Health Care Services: A Public Utility

The current models of health governance do not appear to be working for the public interest.

The regionalization of hospitals of 1992 was intended to take the 55 existing hospitals and place them in an organization that would provide for standardization, efficiency and adaptation to significant trends and future population projections.

The intent in 1992 was that in phases, NB would have a truly integrated health system. Local volunteer boards served well in supporting their local hospitals but the explosion of technology, knowledge, and cost in health care was nearly impossible for local boards to manage.

Essential care service has not kept pace with public need and expectations under the new organizations of two Health Authorities. NB now has a fairly centralized control of health care services while its citizens experience difficulty getting primary and specialist care. Both are great when you get to them, but getting to the right practitioner efficiently is a key public concern.

New Brunswick is blessed with great health care professionals; most will acknowledge that systems and organization are key issues.

It is really very difficult for policy makers to deal with the key issues of developing and maintaining high quality services when all decisions, however small, get scrutinized and subject to reversal by the political arm of government. In reality, the pivotal direction has often come from a central government office where basic issues of quality programming often are sometimes mistaken for election fodder!

Make no mistake: the role of the politician in advancing the causes in their ridings is serious and sacred. At the same time, the face of health care has changed enormously in 30 years. It is no longer a “mom and pop” business but highly complex industry, so says famed management author Peter Drucker. He refers to the “two-headed accountability model” as a central theme.

The issues of running a huge health organization are enormous: nearly 20,000 employees, 1700 physicians, nearly 6000 volunteers, spending well over “$2 billion annually! This requires a governance model that would rival huge corporate enterprises. Doing so with an eye to maintaining the best possible state of the art service for the entire province makes it a very daunting task. The knowledge that is

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required of board members, Administrative staff, clinical staff and policy makers is enormous and growing daily. Knowledge from 2005 is now out of date!

Across the continent there are many models being created that add value to the organization of health care. In the State of Maine, most of the “hospitals” are coming under the direction or influence of the Maine Medical Centre; in doing so, the roles of facilities are changing with customer experience improving significantly.

In other jurisdictions, one sees major Universities playing a role in direction of hospitals large and small, thus creating systems for smooth flow of information and care referral. The University of Rochester System and the Augusta University Health System are two interesting examples of public service governed by a central, non-governmental board.

In New Brunswick we need to find new solutions to old problems. Issues that have compromised service for decades cannot be resolved using current and traditional means.

Consider the recent publicity about beds and emergency in Perth-Andover. The very modern, very expensive hospital in Waterville was sold to and by politicians as “this will replace 4 hospitals”….that did not happen. Nor did the regional health authority believe it would!

Consider the issues of surgery in small communities in which it once was safe and fashionable for small community hospitals to provide limited surgical. With the explosion of knowledge, the refinement of instruments and techniques and the public demand for best practice, it is no longer considered safe for practitioners to operate in isolation. Major teaching hospitals demonstrate every day the influence on quality of service when professionals work together, complementing each other’s knowledge and skill.

It was over 20 years ago that researchers at the University of Toronto observed the high number of unexplained deaths in Canadian hospitals. As a result, there has been rapid growth in formation of organizations that help health service organizations improve patient safety. The Institute on Clinical Evaluative Studies and the Canadian Council for Health Facilities Improvement are Canadian examples. Several organizations such as Planetree, Eden Alternative, Magnet Hospitals, and Pioneer provide much support and information to health care facilities that try to improve their operating cultures.

The OECD has given the Canadian Health System criticism and noted poor system performance on such things as preventable deaths. Those governing the health system must be knowledgeable of issues, trends, reports and what is involved in improving

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system performance. Making the essential changes is not for the faint of heart! Decision-makers cannot be pleasing elected officials on every decision.

Key strategic decisions will never be universally accepted by professional groups or by the public. Imagine if NBPower had to seek permission to make internal operational changes. The lights would soon go out!

Giving health services public utility status would require a regulatory framework that would hold the executives and governing authority accountable. In the arena of public opinion, the current system is not meeting public needs.

A public utility structure is a business enterprise, as a public-service corporation, performing an essential public service and regulated by the federal or provincial governments. Is this a model for Health Care in NB? Maybe or maybe not. But are you satisfied with growing long waits, lack of timely access to essential care, overcrowded emergency units? Something has to give!

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