Recommendations to the New Brunswick Minister of Health

# Moving towards a planned and citizen-centered publicly-funded provincial health care system

New Brunswick Health Council

New Brunswick Health Council | Conseil de la santé du Nouveau-Brunswick

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Final version

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# Executive Summary

Last year, the New Brunswick Health Council (NBHC) travelled the province and heard New Brunswickers express that health and health care is a shared responsibility. They expressed a sense of urgency for all stakeholders to assume their responsibilities. Since The Provincial Health Plan 2008-2012 was implemented the health sector partners have had an outline for confirming their own role. Based on the work of the NBHC on measuring the performance of health care in the province, and based on input from citizens as well as discussions with stakeholders, the three recommendations that follow examine how the partners can begin moving towards a planned and citizen-centered publicly-funded provincial health care system.

It is essential that the Department of Health assume its leadership role in ensuring a better approach to provincial planning of health services in the province. A citizen-centered health care system can be achieved through improved planning that would include measurable desired health outcomes and key health indicators to gauge progress, while respecting geographic and linguistic requirements. Key elements for a citizen-centered health system include:

- A *population health focus,* which means improving the health of the population as a starting point.
- *Engaged citizens*; not only in the evolution of the health system but also in managing their own health.
- The element of *standardized quality*, which is to ensure high quality care regardless of where it is received.
- A *seamless transition* when transferred within the health system. When being treated as a patient, the quality of care should not be affected by a transfer between institutions or health authority.
- Organizations structured to work as an *integrated system*. This suggests that future decisions are taken from a provincial perspective and a provincial approach, rather than trying to manage the sum of requests from all parts of the province.

## RECOMMENDATION #1

**The Government of New Brunswick, through the Department of Health, take steps to develop, within the next twelve month period, a multi-year comprehensive and integrated health services plan for the province.**

**The plan should outline the following: measurable desired health outcomes; measurable service targets (range and volume of services); standards for the level and quality of services; financial and human resources (inputs) required to achieve service targets and the geographical and linguistic allocation of services and resources.**

The primary health care sector in New Brunswick received a grade of D in NBHC's Health System Report Card. Also, the NBHC has recently completed the most comprehensive survey undertaken in New Brunswick on primary health care services. New Brunswickers expressed many concerns they have with primary health care delivery in the province. With so many areas, priorities are often difficult to focus on or pinpoint. Primary care has been identified as a priority area by the Minister of Health and a discussion paper has been released in preparation for a summit in the Fall of 2011. In this document, we offer a number of indicators regarding the performance of the primary care sector, in line with NBHC's quality dimensions.

## RECOMMENDATION #2

**The Government of New Brunswick, through the Department of Health, review the organization and delivery of primary health care in the province with a view to maximizing the utilization of existing human and financial resources.**

**This review should focus on ways to improve access to care and quality of care, as well as integration with other health services programs, namely hospital services.**

New Brunswickers value their health. Citizens participating in NBHC citizen engagement activities see health and health care as a shared responsibility. Yet New Brunswickers rank poorly in many categories of chronic conditions; conditions that can be better managed through an improved systematic and aligned approach to prevention and health promotion in key areas of population health.

## RECOMMENDATION #3

**The Government of New Brunswick, through the Department of Health, ensure that a concerted strategy is developed to improve health promotion and disease prevention in the province. This strategy should consider the determinants of health, and focus first on four key areas: achieving healthy weights, lowering high blood pressure rates, improving mental health and preventing injuries.**

**The strategy must identify the organization responsible for the coordination of the work with related stakeholders for an integrated execution of the initiatives undertaken.**

# Moving towards a planned and citizen-centered publicly-funded provincial health care system

## The New Brunswick Health Council Mandate:

New Brunswickers have a right to be aware of the decisions being made, to be part of the decision making process and to be aware of the health outcomes achieved by health care programs and their cost. The New Brunswick Health Council (NBHC) has the mandate to foster this transparency, engagement and accountability by:

- Engaging citizens in meaningful dialogue
- Measuring, monitoring and evaluating population health and health service quality
- Informing citizens on health system performance
- Recommending improvements to health care partners

These recommendations are the last element of NBHC's efforts in delivering on all aspects of its mandate. We have implemented an annual cycle for reporting on population health, health service quality, citizen satisfaction and on the sustainability of the publicly financed health care programs.

The NBHC's work has been greatly enhanced by what citizens provided in the organization's first provincial citizen engagement initiative,[1] which was held in the spring of 2010. All of these reports are easily accessible through the NBHC website at www.nbhc.ca.

These first recommendations to the Minister of Health are influenced by the provincial citizen engagement initiative. Citizens reacted quite strongly to the information that was provided to them regarding their health, the performance of health services, and the trends moving forward. For example, it is expected that overall health expenditures will increase by approximately $1 Billon in five years (Graph 1), while there is no indication that New Brunswickers will be either healthier or better cared for (Table 1). Citizens provided several observations and ideas regarding these challenges, which can be accessed through the *Our Health. Our Perspectives. Our Solutions. Results of Our First Engagement Initiative with New Brunswick Citizens—October 2010* report.[1]

For these initial recommendations, the NBHC has chosen to focus on three areas: *Comprehensive and Integrated Health Services Plan; Primary Health Care; and Prevention/Health Promotion.*

Graph 1: Public Sector Health Expenditure[2]

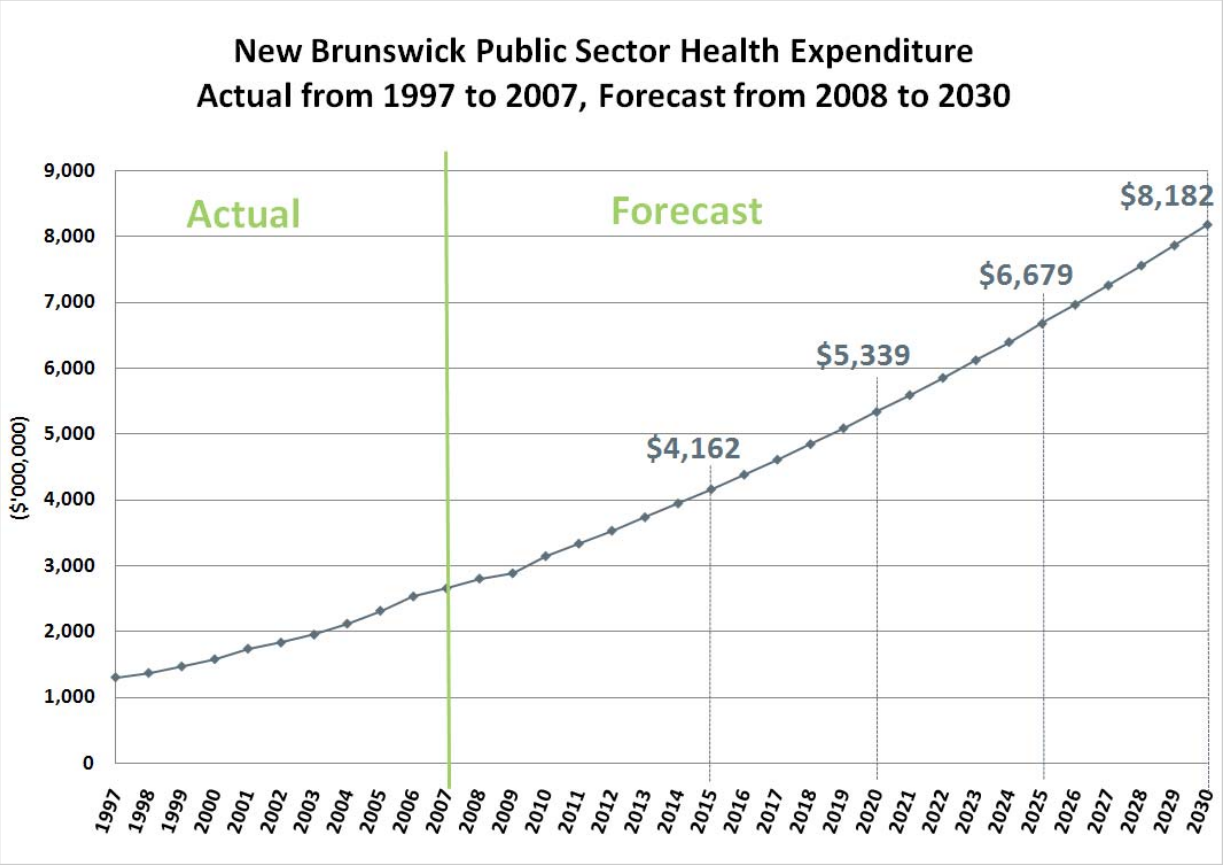



Table 1: Population Health Status in New Brunswick[3]

| Population Health Status | NB Average | Canadian Average | Rank (NB to Canada) | Rank compared with last NBHC snapshot |
|---|---|---|---|---|
| See their health as being very good or excellent *(%, 2009)* | 55.0 | 60.5 | 11/13 | ▼ |
| See their mental health as being very good or excellent *(%, 2009)* | 68.1 | 73.9 | 12/13 | ▼ |
| Pain or soreness that prevents activities (physical or emotional) *(%, 2009)* | 14.5 | 12.3 | 13/13 | ▼ |
| Life satisfaction, satisfied or very satisfied *(%, 2009)* | 91.8 | 92.1 | 5/13 | -- |
| Expected years of life *(age, 2005/2007)* | 80.0 | 80.7 | 6/10 | -- |
| Infant with less than average birth weight *(%, 2005/2007)* | 5.5 | 6.0 | 4/13 | ▲ |
| Infant deaths *(rate per 1,000 live birth, 2005/2007)* | 4.1 | 5.0 | 3/13 | ▼ |
| Premature deaths from heart and stroke *(years of life lost per 10,000 2005/2007)* | 96.2 | 77.5 | 10/13 | ▼ |
| Premature deaths from cancer *(years of life lost per 10,000, 2005/2007)* | 16.5 | 15.2 | 7/13 | ▼ |
| Premature deaths from breathing diseases *(years of life lost per 10,000, 2005/2007)* | 22.0 | 17.4 | 8/13 | ▲ |
| Premature deaths from injuries *(years of life lost per 10,000, 2005/2007)* | 83.1 | 60.1 | 8/13 | ▼ |
| Premature deaths due to suicides/self-inflicted injuries *(years of life lost per 10,000, 2005/2007)* | 39.1 | 34.6 | 8/13 | = |

## Comprehensive and Integrated Health Services Plan

*How publicly financed health services have evolved:*

New Brunswick's publicly financed health services have developed incrementally over a period of more than 50 years, beginning in 1957 with the adoption of the federal *Hospital Insurance and Diagnostic Services Act*.[4] This act introduced, for the first time, public insurance for hospital and diagnostic services across Canada. Several other separate provincial and federal legislative instruments, adopted over a long period of time, have governed these services and programs.

New Brunswick assumed responsibility for its public health care services, with assistance from the Government of Canada, in the mid-1960s with the adoption of the federal *Medical Care Act*[4] (expanding public insurance to cover physicians services outside of the hospital setting ) and the implementation of the provincial Equal Opportunity Program.[5]

In New Brunswick as in the rest of the country, the 1960s and 1970s were years of rapid expansion of publicly-funded health services and programs. Not much attention was paid to planning. Energies were focused on ensuring that the multiple local non-profit health organizations (hospitals owned and operated at the local level) and individual doctors' offices were equipped to deliver on their newly assigned mandate (i.e., providing state-funded hospital, diagnostic and doctor services to all without charge at the point of service).

The first meaningful attempts at province-wide planning in the New Brunswick health services sector were made in the late 1970s and early 1980s and involved hospital services. Components of a hospital services master plan were then assembled. However, this plan was largely the sum of the development projects of the over 50 local hospitals in existence at the time.[6] It was the result of a bottom-up priority setting exercise. It sketched out, in broad terms, how hospital infrastructure was to be developed going forward, but did little to rationalize the organization and delivery of existing hospital services or to improve service integration.

During the same period, the decision by the Government of New Brunswick to introduce a home-based hospital services program (the Extra-Mural Hospital)[7] provided an opportunity to contemplate the design of a service from scratch, that is to say without the constraints imposed by local history or experience. It led to New Brunswick's first true province-wide planned health program. Initially established as a public hospital, this program was implemented over a number

of years and is viewed, to this day, as a success story. Over time, however, the Extra-Mural Hospital grew in isolation of other New Brunswick publicly- funded programs and led to the dismantling of its governing commission and transfer to the general hospital structure in the 1990s.

By the early 1990s, it became obvious that public health services in New Brunswick could not continue to develop in the way they had since the 1960s, i.e., incrementally, locally-driven, and with limited province-wide planning and coordination. The organizational weaknesses of the health services sector became that much more apparent as the provincial government began dealing with a major financial crisis in the form of the federal government proceeding with a reduction of its health transfer payments.[8] Also, strict limits imposed on how to increase financial resources accentuated service and program distribution issues. More central direction and coordination became necessary.

Major provincial government driven initiatives ensued. A new hospital governance model was introduced that would have a major impact on program/ resource distribution, management and planning.[9] Instead of each of the 52 hospitals and health centers having their individual board and administering their own programs, eight regional hospital services boards were created covering the entire province. Programs would be planned, organized and delivered on a regional rather than a local basis. The hospital services master plan introduced in the early 1980s was revisited to reflect this new regional approach and the enhanced Department of Health role in resource allocation.

Other program and service areas were also revisited with a view to consolidate, coordinate, and plan in a province-wide fashion. Thus, the first provincial medical resources plan was instituted. This plan would govern the distribution of medical doctors across the province based on pre-established criteria. It set targets for medical doctors by region and by specialty based on each region's hospital services plan. Each year, billing numbers would be allocated based on this plan.

Work also began to better align ambulance services with the new regionally designed hospital services. At the time, the ambulance system was managed by more than 50 contracts under the auspices of various organizations, from voluntary boards to private interests.[10] Connections with hospital services remained weak and there were no provincial operation standards in place. As we know, these efforts culminated, in 2007, in a province-wide integration of ambulance services — ground and air — closely linked with acute care programs.

Further restructuring took place in the early 21st century with the conversion of regional hospital boards into regional health authorities[11] (assuming responsibilities for mental as well as public health programs). This new organizational

setting greatly enhanced opportunities for program planning, coordination, and integration across the various care sectors.

The latest changes (2008) have involved: a reduction in the number regional health authorities from eight to two;[12] the creation of a provincial body responsible for non-clinical services, FacilicorpNB; and the creation of the New Brunswick Health Council. With the Department of Health and Ambulance New Brunswick, these six organizations and the programs they deliver form what is often referred to as the provincial health system. It should be highlighted that a health care system includes more than the organizations listed above. It "includes all individuals, institutions, and resources involved in the prevention, treatment and management of injury, illness and disability and the preservation of mental and physical well-being through the services offered in the Province by medical and allied health professions**".**[13] An example is long-term care managed by the Department of Social Development.

The reduction in the number of health authorities, and the creation of FacilicorpNB and of the New Brunswick Health Council were perceived as a way to enhance the ability for the above mentioned organizations to work as an integrated system. However, three years after this restructuring, New Brunswick still does not have a comprehensive and integrated health services plan. What we refer to as the 'health system' looks more like a collection of loosely connected services and programs. It amounts to the sum of various parts and therefore does not constitute a system. Duplications and inefficiencies are widespread; negatively impacting on service quality and sustainability.

A number of elements were communicated to help define what this new structure, a citizen-centered health system, would deliver. It is worth repeating these elements given they seem to have been forgotten along the way. According to the health plan proposed in 2008, a citizen-centered health care system would include:[14]

- A *population health focus,* which means improving the health of the population as a starting point.
- *Engaged citizens*; not only in the evolution of the health system but also in managing their own health.
- The element of *standardized quality*, which is to ensure high quality care regardless of where it is received.
- A *seamless transition* when transferred within the health system. When being treated as a patient, the quality of care should not be affected by a transfer between institutions or health authority.
- Organizations structured to work as an *integrated system*. This suggests that future decisions are taken from a

provincial perspective and a provincial approach, rather than trying to manage the sum of requests from all parts of the province.

*Why is improved provincial planning important?*

When citizens were informed of resource levels and financial trends moving forward in a provincial context, they were very surprised.[1]

They also questioned why this type of information was not better circulated. They clearly expressed that greater efforts be undertaken to better inform citizens regarding the state and future challenges of the provincial health system. Fundamentally, they questioned how current decisions were made and, given the extent of the sustainability challenge and current trends regarding population health, they believe important changes are required in how decisions are made moving forward.[1]

While total population numbers for the province have remained relatively stable between 1997 and 2010, the resources available for health services have significantly increased (Table 2).

In this period of time, expenditures in health care have more than doubled, from $1.27 Billion to $2.84 Billion. There are approximately 400 additional physicians and specialists, and approximately 900 more nurses. Looking at the growth in number of employees in the health care sector (Part III) compared to the other parts of the civil service (Parts I and II), the health care sector has grown by approximately 5,000 full and part time employees, while Parts I and II have a combined growth of approximately 180. (Graph 2).

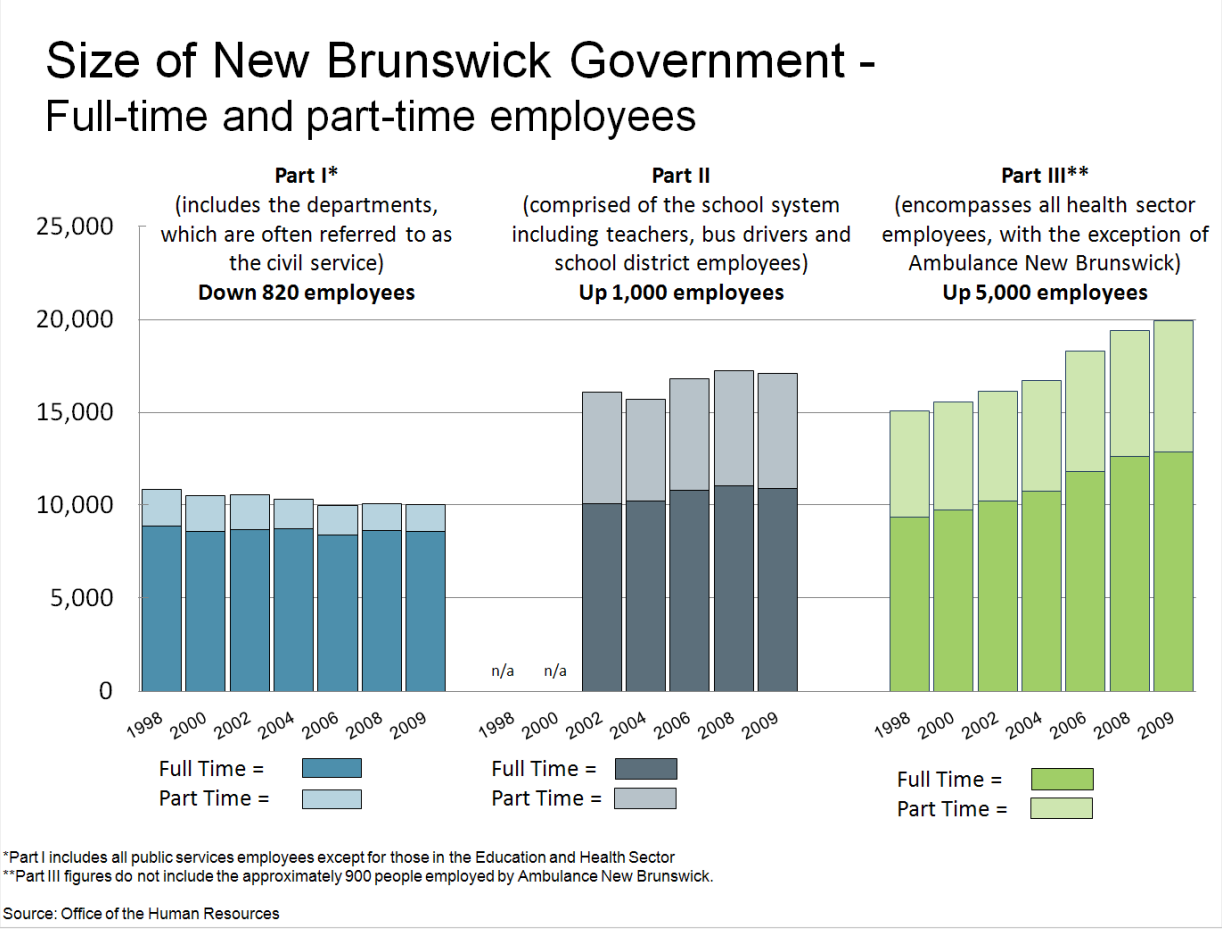
It is also worth considering how New Brunswick compares to the rest of the country (Table 3). Other than in the number of specialists and MRI scanners, New Brunswick ranks above the national average in the number of family physicians, nurses, and overall staffing. The same observation applies when considering the number of hospital beds and CT scanners. Meanwhile, accessibility problems persist, whether in wait times or in having access to a family physician.[17]

Therefore, the issue is not so much one of shortage of resources - financial or human - but one of organization and planning. Although there may currently be shortages in some program areas, it should be possible to do a lot better with what is currently available. A number of elements exist that are conducive to New

Table 2: Health Care in New Brunswick over the years[15]

| | 1997-1998 | 2009-2010 |
|---|---|---|
| Total eligible residents | 742,218 | 744,048 |
| Provincial Government Health Expenditures | $1,269,500,000 (1998 actual) | $2,843,200,000 (2010 projected) |
| Number of family physicians and specialist | 1,354 | 1,743 |
| Number of nurses | 4,334 | 5,249 |

Graph 2: New Brunswick public service employees[16]




*Part I includes all public services employees except for those in the Education and Health Sector
**Part III figures do not include the approximately 900 people employed by Ambulance New Brunswick.

Source: Office of the Human Resources

Table 3: Health Care in New Brunswick compared to Canada[2]

| | NB | Canada |
|---|---|---|
| General/Family Physicians per 100,000 | 107 | 101 |
| Specialist Physicians per 100,000 | 87 | 95 |
| Nurses (RNs) per 100,000 | 1,038 | 786 |
| Nurses (LPNs) per 100,000 | 365 | 223 |
| Staffing per 100,000 population | 2,439 | 1,945 |
| Hospital beds available per 1,000 population | 4.08 | 3.43 |
| CAT (CT) scanner per million population | 20.0 | 12.8 |
| Magnetic resonance Imaging (MRI) scanners per million population | 6.7 | 6.8 |
| Total Health Expenditures (Percent of GDP – Forecasted for 2009) | 15.0% | 11.9% |
| Public Cost Per Capita (Forecasted for 2009) | $3,857 | $3,829 |

Brunswick being a national leader in tackling the health care sustainability challenge. These include having a relatively small territory and population; new regional health authority structures providing opportunities for better coordination; and an existing legislative framework which calls for an integrated health system. Moreover, the Extra Mural Program, Tele-Care, Virtual Interactive Telehealth Assistance Links (TeleCardiology), and Ambulance New Brunswick are excellent examples of New Brunswick's ability to innovate in health services.

However, there are also significant challenges in changing the way health services work. Decades of ad-hoc developments have lead to a culture where a lack of trust, of effective communication, and of collaboration across organizations prevail. Provincial priorities must be better balanced with local and regional preferences and projects. This includes balancing the needs of the two linguistic communities, which represent a challenge unique to New-Brunswick.

Province-wide planning is absolutely essential to build a health care system that will be accessible, appropriate, effective, efficient, equitable and safe. Comprehensive and integrated planning allows an organization to focus on its future direction. It facilitates the setting of priorities and goals and develops a strategy to meet those goals. It also helps an organization to examine how resources are to be allocated and what adjustments in direction may be required in response to change. It assists users in understanding how the various organizational components and programs fit together and how they interrelate.

In fact, based on the reaction of many participants in the NBHC's engagement initiative,[1] most were surprised that a provincial planning approach did not already exist.

*What should be included regarding content and approach for improved provincial planning?*

New Brunswick currently operates under The Provincial Health Plan 2008-2012,[14] and it will be referred to later in this section. The Department of Health's main responsibilities are to plan, fund, and monitor.[18] Therefore, it is understandable that it is seen as being responsible for planning. Meanwhile, a major weakness of the current approach is in the fact that the preparation of past plans have been undertaken in isolation by the Department of Health and mostly communicated to the regional health authorities at the same time as it is communicated publicly. Moving forward, the planning process must be inclusive and this will represent a very different approach than what all involved have become accustomed to.

While the present health plan identifies certain priorities, it does not rank them nor does it include desired outcomes, service targets, timelines and resources. It

is not clear which priorities are critical and how they will be addressed.

An improved approach to provincial planning would include measurable desired health outcomes. A few key health indicators could serve to gauge whether future investments are having the desired effect from a population health perspective. The province should also have an outline for the range and expected volume of our provincial services. Additionally, an improved approach would also clarify standards regarding the quality of services in order to provide guidelines regarding the distribution of services across the province. Finally, to guide efforts aimed at achieving service targets and the allocation of services respecting geographic and linguistic requirements, there must be a clear indication of expected limits regarding financial and human resource requirements moving forward.

Here are some key elements that should be included in efforts for improved provincial planning:

1. **Commitment and alignment with the Provincial Health Plan:**

- As stated earlier, there is currently The Provincial Health Plan 2008-2012[14] in place. To move forward, the government must confirm whether the current plan is still applicable, whether partly or completely. If not, a new one must be presented. The provincial health plan serves to present key elements that all health system organizations are called to align with. The Provincial Health Plan 2008-2012[14] contains six strategic pillars which are currently recognized by most health system organizations.

- At the least, a new provincial health plan will be required after 2012. Efforts in the coming year to improve provincial planning could also serve to set the base for the next provincial health plan.

2. **Establish a clear inventory of programs and services currently offered in the province:**

- The current trend is for decisions regarding new programs and services to be made on a case-by-case basis. Often, announcements are made for one or few locations without any consideration as to when these services will be provided to the rest of the province. There needs to be a clear assessment of how well New Brunswickers are served by existing programs and services.

- It will be important to distinguish what programs and services are meant to be provincial in scope and which are meant to be delivered on a regional or local basis. Accordingly, quality standards need to be established to help appreciate to what extent citizens are adequately served by current programs and services. If there

are inequities, addressing these should be a priority prior to adding new programs and services.

**3. Clarify roles and responsibilities among health system organizations:**

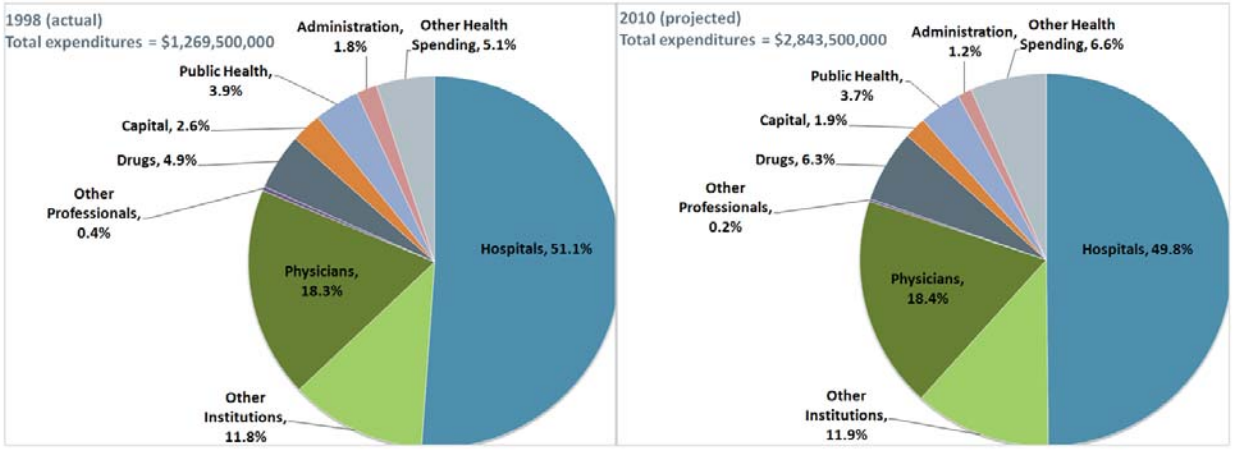
- Considering the health system has mostly evolved by default rather than by design, it is no surprise that there lacks clarity regarding the role of system organizations on a number of fronts. Should the Department of Health be managing programs and services or should it be only focused on planning, funding, and monitoring? If the Department of health is responsible for planning, where do regional Health authorities fit in this process? Why have regional health authorities been developing separate strategic plans?

- In order to transition to an integrated system approach, a number of questions regarding respective roles will need to be clarified. Establishing the list of current programs and services will help identify areas where role clarification is required. It would be irresponsible to expect that the system can clarify these issues in a short period of time. Meanwhile, the system can make a significant improvement in this area in the course of this year. Clarity in roles also determines who is responsible for the improvement of issues such as the percentage of hospital beds occupied by individuals waiting for better care or the effective establishment of a provincial trauma network. In the current context, it is at best a shared responsibility.

**4. Must move towards long-term planning:**

- When compared, health care spending between 1998 and 2010 (Graph 3) has increased by approximately $1.57 Billion in just over 10 years. Also, the pie charts highlight that the money is essentially being spent the same way. When considering the rate of health

Graph 3: Provincial Government Health Expenditure, by Use of Funds, New Brunswick 1998 and 2008[8]



spending increases moving forward and that spending for the health system is about one-third of the total provincial budget, it would be wise to adopt a longer term approach in order to ensure that health spending better reflect identified priority areas.

- A multi-year approach must also look at including health and demographic trends and consider them in any plans moving forward. From a financial perspective, the portion of future increases tied to current commitments such as collective agreements and infrastructure investments can clearly be identified. This enables the system to appreciate the portion of spending increases that can be reduced moving forward.

- When considering new expenditures, whether it is a catastrophic drug plan or adding new procedures to the list of services covered by Medicare, there is a need to appreciate and document the full financial implications of each decision.

- The health care sustainability issue affects all government departments. With such a high rate of growth for a sector that represents one-third of the provincial budget,[19] it means fewer resources are available for education, infrastructure, and labour force development to name a few. Other government departments will need to be involved in order for the Department of Health to change the current approach. At the very least, the Department of Finance will need to see this shift to a longer term approach as a priority.

**5. Improved planning at the regional health authority level:**

- The current legislative framework provides the Minister of Health the powers and responsibilities in order to receive clear annual plans from the regional health authorities.

- In order to effectively develop these plans, the health authorities require direction from the Minister of Health. In addition to what is contained in the provincial health plan, this direction can also include specific priorities and objectives and an accountability framework to facilitate performance assessment. All of these requirements are clearly stated in the *Regional Health Authorities Act.*[18]

- The legislation also indicates that regional health authorities shall be consulted in this process. Therefore, not only does the Act provide guidance as to what needs to be done, it also clearly states that the Department of Health and the regional health authorities must do so together.

- The 2011-2012 fiscal year needs to be dedicated to developing this joint planning approach.

## RECOMMENDATION #1:

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**The plan should outline the following: measurable desired health outcomes; measurable service targets (range and volume of services); standards for the level and quality of services; financial and human resources (inputs) required to achieve service targets and the geographical and linguistic allocation of services and resources.**

## Primary Health Care

*Why is primary health care important?*

In the delivery of primary health care, the goal should be to make it easier for New Brunswickers to receive the health services they need at the right time, in the right place, and by the right provider to achieve the best possible outcomes of care. Many of the points required in a multi-year comprehensive and integrated health services plan would benefit the delivery of primary health care, which has been associated with favourable mortality rates.

Last year, some of the key elements from the NBHC citizen engagement initiative were in making community health centres and clinics the centerpiece of primary care, developing targeted health promotion and illness prevention programs, and optimizing the roles and responsibilities of health professionals.

The NBHC heard over and over again from stakeholders and citizens that in order to address the needs of New Brunswickers, information at the community level was lacking.[1] Last year, the NBHC measured health services quality against the quality dimensions as set out by the *New Brunswick Health Council Act,*[13] (accessibility, equity, appropriateness, effectiveness, efficiency and safety) and the Primary Health Sector received an overall "D" grade,[17] the lowest of the three sectors measured.

In addition, the NBHC is mandated to report on citizen satisfaction regarding health services. The NBHC has completed a survey for the Primary Health Care sector.[20] This survey is the most comprehensive survey undertaken in New Brunswick with a minimum target of 13,500 respondents. The survey has questions on all primary health care services being utilized in New Brunswick. The large sample size is necessary to carry out meaningful statistical analysis of association and prediction of future trends along with the ability to detect differences among selected sub-groups of the population.

Primary health care reform has been gaining attention at the national and provincial levels for several years. The new provincial government has recently launched a discussion paper on primary health care[21] and a summit is planned for the fall of 2011. The information gathered by the discussion paper, primary health care survey and existing information from last year's report card will provide a strong base for discussions on how to improve primary health care moving forward.

*How are we performing in Primary Health Care?*

In order to appreciate potential areas of concern or priorities, the NBHC continues to examine the primary care sector through quality dimensions, which have been clearly identified in the *NBHC Act*[13] as the areas of focus for performance measurement.

**Accessibility**

- Fewer family physicians are providing extended hours of practice in New Brunswick based on National Physician Survey trends from 2004-2007. In 2007, 14.8% of New Brunswick physicians provide extended hours compared to 33.5% nationally.[17]

- New Brunswick ranks second highest in Canada who have a regular medical doctor (92.1% compared to the Canadian average of 84.9%),[3] we have more general practitioners per capita compared to national rate[2] but New Brunswick does not rank as high in contact with a medical doctor in the past year[3] or access to primary health care teams (31% versus 39% for Canada).[20, 22] Is there a story here that needs to be uncovered to help match resources and proper utilization?

- As many as 9.1% of New Brunswickers spend greater than 3% of their after-tax household income on prescription drugs (New Brunswick ranks 6th worst out of ten provinces, the Canadian average is 7.6%).[23] This places an estimated 26,932 households in experiencing financial hardship due to prescription drugs which can affect the health of the population. New Brunswick is one of the last two provinces without a catastrophic drug plan.[24]

**Appropriateness**

- Screening and standard testing are important in achieving better health outcomes. Although New Brunswick ranks highest in mammography rates,[3] the rates within the province's health zones (Appendix B) vary from a high of 94.8% to a low of 76.4%.

- Pap tests are showing that New Brunswick rates are lower than Canadian rates; and again health zones vary from a high of 87% to a low of 70.7%.[3]

- Chronic disease management requires following established standards to achieve better health outcomes. In a report from the Canadian Institute for Health Information (CIHI) based on 2008 Primary Care Experience Survey,[25] New Brunswick ranked below the national average on measurements of blood pressure, cholesterol, blood sugar and body weights.

- Influenza among seniors is an important health problem that frequently requires hospitalizations. The self-reported flu shot rates for

New Brunswick places the province in 9th worst position out of twelve provinces/territories again with variability in health zones ranging from a high of 79.4% to a low of 51.7.[3]

**Effectiveness**

- Better primary health care can reduce the need to treat people in hospital and improve their overall health.[26] One indicator of effective primary health care is the hospitalization rate for conditions that can be treated in the community. These conditions (called ambulatory care sensitive conditions) include angina, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, epilepsy, and hypertensive disease. New Brunswick has one of the highest rates of hospitalizations for these conditions in Canada[3] (10th worst out of thirteen) and the variability within New Brunswick ranged from 399 to 838 cases per 100,000 population. The national average is 320 per 100,000 population.

- A recent presentation on diabetes care and costs in New Brunswick[27] showed that in 2006, 63% of registered diabetes patients are not in the optimal range of glycemic or sugar control of 7% or less. This result is similar to a 2006 report from the Saskatchewan Health Quality Council[28] which found 62% of registered diabetics not in the optimal range. In the United Kingdom a threshold of at least 50% has been used as a target and are being achieved.[29] Better control reduces complications and costs to the health care system.

- In addition, New Brunswick has some of the highest rates of high blood pressure[30] (20.7% compared to Canada at 16.9%) which is usually associated with higher rates of stroke and cardiovascular disease, further increasing demand for hospital admissions. The variability of 19.3% to 28.3% can also have a significant impact on demand in the provincial health zones.

**Efficiency**

- Sixty-five per cent of emergency room visits are used for non-urgent cases (triage codes 4 & 5)[31] and the variability in the health zones from 55.6% to 81.5% could provide an opportunity for review and improvement.

- Preliminary data from the Primary Health Care Survey[20] is showing that 40% of New Brunswickers have used the Emergency Room at least once in the past twelve months, the Canadian average, based on 2008 Primary Care Experience Survey, was 23.9%.[25]

- Primary health sector physician costs were $295.30 per capita in 2009-2010 compared to $272.30 in 2008-2009.[32] The per capita cost for all costs related to Primary Health was $783.68

in 2009-2010 compared to $714.10 in 2008-2009.[33] Therefore, as costs increase in these areas, it is important to also appreciate whether overall quality is also improving.

**Equity**

- Although no statistical difference was found for access to a family physician based on language of service, there are differences in self-reported access based on geography (health zones).[3]

- In addition, rates of screening for certain diseases also vary from one health zone to another.[17]

**Safety**

- Seniors in New Brunswick are being prescribed too many drugs based on the Beers List (ranging from the highest 18.8% in New Brunswick to the lowest 12.9% in Alberta).[34] The drug claims data used in this analysis come from CIHI's National Prescription Drug Utilization Information System (NPDUIS) database.[35] This analysis examines claims trends of seniors on public drug programs in Alberta, Saskatchewan, Manitoba and New Brunswick from 2000 to 2006, with a focus on seniors who made claims for a drug from "the Beers list", an internationally recognized list of drugs that are identified as "potentially inappropriate" to prescribe to seniors due to an elevated risk of adverse effects, developed by Dr. Mark H. Beers.[34]

- Left without being seen (LWBS) rates from the emergency department vary in New Brunswick from less than 1% in some health zones to 11% in other zones, with the New Brunswick average being 5.7% in 2009-2010.[36]

## RECOMMENDATION #2:

**The Government of New Brunswick, through the Department of Health, review the organization and delivery of primary health care in the province with a view to maximizing the utilization of existing human and financial resources.**

**This review should focus on ways to improve access to care and quality of care, as well as integration with other health services programs, namely hospital services.**

## Prevention / Health Promotion

Prevention and health promotion is a component of primary health care but the degree to which it is executed or the strategies that are applied varies based on who is being targeted or where it is delivered. In the primary health care context there are two complementary approaches to promoting health: that which is performed at the individual person level or, that at the general population level. Primary health care is delivered in a variety of settings, including physicians' offices, hospital-based clinics, community health centres, and community-governed health service organizations. This means that different communities can have different prevention and health promotion programs or initiatives based on the resources or community services and networks available for its delivery.

> *"Preventative practices that can improve health, extend life, and reduce medical costs are already well known. The challenge is to apply them."*
>
> *J. Michael McGinnis*[37]

*Why it is important?*

Better control of fewer than ten risk factors — for example, poor diet, infrequent exercise, the use of tobacco and drugs, and the abuse of alcohol could prevent between 40% and 70% of all premature deaths, one-third of all cases of acute disability, and two-thirds of all cases of chronic disability.[37] In contrast, technology oriented medical treatment currently promises to reduce premature morbidity and mortality by no more than 15%.[38] Preventative practices have the capacity to slow down the rate at which people move from good health to illness or disability and finally death. In addition they can reduce the impact of illness and prolong life.

Before moving forward on prevention and health promotion it is important to mention a few key items:

- Changing risk factors and conditions that lie outside the health sector
- Providing population health promotion initiatives and public health services working with and in support of, the communities and families they are meant to serve
- Ensuring New Brunswickers can access and use appropriate effective clinical prevention services

- Helping New Brunswickers learn and practice healthy ways of living
- Undertaking and utilizing research to build the evidence on what creates health and wellness as well as the broad causes of disease and injury, and how to influence them.

Disease prevention can be grouped into three levels. The levels are named for the stages of disease they target:[4] primary, secondary, and tertiary.

We use primary prevention[4] methods before the person gets the disease. Primary prevention examples involve leading a healthy lifestyle; physical activity, good nutrition, getting enough rest, reducing stress, having regular medical check-ups, and trying to stay away from environmental risks and harmful substances.

Currently, prevention and health promotion at the population health level is primarily in the hands of Public Health. In addition, the department of Wellness, Culture and Sport has responsibilities for wellness and supports community mobilization through various networks. These networks are often comprised of non-government community groups who are involved in all areas of determinants of health. These activities represent important contributions towards having a healthier province but there does not appear to be an appreciation with respect to the impact of these activities.

Secondary prevention[4] means trying to detect disease and prevent it from getting worse. Much of this is done through primary health care providers including, but not limited to, doctors, dentists occupational therapists, pharmacists, social workers, physiotherapists, nurse practitioners, public health nurses, nutritionists, family practice nurses, and mental health professionals.

Tertiary prevention[4] is trying to improve the quality of life and reduce the symptoms of disease a person already has. This can be in form of chronic disease or specialized care. A number of programs and services are available for New Brunswickers but often navigation or coordination is extremely difficult. This type of prevention is offered in a number of different hospital or community facilities.

In terms of money being spent on prevention and health promotion in the context of the health care system, particularly in preventing disease aimed at the population health level, it is estimated at about $58 Million or 1.9% of the total health care system budget (the Department of Health, the regional health authorities, and the wellness portion of the Department of Wellness, Culture and Sport).[38] However, these figures do not include community groups or networks which are often engaged in this work as well.

The cost of all community services, which can include primary, secondary and

tertiary prevention, are embedded in ambulance services, telecare services, health centres, community health centres, physician offices, community mental health centres, the extramural program, rehabilitation services, ambulatory care clinics, and additional mental health and addiction programs and services. How much prevention is occurring or even being offered as part these services is unknown or often difficult to measure.

New Brunswickers value their health. Promoting good health just makes sense. Meanwhile, New Brunswick ranks the worst in obesity, high blood pressure, in perceived mental health when compared to all the provinces, and rank nine out of ten from injuries (Table 4).

It is apparent there is a lack of systematic and aligned approaches to prevention and health promotion in the province related to key areas of population health.

This has a direct impact on the accountability of the resources being used. It is important that clarity must be given to this situation in order to achieve better health outcomes. The health sector alone cannot solely be responsible for the health and well-being of New Brunswickers. Health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and volunteer organizations, by local authorities, by industry and by the media.

Health promotion strategies and programs should be adapted to the local needs of the community. In addition, professional, social groups and health personnel have a major responsibility in empowering or encouraging individuals to take more responsibility for their own health.

Table 4: Chronic Disease prevalence, New Brunswick compared to Canada, 2009[30]

| | | NB | Canada |
|---|---|---|---|
| Chronic Disease Prevalence | Does not perceived their mental health as being very good or excellent | 45.0% | 39.5% |
| | Adults with unhealthy weight (obese) | 28.5% | 17.9% |
| | High blood pressure | 20.7% | 16.9% |
| | Arthritis | 17.8% | 15.2% |
| | Asthma | 7.6% | 8.1% |
| | Diabetes | 6.6% | 6.0% |
| | Chronic obstructive pulmonary disease (COPD) | 5.4% | 4.2% |
| | Premature death from injuries (potential years of life lost, age – standardized rate per 10,000 population)[39] | 88.9 | 62.0 |

## RECOMMENDATION #3:

**The Government of New Brunswick, through the Department of Health, ensure that a concerted strategy is developed to improve health promotion and disease prevention in the province. This strategy should consider the determinants of health, and focus first on four key areas: achieving healthy weights, lowering high blood pressure rates, improving mental health and preventing injuries.**

**The strategy must identify the organization responsible for the coordination of the work with related stakeholders for an integrated execution of the initiatives undertaken.**

# Appendix

# Appendix A

*New Brunswick Health Council Members*

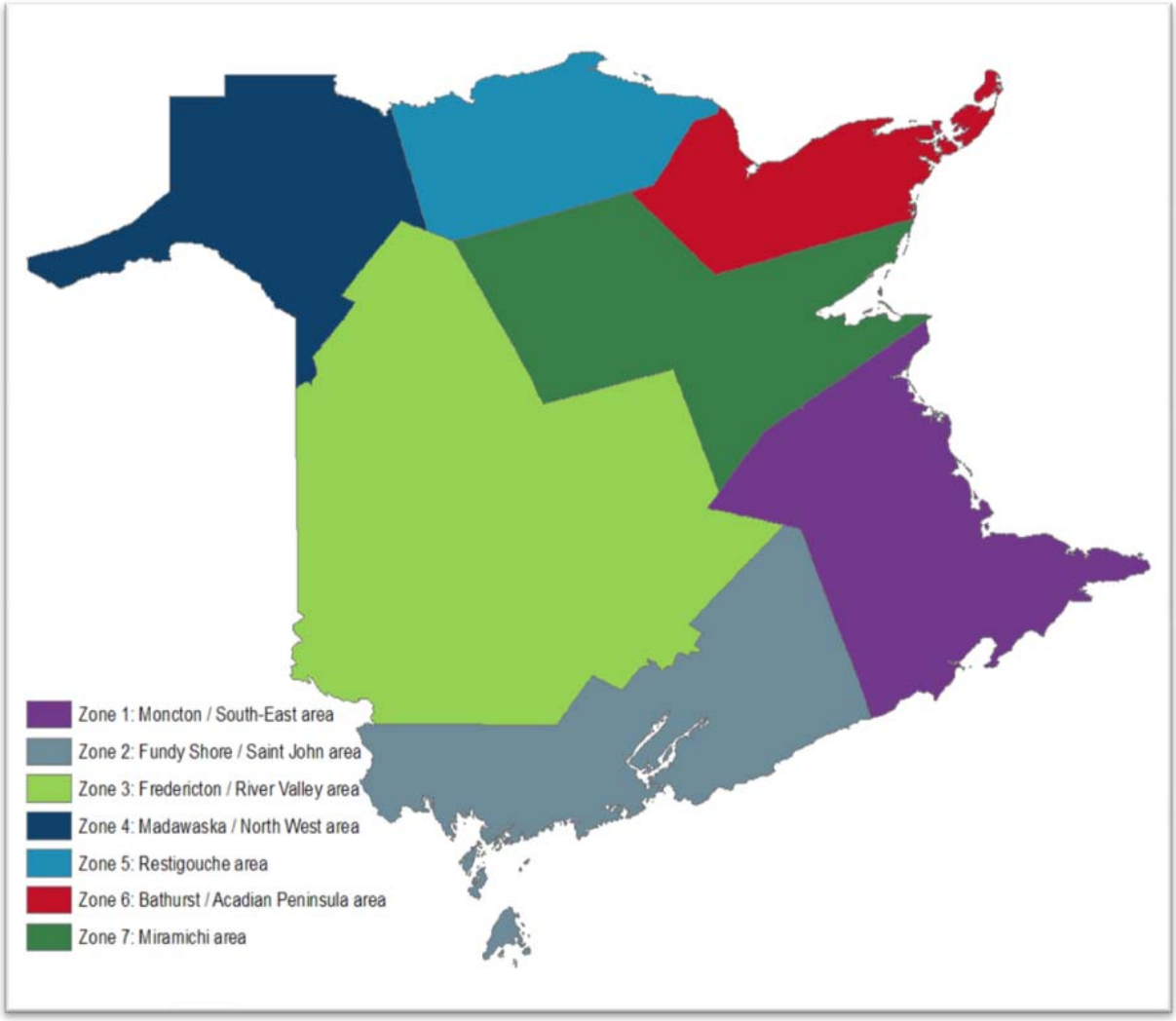
| | | |
|---|---|---|
| Pier **Bouchard** | Memramcook | |
| Christian **Couturier** | Fredericton | |
| Gisèle **Daigle Michaud** | Grand Falls | |
| Randy **Dickinson** | Fredericton | |
| Linda **Duffett-Leger** | Fredericton | |
| Charlene **Hayes** | Saint John | |
| Gwen **Jones** | Florenceville | |
| Colleen **Knudson** | Saint John | Vice-Chair of the Council |
| Barbara **Losier** | Landry Office | |
| Himu **Mukherjee** | Fredericton | |
| Anne-Marie **Picone Ford** | Moncton | |
| Daniel **Savoie** | Moncton | |
| Claudia **Simon** | Elsipogtog | |
| Lucien **Sonier** | Caraquet | |
| Norma **Sugden** | Miramichi | Secretary-Treasurer of the Council |

*New Brunswick Health Council Past Members*

| | | | |
|---|---|---|---|
| Rino **Volpé** | Saint-Jacques | 2008-2011 | Chair of the Council |
| Jeannot **Castonguay** | Edmundston | 2008-2010 | |
| Nathalie **Godbout** | Saint John | 2008-2010 | |

# Appendix B

*Map of New Brunswick Health Zones*



# Appendix C

1. New Brunswick Health Council, *Our Health. Our Perspective. Our Solutions. Results of Our First Engagement Initiative with New Brunswick Citizens – October 2010* (2010), [online], from < http://www.nbhc.ca/citizen_engagement.cfm >.

2. New Brunswick Health Council, *Understanding New Brunswick`s Health Care Costs and Capacity to Deliver Health Care: Relationship Between Health Care and Sustainability* (2010), [online], from < http://www.nbhc.ca/sustainability.cfm >.

3. New Brunswick Health Council, *Population Health Snapshot Technical Document Fall 2010* (2010), [online], from < http://www.nbhc.ca/communities_map.cfm >.

4. Health Canada, *Canada's Health Care System* (2005), ISBN: 0-662-42049-7, [online], from < http://dsp-psd.pwgsc.gc.ca/Collection/H21-261-2005E.pdf >.

5. Royal Commission on Finance and Municipal Taxation in New Brunswick, *White Paper on the Responsibilities of Government* (1965), [online], from < http://www.lib.unb.ca/Texts/NBHistory/Commissions/ES81E/byrne_1E.html >.

6. Department of Health, *Hospital Services of the Department of Health and Welfare 1970* (1970).

7. Department of Health, *Healthcare without Walls – The New Brunswick Extra-Mural Program* (July 2006), [online], from < http://www.gnb.ca/0051/0384/pdf/1985e.pdf >.

8. Canadian Institute for Health Information, *National Health Expenditure Trends 1975 to 2010* (2010), [online], from < www.cihi.ca >.

9. Government of New Brunswick, *CHAPTER H-6.1 Hospital Act* (NB: GNB, Assented to May 20, 1992).

10. Department of Health, *News release- Ambulance New Brunswick to operate all ambulance services* (07 June 2007) [online], from < http://www.gnb.ca/cnb/news/he/2007e0751he.htm >.

11. Times and Transcript, *Tories outline health-care reform; N.B.`s eight new Regional Health Authorities, which take over from existing Regional Hospital corporations April 1, is first step in move toward 'one-stop health care'*, (15 Dec 2001).

12. Government of New Brunswick, *News Release – New Provincial Health Plan puts needs of patients first* (01 April 2008), [online], from < http://www2.gnb.ca/content/gnb/en/news/news_release.2008.04.0384.html >.

13. Government of New Brunswick, *CHAPTER N-5.105 New Brunswick Health Council Act* (NB: GNB, 2008), [online], from < http://www.gnb.ca/0062/PDF-acts/n-05-105.pdf >.

14. Government of New Brunswick, *Transforming New Brunswick's Health-care System: The Provincial Health Plan 2008-2012* (2008), [online], from < http://www.gnb.ca/cnb/promos/php/PHP-e.pdf >.

15. Department of Health, *Annual Report 1997-1998* in combination with the *Annual Report 2009-2010*, as well as the Canadian Institute for Health Information, *National Health Expenditure Trends 1975 to 2010* (2010), [online], from < www.cihi.ca >.

16. Government of New Brunswick, *Office of the Human Resources* (2010).

17. New Brunswick Health Council, *New Brunswick Health System Report Card 2010* (2010), [online], from < http://www.nbhc.ca/care_experience.cfm >.

18. Government of New Brunswick, *CHAPTER R-5.05 Regional Health Authorities Act* (NB: GNB, 2002), [online], from < http://www.gnb.ca/0062/PDF-acts/r-05-05.pdf>.

19. Government of New Brunswick, *New Brunswick Statement of Public Accounts for the fiscal year ended 31 March 2010 – audited Financial Statements* (2010), [online], from < http://www.gnb.ca/0087/pubacct/PA10v1e.pdf >.

20. New Brunswick Health Council, *2011 Primary Health Care Survey* (2011), [online], from < http://www.nbhc.ca/nb_primary_care_health_survey.cfm >.

21. Department of Health, *Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010), [online], from <http://www.gnb.ca/0053/phc/pdf/2011/PrimaryHealthCareDiscussionPaper.pdf >.

22. Statistics Canada, *Health Research Working Paper Series, Primary Health Care Teams and Their Impact on Processes and Outcomes of Care* (2010), ISBN 978-0-662-48998-6, [online], from <www.statcan.gc.ca >.

23. Statistics Canada, *CANSIM Table 109-5012*, [online], from < www.statcan.gc.ca >.

24. Library of the Parliament, *Catastrophic Drug Coverage in Canada* (2009), [online], from < http://www.parl.gc.ca/Content/LOP/ResearchPublications/prb0906-e.pdf >.

25. Canadian Institute for Health Information, *Experiences with Primary Health Care in Canada* (2009), [online], from < www.cihi.ca >.

26. Public Health Agency of Canada, *Creating Healthier Canada: Making Prevention a Priority* (2011) [online], from < http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/index-eng.php >.

27. Department of Health, Internal presentation made at the *Cost-Effectiveness of Diabetes Management Programs*, organized by Health Canada in Ottawa on Feb 24, 25 2011 (2011).

28. Saskatchewan Health Quality Council, *Quality of Diabetes Management in Saskatchewan* (2006), [online], from < http://www.hqc.sk.ca/portal.jsp?ufjZy5DBM1FagXU/qP03CTBIzBf0QfLQkUwK4QBZaJsE2TmgEoiHRFVvI5thiwzu >.

29. NHS – The Information Centre for health and social care, *Quality and outcomes framework Online GP practice results database* (2009/10) [online], from < http://www.qof.ic.nhs.uk/index.asp >.

30. Statistics Canada, *CANSIM Table 105-0501*, [online], from < www.statcan.gc.ca >.

31. Department of Health, *Annual Report of hospital Services for the Fiscal Year Ending March 31, 2010* (2010).

32. Calculated by author based on internal information (2011).

33. Calculated by author based on internal information (2011).

34. Canadian Institute for Health Information, *Drug Claims by Seniors: An Analysis Focusing on Potentially Inappropriate Medication Use, 2000 to 2006* (2007), [online], from < www.cihi.ca >.

35. Canadian Institute for Health Information, *Drug Use Among Seniors on Public Drug Programs in Canada 2002 to 2008* (2010), [online], from < www.cihi.ca >.

36. Department of Health, Internal information – Emergency Room Statistics (2009/10).

37. National Priorities in Disease Prevention, *J. Micheal McGinnis*, [online], from < http://www.issues.org/19.4/updated/mcginnis.pdf >.

38. Calculated by author based on internal information (2011).

39. Statistics Canada, *CANSIM Table 102-4309*, [online], from < www.statcan.gc.ca >.

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