Settling for Mediocrity :

Aging and Health in New Brunswick

Disclaimers

- CEO since I was 26 years old in healthcare;
- Taught by the best in union relations and leadership;
- National professional leadership roles
- Taught a few classes in med schools and public policy programs
- After McKelvey/Levesque (1989) chaired the committee recommending to the McKenna government that hospitals services be regionalized 1991

More disclaimers:

- Leadership role during tumultuous regionalization of Hospital Services 1992-5
- Regionalization of Hospitals was Phase 1 of a two Phase restructuring of health care in NB.
- 30 years after the first consulting report recommended regionalization.
- 60 years after Anne Somers' "Health Care in Transition"
- Happy to do it because I believed in it; we were the first in Canada and those involved in leadership believed we could be a model for the country!

A Little History: 1992 reform

- 51 hospitals/health centres, 40+ nursing homes, 400 special care homes, home care a bit disjointed
- Hospitals were assets of the province except church-owned buildings
- 1968-9: Llewellyn Davies Weeks: regionalize
- 1989: McKelvey Levesque: regionalize
- 1991: Medical/Nursing/Hospital Association: regionalize
- 1992: 51 boards abolished, replaced by 8 regional boards (7 hospital regions and EMH)

More History!

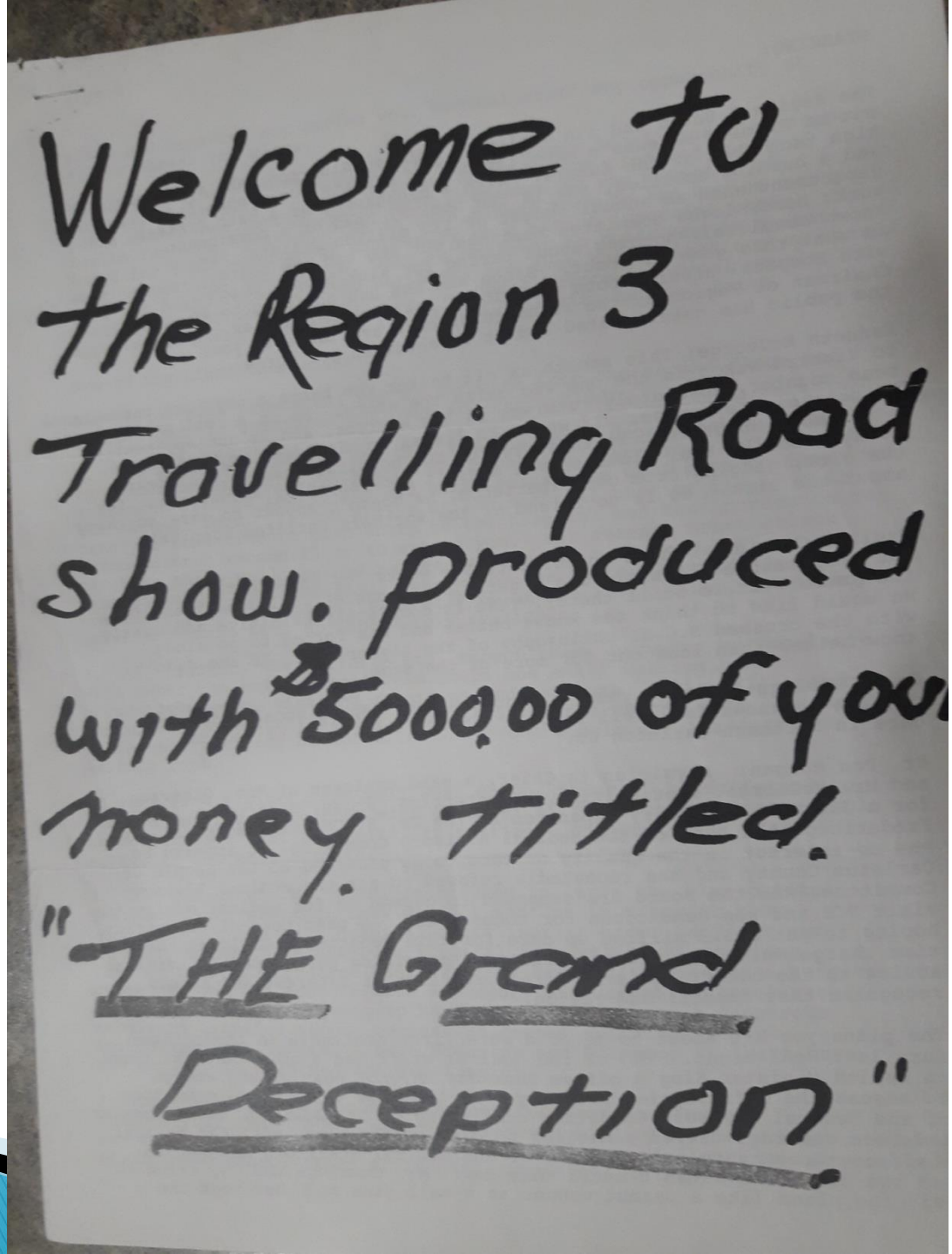
- 1996 The Extramural Hospital corporation was dissolved; merged with hospital regions
- 2002: 7 regional hospital boards were dissolved and replaced by 7 health authorities; Premier's Quality Health Council recommendation
- 2007 Dialogue Sante, extensive public consultation in the Acadian Peninsula
- 2008: 7 RHAs merged into 2 health authorities based on cultural and linguistic considerations

A Little More History: prior to 1992

- Most hospitals were struggling with capital and operating costs
- Costs to government spiralling 2-4 times inflation since 1959
- Competitiveness between communities even minutes apart
- Clinical interventions best done in a place with back-up
- A disaster for Department of Health with 51 hospital/health centre boards all competing for dollars

Lessons from 1992

- Condition and educate the public
- Ensure physicians and nursing staff are aware, hopefully onside, serve as ambassadors for change
- Strong management and leadership development
- Organize in a way that promotes integration and working together between communities
- Importance of engagement: do's and don'ts
- The Rural/Urban Divide
- Learn from others' successes and failures


Welcome to
the Region 3
Travelling Road
show. produced
with $500,00 of your
money titled.
"THE Grand
Deception"

By 1995 the political heat had taken a toll……

Thursday

The Daily Gleaner

Forecast
Today, sunny with cloudy periods. Maximum uv index 5.9, a moderate value. Winds northwest 20 kmh. Highs 22. Tonight, clouding over with showers developing. Lows 13.

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cKenna Promises No More Cuts

Health Care Spending Maintained

By DAVID MEAGHER
Staff Writer

New Brunswick under a new Liberal government would meet or exceed national health care standards in such areas as surgical waiting lists and the number of hospital beds and physicians, Premier Frank McKenna promised yesterday.

The premier also promised further investment in prevention programs and the expansion of TeleCare and TeleMedicine programs.

He promised, moreover, that a legislature committee would hold public hearings on the accountability and governance of hospital boards.

These initiatives were contained in the Liberal Party's health care policy released by the premier in Ste.-Anne-de-Kent.

Frank McKenna

Brunswick is five beds per thousand residents. The Canadian average is 4.5.

The New Brunswick ratio is based on the McKelvey-Levesque Commission recommendation, but it also recognizes that New Brunswick's rural nature requires more health care facilities than would otherwise be the case, the premier said.

The premier recommitted his government to increasing the number of doctors but in an orderly way.

New Brunswick has one doctor for every 606 people. The target is to increase the ratio to one doctor for every 595 people by 2001.

The World Health Organization recommends a ratio of one to 600. The Canadian average stands at one to 611; the Atlantic average is

Health Authorities

- Horizon became one of the largest health authorities in the country
- Government acceded to public pressure to construct boards that do not resemble standards of good governance
- Both health authorities pushed into a centralization and consolidation mode with leadership and decision-making centralized
- Critics suggest they are too large to be managed for excellence
- Other critics suggest merging into one super-health authority; tried and failed in Alberta

The Reality:

- Health and Social Services accounts for nearly 50% of the Provincial expenditures; this will grow at rates 2-3 times inflation for the foreseeable future! Structural cost drivers!
- Simply concentrating on micro-cost management and re-organizing the head office will never, never lead to sustainability.
- Getting to a better place requires:
  - Serious political understanding
  - Serious political commitment to a new day
  - Courage to innovate and support tough decisions
  - **Commitment to patient-centred focus!**
  - Higher level of engagement of physicians, nurses, unions, and others interested in the system

More Reality:

- Jeffrey Simpson in *Chronic Condition* refers to Canada's Health System as **the third rail in Canadian Politics; touch it-you die!**
- Dr. Danielle Martin, in *Better Now*, says emphatically: "**we know what we have to do to fix the system; we just need to do it!**"
- Physician resource management is completely absent
- Sources of push-back:
  - Professions; unions
  - The Medical Industrial establishment
  - Compensation models
  - Disinformation at local level (votes)

More reality

- Population demographics: NB and NS vie for oldest population; https://nbhc.ca/
- Well spelled out in “Over The Cliff” by Richard Saillant
- Secondary, tertiary and quarternary care must be consolidated for quality and cost reasons
- Some health care organizations have limited problems recruiting and retaining great staff….why?
- Hospitals are risky places so you want the shortest stay possible, if any….
  - Cross infection
  - Iatrogenic disease

The Evolution: since 1995

- Subsequent governments ignored a plan
- Long Term Care struggles
- Health and Social Development split
- Workplace culture issues
- Rural health strategy not there yet
- Centres of excellence with Cardiac Services, Cancer Dx and Care, Ophthalmology
- Each clinical specialty was to get organized for excellence but that process has lagged

THE BIG VOID OF UNDERSTANDING & COMMUNICATION

Departments of Health & Long-Term Care

- Regulation
- Standards
- Legislation
- Inspection
- Ministerial Advice
- Budgets/ Finance
- Planning
- Policy Analysis
- Capital Financing
- Health Manpower Policy
- Over-Regulation & Management at a Micro Level
- Employment Security
- No Accountability for Errors in Judgement
- Unrealistic Expectations for Governance
- Almost no Financial Support for Education
- Limited Participation by Civil Service Staff in Continuing Education
- Ambiguity in Direction
- Facility Planning Process wanting for Expertise

Impacts of the Gulf of Understanding

- Nil Collegiality, Comeraderie
- Flawed Program Roll-outs
- Tension
- Lack of Trust: Both Ways
- Toxicity

Clinics, Hospitals, Long-Term Care Facilities: The World of Service Delivery

- Physician Offices
- Physician Recruitment
- Nurse Education & Recruitment
- Nurse Practitioner Development
- Hospitals & Health Care Politics
- Trade Unions: Negotiating; Contract Admin
- WorkSafe Issues
- Accreditation & Standards
- Financing Old, Out Modeled Funding Formula
- Capital Financing
- Health Manpower Shortages
- Public Image, Accountability
- Litigation Issues
- Fundraising
- Governance Issues including Education/ Training
- Training Generally
- Assessment Process: Financial, Care
- Quest for Excellence
- Managing Ambiguity
- Budget Confirmation 6 Months into the Fiscal Year

The Way Forward

- Serious **acknowledgement** that the public is not nearly as well served as may be thought;
- Serious **commitment** to excellence by government, health, DSD, and health authorities
- High level willingness to external review
- **Health Council structure** and mandate to be changed
- **High level commitment** to major change in culture: Patient Centred Model (Planetree?)
- **Jim Sinegal, Costco**: "culture is not the most important thing; it is the ***only*** thing!"

The Way Forward, cont'd.

- Major priority on leadership and culture.
- Appoint people to leadership who have all the requisite personal, training, education, and certification requirements of the position; this system needs overhaul.
- Accelerate, in conjunction with the Medical Society, the Nursing and other professions, the development of alternate models of Primary Care Services
- Appoint a Health Restructuring Commission, body composed of external expert advisors to oversee new directions

The Way Forward, cont'd:

- All Party Committee of the Legislature to become conversant with the real issues
- External Reviews modeled after either Clinical Academic Program Reviews or the Ontario Inspector/Supervisor system
- Create a Centre for Health Leadership and Governance Excellence
- Use Commissions or some such arms length entities.

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HELP WANTED

Bold political leaders with the guts to take a troubled province in a brave new direction.

Also needed: An electorate that is willing to get out of the way and let them do their job.

Summary

- Insanity is doing the same old things the same old way and expecting a different result.
- We do have some excellent clinical programs and personnel.
- But the inconsistencies are atrocious and unnecessary.
- I have personally managed better, received better, seen better with my family who live elsewhere
- We can do better…….leadership and vision!
- Ken McGeorge, 447-7947; kenmc1@bellaliant.net