Health Care Reform in New Brunswick:

some tips for policy-makers

The provincial government has sent many signals promising that we would see major health care reform in New Brunswick in January 2020. So what will it look like really?

Regionalization of hospitals in 1992 was the last time that the health care system in New Brunswick was truly shaken up. It is true that the two health authorities were formed long after that but the public hardly noticed except to note that there was a division between French and English.

Following the 1992 "incursion into the health system" some of us who were involved believed that it would be helpful to assess what went well and what did not go well in this major change implementation. But governments that followed McKenna seemed to lose all appetite for serious health planning; assessment of past initiatives would have been the starting point. Our thinking was based on the old adage that "he who fails to learn from history is destined to repeat it."

And while regionalization of hospitals was long overdue and a much-needed first step in putting structure to health care services, and while those who designed the approach were remarkable in getting government to take this bold initiative, all have acknowledged that if we were to do it over again there are some things that could have made the tough and bitter medicine go down easier….maybe!

Since that time, I have made it my business to study how successful major change is successfully implemented and have read widely on the topic. One of my favorite authors on Change is Prof. John P. Kotter of the Harvard Business School. In his book, Leading Change, he lists 8 stages that are essential in successfully changing any large system or organization. With some reforms about to be announced, it seems prudent to review what this author has to say.

First there needs to be a sense of urgency established. In this province the sense of urgency is certainly felt amongst consumers, seniors, policy makers. The sense of urgency felt by service providers and their governing structures is not clear. Why else would there have been such inertia for so many years on the hot-button issues of Emergency/Urgent Care and ALCs? Why else would we be having the same conversation about Nursing Crisis that we have had ritually every decade?

Then he says that a Guiding Coalition needs to be formed; "putting together a group with enough power to lead the change; getting the group to work together as a team." New Brunswick has a tradition of not engaging system leaders in change. If policy makers are reliant totally on inside counsel, that raises public skepticism and, indeed, cynicism since the existing structures are seen, in the public eye, as creators and maintainers of the problems.

Vision and Strategy is absolutely crucial and I personally learned this lesson many years ago. When we changed the vision at York Manor to York Care Centre: Centre of Excellence that, along with the training

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that accompanied it, served to enable and propel much change from the Poor House image. Policy makers need to be clear and need to express and communicate a compelling vision that ignites people.

The communication process is absolutely essential. It will not be enough for the Premier or the Minister of Health to recite their dream but they need to engage influential thought leaders across the province to help communicate, using every vehicle possible.

Empowering broad-based action is cited as element number five. This is the step at which the rubber hits the road for it involves changing systems, eliminating obstacles where they exist. This could take the form of finally approving some of the innovative demonstration models that have been sitting on shelves for years.

It is essential to generate some short term wins and if the authors of change are listening to the people clearly they will know that there are many low hanging apples that could, without major confrontation, win much support for change. We saw that in the Aging Council process when stakeholders were simply looking for leadership, direction, and true engagement.

Consolidating gains and producing more change is critical. The type of changes required to make our health care system shine will require some short term decisions that will not be universally popular, but mostly a longer term focus. In the regionalization of hospitals in 1992, it was intended that there be many follow-on steps in creating a coherent health and long term care strategy. And such it is now in that whatever is announced now must be seen as a major first step in creating that for which we have dreamed for over 30 years: an integrated health and long term care system that serves the public efficiently and has excellence as its goal.

Then the author underscores the need for anchoring the new approaches in the culture. In the current health care system in New Brunswick we are blessed with many wonderful physicians, nurses, diagnostic service personnel, rehab…and the list is very long. In several previous commentaries, some of the conflicts with organizational structure have been cited as key to many of the problems that patients and families experience. But overall, the system, starting at Primary Care, After Hours, Urgent Care, Emergency, Diagnostics and more, is organized for the convenience of service providers.

As an illustration I invite readers to call a typical primary care physician office after hours or on the weekend. While there are exceptions, normally the response will be to try the afterhours clinic or go to the Emergency Department, neither being great options for non-life-threatening situations. Or when an ultrasound is ordered in Fredericton and the wait is 2-3 months when the same procedure could be performed on the day or order in facilities only an hour's drive away. But who would know?

Delays in access to surgery are caused by many factors as are periodic cancellations; often the public does not get a totally honest reason for delays and cancellations.

And of course one has to open the question of the recognition by professional bodies of non-NB credentials. While there is a legal and professional duty to ensure training and certification is equivalent, the long delays reported by doctors and nurses alike are not only avoidable but give the

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impression of professional protectionism. Indeed, in my own career, some of the stellar physicians and surgeons with whom I have worked came from South Africa, Ireland, Scotland, Great Britain, India, Iran, Turkey, and Australia. Due diligence is to be commended; protectionism not.

And while we are discussing Elephants in the Room, when will we get to engaging Nurse Anaesthetists or widespread engagement of Nurse Practitioners in Primary Care? And when do we prescribe job descriptions and performance targets for physicians? And will part of the anticipated change involve a stronger physician presence in the executive ranks of the health authorities?

Much of the major change now required in the system could have been happening incrementally had there been strong governmental commitment to the intent of the 1992 reform. So now we need to pick up the pieces and create a system that provides essential care to the right people at the right time by the right service provider.

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