners on what citizens believe is required to achieve this vision of a citizen-centered health system. It was a three-phase process designed to involve New Brunswick citizens and health stakeholders in a dialogue on what people value most with regards to the provincial health system, how the system can be strengthened and what can be done to improve provincial health outcomes.

Figure 2: A Three-Phase Citizen-Engagement Initiative



- **Phase I** focused on exploring the perspectives and concerns of citizens with respect to the current state of New Brunswick's health system with a view to identifying what they see as the system's greatest strengths and most important challenges.
- **Phase II** looked to the future to envision the kind of health care system New Brunswickers want to have and to identify possible solutions to the challenges identified in Phase I.
- **Phase III** allowed participants to identify shared priorities and elements of a common vision to inform and guide decision and policy-making.

The NBHC recognizes that citizens want to have a presence at the decision-making table in order to influence policy outcomes and believes they have much to contribute to the creation of viable

[1] **New Brunswick Government,** ***Transforming New Brunswick's Health-care System: The Provincial Health Plan 2008-2012*****, April 2008, p.10.**

solutions. The outcomes of this process will therefore help the NBHC develop recommendations to government and other health system partners.

> *This report presents an overview of the engagement methodology adopted for this initiative, a profile of participants and a summary of "what participants said" during the three phases of the process. The views contained herein reflect those of the participants and are not the NBHC official recommendations to the health system partner.*

2. METHODOLOGY

The NBHC's three-phase approach brought together a mix of citizens and stakeholders and was designed with a view to providing them with an opportunity to engage in an "iterative" learning and dialogue process: inviting the same individuals to attend multiple dialogue sessions meant that participants could deepen their understanding of the issues as they progressed, reflect on and integrate what they heard between phases and thus offer richer and more informed perspectives throughout the dialogues.

Four dialogue sites were selected for Phase I and Phase II, in each of New Brunswick's four corners: Moncton, Bathurst, Edmundston and Saint John. These locations were selected to ensure that any New Brunswicker could attend an event without having to travel more than 200 kilometres.

At the outset, a target of 125 participants was set for each of the Phase I dialogues; half of these participants were to be randomly recruited[2] citizens, while the other half was to be comprised of stakeholders who work in, or have an influence on, various components of the health system. These include representatives of various community and public interest groups, health and wellness managers, academics, health professionals, provincial government representatives and municipal officials *(a breakdown of stakeholder recruitment targets is provided in* ***Appendix A****).*

During Phase II, each of these groups was to reconvene in the same locations for another day of dialogue to continue their work together. Phase III was to consist of a provincial dialogue held in Fredericton, which would bring together a total of 200 participants drawn from each of the four locations.

Despite efforts invested in the recruitment phase, the initial goal of 125 participants per Phase I dialogue (for a total of 500 participants) was not met. Securing this number of participants in each dialogue location proved to be a challenge, despite over 38,000 phone calls made to potential participants by the recruitment firm.

> **In total, 479 qualified participants confirmed their participation in the Phase I dialogues, and 310 ultimately attended. Of these, 223 returned to participate in Phase II, and roughly half of this number (111) took part in the third and final phase.**

The recruitment challenge was compounded by the participant attrition rate (the percentage of confirmed participants who ended up not attending the event). This was particularly true in Phase I where, on average, one-third of confirmed citizen participants did not present at the event. On the

[2] **Random recruitment of participants was led by a third-party firm, *Bristol Omnifacts*.**

other hand, the attrition rate among confirmed stakeholder participants was significantly lower, averaging approximately 3%.

While the citizen attrition rate in Phase I may appear high, this is not uncommon for citizen engagement initiatives. In this case, it can likely be attributed to a combination of factors:

- the NBHC is still a relatively new organization
- there were no honoraria (or other incentives) provided to participants
- while weekend sessions are more accessible to those who work, there is always a risk that people make a last-minute decision to simply choose to spend their Saturday doing something else.

The most effective strategy for countering this type of attrition is to over-recruit, that is, to confirm a greater number of qualified participants than is actually required (by as much as 25% to 30%) – a strategy which was unsuccessfully attempted in this case.

However, as outlined in **Figure 3**, the proportionally high rate of citizen attrition in Phase I diminished significantly in Phase II and Phase III to match the stakeholder attrition rate – a testament to citizen participants' commitment to the process once they fully embarked on this journey.

Figure 3: Participant Attrition Rates

Category	Phase I	Phase II	Phase III
Citizens	32%	11%	3%
Stakeholders	3%	10%	3%

The agenda for the day was designed by Ascentum, Inc. in collaboration with the NBHC, and included a mix of learning sessions, facilitated small-group work, sharing of perspectives in plenary and keypad voting.[3] Table facilitators were assigned to each table and were responsible for facilitating the table conversation, for note-taking and for ensuring that citizens and stakeholders alike had an opportunity to express their views.[4]

2.1 Phase I Objectives

The purpose of this first set of dialogues was to engage New Brunswickers in an informed conversation on the state of the province's population health and health services. In order to prepare for this event, a ***Participant Conversation Guide*** was prepared by the NBHC and distributed to participants. It provided an overview of the initiative, explained the objectives of Phase I and provided detailed background information on the New Brunswick health system. Participants were invited to contribute to Phase I in three ways.

[3] **Keypad voting is an interactive technology that allows participants to select their preferred response to a multiple-choice question projected on the screen and then instantaneously produces a graph to illustrate how the group's responses were distributed.**

[4] **Table facilitators were trained and recruited by Ascentum, Inc. for each event.**

- **Learn about New Brunswick's population health and health system:** the NBHC gave two information presentations. The first provided a brief overview of the province's health sector and the cost of health care services in New Brunswick. The second described the other factors that work together to foster a healthy population and outlined how New Brunswick has been performing compared to other jurisdictions in Canada. Participants were also asked to share (through keypad voting) their perspectives on a number of general questions pertaining to health and health care in New Brunswick.
- **Share their thoughts on what they value most in the province's health system:** from their personal experience and what they see in their communities, participants were asked to state what they valued most in an "ideal" health system. In a later exercise, they were also asked to identify what they saw as the key strengths of the New Brunswick health system.
- **Identify the issues they feel require most urgent attention:** knowing that there are not infinite resources to address the province's health challenges, participants were asked to identify what they saw as priority issues within the New Brunswick health system.

Each Phase I dialogue was held on a Saturday from 9:30 a.m. to 4:00 p.m. (sessions were held in Moncton, Bathurst, Edmundston and Saint John). Participants were assigned to a table upon arrival based on language and perspective: tables worked in either French or English, and, where possible, each table brought together a balanced mix of citizens and stakeholders. Simultaneous interpretation was available at all sites for the plenary presentations and discussions.

Additional information on the Phase I agenda, dates and venues is available in ***Appendix B****.*

2.2 Phase II Objectives

All Phase I participants were invited to return to the same location (Moncton, Bathurst, Edmundston or Saint John) to attend one of the four Phase II dialogues. Again, these were day-long sessions held from 9:30 a.m. to 4:00 p.m. on Saturdays and comprised of a mix of plenary discussion and facilitated small-group work.

The Phase II dialogues were designed with two objectives in mind:

- **Validate and prioritize** Phase I findings, i.e., the key themes that emerged at the provincial level with respect to what citizens valued most in an "ideal" health system, the priority issues they felt must be addressed and the key strengths of the health system.
- Seek input on key ways in which the **health system** and individual **citizens** can help foster a healthier population in New Brunswick.

The ***Phase II Conversation Guide*** provided participants with a detailed summary of Phase I findings along with additional information on the health system in response to specific questions raised by Phase I participants.

Keypad voting was used to validate and prioritize Phase I findings, and a variety of small-group exercises were developed to allow participants to explore three focus questions:

- What are the qualities or characteristics of a "citizen-centered" health system?
- How can the *health system* help citizens and their families be healthier?
- What can *citizens* do to help themselves and their families be healthier?

Additional information on the Phase II agenda, dates and venues is available in ***Appendix B****.*

2.3 Phase III Objectives

The third and final phase of this initiative was a single day-long session (9:30 a.m. – 4:00 p.m.) held in Fredericton. A total of 111 participants were in attendance, all of whom had previously participated in Phase I and Phase II.

Phase III objectives were to:

- **review and validate** Phase II findings (i.e., where and from whom citizens wish to receive their health care services and supports; what the health system should do more of and less of)
- **link** ideas generated in Phase I and Phase II to the various sectors of the health care system
- **prioritize** potential areas for action (based on Phase I and Phase II findings) with a view to meeting the needs and expectations of New Brunswickers and ensuring health system sustainability over the long term.

To stimulate the dialogue process, Phase III participants received a summary of Phase II findings along with a copy of the New Brunswick Provincial Health Plan 2008-2012. Highlights from the Provincial Health Plan were presented during the opening session, to help inform and contextualize subsequent discussions on priorities. Keypad voting was also used to validate Phase II findings.

While the first two phases were more *generative* in nature – focused on sharing perspectives and generating ideas – Phase III was meant to be more *deliberative*. Deliberative processes are designed to allow participants to consider various options; to weigh their respective benefits, drawbacks and tradeoffs; and to make what are often difficult choices among the options based on both their personal values and their rational appreciation of the issues at hand.

To this end, the most salient and frequently mentioned ideas collected throughout Phase I and Phase II were grouped thematically and presented to participants as a list of 18 possible areas for action to strengthen New Brunswick's health system and make it a more citizen-centered system.

Half of these related to primary care, while the other half related to acute/supportive care.[5] Through a combination of individual reflection, small-group work, keypad voting and dot-voting, participants were asked to imagine they were Health Minister for a day and identify which of these areas for action they would prioritize moving forward. Two decision criteria were specified to help guide this process:

- making choices that meet the needs and expectations of New Brunswickers (as articulated throughout Phase I and Phase II of this process)
- making choices that help ensure the long-term sustainability of the New Brunswick health system.

Additional information on the Phase III agenda, dates and venues is available in ***Appendix B.***

2.4 An Emphasis on Dialogue

The NBHC placed a great deal of importance on the notion of dialogue throughout this process. Participants were reminded that the goal in a dialogue is to work together to explore and understand different points of view. Rather than creating a "winner" and a "loser," dialogue focuses on building common ground.

As such, participants were frequently reminded that there were no "right" and "wrong" answers – only individual experiences and points of view, each of which carry equal weight and legitimacy in the eyes of the NBHC.

In support of this, the "Ground Rules for Dialogue" (see **Figure 4**) were highlighted at the beginning of the day and prominently displayed at the centre of every table.

Figure 4: Ground Rules for Dialogue

GROUND RULES FOR DIALOGUE

1. **Respect** all points of view.
2. **Listen** openly and carefully to others.
3. **Suspend** judgment – there are no "wrong" opinions.
4. **Test** your own assumptions.
5. **Express** disagreement with ideas, not personalities.
6. Work **together** and have **fun**!

[5] **It is important to note that some of the ideas put forth by participants fell outside of Primary Care and Acute/Supportive Care; however, for the purpose of this exercise, all ideas were grouped in one or the other category based on wherever they fit best.**

In addition, if participants wished to raise issues that were clearly off topic, or if they wished to obtain responses to specific questions, they could at any time write down their comment or question on a post-it note and place it in the "**Parking Lot.**" These "parking lot" items were collected at each session, and included in the data analysis. Furthermore, participants could also provide their name and table number to allow for an NBHC team member to follow up with them during the day and/or provide their phone number or e-mail address for follow-up after the event.

2.5 Participant Recruitment

As previously noted, **citizen participants** for each of the dialogue sessions were randomly recruited by a third-party public opinion research firm. Recruitment criteria were designed to construct a sample reflecting the diversity of New Brunswick's population in terms of key demographic characteristics: age, gender, language, education, employment status, family situation and income. Potential participants were contacted by telephone and screened according to these criteria. If they met the recruitment criteria *and* were ready to commit to participating in the Phase I and Phase II dialogues in their area, they were contacted again during the week prior to the Phase I event to reconfirm their participation.

The recruitment of **stakeholder participants** was led by the NBHC with assistance from *Bristol Omnifacts*. *A breakdown of stakeholder categories and recruitment targets is provided in Appendix A.*

Recruitment efforts were supported by an NBHC media campaign, which included the distribution of a press release, advertising in local newspapers and radio stations, and interviews in response to media requests. No honoraria were provided to participants; however, those citizens for whom financial concerns proved to be a barrier to participation were offered financial reimbursements from the NBHC. In addition, every effort was made to accommodate the needs of persons living with disabilities and those facing special circumstances.

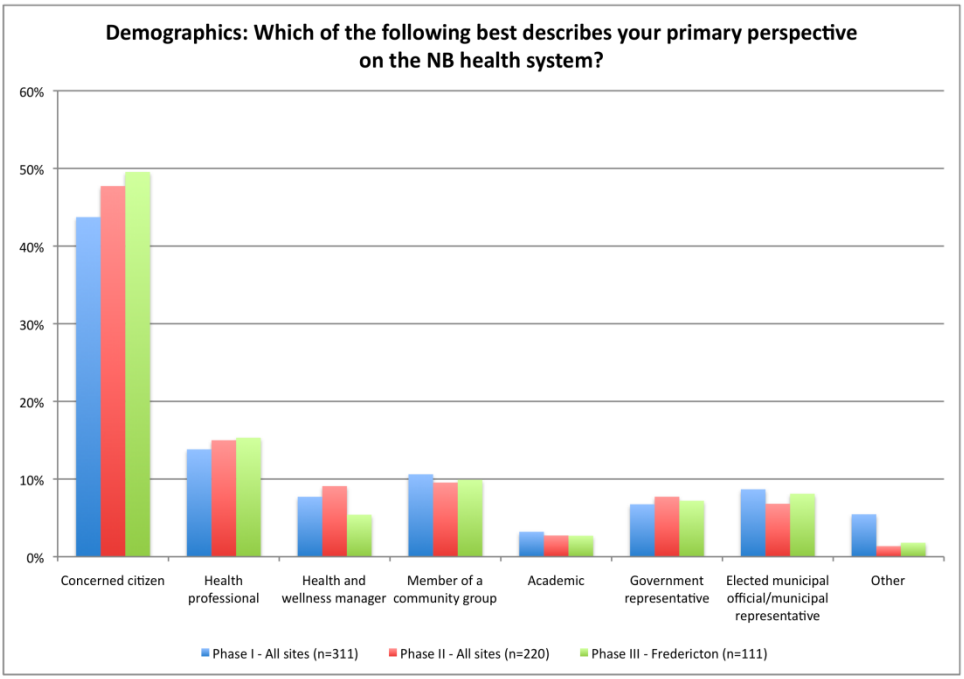
Although the Phase I and Phase II dialogues were held in the "four corners" of the province, all New Brunswickers had an equal chance of being randomly selected to participate at the session they considered most convenient to attend.

3. PROFILE OF PARTICIPANTS

As previously mentioned, a total of 479 qualified participants confirmed their participation in the Phase I dialogues, and 310 ultimately attended. Of these, 223 returned to participate in Phase II, and roughly half of this number (111) took part in the third and final phase (*for the complete profile of participants, see **Appendix C**).*

The final mix of participants at each dialogue, and across dialogues, did ultimately reflect the desired balance of citizen and stakeholder perspectives, with the average proportion of citizens climbing from 44% in Phase I to 50% in Phase II.[6] The mix and profile of stakeholders was also fairly stable across the three phases (see **Figure 5**).

Figure 5: Distribution of Participants by Perspective (Self-Identified)



[6] **The demographic profile presented in this chapter is based on keypad voting results and therefore illustrates how participants self-identified in response to each question. It should also be noted that sample size varied between questions depending on whether participants opted to respond.**

As illustrated by the charts that follow, participation was also diverse in terms of age, gender and language – somewhat reflective of the provincial profile.

- The 45-54, 55-64 and 65-74 age groups were over-represented, while the younger and older age groups were under-represented – something that was brought to participants' attention at every session to encourage them to think not only of their own needs and experiences but also of the needs and experiences of those not in the room.
- The male-female balance was skewed towards females (close to 60% female).
- Approximately one-third (35%) of participants self-identified as Francophones and half (50%) as Anglophones. The remaining 15% of participants indicated that they spoke both French and English at home.

Figure 6: Distribution of Participants by Age

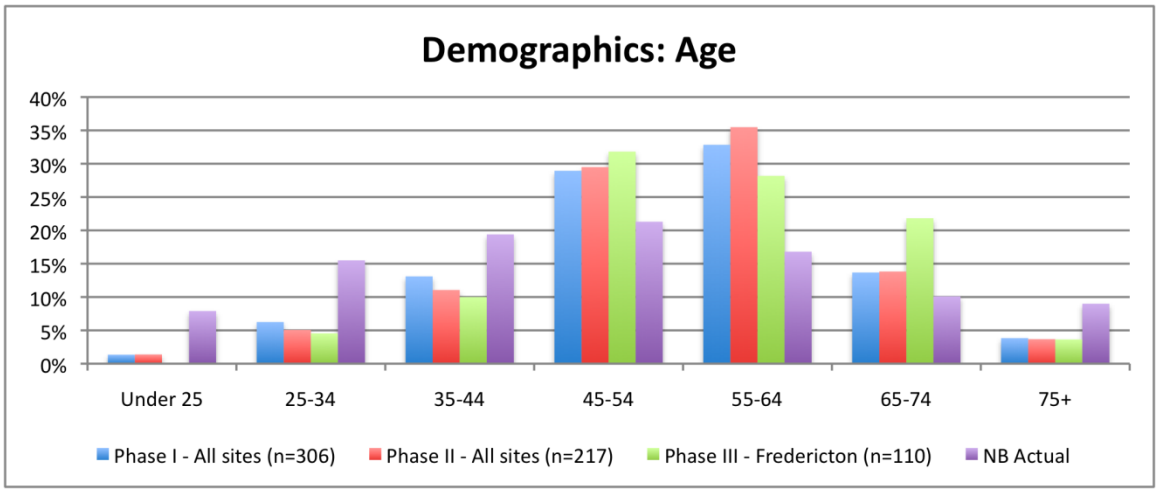


Figure 7: Distribution of Participants by Gender

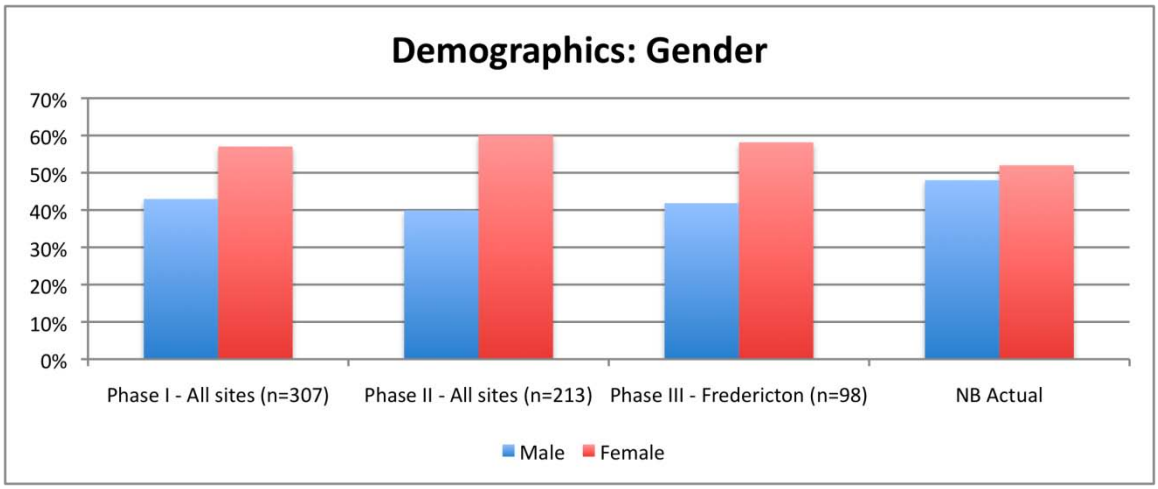
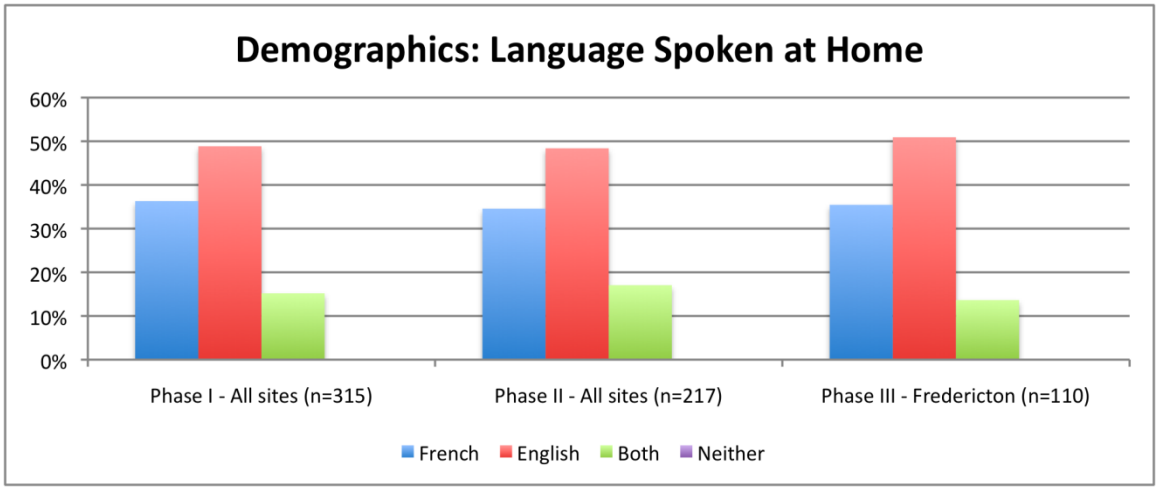
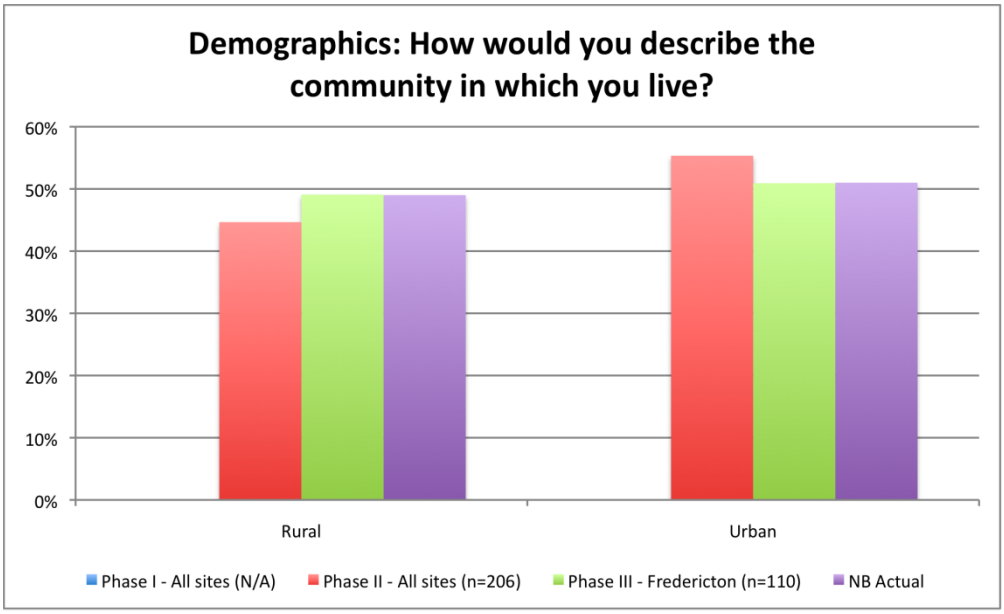


Figure 8: Distribution of Participants by Language



The vast majority of participants at each dialogue were locally based, that is to say, they attended the dialogue session closest to where they reside. In addition, the rural/urban balance of participants was reflective of the province's profile.[7]

Figure 9: Distribution of Participants by Rural/Urban Community (Self-Selected)



[7] **In New Brunswick, as per Statistics Canada's definitions *(Statistics Canada, The Online Catalogue 92-591-XWE (2006) [online], from http://www.statcan.gc.ca)*, 51% of the population is urban (includes larger and smaller urban areas). Larger urban areas include only Moncton (and surrounding area) and Saint John (and surrounding area) since both have a population greater than 100,000. Smaller urban areas include communities such as Tracadie-Sheila, Oromocto, Shediac and Sackville with a population density greater than 400 inhabitants per square kilometer. The remaining 49% of the New Brunswick population is considered rural, residing in communities such as Rogersville, Saint-Leonard and Dalhousie.**

Moving forward, however, the NBHC will make every effort to ensure that its citizen engagement initiatives include strategies for ensuring adequate representation of vulnerable or hard-to-reach groups of citizens that were under-represented throughout this process; these include youth, ethno-cultural groups, aboriginal peoples, linguistic minorities and persons living with physical and/or mental disabilities.

4. PHASE I: PERSPECTIVES

As previously outlined, the four Phase I dialogues were focused on exploring the general perspectives and concerns of citizens with respect to the current state of New Brunswick's health system. More specifically, participants were tasked with identifying what they would value most in an "ideal" health system, what they believe to be the current system's most important challenges and what they see as the system's greatest strengths and opportunities.

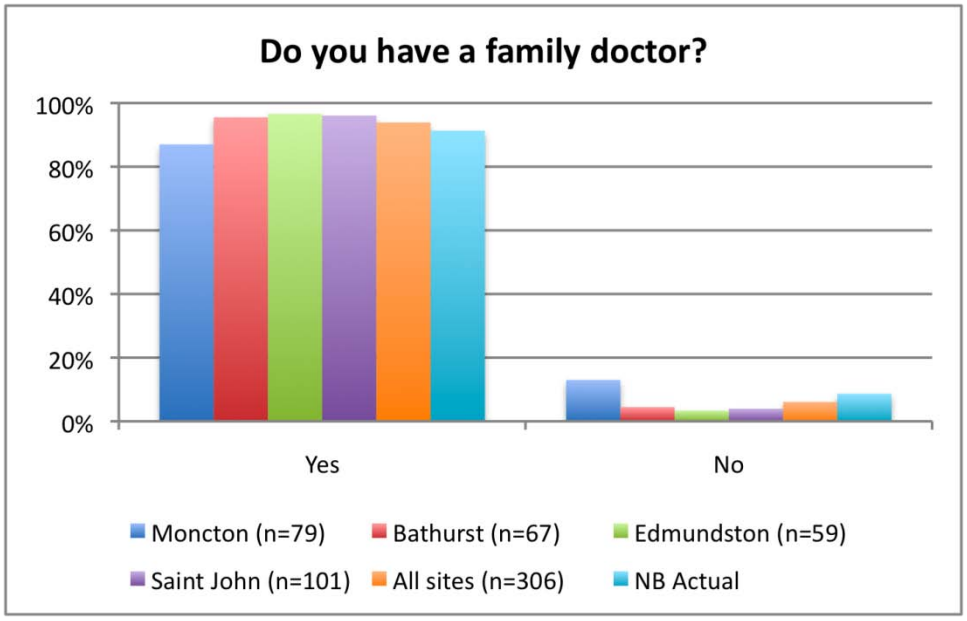
4.1 General Perspectives

Keypad voting was used in Phase I to probe participants' perspectives on a few general questions.[8] These were meant to help contextualize participants' comments during the discussion sessions and provide some additional insights into their general perspectives on the New Brunswick health system.

4.1.1 Access to a Family Doctor

The vast majority of participants (over 95% in all sites except Moncton, where this figure was 87%) indicated that they had a **family doctor**, which reflects New Brunswick's above-average performance in this regard (the provincial average is 91%).

Figure 10: Access to a Family Doctor



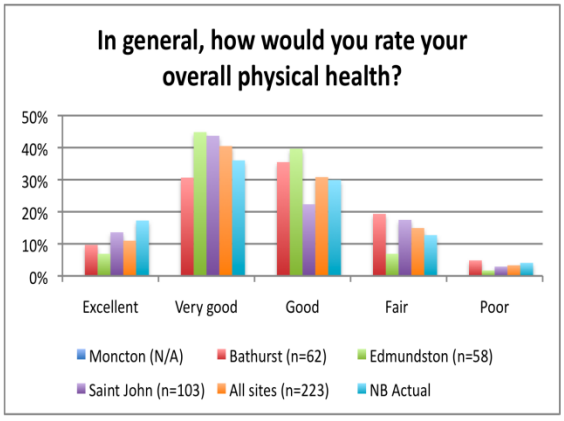
[8] **Many of the keypad voting questions were modified or replaced for greater clarity and relevance following the Moncton dialogue. As such, certain voting results are not available for Moncton.**

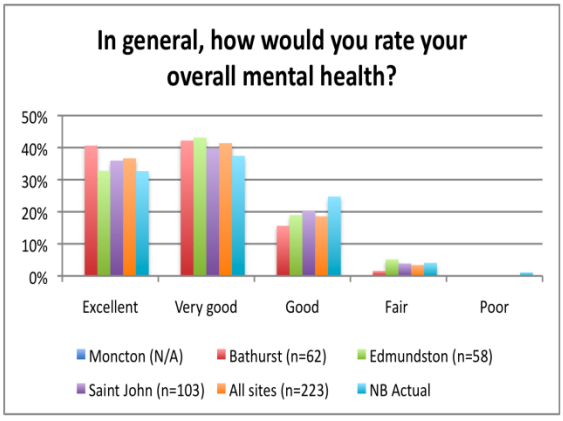
4.1.2 Impact of the Health System on Overall Physical and Mental Health

Participants were asked to self-assess their **overall physical health** and **overall mental health**. The New Brunswick average of those who rate their overall physical health as "excellent" or "very good" is 55%, according to the 2008 Canadian Community Health Survey (CCHC). This is comparable to the responses from Phase I participants, as a whole, at 50%. The responses to this question varied across regions: ratings were lowest in Bathurst at 40%, rose to 52% in Edmundston and peaked at 57% in Saint John (data unavailable for Moncton).

Overall, participants tended to rate their mental health more positively. Interestingly, while Bathurst participants ranked their overall physical health the lowest out of the sessions, they ranked their mental health the highest, with 83% of respondents choosing either "excellent" or "very good." In both Edmundston and Saint John this figure was 76%. Again, this is comparable to the provincial average of 71% from the 2008 CCHC.

Figures 11 and 12: Overall Physical Health and Overall Mental Health





Participants were then asked to indicate the extent to which they believed the health system influenced one's overall health. While some research studies have placed this figure at 10%, participants across all dialogues were more likely to believe it was higher (e.g., over one-third of participants in Bathurst and Edmundston and close to 20% in Saint John believed the health care system influenced 50% of one's overall health).

Figure 13: Perceived Influence of the Health Care System on Overall Health

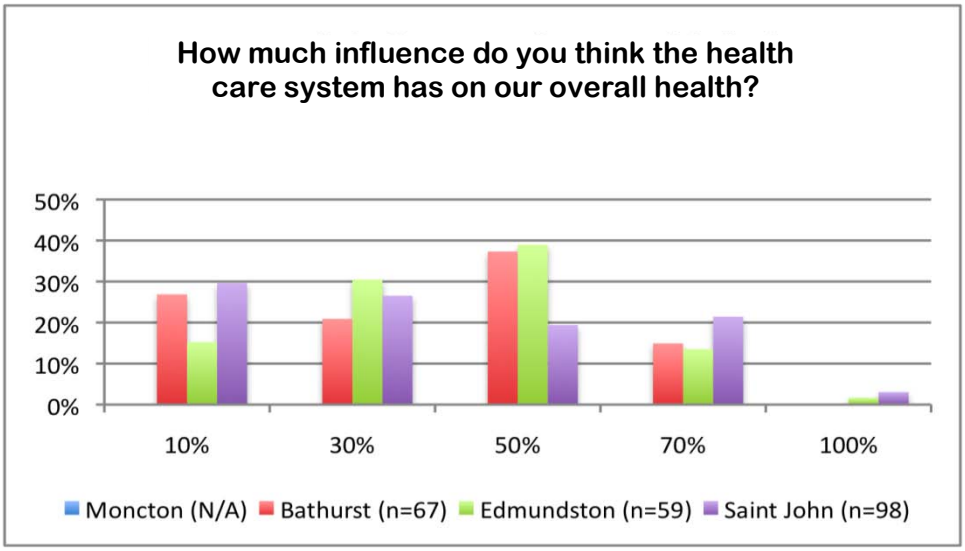
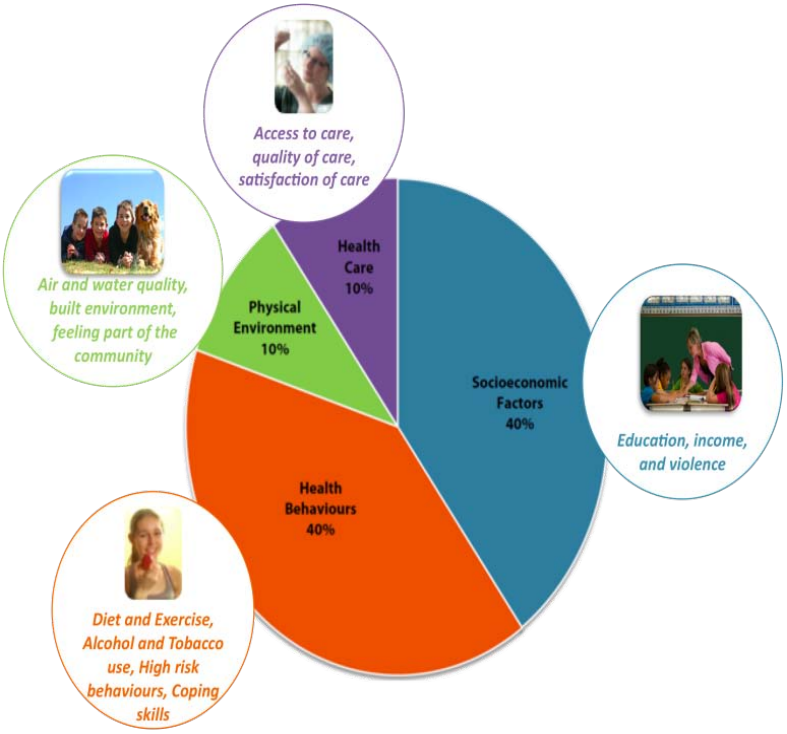


Figure 14: Factors Affecting Population Health

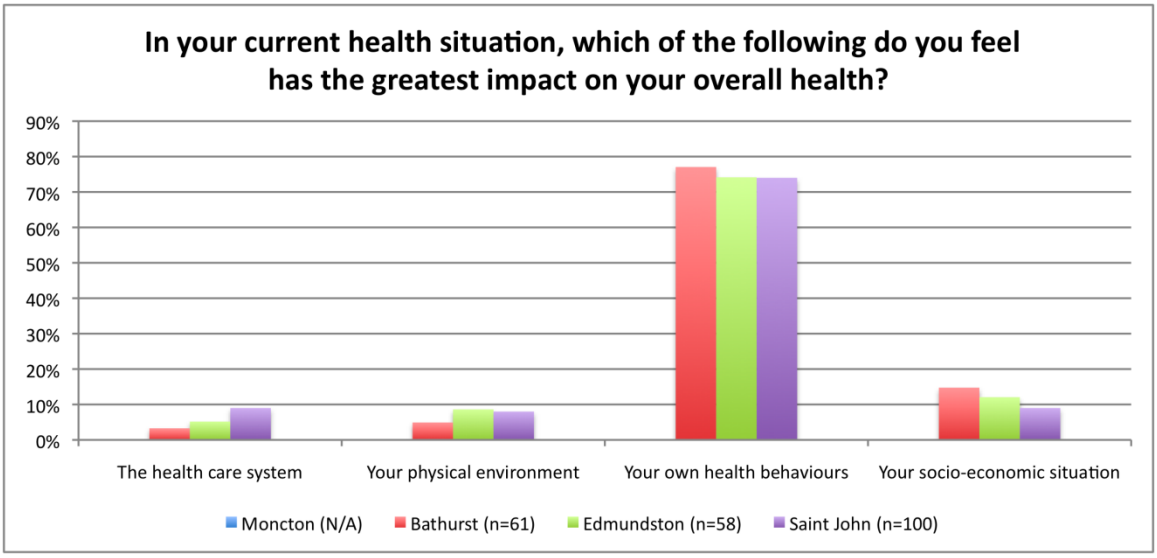


The NBHC uses the following model (**Figure 14)** to represent the determinants of health. The model demonstrates the percentage by which each category affects the overall health of individuals. This was presented and explained to participants.

Following this, participants were asked to indicate which category they saw as having the greatest and least impact on their overall health, given their current health situation.

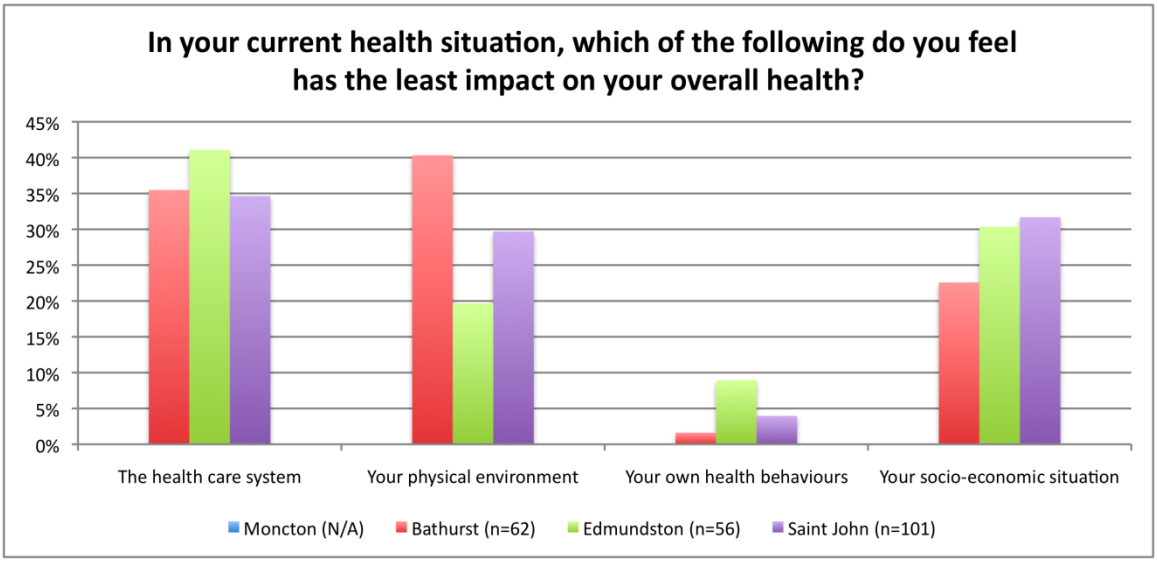
Overwhelmingly (approximately three-quarters), participants felt that their **own health behaviours** had the greatest impact on their overall health. This reflects participants' belief – frequently expressed during the dialogues – that each person carries some personal responsibility for managing his or her own health.

Figure 15: Factor Having the Greatest Impact on Overall Health



Participants were somewhat more divided on which category of factors had the *least* impact on their overall health. Strikingly, at least one-third of participants in each dialogue indicated that the health care system was the factor having the least impact on their overall health.

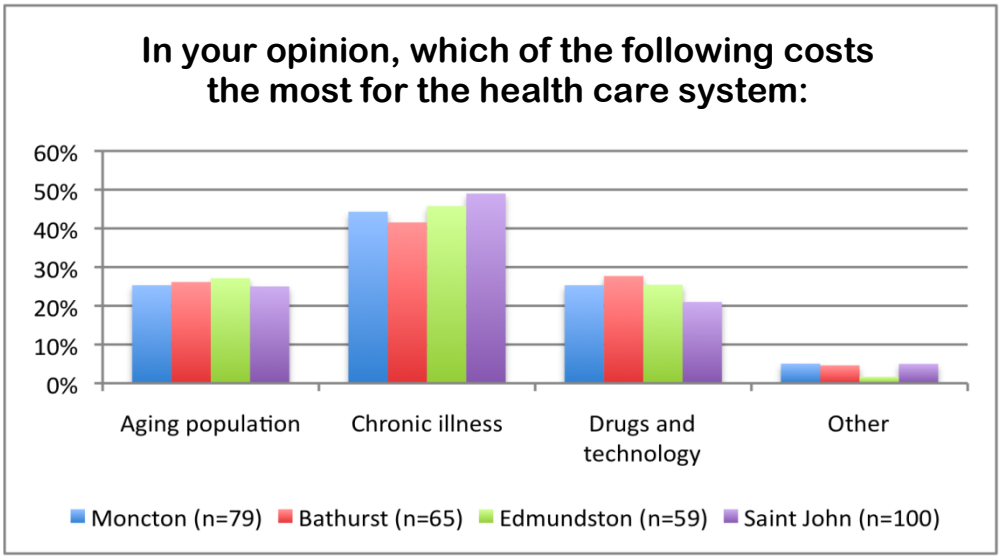
Figure 16: Factor Having the Least Impact on Overall Health



4.1.3 Perspectives on the Cost of Health Care in New Brunswick

A third set of questions was designed to probe participants' understanding of, and thoughts on, the cost of health care in New Brunswick.

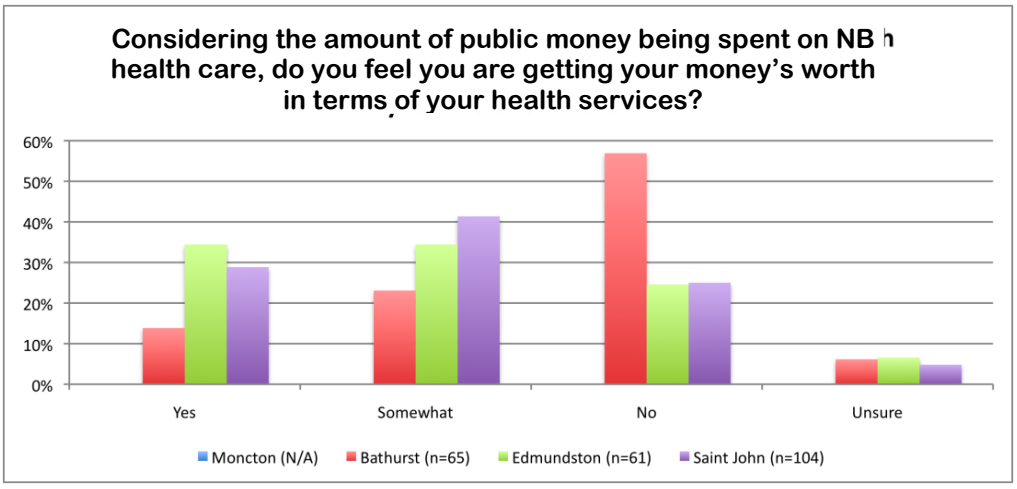
Figure 17: What Costs the Most for the Health Care System?



First, participants were asked to indicate which of four elements costs the most for the health care system. Less than half (approximately 40% to 45% per dialogue) were aware that chronic illnesses are the key cost driver of the health care system. This highlights the importance of continued efforts to raise public awareness about chronic disease prevention and management.

Participants were also asked to indicate whether they felt they were "getting their money's worth" in terms of their health services, given the amount of public money being spent on health care in New Brunswick. Perspectives on this question differed by region, with Bathurst participants expressing the greatest levels of dissatisfaction by far (over 50% voted "no" compared to 25% in both Edmundston and Saint John).

Figure 18: Getting Money's Worth in Terms of Health Services in NB

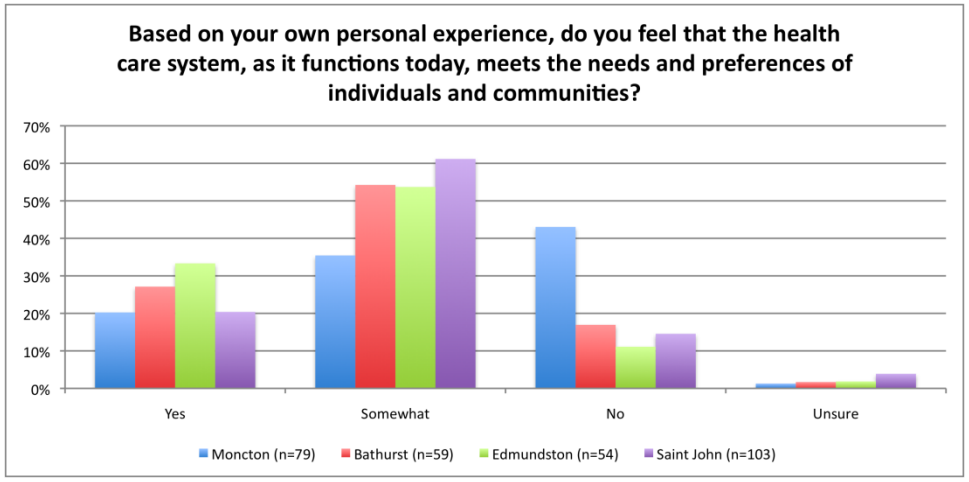


4.1.4 Towards a Citizen-Centered Health System

As the day drew to a close, participants were asked one final question designed to assess the extent to which participants felt the New Brunswick health care system was "citizen-centered" (based on the definition of a citizen-centered health system provided in the Provincial Health Plan 2008-2012).

Interestingly, perspectives varied greatly on this question across dialogues: respondents from the Moncton session were the most critical, with 43% responding that the system did not meet the needs and preferences of individuals and communities. Respondents from the other sessions were somewhat less categorical, with approximately 50% (Bathurst, Edmundston) to 60% (Saint John) indicating that it "somewhat" met the needs and preferences of individuals and communities.

Figure 19: Meeting the Needs and Preferences of Individuals and Communities



4.2 Values

In the first table discussion of the day, participants were asked to imagine an "ideal" health system and to discuss two questions.

- What would be most important to them?
- What kinds of values they would like to see reflected in the way the health system functions?

The purpose of this exercise for participants was to identify and articulate the underlying values that guide the opinions they hold and the choices they make. The goal was *not* to reach a consensus around the table but rather for people to share their different perspectives and to learn from one another. As such, each table, and each room, became a "microcosm" of the province to illustrate the spectrum of what New Brunswickers value.

Following their table discussion, participants were asked to each write down the thing they would value most in an "ideal" health system and to explain what this thing means for them. These worksheets were then collected, and during the lunch period, a "theme team" reviewed and grouped their comments. These themes were then converted into a "word cloud" – an image that presents the various theme-words and their relative frequency of appearance (the bigger the word, the more often it appeared in the synthesis).

The word clouds for each of the four dialogue sessions are presented on the page that follows. ***It is important to note, however, that these reflect a very rapid on-site analysis of the input collected.*** The provincial summary presented later in this section was based on a more thorough analysis of *all* the data collected across all four Phase I dialogues.

Figure 20: Moncton Session: What You Value Most in an Ideal Health System

Figure 21: Bathurst Session: What You Value Most in an Ideal Health System

Figure 22: Edmundston Session: What You Value Most in an Ideal Health System

Figure 23: Saint John Session: What You Value Most in an Ideal Health System

What immediately stands out when looking at these four word clouds is the emphasis placed by participants on values relating to:

- the accessibility of health care services
- equitable care and services for all
- education (health literacy), health promotion and illness prevention
- system effectiveness, efficiency and accountability
- heath care quality and safety (human, compassionate, respect)
- system citizen-centeredness (holistic, community-based, client-based, citizen responsibility, communication).

4.2.1 Core Values: Definition

A more thorough analysis of this data across the four Phase I dialogues allows us to explore the meaning given to these high-level values by participants. It should be noted that participants' values also closely reflect the six quality dimensions through which the NBHC evaluates the quality of health services in New Brunswick: accessibility, appropriateness, effectiveness, efficiency, equity and safety *(see **Appendix D** for the NBHC's definition of each of these quality dimensions).*

Table 1: Values - Accessibility

Accessibility of health care services	
Timely access to health care services	• Having access to needed care within a reasonable time, without undue delays, long wait times and time lags between visits. • Having the "right care at the right time" (a value that was closely tied to the notion of "appropriate care").
Availability of physicians, specialists, tests, etc.	• Having access to a family physician and being able to see a specialist or receive tests when needed.
Enough time with health care providers	• Care providers, particularly family doctors, taking the time necessary to listen to their patients in order to properly diagnose.
Access to health care services in official language of choice	• Being able to access services in the language of one's choice, whenever and wherever these services are needed.
Cost should not prevent access to treatment and services	• Ensuring that the cost of prescription drugs, dental and optometry services does not become a barrier to access.

Table 2: Values - Equity

Equitable care and services for all	
Universal health care	• Publicly funded, universal health care as an important factor in protecting equitable access to services for all.
Regardless of socio-economic status	• Addressing poverty in order to promote health and take better care of all citizens, including the most vulnerable.
Regardless of location	• Providing rural and remote communities equitable access to care. • Ensuring distance, travel and transportation issues do not prohibit access to care.
Regardless of language	• Equitable, bilingual services in Anglophone and Francophone communities.

Table 3: Values - Promotion & Prevention

Promotion of health and prevention of illness	
Awareness and education about healthy living (health literacy)	• Early childhood through to adult education on how to increase health and wellness, live well and prevent illness.
Physical activity and exercise	• Exercise is valued as a means of reducing obesity and related chronic illnesses.
Nutrition and healthy eating	• Having access to affordable, nutritious food and knowledge about healthy eating will also promote health and prevent illness.
Healthy environment	• A clean, healthy environment with green space in the community is valued for health promotion and prevention of illness.
Personal responsibility for own health	• Empowering citizens to take responsibility for their own health (e.g., through government incentives and supports); people taking more responsibility for maintaining their own health and that of their families, for educating themselves about healthy living and for understanding their condition when ill.

Table 4: Values - Quality

Quality health care in a sustainable system[9]	
Appropriate care	• Being able to trust that you are getting the right care, in the right place, from the right health care professional.
Compassion for patients	• A health care system that is more "human" and health care professionals that treat patients with dignity and respect.
Safety of care	• Health services that are safe. For example, patients don't want to be concerned about catching something while in hospital.
Effective care	• Care that achieves the desired results, delivered by health care providers that are competent and knowledgeable.
Efficiency	• A health care system that is more cost-effective in order to be sustainable but which upholds fairness in the allocation of funds.
Accountability	• Transparency on how and where health care funds are distributed. • Making health care providers accountable for what they are charging the health system.

[9] **This grouping partially reflects the NBHC's quality dimensions (accessibility, appropriateness, effectiveness, efficiency, equity and safety). However, because participants placed particular emphasis on accessibility and equity, these stand alone as separate values. Accountability was included here because it was often discussed as an extension of efficient and effective care, while compassion fed into the notion of "appropriate" care.**

Table 5: Values - Citizen-Centeredness

Citizen-centered health system	
Community health centres	• Creating well-integrated, multi-disciplinary health centres to help foster healthy communities. • Placing community health centres at the heart of a citizen-centered "human needs" model.
Continuum of care	• Health care services that are well-coordinated, with separate silos broken down, in order to provide seamless treatment for patients. • Ensuring that politics do not interfere with service delivery.
Holistic and alternative care	• Ensuring that the health care system focuses on people's overall health ("whole person" approach) and not only on treating individual symptoms. • Making non-medical, non-drug based treatments and therapies an integral part of the health system. • Providing greater access to a wide range of alternative medicine, such as naturopathic doctors.
Citizen decision-making	• All populations, including the most vulnerable (e.g., people with disabilities, children, seniors), should be included in decisions affecting their health and be given a choice in their treatment.

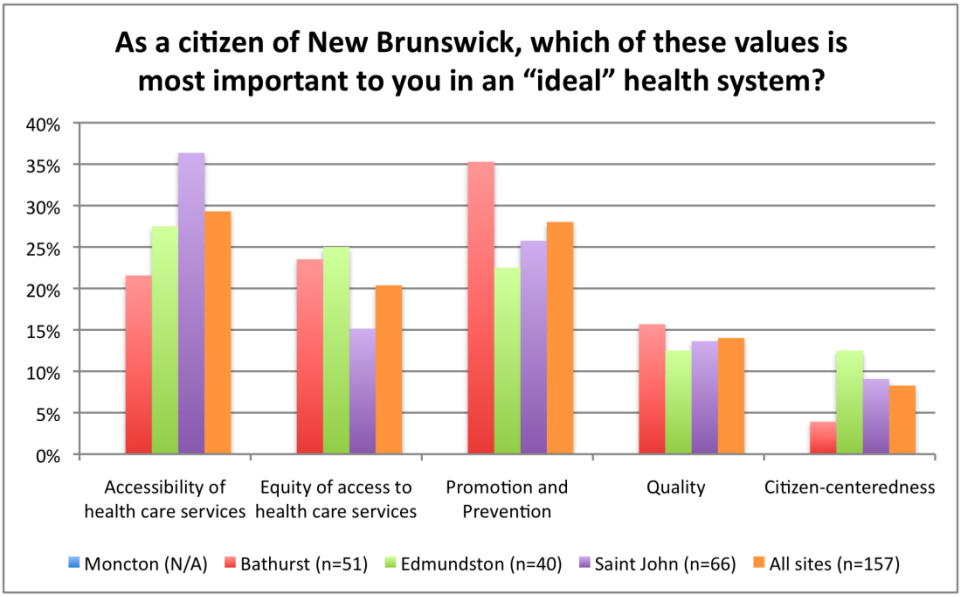
4.2.2 Core Values - Validation and Priorities

In Phase II, participants were asked to validate whether the values synthesized from Phase I findings **(above in Tables 1 to 5)** taken together accurately reflect what they would expect from an "ideal" health system.

> **Through keypad voting, 90% of participants (n=217) indicated that they either "strongly agreed" or "agreed" with this list of core values.**

Phase II participants were also asked to identify which of these five core values would be *most important* to them as citizens of New Brunswick. Accessibility was selected by 29% of participants, while health promotion and illness prevention was chosen by 28% of participants. Equity ranked third (20%) but was considered by many as a value which is complementary and closely intertwined with the notion of accessibility.

Figure 24: Most Important Value in an "Ideal" Health System[10]



4.3 Issues

During the second exercise of the day, participants were asked to discuss at their tables what they saw as the priority issues that should be addressed in order to create the kind of health system they want for New Brunswick. There were four discussion questions:

- What are the most pressing problems?
- Where are the greatest needs?
- How can we have the greatest positive impact on the overall health of New Brunswickers?
- How can we make our health system a truly citizen-centered health system?

Following a free-flowing table discussion on these questions, individual participants were asked to write down their "top 3" priority issues. These were then grouped into themes at the table, and during the "Issues Plenary," a representative of each table reported back on at least one priority issue identified by his or her group.

Each set of individual and table inputs, across all four dialogue sessions, was then collected and analyzed to develop the following list of priority issues.

4.3.1 Issues: Definition

As outlined in the tables that follow, participants expressed concerns that were grouped in the following broad categories: accessibility of health care services; cost/funding of the health care system; promotion of health and prevention of illness; optimization of health care services; and systemic changes required for a citizen-centered system.

[10] *This voting question was added subsequent to the Moncton dialogue.*

Table 6: Issues - Accessibility

Accessibility of health care services	
Access to primary and specialty care	• Perceived lack of access to primary care, e.g., family doctors, as well as supportive/specialty services, such as mental health and addiction programs.
Timely access to services	• Wait times to see a family doctor or a specialist are too long, as are the delays for obtaining tests and results. • Lack of human resources a contributing factor.
Access to services for rural residents	• Minimal local access to health care in rural areas. • No choice but to travel from rural communities to access centralized services, which implies expense and hardship for both patients and their loved ones. • Lack of access to and/or cost of transportation are barriers to receiving care for some.
Access in language of choice	• Patients are not always able to access health care in their language of choice. • Need for better bilingual services throughout the province: it is problematic to have strictly English services in English areas and French services in French areas. • Not always possible to access specialists in one's language of choice.

Table 7: Issues - Cost / Funding

Cost / funding of the health care system	
Efficiency of the health care system	• General concern about the management of health care spending. • Need to seek ways to reduce wastage and make spending more cost-effective. This is critical to ensuring the sustainability of the system and maintaining and improving the quality and effectiveness of care and services while keeping costs in check.
Distribution of funds	• Health care funds need to be fairly distributed throughout the province. • Increase investment in health promotion and prevention of illness, which would in turn reduce the expenditure on acute care in the province.
Direct costs to patients	• Free-to-users, publicly funded, universal health care system highly valued. • Concerns about out-of-pocket costs to patients, particularly for ambulance services and prescription drugs.

Table 7: Issues - Cost / Funding (cont.)

Cost / funding of the health care system (cont.)	
Education/awareness about health care costs	• Severe lack of understanding among the public on the costs of the health care system: how much is spent and how funds are distributed. Public education is required to foster more responsible use of the health system by citizens.

Table 8: Issues - Promotion and Prevention

Promotion of health and prevention of illness	
Education	Increase available information, programs and campaigns to: • Educate educators, parents, employers, etc. on health and well-being. • Educate the general public and patients on chronic disease prevention and mitigation. • Dissuade unhealthy habits, e.g., drug, alcohol abuse. • Promote healthy living, particularly nutrition and exercise.
Nutrition	• Need to address poor nutritional habits for illness prevention (e.g., as a contributing factor to many chronic diseases, such as obesity and diabetes). • High prevalence of junk food in, e.g., schools and even hospitals. • Cost is a barrier to healthy eating: health food is expensive and junk food is cheap.
Exercise	• Greater opportunities for physical activities in school, in the community, e.g., bike paths. • Remove cost barriers/provide incentives for participating in recreational activities.
Responsibility for own health	• People value universal health care when sick but need to take more personal responsibility for their own health and well-being. • Parents in particular have a responsibility to instil healthy behaviours in their children.

Table 9: Issues - Optimization

Optimization of health care services	
Elder care for our aging population	• The demographic shift towards an increasingly aged population is impacting the sustainability of our current health system by significantly shrinking the provincial tax base. • Concerned about the cost, to families and to the system, of providing health care for our aging population. • The elderly are occupying hospital beds while waiting to access home care, a nursing home or palliative care.
Emergency and ambulance services	• Wait times are too long in emergency rooms. • People are overusing/abusing emergency rooms and/or ambulances when the situation is not critical because they don't have access to a doctor and/or other forms of transportation.
Mental health support services	• More focus and resources need to be directed towards mental health care services. • More time must be invested in evaluating the mental health needs of patients.
Other specialized services requiring priority attention	• Chronic diseases (treatment, prevention and control). • Cancer care. • Cardiac treatment. • Gynecological services. • Availability of sufficient hospital beds.
Education	• Lack of awareness about the health care system. • Need to educate the public on what health care services are available and how to access them.

Table 10: Issues - Systemic Changes

Systemic changes required for a citizen-centered system	
Continuum of care	• Break down administrative silos and "de-politicize" the system to remove barriers to continuity of care. • Better coordination of care/services. • Better communication between doctors and specialists, between institutions, between doctors and patients. • Better follow-up with patients after doctor appointments and tests.
Care based on patient needs	• Perception that in the current system, standards are set and protocols followed in treatment plans that do not address the specific needs of individual patients: "One size does not fit all." • Need to listen more to patients.

Table 10: Issues - Systemic Changes (cont.)

Systemic changes required for a citizen-centered system (cont.)	
Choice in health care	• More choice of alternative options covered by Medicare, e.g., naturopathic doctors, chiropractors, midwives. • More holistic care available.
Reform roles and responsibilities	• Less dependence on physicians and more decision-making power to nurses and alternative health care practitioners.
Community health centres	• More multidisciplinary, community-based health care centres with a coordinated team approach. • Supported by community leadership.

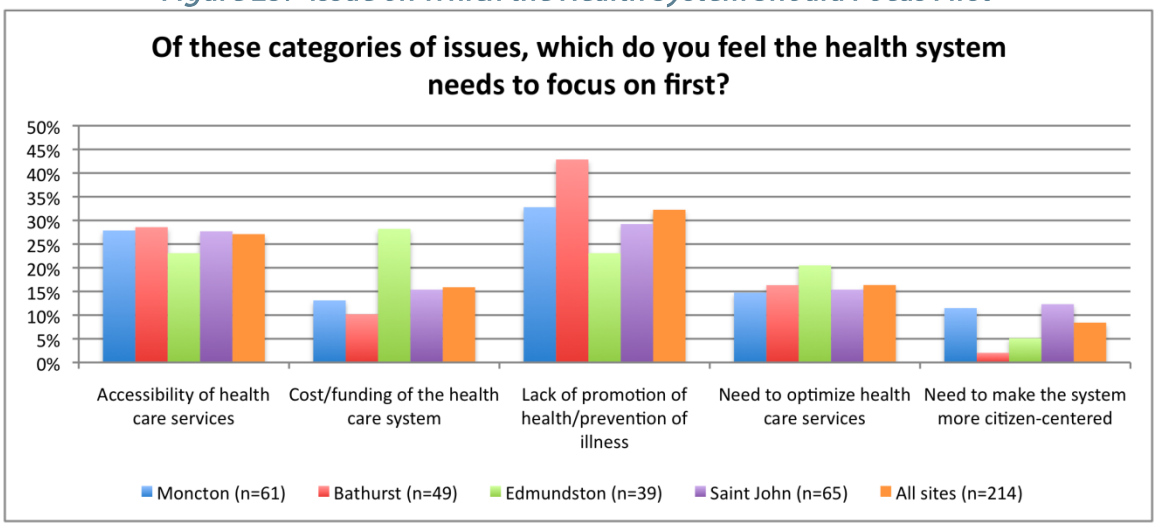
4.3.2 Issues: Validation and Priorities

Again, Phase II participants were invited to validate these findings:

> **91% of participants (n=216) either "strongly agreed" or "agreed" that these issues taken together accurately reflect the key challenges faced by New Brunswick's health system.**

Phase II participants were then asked which categories of issues they felt the New Brunswick health system needed to focus on first. Remaining consistent with what they valued most, participants prioritized addressing the lack of promotion of health/prevention of illness (32%) and increasing the accessibility of health care services (27%).

Figure 25: Issue on Which the Health System Should Focus First



4.4 Strengths and Opportunities

The third and final table discussion of the day challenged participants to shift their focus from issues and concerns with the health system to the strengths and opportunities that the system can build upon to create the kind of health system they want. Discussion revolved around four questions:

- What are you most proud of when you think of the New Brunswick health system and the overall health of New Brunswickers?
- What do we do well here in New Brunswick?
- What are the biggest strengths of our health system?
- What opportunities exist that we can leverage to create the kind of citizen-centered health system we want?

Participants were asked to discuss these questions in pairs and then shared highlights of their discussion with their tablemates. During the "Strengths Plenary," a representative of each table reported back on at least one of the health care system strengths identified by his or her group.

Each set of paired discussion and table input, across all four dialogue sessions, was then collected and analyzed to develop the following list of health care system strengths.

4.4.1 Strengths and Opportunities: Definition

Participants were keen to recognize and celebrate New Brunswick's strengths and successes, enthusiastically noting that the system's biggest strength was the **"people who make the system work."** They also strongly valued the province's Medicare program (and universal access to health care) as well as several state-of-the-art services, such as the Extra-Mural Program and Tele-Care. Finally, they highlighted what they saw as key opportunities to drive change and improvements to the New Brunswick health system: the province's (and health system's) small size; leveraging citizen and stakeholder commitment to change through meaningful engagement; and increased focus on and investment in health promotion and illness prevention to reduce the burden on the health system.

Table 11: Strengths – Our People

"Our biggest strengths… are the people who make the system work"
• Warm, caring, compassionate and empathetic with patients.
• Competent, knowledgeable, well-trained and qualified.
• Professional, dedicated, hard workers.

Table 12: Strengths – Publicly Funded Health Care

"Medicare (universal health care) in New Brunswick is the most valuable thing we have"
• Available to everyone.
• Accessible when citizens need urgent care (prioritized by urgency).
• Core services free for everyone, independent of socio-economic status.

Table 13: Strengths – World-Class Services

"We have several services in which we excel and which we should be proud of"
• The Extra-Mural Program, which allows patients to receive quality care at home.
• Tele-Care, which allows 24/7 access to health care from anywhere in Canada.
• Modern technologies: specialized equipment and machines, information systems, *One Patient, One Record* initiative.
• Access to quality ambulance and emergency services.

Table 14: Opportunities

"The opportunities we must seize to drive change"
The size of the province, and the health care system, is small enough to realistically effect change.
There is a willingness to change and improve things in the province (as illustrated in part by the *"Our Health. Our Perspectives. Our Solutions."* initiative). • Recognizing opportunity for improvement. • *"We can do better."* • We are a "can-do" province.
Citizens are committed to the health system and to improving their health. • Citizens support the health care system in their attitude and through volunteering. • There is strength in communities and a sense of ownership of health care.
Meaningful citizen and stakeholder engagement. • Allowing citizens to provide input on the health care system. • Involving the public in decision-making processes. • Demonstrating that the government is listening. • Consulting front-line workers to find out what is working and what needs improvement.
Increasing focus on, and investment in, the promotion of health and the prevention of illness can help reduce the burden on the health system.

When asked to validate these findings in Phase II, 91% of participants (n=217) either "strongly agreed" or "agreed" that these strengths and opportunities taken together reflect the best aspects of New Brunswick's health system.

5. PHASE II: SOLUTIONS

After considering the current state of the New Brunswick health system in Phase I, participants were invited to turn their minds to the future in Phase II to imagine the kind of health system they want and to identify possible solutions for achieving this vision. To this end, the day began with a visioning exercise designed to refocus the discussion on the notion of a "citizen-centered health system" and allow participants to define what this means to them. This was followed by a series of table and plenary discussions on how to best utilize available resources to ensure that the health system meets the needs and expectations of New Brunswickers.

5.1 *"Image-ining"* a Citizen-Centered Health System

In the opening session, Phase II participants were challenged to offer their description of what a citizen-centered health system might look like. To do this, they were invited to "think in pictures" and choose from among a series of images the one that, in their opinion, best illustrates the qualities or characteristics of a "citizen-centered health system." (The images provided did not represent the health care world but instead were images that metaphorically evoked higher-level values or principles.)

The following are the five images that were most frequently chosen by participants combining all sessions across the province (the total number of submissions for this exercise was 234),[11] including a summary of the comments used to describe them.

Image 1: Selected by 19% of participants

- Availability of health care from young to old.
- Meeting the needs of different age groups; personalized care.
- Working together across generations to create a good health system.
- Generations working together, learning from the past and working towards the future.
- Connections between people (intergenerational, family); social partnerships rooted in the community (not just government).

[11] **Although Phase II had a total of 223 participants, some participants submitted more than one image.**

Image 2: Selected by 16% of participants

- The system is a network in which each component is important.
- The spider is the citizen, and the system is centred on the citizen.
- The links within the web (collaboration) represent its strength.
- Web catches all, nothing falls behind.
- A web through the whole province without duplication.
- Complex, efficient, well-balanced but fragile system; resilient and reliable.

Image 3: Selected by 9% of participants

- It takes pieces to make a whole, well-functioning health delivery system. Citizen contribution is one of the most important aspects. It is important to see the whole picture from all perspectives.
- Visionary building blocks, working towards coming together. Hopeful because of the image (blue sky).
- Parts of the health system that need to come together. Inserting the final piece of the puzzle.
- Lots of pieces (diversity of health), and each block has an equal place.

Image 4: Selected by 9% of participants

- Everybody in the health system needs to work together.
- Working as a team towards a common goal (to help patients navigate more effectively in the system, to prevent diseases).
- Remaining active, in motion and healthy and keeping the health system vibrant.
- Need to have people who enjoy their work to give excellent services.

Image 5: Selected by 8% of participants

- Caring and compassion is the basis for a good health care system.
- Compassion and dignity for the elderly.
- More care and resources to the elderly; home care.
- Emphasis on mental and physical health in nursing homes.
- Being prepared for an aging population.

5.2 Where and by Whom Health Care, Services and Supports Should Be Delivered

Phase II discussions were meant to be solution-oriented. Participants were therefore invited to reflect on what the health system could do to help them and their families be healthier. More specifically, they were challenged to think about how to best use available resources and to consider where and by whom the health care, services and supports they require should be delivered.

5.2.1 WHERE would you like to receive the health care, services and supports you need to keep you and your family healthy?

Participants underscored that the answer to this question is in large measure dictated by the patient's needs. For example, they felt that elder care should be delivered at home, if possible, or in a nursing home, if specialized care or supports are required. They believed that hospital emergency departments should be available and accessible to treat emergencies. They suggested creating specialized clinics to support chronic disease management outside of a hospital setting.

In more general terms, participants suggested that the following guiding principles help inform where health services and supports should be delivered: locally, at home, in community health centres, in hospitals, in clinics, in pharmacies, and where people live, work, and study.

- **Locally:** as close to home as possible, particularly for primary care and emergency services. It is understood that patients may need to travel to access more specialized services in a central location, and New Brunswick's centres of excellence for specialized care (e.g., New Brunswick Heart Centre in Saint John) are recognized and respected.

> ***"Services should be rendered in the local area... The hospital is one of the most important places for health care, but we can't forget home care for the extremely ill and for those who can't get out of their homes."***
>
> **Bathurst session participant**

- **At home, when possible:** by family members, Extra-Mural Program professionals, physicians doing home visits and through Tele-Care; particularly for senior care and palliative care as well as for follow-up after surgeries.
- **In community health centres:** staffed by well-integrated, multidisciplinary teams and providing a range of services including education/health promotion and preventive care; closely connected to the community; accessible and close to home (increased investment in community health centres would help reduce demand for services provided through doctors' offices and hospitals). Community health centres are also an effective way of bringing health care and information closer to people – a strategy that is particularly important for overcoming barriers to access caused by, for example, distance to care/transportation challenges and low literacy levels (which make it difficult for some to access resources via the Web or other written media).
- **In hospitals:** the primary role of hospitals should be to provide acute care and emergency services.
- **In clinics:** make greater use of clinics to offer services that do not need to be delivered in a hospital setting and/or to increase the availability of services in rural areas. Participant suggestions include: after-hours clinics and walk-in clinics (could play a role in decreasing demand on emergency departments); specialized or multidisciplinary clinics (could offer a more effective approach to chronic disease management); and alternative medicine clinics (could provide a broader range of services that would lead to decreased demand on physicians and lower drug costs).
- **In pharmacies:** some participants suggested that delivering a greater number of services through community pharmacies could be a way to move services closer to people and away from hospitals. They suggested, for example, that pharmacy teams could include nurses playing various roles (checking blood pressures, chronic disease management education, public health information, etc.).
- **Where people live, work and study:** facilitate access to health information and integrate health promotion into daily life by bringing information and health workers (e.g., nurses) into schools and work places, for example.

> **When asked to validate these findings in Phase III, 98% (n=104) of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflected *where* health care, services and supports should be delivered.**

5.2.2 FROM WHOM would you like to receive the health care, services and supports you need to keep you and your family healthy?

Participants expected to receive the health services and supports they need from health care workers that are competent, properly educated, trained and qualified, available and accessible, and able to communicate with them in the official language of their choice (particularly in the case of first responders, such as paramedics and nurses). They also expected to be cared for by health professionals who have time to dedicate and listen to patients.

More specifically, participants had a number of suggestions:

- **Teamwork and collaboration** among health care workers is critical to providing consistent quality care to patients. This means that physicians (family physicians, specialists), working in collaboration with pharmacists, nurses, paramedics, public health nurses, etc. in particular, clarify and optimize the role of each health professional to ensure that each is working to the full scope of his or her competencies, and that tasks that can be done by non-physicians (e.g., vaccination, education) are diverted to the right health professionals.

> ***"We need more shared responsibility between doctors and nurses and patients."***
> **Moncton session participant**
>
> ***"Expand the role of nurses, paramedics and ambulance services to minimize the need for so many doctors. For example, at the Bathurst Hospital, nurses can 'treat and release' patients in Emergency without their having to see a doctor." (Translated)***
> **Bathurst session participant**

- **Nurses** should be given more responsibility and decision-making power.
- Professionals who care for and support those with **mental health** issues (e.g., psychologists) must be made an integral part of the health system.
- **Pharmacists** are seen as important players on the health care team who could be empowered to do more to alleviate the burden on physicians (particularly with respect to prescribing and prescription renewal, public health education and chronic disease management).
- **Paramedics** could be called upon to *"do more than transport patients around"* and assist with other tasks (e.g., wound treatment) or public education work.
- **Nutritionists and dietitians** have an important role to play given the importance of a balanced diet in maintaining a healthy lifestyle and preventing chronic diseases.
- The health system must integrate **alternative and holistic practitioners**, e.g., chiropractors, naturopaths, physiotherapists, massage therapists, osteopaths, reflexologists and acupuncturists.
- There is a great need for professionals who can assist patients in effectively **navigating the health system** (e.g., social workers, client navigators, case managers), particularly for the most vulnerable populations (e.g., low income or literacy level, the elderly, people living with mental health issues).
- A number of **non-health professionals** can and should play an important role in health promotion and illness prevention. These include educators, mentors, volunteers, peer support groups, community organizations, sports and wellness organizations that target youth, and employers. Groups such as the Saint John Ambulance could also be supported to play a (greater) role in supporting promotion and prevention initiatives.
- Services that allow people to better care for themselves or their loved ones at home – **Extra-Mural Program** and **Tele-Care** – play a critical role in the health system.

- **Family members** can play an important role in providing care to loved ones – providing they have access to the necessary information, training and supports. As one Moncton group stated: *"Give family members or clients the skills they need to practise self-care (for example, changing the dressing on a wound)." (Translated)*

Some participants also highlighted that the **media** have an important role to play in communicating information about the health system, its performance and the services it offers as well as a channel for communicating health promotion/illness prevention messages from the health system. They noted the importance of **social marketing** strategies as a means of driving behavioural changes, of advertising in order to raise **awareness** about key health-related issues and of **social media** (such as Twitter and Facebook) for reaching out to the public in new ways.

> ***"The Department of Health should blow its own horn a bit and contact the TV and tell the public what's going on in the system. Lots of good things are happening."***
>
> **Saint John session participant**

Other participants suggested specific **resources** that might be developed and promoted by the health care system to facilitate access to information and system navigation, thus lessening the need for citizens to seek services from hospitals or community health centres:

- **"Care maps"** which would outline the health professionals involved in and services available for the care of specific diseases (e.g., chronic illnesses such as cancer or diabetes) and assist patients in their efforts to navigate the health system.
- **"Family care guides"** that would provide information ("tips and tricks") on how to identify and care for common illnesses and allow families to practise more self-care in the home.
- **"Community health guides"** which would outline the services, resources and supports available in the community.

Finally, participants reinforced that **each New Brunswicker** has to assume responsibility for his or her own health.

> **Again, 98% of Phase III participants (n=108) either "strongly agreed" or "agreed" that these ideas taken together accurately reflected *by whom* health care, services and supports should be delivered.**

5.3 What the Health System Should Be Doing More of and Less of

Given the need to make optimal use of available resources for health care – and recognizing that unless trends change, 50% of New Brunswick's budget will be directed to health care by the year 2015 – participants were asked to consider what they felt the health system should be doing MORE of and what it should be doing LESS of in order to help citizens and their families be healthier. They

brought forward a number of ideas that can be linked back to the core issues identified in Phase I.[12]

In Phase III, 96% of participants (n=107) either "strongly agreed" or "agreed" that the following ideas taken together accurately reflect what the health system should be doing *more* of. Slightly fewer participants (87%, n=109) either "strongly agreed" or "agreed" that these ideas taken together reflect what the health system should be doing *less* of.

5.3.1 Improving Access

Participants felt that more should be done to improve access, such as:

- Making it easier to **access specialists**, for example, by making it less difficult and time-consuming to obtain a referral (e.g., reducing the number of steps involved, eliminating the need to first see a family physician).
- Providing incentives for physicians to spend **more time** with patients during a visit (e.g., allowing patients to discuss more than one issue per visit).
- Ensuring a **better and more equitable distribution of clinics and health care professionals** throughout the province and in rural areas (versus concentrating them all in certain areas). Providing doctors with incentives that would encourage them to remain in needy areas.

> ***"We could manipulate the fee structure for doctors to encourage them to provide certain advice to patients, for example, on how to stop smoking… In some countries, a 'pay for performance' model exists." (Translated)***
>
> **Moncton session participant**
>
> ***"More physicians on salary versus fee for service." (Translated)***
>
> **Edmundston session participant**

- Providing citizens greater choices in their health services and supports by integrating **alternative medicine** into the health care system and allowing such treatments to be covered by Medicare (e.g., chiropractic treatment, naturopathy). One group at the Moncton session also noted the need to *"stop 'medicalizing' pregnancies"* and to provide access to midwifery services.
- Putting in place the **facilities and resources required to care for New Brunswick's growing population of seniors**. This includes planning for more facilities (e.g., nursing homes) and beds for seniors so that they do not block scarce hospital beds while awaiting placement; and increasing the quality of care provided in nursing homes through better monitoring and access to support providers such as social workers and dietitians. This also requires **home-**

> ***"People with health care training working in the community could help alleviate demand." (Translated)***
>
> **Edmundston session participant**

[12] **In many cases, similar ideas were framed as both a "more" and a "less," e.g., "more equitable distribution of clinics and health professionals across the province" and "less centralization of health services." In such cases, the dominant theme is presented under either the "more" or "less" heading based on the most common description provided by participants.**

based and community-based elder care strategies, such as recreational programs for seniors, and the provision of information, training and financial assistance to family caregivers. As one group at the Saint John session put it, *"nursing homes and long-term care facilities… it's not about going there to die, but going there to live."*

- Investing in community-based programs that are designed to **reduce hospital admissions** (e.g., Extra-Mural Program).
- Accommodating factors such as **language** and **distance/inability to travel** so that they do not become barriers to access.

Participants felt the following should be reduced to improve access:

- Wait times to consult a physician (both specialists and family physicians) or to obtain services.
- **"Red tape"** to see specialists or gain access to alternative care.

5.3.2 Investing in Health Promotion and Illness Prevention

Participants felt that more should be done to improve health promotion and illness prevention:

- Education on the prevention and management of **chronic diseases**.
- Greater access to, and visibility of, healthy living **role models**.
- Creating a "culture of health" **early in childhood** by **making health an integral part of school life** through health education, more physical activity and early health assessment and intervention.
- More **community-based** initiatives, programs, resources and facilities to encourage the population to be active (e.g., green spaces, cycling paths).
- More emphasis on **primary care** and its role in prevention and health promotion.
- More **deterrents** (e.g., taxes, regulations) **to making unhealthy choices** (e.g., smoking, junk food).
- Recognizing that the majority of New Brunswick employers are small businesses that may not have the resources to provide large-scale workplace wellness programs; investing more in supporting **workplace-based health promotion strategies** (e.g., tax credit for employers who provide sustainable workplace wellness programs).
- Measures to encourage people to **take responsibility** for their own health. For example, participants suggested the creation of a "health status report card" for each citizen that would track improvements or deterioration in the person's health and their use of the health system.

> ***"Early intervention and assessment in school by health nurses…"***
> **Moncton session participant**
>
> ***"Health is a lifelong project, from cradle to grave. We must foster a culture of health from a very young age…" (Translated)***
> **Bathurst session participant**
>
> ***"We need to make health education pervasive in schools… Kids can pull their parents forward."***

5.3.3 Cost/Funding of the Health System

Participants felt that the following should be done to <u>reduce</u> the cost of the health care system:

- Less **bureaucracy** in the administration of the health system.
- Reducing **inefficiencies** in health care delivery. Examples provided include reducing waste of all kinds; minimizing the amount of time that costly equipment sits idle; requiring less clerical work of nurses; less duplication of services and testing; less use of emergency rooms for non-emergencies; and less hospital-based care when hospitalization is not necessary.

> ***"At the end of the year, each patient should receive a statement with all the costs charged to the health system for all the care and tests he or she received during the year." (Translated)***
>
> **Moncton session participant**

- Making **greater use of available facilities and infrastructures** (particularly schools) to reduce costs and to bring services closer to people.
- Striving to reduce the cost of **drugs** in the health system: encourage doctors to prescribe fewer medications (avoid over-prescription, control the influence of pharmaceutical companies); seek alternatives to drug-based therapies if other options are available; fund preventive interventions (e.g., quit-smoking aids); and encourage greater use of generic drugs. Also, ensuring that cost does not become a barrier to accessing medication when medication is necessary (e.g., catastrophic drug plan). As one Bathurst session participant put it, "*Less over-prescribing of drugs. PERIOD.*"

> ***"We have to change the way we think about infrastructure. Health care is not the buildings in the community. Let's not take services away too quickly upon restructuring or reforming the system. Like potty training, you don't throw out all the diapers the moment you start training."***
>
> **Edmundston session participant**
>
> ***"Entry points can be hospitals, but hospitals are not the answer to everything, especially for chronic illnesses... Some people are better off in the home, [but we also need to be looking at] other places like Church halls."***
>
> **Saint John session participant**

- Reducing abuse of the health system (demand more accountability) by educating and informing citizens and patients on the **true costs of the health care they seek and receive**; encouraging physicians to make more controlled use of drugs and tests; and controlling the influence of large pharmaceutical companies.

> ***"If we had to pay for [tests] ourselves, would we want as many tests done?"***
>
> **Moncton session participant**

5.3.4 Optimizing Health Services

Participants felt that more should be done to optimize health services:

- Making greater use of **information technology** to share information and prevent duplication of efforts. In particular: ***One Patient, One Record*** management for better communication between doctors, specialists, hospitals and pharmacies and easier access to patient information, including lab results, across the province. Utilizing technology to help standardize policies and procedures at the administrative level.
- Making greater use of existing **communication technologies**, e.g., videoconferencing, websites, CDs, webcasts and e-mail for improving communication and educational outreach.
- Consulting with and learning from the experience of **front-line workers**.
- Strengthening **obstetrical/maternal/women's health services** by providing Medicare-funded access to midwifery services and maternal health programs; and offering wellness programs tailored specifically to the needs of women (e.g., menopause-related information and supports). Although not as frequently mentioned, making abortions accessible also arose in relation to women's health services.
- Ensuring **privacy rules** do not interfere with the ability to deliver timely quality care to patients.

5.3.5 Making the Health System More Citizen-Centered

Participants felt that more should be done to make the health system more citizen-centered:

- Enabling **home care** as much as possible by providing more services, resources and financial supports to assist families in keeping seniors or others requiring special care at home. This includes providing greater access to qualified home care and Extra-Mural Program services; teaching family members or other caregivers how to properly care for patients; and providing financial aid to help/encourage family members to keep aging or ailing relatives at home.
- Investing in the province's network of **community health centres** to offer more services in the community, to decongest hospitals and emergency rooms and to improve access to care, particularly in rural areas.

> ***"More decision-making power for decisions that affect the community."***
>
> **Bathurst session participant**

- Supporting the role of **communities** and **local decision-making** in health and health care and recognizing the distinct needs of rural and urban New Brunswick.
- With respect to **end of life/palliative care**, doing more to respect people's wishes and taking, as one group at the Moncton session put it, "*fewer heroic measures." (Translated)*
- Considering the needs of the most **vulnerable and disenfranchised citizens**. This includes, for example, the unique needs of and challenges faced by the province's **homeless population** and the high rate of mental illness and addiction issues they face.

Participants felt that the following should be reduced to make the health system more citizen-centered:

Participants also frequently emphasized the need to **"take politics out of health care."** They sought less political interference and influence in decisions about the health care system; fewer costly studies and reforms; and **greater collaboration across departments**, particularly on issues relating to health promotion and illness prevention.

> ***"Better partnership between the Departments of Health and Education." (Translated)***
>
> **Edmundston session participant**
>
> ***"In education, justice, social work and health, there seems to be a divide amongst the different departments, while people need access to health care in schools and in the community. We need to be looking to a team approach with doctors and everyone working together."***
>
> **Saint John session participant**
>
> ***"Less consultation and more action; less politics; less politics over language." (Translated)***
>
> **Bathurst session participant**
>
> ***"We must make long-term decisions… Decisions must last longer than a political mandate." (Translated)***
>
> **Edmundston session participant**
>
> ***"The focus in Fredericton is not always reflective of what goes on in rural areas. Provincial politicians don't always know, like municipal politicians, what goes on at the municipal level. Mindset changes are required."***
>
> **Moncton session participant**

5.4 Encouraging Healthier Choices and Behaviours

During the last exercise of the day, participants were invited to reflect on what they could do to help themselves and their families be healthier. To this end, they were asked to consider two questions:

- What health choices and behaviours do you see as being within the personal control of most individuals?
- What kinds of incentives or supports might encourage New Brunswickers to adopt healthier choices and behaviours?

The tables that follow summarize participants' ideas on the kinds of health choices New Brunswickers should be making and on what incentives and supports might facilitate or encourage these choices.

Their ideas are grouped under the seven following themes:

- regular exercise
- proper diet

- practising self-care/taking responsibility for one's health
- lessening the use/consumption of harmful substances
- becoming health conscious/staying informed
- creating safe and health-conscious communities
- promoting/educating about healthy lifestyle choices in schools
- other.

When asked to validate these findings in Phase III, 97% of participants either "strongly agreed" or "agreed" that these ideas taken together accurately reflect the kinds of *incentives* and *supports* required to encourage healthy choices and behaviours by New Brunswickers.

Table 15: Regular Exercise

"Wouldn't it be nice if you could take your Medicare card and swipe it in the machines at the gym and get 'credits' for exercising?" – Saint John session participant	
Behaviours	**Incentives and Supports**[13]
• Physical activities, recreation, hobbies and pastimes, outdoor activities • Daily activities, e.g., taking the stairs instead of the elevator, walking instead of driving, walking to school instead of taking the bus • Teaching children to be active (and to spend less time in front of the TV or the computer) • Activities for youth, for the elderly • Group activities, finding an exercise partner ("buddy system") to increase motivation to exercise and for consistency	• More money for communities to organize recreation programs for all ages: running, cycling, canoeing clubs; team sports; etc. • More indoor and outdoor community infrastructure; free and publicly accessible walking and cycling trails, pools and playgrounds, green spaces in subdivisions • Funding/tax credits/support for workplace wellness programs: o Exercise rooms on the job site or subsidies for gym memberships o Integrating exercise into the work day, e.g., walking/running club at lunch hour; workplace pedometer challenge o Contests to encourage healthy habits • Increasing the number of hours of physical education in school curriculum • Tax deduction/credit/incentive for gym memberships and other costs associated with exercising, e.g., reducing the tax charged on, or provide tax credits for, sporting goods, gym memberships, etc. • Promote "active transportation": walking to school or work • Ensuring effective, affordable public transit

[13] **Although the behaviours and incentives and/or supports are grouped under a common theme, the incentives do not lead directly to specific behaviours.**

Table 16: Proper Diet

"Reduce the fat and sodium content in the products we find at the supermarket." (Translated) – Edmundston session participant	
Behaviours	**Incentives and Supports**
• Cut out junk food and fast food; consume less fat, salt, sugar • Drink more water • Cook healthy meals at home • Follow Canada's Food Guide; change unhealthy eating habits, e.g., no over-eating • Buy locally grown, organic produce • Eat smaller portions • Exercise self-control	• Subsidize the cost of locally grown, organic produce and other healthy foods; support local farmers to increase the availability and lower the cost of local food at an affordable price • Regulate/tax/ban junk food and energy drinks; health warning on junk food as is done on cigarette packages • Create/support community gardens and community kitchens • Education campaigns that include, for example, cooking classes (in collective community kitchens, local grocery stores); information sessions on nutrition; or advertisements on television • Promote healthy alternatives for various seasonal holidays (e.g., fruit at Easter instead of chocolate) • Healthy school breakfast and lunch programs

Table 17: Practising Self-Care/Taking Responsibility for One's Health

"Promote the patient as part of the health care team" – Moncton session participant	
Behaviours	**Incentives and Supports**
• Get enough sleep, rest and relaxation; slow down: "Take time to smell the roses" • Maintain work/life balance • Recognize, manage and lower stress levels; avoid stressful situations • Positive attitude, like yourself; control anger, negative thoughts and road rage • Exercise your mind, maintain mental stimulation and activity • Healthy interpersonal and family relationships; socializing • Healthy sexual relations and safe sex practices • See your physician annually for a complete medical, including appropriate preventive screenings • Develop your spirituality • Check into your family histories, if possible • Comply with medical advice • Seek peer/group supports if needed (e.g., AA, quit-smoking groups) • Wash your hands • Develop time management skills • Don't be afraid to seek help	Provide services to support healthy living: • Counselling for addictions • Regular access to a doctor • Mental health support • Financial assistance or food stamps to help lower-income families purchase healthier foods • Support basic needs, e.g., affordable housing, tax credits for heating, supports for single mothers • Offer rewards for being/staying healthy, e.g., for not using sick days or health care services • Sexual education in school, free contraceptives for teens • Workplace programs (and cultures) promoting work/life balance and family-friendliness • Drop-in centres for adults (much like youth drop-in centres) where people can seek information, assistance, activities and social networks

Table 18: Lessening the Use/Consumption of Harmful Substances

"It would be important to educate people in order to prevent various kinds of abuse such as alcohol, drugs, [and] unhealthy eating." (Translated) – Edmundston session participant	
Behaviours	**Incentives and Supports**
• Eliminate illegal drug use and abuse of prescription medications • Avoid, quit or lessen tobacco consumption • Consume alcohol in moderation • Use prescription drugs as prescribed	• Higher taxes on unhealthy substances to discourage use, e.g., tobacco, alcohol, energy drinks • Prevention initiatives targeting youth to reduce drug and alcohol use • Needle exchange programs • Methadone clinics

Table 19: Becoming Health Conscious/Staying Informed

"People should be distributed timely information on healthy lifestyles." – Moncton session participant	
Behaviours	**Incentives and Supports**
• Consciously make healthy lifestyle choices • Educate yourself on your health condition and be aware of your family history	• Provide information to the public so they can make educated decisions • Hold community information sessions and courses on health and healthy living • Use the media to disseminate health information

Table 20: Creating Safe and Health-Conscious Communities

"We have a responsibility to reach out to and help those who cannot help themselves." – Saint John session participant	
Behaviours	**Incentives and Supports**
• Adopt safe behaviours: wear a seatbelt, a cycling helmet, etc.	• Foster safe home and work environments • Reduce environmental pollution (e.g., use of pesticides and harmful chemicals in cosmetics, household cleaning products) • Mandatory driver education courses for teens • Mandatory driving tests for drivers aged 65 or older

Table 21: Promote/Educate about Healthy Lifestyle Choices in Schools

"During the school year, nurses should come into the schools to speak about nutrition, physical education and health." (Translated) – Bathurst session participant	
Behaviours	**Incentives and Supports**
• Parents, schools promoting healthy eating and exercising with kids	• Increase hours of physical education in schools for all grades; ensure a minimum amount of physical activity daily • Have a "health report card" in schools reporting on the health status of each student • Educate students about proper nutrition • Sexual education in schools • Healthy food in schools • Ensure that daycares and before and after-school care programs include sufficient physical activity

Table 22: Other

OTHER
"We can control how we vote" (Bathurst session participant)
Provide rewards to health care professionals for healthy patient outcomes
Discount on driver's license renewal to people who sign their organ donor card
Learn from best practices in the field of social marketing for promoting behavioural changes

6. PHASE III: COMMON GROUND

In the third and final phase of this 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 in two broad categories – Primary Care and Acute/Supportive Care – and presented to participants for their consideration (see **Table 23** for a summary). Each participant received a Primary Care and an Acute/Supportive Care worksheet (see **Appendix E**).[14]

Table 23: Possible Actions

Primary Care	Acute/Supportive Care
Make community health centres (CHCs) and clinics the centrepiece of primary care.	Minimize "distance to care."
Make maximum (and innovative) use of available infrastructure to deliver primary health services locally/close(r) to home.	Facilitate access to specialty care.
Promote and support interprofessional collaboration.	Strengthen supports for home-based care.
Develop targeted health promotion/illness prevention programs.	Fully integrate the mental health and physical health systems.
Optimize the roles and responsibilities of health professionals.	Make the health system easier to navigate.
Integrate alternative or holistic practitioners into the health system.	Develop chronic disease prevention and management strategies or programs.
Incent individuals to take greater responsibility for their own health, to make healthier choices.	Augment capacity for care for the province's aging population.
Create safe, supportive and health-conscious communities.	Strengthen obstetrical/maternal/women's health services.
Rein in the mounting cost of medication.	Respect patients' wishes.

Participants were asked to imagine that they were Health Minister 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 and two acute/supportive 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.

[14] **It is important to note that some of the ideas put forth by participants fell outside of Primary Care and Acute/Supportive Care; however, for the purpose of this exercise, all ideas were grouped in one or the other category based on wherever they fit best.**

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.

6.1 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.

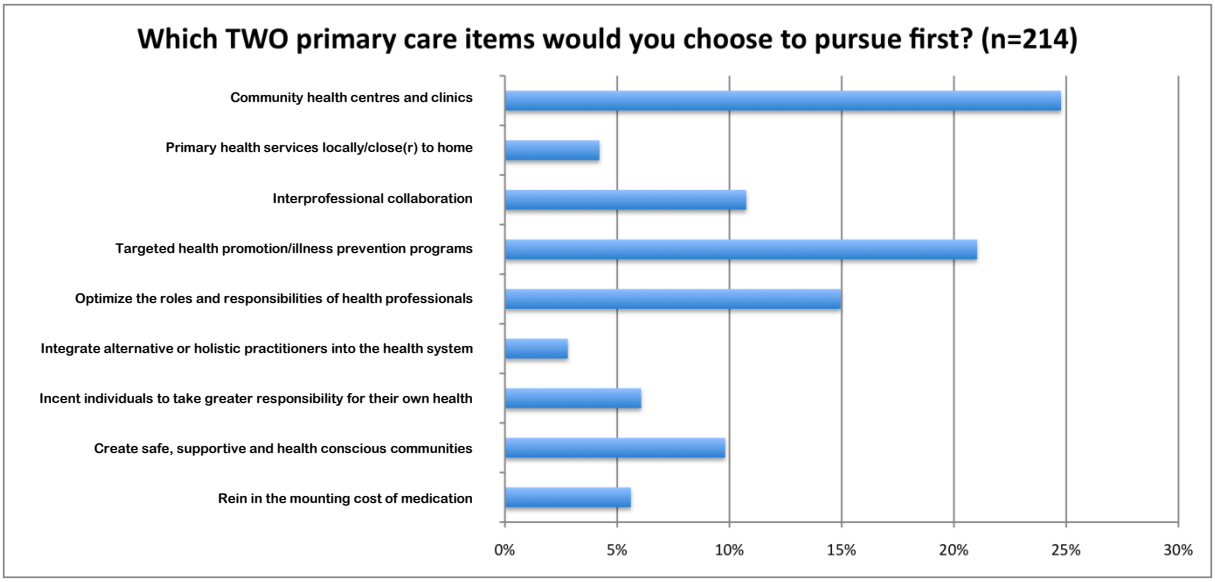
After hearing the arguments in favour of each proposed area for action, participants were then called upon to vote (using the voting keypads) for the two primary care items they would choose to pursue first.

As illustrated in **Figure 26**, "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.[15] Each section begins with a description of the area for action as presented on the participant worksheet used for this exercise (see **Appendix E**).

[15] **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 26: Primary Care – Priority Areas for Action[16]



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

> ***"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**

- **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

[16] **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 also applies to Figure 26.**

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."*

6.1.2 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" (above). 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.

6.1.3 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.

6.1.4 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. 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.

> ***"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."***
>
> **Phase III participants**

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.

6.1.5 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., dietitians, 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.

6.1.6 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."*

6.1.7 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.

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!)"*

> ***"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**

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!"*

6.1.8 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."*

6.1.9 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).

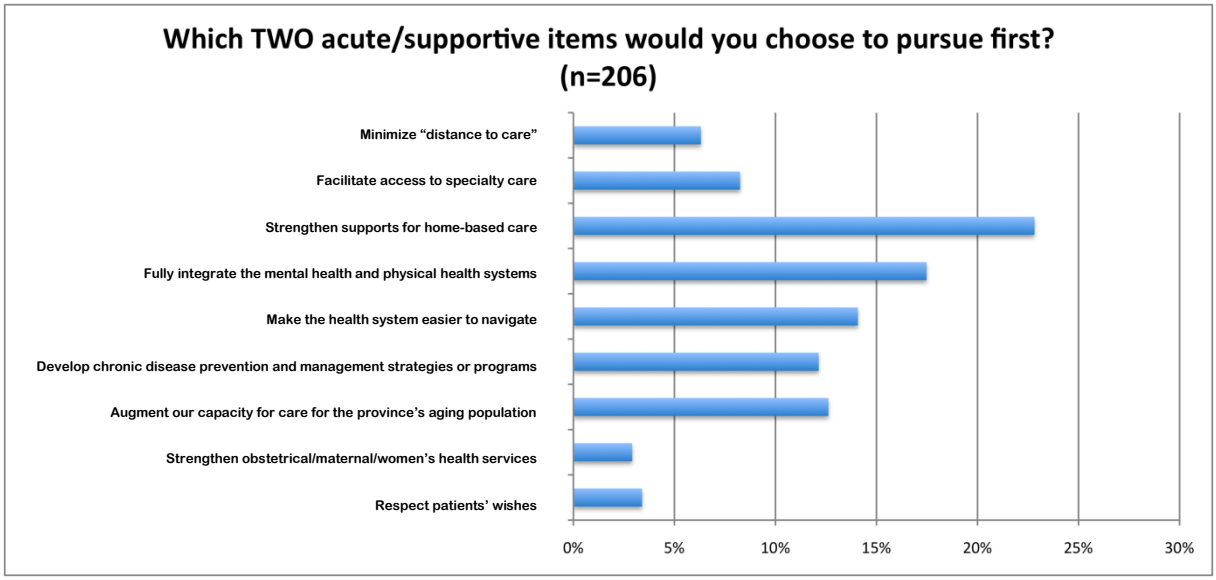
Finally, participants expressed concern that many people without private health insurance coverage cannot afford the prescription medications they need.

6.2 Acute/Supportive Care Priorities

Participants repeated the same exercise to review and prioritize nine possible areas for action relating to acute/supportive care. "Strengthen supports for home-based care" was most popular (23%), followed by "Fully integrate the mental health and physical health systems" (17%), "Make the health system easier to navigate" (14%), "Augment our capacity for care for the province's aging population" (13%) and closely followed by "Develop chronic disease prevention and management strategies" (12%). (See **Figure 27** for the complete list).

The following chart summarizes the reasons provided by participants for selecting particular areas for action. Each section begins with a description of the area for action as presented on the participant worksheet used for this exercise (see **Appendix E**).

Figure 27: Acute/Supportive Care – Priority Areas for Action



6.2.1 Minimize "distance to care"

Ensure that the distance one needs to travel to access emergency and acute/specialty care is reasonable; distribute hospitals/clinics/community health centres equitably across the province.

Participants readily acknowledged that it can be extremely challenging – and costly – to provide the same services to everyone, everywhere. However, they felt strongly that equitable access to health care was paramount and that everyone should have access to services, especially emergency services, wherever they live.

> ***"How do we decide how far is too far?"***
>
> ***"Some specialized services may not be able to be everywhere."***
>
> **Phase III participants**

They suggested that when services are nearby, people are more likely to seek treatment sooner, thus increasing chances of early detection and intervention (e.g., in the case of chronic diseases). Proximity to care, they added, also alleviates stress on patients, families and caregivers as well as being better for the environment. Distributing care equitably across the province would also help to alleviate the burden on larger centres.

Participants also spoke about the transportation challenges (to access care delivered afar) and made a number of suggestions on how to address these:

- Creating a travel reimbursement program (for travel and accommodation) to offset the costs of seeking care in distant centres (especially for people from the northern and rural regions of the province who must travel to the larger southern centres).

- If specialized services are kept in large centres, invest in videoconferencing equipment to facilitate more tele-health.
- Utilize school buses (when they are not in use) to transport groups of patients to and from medical appointments.
- Establish a north-south helicopter ambulance link for emergency transfers (e.g., trauma or acute cardiac cases).

6.2.2 Facilitate Access to Specialty Care

Expand the ways in which one can access specialty care (beyond requiring a referral from a family physician); leverage information technologies to facilitate communications with health care providers (e.g., videoconferencing, tele-health); and reduce inefficiencies in the delivery of specialized services (e.g., reducing the amount of time testing equipment sits idle due to lack of personnel; reducing the amount of clerical work required of nurses).

As highlighted in Phase II, participants believed that improving accessibility includes facilitating access to specialty care. The issue of referrals was particularly important to participants, who felt that repeatedly requiring a referral from a family physician to access the same specialist was a waste of time and resources.

They also reiterated their belief in the potential of tele-health technologies (such as videoconferencing) to enable remote diagnosis or follow-up, thus reducing the need for travel: *"a health professional equipped with the right technology could go to a patient's house in a rural area, with a camera, and be connected to a doctor in an urban centre. The doctor could provide his or her advice, and 'voilà': a house call." (Translated)*

6.2.3 Strengthen Supports for Home-Based Care

Provide more information, training and financial assistance to family caregivers; strengthen the Extra-Mural Program, Tele-Care and other home-care programs to support more home-based care, particularly for people suffering from chronic diseases, the elderly and for end-of-life care.

Participants felt that it is much more cost-effective for the health care system when patients can return home sooner and/or avoid being admitted (or re-admitted) to the hospital system at all.

> ***"Relieves stress on current system by keeping people at home."***
>
> ***"A person's environment plays an important role in their recovery." (Translated)***
>
> **Phase III participants**

In this regard, they frequently underscored the effectiveness of the Extra-Mural Program and Tele-Care, noting that the cost per patient for both of these programs was significantly less than the cost of an emergency room visit or hospitalization.

Participants added that keeping patients at home – provided they are receiving proper care – is also beneficial for the patient in that it is often more comfortable/less disruptive, allows people to maintain contact with their family and social networks (as one participant noted, *"It helps keep the human contact element, personal touch"*) and reduces the risk of contracting hospital-borne infections.

> ***"The family is very often involved when a citizen experiences a challenging health situation. It seems to me that we should mention the key and indispensable contribution of family members." (Translated)***
>
> **Phase III participant**

However, some participants cautioned that any increased reliance on home-based care must be accompanied by the provision of adequate supports for caregivers. In particular, they stressed the emotional, physical and financial strain that home care can place on family members in general and women in particular *("[home-care] often falls on women and they are not always supported")* and on seniors caring for seniors *("Keeping elderly individuals healthy when they are taking care of family members, especially in a spouse situation").* Others felt that the home is not always the best place to receive care, noting that home care – especially if improperly supported or supervised – could entail risks to the patient's health and safety.

Finally, some participants highlighted that funding/managing home care-related services outside the Department of Health meant *"two buckets of money fighting each other: Social Development vs. Health."*

6.2.4 Fully Integrate the Mental Health and Physical Health Systems

Strengthen mental health care, services and support and make them an integral part of the health system; and ensure mental health services address the needs of vulnerable populations (such as the homeless) as well as addiction issues.

> ***"Remove the myths around mental health. Treat the whole person. Allow Medicare coverage for mental health needs."***
>
> ***"Mental health is just dangling, no home... no support."***
>
> **Phase III participants**

When discussing the integration of the mental health and physical health systems, participants were quick to point out that mental health did not receive either the attention or the investment it deserved.

Moreover, they felt that not only were there insufficient mental health services available to New Brunswickers, but that the services that are in fact provided are too often unknown, misused and/or inaccessible (e.g., due to wait times or costs). This, they stated, results in too many people not seeking/getting the care they need or turning to a family physician (if they have one), who can do little more than medicate them.

They advocated for a system that would be easier to navigate, particularly for the youth and vulnerable populations that often *"get left out [or] lost in the system."*

Participants underscored the importance of adopting a "whole person" approach, stating that mental health and physical health are closely interconnected. Moving in this direction, they said, also requires that we address the stigma associated with mental health issues and raise general awareness and understanding of mental health issues and of the relationship between mental health issues and addictions. *"Too many see addiction/mental illness as [having] simple solutions and not [as a] real illness."*

Participants also expressed concerns over the challenges of attracting and retaining qualified mental health professionals. In particular, they noted that many practitioners are opting to enter into private practice, which makes their services more difficult to access due to lack of Medicare coverage. Others worried that the lack of cooperation between physical health and mental health professionals is ultimately detrimental to the patient: *"We must work as a team. In reality, there is no room for compromise." (Translated)*

6.2.5 Make the Health System Easier to Navigate

Provide assistance (e.g., "system navigators," patient advocates, volunteers, peer support workers) and resources (e.g., "care maps") to help patients and families understand what services are available to them and how to best access them; and make greater use of electronic health records and **One Patient, One Record**.

> ***"Families are confused – where do we have to go?"***
>
> **Phase III participant**

Participants often discussed the complexities of navigating the health system, and many thought that there is a lack of information available on how to access services and navigate the system and also a lack of awareness on how to find the information that is available. This was felt to be particularly true for those suffering from complex conditions or mental health issues and for certain populations, such as youth, new parents and seniors.

Some noted that the fact that "making the health system easier to navigate" was listed as a possible area for action was in itself confirmation that the health system needed to be made more citizen-centered and user-friendly, suggesting that a single point of entry should be sufficient to access the services required.

Again, participants supported the use of *One Patient, One Record* as a strategy for simplifying system navigation and information-sharing among health professionals but cautioned that confidentiality issues would need to be addressed.

6.2.6 Develop Chronic Disease Prevention and Management Strategies or Programs

Create clinics or programs that target a specific disease or condition and offer, for example, preventive care, education on chronic disease management and the required array of specialized services and supports.

Participants recognized the heavy burden of chronic illnesses on the province's health system and the health of its population and felt that it was imperative that this be addressed. They also underscored that doing this requires greater focus on prevention and promotion (as discussed in section 6.1.4).

> ***"Patients need information to take better care of themselves."***
>
> **Phase III participant**

Again, they stressed the importance of providing adequate self-care information (e.g., through clinics), of fostering personal responsibility for one's health and of interprofessional and interdepartmental collaboration.

6.2.7 Augment Our Capacity for Care for the Province's Aging Population

Make more nursing home beds available to free up hospital beds; ensure that nursing homes provide a safe environment and good quality of life for their residents; and provide more community-based wellness programs targeting seniors.

The need to adequately plan and care for the province's aging population was also frequently underscored. In particular, participants felt more ought to be done to ensure that ailing seniors can be cared for outside of hospitals where they too often occupy scarce hospital beds while awaiting placement in more adequate facilities, such as nursing homes. Participants added that home-based or nursing home care can offer seniors a much better quality of life – physically, mentally and socially. As one participant put it, *"Hospitals are not the place for many at end of life."*

> ***"[We have an] aging population. We can't afford to keep our heads in the sand regarding this [...] Nursing home beds: where does the money come from? It's a difficult decision."***
>
> **Phase III participant**

However, participants stressed that in addition to creating more nursing home beds, it was imperative that the province's nursing homes be better staffed and that the same quality and safety standards be applied to both private and public institutions.

Finally, some participants suggested that creating a Tele-Care number exclusively for seniors might be an effective way to provide customized assistance to this population. For example, a phone number where seniors could call to obtain guidance on what to do if they have forgotten to take a medication one day.

6.2.8 Strengthen Obstetrical/Maternal/Women's Health Services

By providing Medicare-funded access to midwifery services, programs for maternal health; and offering wellness programs tailored specifically to the needs of women (e.g., menopause-related information and supports). Although not as frequently mentioned, making abortions accessible also arose in relation to women's health services.

Some participants highlighted the importance of paying attention to women's health, as they felt that this would improve the health outcomes not only of women but also of children and families.

> ***"Shift thinking… Women's health is family health."***
>
> **Phase III participant**

They highlighted that the needs of the most vulnerable women, such as single mothers and those living in poverty, should be focused on.

The idea of birthing centres as an alternative to hospital births was also supported by a number of participants.

However, a few participants also underscored that putting women's issues on the table can be at times politically challenging. One commented that *"predominantly male leadership may not always recognize the importance of women's health. "* Another added that *"accessible abortions are very much a prevention [issue], preventing health cost and future long-term social problems… This did not come out as much at these sessions as it might have at a more anonymous sort of consultation. When it is mentioned at a table, it still does not get expressed at the microphone. Some people hesitate to talk in public about abortion."*

6.2.9 Respect Patients' Wishes

Whether it is for end-of-life care or with respect to choosing among treatment options (including declining treatment), ensure that patients have sufficient information to make informed decisions and that their wishes are respected.

Participants generally supported the intent behind this option and placed much emphasis on the importance of empowering people to make informed decisions – and on respecting these decisions thereafter, particularly as they relate to end-of-life care.

> ***"I have a right to tell them when and how I want to die. Live with dignity. Death is a natural function."***
>
> **Phase III participant**

While some worried about possible abuses *("…possible abuse, such as assisted suicide" – translated)*, most agreed that the right to die with dignity was fundamental.

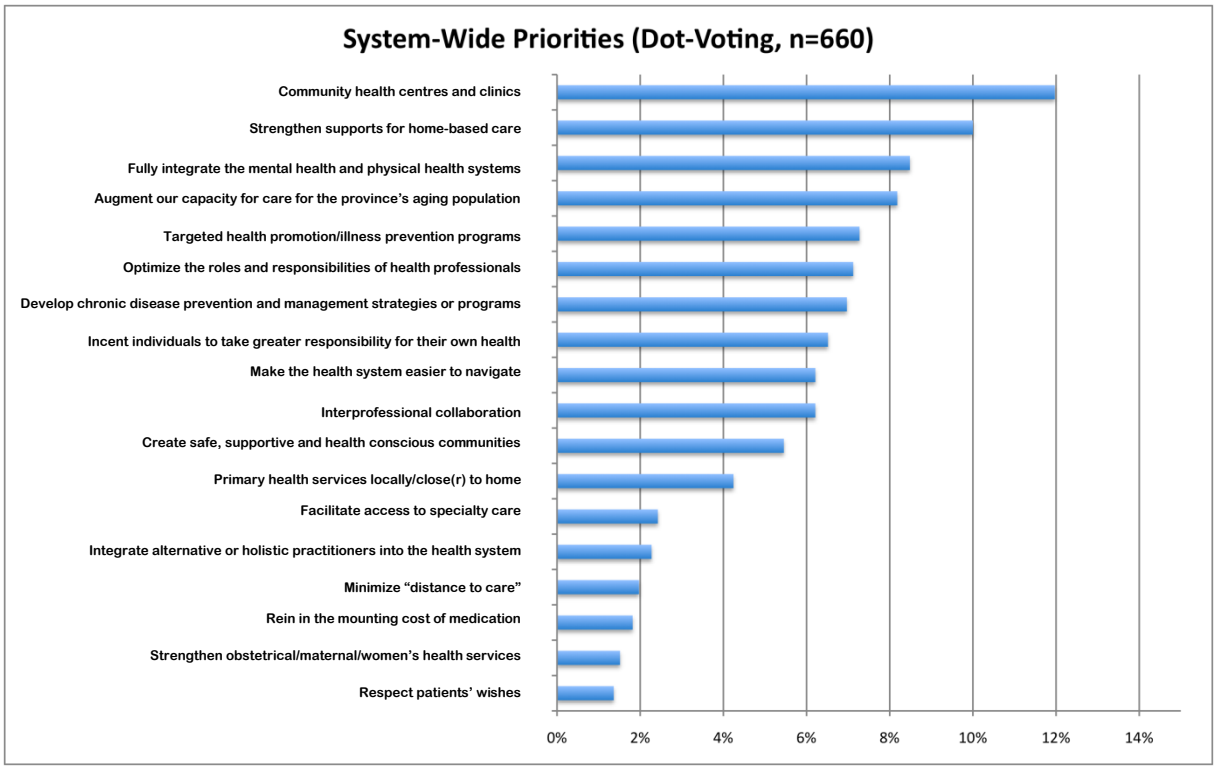
6.3 System-Wide Priorities

After having thoroughly reviewed the possible areas for action in each of the two health care sectors (Primary Care and Acute/Supportive Care), participants were then asked to identify their priorities at a system-wide level: the 18 possible areas for action (nine per sector) were listed on the wall on large posters. Each participant was provided with six "sticky dots" and was invited to select six possible areas for action that they would prioritize 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.

Participants could allocate only one dot per item but were free to distribute them across the two sectors as they wished.

Figure 28: System-Wide Priority Areas for Action



As can be seen in **Figure 28**, participants' priorities were quite equitably distributed across the options presented, and across sectors, with no single choice garnering more than 12% of votes. "P" refers to Primary Care items, while "A/S" refers to Acute/Supportive Care items.

- "Community health centres and clinics (P)" ranked first (12%), followed by "strengthening supports for home-based care (A/S)" (10%).
- "Fully integrate the mental health and physical health systems (A/S)" and "Augment our capacity for care for the province's aging population (A/S)" tied in third place at 8%.

- These were followed closely by "Targeted health promotion/illness prevention programs (P)," "Optimize the roles and responsibilities of health professionals (P)," "Develop chronic disease prevention and management strategies or programs (P)" and "Incent individuals to take greater responsibility for their own health (P)" at 7%.

6.4 Health Care Sustainability and Funding Models

Some participants noted that the rising costs of health care were clearly communicated throughout this process (and shocking to many) and commended the New Brunswick Health Council for its responsiveness and transparency in addressing their questions on this topic. However, they suggested that a discussion on the sustainability of the health care system could not exclude open dialogue on possible funding models for the health system – a subject that was not explicitly put up for discussion but which is of the greatest interest to New Brunswick taxpayers. This was, in many ways, "the elephant in the room."

As one participant put it during the final plenary: *"We have reached the afternoon of the third day and one thing that has not directly come up is funding models. This is somewhat disappointing, as if organizers thought we, the public, are not to be trusted on that topic. Funding: don't go with activity-based funding for hospitals and eliminate activity-based funding for doctors. Doctors are not rewarded for providing better service."*

7. MOVING FORWARD: CITIZEN ENGAGEMENT

It is important to note that 100% of Phase II participants either "strongly agreed" or "agreed" that citizens have an important contribution to make regarding decisions on health and should be consulted.[17]

In order to explore this further, the final exercise of Phase III was dedicated to seeking participants' views on how this might best be achieved. Participants were asked to reflect on their experiences over the course of this process and to consider what "citizen engagement" means to them now. They were then asked to think about:

- the **issues or decisions** they would expect citizens to have a say in when it comes to health and health care in New Brunswick; and
- **how and by whom** they would expect to be engaged.

7.1 Issues for Citizen Engagement

Participants felt that citizens should be consulted on *"major issues that affect the majority of New Brunswickers,"* for example, decisions relating to the development of the provincial health plan and the creation/evolution of the health regions. They also believed that citizens should have a voice on a number of other issues.

> ***"People want to have a say in what happens in their community – their priorities." (Translated)***
>
> **Phase III participant**

- **Current or emerging issues that may affect citizens directly.** For example, on issues that are pertinent to a specific population group, such as age groups (e.g., youth, seniors), a specific community or those suffering from a particular chronic disease (e.g., diabetes).
- **Costs and funding of the health system.** Participants felt that citizens should be given an opportunity to learn about and provide input on where money should be spent in the health care system. This includes, for example, questions relating to budgets, funding models (e.g., private-public partnerships) and doctors' salaries. It also implies helping citizens understand the true costs of health care and the benefits, drawbacks and tradeoffs of major funding decisions.
- **Major infrastructure decisions.** Given the cost of building and maintaining health care infrastructure, participants believed that citizens should be consulted on major infrastructure decisions such as the location of new facilities or the closing of hospitals.
- **Programs and services.** Participants want citizens to have adequate opportunity to provide input on programs and services, for example, on potential changes to service levels, whether this relates to a proposed reduction in available services, the development of new services or

[17] **Data collected in the Phase II evaluation form. See Appendix F for a summary of evaluations by Phase.**

the establishment of service priorities. They also believed that citizens can offer valuable insights into the development and evaluation of innovative programs and service models.

Some participants also noted the importance of targeting specific groups, such as youth and front-line health care workers, to seek their unique perspectives on population health and health care in New Brunswick.

7.2 How and by Whom Citizens Should Be Engaged

Participants expressed a clear desire to see the New Brunswick Health Council continue to deliver on its mandate of citizen engagement, but they also felt that the Government of New Brunswick must engage citizens on issues that affect them.

They offered a variety of suggestions on how this might be achieved:

- **Through the creation of citizen committees.** For example, one Phase III group suggested *"an oversight committee of citizens [which is consulted] before major changes in the roles of health care professionals and major changes in health care delivery, i.e., Medicare. […] These committees should be small and represent 'concerned citizens' of various education/professional levels, volunteers mostly, meeting in community centres (low cost) 2-4 times a year."* Another called for *"town hall session(s) to get voting input on issues from citizens and stakeholders for transparency in all aspects of government programs and vision."* Participants also felt that citizens should have a voice on hospital or community centre committees and regional committees or councils that touch on population health and health care.
- **Online consultation** through e-mail, discussion boards, websites, webinars and social media such as Facebook and Twitter.
- **In person** through dialogues such as *Our Health. Our Perspectives. Our Solutions.*, issue-specific forums, focus groups, discussion groups and community or town hall meetings.
- **By working with community partners.** For example, *"build on the results of the FJFNB [Fédération des jeunes francophones du Nouveau-Brunswick] process currently underway and its youth strategy, which are looking at issues such as how health/wellness are perceived by youth aged 12 to 30." (Phase III participant, translated)*
- **Through public opinion research** using Web, paper or phone-based surveys or questionnaires.
- **Through referenda** on strategic issues during elections.

Participants also reiterated the importance of communicating the true costs of health care to New Brunswickers and felt that media should be actively engaged to raise public awareness.

7.3 Conditions for Meaningful Citizen Engagement

In their discussions, participants noted numerous conditions for meaningful citizen engagement:

- Participants stressed that citizen engagement could not be limited to calling on New Brunswickers to validate decisions that have already been made: *"It should not always be 'top-down' management. Citizens should be part of the process." (Phase III participant)*
- They felt that citizens should be consulted regularly and regionally and hoped for *"the possibility that the NBHC meet with citizens on an annual basis for consultations and to report back to the regions." (Phase III participant, translated)*
- They also underscored that "citizen" engagement needed to include communities, as communities are closest to citizens and key partners in the delivery of health and social services: *"Give more power to municipalities because they are best positioned to understand citizens' needs." (Phase III participant, translated)*
- Participants noted the importance of informed participation by not only providing citizens with an opportunity to provide input but also ensuring they are equipped to do so in a meaningful way: *"Facts given to New Brunswickers, followed by an effective process (referendum). Citizens involved, informed. Present information that is not given with a political slant." (Phase III participant)*
- They also stressed that citizen engagement should be open and transparent, "*public consultation not behind closed doors"* and with *"freedom to express concern without fear of consequences." (Phase III participant)*

Finally, while participants greatly valued citizen engagement, they also cautioned that citizen engagement decisions needed to include a cost-benefit analysis to ensure resources are used as effectively as possible.

8. CONCLUSION

Participants in the three phases of this initiative provided rich feedback to the New Brunswick Health Council – feedback that was deeply rooted in their personal and/or professional knowledge, experience and wisdom and which they shared with great generosity.

While a great variety of perspectives were provided, the degree of consistency in participants' comments across dialogue sites, and throughout the phases, highlights a powerful province-wide consensus on a number of key elements which together lay the foundation for a common vision for health care in New Brunswick:

- A firm belief in the importance of addressing barriers relating to distance, language, socio-economic status and cost to ensure equitable access to health care services province-wide.
- Strong endorsement of community health centres, clinics, home-based care (i.e., Extra-Mural Program), Tele-Care and tele-health as strategies for bringing health care closer to citizens and for ensuring that hospitals remain focused on their primary purpose: acute and supportive care.
- A call for a shift in thinking towards wellness, health promotion, health literacy and illness prevention ("health care" versus "sick care") with a particular focus on reducing the incidence of chronic diseases and fostering a culture of health early on in childhood.
- The belief that more must be done to optimize the roles and responsibilities of health care professionals and to ensure that all available health human resources are used to their full capacity within the framework of the province's public health system. This includes promoting interprofessional collaboration, giving more responsibilities to traditional health professionals such as nurses and pharmacists to alleviate the burden on physicians, fully integrating mental health and physical health care, and allowing greater access to alternative/holistic health professionals (e.g., naturopaths, chiropractors, midwives).
- Recognition that the rising costs of health care must be better communicated to citizens and reined in through improved systems and processes (e.g., *One Patient, One Record*, less "red tape"), promotion and prevention (e.g., reducing the incidence of chronic diseases), more creative use of available public infrastructure (e.g., establishing community health centres in schools) and reducing the cost of drugs (e.g., generic drugs, limiting the influence of pharmaceutical companies).
- A strong sentiment that health care is a valued public good in which citizens and communities alike have a high stake.
- Strong support for strategies that encourage and empower citizens to take responsibility for their own health.
- Deep appreciation for the commitment and generosity of the people who make the health system work – front-line health care workers.

Participants were ready to assume their share of responsibility for their own health. They also expected health system partners to do their part by working together and *"taking the politics out of health care."*

As one participant stated:

> ***"As Health Minister of the day, I would call a meeting with the Departments of Education, Public Safety and Health [in order to collaborate on] proposed initiatives. [...] The Department of Health cannot and should not do it alone. We must bring the money forward to kick off these initiatives. We need accountability from all departments and we will save in the long run. [...] Let's push the bar a little further."*** **(Phase III participant)**

The participants' message was clear and simple: citizens, communities and health system partners all have a role to play in ensuring the best possible health outcomes for New Brunswickers.

And now is the time for action.

APPENDIX A:

STAKEHOLDER RECRUITMENT TARGET PER SESSION

Group	Definition	Number
Community groups	Groups within a community, representing the interests of the community within any given field	9 total
Public interest groups	Groups with an interest in health and health services or specific community-related health campaigns	9 total
Health and wellness managers	Individuals employed within the health system and responsible for the development and/or management of programs and services	9 total: • Vitalité Health Network (3) • Horizon Health Network (3) • FacilicorpNB (2) • Ambulance New Brunswick (1)
Academics	Educators or researchers in post-secondary institutions within the health or public policy-related fields	9 total
Health professionals	Individuals directly involved in providing health services, for example, nurses, paramedics, technicians	9 total: • Vitalité Health Network (3) • Horizon Health Network (3) • FacilicorpNB (2) • Ambulance New Brunswick (1)
Government representatives	Individuals employed within a variety of government departments with an emphasis on programs and services relating to the determinants of health; these include individuals employed within the departments of Health, Social Development, Education, and Wellness, Culture and Sport	9 total
Elected officials (municipal)	Municipal representatives selected randomly from a list of elected municipal officials available from the Department of Local Government	8 total
Total stakeholders *per dialogue session (Phase I & Phase II)*		**62**

APPENDIX B:

AGENDA AT A GLANCE BY PHASE

Phase I:	**Perspectives**
Moncton	Saturday, March 13, 2010 – Crystal Palace
Bathurst	Saturday, March 20, 2010 – Danny's Inn
Edmundston	Saturday, March 27, 2010 – Centre des congrès (Château Edmundston)
Saint John	Saturday, April 10, 2010 – UNBSJ Grand Hall

Time	REGISTRATION
8:30 – 9:30	Participant registration
Time	**BLOCK 1: OPENING**
9:30 – 9:55	Welcome and opening remarks Keypad voting (demographics) *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*
9:55 – 10:10	Table introductions: New Brunswick Health System Trivia Cards
Time	**BLOCK 2: LEARNING**
10:10 – 11:10	Learning session: Provincial Context and the NB Health Sector *Shirley Smallwood, New Brunswick Health Council* • PLENARY Q&A
Time	**BLOCK 3: VALUES**
11:10 – 11:45	TABLE DISCUSSION (personal reflection and sharing): What would you value most in an "ideal" health system?
11:45 – 12:30	**LUNCH**
12:30 – 12:40	PLENARY: What would you value most in an "ideal" health system?
Time	**BLOCK 4: PRIORITY ISSUES**
12:40 – 1:05	Learning session: How Are We Doing? *Shirley Smallwood, New Brunswick Health Council*
1:05 – 2:00	TABLE DISCUSSION (personal reflection, sharing and Post-It Note exercise for prioritization): Reflect on the health system – broadly defined – and collectively identify your "top 3" priority issues based on what you believe to be most important for all of New Brunswick.
2:00 – 2:15	**BREAK**
2:15 – 2:45	PLENARY: Priority Issues
Time	**BLOCK 5: STRENGTHS AND OPPORTUNITIES**
2:45 – 3:25	TABLE DISCUSSION (paired interviews and sharing): Identify the strengths and opportunities that we can build on to create the future health system you want.
3:25 – 3:40	PLENARY: Strengths and Opportunities to Build On
Time	**BLOCK 6: CLOSING**
3:40 – 4:00	Closing remarks *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*

Phase II: Solutions

Moncton	Saturday, April 24, 2010 – Crowne Plaza
Bathurst	Saturday, May 1, 2010 – Danny's Inn
Edmundston	Saturday, May 15, 2010 – Centre des congrès (Château Edmundston)
Saint John	Saturday, May 29, 2010 – UNBSJ Grand Hall

Time	REGISTRATION
8:30 – 9:30	Participant registration
Time	**BLOCK 1: OPENING**
9:30 – 9:55	Welcome and opening remarks Keypad voting (demographics) *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*
Time	**BLOCK 2: VISIONING AND TABLE INTRODUCTIONS**
9:55 – 10:15	Table introductions: "Image-ining" a Citizen-Centered Health System (visioning exercise using image cards)
Time	**BLOCK 3: PHASE I REPORTING AND VALIDATION**
10:15 – 10:55	What YOU Valued Most in an "Ideal" Health System Priority Issues and Key Strengths of the New Brunswick Health System • Presentation of key findings and keypad voting PLENARY: Comments on Phase I Validation
Time	**BLOCK 4: How can the HEALTH SYSTEM help citizens and their families be healthier? PART 1**
10:55 – 11:35	TABLE DISCUSSION (personal reflection and sharing): How can the HEALTH SYSTEM help citizens and their families be healthier? • Q1: WHERE and FROM WHOM would you like to receive the health care, services and supports you need to keep you and your family healthy?
11:35 – 12:00	PLENARY: How can the HEALTH SYSTEM help citizens and their families be healthier? • Q1: WHERE and FROM WHOM would you like to receive the health care, services and supports you need to keep you and your family healthy?
12:00 – 12:45	**LUNCH**
Time	**BLOCK 4: How can the HEALTH SYSTEM help citizens and their families be healthier? PART 2**
12:45 – 12:55	• Housekeeping: Phase III • Visioning: Characteristics of a Citizen-Centered Health System
12:55 – 1:35	TABLE DISCUSSION (personal reflection and sharing): How can the HEALTH SYSTEM help citizens and their families be healthier? • What would you like to see the Health System do MORE of and LESS of?
1:35 – 2:00	PLENARY: How can the HEALTH SYSTEM help citizens and their families be healthier? • What would you like to see the Health System do MORE of and LESS of?
2:00 – 2:15	**BREAK**

Phase II (cont.)

Time	BLOCK 5: What can CITIZENS do to help themselves and their families be healthier?
2:15 – 3:00	TABLE DISCUSSION (personal reflection, sharing and Post-It Note exercise for prioritization): What can CITIZENS do to help themselves and their families be healthier? • PART 1: What health choices and behaviours do you see as being within the personal control of most individuals? • PART 2: What kinds of incentives or supports might encourage New Brunswickers to adopt healthier choices and behaviours?
3:00 – 3:30	PLENARY: What can CITIZENS do to help themselves and their families be healthier? • What health choices and behaviours do you see as being within the personal control of most individuals? • What kinds of incentives or supports might encourage New Brunswickers to adopt healthier choices and behaviours?
Time	**BLOCK 6: CLOSING**
3:30 – 3:45	Closing remarks *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*

Phase III: Common Ground

Fredericton Saturday, June 12, 2010 – Delta Hotel

Time	REGISTRATION
8:30 – 9:30	Participant registration
Time	**BLOCK 1: OPENING**
9:30 – 9:55	Welcome and opening remarks *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*
9:55 – 10:15	Table introductions: What You Learned and What You Heard in Phases I and II
Time	**BLOCK 2: PHASE II REPORTING AND VALIDATION**
10:15 – 10:45	WHERE and BY WHOM health care, services and supports should be delivered What the health system should be doing MORE OF and LESS OF • Presentation of key findings and keypad voting PLENARY: Comments on Phase II Validation
Time	**BLOCK 3: SELECTING PRIORITIES**
10:45 – 11:00	What We Mean by "Making Tough Choices" *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*
11:00 – 11:45	TABLE DISCUSSION (personal reflection, choice work, sharing): Primary Care – If you were Health Minister for one day, which items would you choose to pursue first in order to ensure that the health system: • Meets the needs and expectations of New Brunswickers AND • Is sustainable over the long term
11:45 – 12:15	PLENARY: Primary Care • Keypad voting • Plenary comments
12:15 – 1:00	**LUNCH**
1:00 – 1:45	TABLE DISCUSSION (personal reflection, choice work, sharing): Acute/Supportive Care – If you were Health Minister for one day, which items would you choose to pursue first in order to ensure that the health system: • Meets the needs and expectations of New Brunswickers AND • Is sustainable over the long term
1:45 – 2:10	PLENARY: Acute/Supportive Care • Keypad voting • Plenary comments

Phase III (cont.)

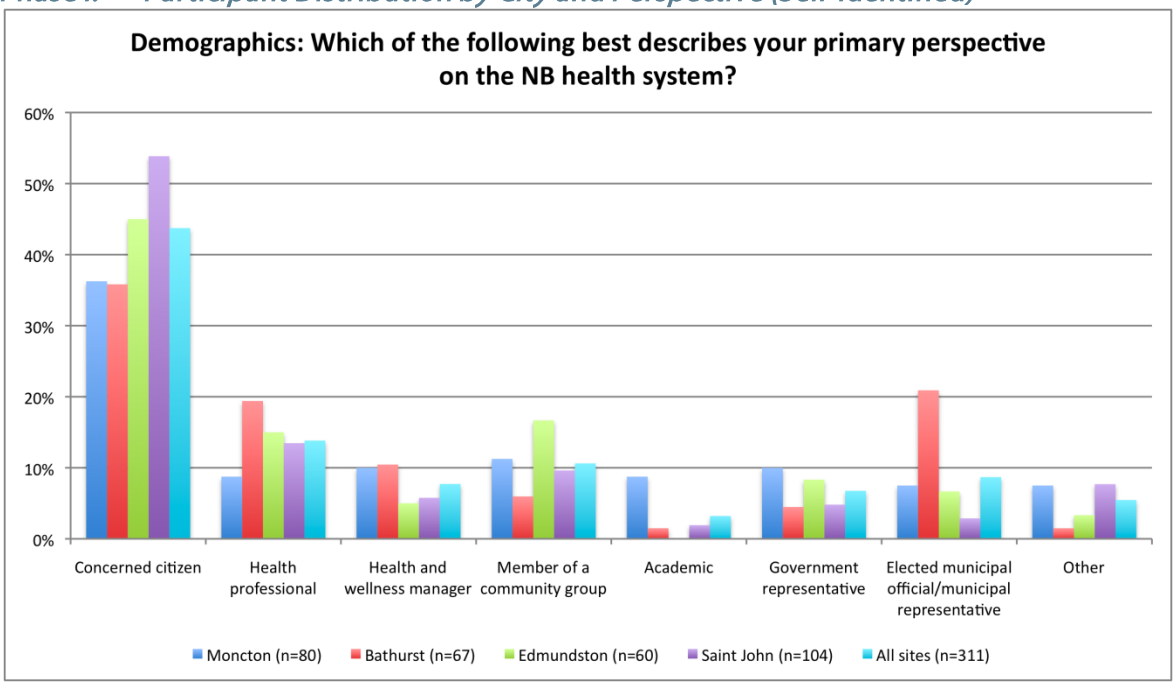
Time	BLOCK 3: SELECTING PRIORITIES (cont.)
2:10 – 2:30	**BREAK and Dot-Voting** Dot-Voting: Now that you've explored Primary Care and Acute/Supportive Care individually, what choices would you make if asked to prioritize across these two areas?
2:30 – 2:40	PLENARY: Dot-Voting Results
Time	**BLOCK 4: CITIZEN ENGAGEMENT**
2:40 – 3:30	TABLE DISCUSSION (World Café): • What are the kinds of ISSUES or DECISIONS you would expect citizens to have a say in when it comes to health and health care in New Brunswick [issues for citizen engagement]? • HOW and BY WHOM would you expect to be engaged?
3:30 – 3:50	PLENARY: • What are the kinds of ISSUES or DECISIONS you would expect citizens to have a say in when it comes to health and health care in New Brunswick [issues for citizen engagement]? • HOW and BY WHOM would you expect to be engaged?
Time	**BLOCK 5: CLOSING**
3:50 – 4:00	Closing remarks *Moderator: Stéphane Robichaud, CEO, New Brunswick Health Council*

APPENDIX C:

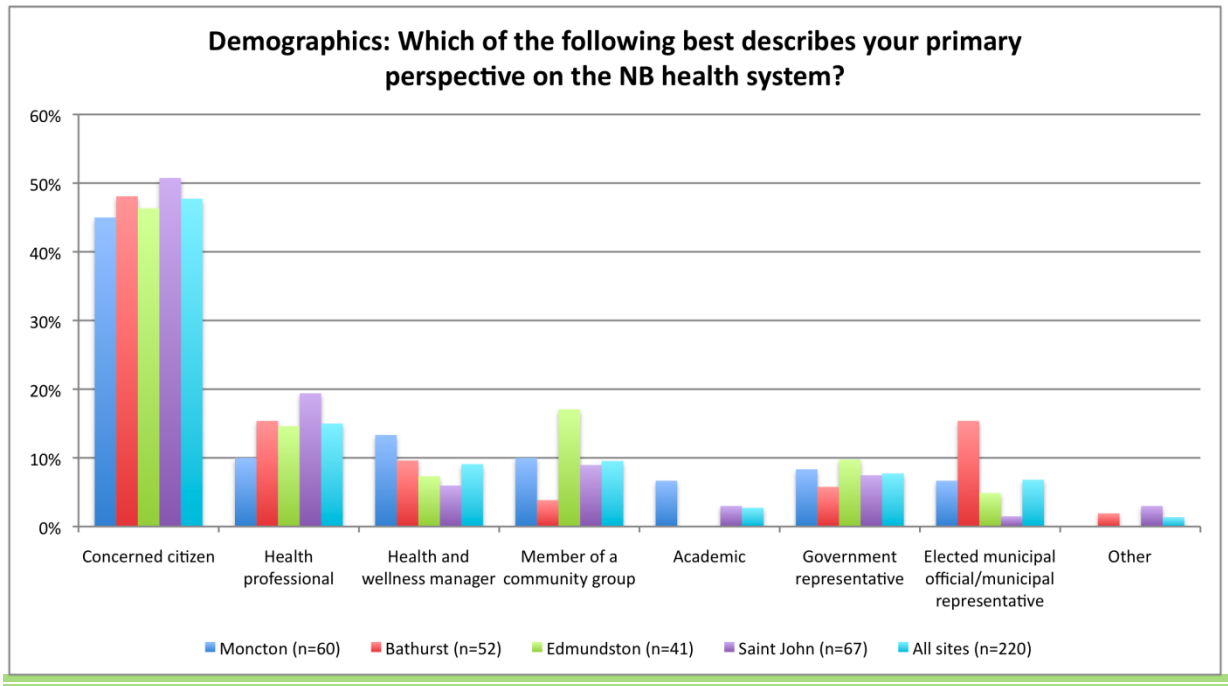
PROFILE OF PARTICIPANTS

Perspective

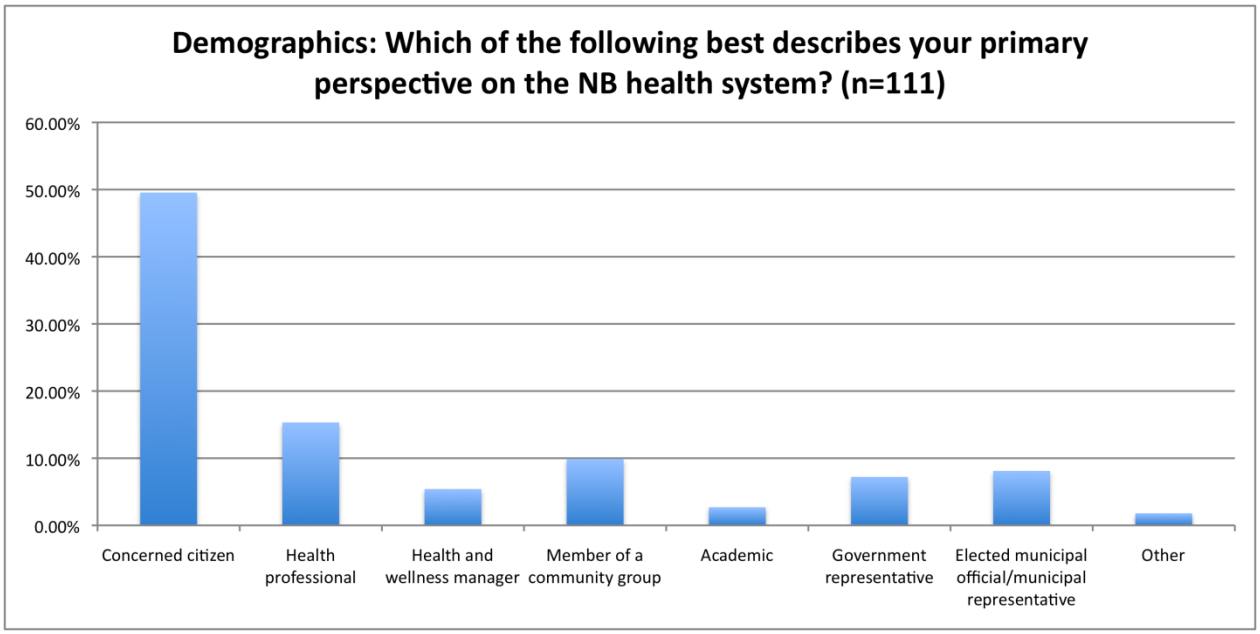
Phase I: Participant Distribution by City and Perspective (Self-Identified)



Phase II: Participant Distribution by City and Perspective (Self-Identified)

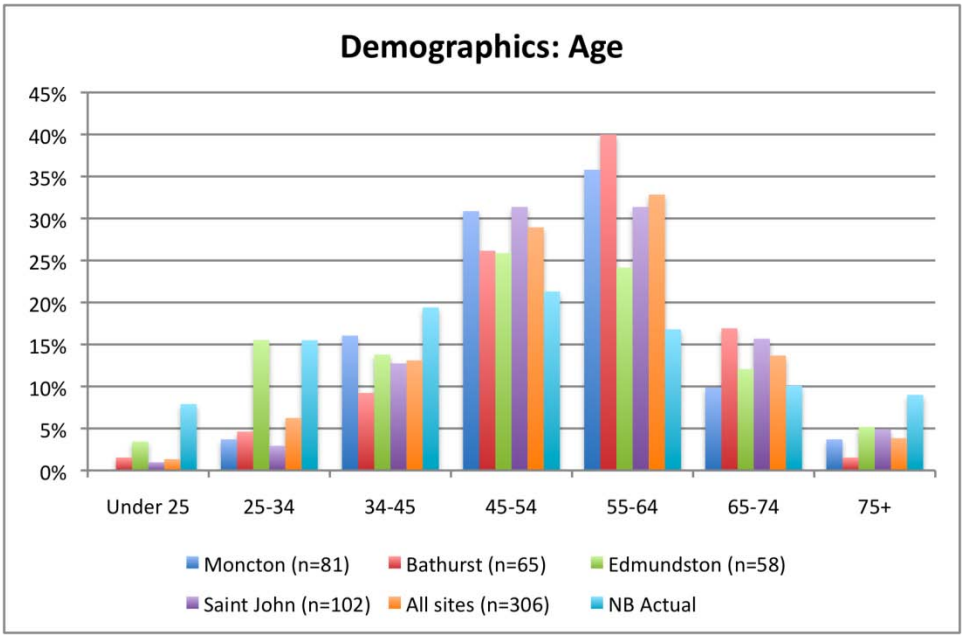


Phase III: Participant Distribution by Perspective (Self-Identified)

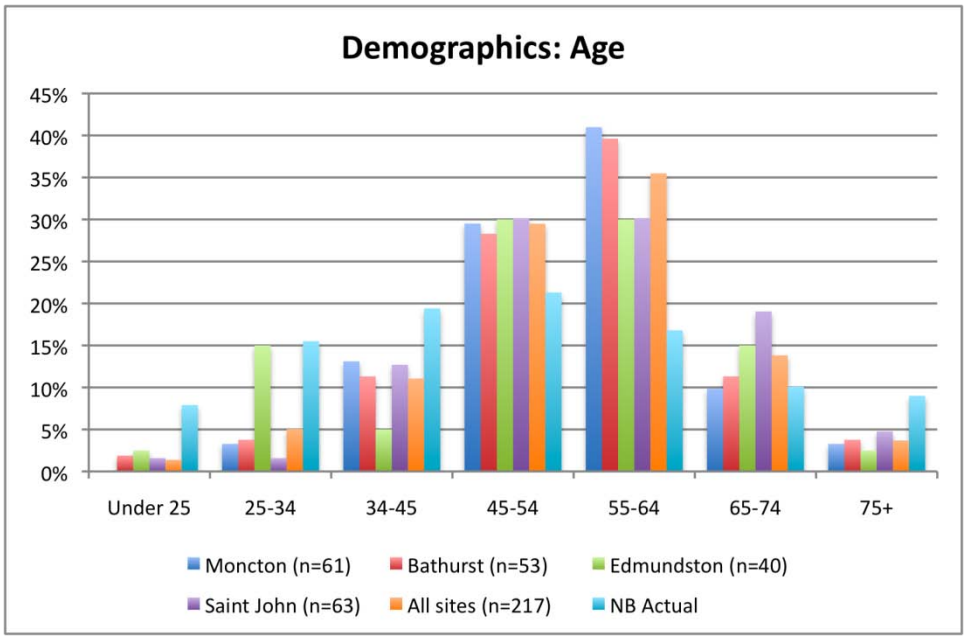


Age

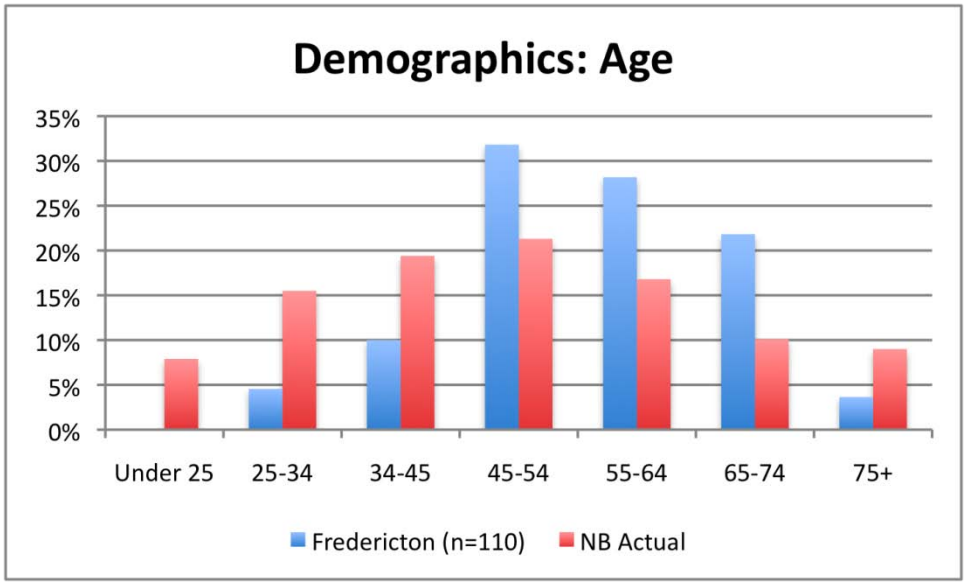
Phase I: Participant Distribution by City and Age



Phase II: Participant Distribution by City and Age

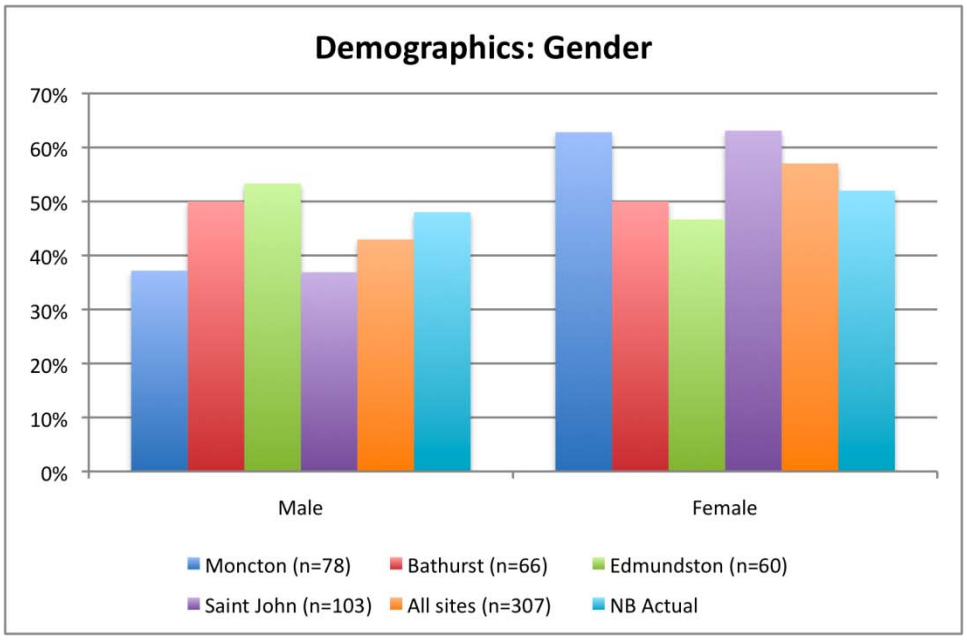


Phase III: Participant Distribution by Age

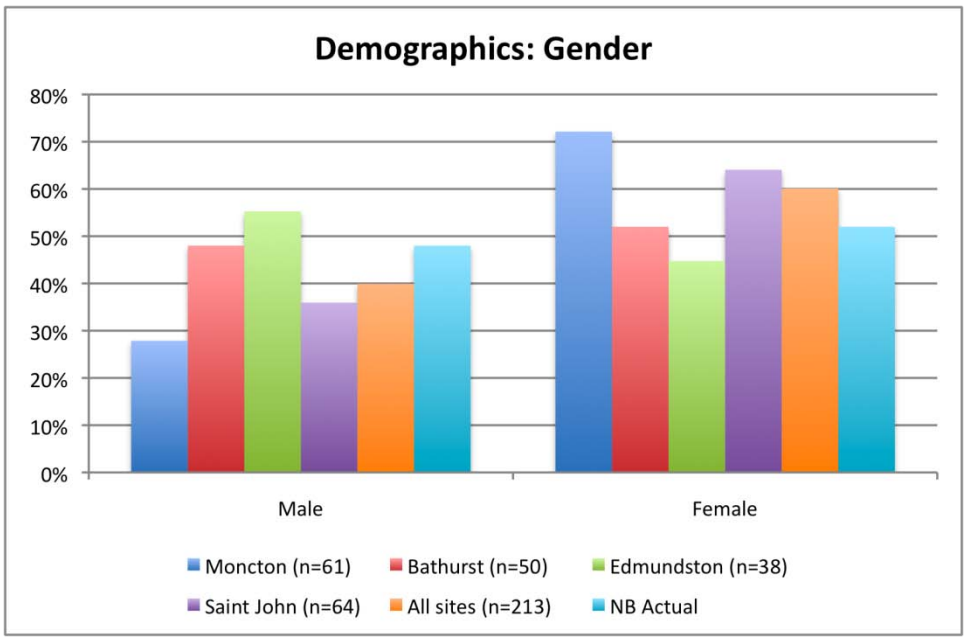


Gender

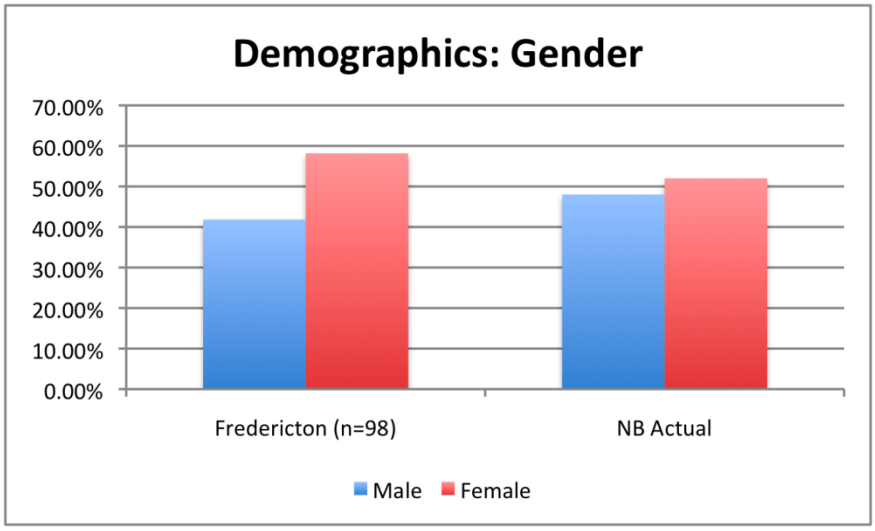
Phase I: Participant Distribution by City and Gender



Phase II: Participant Distribution by City and Gender

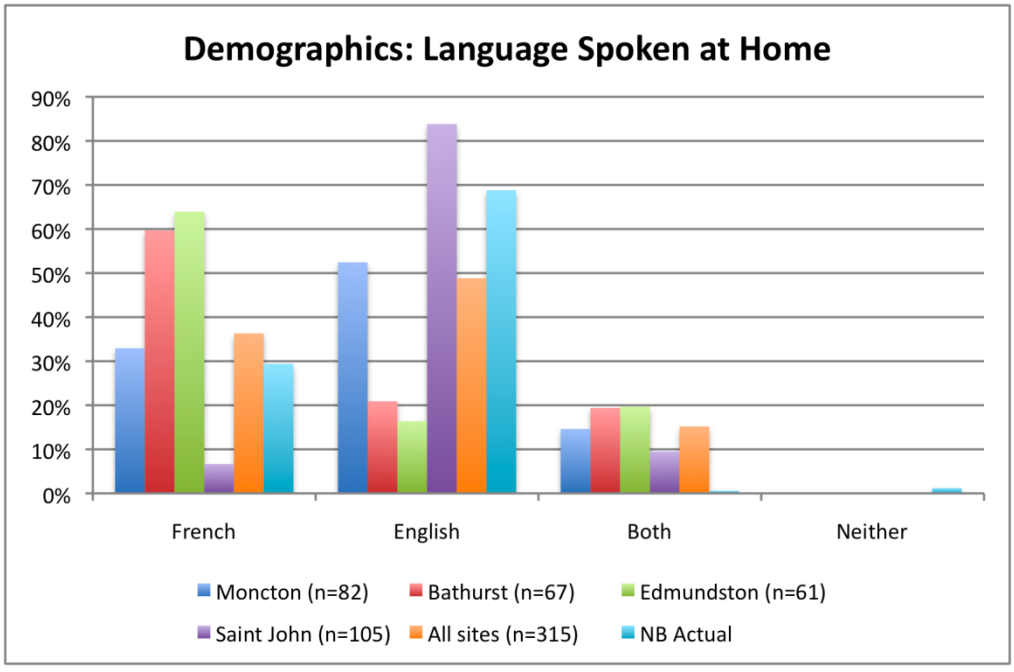


Phase III: Participant Distribution by Gender

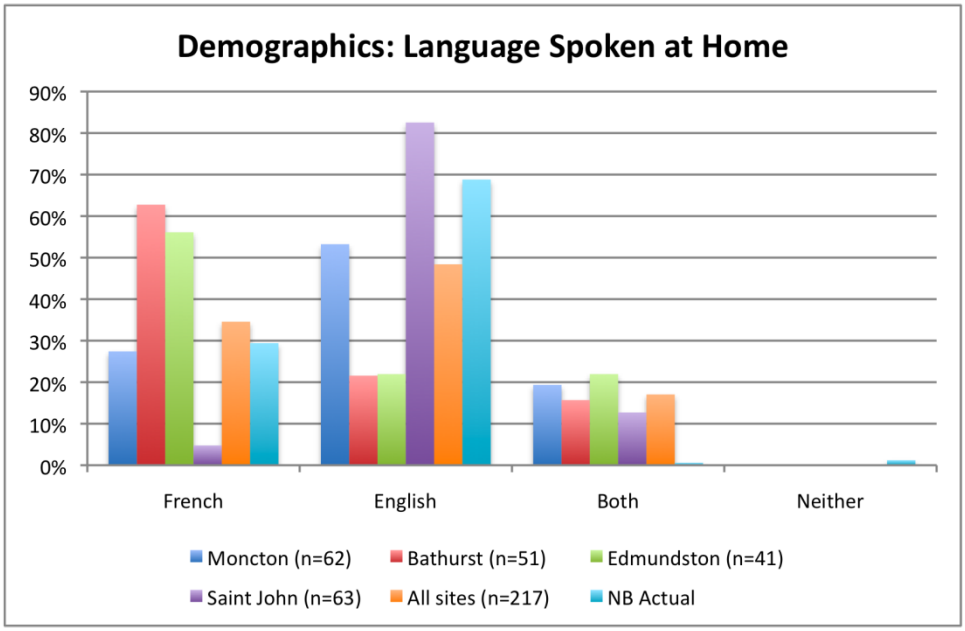


Language

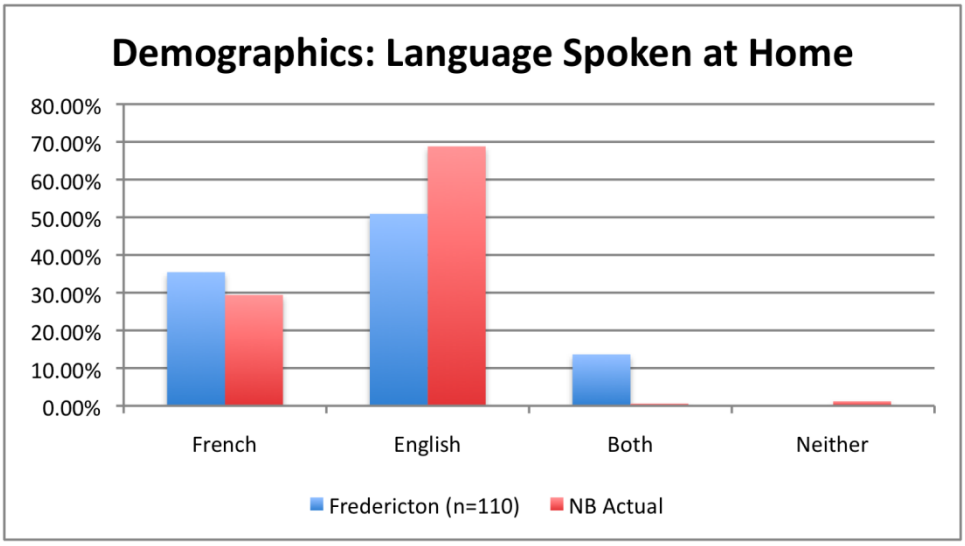
Phase I: Participant Distribution by City and Language



Phase II: Participant Distribution by City and Language

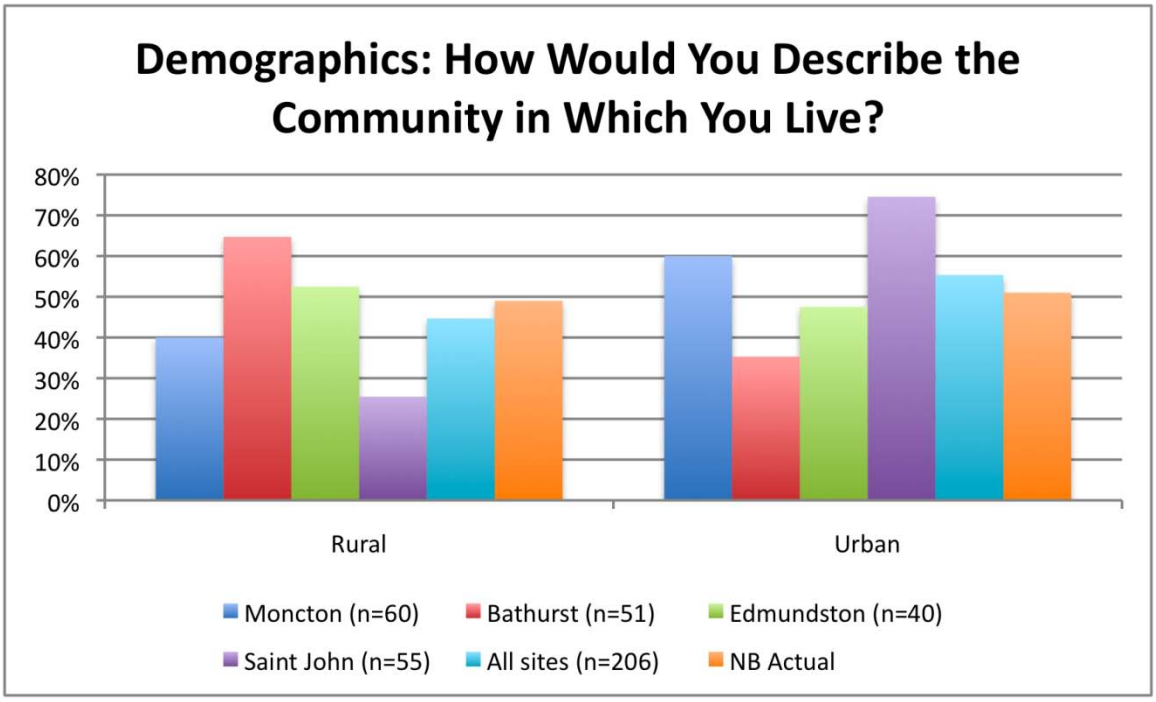


Phase III: Participant Distribution by Language

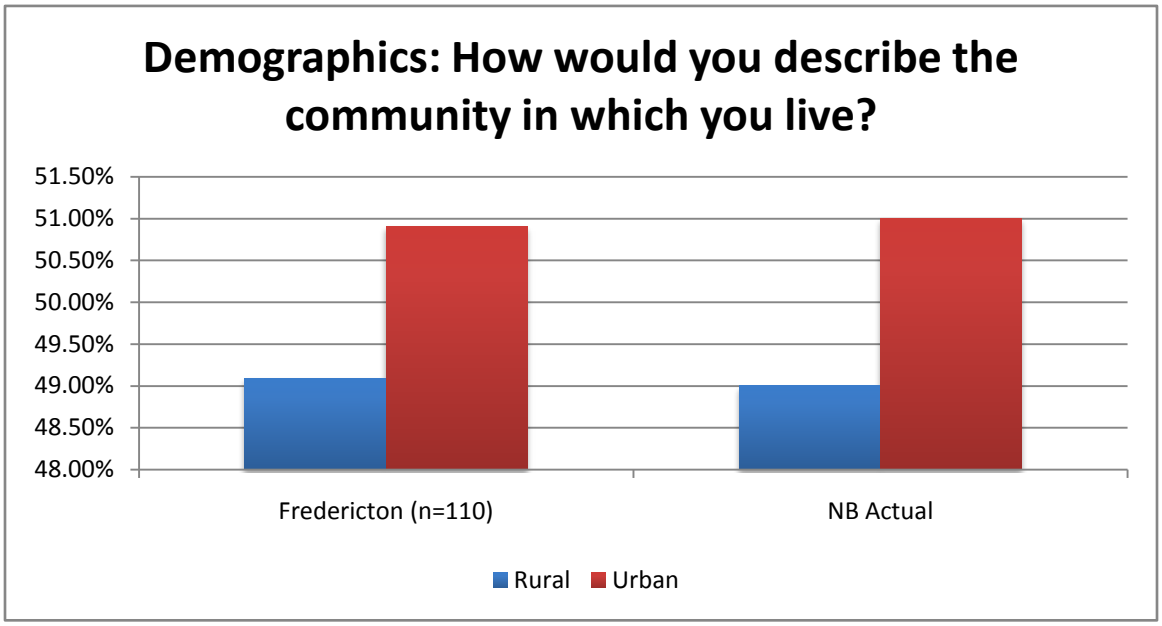


Rural/Urban Mix (Phases II and III Only)

Phase II: Participant Distribution by Rural/Urban Communities (Self-Selected)



Phase III: Participant Distribution by Rural/Urban Communities (Self-Selected)



APPENDIX D:

NBHC QUALITY DIMENSIONS

Quality dimension		Descriptor
Accessibility	Providing timely services	The ability of patients/clients to obtain care/service at the right place and the right time, based on respective needs, *in the official language of their choice.*
Appropriateness	Relevant and evidence-based	Care/service provided is relevant to patients'/clients' needs and based on established standards.
Effectiveness	Doing what is required to achieve the best results possible	The care/service, intervention or action achieves the desired results.
Efficiency	Making the best use of resources	Achieving the desired results with the most cost-effective resources.
Equity	Aiming for equitable care and services for all	Providing quality care to all, regardless of individual characteristics and circumstances, such as race, colour, creed, national origin, ancestry, place of origin, language, age, physical disability, mental disability, marital status, family status, sexual orientation, sex, social status or belief or political activity.
Safety	Keeping people safe	Potential risks of an intervention or the environment are avoided or minimized.

APPENDIX E:

PARTICIPANT WORKSHEET – PRIMARY CARE

Please circle the two (2) items you would choose to pursue first in order to ensure New Brunswick's health system meets the needs of citizens and is sustainable over the long term:

	Primary Care Choices as Identified by Phase I and II Participants	Reasons for Your 2 Choices
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, after-hours, for specific needs such as chronic disease management or maternal/women's health).	
2.	**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; making greater use of community pharmacists and pharmacies.	
3.	**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; ensure the privacy rules don't interfere with the ability to deliver timely services to patients).	
4.	**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; create workplace-based health promotion strategies (e.g., tax credits for employers who provide sustainable wellness programs in the workplace).	
5.	**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; do a better job of integrating other health professionals (e.g., dietitians, paramedics) into multidisciplinary health teams.	
6.	**INTEGRATE ALTERNATIVE OR HOLISTIC PRACTITIONERS INTO THE HEALTH SYSTEM:** chiropractors, naturopaths, massage therapists, etc.	

7.	**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"; provide more information on the true costs of health care.	
8.	**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); consider the unique health needs of those facing specific challenges (e.g., homeless population, those suffering from mental illness or addictions).	
9.	**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).	

PARTICIPANT WORKSHEET – ACUTE/SUPPORTIVE CARE

Please circle the two (2) items you would choose to pursue first in order to ensure that New Brunswick's health system meets the needs of citizens and is sustainable over the long term:

	Acute/Supportive Care Choices as Identified by Phase I and II Participants	Reasons for Your 2 Choices
1.	**MINIMIZE "DISTANCE TO CARE":** ensure that the distance one needs to travel to access emergency and acute/specialty care is reasonable; distribute hospitals/clinics/community health centres equitably across the province.	
2.	**FACILITATE ACCESS TO SPECIALTY CARE:** expand the ways in which one can access specialty care (beyond requiring a referral from a family physician); leverage information technologies to facilitate communications with health care providers (e.g., videoconferencing, tele-health); reduce inefficiencies in the delivery of specialized services (e.g., reducing the amount of time testing equipment sits idle due to lack of personnel; reducing the amount of clerical work required of nurses).	
3.	**STRENGTHEN SUPPORTS FOR HOME-BASED CARE:** provide more information, training and financial assistance to family caregivers; strengthen the Extra-Mural Program, Tele-Care and other home care programs to support more home-based care, particularly for people suffering from chronic diseases, the elderly and for end-of-life care.	
4.	**FULLY INTEGRATE THE MENTAL HEALTH AND PHYSICAL HEALTH SYSTEMS:** strengthen mental health care, services and supports and make them an integral part of the health system; ensure mental health services address the needs of vulnerable populations (such as the homeless) as well as addiction issues.	
5.	**MAKE THE HEALTH SYSTEM EASIER TO NAVIGATE:** provide assistance (e.g., "system navigators", patient advocates, volunteers, peer support workers) and resources (e.g., "care maps") to help patients and families understand what services are available to them and how to best access them; make greater use of electronic health records and *One Patient, One Record*.	
6.	**DEVELOP CHRONIC DISEASE PREVENTION AND MANAGEMENT STRATEGIES OR PROGRAMS:** create clinics or programs that target a specific disease or condition and offer, for example, preventive care, education on chronic disease management and the required array of specialized services and supports.	
7.	**AUGMENT OUR CAPACITY FOR CARE FOR THE PROVINCE'S AGING POPULATION:** make more nursing home beds available to free up hospital beds; ensure that nursing homes provide a safe environment and good quality of life to their residents; provide more community-based wellness programming targeting seniors.	

8.	**STRENGTHEN OBSTETRICAL/MATERNAL/WOMEN'S HEALTH SERVICES:** provide Medicare-funded access to midwifery services and programs for maternal health; and offer wellness programs tailored specifically to the needs of women (e.g., menopause-related information and supports). Although not as frequently mentioned, making abortions accessible also arose in relation to women's health services.	
9.	**RESPECT PATIENTS' WISHES:** whether it be for end-of-life care or with respect to choosing among treatment options (including declining treatment), ensure that patients have sufficient information to make informed decisions and that their wishes are respected.	

APPENDIX F:

EVALUATION SUMMARY

Phase I: Provincial Evaluation Summary

Moncton, Bathurst, Edmundston, Saint John

Dialogue Format	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
The table facilitators were effective.	77.7%	21.3%	0.7%	0.3%	0.0%
The NBHC presentations were informative and helpful.	66.9%	30.5%	2.6%	0.0%	0.0%
There was a good mix of participants at my table.	70.0%	25.7%	4.3%	0.0%	0.0%
The keypad voting gave me a good sense of the perspectives in the room.	83.5%	16.2%	0.3%	0.0%	0.0%

Dialogue Content	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
The information presented in the participant's Conversation Guide was relevant.	54.4%	44.0%	1.3%	0.3%	0.0%
The dialogue agenda focused on the right topics.	54.2%	40.4%	4.4%	1.0%	0.0%
There was enough time for informed discussion on the strengths and challenges of the health care system.	51.2%	43.3%	4.5%	1.0%	0.0%
The participant's Conversation Guide helped me provide more informed input into this conversation. *Moncton: Not Applicable*	51.2%	41.6%	6.2%	1.0%	0.0%

Your Experience	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
I value this opportunity to contribute my perspectives and concerns.	78.5%	21.2%	0.0%	0.3%	0.0%
I was able to gain a better understanding of the views and experiences of other participants.	69.9%	29.3%	0.8%	0.0%	0.0%
I learned a lot about health in NB from this experience.	53.2%	40.0%	6.0%	0.8%	0.0%

Will you attend the next dialogue in Phase II?	Yes	Maybe	No
Participation in Phase II	93.0%	4.5%	2.5%

Phase II: Provincial Evaluation Summary

Moncton, Bathurst, Edmundston, Saint John

Dialogue Format	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
The table facilitators were effective.	71.1%	26.9%	0.6%	1.4%	0.0%
There was a good mix of participants at my table.	57.0%	36.8%	4.7%	1.5%	0.0%
I felt free to share my opinions.	73.2%	25.3%	1.5%	0.0%	0.0%
The keypad voting exercises were efficient in validating the elements that arose in Phase I.	70.4%	24.8%	3.3%	1.5%	0.0%

Information	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
The NBHC effectively communicated the objectives of these dialogues as well as how the information collected will be used.	49.5%	47.2%	3.3%	0.0%	0.0%
The Conversation Guide for Phase II responded to the questions and concerns that arose in Phase I.	52.6%	44.0%	2.8%	0.6%	0.0%
The "What We Heard" section of the conversation guide helped me appreciate the key findings of Phase I.	51.7%	45.5%	2.4%	0.4%	0.0%

Your Experience	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
I appreciate the approach undertaken by the NBHC to engage citizens in a dialogue on our health system.	69.6%	27.2%	2.6%	0.0%	0.6%
In participating, I developed a greater appreciation for the challenges and the compromises that must be made in order to have a citizen-centered health system.	55.5%	39.3%	4.7%	0.0%	0.5%
In participating, I developed a greater appreciation for what citizens can do to ensure their own health and the health of their families.	46.6%	43.0%	9.4%	1.0%	0.0%
I believe that citizens have an important contribution to make regarding decisions on health and should be consulted.	72.0%	28.0%	0.0%	0.0%	0.0%

Phase III: Provincial Evaluation Summary

Fredericton

Please select the Phase ll location you participated in.

Moncton: 26.8% Bathurst: 26.8 % Edmundston: 14.0 % Saint John: 32.4 %

Which of the following groups were you recruited to represent here today?

Citizens : 54.0%
Stakeholders: 46.0%

Stakeholder breakdown by category:

Academic:	3.6%	Health and Wellness Manager:	5.5%
Community Group:	19.6%	Government Representative:	14.3%
Public Interest Group:	8.9%	Municipal Representative:	16.0%
Health Professional:	32.1%		

Feedback on Phase lll:

Dialogue Format	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
There was a good mix of participants at my table.	59.2%	33.0%	3.9%	2.9%	1.0%
The keypad voting exercises were efficient in validating the elements that arose in Phase ll.	73.0%	23.0%	2.8%	1.2%	0.0%
I felt that my participation provided value to the process.	53.0%	46.9%	0.1%	0.0%	0.0%

Information	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
The NBHC effectively communicated the objectives of these dialogues as well as how the information collected will be used.	55.8%	44.2%	0.0%	0.0%	0.0%
The "What We Heard" section helped me appreciate the key findings of Phase ll.	55.0%	45.0%	0.0%	0.0%	0.0%
"Making Tough Choices" highlighted the benefits, drawbacks and trade-offs to be considered in implementing certain solutions.	41.9%	55.2%	2.9%	0.0%	0.0%

As the NBHC continues to engage citizens in issues relating to health in New Brunswick, we would like to better understand when you want to be engaged and what format you prefer. Please share your opinion on the following:

I would like to participate in:	Very Interested	Interested	Somewhat Interested	Not Interested
A province-wide public conversation with many phases, much like the one we just completed.	50.0%	35.5%	8.8%	5.7%
A one-phase, public dialogue in my community or region about issues that affect my region.	61.8%	27.0%	5.6%	5.6%
A citizen jury or focus group on health.	56.5%	31.7%	7.0%	4.8%
An online discussion.	34.0%	28.4%	20.5%	17.1%
Filling out an online survey or questionnaire.	37.0%	32.6%	17.1%	13.3%
Filling out a mailed-out survey or questionnaire.	36.0%	32.5%	20.9%	10.6%

I would like to participate in an engagement process when:	Very Interested	Interested	Somewhat Interested	Not Interested
Policy-makers need to hear about the **experiences** of citizens on health issues.	54.4%	33.3%	5.7%	6.6%
There is a need for citizens to **debate options** on health challenges.	51.7%	33.7%	7.8%	6.8%
Decision-makers want citizens to help them make "tough choices" or "trade-offs" relating to health matters.	51.1%	34.4%	7.9%	6.6%

Citizen Engagement Initiative – Overall Comments

In addition to the specific questions asked on the evaluation forms, a number of comments were left by Phase I and Phase II participants across all dialogue sites. The following is an example of these comments:

- "Excellent day . . . educational . . . diverse people and format . . . Thanks!" *(Translated)*
- "A great deal of time was obviously spent on creating a concise structure."
- "The good organization and adherence to the schedule was much appreciated. The wide range of people at the table proved very interesting." *(Translated)*
- "A better representation of certain marginalized groups would have been better." *(Translated)*
- "Wording of questions sometimes not fully explained. Could have 2 meanings."
- "Presenters were clear & concise."
- "The varied options: brainstorming, pictures, immediate feedback with voting devices was very good."
- "Sometimes topics were redundant. What we identified as problems turned into solutions; but then we had separate discussions on solutions."
- "The questions asked were clear which allowed for clear responses."
- "Most of the information and issues identified date back at least 20 years." *(Translated)*
- "I'm grateful for the opportunity to participate. I learned a lot. It was validating for me to find that my items were welcome."
- "As a manager, I really like to be able to talk with members of the community." *(Translated)*
- "Short on emphasis for mental health. Overall, excellent session."
- "Not a lot of time to explore issues in depth so some were rather superficial."

- "These sessions provided me with a greater understanding/appreciation of the current NB health services situations and challenges."

- "I am a bit cynical because I participated in the Romanow Commission consultations (federal, 2001) and felt that much of today's discussion is re-inventing the wheel. Citizens certainly have a role in conveying their perspective on the system as it exists now and in voicing opinions on what they want to see in the future. We don't, however, have the knowledge to provide specific solutions."

- "I hope the positive elements will be retained and applied." *(Translated)*

- "The statistical portrait was of great use (in fact indispensable) to me." *(Translated)*

- "Showed me the difference between the expectations and perceptions of the general population and those who understand the healthcare sector." *(Translated)*

- "I hope these recommendations will be taken into account." *(Translated)*

APPENDIX G:

List of Figures, Tables and Images

List of Figures

List of Tables

List of Images