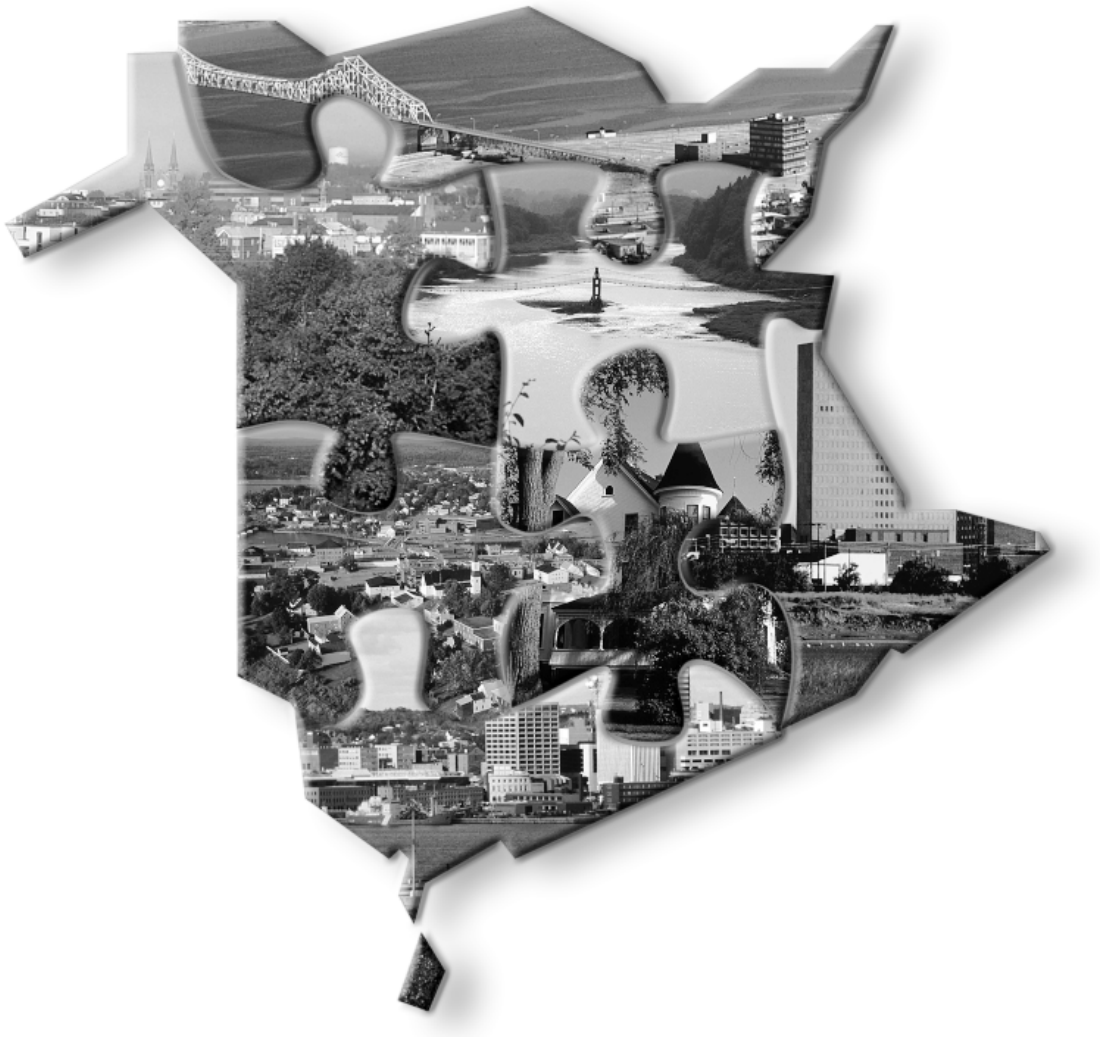
HEALTH *Renewal*

Report from the

Premier's Health Quality Council



New Nouveau Brunswick
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Executive Summary

The Premier's Health Quality Council was established in January 2000 by the Premier with a specific two-year mandate to:

- Develop an action plan to move to a system of Regional Health Authorities and Regional Health Boards;
- Oversee the development and implementation of the Health Care Report Card, health quality standards, and performance measures;
- Assist in the development of the Patient Charter of Rights and Responsibilities;
- Provide advice on the implementation of the recommendations of the Health Services Review report conducted with New Brunswickers in 1998/1999.

In mid-2000, the government of New Brunswick also requested specific recommendations from Council on primary care reform, in light of the Federal Government's commitment to the renewal of primary care.

To address these many tasks, Council reviewed experiences from other jurisdictions and advice from health policy experts and health professionals. From these, Council concluded the proposed government strategies were positive ones. Yet, it quickly became apparent that more is needed if the province means to achieve a sustainable, community-based and person-focused health system, capable of continuously responding to the province's health needs.

Today's health care system consists of people, programs, processes, technology, organizations, and structures. Successful outcomes depend not only on each individual part but on how each part fits into the whole, thereby providing patients with improved access and better health care service delivery.

Council worked to develop a blueprint to guide New Brunswick's health. Essential to this blueprint, is a clear vision which describes the goal for our health care system and outlines it. This vision will serve as a reference point for government, policy makers, managers and health service providers, allowing individual initiatives to contribute to a common goal. Council's proposed vision serves as a starting point and will need to be complemented with the input of all stakeholders. Undeniably, this will be challenging and will require dedication and cooperation from all stakeholders; including government, health professionals and communities. However, if achieved, this vision will result in better health care for New Brunswickers and a work environment that allows providers to excel in their respective professions.

Themes

This report is organized around the components of the mandate set out for Council. As Council worked to set out a blueprint for the future of New Brunswick's health system, four themes emerged. These themes are:

- Integrated and Accessible Health Care System
- Management Structure and Accountability
- Rights and Responsibilities
- Program Improvements

Council has developed a number of key targets within each of the above themes. The provincial government may choose to address these targets separately as some of the targets are independent of each other. For example, the Charter of Rights and Responsibilities recommendations can be carried independent of establishing he Regional Health Authorities. However, in other cases there are dependencies. The Report Card target, for example, does depend on the implementation of the health research and information technology recommendations. Therefore, Council recommends that a holistic approach be adopted for the renewal of the health care system.

Note that action on the recommendations related to Management Structure and Accountability can proceed independent of the timing of action on the other recommendations and Council recommends that action be taken accordingly.

The key targets within each theme are as follows:

Integrated and Accessible Health Care System

- Integrating a wellness focus alongside the current treatment focus
- Local/provincial requirements
- Definitions of primary, secondary and tertiary care for purposes of access and sustainability
- Community Health Centres for access and effective use of resources
- Regional Health Authorities for integration of generic delivery and local responsiveness
- Redefining the roles of health professionals
- Creating a single electronic patient record

Management Structure and Accountability

- Evidence-based management
- Innovation and continuous improvement
- Management practice (integrated plan/budget)
- Information system
- Health research institute
- Report Card

Rights and Responsibilities

- Charter of Rights and Responsibilities
- Public Trustee/Guardian
- Citizen Advocate
- Advanced Health Care Directives

Program Improvements

- Provincial Health Plan
- Short term care
- Long term care
- Ambulance
- Pharmaceuticals
- Public Health
- Mental Health
- Rehabilitation

To be person-focused and community-based, the delivery of health services must move away from the current management by program approach. Instead, Council recommends that services be integrated and offered as a continuum. Service sites and health professionals must coordinate access, ensuring each patient receives the right service at the right time by the right person in the right place.

Implementing the recommendations put forward by the Premier's Health Quality Council in this final report will require the adoption of a change management process that is inclusive of various stakeholders. Given cost implications and current health professional shortages, the government may choose to implement some of the recommendations over time. However, Council strongly recommends that the government foster the engagement of community stakeholders, including health professionals from the outset.

The Department of Health and Wellness and the Regional Health Authorities must actively demonstrate a leadership that will invite the participation and ideas from citizens within the regions, health professional organizations, employees and involved unions. Ongoing consultation and open dialogue must take place at each stage of the process.

The government has an opportunity to instill a new culture within New Brunswick's health system; one that is forward looking, thrives on innovations and continuous improvement and one that introduces change through a participatory approach. The Premier's Health Quality Council firmly believes that such a culture is imperative for a health system that meets the changing needs of New Brunswickers, today and tomorrow.

1. Introduction

1.1 The Council

The Premier's Health Quality Council was established in January 2000 by the Premier with a specific two-year mandate to develop an action plan to move to a system of Regional Health Authorities and Regional Health Boards; oversee the development and implementation of the Health Care Report Card, health quality standards, and performance measures; assist in the development of the Patient Charter of Rights and Responsibilities; and provide advice on the implementation of the recommendations of the Health Services Review report conducted with New Brunswickers in 1998/1999.

The Premier appointed fourteen members from across the Province to Council representing a wide array of interests, expertise and perspectives, including health administrators, front-line service providers, academics, researchers and consumers. The full membership of Council can be found in Appendix A.

To fulfill its mandate, Council built a knowledge-base upon which advice and recommendations could be developed for the Premier's consideration. To build this knowledge base, Council:

- Held three-day monthly meetings of full Council. In all, Council will have met twenty-four times;
- Established a number of sub-committees who met in order to more fully explore specific issues. Sub-committees were established in areas such as Governance, Report Card, Charter of Rights and Responsibilities, Primary Care, Secondary and Tertiary Care, Roles of Health Professionals and Accountability Framework;
- Held a series of 'think-tank' dialogue sessions with front-line service providers to more fully understand the programs and services offered under the umbrella of the health system and to benefit from their perspectives on how to improve the system;
- Invited a number of speakers and experts in various related fields to share their knowledge and views with Council;
- Built a knowledge-base around best-practices as identified in the current literature;
- Held public sessions across the province to ask New Brunswickers' views with respect to the changes needed in the health system; and
- Met on a continuous basis with government departments who now impact on the health system and who will be impacted by the implementation of government's decisions.

1.2 The Context

Like all Canadians, the people of New Brunswick consider the health system to be a priority. In most instances, New Brunswickers who have accessed the system were satisfied with the quality of the services they have received. Still, there is a growing unease that the system may not be sustainable in the future and New Brunswickers have repeatedly identified problems and inefficiencies in our health care system.

As in many parts of the country, New Brunswick's health system continues to face challenges in delivering health services efficiently and effectively. Costs continue to rise and despite significant increases in health care spending during the past two years, New Brunswickers still have a system that is not meeting all of their needs. Due to a nation-wide shortage of health professionals, accessing the system is a growing challenge for many New Brunswickers. Yet, thousands of health professionals work very hard to ensure that each New Brunswicker receives the best possible care and service available.

Fundamental change is needed to ensure our health system is truly responsive and sustainable. Governments across the country are now grappling with this same task and are searching for alternative methods and approaches that will ensure a sustainable and responsive health system. The challenge is not limited to the way services are delivered, but also encompasses how health professionals work within the system.

A central problem is the lack of a vision to guide planning and priority setting. There are difficulties in accessing the system on a timely basis, tracking individuals and their care throughout the system and determining who is responsible for what. In many instances, these difficulties can affect the quality of care and the costs of providing care.

Also, there has been little investment in wellness, resulting in a system more concerned with disease management rather than prevention of illness and health promotion for individuals, families and communities.

The health of the New Brunswick population is not determined by investment in the health system alone. It is socially determined by income, working conditions, environment, early childhood development, education and social support, as well as lifestyle choices and health care services. Sustainable change in the health of New Brunswickers must be an outcome of all these factors.

In addition, there is a general feeling of disenfranchisement among the population and providers within the system. Over time New Brunswickers feel they have lost their voice in the decisions that affect their lives and their communities. Local initiative and good ideas have been lost because of the over-centralization of decision-making authority.

To build a healthy system for the future we must address the realities and the problems within our current system. More than ever we need to develop a long-term vision that focuses on individuals and communities. We need to develop a system that is more concerned with good health as a way of life, a system that can sustain itself and be there for New Brunswickers in the future.

1.3 Evolution of the Mandate

Council's mandate was essentially to develop a blueprint that would move New Brunswick's health system to a person-focused, community-based reality. To do so, Council is bringing forward in this report recommendations for a governance structure that will allow for greater participation and public accountability through the advent of the Report Card and the Accountability Framework. This report recommends a process by which New Brunswickers can be informed of the rights and responsibilities all citizens have towards their own health, as well as a number of recommendations on how current programs and services can be improved.

A true renewal of the health system must be open to innovation. It must go beyond structural change and include process changes. It needs to be predicated on a shared vision and be coordinated to achieve efficiency for the system and better quality service for the people who access the system. Improved information systems are essential and will require new investments.

The lack of a coordinated and integrated primary care system has led to an over-reliance on, and often inappropriate use of, our hospital facilities. Our health professionals, many of whom are in short supply, often work in isolation from one another. Also, health professionals are not being utilized to their full potential, even while each brings education and a host of skills to the system.

Council therefore invested a significant portion of its time developing recommendations on the health system itself. Focusing on primary care, Council attempted to sketch a blueprint that would ensure that each person receives the right service at the right time by the right person in the right place.

1.4 The Report

Council is pleased to present this Report to the Premier for consideration. In its entirety, the Report represents Council's best advice on a blueprint for change. Council took the mandated responsibility seriously and realized the challenge such a mandate presented. Due to the complexity of the health care system, Council does not purport having considered all aspects and all issues confronting the system. A blueprint is a first step in effecting true, sustainable change. Many challenges remain for government on the road to implementation. Yet both the population and the health professionals are ready for change. The keys to success include the continued involvement of all stakeholders and a willingness to be bold and creative. The keys to sustainability include the will to invest in long-term, evidence-based alterations and the will to rebuild the system without resorting to stop-gap measures.

New Brunswick is not pursuing health care renewal in isolation. The entire country is moving in this direction and New Brunswick must seize every opportunity presented over the next several years recognizing the need to move forward in a cooperative manner with all stakeholders. The responsibility of the government, and of all parties, is to embrace and be responsive to innovation.

2.0 A Health Vision for New Brunswick

Good health is a priority and a way of life for New Brunswickers. A healthy province means having a social, economic and physical environment that enables people of all walks of life to practice good health habits in their daily lives in order to achieve and maintain well-being. This is supported by public policy.

2.1 Introduction

Council's first step was to construct a vision outlining how a renewed health system should perform. The vision provided direction for Council to address the four components of the mandate.

The vision creates the foundation from which to address the various dimensions of a person-focused, community-based and integrated health system. This perspective required Council to consider the structure and processes of the system at both the governance and service delivery levels. For example:

- Moving toward a health governance system consisting of Regional Health Authorities and Regional Health Boards required Council to consider which services should fall under Regional Health Authorities, how these should be structured and where they should be delivered;
- Overseeing the development and implementation of a Health Report Card, health quality standards and performance measures required looking at what is currently available and what will be needed to provide good information to the public and guide decision-making;
- Developing a Charter of Rights and Responsibilities required looking at what rights are and what needs to be in place to deliver those rights and support individuals to fulfill their responsibilities; and
- Providing advice on implementing the recommendations contained in the Health Services Review required looking at the best possible ways to address the areas New Brunswickers identified as needing improvement.

All these dimensions required that Council look at the system in its entirety. Movement on the national scene on primary care reform was yet another consideration and an opportunity for Council to include this at the forefront of its deliberations. It became clear that in order to be true to today's realities and Council's vision, all these areas needed to be included to elaborate on and support the fulfillment of the mandate.

Subsequently, Council is making a number of recommendations for government to consider in all those dimensions to support the evolution of a system based on the proposed vision.

2.2 The Vision

The lack of a provincial vision for health was seen as the largest, most significant gap in the current system. Any blueprint for the future system must be based on a clearly stated vision for the future.

The Health Vision for New Brunswick is considered a long-term commitment by the government and the health system. It is our vision that New Brunswickers, looking at where we are in 2005 will see considerable progress. However, it must be recognized that many elements will still be at the developmental and planning stages.

The Premier's Health Quality Council proposes the following:

Good health is a priority and a way of life for New Brunswickers. A healthy province means having a social, economic and physical environment that enables people of all walks of life to practice good health habits in their daily lives in order to achieve and maintain well-being. This is supported by public policy.

To achieve health as embodied in the vision a fundamental renewal of the health system in New Brunswick will be required, such as:

- Defining health as a state of complete physical, mental, spiritual and social well-being, not merely the absence of disease or illness;
- Making New Brunswickers aware of health risks, healthy lifestyles and factors impacting their health;
- Keeping New Brunswickers informed about health issues and encouraging the population to take pride in active participation as volunteers in their communities and as members of local boards;
- Ensuring health services are provided by teams of professionals working in collaboration, are fully integrated, work closely with community agencies, and are easily accessible at all times;
- Ensuring basic services are available within the community and specialized services are available in secondary and/or tertiary hospitals;
- Creating an electronic health record to follow each individual, and ensuring confidentiality of the record is protected;
- Ensuring individuals are valued, involved and respected;
- Supporting and valuing the professionals working in the system;
- Reporting performance results and health outcomes designed to guide system planning and service delivery;
- Delivering health services in an affordable and sustainable manner; and
- Continuing the renewal process.

This assumes compliance with the Canada Health Act and its five principles; accessibility, portability, public administration, comprehensiveness, and universality.

Principles	*Concepts*
• Quality Health/Wellness	• Mechanisms to support access
• Person-focused	• Community Health Centres - 24 hrs/7 days
• Community Involvement	• Maximize role of each health professional (RN, MD, pharmacist, community health worker, etc.)
• Integration/seamless service	• Service from an integrated, multi-disciplinary team of health professionals
• Shared responsibility for health (people/ health system)	• "Wired and connected" health system
• Accessibility	• One health record per person, with protected access
• Affordability/Sustainability	• Regional Health Authorities
• Accountability	
• Respectful of New Brunswick 's Diversity	

The Council's vision statement translates into a series of important principles and concepts that should guide the renewal of the system:

The principles which anchor the health system renewal are clarified as follows:

Quality health

Positive health outcomes must be rooted in the delivery of programs and services. A quality health system is one that provides the right service at the right time in the right way by the right person in the right place.

Wellness

The health system must focus not only on disease management, but also on wellness promotion. New Brunswickers must live in an environment that promotes health and provides access to illness prevention services and education. They must also have access to health and wellness resources that support responsible life choices and healthy, active lives.

Person-focused and responsive to individual needs

The health system must be concerned with individuals as whole persons, not as parts to be fixed. People should have the support to make informed choices and be encouraged to participate in decisions regarding their personal health care.

Affordable

A sustainable health system for the future must be an affordable one. The health system must look at alternatives to spending increases in an attempt to renew the system. The system should be based on an affordable, long-term plan.

Sustainable

The health system will continue to be available and affordable to all New Brunswickers for many years to come. The system will continue to provide high quality service and invest in and encourage innovation and continuous improvement.

Integrated

The health system must be designed to respond to individual needs and health professionals need to collaborate to ensure continuous, responsive care. Service delivery needs to be appropriately organized and coordinated at each level to respond seamlessly to the individual's needs.

Community focused

Primary care services must be available at the community level. Most secondary services will be available within each region and tertiary services will be available in some regions. New Brunswickers must have equitable access to services. Each community should participate in decisions affecting health services and programs.

Accessible

The health system must respond to family and work reality by offering flexible hours of service based on each individual community's needs. The roles and responsibilities of health providers should be adaptable to individual's needs. The health system must provide measures to eliminate barriers to access arising as a result of the travelling distance between the individual and the service.

Accountable

The health system should inform New Brunswickers about its performance and of its success in attaining its health quality standards. The results of this monitoring and reporting should help influence and direct policies and programs. The health system must remain accountable to the citizens of New Brunswick.

Shared responsibility

Each of us has a stake in the health system. New Brunswickers will understand what they can expect from the health system as well as their own responsibility to make healthy choices for themselves and for their communities to ensure a sustainable health system. Public policy will create an environment that promotes health among New Brunswickers as well as an efficient, effective health care system.

Respectful of New Brunswick's diversity

The health system must be structured to respect community and individual differences. New Brunswickers are treated with dignity and compassion. Cultural, lifestyle, linguistic and geographic differences need to be respected.

3. Proposed Health System

3.1 Introduction

In order to carry out the vision recommended in this report, a significant change must occur in the way services are designed and delivered. Council believes the health system should address the needs of people in an holistic fashion as opposed to categorizing and delivering the services according to isolated needs. Therefore, health care services must be integrated and coordinated in order to be truly person-focused. Needs will vary depending on age and life circumstances, requiring the health system be based on a comprehensive continuum of services ranging from wellness, promotion and prevention services to primary, secondary and tertiary care.

Council's vision calls for a health system which does not focus solely on illnesses affecting only a portion of the population and recognizes that the health system of the future must focus on the wellness of the population. To further this concept, Council supports the need for a wellness strategy.

In its second report (Working Together For Wellness: A Wellness Strategy for New Brunswick, dated April, 2001) the Select Committee on Health Care defined wellness as "a state of emotional, mental, physical, social, and spiritual well-being that enables people to reach and maintain their personal potential in their communities." The report included a Strategic Framework for Wellness that provides direction for government in areas such as government leadership, healthy public policy, linking wellness and illness, collaboration, supporting and sharing best practices, evidence and research, measuring, monitoring, tracking progress and public reporting, citizen participation, and long term commitment. The Committee also recommended government ensure all departments develop a healthy public policy, review existing policies impacting on the wellness of New Brunswickers or their ability to improve their own health. Council advocates the idea that the government should work to identify opportunities to collaborate with the various levels of government, the business sector, universities, non-governmental organizations, and communities to improve wellness.

Council supports the Select Committee on Health Care in its comprehensive and thoughtful recommendations. Council proposes that the government seriously consider the advice and present a wellness strategy to New Brunswickers. The blueprint presented in Council's report is predicated on the implementation of effective initiatives and strategic investments in wellness initiatives.

3.2 Primary Health Care

3.2.1 Definition

Council defines primary health care as individual and community-focused health care that is seamless, integrated, coordinated, accessible and sustainable. It supports individuals, families and communities and helps make the best decisions for their health. It includes information and advice on health education and promotion, injury prevention, individual health assessments, diagnostic and treatment of acute episodic and chronic conditions, and supportive and rehabilitative care. Services are provided by health care professionals who have the right skills to meet the needs of individuals and the communities being served. The primary health care team works in partnership with consumers, and facilitates their use of other health-related services when required. Health care is provided as a continuum of services ranging from public policy, health education and promotion, illness prevention, primary, secondary and tertiary care. The focus of integrated health care is on the coordination of services across the continuum of care, as well as collaboration and communication among providers in the planning and delivery of health care services. Individuals are assured of continuity of care.

3.2.2 Primary Care

The primary care sector encompasses a number of programs and services. Services focus on health prevention and promotion, and the management of on-going chronic problems. It is the sector in health care that is the most extensively used by the population and therefore is present in one form or another in every community. Some services are accessible through the publicly funded health care system (the province pays for the service) while others are offered by the private sector whereby the user pays the provider directly. Using today's terminology and labels recognized by the general population, a few examples of primary care programs and services are listed below to help further define the sector:

- General family medicine / Doctor's Office
- Pharmacy / Clinical Pharmacy Services
- Extra-Mural Program / Home Health Care, Palliative Care
- Mental Health / Centers, Private Psychologist's Office
- Dental Health / Dentist's Office
- Long Term Care / Nursing Homes, Special Care Homes
- Public Health / Immunizations, Nutrition, Sexual Health

- Rehabilitation Services / Physiotherapy, Occupational Therapy, Audiology, Speech Language Therapy
- Outpatient Services and Clinics
- Chiropractor's Office
- Alternative Therapy
- Addiction Services / Detoxification Centers

Unlike secondary and tertiary sectors where services are accessed via the hospitals, the primary care sector tends to have more access points. There are many service sites and programs involving a number of public and private health care providers. Organizationally, most operate independently with their own patient health records system. Communication mechanisms and linkages between the various service sites tend to be unstructured which require the user/patient to be more vigilant in terms of accessing the right care, at the right time, by the right provider.

Many recommendations proposed by the Premier's Health Quality Council for primary care are aimed at improving access to services through a more co-ordinated and structured service delivery, particularly for those primary care services that are funded by the province.

3.2.3 Guiding principles

Council proposes the renewal of primary care be based on the following guiding principles which will facilitate the implementation of Council's vision for a seamless, integrated, co-ordinated, sustainable, person-focused primary care service. The principles are as follows:

Person-focused access

Services must be delivered as close as possible to where people live. Some health services, such as acute care, palliative care and long term care should continue to be provided in the person's home.

The system must clearly inform individuals which primary care services they can expect to receive within their community and where other primary care services are provided if services are not available in their immediate community.

To facilitate access to services, a comprehensive range of ambulatory services should be coordinated from one location. Individuals referred to another provider should be informed who the provider will be and when the service will begin.

Emphasis on health promotion, education and prevention of illness

Primary care includes a vast array of services aimed at maintaining good health and preventing illness as well as the diagnosis and treatment of illness. Primary care providers must reach out to the unmet needs of communities with activities like screening programs, callback service and health education. Educational health programs must be made readily available to the population within local communities.

Community-based, non-institutional setting

Primary care must be provided in settings close to where people live. Primary health services presently provided in hospitals would be transferred to facilities where they will be easier to access. However some expensive equipment, for instance, used by both primary and secondary services, in the same community, should not be duplicated.

In order to increase efficiency and avoid duplication, it may be advisable in some communities for primary care and hospital services to co-locate, however each should be distinctly managed by the Regional Health Authority.

Accessibility of services

Service hours for primary care services must be based on the need of the community and the availability of resources. Hours need to reflect the work and family life of the area. Hours of operation need to reflect the community life. New Brunswickers must have access to services 24-hours a day, 7-days a week.

Coordinated and visible continuum of services

Individuals must have access to a comprehensive selection of primary care services, including health promotion/education/prevention. The range of primary care services would be determined based on the needs of the community and availability of resources. However, access would be coordinated.

Interdisciplinary team approach to service delivery

Each provider or team of health professionals must take responsibility for a community or geographic area, reaching out to fulfil needs. The team will plan and deliver services by focusing on all aspects of the continuum of primary health care including health education, promotion, prevention, secondary, and tertiary care. The roles of various providers would be enhanced by having clearly defined responsibilities amongst the various professions involved. The goal is to make full use of all providers based on their respective knowledge, skills and abilities.

One electronic health record per person (secure and confidential)

Primary care service providers should have access to a single individual electronic health record per person/patient. This would ensure that appropriate information is available regardless of where and how (in person or by phone) people access services. Providers would not need to depend only on the patient's ability to explain services and treatments he or she received previously from another health service provider and will help improve utilization of services and treatments, including prescription drugs.

Achieving the one electronic health record per person would require particular attention to confidentiality. This health record system should be built on "a need to know" basis in terms of provider access. Protocols should be established to ensure the person/patient becomes the "owner" of his or her electronic health record, thus promoting the concept that the patient would control as much as possible who would have access to the record. There should also be an understanding that access would still be obtained for medical emergency reasons if the patient is unable to communicate permission to do so. The record should have a tracking feature that allows the patient to see who has accessed his or her health record.

Services sites and providers are electronically linked

Primary care service sites, including physicians working in solo and/or in group practices and other settings, must be electronically linked as part of the health system. This would allow electronic exchanges that would improve communications and service delivery processes, including access to the patient's electronic health record. The primary care sector must also be electronically linked to secondary and tertiary care facilities.

3.2.4 Primary Health Service Delivery

Delivery Distinctions

The variety of services in primary care is not only exemplified by the different providers involved but also by the various settings from which the services are dispensed.

The majority of services are accessed by individuals and groups traveling to service locations. It is recognized some service providers go to the location of the individual or of the client group. Programs such as Extra-Mural and Public Health are just two examples where the majority of the providers would go on-site to deliver services (home, schools, nursing homes, community centers, etc.).

Council proposes these distinctions must be incorporated into the redesign of the primary care sector.

Service Delivery

The Premier's Health Quality Council recommends that the renewal of the health system include the notion of offering services as close as possible to the person. Advances in medical treatments and technology increasingly make this goal more attainable. Interventions that in the past would only be performed in secondary and tertiary facilities are now being provided in primary care settings or in the patient's home.

Council acknowledges that at present many primary care services are provided from the physician's office and that this situation will continue. However, to enhance local access Council recommends all primary care services where feasible should be provided or coordinated through a network of Community Health Centres. While it will take time to achieve this objective, the government can build on the models presently operating in the province.

Certain elements were identified as essential to the establishment of Community Health Centres. Council considered it essential that:

- The Community Health Centre be viewed as the physical "nucleus" of primary care in the community;
- Basic health care services, including basic emergency services, be accessible 24 hours a day, seven days a week;
- Community needs determine the full service hours and the range of services provided by a Community Health Centre;
- There is an interdisciplinary team approach to service delivery;
- Continuity of care be supported by the creation of one electronic health record for each citizen;
- Larger communities may need to have more than one Community Health Centre; and
- There would be no acute care beds.

The extent to which Community Health Centres should offer all primary care services will vary depending on the size and needs of the population within the Community Health Centre's catchment area. For those communities, some primary care services would be available only in larger centres, however the local Community Health Centre should be linked with the larger centre and referral will be facilitated.

Community Health Centres should perform a triage and intake function and an assessment and diagnostic function including basic x-ray, specimen collection transportation, basic laboratory, and EKG. The treatment and intervention function will need medical, surgical and pharmaceutical supplies and a treatment room to support family medicine and basic emergency health care services. Health information, health education and promotional programs and illness prevention must also be part the services one will find in a Community Health Centre.

Although patients and clients will be encouraged to make appointments to access services, some services would be available by phone and basic emergency services will be available during all hours of operation. Individuals should be directed to the appropriate services and whenever possible appointments should be arranged before individuals leave the centre.

Council proposes that every New Brunswicker should have a family physician in order to ensure continuity of care and best possible outcomes for patients, and to facilitate physicians offering the best possible care. However an individual without a family physician and in need of medical attention would be able to access medical services at the Community Health Centre through the attending physician until arrangements can be made for a family physician. This would also apply to an individual whose regular physician is unavailable, with the information going to the family physician at the end of each day.

Council recognizes that various access points to primary care will continue to exist, including the office of a physician who works collaboratively with a nurse or with other colleagues. All service sites will be linked to the closest Community Health Centre for purposes of referring patients for other services and for medical coverage for the physician practice outside of office hours.

Through the collaborative model and a team approach to providing primary care, Council proposes that it should not be necessary for the family physician to see every patient with a basic medical need. Other members from the team of health providers could provide consultation and/or perform treatment services. These other providers could be accessed via telehealth and/or on site at the Community Health Centre. For continuity of care purposes, however, it is important that the family physician continues to play a central role in the patient's care plan. Effective communication mechanisms, including the electronic health record, should be established to support the key role that the family physician must perform.

Services provided at the Community Health Centre must be delivered in a way as to support and complement the work of the physician/nurse collaborative team being performed in the physician's office. These services could include:

- Provision of general information regarding health related services, locations and access processes, including facilitated referrals;
- Education and promotion of healthy lifestyles for children, adults and seniors;
- Comprehensive child health services which include pre-natal and post natal care, breastfeeding counselling, early childhood development/school readiness, parenting / life skills training, nutrition, immunization, well-baby and pre-school clinics;

- General family medicine supported by basic diagnostic tools and equipment;
- Health promotion and disease prevention clinics as well as chronic care follow-up, and risk behaviour management;
- Sexual health education and counselling, and treatment of sexually transmitted diseases;
- Palliative care services, including pain management;
- Geriatric assessment; and
- Medication assessment and education.

Access to basic emergency health care

Individuals must be assured of available expertise to respond to their health needs around the clock in person or by phone. Some Community Health Centres would not be open 24 hours a day, however when those sites are closed, phone calls would be re-directed to an around the clock service site. For those accessing the service site in person, they would be informed where they may physically access the nearest service site.

Council advises the evolution of Community Health Centres and their location be guided by the number of people, the number of physicians and other health care providers available, with each Centre reaching out about 50 km. A Community Health Centre or a secondary care facility providing such service would be staffed full time with a nurse with access to a physician on site or by telephone. As a result, there would be less pressure on emergency rooms at secondary and tertiary hospitals.

At present, a Telecare program complements the emergency service. The service is provided by nurses and may include assessment and referral, health information and education, and self-care support. During the public and stakeholder sessions, Council heard both positive and negative comments related to the service. Some regions of the province make good use of the service and residents are encouraged to use the system by the existing health care staff. In other areas people will still fill up emergency rooms after accessing the Telecare service, regardless of the advice received. Consequently, Council recommends an external review of the Telecare Program.

Each Regional Health Authority may choose to enter into a contract with Clinidata. After an evaluation of the current contract, Regional Health Authorities may expand the present arrangement so those callers referred to a Community Health Centre or an emergency room are expected, and all information is relayed to the family physician. A means for integrating Clinidata calls into a single health record would be essential in the provision of seamless care.

Council acknowledges the present fee-for-service system for physicians is a barrier, preventing innovative approaches to the delivery of primary care. Our research is suggesting that a salaried arrangement or other form of compensation will need to be present in order to implement the Community Health Centre model. Council also proposes that physicians should not be coerced to work in Community Health Centres but should be encouraged to do so with specific incentives.

Ambulance Services

Ambulance services constitute an integral and essential component of the health care system. The service provides a safety net to New Brunswickers as they increasingly depend upon a reliable system of pre-hospital emergency care. Ambulance service is more than a transportation service; it brings patient care available in an emergency service department to patients. As a result of the restructuring of hospital-based health care, the need to transfer patients between health care facilities has increased. Also, this restructuring resulted in an increased severity of illness being treated during transfer. An effective ambulance service is necessary to support a patient focused, community-based health care system. Further changes to the health care system may necessitate a revision to the air ambulance program including the addition of helicopter capability.

It has been demonstrated that a well developed ambulance service reduces death and the degree of illness or injury by delivering rapid and effective pre-hospital care. The key components of a well developed ambulance system include:

- An emergency 911 telephone system;
- A dispatch system that rapidly assesses caller needs and dispatches appropriate resources;
- The capacity for an ambulance to reach the person in need as quickly as possible, ideally in less than 10 minutes; and
- The ability of ambulance personnel to provide life saving interventions, for instance CPR, airway management, defibrillation and oxygen, fluid and drug administration.

In 1999, government directed the Department of Health and Wellness to conduct an internal review of ambulance services. This review was intended to provide policy options for future consideration in the design, delivery and funding of ambulance services. The process included consultation with stakeholders, a national survey regarding the provision of ambulance services and consultation with an expert panel on Emergency Medical Services systems.

In terms of delivery costs and response time, the review revealed that New Brunswick's ambulance services system is generally in keeping with most provinces. In areas such as centralized dispatch, vehicle procurement and system administration, New Brunswick is viewed as a leader. However, in several other areas, major improvements are required, most notably: the lack of formally established response times, the absence of provincial medical direction, the relatively low level of training of ambulance service personnel, and the lack of a planned approach to the provision of Advanced Life Support services.

Council supports several key recommendations put forth by the review process. These recommendations should be implemented in collaboration with Regional Health Authorities and the appropriate stakeholders. The review recommended:

- An emergency response time for ambulance services. The urban response time should be less than 9 minutes for 90% of calls; the rural response time should be less than 25 minutes for 90% of the calls. Response time is defined as the time interval between the receipt of the call for assistance, by the ambulance dispatcher, and the arrival of the ambulance at the scene.
- Provincial medical direction for ambulance services. The involvement of physicians will provide the mechanism to enhance clinical programming, to address public education needs, and to develop system linkages and integration.
- Basic Life Support (BLS) be established as the minimum clinical service level province-wide and the training for ambulance personnel be consistent with the competency profile approved by the Canadian Medical Association. Clinical service level refers to the type of care the ambulance service is mandated to provide and the clinical expertise of the service providers. This will result in an increase of training hours from 350 to approximately 1200 hours.
- Advanced Life Support (ALS) should be provided where feasible. With ALS, patients are artificially ventilated, intravenous lines are started, EKGs performed, and medication administered. Decisions to offer the ALS should be based on evidence. The information should clearly demonstrate that an Advance Life Support service has positive patient outcomes.
- Further integration of ambulance services personnel into the health care system. This can be accomplished by identifying appropriate and feasible opportunities to expand the scope of their involvement in health care delivery without negatively impacting response times.
- A single centralized dispatch for land and air ambulance. Through a dispatch function, a request is evaluated by trained personnel and an ambulance response initiated. As well pre-arrival service is provided to the caller. Saint John is the only area with its own ambulance dispatch service.

Additional recommendations from Council

Although Council supports the single centralized dispatch function for ambulance service, it recognizes the lack of coordination between the dispatch of ambulances and other emergency service dispatch functions, including fire department and police based first responder medical assistance programs. (First responder refers to police, fire fighters, and other individuals, such as lifeguard and industrial first aid attendants, who respond to emergency medical situations.) Council recommends the examination of the current medical first responder agencies in order to encourage increased integration and a more efficient service. Where examination warrants, Council believes a first responders program should be established to shorten emergency response times. It is likely many such programs would be required in rural New Brunswick, where response times are longer. Also Council recommends the introduction of a common dispatch center to promote a more integrated approach to the dispatch of all public safety services.

In accordance with the Internal Review Report recommendation, Council recommends the reduction in the number of land ambulance service contracts. There are currently 52. In the proposed system the number of service contracts would coincide with the number of health regions, as a first step toward consolidation.

Inter-facility transfers, such as trips between hospital and nursing home, account for a majority of annual ambulance calls. No distinction is made between inter-facility transfers and other more urgent calls such as motor vehicle and job site accidents or calls from New Brunswick residents. Some efficiency could be achieved by exploring alternative transportation systems for the non-medical transfer of patients between hospitals and nursing homes.

At the present time the following functions are centralized: central ambulance dispatch, revenue management, vehicles and equipment procurement, and quality monitoring. For these, centralization was introduced to increase the effectiveness of ambulance service delivery and the four services are provided privately, by contract with the Department of Health and Wellness. Council is not aware of any major issues that would suggest changes to the present arrangement. Future decisions to modify the present infrastructure should be evidence based.

Regional Health Authorities Responsibilities

At present, primary care is not managed as a system. It consists of a myriad of doctors' offices, clinics, after-hours clinics, services offered by Regional Hospital Corporations within and outside hospital walls including the Extra-Mural Program, 19 existing health centres and Addiction and Detox Services. It also consists of programs and services provided by the Department of Health and Wellness, such as Public Health and Mental Health Services, Long Term Care and Nursing Homes provided by the Department of Family and Community Services.

In order to achieve the vision of a truly person-focused, integrated, and coordinated health system, Council recommends placing the delivery of primary care under the auspices of a single governance structure, the Regional Health Authority. Placing the full range of primary care within a single regional governance structure will refocus health care in the province. Under one structure, stakeholders can better look at the important issues and challenges in primary health care: its organization, the elimination of gaps, the reduction of silos between services, the continuity of care among primary health services and cooperation with secondary and tertiary services. Regional Health Authorities would be responsible for working with family physicians and other health professionals to enhance the delivery of the primary care system. They would identify the primary health care needs of the population within their respective regions and play an active part in the development of a provincial health plan. All services would be managed in a manner that focuses on the needs of individuals and communities and integrates services and programs in the region.

As well, Council recommends that Regional Health Authorities be responsible for the provision of ambulance service in their region. Subsequently Regional Health Authorities would be expected to enter into an agreement with a provider. The agreement would reflect provincial approved program standards and performance indicators and would be consistent with the provincial health plan. The Regional Health Authorities would also provide the necessary funding and monitor the effectiveness of the service. Regional Health Authorities would submit for approval a three-year plan for ambulance services in their region.

Consistent with other programs under the management of Regional Health Authorities, the Department of Health and Wellness would be responsible for setting program standards and performance indicators, and approving the regional health plan. In addition, Council recommends that the Department of Health and Wellness support Regional Health Authorities in their effort to integrate programs and services at the regional level.

The Roles and Responsibilities of Regional Health Authorities are described in the Chapter on Accountability Framework.

Role of Department of Health and Wellness

As stated previously by Council in its Health Renewal Discussion Paper, the Department of Health and Wellness will need to modify its role for the future. The primary responsibility of the Department would be to establish the health system's priorities and overall direction through the Provincial Health Plan. Regional Health Authorities would manage and deliver the services and programs in accordance with the Provincial Health Plan. Therefore the Department of Health and Wellness responsibilities in the delivery of health services will be diminished.

However, Council believes that some programs and services should continue to be managed by the Department of Health and Wellness. These would include the Office of Chief Medical Officer, Public Health Inspection, Medicare, Prescription Drug Program, Provincial Epidemiology, Provincial Cancer Registry and Vital Statistics. These programs and services require a small number of very specialized professionals; central management of these ensures the best utilization of those resources.

In 2000, the Auditor General carried out an audit on Food Establishment and Potable Water inspections. The Report of the Auditor General – 2000 indicated a greater need for provincial accountability and control. The Auditor General drew specific attention to provincial/central monitoring, the control of regulatory functions, a lack of consistent application of regulations, and the lack of appropriate supervision and management at the regional level in both the Food Service Establishment and Potable Water. Council believes that a more direct control of food and water inspections allows the Minister to be more responsive and accountable for public health inspection and the safety of the public. Council is also recommending that Regional Health Authority staff, under the direction of the Provincial Office of Chief Medical Health Officer, carry out the investigation of infectious disease outbreaks.

3.3 Secondary and Tertiary Care

3.3.1 Introduction

A renewal of the primary health care system calls for a revised role for hospitals in New Brunswick. A shift in the allocation of resources should then logically follow, as should a redefinition of the role and responsibility of hospital-based services. Both are key for the success of the health renewal. Hospital care needs to focus on two levels of care: secondary and tertiary. To ensure the health system is delivering client focused, coordinated and integrated health services, a close relationship must continue to exist between the hospital system and primary care sector.

Providing service to a small and dispersed population (a little over 50% of the 753,000 New Brunswickers live in rural New Brunswick) is a challenge for the delivery of public services in general. This is particularly true for secondary and tertiary health care services that rely on advanced equipment and skills. For example, acute medical care and surgery require physicians, nurses, and other providers with special training. Diagnostic tests such as computerized tomography (CT), ultrasound, magnetic resonance imaging (MRI), require specialized technicians to operate the equipment and radiologists to interpret results. Most hospital care services are utilized by a small percentage of the population but must be accessible by all.

Attracting and keeping physicians and other highly trained personnel needed to deliver specialized services in New Brunswick continues to be a challenge. With the shortage of physicians, nurses and hospital pharmacists across Canada, the challenge is even greater. This shortage of resources will impact the delivery of all health services but particularly hospital related services.

3.3.2 Definition

Secondary care services consist of specialized care requiring sophisticated and complex diagnostic procedures and treatment processes normally provided in a hospital. Tertiary care services consist of care that requires highly specialized treatments and skills; usually expensive treatment or diagnostic modalities supported by special technology and specialized support services.

Some secondary and tertiary services are delivered on an outreach basis in primary care facilities, patient's home or secondary care facilities, and these services are clinically managed (diagnostic assessment, care planning and monitoring) and supported by the secondary or tertiary care facilities

Secondary Care Services

The major secondary care services provided in the province consist of the following:

- Anesthesia (general and specialty)
- Cardiology
- Complex Primary Care
- Dermatology
- Emergency Services
- General Internal Medicine
- Geriatrics Medicine
- General Surgery
- Infectious Disease
- Nephrology Outreach Services
- Medical Oncology Outreach Services
- Neonatal Intensive Care
- Obstetric/gynecology (Basic)
- Obstetric/gynecology (high risk)
- Otolaryngology
- Ophthalmology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Psychiatric Care (short term)
- Secondary Lab Services
- Urology
- Secondary Rehabilitation

Tertiary Care Services

The following services fit in the tertiary care category:

- Cardiac Surgery
- Neonatology
- Neurosurgery / Neuro Intensive Care
- Nephrology
- Oncology
- Tertiary Psychiatry
- Tertiary Rehabilitation

3.3.3 Guiding Principles

Fundamental to change in any system is adherence to a set of evidence-based guiding principles for decision-making. In a system as large and complex as our health care system, decisions involve a large number of stakeholders, making these principles even more indispensable. New Brunswickers are very concerned about the reliability and sustainability of their health care system and each day witness or hear about the system's failings or successes.

Because of demographic changes, the future will be an environment of increasing demand, stretching resources in terms of the availability of health care professionals and financial resources. Therefore it is critical that decisions are made on the basis of sound evidence. Accordingly Council identified several key principles that should be factored into all decisions related to the Provincial Health Plan:

- Quality – maintaining critical mass and aligning dependent services together to ensure best patient outcomes
- Sustainability – enhancing the long term viability of services
- Accessibility – proximity, timeliness, appropriateness, and availability
- Efficiency – providing access with a minimum of duplication

Most acute care requires the provision of continuously available services to meet emergent and urgent needs. Planning must be based on population and patient needs. A critical mass of patients is required to support an adequate number of providers, ensuring continuous coverage and the maintenance of clinical skills. This would translate into a minimum of four active physicians to adequately staff a secondary or tertiary care service, as suggested by the Canadian Medical Association. On-call coverage, demand fluctuation, periodic absences, recruitment and retention, and medical education activities would all be supported by this number. This service must also be able to operate without significant disruption in the face of loss of key individual providers of care.

Quality within specialized services requires that specialists can work where they can consult their peers, have access to special diagnostic and operative equipment and access to the expertise of colleagues in other disciplines.

Ensuring proper access to services is contingent on various factors. One must consider where the service sites need to be located, which health professionals are required for clinical programs, how to provide efficient access to service/treatment, and which measures will provide service in the person's official language of choice.

Council is aware that the Department of Health and Wellness began a planning initiative in early 2000 in collaboration with the present eight Regional Hospital Corporations. This initiative was aimed at identifying opportunities for the improvement of the present hospital system through the realignment of clinical services. The work group was specifically mandated to provide clinical input into system planning at the secondary and tertiary care service levels. The mandate includes the identification of clinical programs and the number and types of beds required for all levels of care. The working group reviewed the existing distribution and nature of hospital clinical services provided to the population of New Brunswick based on discharge data for in-patient and day surgery programs. It also included the distribution and activities of physicians within the province, and the aggregation of clinical services in individual hospitals.

Secondary and Tertiary care system planning must go beyond current utilization of services by the population of New Brunswick. Population mobility, demographics, changing population needs, advances in such factors as medication therapy, medical care and technology for both the diagnosis and treatment of patients, must also be factored into the Provincial Health Plan.

Although the working group process is on going, their findings to date have been shared with the Premier's Health Quality Council. At present over 70% of high-volume in-patient and day surgery secondary services and some tertiary services have been analyzed. The evidence gathered to date forms the basis for Council's recommendations related to the secondary and tertiary care services.

3.3.4 Service Delivery

Secondary Care Services

Council concluded that based on the principles of quality, sustainability, access and efficiency, the eight existing regional hospitals should continue to function as regional hospitals. Council also believes that some regional hospitals will not be able to provide the full range of secondary care services mentioned earlier.

Complex Primary Care conditions represent about 33 per cent of the total in-patient and day surgery admissions in the New Brunswick hospital system. The program consists largely of common, relatively low-complex situations such as general digestive disease, pneumonia and pleurisy, lung disease, bronchitis, heart failure, dementia, palliative and convalescent care. Most patients are treated within their own community, in Community Hospitals and receive their care under the supervision of family physicians.

Community hospitals help to ensure that beds within the secondary/tertiary hospitals will be used for the provision of complex acute care on a short-term basis and not taken up by "bed blocking" situations. Community hospitals are effective in stabilizing and transferring patients to more specialized facilities; receiving transfers from secondary or tertiary centres for palliative care, convalescent and/or rehabilitative care.

All community hospitals are providing Complex Primary Care service and Emergency Services 24 hours a day, seven days a week. Some hospitals have sufficient critical mass to provide general surgery or day surgery and a small number are providing obstetric services.

Without compromising scope or access, quality of care could be improved by consolidating certain secondary services into one location. But, Council does not have the required information to complete the Provincial Health Plan for secondary care facilities. Therefore Council recommends that the Department of Health and Wellness, in collaboration with Regional Health Authorities finalize the regional hospitals secondary care services component of the Provincial Health Plan. Furthermore, Council recommends the decisions be based on the guiding principles outlined earlier.

Council recognizes that some community hospitals offer services such as surgical and obstetric services because of the existence of a sole surgeon or family practitioner. By their nature, these services are not sustainable. In these cases, Council recommends that these services continue to be offered as long as the current practitioner and infrastructure are available.

Tertiary Care Services

Council received expert opinion on the maintenance of quality, sustainable tertiary care services. All in-province tertiary services are provided in more than one site, with the exception of cardiac surgery. Demand for service and specialist availability may call for the relocation of some tertiary services to a single site. Also, as a small province with a dispersed population, New Brunswick has unique needs which must be considered in determining the sites of tertiary services.

Absence of evidence prevents Council from making specific recommendations with respect to service sites for tertiary services. However programs already provided in more than one physical location need to be considered against present and future utilization and consolidated if warranted.

Regardless of the number of service sites, tertiary services must maintain a provincial perspective while maintaining involvement from all Regional Health Authorities. Mechanisms to ensure regional access, equity and communication must be written into the Provincial Health Plan, ensuring regional follow-up and linkages. Evaluation must also be a prevalent feature. These issues will remain important as New Brunswickers access the system in greater numbers.

3.3.5 Role of Regional Health Authority

Acute care in New Brunswick must be part of an integrated health system where planning is based on population and patient needs. Services provided by New Brunswick hospitals must also be part of an integrated hospital system. Such a system harmonizes the relationship between hospitals and health providers. It also ensures the network of hospitals provides the best possible service at the most appropriate site and at the most appropriate time.

Within such an integrated hospital system, patients are regularly transferred from smaller facilities to larger facilities, where more complex needs can be met. Patients are often transferred back to local facilities or the home health care program for convalescent and/or palliative care.

Within the context of the accountability framework covered later in this report, Regional Health Authorities need to identify the secondary and tertiary care needs of the population within their respective region. They will need to play an active part in the development of a Provincial Health Plan and be responsible for the implementation and management of the approved plan for secondary and tertiary care services. To date, some secondary care services are not available province-wide and tertiary services are available in only a few regions. This situation will continue to exist, so Regional Health Authorities must ensure access for people in their region to quality secondary and tertiary care services not provided in their own region.

The renewal of primary health care will reduce the hospital admissions of patients needing specialized diagnostic and treatment procedures. The increased emphasis on health promotion, education and the pro-active management of chronic illness will also relieve the pressure currently choking our hospitals. That is why secondary/tertiary service system planning must become an annual initiative.

3.4 Health Care Services Delivery Team

3.4.1 Introduction

Council's proposed health system is based on appropriate and maximum roles for all health professionals and service providers who work in the system. It is also based on an interdisciplinary approach which makes use of all providers' skills to achieve the best outcome possible for people they are serving.

The interdisciplinary approach does not mean an individual will always have a team of people addressing his or her needs. Depending on the need, each person will have access to the most appropriate provider for the need, with the skills of other providers coming into play when and if warranted. This approach will ensure continuity of care because the individual's health information will be contained in one single electronic file. Barriers to sharing of information will be eliminated while protecting client privacy.

The interdisciplinary approach calls for true collaboration among providers. Traditional "professional turf" issues must be resolved and each provider will be able to fully use their skills for which they have been trained.

The transition to a new approach for delivery of service will require the collaboration of our health professionals, who are our most valuable resource within the service delivery system. Their concerns and issues will need to be heard and addressed.

3.4.2 Primary Care Delivery Team

The Physician's Office

A fundamental building block of primary care delivery will continue to be the family physician working in collaboration with a nurse. Collaboration in this context means both the physicians and the nurses are involved in patient care, prevention and education and follow-up. Many family physicians are choosing not to practice in a solo setting but are moving toward a group practice model where a number of physicians work collaboratively, often with other health professionals, such as nurses, to serve a group of patients. Many New Brunswickers will continue to receive quality health care services from these physician/nurse teams. However, many patients will have needs that are more complex or require other services and diagnostic tools. This is where the Community Health Centres step in. The physician's office should be linked to and supported by a larger interdisciplinary team based in the centres. The nearest Community Health Centre should also be of assistance for phone coverage in non-office hours therefore ensuring access for patients 24/7. Compensation mechanisms for physicians practicing in these models will need to be reviewed, particularly as the role of the nurse and other health professionals is enhanced.

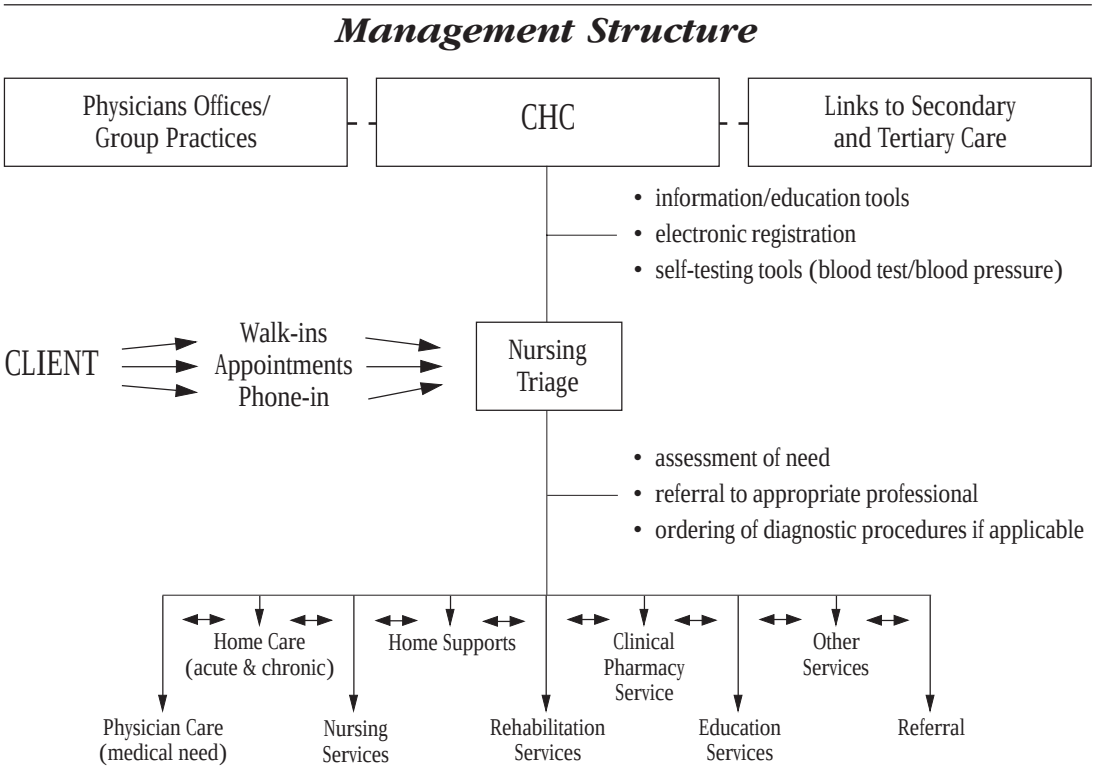
Community Health Centre

Teams of health professionals will be responsible for providing services to a given community or geographic area. The team may include but not be limited to: physicians, nurses (including public health, mental health, VON, extra-mural, health center nurses), pharmacists, physiotherapists, audiologists, occupational therapists, speech language pathologists, social workers, dietitians, nutritionists, rehabilitation assistants, psychologists, and others. Over time members of the team may be co-located to provide a wider range of services in one location, but where this is not possible members should be linked electronically and continue operating as a team.

The Community Health Centre should serve not only their regular patient/client groups but also the population of the community who do not have access to services through other means (i.e. have no family doctor, regular health care provider is unavailable, need occurs after-hours).

3.4.3 Management Structure

Each professional within the team will have specific and in some instances enhanced roles. From the provider's and client's perspective, the Community Health Center can be depicted as follows:



Community Health Centres will benefit from the enhancement of nursing roles. In the area of triage services nurses would require experience in acute and community care and additional training in assessment skills and pharmacology. Nurses' responsibilities should be widened to include the ordering of diagnostic procedures, the referral of patients to appropriate professionals and discharge procedures if applicable. Nurses could also perform many of the education services functions, becoming the leaders in patient education, health promotion, prevention and management of chronic illness. It is vital to this proposed system that nurses practice at full scope. Advanced practice nurses, such as Nurse Practitioners, should be able to assess, diagnose, prescribe, develop and carry out treatment plans for basic conditions. Some nurses may wish/need to pursue additional education in specific areas or have the necessary preparation and experience to enhance their contribution to patient care.

In addition, the Extra-Mural Program and its experienced nurses will be part of the Community Health Centre team. Their contribution to the home care element and to the team within the centre will be significant. The presence of public health and mental health nurses will be equally valuable.

The clinical pharmacist's role on the health care team within the community will benefit patient /client outcomes. Their expertise in areas of pharmacotherapy will allow the identification, resolution and prevention of drug related problems. Pharmacists also play a key role in patient education and medication assessment and management, for both acute and chronic conditions, thereby enhancing patient outcomes. To handle some disease states and indications, the pharmacist should be placed in charge of medication dose adjustment and prescribing functions.

Pharmacy technicians are fully integrated in the hospital setting in the preparation and distribution of medications to patient care areas. Their role could be extended further into the primary care setting. Technicians should be supported in obtaining official recognition in the health system as a recognized and regulated occupational health group.

In rehabilitation care, the system would benefit from the introduction of a Rehabilitation Assistant. This new role would assist in carrying out established rehabilitation care plans and should be incorporated into primary, secondary and tertiary care settings.

The team associated with the Community Health Centre will provide services at other sites as well. Wherever possible and efficient, services should be delivered close to the population group being served. In this fashion, the team will be providing services in schools, nursing homes, special care homes, and the personal residence of the individual.

3.4.4 Other Primary Care Service Settings

In the same context of the maximization of the roles and contributions of all providers, there will be a need for an enhanced nursing role within the nursing home setting. Nurse Practitioners, where appropriate, should be able to assess, order tests, refer to other services and administer basic medications without prior approval of a physician. Nurses who have had additional training in specific areas should also be able to enhance their contribution to patient care. All registered nurses and registered nursing assistants should fully utilize the skills for which they have been trained.

The hospital emergency room has become a major site of primary health care delivery because people have not had other options to have their needs addressed. Here also is required a collaborative approach and the advancement and enhancement of nursing roles. The nurse should play a key role in dealing with non-emergency cases and in some instances the client may not need to see the physician. Whether or not the doctor is required, there are functions nurses can undertake to facilitate the physician's work and provide more efficient and effective services for clients/ patients. Nurses could order certain diagnostic tests, such as x-rays, to facilitate the physician's diagnosis or refer the patient to a more appropriate service site or provider. As the renewed health system evolves, emergency rooms will return to their original role; handling emergency trauma cases. The collaborative approach will continue to be relevant as patients will subsequently visit their physician's office or the Community Health Centre for follow-up care.

3.4.5 Secondary and Tertiary Care Delivery Team

As the individual's situation becomes more complex and requires specialized services that can only be delivered through a secondary or tertiary care facility, the interdisciplinary team is expanded to include specialists and other health professional resources as required. The working relationship between the primary sector and the secondary and tertiary sectors is critical to ensure continuity of care through the various phases of institutional care and follow-up care back in the individual's home community.

Specialized professional resources within secondary and tertiary care sectors will have an outreach responsibility to the primary care teams. Where situations and volumes warrant, the specialized service may travel to the communities, probably to the Community Health Centre to provide on-site service.

3.4.6 Tools to Facilitate Interdisciplinary Team Approach

The redefinition of roles of various service providers must occur in the next five years; work must be initiated immediately. To facilitate and support the team approach, a provincially coordinated process should be undertaken to develop a series of care maps (or "clinical paths") for major health conditions/diagnosis. The maps would identify standards pertaining to expected care requirements and the time frames within which interventions are anticipated to be initiated. The maps would also identify the roles of each professional to ensure quality, seamless care. The development process of these maps must also be interdisciplinary in nature.

As primary health care renewal evolves and the roles of the health professionals evolve, public education initiatives will be needed.

3.4.7 Health Profession Resource Planning

The availability of appropriate numbers of professionals will likely challenge the health system renewal in New Brunswick. Council supports a strong health human resource planning focus for the province. Federal initiatives in this area are also supported. Any effort in human resource planning will need to be sustained and linked to the renewal process and evolving roles of health professionals.

4. Governance and Structure

4.1 Introduction

The Premier's Health Quality Council's first assigned mandate was to "develop an action plan to move to a health governance system of Regional Health Authorities and Regional Health Boards". Government's key objective underpinning this mandate was a need to restore local community and citizen involvement in matters of health care governance. Council was asked by the Premier for advice on the best means of moving forward. Prior to evolving a suggested model of governance for New Brunswick, Council studied and assessed similar models that exist in this country and elsewhere.

Council determined that the advent of Regional Health Authorities has been experienced as a positive and progressive step forward wherever implemented. And, where implemented, communities were able to adjust to and improve upon the delivery of health care services on an integrated basis.

Council identified a number of key lessons learned by other jurisdictions as they implemented Regional Health Authorities. These lessons showed the need for:

- A well articulated provincial vision and plan for health that is understood and supported by all parties;
- Clear definitions of the separation of roles and responsibilities between the Department of Health and Wellness and Regional Authorities;
- Accountability parameters at all levels of the system;
- Collaboration among the regional authorities as each works toward the common goals outlined in the health plan for the province; and
- The widest service delivery jurisdiction possible for the Regional Health Authorities to allow for greater flexibility in addressing and meeting the local needs of the population.

One message was repeated again and again through the many dialogues with jurisdictions who had implemented Regional Health Authorities: the need to have a single regional governance system for the full continuum of services. Some provinces have not integrated community and hospital care and have thus continued to perpetuate a 'silo system'.

The following sections represent Council's advice with respect to the implementation of Regional Health Authorities and Regional Health Boards in New Brunswick.

4.2 Objectives Relating to the Establishment of Regional Health Authorities

The implementation of Regional Health Authorities in New Brunswick will benefit patients, caregivers and the province by:

- Providing a structural framework in which service delivery changes can occur while creating a new culture with a focus on continuous improvement;
- Recognizing and responding to the uniqueness of each region;
- Providing a vehicle by which services can be integrated and transformed into a seamless system;
- Ensuring better access to services within each region and between regions; and
- Provide an apparatus through which people and communities can actively participate in their health system.

Council further recommends Regional Health Authorities become functional, with the necessary legislative authorities in order to become functional, on April 1, 2002, the date on which Council's work is premised. Should government choose a different timetable the various timeframes included herein would require adjustment.

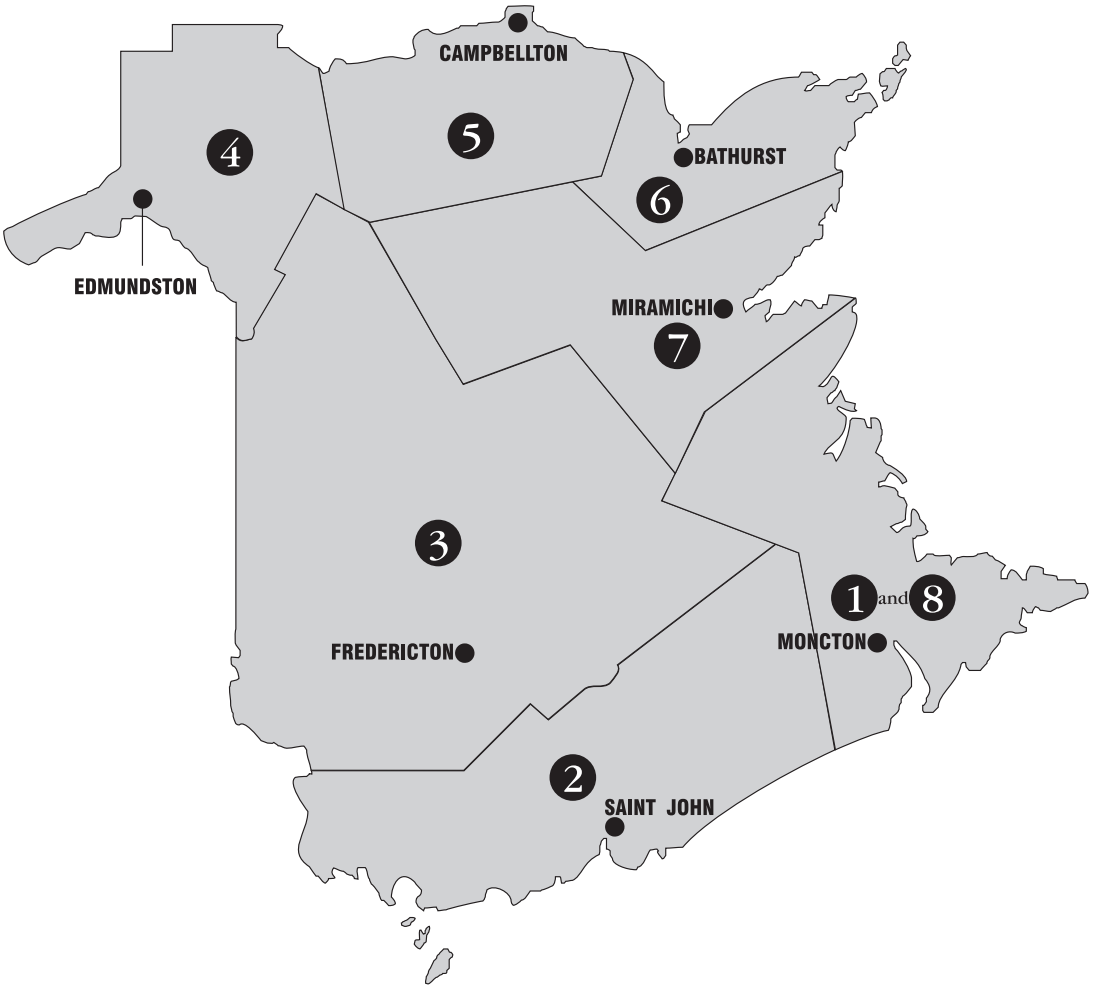
4.3 Regional Configuration

Council considered the geographical, cultural and linguistic realities of the province to determine the appropriate number and size of regions to be proposed. Factors considered included current patterns of population migration to service and already established regional identities.

After assessing numerous options and taking into account the views of the population as expressed in the May-June 2001 public consultation process, Council recommends the establishment of eight Regional Health Authorities based on the regional configuration shown in the following map. This recommendation essentially reflects the status quo with respect to regional boundary lines. Council believes there will be significant changes to governance and service delivery systems without needing to change regions which are already well known to New Brunswickers. Council also recognizes that Regional Health Authorities in some provinces serve a much larger population than what is being proposed for New Brunswick. However, the province's population is dispersed and the jurisdictions as proposed will enhance citizen participation, which is a key objective.

Council believes these regional configurations will allow the Regional Health Authorities to create a fully integrated health system.

Regional Health Authorities



4.4 Regional Health Boards

Council recommends each of these Regional Health Authorities be governed by a Regional Health Board made up of 15 citizens from the respective regions. To ensure citizen participation, Council further recommends five of these members be elected by the population through a process to take place each year at the time of the annual meetings. This will require the establishment of sub-districts in each of the regions. The remaining ten members are to be appointed by the Minister of Health and Wellness. All members are to be residents of the catchment area served.

Council received significant feedback on the composition of Regional Health Boards during public consultation sessions earlier this year. Generally, New Brunswickers said they would like to see more elected members than appointed members to these boards. Council considered this advice, but also researched best practices elsewhere in the country. The literature, particularly the work of Jonathan Lomas points to the need to guard regional perspectives and a balance of interests and skills at the Board level. Informed opinion led Council to propose a balanced model. However, Council recognizes that New Brunswick's unique realities may call for a longer learning process. Therefore, it is recommended that government conduct a full evaluation after a five-year period and adjust the number of members elected if indicated.

There will be significant responsibilities and challenges before these Regional Health Boards. It will therefore be critical for the Minister of Health and Wellness to consider factors such as geographical, linguistic, culture and gender balance when making appointments. In order to assist the Minister in this task, Council will prepare a board member profile to be used as a guideline by the Minister.

Because the establishment of the Regional Health Authorities is recommended for April 1, 2002, the first Boards may need to be interim in nature, composed entirely of members appointed by the Minister of Health and Wellness. The life span of the interim Boards should not exceed two years, at which time first elections should occur. At this point, terms of office for the elected members should be for three years and staggered terms of office of one, two, and three years should be implemented for appointed members. This will allow for continuity of experience on the Boards. A maximum of twelve years in office is suggested.

Boards will set direction and develop regional policies consistent with the provincial plan. The policies will be carried out by the administrative arm of the Authority headed by a Chief Executive Officer (CEO) to be appointed by the Boards. In this context, it is recommended that the following be excluded as voting members of the Board: staff of the Regional Health Authorities, staff of provincial Departments on whose behalf the Authorities are delivering services (i.e. Departments of Health and Wellness and Family and Community Services) as well as providers who are granted contracts or practicing privileges by the Authorities.

This is not to say that the perspectives of these individuals are not valued and important to the decision making process. Indeed, their voices have not been heard often enough. For this reason Council recommends the creation of a Health Professionals Advisory Committee, made up of health service providers, to regularly advise the Board.

To aid Board members in the fulfillment of their responsibilities, a comprehensive orientation strategy is recommended both for the initial Boards and new members. Council developed a strategy to guide the Department of Health and Wellness as it ensures Board members are given the necessary orientation and tools to meet their obligations. On-going orientation should become a responsibility of each Board.

To meet the goals of the vision, Council believes skilled, competent individuals will be needed as Board members. Because the commitment required from these individuals will be significant Council recommends compensation for Chairpersons and Board members based on experience, duties and level of responsibility. In addition, all members of these Boards should be provided with appropriate communication tools to facilitate their work and enhance their involvement.

4.5 Roles and Responsibilities

Key to successful implementation are the clearly defined roles and responsibilities divided between the Regional Health Authorities and the Minister of Health and Wellness. These also serve to ensure accountability.

Council elaborates on each of these roles and responsibilities in the Accountability Framework chapter of the report.

The following table briefly explains individual responsibilities and areas requiring joint involvement.

Minister of Health and Wellness	**Joint**	**Regional Health Authorities**
Sets provincial vision, values, principles and philosophy.	All participate in the provincial plan.	Sets regional vision, values and principles consistent with the provincial plan.
Establishes overall direction, priorities, and standards for the system.	All participate in the provincial plan.	Sets regional direction, priorities and standards consistent with the provincial plan.
Approves regional plans.		Develop regional plans.
Secures appropriate funding.		Responsible spending of provincially allocated resources.
Delivers provincial services.		Delivers regional services.
Monitors health status of population and provincial plan and reports to the public.		Monitors regional health status of population and regional plans.
Effective and efficient management of provincial resources (financial, human, information technology).		Effective and efficient management of regional resources (financial, human information technology).

These roles and responsibilities assume the presence of a health vision for the province and a Provincial Health Plan to which all parties have contributed. Regional Health Authorities are clearly expected to collaborate with the province and among themselves. Mechanisms will be required to facilitate this process.

4.6 Suggested Board and Operational Structures

Council does not intend to be prescriptive but would like to offer suggested guidelines and considerations in moving forward.

4.6.1 Possible Regional Health Board Structure

Regional Health Boards are the key to the renewal of New Brunswick's Health System. As such, they are expected to be 'forward-looking, forward-thinking', innovative and creative entities that will create a better coordinated system for New Brunswickers. They will need to provide the necessary leadership to change management occurring at the regional level. They will need to be able to exercise the necessary flexibility to meet the needs of the people in their region.

Most organizations with proven innovative capabilities structure their Boards with three Committees: Governance, Audit and Leadership and Human Resources. A similar structure could prove beneficial for Regional Health Authorities.

4.7 Suggested Organizational Structure

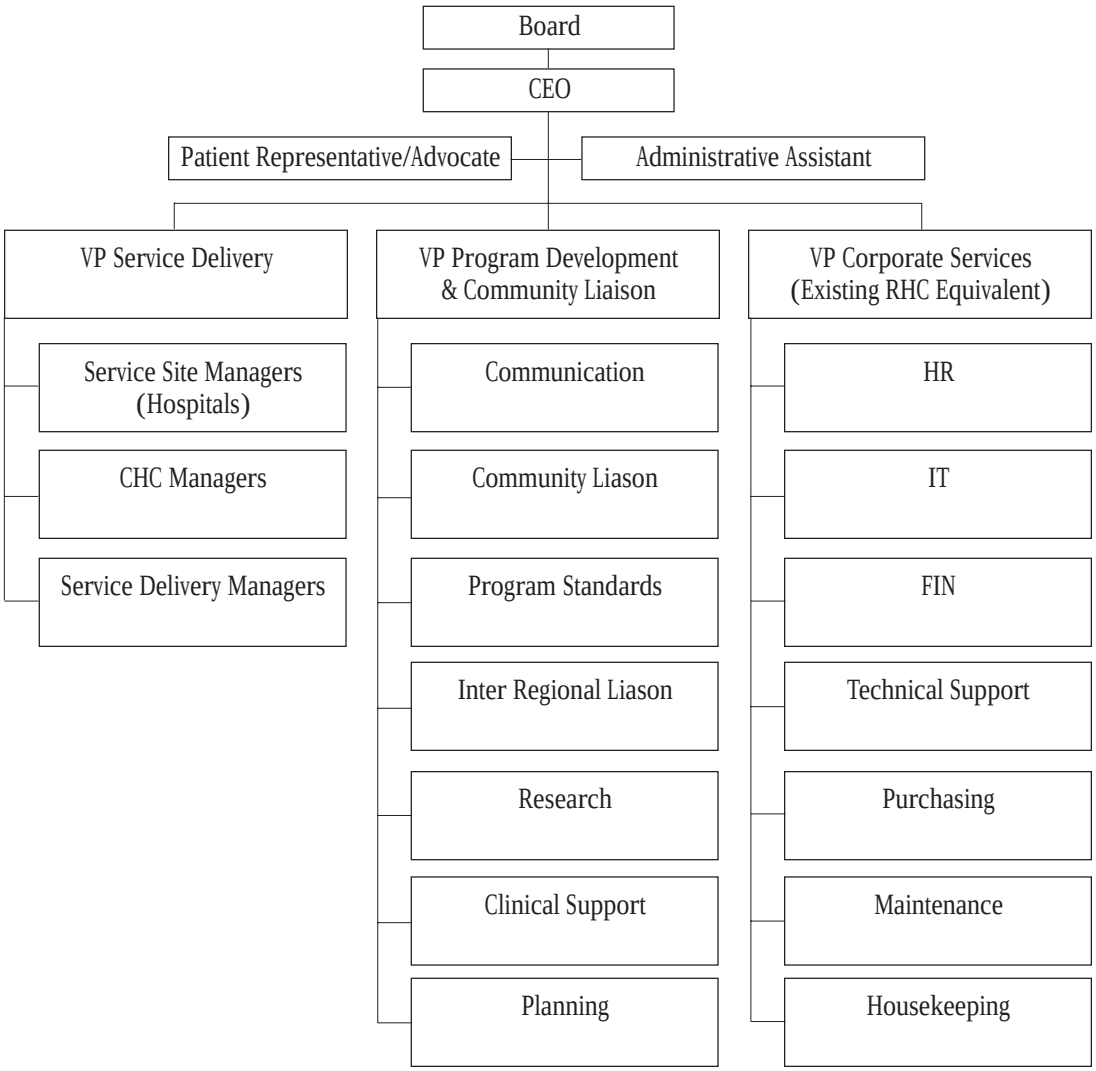
Council recognizes that the size and the complexity of a region will influence the type of organizational structure to be set up by the Regional Health Authorities in order to meet their responsibilities. However, a lean and simple management team that focuses on integrating services is envisioned.

The following possible structure is offered as a guideline only.

A number of key principles should be highlighted, the need to:

- Focus on the provision of services rather than on building bureaucratic structures;
- Build on the resources and the expertise already present in the system;
- Ensure clinical leadership is present at the regional level;
- Ensure local management and responsiveness by assigning a leader to each service site.

Regional Health Authority
Sample Organizational Chart



4.8 Transition of Existing Governance Structures

Council recommends the dissolution of the Boards of the Regional Hospital Corporations simultaneously with the establishment and the appointment of the Regional Health Boards. This will be necessary because of the proposed transfer of services currently under the auspices of the Regional Hospital Corporations to the Regional Health Authorities. Should a transition period be required, it would be the advice of Council to have the necessary authority and powers vested in the Minister of Health and Wellness for a short period of time. Moreover, Council does not recommend the establishment of individual boards for each hospital facility. No change is recommended in the governance of nursing homes.

4.9 Suggested Transition Provisions and Possible Implementation Schedule

Council believes that the following sequencing of activities would facilitate the successful implementation of Regional Health Authorities premised on the April 1, 2002 start date. The process assumes the involvement of all parties in the creation of the vision and the Provincial Health Plan.

Action	Timeframe
Introduction of enabling legislation for the establishment of Regional Health Authorities.	Fall 2001 Session of the Legislative Assembly
Appointment of Interim Regional Health Board Members.	January, 2002
Orientation strategy implemented for Regional Health Board Members.	As soon as possible after members have been appointed.
Appointment of CEOs by Regional Health Authorities.	March, 2002
Communication between management and Labour to ensure fair and equitable transition.	March, 2002
Dissolution of the Regional Hospital Corporations.	March 31, 2002
Regional Health Authorities become operational.*	April 1, 2002
Services are transferred under the authority of the Regional Health Authorities.	April 1, 2002
First annual meeting elections held.	April - June, 2004
Orientation implemented for new Regional Health Board Members.	June, 2004

** Council believes Regional Health Authorities must be given the responsibility to deliver the full range of health services in order to create an integrated and coordinated system. The full transfer of these services may not be feasible immediately. Council urges government to move as quickly as possible in this regard. Problems could result, for example, if only hospital services were transferred initially because the necessary elements might not be in place to begin building an effective primary care alternative. Council realizes the final sequencing of all actions will depend on government's full consideration of all recommendations.*

4.10 Conclusion

The implementation of Regional Health Authorities will present a number of challenges as we work toward a balance between provincial imperatives and local realities in the health system. Council believes that New Brunswick must meet these challenges, learning and adjusting over time in order to provide the best system possible for the people of New Brunswick.

5. Accountability Framework

5.1 Accountability in the Health Care System

The introduction of a new regionally based governance model for the health care system introduces the challenge of implementing an appropriate accountability framework from the beginning.

Accountability is a significant issue in the publicly funded health care system. On one hand, there is a demand for accountability to the citizens. On the other hand, delivery agents must be accountable to the Minister of Health and Wellness and are obligated to account for the performance of service delivery goals and financial results. Regional Health Authority Board membership will be made up of ministerial appointments and publicly elected members, requiring a well-defined accountability framework to ensure everyone involved clearly understands their own and each other's roles and responsibilities.

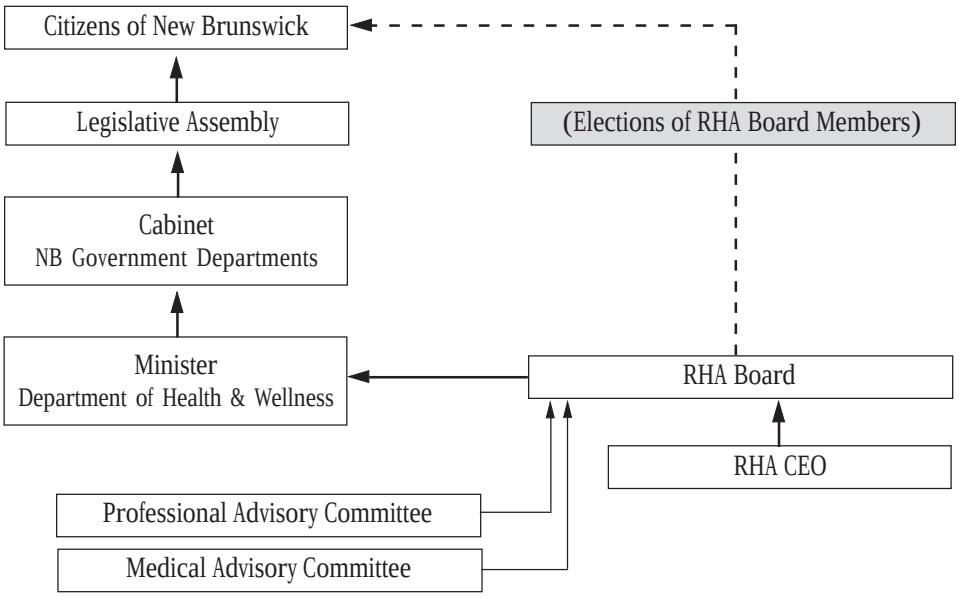
Because the concept of accountability is often interpreted vaguely, the Premier's Health Quality Council used the following definitions as a common denominator to form an understanding during its deliberations:

- **Accountability:** *The obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities*
- **Responsibility:** *The obligation to act or make a decision; one is responsible for something but accountable to someone*
- **Answerability:** *The obligation to provide information and explanation to another party; an answerable party is not subject to direction or sanction by the party requesting the information*

An important distinction is the notion that an individual or organization is ultimately accountable to the person or organization vested with the authority to assign or remove responsibilities from that individual or organization. It is therefore essential that the process by which responsibilities are assigned and removed is clearly understood by the health ministry and Regional Health Authorities, and is complemented with an effective performance measurement system that outlines explicit performance expectations in the areas of clinical outcomes, financial management and patient satisfaction.

To achieve effective accountability, three essential elements must be in place:

- clear accountability relationships between stakeholders
- well-defined roles and responsibilities for all stakeholders
- effective accountability management processes and tools



Council used these three elements as the foundation for its proposed accountability framework. The figure above summarizes the accountability relationships by illustrating the reporting lines between the various stakeholders as envisioned by Council for the overall structure of the health system.

As revealed by the stakeholders shown in the figure, the Premier's Health Quality Council focused on the responsibilities of the Minister of Health and Wellness, the boards of the Regional Health Authorities, the Chief Executive Officers (CEOS), the Professional Advisory Committees and the Medical Advisory Committees.

5.2 Minister of Health and Wellness/Regional Health Authorities Responsibilities

Final authority over the health system lies with the Department of Health and Wellness and as such, the Department has the primary responsibility of 'steering' the health system. However, the department must create a constructive climate that engages the participation and cooperation of Regional Health Authorities if the health system is to remain close to the communities, as envisioned. The notion of 'one provincial health system' will depend greatly on the ability of the Regional Health Authorities to work together and with the Department.

By using comparisons within seven key activity areas, the Council sets out the proposed responsibilities of the Minister and the Regional Health Authorities as follows:

1. Planning

Minister of Health and Wellness	Regional Health Authorities
Develop the vision, values, principles and philosophy that will guide the provision of health services in New Brunswick.	Develop the vision, values, principles and philosophy, consistent with the provincial vision, which will guide the provision of health services in the region.
Establish the overall direction and priorities of the health system through a consensus with Regional Health Authorities. Key goals include: • Identify overall policies/strategies • Identify core programs and services that will be available to all New Brunswickers: - promotion, prevention / protection, primary, secondary and tertiary care • Develop Provincial Health Plan based on a consensus with Regional Health Authorities • Establish program standards and performance indicators for all core programs and services in the health system.	Play an active role in the Provincial System Planning Forum (shared ownership). To provide input and work with the Department of Health and Wellness in the development of : • a Provincial Health Plan; and • Program standards and performance standards for all programs and services, including those programs unique to the region.
Develop a three-year business plan for the provincial health system that would include provincial and regional priorities. Plan to include: • Services/programs delivered by Department of Health and Wellness and Regional Health Authorities Human Resource Plan • Integrated province-wide information system • Major equipment • Major renovations and new construction Minister to be responsive to changing needs during current year and react appropriately and in a timely fashion.	Develop a three-year business plan (objectives and priorities) for the provision of health services, which meet the health needs in the region based on evidence, and which are consistent with provincial objectives and priorities (Provincial Health Plan). Plan to include: • Health needs • Services/programs delivered by Regional Health Authorities • Human Resource Plan • Major equipment • Major renovations and new construction • Operating budget Regional Health Authority to be responsive to changing needs during current year and react appropriately and in a timely fashion.
Approve Regional Health Plans (such decision should be thoroughly discussed with Regional Health Authorities).	Regional Health Authorities to support their regional health plans with factual evidence, projections and assumptions, success targets, etc.
Approve proposals from Regional Health Authorities relating to the establishment, closure and/or conversion of hospitals and community health centers.	Determine and approve changes to the menu of services of hospitals and community health centers within the region. (addition/removal of services)
Obtain advice and input from various stakeholders, including the public and service providers, to help plan the delivery of services not decentralized to Regional Health Authorities.	Obtain input and advice from the general public and service providers within the region.
Establish policies that will protect/promote the health of people in the province and prevent disease and injury.	Participate with the Province in the development of policies that will protect/promote the health of people in the province and prevent disease and injury.

Minister of Health and Wellness	Regional Health Authorities
Advocate the "health perspective" in government-wide policy development and in discussions at Cabinet committees.	Work with regional offices from other government departments to ensure a comprehensive approach in establishing the health agenda for the region.
Develop a provincial Human Resources Plan to ensure the proper number and mix of human resources, are available to support health services in the province.	Develop and submit for information a regional Human Resource Plan that ensures that the proper number and mix of human resources are available to support health services in the region.
Participate actively with Board of Management and the Office of Human Resources in collective bargaining with other health professionals/employees of the health system. Set and act as lead on behalf of government in the establishment of rates for salaried, contracted and fee for service physicians.	Participate actively with Board of Management and the Office of Human Resources and the Departments of Health and Wellness and Family and Community Services: • in collective bargaining with health professionals/ employees of the health system; and • in the process of establishing rates for salaried physicians
Develop a plan jointly with Regional Health Authorities that will provide an integrated province-wide information system for use in all Regional Health Authorities and for all provincially managed programs. The information system will link the health system together.	Provide input and work with the Department of Health and Wellness in the development of an integrated province-wide information system.

2. Funding

Minister of Health and Wellness	Regional Health Authorities
Secure funding from Legislature for: • the delivery and operation of centrally managed programs • the allocation of funds to Regional Health Authorities based on the approved Regional Health Authorities Plans (to include full funding required for the operation of services that Department of Health and Wellness insists be maintained despite evidence based proposals from Regional Health Authorities suggesting such services be eliminated or reduced)	Engage and fund services of Nursing Homes, Non-Government Organizations Service Providers (VON, home care, mental health education/promotion, etc.).

3. Collaboration

Minister of Health and Wellness	Regional Health Authorities
Accountable for: _ the collaboration among Regional Health Authorities and the department _ to develop a mechanism in cooperation with Regional Health Authorities, that ensures collaboration amongst them	Accountable for collaborating with the Department of Health and Wellness and other Regional Health Authorities to obtain maximum quality of patient care and efficiency and effectiveness within service delivery in the health system.

4. Assessing, monitoring, and reporting

Minister of Health and Wellness	Regional Health Authorities
Monitor and assess: • the health of New Brunswickers • the performance of the health system, including Regional Health Authorities Provide information, including assessment results, to Regional Health Authorities and general public. Report to the general public no less than on an annual basis and no later than June 30th of each year, on the achievement of the provincial business plan. Report to include assessment of progress on key initiatives.	Monitor and assess: • the health needs of individuals, families, and communities in their region • the delivery of program and services and share the findings with the general public and identify patterns of health that require investigating • the performance of all administrative and clinical activities within the Regional Health Authority Report to the Minister of Health and Wellness on a regular basis (quarterly) and to the regional general public (no less than on an annual basis and no later than June 30th of each year) on the achievement of the regional business plan. Report to include assessment of progress on key initiatives.

5. Service delivery

Minister of Health and Wellness	Regional Health Authorities
Provide timely support, advice and assistance to Regional Health Authorities in the implementation and ongoing management of their respective Regional Health Plan. Manage those services not assigned to Regional Health Authorities, including: • Office of Chief Medical Officer • Public Health Inspection • Medicare • Prescription Drug Program • Provincial Epidemiology • Provincial Cancer Registry • Vital Statistics The Department shall establish mechanisms to seek and receive input from Regional Health Authorities, to assist in the ongoing management and service delivery improvement within the above noted services. (ex: Prescription Drug Program coverage vs. drug coverage in hospital)	Implement and manage an approved Regional Health Plan (objectives and priorities) for the provision of health services which: • meets the health needs in the region; • is consistent with provincial objectives and priorities (Provincial Health Plan); and • is supported by evidence (from a research institute and other sources) Range of services included within all Regional Health Authorities will include health promotion and education, prevention, primary care and hospital care. Specific programs will include Public Health, Mental Health, Long Term Care, Extra-mural/Home Care, Rehabilitation, Addictions and Secondary Hospital Services. Some Regional Health Authorities will also manage and operate provincial tertiary hospital services.
Assist Regional Health Authorities in ensuring access to out-of-region and out-of-province services.	Collaborate with other Regional Health Authorities and the Department of Health and Wellness to ensure access for people in the region to tertiary or other health services not provided in the region.
Support Regional Health Authorities in their effort to integrate program/services at the regional level.	Manage health services in a manner that focuses on the needs of individuals and communities and integrate services and programs in the region.
Sharing and supporting best practice and innovation, experimentation and continuous improvement.	Foster a culture whereby services are managed by promoting and supporting best practice, innovation, experimentation and continuous improvement.

6. Managing Resources

Minister of Health and Wellness	Regional Health Authorities
Manage all financial, human and information technology resources required to deliver province-wide services not delegated to Regional Health Authorities. Support Regional Health Authorities by facilitating the establishment of provincial forums, systems, processes and mechanisms required for true cooperation amongst Regional Health Authorities and with the Department, for effective and efficient management of all resources.	Financial: • Manage financial resources and operate within the budget approved as part of the regional health plan. Human Resources: • Manage all functions of Human Resource management including staffing, labour relations, training and development and compensation. • Human Resource systems (performance management, payroll, Human Resource Information System, compensation, etc.) should be common for all Regional Health Authorities unless otherwise necessary for unique operational requirements. Material, Equipment and Physical Space: • Perform all management activities related to materials / equipment / physical space management consistent with provincial/ regional infrastructure and systems.
Information Technology: • Facilitate, in cooperation with Regional Health Authorities, the development of overall provincial information technology strategy and standards. • Facilitate the establishment of a provincial health data repository.	Information Technology: • Perform day to day management functions related to the operation and maintenance of information technology systems, including data management (and timely transfer of data to provincial data repository), network maintenance, desktop tools, software and hardware acquisition, user assistance, etc. • Perform system development and implementation in accordance with the provincial information system strategy and standards.

7. Communication

Minister of Health and Wellness	Regional Health Authorities
Communicate the aggregate health system picture to the total population • Provincial business plan	Establish an on going communication strategy with the population in the region to facilitate their involvement in their health care.

To achieve greater efficiency and effectiveness, the Minister of Health and Wellness and the Regional Health Authorities should explore the centralization of certain administrative duties that are otherwise delegated to the proposed eight regions. To prevent duplication and increase efficiencies, certain functions under corporate support services such as Human Resources/Personnel, Information Technology, Materials Management and Financial/Accounting services could become the responsibility of a special operating agency or a provincial corporation.

Provincial functions will need to be introduced without impeding the management flexibility and innovation required for Authorities to create the best service delivery for each community. However, standardization will balance this flexibility to ensure Regional Health Authorities deliver consistent, acceptable service. Provincially regrouped functions would not prevent Authorities from establishing strategic capabilities within these corporate service functions, which must be present regionally as part of the Regional Health Authority's management capacity. Examples of functions that could be housed under a provincial administrative entity include: Payroll, Purchasing, Information Technology Standards/Data Integrity and Accounts Payable and Receivable.

In keeping with New Brunswick's bilingual status, the provincial administrative entity would need to be able to serve and interact with Regional Health Authorities in both official languages at all operational levels.

The location of the provincial administrative entity should consider any economic impact it could have for various potential sites in the province.

The description of the responsibilities of the Minister of Health and Wellness and the Regional Health Authorities above is intended to provide a clear understanding of the roles these two levels of the health system are to perform in the future. On this understanding, the effectiveness of these accountability relationships depend. Accountability relationships must be supported by explicit and accepted performance expectations which provide sufficient resources and authority to act and follow-up, including the use of approved rewards and sanctions.

5.3 Chief Executive Officers of Regional Health Authorities Responsibilities

The Premier's Health Quality Council firmly believes the role of the Chief Executive Officer is pivotal in making the establishment of Regional Health Authorities a success. Individuals undertaking the role must become lead change-agents in the pursuit of health renewal at the regional level. The breadth of services to be managed by Regional Health Authorities will require strong linkages with other public services present in the region such as schools, provincial and local governments, and a multitude of not-for-profit and private sector organizations. CEOs will need to ensure these linkages are implemented as early as possible.

In addition to its recommendation that CEOs be appointed by and report directly to their respective Regional Health Authority Board, Council recommends CEOs become responsible for:

- General management and conduct of the affairs of the Regional Health Authority;
- Establishing strategic plans in cooperation with the Board, based on best available evidence, to address population needs and to achieve desired outcomes;
- Leading the operational activities of the Regional Health Authority in order to achieve its goals and objectives as approved by the Board;
- Directing and coordinating activities to achieve optimal use of financial, material and human resources;
- Creating a seamless continuum of health services for the region, including continuous improvement of primary health care service delivery;
- Maintaining an organizational design and service delivery approach consistent with the overall direction and strategic goals of the Regional Health Authority;
- Collaborating with regional stakeholders (citizens, non-government organizations, health care professionals, government agencies) to improve health outcomes for the citizens of the region;
- Working with the Board to ensure objectives of the New Brunswick Health Plan are being promoted;
- Providing timely, comprehensive and evidence-based information to the Board for full discussion;
- Understanding the characteristics of the region and maintaining a constant evaluation of public satisfaction;
- Representing the Regional Health Authority in working with other levels of government, other Regional Health Authorities, health care organizations, professional groups and associations, and public officials; and
- Working with the above stakeholders to establish a continuous culture of improvement in the health system.

5.4 Professional Advisory Committee

As stated previously, Council recommends a Professional Advisory Committee be established within each Regional Health Authority to advise the Regional Health Board. The Committee's mandate will be to advise on:

- Overall delivery of clinical services, including standards of care
- Criteria for admission and discharge (eligibility)
- Quality assurance and risk management
- Any other issue the Board may request the committee to consider.

The Committee's membership should consist of representatives employed by the Regional Health Authority from the various health professions servicing the community and institution-based health sectors, and would be appointed according to Regional Health Authority by-laws.

5.5 Medical Advisory Committee

In keeping with the regulations under the Hospital Act, Council recommends the preservation of the Medical Advisory Committee with its mandate to provide advice on overall clinical care issues and processes to the Board (in this case, the Regional Health Board). It focuses primarily on issues related to medical and dental staff, e.g. credentials, privileges, and peer review.

5.6 Effective Accountability Management Processes and Tools

The proposed accountability framework also includes management processes and tools. These are key instruments in making accountability work. Performance measurement and management systems fail when the accountability management processes and tools are ineffective in providing the discipline and rigor required for a culture of innovation and continuous improvement.

The Premier's Health Quality Council believes the following activities are essential to the implementation of a continuous improvement process:

- Establishing goals and performance indicators that are outcome oriented and measurable;
- Selecting strategies;
- Taking action and monitoring progress;
- Reporting on results;
- Evaluating results;
- Maintaining or changing the course of action.

These activities must be performed at provincial and regional levels. Regional Health Authorities need to be actively involved in the continuous improvement process activities related to the performance of the provincial health system. This will enable Regional Health Authorities to bring the provincial outlook to their respective region and thus ensure consistency between the priorities of both levels. A climate of collaboration should result, rather than competition. The continuous improvement process must be flexible enough to allow quick action when immediate changes are required.

Council identified a number of processes through which accountability could be achieved in the areas of planning, funding, performance and communication. These are listed as follows:

5.7 Planning and Priority Setting

- Premier's Health Quality Council Vision for the health system
- Orientation for Regional Health Authority Boards and Departments (Health and Wellness and Family and Community Services)
- Health needs assessment tools
- Provincial Health Plan
- Regional Health Plans, including:
  - Key goals
  - Objectives
  - Assumptions/projections/evidence
- Provincial and regional human resources plans
- Provincial and regional information technology plans
- Provincial and regional responsibility centres for best practice/ innovation and continuous improvement.
- Ongoing provincial and regional evidence based system planning forums to determine priorities and ensure collaboration at all levels:
  - Overall health system planning group (Health and Wellness Deputy Minister, Regional Health Authority Board Chairs and Chief Executive Officers)
  - Clinical advisory groups by program/speciality
  - Provincial Human Resource coordination (collective bargaining, employer/employee relations, compensation systems, training, job design, payroll, etc.)
  - Provincial IT coordination (information systems hardware and software standards, data integrity, etc.)
  - Health services utilization management working groups

  - Supplies and equipment inventories, medical technology and physical space planning

- Inter-departmental regional forum for groups such as:
  - administrators
  - clinicians
  - support services
- Topic specific advisory committees to the Regional Health Authority Board
- Legislation and Policies

5.8 Funding

- Provincial and Regional Health Authority budgets to dedicate a minimum percentage of funding for information systems, prevention/promotion, human resource training and development, innovation and research
- Service agreements between Regional Health Authorities, nursing homes, and non-government organizations, including funding for services based on provincial standards
- Funding mechanism between Family and Community Services and Nursing Homes for capital expenditure projects
- Protected funding arrangements for specific programs / Non-Government Organizations
- Annual funding by Department of Health and Wellness to the provincial health research institute[1] in exchange for specific research/studies agreed to by the Department of Health and Wellness, Regional Health Authorities and the research institute
- Provincial and regional budgeting processes. (Financial planning and monitoring, etc.)

5.9 Performance Measurement

- Health system performance measurement - all health services (Balanced Scorecard[2])
- Health Policy Evaluation
- Health Services Utilization Research
- Social Determinants Research
- Population Health Status Research
- Linkage with the Government's Corporate Outcomes Initiative
- Community surveys/results published

- Penalties/corrective actions to address non-compliance with the Provincial Health Plan / Rewards for outstanding performance. Circumstances warranting these measures must be understood in advance - clear expectations
- Provincial health research institute[3] (independent 3rd party) that provides evidence to guide/support the development of provincial and regional health plans (services utilization analysis / policy evaluation)
- Department of Health and Wellness and Regional Health Authorities responsibility to collect and share data with health research institute.
- Provincial Health Report Card[4]
- Charter of Rights and Responsibilities[5]

5.10 Communication

- Public consultation / notice mechanism
- Regular public statements from the Minister of Health and Wellness and from Regional Health Authorities to foster greater sensitivity to the health perspective
- Population health reports from provincial health research institute
- Department of Health and Wellness and Regional Health Authorities annual reports
- Community surveys / results published
- Publication of the three-year business plan
- Quarterly publication by each Regional Health Authority

5.11 Department of Family and Community Services Linkage

As proposed, Regional Health Authorities will be responsible for delivering long term care services, requiring joint planning and coordination with the Department of Family and Community Services.

This joint planning would require that the portions of Authorities' three-year plans and annual plans relating to long term care services be approved by the Minister of Family and Community Services. Council recommends such an agreement.

Further review is needed to determine whether a transfer of staff from the Family and Community Services regional staff now involved in the delivery of Long Term Care to the Regional Health Authorities is required. Central Office staff will continue to operate under the authority of Family and Community Services and will support the work of Regional Health Authorities by providing standards, performance monitoring, expertise knowledge on best practices in long term care, inspecting and licensing of nursing homes.

Family and Community Services would provide the necessary funding for Regional Health Authorities to deliver an agreed-upon menu of services, including the purchase of nursing home services. Funding levels must be based on an approved set of provincial service standards, established jointly by Family and Community Services and Regional Health Authorities.

The Minister of Family and Community Services is accountable to the government for the overall Long Term Care Program. As such, the Minister shall monitor and assess the performance of Regional Health Authorities as it relates to the delivery of long term care services. Accordingly, Regional Health Authority Boards must be accountable to the Minister of Family and Community Services for the delivery of long term care services.

5.12 Conclusion

The Council's proposed accountability framework features the notions that accountability relationships are defined by structure (authorized roles, responsibilities and reporting lines), require supporting processes (clear expectations, monitoring, reporting and follow up actions) and focus on results.

1 Featured in later sections of the Report

2 Featured in later sections of the Report

3 Featured in later sections of the Report

4 Featured in later sections of the Report

5 Featured in later sections of the Report

6. New Brunswick Health Report Card

6.1 Introduction

Council's recommendations for the development of the New Brunswick Health Report Card are broad-based and intended to provide an overall direction.

The ideas and concepts put forward by Council result from a thorough review of best practices and experiences of other jurisdictions in public reporting of health system performance, health status of the population and social determinants of health. Expert advice received through discussions with academics, health researchers, information technology consultants and federal / provincial public servants involved in performance measurement activities within the health field, has been invaluable in guiding Council members through a very specialized domain.

A successful and credible report card depends on the availability and integrity of data. Experts cautioned Council that it is necessary to have a minimum of three to five years of data for the proper investigation and scaling of performance results. This particular challenge will only take time to remedy. The credibility and accuracy of the report card will improve as the health system evolves toward seamless care, an evolution that will be supported by the Report Card itself.

Expert advice clearly stressed the importance of impartiality and its 'perception' in the eyes of the public to the integrity and credibility of the Report Card. Council proposes this issue be addressed through the creation of an independent health research organization for New Brunswick described in the latter part of this chapter. In addition to producing the Report Card, this organization will support accountability in health care by evaluating changes to practice, programs, and the health status of New Brunswickers.

6.2 Purpose

In keeping with the main thrust of Council's vision, the New Brunswick Health Report Card must strive to:

- Inform the public of the performance of the health system, including health standards, future readiness, education of health care providers, research utilization as well as progress made in the future on priority initiatives (i.e. development of primary care, integration of all health services, prescription drug access and utilization, etc.);
- Inform and educate the public of the health status of New Brunswickers and factors affecting good health; and
- Assist government, health system managers and providers on health policy, health system planning and evaluation, and service delivery decisions.

6.3 Target Audience

The Health Report Card is a vehicle through which New Brunswick can share with many stakeholders information on the health of its population and the performance of its health system. These stakeholders include health care providers, health system managers, and the research community. However Council recognizes the primary target audience should be the citizens of the province.

6.4 Performance Monitoring

Provincial governments across Canada are faced with increased pressures on their health systems. In the eyes of an increasingly demanding public, the government is responsible for the performance of a health care system battered by rising costs, professional shortages and access issues. Internally, expectations are high. Elected officials want health system managers and providers to offer improved services while containing costs. At the same time, managers and providers themselves require the tools and systems to make the appropriate decisions, operate efficiently, and better respond to the needs of the population. There is a need for factual, evidence based information with which to make good decisions at all levels of the health system.

Federal, Provincial and Territorial governments (F/P/T) reached an agreement in the fall of 2000 to develop a common base from which the performance of health systems across the country could be monitored and reported to the public. First Ministers asked health ministers to:

- Provide comprehensive and regular public reporting by each government on the health programs and services they deliver, on health system performance and on progress towards the priorities set forth above; and
- Collaborate on the development of a comprehensive framework using jointly agreed comparable indicators that each government will begin reporting by September 2002. These comparable indicators will address:
  - health status (i.e., life expectancy, infant mortality, low birth weight, people reporting their health as excellent);
  - health outcomes (i.e., change in life expectancy, improved quality of life, reduced burden of disease and illness); and
  - Quality of service (i.e., waiting times for key diagnostic and treatment services, patient satisfaction, hospital re-admissions, access to 24/7 first contact health services, home and community care services, the adequacy of public health surveillance and health protection and promotion activities).

The Premier's Health Quality Council views the Federal, Provincial and Territorial performance measurement initiative as an opportunity for New Brunswick to develop its measurement capacity for health services and be able to compare results with other jurisdictions. Some of the indicators proposed by Council are consistent with those under the Federal, Provincial and Territorial September 2000 Agreement.

Already in New Brunswick, efforts are underway to create the capacity to monitor the performance of the health system, particularly in the hospital sector. In 1999, the Department of Health and Wellness and hospital corporations joined efforts to develop a performance measurement system that uses a balanced set of indicators to measure the quality and sustainability of the regional hospital system. The measurement system ("Balanced Scorecard") is required to support continuous performance improvement and enhance regional hospital accountability by enabling evidence-based evaluation of performance. Areas of focus include financial, clinical and non-clinical operations, system integration and learning, and patient/community satisfaction.

The distinction between the Report Card and the Balanced Scorecard is twofold according to work done by the Ontario Hospital Association and the University of Toronto: the level of analysis and the target audience. According to their model, a report card is a high-level set of indicators, which focus on external stakeholders. A balanced scorecard is a more detailed report with a set of indicators designed for the operational needs of internal stakeholders such as managers and providers.

Based on its own review of the work on the Balanced Scorecard initiative, Council recommends this measurement approach be expanded to cover all services and programs that will eventually be managed by Regional Health Authorities (Public Health, Mental Health, Long Term Care, etc.). Council considers this recommendation essential to the management of an integrated and seamless service delivery.

The Balanced Scorecard performance measurement approach is directed at fulfilling the need for internal monitoring and reporting. Although not typically intended for public reporting, this measurement system requires rigor in data management that will provide a more complete and reliable database for the development of the Provincial Health Report Card, insofar as it relates to the performance of the health system.

6.5 Framework

Consistent with its vision for New Brunswick, the Premier's Health Quality Council believes citizens must be informed about the performance of the health care system, the health status of the population and the social factors that impact the health of New Brunswickers.

This position is consistent with the mandate of the Department of Health and Wellness, a mandate which looks to focus on wellness as well as illness. It is also consistent with the approach adopted within the Federal/Provincial/ Territorial Agreement (F/P/T). The consistency is required to enable New Brunswick to draw comparisons with other provincial jurisdictions.

6.5.1 Performance Measurement Dimensions

The Premier's Health Quality Council recommends the Report Card cover four specific dimensions:

- Social determinants of health;
- Health status of New Brunswick's population;
- Performance of New Brunswick's health care system; and
- Community and health system characteristics.

For each dimension, a number of indicator categories are possible. The table below highlights categories put forward by Council for each proposed dimension:

Social Determinants of Health	**Population Health Status**	**Health System Performance**	**Community and Health System Characteristics**
• Health Behaviours • Living and Working Conditions • Personal Resources • Environmental Factors	• Health Conditions • Human Function • Well-being • Deaths	• Acceptability • Accessibility • Appropriateness • Competence • Future Readiness • Effectiveness • Efficiency • Safety	• Demographics • Health System Expenditures • Health Personnel • Service Volumes

The menu of indicators published in the Report Card will vary in each publication. Council considered elements of its proposed vision to identify priority indicators. While concerns remain regarding the inability to compile enough data in the first few years for a reliable Report Card, Council nonetheless identified the following list as possible indicators:

Social Determinants of Health

- Lifestyle
  - Addiction rates (smoking / tobacco, alcohol, drug, gambling)
  - Physical activity
  - Nutrition / diet
- Education
- Employment / Unemployment
  - Employment status distribution (full-time, part-time, seasonal)

  - Employment conditions (employment security, benefit coverage, retirement options, etc.)
  - Unemployment status distribution (Employment Insurance, income assistance)
- Early childhood development, (child health programs availability, school readiness, etc.)
- Environment
  - Regulations/enforcement
  - Quality management tracking – waters, air, soil, etc.
  - Toxic exposure, ecological integrity, use of pesticides, recycling, marshland preservation, etc.
- Criminal rates and other justice statistics, including:
  - Incidents of domestic violence
  - Sexual assaults
- Income & poverty levels
  - Groups (incl. single parent family, age 65+, etc.)

Population Health Status

- Obesity (Body Mass Index - by age/sex)
- Disability rates (lost functions/absenteeism - lost days of work)
- Population fitness
- Improvements achieved on population health status
- Premature mortality
- Incidence of preventable disease (diabetes; hypertension, etc.)
- Incidence of diseases (cardiac, cancer, AIDS, depression, Alzheimer, Arthritis, etc.)
- Self-rated health status, self-esteem and quality of life

Health System Performance

- Access to primary care services
  - 24/7
  - Comprehensiveness
- Patient satisfaction/ population satisfaction / level of confidence in the system
- Service access in the language of choice (number of complaints)
- Satisfaction rate of providers / staff moral rating / annual staff turnover

- Wait time in referral to specialist / time from specialist to treatment / care sought
- Timely intervention treatment
- Waiting list to secondary, tertiary care source
- Percent of tertiary care use by region
- Waiting time to access tertiary care by region (tertiary index)
- Health promotion/prevention initiatives/clinics (e.g. yearly physicals)
- Regional Health Authorities financial management performance
- Regional Health Authority responsiveness to community needs
- Overall health budget and cost breakdown by programs / services

Community / Health System Characteristics

- Recruitment / retention - professional resources
- Profile of drug coverage per region
- Education/ research capacity / research dollars accessed
- Age demographics by province and by region
- Overall health budget by program / year over year comparisons
- Description and number of primary, secondary and tertiary centres
- Tracking volumes/patterns of usage of emergency rooms/community health centres (weekends/nights), progress in people appropriately accessing services
- Number of prevention / promotion programs by region

Further refinement, particularly in the selection of indicators, will require the assistance of indicator experts and health researchers from the proposed third party research institute.

6.5.2 Levels of Comparisons

The proposed framework of indicators is consistent with other provincial and national performance measurement initiatives. By adopting a similar approach, New Brunswick will be better able to inform its citizens on the performance of its health system and the health status of its population in relation to other areas of the country. Furthermore, as other public reports originating from outside sources (federal/provincial research bodies, etc.) often profile New Brunswick, the proposed framework recommended by the Premier's Health Quality Council will enable New Brunswick to interpret findings contained in such reports through further research conducted in the provincial context.

Information contained in the Report Card should include comparisons at several levels: national (New Brunswick vs. national average / other provinces), provincial (Population-wide / system-wide) and regional (by communities and Regional Health Authorities). Council recognizes that Regional Health Authorities will be focused on implementation issues during their first year in operation. It is therefore preferable that health system performance measures initially be reported on a province-wide basis. Only once Regional Health Authorities are fully established should performance comparisons between regional services be used to determine best practices and influence changes to the Provincial Health Plan.

6.5.3 Health Quality Standards

Council's mandate specified that the New Brunswick Health Report Card also address health quality standards to ensure New Brunswickers know what can be expected from the health system, particularly in the context of service access. Against these standards, performance measurement should support the introduction of the Patient's Charter of Rights and Responsibilities, and its effectiveness over time.

Some standards can be identified now (i.e. response time and training levels for ambulance services). However, much more reliable information about the health system's current performance is required in order to establish standards that are attainable and sustainable yet truly reflect appropriate care. Standards will be set over time as accurate data is collected and evaluated by the third party research institute.

6.6 Design Considerations / Challenges

6.6.1 Design Considerations

For the implementation of a successful Report Card, Council recommends that:

- Content be responsive to the information needs of the target audience: the public;
- Information relate to the regional/local community context as well as to the overall provincial picture;
- Measures relate to good health and good health care;
- Each publication focus on a few indicators as opposed to measuring and reporting everything at once! (Less than 10);
- Content vary from publication to publication, using both short and long-term indicators;
- Information include positive and negative results, where possible information on negative results must be "actionable" (indication of what will be done to improve the results);
- Easy-to-understand information be provided about quality of care and outcomes;

- Various forms of communication be utilised (including Web-based technology) to foster engagement by the majority of the public;
- Development be supported by 'best practices' (draw from public report card experiences of other jurisdictions); and
- Impartiality and the perception of impartiality remain crucial for the integrity and credibility of the New Brunswick Health Report Card. Government must avoid self-promotion and should mandate an independent 3rd party (Research Institute) to develop the Report Card.

The Report Card should be published at least once a year. Council further recommends that quarterly reports be introduced to address timely issues concerning the health status of the population and the performance of the health system.

6.6.2 Challenges

The limited scope of data collection must be addressed. The Department of Health and Wellness already collects data about health care system performance and epidemiological data. But, data related to determinants of health such as income levels, environmental conditions, education levels, employment and working conditions is not routinely being examined for its links to the health status of New Brunswickers. Nor is it being utilized to guide public policy changes by other government departments that affect health. More resources are essential to expand the range of data collected; this data is essential for understanding the complex interplay of factors influencing the health status and the effective delivery of health care in New Brunswick.

The Departments of Health and Wellness and Family and Community Services need to allocate additional resources to refine and link existing health data bases in such a way that individual cases can be tracked among diverse data bases.

The Department of Health and Wellness also requires immediate additional resources to address the completeness and quality of current data collection, particularly the gaps in ambulatory, post acute and community care, such that the data can be effectively used in the proposed Report Card.

6.6.3 First publication

The Report Card should be published at least once a year after Regional Health Authorities begin to manage the delivery of health services (first publication in the spring of 2003). Because the availability of valid data is likely to remain a critical issue for some time, the first publication may focus on progress made in the establishment of Regional Health Authorities and seamless service delivery between health programs. Information readily available in the areas of population health and social determinants of health should also be incorporated in the first publication. As evidence mounts over time through research and other means, further publications of the Report Card should be able to feature additional findings related to social determinants of health, population health status and the emerging trends and linkages between these and the performance of the health system.

6.7 Health Research - Objective, Evidence-based Information

To be credible, the public must perceive the New Brunswick Health Report Card as an objective assessment. The experiences of other jurisdictions and recent publications on report cards reveal that an independent third party should be retained for the development and publication of the Report Card.

The government's health and wellness vision moves beyond the delivery of health care services. In order to evaluate the health status of New Brunswickers and the effectiveness of the health care system, data must be collected not only from the Department of Health and Wellness but also from other departments and agencies collecting information related to social determinants of health. Production of the Report Card requires the thorough investigation of relationships between various data to identify why such relationships exist.

New Brunswick does not have an established health research body capable of presenting such findings for all four dimensions of the proposed performance measurement framework.

As stated in the Health Services Review Report, charting a course for the health care system requires ready access to relevant information on current and emerging trends and issues in the health field. This access is a must for all stakeholders including the departments of Health and Wellness and Family and Community Services, Regional Health Authorities, health professionals and the public.

Council is convinced that reliable information for evidence-based policy and service must be collected by a credible, high profile organization whose primary focus is to research, analyse and comment on a wide range of quality and performance-oriented matters in the health system. Council is equally convinced this organization must remain at arms length from parties directly involved in the provision and management of health care. As stated in the Fyke Report (Commission on Medicare in Saskatchewan), *"such an organization must preserve an independent voice and its views and conclusions must not be compromised by everyday contingencies and pressures".*

The third party/research institute would be responsible for the ongoing publication of the Report Card and would commission various stakeholders for research, design and publication activities. Data would be secured through internal government sources (health system, and other government departments including Family and Community Services, Education, Environment and Local Government and Finance) and external sources (Statistics Canada, non-government health organizations, universities, etc).

Today, New Brunswick is the only province in Canada that has neither a provincial health research organization nor invests substantially in health research. This is a significant disadvantage. Council urges the provincial government to invest substantially in building the research capacity that is so desperately required in order to provide "made in New Brunswick solutions" stemming from "made in New Brunswick research".

The Premier's Health Quality Council proposal for a health research institute is as follows:

Proposed name

New Brunswick Health Research Institute (NBHRI /Institut de recherche en santé du Nouveau Brunswick (IRSNB)

Role

- To increase health research capacity in New Brunswick by supporting existing and new health researchers and research activities in the Province. (The "hub" of health research)
- To provide relevant information (evidence-based) on current and emerging health trends and issues to government, providers, research community and the public
- To conduct research on the health status of New Brunswickers, the performance of the health system and the broader determinants of health, and to communicate findings through various media, including the publication of the New Brunswick Health Report Card
- To establish linkages where appropriate with other government bodies with the responsibility for key determinants of health as well as with other provincial and national health research bodies
- To inform health researchers in the province on the salient health research issues.

Other possible functions

- To serve as a data repository for data collected by the Department of Health and Wellness, Regional Health Authorities and other pertinent government departments, as well as to make such data available to the research community, based on appropriate confidentiality measures
- To stimulate health research in New Brunswick by participating in the process of securing funds from various government levels and the distribution of such funds to targeted research priorities
- To enhance research output and capacity in New Brunswick by leveraging targeted research monies from various government and non-government agencies such as Canadian Institutes of Health Research, Canadian Health Services Research Fund, Heart and Stroke Foundation, Canadian Diabetic Association to address important health research questions.

Distinction with the role of the Department of Health and Wellness

Based on the model proposed by the Premier's Health Quality Council, the future role of the Minister/Department of Health and Wellness can be summarized as follows:

- To set policies, goals and standards for the provincial health care system (in cooperation with Regional Health Authorities)
- To monitor and evaluate the performance of the health care system (including health programs and services delivered by Regional Health Authorities)
- To fund the health care system
- To collect data and forward it to the Institute with appropriate confidentiality precautions

To effectively carry out these functions, the Department of Health and Wellness will need to rely increasingly on evidence emerging from research on numerous facets of health, including progress made on health outcomes, innovations in service deliveries and best practices. This type of support is not typically found in health ministries. Instead, in the other jurisdictions, it is lodged within an organization whose main purpose is health research such as the one proposed herein.

Structure / Governance

To ensure appropriate accountability and an appropriate degree of independence, a Board reporting directly to the Legislature would govern the proposed health research institute. Membership could be struck with the aim of creating the leverage, influence and leadership to establish the desired effectiveness and presence of such institute.

Suggestion for Board membership could include representation from:

- the provincial government (one or two deputy ministers from departments such as Health and Wellness, Family and Community Services, Education and Environment and Local Government)
- Regional Health Authorities and professional groups
- academic institutions from within and outside New Brunswick
- other health research organizations (Canadian Institute for Health Information, GPI Atlantic, Manitoba/Saskatchewan Centres)
- health charities actively supporting health research, and
- the private sector (including expertise areas such as accounting/ auditing firms)

To assist the Board in its work, supporting committees such as Scientific Review and Ethical Standards would be established.

Advisory panels would also assist the staff on specific subject areas for which the institute would conduct active research. (e.g. Advisory Panel on Health Services Utilization, Advisory Panel on Clinical Outcomes, Provincial Strategy Committees for Heart, Cancer, Diabetes, Asthma, etc.)

To serve as 'the hub' for the health research community in New Brunswick, the institute would encourage all New Brunswick health researchers to become associate members. Access to provincial data and funding grants would serve as incentives to motivate researches to establish a formal link with the institute.

An Executive Director would be responsible for the general management and conduct of the affairs of the institute and would report directly to the Board.

Once fully operational, the institute would employ researchers, computer programmers, systems analysts, administrative staff and secretarial support.

Funding

The proposed research institute is similar to the models used in other jurisdictions such as Manitoba and Saskatchewan with respect to its purpose/roles, staffing and funding arrangement.

As a funding benchmark for health research, the Province of New Brunswick should target as much as 1% of the public health care budget ($1.683 billion for 2001/02) which would represent a sum of approximately $16 million. A substantial portion of this amount should be immediately set aside for the establishment of the institute and to initiate major studies on pressing issues related to health care in the province such as the quality and utilization trends for health services.

The above-noted funding may appear excessive. However, studies have shown that health research institutes bring long-term benefits to the performance of the health system and the economy that greatly exceed its required funding. The potential effect on the economy is substantial, as is the improvement in government policy and decision-making for the field of health care. More evidence-based decisions will lead to better use of health care dollars over time. Through the institute, federal research funding could finally be accessed whereas in the past, various provincial research initiatives were unable to secure such funding as no matching funds could be obtained from the provincial government. Other benefits for New Brunswick will include a new potential for hosting conferences in the health care field, job creation and commercialization activity arising from the research findings. Similar results occurred in other jurisdictions that have established research institutes, including Prince Edward Island.

Implementation

The Premier's Health Quality Council strongly recommends that the Board and the Executive Director be in place by the spring of 2002. This would serve as the catalyst to have the institute fully operational within that same year.

Developmental work related to the first publication of the New Brunswick Health Report Card would be under the responsibility of the Board. Initially, some staff resources could be seconded on a full-time basis from departments such as Health and Wellness, Family and Community Services and Supply and Services (Info. Tech.), to support the work of the institute until this one is fully operational (permanent staff recruited, information system in place, etc.), ideally by the fall of 2003. However, experienced and credible health researchers are essential for the success of this institute as a third party institute.

List of Additional Indicators

Social Determinants of Health

- Food banks/community kitchen utilization
- Opportunities to contribute
- Volunteerism
- Staying involved after retirement
- Social supports / social networks
  - Individual level
  - Community level
  - Homelessness
- Opportunities for physical activity
- Educational options over life span

Population Health Status

- Life expectancy
- Leading causes of death
- Appropriate nutrition (undernourished)
- Functional health / activity limitation / chronic pain
- Teenage birth rates
- Utilization indicators (drug therapy, treatment/intervention, etc.)

Health System Performance

- Public's understanding of the system
- Utilization of services overtime - trends - physicians offices, tele-care, Emergency Room, Community Health Center - access pattern changes
- Number and type of prevention programs per region
- Outcomes on interventions
- Iatrogenic rates (medical treatment / introduced errors by health professionals)
- Progress in business planning (long term / Provincial Health Plan)
- Level of community involvement/innovation in system/services at local/regional level
- Response times (ambulances)
- Mean response time to respond/stabilize and transfer
- Median travel time to your Primary Care provider
- Seamless delivery/level of integration/continuity of care/ interdisciplinary care
- May not require hospital admission
- Client/Community-Focus (communication, confidentiality, respect and caring, participation, involvement in the community, etc.)
- Utilization rates / volume of services rendered (number of patient days, MRIs, CAT Scans, visits to General Practitioners / Specialists, etc.)
- Training, in-service development - Health Professional
- Student enrollment in health professions
- Progress towards "One health record per person" - personal access to that record (in whole or in part)
- Number of family physicians and specialists positions (vacant, filled-average age / gender) per region (for primary and secondary care) per thousand of population

- Number of tertiary physician specialists positions (vacant, filled - average age / gender) for the province per thousand of population
- Number of other professional positions (vacant, filled- average age / gender), (nurses, occupational therapists, physiotherapists, speech language therapists, psychologists, etc.) per region, per thousand of population

Community and Health System Characteristics

- Number of ambulances, number of CAT Scans, number of MRIs, etc. / Average age of equipment, vehicles, etc.

Appropriate use of resources

- Electronic health record - progress in integrating information technology/information system infrastructure
- Pattern of secondary procedures per region
- Number of full time positions (using regular worked hours instead of number of individuals by profession); provincial ratio "Full-time Equivalent (FTE)" / per capita
- Volunteerism (provincial, regional, community figures)
- Capital investments (modernization) by all sources and linkage with three year planning activity
  - From Provincial Government
  - From Federal Government
  - From foundations
- Usage of non-publicly funded health services (physiotherapy, mental health, etc.) – Usage percentage of private pay system.

7. Charter of Rights and Responsibilities

7.1 Introduction

Part three of Council's mandate asked Council's input in the development of a Patient Charter of Rights and Responsibilities. First, Council outlined their vision for this Charter. Council adopted certain basic premises for its development, agreeing that a Charter should:

- Stem from the overall Vision of the renewed health system;
- Outline rights and responsibilities at every level: individual, health professional and system;
- Inform, educate and support informed decision making for individuals/professionals and the system;
- Promote collaboration and cooperation in achieving a shared responsibility for health and the system;
- Apply to all health services for all citizens, prior to, and after discharge from the health care system;
- Provide transparency and demystify access to health services for both the individual and the professional working within the system;
- Be supported by mechanisms which provide the necessary supports for individuals to fully exert their rights and for the system to be able to deliver consistently;
- Be monitored and evaluated to measure success on delivering rights and on creating a climate that allows for citizens to assume their responsibilities;
- Evolve with a system in transition, be acted upon, respected and followed.

The proposed Charter addresses the rights and responsibilities of an audience broader than patients. The goal of this Charter is to encourage individuals to take an active role in maintaining good health. With this in mind Council proposes the adoption of the following name for the Charter:

New Brunswick Health Charter of Rights and Responsibilities

The proposed Charter was developed to clarify for New Brunswickers what can be expected from their health system during transition and after the renewal process is completed. Some of the supporting mechanisms and features associated to the Charter will be implemented gradually as the system evolves. The Charter clarifies this new orientation but is dependant on these features coming in place to enhance access, communication, and right to decide.

The rights referred to in the Charter are not new rights. These rights are in complete accordance with various federal and provincial statutes governing health care and are consistent with the ethical codes of conduct governing health professionals. To write the Charter, Council drew upon the five principles of the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility. This Charter serves to reinforce these principles by further defining what they mean in the New Brunswick Health System.

The Charter is not meant to address finite details of every service or program delivered within the health system. The terminology used throughout the Charter is as specific as possible. However, when a term open to wide interpretation such as 'reasonable' is used, it will be defined through program specific provincial standards.

The Charter has been designed to balance expectations with responsibilities. Those who work within the system and those who access it each have very clear contributions to make in ensuring optimal health outcomes. This Charter will serve as a guide to all concerned in moving toward that direction.

7.2 Purpose of the Charter

The Charter as proposed performs three specific functions: the explanation of expectations, the explanation of responsibilities and the support of a service delivery which will meet collective expectations.

The Charter will explain to New Brunswickers what can be expected from the health system and from health professionals. Council believes individuals must be informed of how health services are delivered and what their rights are when accessing those services

New Brunswickers will have their individual responsibilities within the health system and toward health professionals explained as well. This serves to promote a shared responsibility for health and the health system by clarifying what each individual can contribute to ensure optimal efficiency.

The terms of the Charter were further written to support a spirit of service delivery that meets collective expectations. Service standards and monitoring through the Health Report Card will enable an assessment of the system's performance vis-à-vis the identified rights and responsibilities.

7.3 The Charter as a legislated act or part of public policy

Council's responsibility includes laying out the potential application of the Charter. However, it is the government who must decide whether the Charter be legislated or brought into public policy.

Council's had several major considerations about the Charter's possible application. These include that the Charter should:

- Put mechanisms in place to ensure the Charter is applied and respected, such as the Public Trustee/Guardian office, legislated provisions for Advanced Health Care Directives;
- Be used as an instrument to identify the strengths and weaknesses of the health system as it relates to the rights and responsibilities of individuals and professionals, while remaining open to remedial action;
- Remain a positive feature within the system for the professionals working within the system and for the individual that accesses services;
- Put mechanisms in place to address individual complaints or issues, should be easily accessible and at no cost to the individual;
- Be implemented in the spirit of helping health professionals and individuals work together towards good communication and achieving common goals; and
- Serve to educate and inform the public.

7.4 The Proposed Charter

The Charter addresses the following five broad categories of rights.

Access to health services: *addresses access, equity, responsiveness to individual need, continuity of care, linguistic, ethnic, spiritual/religious, family and cultural factors. These are supported by mechanisms such as improved access through a network of Community Health Centres, and maximizing roles of professionals.*

Making your own decisions: *supports the ability of individuals to make decisions, ensures individual control of care, and supports informed decision-making. These are supported by mechanisms such as, legislated provision for "Advanced Health Care Directives", and the creation of an Office of Public Trustee/Guardian.*

Good communication and information *sets the foundation necessary for individuals to make informed decisions about their care, right to access their own information, to know how the information is used, to question, and to understand what is expected of them through their care. These rights are supported by mechanisms such as a new service delivery model where the right health professional provides the right care at the right time and at the right place. This will ensure that professionals can spend more time answering questions/issues and provide individuals with enough information and support to pursue health goals.*

Personal consideration and respect *states accepted standards of professional courtesy and outlines individual respectful treatment to which every New Brunswicker is entitled. These are supported by a system that emphasizes good communication and information, a continuum of care that is person-centred and provides opportunities for more individual involvement.*

Addressing your issues/complaints/questions *addresses the individual's right to advocacy within the health system. It is recommended that the right to advocacy be supported by a Provincial Advocate and Regional Advocates to assist individuals with their issues about a service or the outcome of a service/intervention within the scope of the Regional Health Authority. The advocacy system is not meant to replace other mechanisms such as professional association complaint processes, or the legal system. Rather, the role is to facilitate communication between a professional(s) and family/individual when problems arise, or review and direct individual inquiries.*

The Charter outlines a number of specific rights and responsibilities for the individual, the health professional and the system. The complete Charter can be found at the end of this Chapter.

7.5 Supporting Mechanisms

While developing the Charter it became apparent that the system must support individuals and health professionals with the appropriate mechanisms , if it is to be effective. A number of mechanisms need to be in place to facilitate and respect the rights as stated. These mechanisms allow individuals to fully exert their rights in areas that extend beyond the health system but nonetheless impact on health outcomes. They are:

- The creation of an office of Public Trustee/Guardian
- The creation of regional and provincial advocate positions
- Legislation allowing for the use of Advanced Health Care Directives
- A renewed health system and service delivery model.

7.5.1 Public Trustee/Guardian

The Public Trustee/Guardian initiative has been studied on numerous occasions in New Brunswick over the years. The idea has again re-surfaced as part of a comprehensive and integrated health system, at Council's recommendation. The problems and issues that continually brought the idea to the forefront still exist in today's health system.

Purpose of the Public Trustee/Guardian

To assist and protect individuals who are not capable to make their own decisions regarding the management of their estates, their personal care or their health care, and have no one to assume that responsibility.

Scope of Public Trustee/Guardian

The Trustee of last resort , as recommended by Council should provide services to the people of New Brunswick by:

- Administering the estates of people who have died in New Brunswick with no one else capable or willing to act as administrator;
- Administering the estates of people who are not mentally capable of doing so and making financial and care decisions on their behalf;
- Administering the estates of people who have granted a Power of Attorney to the Public Trustee;
- Administering trust monies on behalf of people who are under 18 years of age;
- Supporting all these functions with legal, financial and accounting expertise; and
- Fulfilling additional roles pursuant to legislation or as ordered by the Court.

Description of the issues

Research revealed limitations of the protective measures for vulnerable adults in the current system. Some of the major gaps leave individuals with very few options to guard their well being. This inability to act leaves the system vulnerable to higher costs and/or improper utilization of expensive resources.

In its deliberations on the issue, Council discussed many of the challenges in the province.

Demographically, New Brunswick's population continues to age. This aging generation has accumulated more than their predecessors ever did, in the form of retirement pension plans, insurance, property. This aging population also has more debts to manage than their predecessors. Because of these factors, estates are expected to be worth more and be more complex to manage.

These difficulties will touch more than just financial matters, moving into every aspect of decision making, including personal care, medical care, and living arrangements.

At the same time concerns have risen that many individuals facing declining mental states have not prepared for the day they will no longer be competent to make their own decisions. The same type of concern applies to intellectually or mentally challenged individuals who need support and assistance to make decisions, and whose financial affairs may be left unmanaged. This leaves the door open to financial abuse.

Without the protection of a Public Trustee/Guardian, or a pre-selected surrogate decision-maker, the now disabled adult can be vulnerable to financial abuse. The current protection mechanisms require an application to the courts, which can be costly and time consuming. Many individuals do not have someone willing or able to act for them.

There are a number of vulnerable/disabled adults in hospitals. They may have been admitted for a minor health problem, then during the course of their in-patient stay lose their ability to make decisions. The process of moving these individuals to more appropriate settings or providing appropriate care depends largely on their ability to understand the situation, provide the necessary information and give their consent to be moved. Many disabled adults spend months in hospital beds before an appropriate placement can be made, because they lack the ability to give informed consent.

The current situation presents a number of issues for nursing homes who are admitting individuals whose financial situation is not clear. It presents major difficulties for the nursing home to access the client portion of the cost deemed the responsibility of the resident. This can have major financial implications for these nursing homes, which are non-profit operations.

Current legislated mechanisms, such as the Infirm Person's Act and the Mental Health Act, address certain aspects of the protection of vulnerable adults. But these are limited to very specific situations/groups. Examples of this include access for psychiatric patients to a patient advocate system and administrator of estates and the preparation for future loss of autonomy by the naming of a surrogate decision-maker through power of attorney who will make decisions for them when they can no longer make their own.

The provisions under the Infirm Person's Act and Mental Health Act offer some options and flexibility. However, these provisions are not sufficient and do not serve the needs of the entire population.

Recommendations

Council recommends the establishment of an Office of Public Trustee/ Guardian to ensure the protection of all vulnerable adults for personal and health care and estate management. While proceeding with the establishment of the Public Trustee/Guardian, Council recommends the Act include provisions to assess competency based on 'domain specific capacity'. (This paradigm recognizes that people may have the capacity in one domain, e.g. health care, but lack it in another e.g. finances. This model presumes that a person has or lacks capacity for all decisions in that particular domain and each domain is treated separately[1].) Currently in New Brunswick, individuals assessed for competency are found to be either fully 'competent' or 'incompetent', thus removing the ability to continue making decisions even in domains where they are still capable.

Council further recommends the following be considered in establishing the role and scope of the Public Trustee/Guardian, that:

- Existing mechanisms (legislated acts) addressing the protection of vulnerable adults in the areas of decision making for personal care, health care, and estate management, as well as the administration of trusts for children under 18 years of age be regrouped under new legislation under the authority of the Public Trustee/Guardian. Also to be included is the administration of the estates of people who have died in New Brunswick with no one else capable or willing to act as administrator;
- The possibility of establishing the office of Public Trustee/Guardian as a Special Operating (independent) Agency be examined as a means to address sustainability and accountability issues; and
- The possibility of extending the Public Trustee/Guardian responsibility to include administering the estates and personal care of vulnerable but competent individuals with modest estates through delegation in a Power of Attorney be examined.

Scope of responsibility of Public Trustee/Guardian

Council recommends that the Public Trustee/Guardian:

- Act as 'committee' for mentally incompetent persons;
- Consent or refuse consent to psychiatric treatment for mentally incompetent patients in psychiatric facilities and for medical treatment to mentally incompetent patients on medical wards;
- Act as substitute decision-maker for personal care, health care and/or property for vulnerable persons;
- Act as Official Administrator for the province;
- Act as Official Guardian for the province;
- Act as Litigation Guardian for infants and mentally incompetent persons who have no one else competent to act on their behalf;
- Act as Trustee for funds payable to infants;
- Review all applications for private committeeship; and
- Manage financial affairs under powers of attorney for vulnerable but competent adults who have modest estates that would not likely be attractive to private trust companies.

Council recommends the clear legislated delineation of the limits of the Public Trustee/Guardian's surrogate decision-making. This is especially sensitive for intellectually or emotionally disabled individuals who require a surrogate decision maker for refusing treatment or in the event of a life-threatening tragedy. Council firmly believes further consultation should be conducted prior to adopting a model and recommends applicable legislation be in place to ensure the most vulnerable in our society are protected.

7.5.2 Health System Advocates

Council sees the need for a Advocate system as a supporting mechanism of the Charter of Rights and Responsibilities within the health system.

Purpose

The Health System Advocates would facilitate citizen interface with the system. This is especially important when issues need to be addressed, when information that is not easily accessible is needed, or when a citizen feels he/she is not receiving appropriate information or treatment.

Current situation/issues

Currently, only a few Hospital Corporations provide a Patient Representative within hospital facilities. However, where provided, they have proved to be valuable for both the corporations and individuals. Individual requests for assistance have grown over the years. The proposed model is based on what is currently in place.

Council understands that the health system is very complex and individuals who need to use it are often at a loss in dealing with access issues, treatment options and getting their issues addressed. In a person-centred system there is a need to enhance the system's responsiveness, transparency and effectiveness in dealing with individual's issues.

Proposed Model for Health Advocates

Council proposes a two-pronged model to facilitate citizen access and communication within the health system. First a Regional Advocate position should be established in each of the Regional Health Authorities. And second, a Provincial Advocate position should be established to address broad province-wide policy and communication issues that are common to all regions and/or out of the scope of regional responsibility. The Provincial Advocate would also address issues in all services under the scope and mandate of the Department of Health and Wellness delivered provincially.

The Regional and Provincial Advocate would address questions/concerns and complaints within a clearly delineated scope, and are not deemed to replace existing professional associations guiding codes of practice or the legal and judicial system.

Scope

Council firmly believes the proposed system of advocacy should:

- Provide a venue for citizen representation when needed, within the entire health system (all services under the scope of Regional Health Authorities and services delivered centrally by the Department of Health and Wellness);
- Ensure citizens can access a Regional Advocate within the region where a service is located to help with questions/issues. This service needs to be broad enough to assist those attempting to access a service or have questions about the outcome of a treatment or intervention for themselves or a family member;
- Provide strong linkages between the Provincial Advocate and the Regional Advocate to promote collaboration in resolving common issues;
- Mandate both regional and provincial positions to support and facilitate equity of access for inter-regional and centralized health services;
- Inform and re-direct citizens to the appropriate person or service when an issue cannot be dealt with within their scope and mandate. The Advocate will be knowledgeable of the broad system and support citizens in accessing the appropriate mechanism or service;
- Work from the premise that most citizen issues can be satisfactorily resolved by ensuring good communication between the citizen and the system as well as timely responsiveness to citizen issues; and
- Emphasize that there is a need for and an opportunity to provide impartial advocacy between citizens and providers while promoting effective communication to reconcile differences.

Responsibilities of the Regional Advocate

The duties and functions of a Regional Advocate would include:

- Assisting patients, individuals and/or their families and others as appropriate, with their issues, questions and/or problems originating from the region where a service is accessed;
- Providing an independent and confidential forum where concerns are heard respected and documented;
- Reviewing and directing inquiries and issues to the appropriate source and act as facilitator to provide an interface between the service provider and others as appropriate;
- Providing a liaison between the individual/family or others as appropriate and the Regional Health Authority;
- Informing Regional Health Authority Boards of individual issues and complaints of a regional nature;

- Ensuring that individuals/family or others as appropriate are able to obtain information on their rights and responsibilities as set forth in the Charter of Rights and Responsibilities; and
- Providing on-going feedback to the patient/individual, family or others as appropriate to action and outcome.

Responsibilities of the Provincial Advocate

The duties and functions of the Provincial Advocate would include:

- Overseeing and surveying the Charter;
- Ensuring the Charter of Rights and Responsibilities is evaluated and monitored on an on-going basis for compliance and effectiveness;
- Investigating and addressing unsatisfactory results stemming from the evaluation and monitoring of the delivery of rights;
- Receiving, understanding and addressing Regional Advocates' concerns regarding issues with a provincial scope;
- Liaising with Regional Advocates to innovate solutions for issues that are common to all regions but need to be addressed on a provincial level;
- Providing consistent and regular opportunities through meetings or forums for Regional Representatives to work in collaboration and to share issues and best practices in performing their duties;
- Networking with other government departments/agencies and work collaboratively to address policy issues crossing various mandates; and
- Reporting activities, successes, news stories and events to the public to establish a positive open profile and a transparent approach to hearing and addressing citizen issues within the health system.

Reporting structure

The Regional Advocate would report to the Regional Health Authority CEO with regular reports going to the Regional Health Authority Board. The Provincial Advocate would report to the Deputy Minister of Health and Wellness. Consideration should be given to providing regular public reports on the role, business and progress of the Advocate. Strong linkages should be established between the Provincial Advocate and Regional Advocates facilitating cooperation and collaboration in addressing citizen issues.

7.5.3 Advanced Health Care Directives

Introduction and Definition

"An advance directive is a written statement that expresses a person's wishes in advance…An advance directive is only used if you are incompetent and unable to make your wishes known."[2]

Council understands that maintaining control over end of life decisions is a difficult topic for most individuals. Legislated provisions for the preparation of Advanced Health Care Directives flow from the right of individuals to make their own decisions. As a society we have become much more aware of the need to inform loved ones about what is acceptable and unacceptable in end of life decisions. Council considers that Advanced Health Care Directives make it much easier to broach the subject and inform loved ones of those wishes.

Advanced Health Care Directives will offer the individual the option to ensure control over these decisions. The intent of the recommendation is to provide choice.

Description of the issues

The Charter states a person has the right to make Advanced Health Care Directives and have those directives respected.

Currently individuals can prepare a Living Will or a Power of Attorney stating their health care directives in advance. These are generally prepared by a lawyer who does not have the medical background to fully explain the medical care alternatives to their client. Consequently, these documents do not provide the same level of detail as an Advanced Health Care Directive would and are less effective in providing the necessary guidance to family members, and health professionals in executing the person's wishes. Currently Living Wills or Powers of Attorney may be overruled or ignored in the area of personal and health care.

There is no legislative authority or protection for physicians who respect the wishes of an incompetent or disabled adult's advance care directives. The threat of a liability suit is a great disincentive to respecting a person's wishes.

Further, a mechanism to store or access Advanced Health Care Directives in the health care system is lacking. These may exist somewhere but may not be brought to the attention of physicians in a timely manner. This can result in unwanted interventions being performed.

Council believes individuals should be able to decide and maintain control over end of life decisions. With the proper mechanism in place individuals who wish to maintain control over their personal health care will have the opportunity to do so.

Recommendations

Council recommends that:

- Legislation be drafted and implemented to allow for the provision for Advanced Health Care Directives;
- Existing models and tools available through, "Let Me Decide", Molloy, Dr. D. William, and "Let Me Pass Gently", Molloy, D.W., Russo, R.M. serve as the basis to implement a model for New Brunswick;

- A committee be established to oversee the development and implementation of legislation allowing for the use of Personal Health Care Directives;
- The legislation provides the necessary liability protection for health professionals to be able to execute and respect the individual's wishes;
- A public education campaign be launched to inform citizens about Advanced Health Care Directives with the opportunity for citizens to access more information and assistance in preparing directives;
- Government develop a network of trained individuals to assist individuals in preparing Advanced Health Care Directives;
- The health system provides for the storage of information in the citizen's health record cueing that the individual has prepared Advanced Health Care Directives. These directives should easily be accessible while respecting right to privacy, right to information legislation; and
- Training be provided to health professionals across the system to ensure proper understanding and application of the process.

Implementation Considerations

Council agreed it was not enough to state rights. The health system must provide mechanisms and means through which people can exert their rights. It is necessary to provide ways to support and implement the desired rights.

7.5.4 Addressing Barriers to Access

Many barriers to equitable access have been identified. Fundamental strategies to address such barriers include assisting those who must travel long distances or short distances frequently to seek needed services, providing wheelchair accessible facilities and bilingual service.

These barriers must be eliminated if the principles idealized in the Charter are to be upheld. However, wide collaboration among all stakeholders is required to achieve effective solutions. For example, Regional Health Authorities will need to work in concert with community resources to identify and address the barriers that stand between individuals and needed services. Many community groups will need to continue to work toward the education of the population.

Facilities accessible to all

All new service locations must be accessible to those living with a physical challenge. Buildings must be equipped with ramps and elevators and accessible washroom facilities.

Provision of services in both official languages

It is a fundamental principle of the health system that an individual be able to access services in the official language of choice within their region, the province and out-of-province.

Travel assistance

Difficulties and costs associated with travel are barriers to equitable access to health services. Many New Brunswickers must travel considerable distances out of their region to access tertiary services. The costs of travel, food and lodging for the family members who accompany a patient are a significant burden to those families. Some New Brunswickers must travel significant distances to access secondary care within their region.

Council believes citizens have a right to equitable access to health services and as such recommends that the issue of travel costs should not be a barrier to access. This is not to say that all travel will be compensated, but that guidelines must be established to achieve balance and fairness for all citizens. The following merit further exploration:

- Use of tax credits.
- Direct compensation for cost of travel for all within a limited set of criteria based on distance, circumstance or frequency of travel.
- Direct compensation for cost of travel for those who would suffer hardship due to frequent and/or out of region traveling to service. It is important not to subject individuals to means testing in order to access assistance.
- Involve the Regional Health Authority of a particular tertiary program in developing subsidized options for accommodations and meals to assist those having to remain on site to support a loved one through a health crisis.
- Involve a number of stakeholders in establishing community-based/ provincial assistance to citizens for travel. A good example of this is the "Dial-a-Ride" (www.gov.ns.ca/snsmr/dialaride) program established in Nova Scotia.
- Revise income assistance policies to ensure those in need receive assistance to travel to health services. However, with this option, a separate mechanism would also need to be in place to assist low-income working families.

Council concluded that a number of options should be implemented to ensure the goal of equity of access is achieved. There is not one easy solution. The intent is not to replace or eliminate any of the community-based supports that exist but rather to build upon these in each region.

1 Molloy, D.W., Russo, R.M., Let Me Pass Gently NEWGRANGE Press, 2000

2 Molloy, D.W., Russo, R.M., Let Me Pass Gently NEWGRANGE Press, 2000

7.6 The Charter

Access to Health Services

You have the right:	You have the responsibility:	Your health system has the responsibility:
1. To receive publicly funded health services on the basis of your need, not your ability to pay, your lifestyle or any other factor. 2. To access primary care services in your local area. Secondary health services will be provided in hospitals, while tertiary services will be provided in more specialized settings within or outside the province when situations warrant. 3. To receive health services from your family physician or collaborative practice team. 4. To equitable access to health services. 5. To obtain a second opinion. 6. To receive continuity of care. 7. To receive health services in a manner that recognizes, responds and respects your individual needs and preferences, including those based on ethnic, spiritual/ religious, linguistic, familial and cultural factors. 8. To receive services in the official language of your choice. 9. To access services in a facility that is wheelchair accessible and free of barriers.	1. To learn how to access health services. 2. To use services appropriately and wisely. 3. To live a healthy lifestyle.	1. To respond to your needs in a timely manner based on established standards. 2. To answer your questions and provide information about treatment and services available to you. 3. To provide a seamless continuum of care. 4. To deliver services and care in an effective and efficient manner without compromising the quality of that care. 5. To spend allocated public funds prudently and wisely. 6. To provide clear policy outlining how health professionals are to report concerns about risks for patients. 7. To provide a safe environment for workers. 8. To promote an atmosphere where personnel are treated with due respect and consideration in the execution of their duties. 9. To ensure facilities are wheelchair accessible and barrier free.

Making your own decisions

You have the right:	You have the responsibility:	Your health system has the responsibility:
1. To be informed. 2. To refuse treatment. 3. To exercise your choice of treatment. 4. To have advanced health care directives concerning treatment or to designate a surrogate decision-maker. 5. To agree or refuse participation in any teaching or research program. Your decision will not affect the quality and level of care you receive. 6. To the protection of a Public Trustee in the event that you have been declared mentally incompetent and have not assigned someone to make decisions for you. 7. To information on qualifications and the level of experience of the health professionals from whom you receive services.	1. To participate in your personal health care decisions and ask questions when you need more information. 2. To ensure you maintain control over your personal care decisions by having "Advanced Health Care Directives" in place that state your wishes. 3. To chose someone you trust as your advocate or trustee of your personal care decisions.	1. To thoroughly inform you about what any treatment will entail, what will happen when a diagnostic procedure is prescribed, and the potential implications of a procedure, treatment or medication. 2. To respect your health care decisions and to provide you with thorough and complete, but impartial and unbiased information about the implications of any decisions. 3. To keep on file, in confidence, any legal document you provide expressing your wishes should you become unable to communicate. 4. To work with your selected trustee or advocate, to ensure your decisions are fully understood and executed. 5. To respect and assist you in incorporating your personal care wishes in your health record. 6. To ensure the protection of mentally or emotionally challenged individuals is included in legislation allowing surrogate decision making mechanisms.

Good communication and information

You have the right:	You have the responsibility:	Your health system has the responsibility:
1. To have the appropriate professional clearly explain the proposed treatment, including any risks involved in that treatment, any possible side effects and any alternatives. 2. To be informed about new advances which are relevant to your condition or your health. 3. To have access to your health records at no cost. 4. To privacy and confidentiality of all information and records regarding your care. 5. To be informed of how your information will be used, who has access to/or seen your records, and what has been discussed regarding your condition/ situation. 6. To receive information on health services. This includes information on the standards of service you can expect, and points of access. 7. To be provided with clear directives outlining continuing treatment you are expected to follow either upon discharge from a facility or point of service or as part of your community-based care plan. 8. To be informed of policies which relate to your care, treatment and responsibilities. 9. To receive complete information about choices that promote good health and measures to prevent illness and accident. 10. To be involved in the planning, evaluation and review of your care. 11. To communicate in the official language of your choice.	1. To exercise your option to ask questions if you need more information. 2. To ensure you understand your treatment plan and seek clarification when necessary. 3. To follow specific instructions in preparation for admission to the hospital or for a diagnostic procedure 4. To request information and ask for options available to assist/support you in making lifestyle changes to improve or maintain your health status. 5. To participate in your care to the extent you are comfortable. Offer information that will help you and health professionals decide options mutually agreeable to both of you to ensure positive health outcomes. 6. To make your language and communication needs known to the health professionals.	1. To answer your questions about your care, options and alternative approaches to your treatment. 2. To provide you with the opportunity to participate in all decisions about your treatment and discharge. 3. To ensure your informed consent is given prior to providing you with any treatment or procedure and prior to releasing information on your health situation. 4. To make every reasonable effort to ensure you receive the information you need in a manner you can understand. 5. To provide you with and assist you in examining your health records upon your request and at no cost. 6. To ensure information on health services can be easily accessed at various and numerous points in the system. 7. To ensure your discharge plan is discussed with you prior to leaving the treating facility. Should your care continue in the community, health professionals will ensure the continuum of care is in place prior to your discharge. 8. To provide you with support and services to assist you in maintaining/developing healthy lifestyles. 9. To include you in the process of developing your care plan and provide you with options that will work for you and mutually agreed upon to reach positive outcomes. 10. To maintain a code of confidentiality for persons under their care as well as any information they might become privy to on other people accessing health services 11. To determine language and communication needs of health regions and work pro-actively with the community to develop the capacity to meet the needs. 12. To ensure all health facilities are equipped with a cart containing communication assistance devices to better assist those with special communication needs. 13. To access interpreters to assist communication.

Personal Consideration and Respect

You have the right:	You have the responsibility:	Your health system has the responsibility:
1. To be cared for in an environment which is clean and safe. 2. To have reasonable measures taken to ensure your personal safety and protection. 3. To be treated with dignity and respect. 4. To be comfortable and free of distress. 5. To have reasonable measures taken to respect your privacy.	1. To collaborate with personnel in their duty of assessing and improving your health. 2. To be courteous and understanding of other individuals accessing services, personnel, students in training and volunteers. 3. To be respectful of your surroundings and the property of others. 4. To make your privacy needs known.	1. To ensure personnel are tactful, reassuring, patient, understanding and sympathetic towards you, your relatives and friends. 2. To ensure you are treated with respect, empathy and professionalism. 3. To ensure your condition is never discussed with any unauthorized person.

Addressing your questions/issues/complaints

You have the right:	You have the responsibility:	Your health system has the responsibility:
1. To raise your issues without fear of reprisals. 2. To be informed of the procedure and appropriate channels to have your issues addressed.	1. To raise your issues following the process outlined by your Regional Health Authority to the Regional Advocate. 2. To direct any unsatisfactory resolution of your concern to the Provincial Advocate when the need warrants.	1. Provide you with mechanisms to hear your questions/issues/ complaints. 2. To inform you of the mechanisms in place to address your questions/ issues/complaints. 3. Investigate complaints within the timeframe set out in the process. 4. To inform you of the outcome of an investigation and take appropriate action.

Glossary of Terms

The following terms are defined and applicable in the context of the Charter of Rights and Responsibilities.

1. "Advanced Health Care Directives" means a written statement that expresses a person's wishes in advance. It can only be used if a person is declared incompetent and unable to make his/her wishes known.
2. "Care Plan" means a plan developed between the health professional and the individual or guardian/parent that outlines strategies to attain health goals.
3. "Charter of rights and responsibilities" means the statement of rights and responsibilities for New Brunswickers.
4. "Provincial/Regional Advocate" means the regional and the provincial advocate within the health system that deals with citizen question/issues and complains vis-à-vis the health system.
5. "Dignity and respect" means a code of behavior between individuals and health professionalss. The code of behavior is one of understanding, courtesy, and civility.
6. "Discharge plan" means a plan elaborated between the health professional(s) and the individual or parent/guardian outlining what is expected of the "patient" upon discharge from a health facility or program. It outlines the strategies for recovery from an injury or illness.
7. "Equitable access" means that access to health services is equalized for all the constituents. By such, it also means considering the barriers to access by virtue of distance, communication barriers, physically accessible locations etc. and for the system to provide equilibrium in addressing those barriers.
8. "Health services" means all health services managed under Regional Health Authorities and health services managed centrally, including insured and non-insured services, and services contracted by the province or Regional Health Authorities to a third party.
9. "Healthy lifestyle" means adopting routine or daily practices, such as exercise, and nutritious diet, as a lifestyle choice to enhance and maintain good health.
10. "Informed consent" means having information and understanding the implications of a proposed course of action suggested to you by a health professional prior to giving your consent to accept what is proposed.
11. "Primary care" means the provision of basic individual and community-focused health care that is seamless, integrated, coordinated, accessible and sustainable. It supports individuals and families making the best decisions for their health.
12. "Public Trustee/Guardian" is an individual tasked with the responsibility to assist and protect individuals who are no longer able to make their own decisions regarding the management of their estates and their personal and health care, and have no one else to assume that responsibility.
13. "Responsibilities" means the actions that fall within the control and purview of individuals in order to achieve or maintain good health.
14. "Rights" means the number of statements outlined in the Charter that define what one can expect in terms of health services.
15. "Seamless continuum of care" means the array of services that come together to provide timely, accurate and coordinated care.
16. "Secondary Care" means specialized care requiring sophisticated and complex diagnostic procedures and treatment processes normally found in the hospital setting.
17. "Tertiary care" means care that requires highly specialized skills, special technology and specialized support services.
18. "Treatment" means a prescribed or suggested course of action provided to an individual by a health professional to address solutions, alleviate symptoms, or treat an illness or injury for which relief is sought.

8. Program Issues and Health Services Review Recommendations

8.1 Introduction

This section of the report focuses on Council's advice on the Health Services Review Report and its recommendations. Also included are recommendations not found in the Health Services Review Report and program areas not addressed in the Proposed Health System chapter of this report.

If Council's vision for the renewal of the health system is to be a reality in New Brunswick, a new method of providing health services will be required. The Health Services Review Report provided extensive recommendations which Council addressed in an attempt to provide government with a blueprint for renewal.

The Health Services Review provided Council with context and direction but discussion was not limited to the report and its recommendations, nor was it considered binding. The review did provide Council with direction for its first three mandates as well.

Recommendations one through 39 (with the exception of eight, nine, and sixteen) deal with role changes in the Department of Health and Wellness and Regional Health Authorities.

Health Services Review Recommendations

1. That the Department of Health and Community Services limit its role to setting goals and objectives and monitoring progress towards their achievement, except in program areas where greater efficiencies can be achieved if managed centrally (e.g., Medicare and the Prescription Drug Program).
2. That the Department of Health and Community Services be responsible and accountable for:
   - Establishing overall direction through legislation, policy, regulations, standards and the level of funding within which the health care system must operate;
   - *Ensuring* the development and maintenance of a comprehensive information system to link all elements of the system together;
   - *Planning* services and programs that make up the health care system; (i.e., the Master Plan);
   - *Planning* and co-ordinating the Prescription Drug Program (PDP); Medicare; and services where greater efficiencies can be achieved if managed centrally.

3. That the Department of Health and Community Services take deliberate steps to refocus their activities to accommodate the new model.

4. That the Minister of Health and Community Services establish Regional Health Authorities in each of the existing health regions.

5. That the Minister of Health and Community Services ensure the establishment of Boards for the Regional Health Authorities.

6. That the Minister of Health and Community Services ensure adequate representation from the Local Advisory Committees on the Boards.

7. That the Boards be responsible and accountable for:

   - *Promoting* and protecting the health of the population in the region and working toward the prevention of disease and injury;
   - *Assessing* the health needs of the people living in the region;
   - *Determining* priorities for the provision of health services in the region and allocating resources accordingly;
   - *Planning* and co-ordinating the delivery of accessible required health services including primary care, secondary care, and tertiary care where designated in the Master Plan, community care, short term care, rehabilitative care, long term care, as well as ambulance, public health and mental health services;
   - Ensuring reasonable access for people in the region to tertiary or other health services not provided in the region;
   - *Monitoring* and evaluating the effectiveness and efficiency of health services in the region;
   - Establishing formal linkages between and amongst health service providers within the region and between regions providing needed tertiary care services;
   - Managing the allocation of public funds for the delivery of all services for which they are responsible.

8. That the Boards ensure the establishment of Local Advisory Committees for each of the communities in their region.

9. That Local Advisory Committees be mandated to provide information and advice to the Regional Health Authority Board on matters of concern with respect to the health care services in their communities.

Council has not included any direction on recommendations eight and nine, trusting each Regional Health Authority to find its own methods of involving its communities.

Health Services Review Recommendations

10. That the roles and responsibilities of the Boards and the Committees be clearly and fully delineated and communicated to the appropriate bodies.

11. That the Minister of Health and Community Services take specific measures to ensure that there are no disincentives for the use of community care delivery options or conversely that there are no incentives for the use of institutional care delivery options.

12. That the Department of Health and Community Services develop, in collaboration with key players from the field, a set of system-sensitive goals, objectives and performance indicators.

13. That the Department of Health and Community Services communicate these goals, objectives and performance indicators to the Boards for the Regional Health Authorities.

14. That Boards be mandated to collect the appropriate information to facilitate the measurement of their performance.

15. That Boards be accountable to the Minister for their performance against the established goals and objectives.

16. That the Minister of Health and Community Services review the existing Advisory Committees with a view to ascertaining their relevance and effectiveness.

The content of recommendation 16 was addressed by the Government ABC Review Committee. No changes were recommended.

Health Services Review Recommendations

17. That the Minister of Health and Community Services establish a New Brunswick Health Research Council.

18. That membership on the Council include representatives from the Advisory Committees, the Regional Health Authority Boards, the university community and others as appropriate.

19. That the Council initially have as its mandate to provide the Minister with relevant information on trends and issues confronting the health care system, as a framework for goal-setting.

20. That the Council take on as a second step the mandate of assessing the health care system on an ongoing basis and making recommendations to the Minister for evidence-based change.

21. More specifically, that the Council assume responsibility and accountability for:

- Measuring the health status of the population;
- *Measuring* the performance of the health care system;
- *Publishing* performance ratings of the Regional Health Authorities.

22. That the Council facilitate continuous quality improvement by acting as a clearing-house for relevant research evidence, and supporting the work of local champions.

23. That consideration be given to establishing linkages between the New Brunswick Health Research Council and a proposed Atlantic Health Council.

24. That linkages be established where appropriate with other government bodies with responsibility for the determinants of health: e.g., the Cabinet Committee on Social Policy Renewal.

25. That the Province adopt a "wellness" model of health care through the establishment of a broad array of delivery organizations such as Community Care Centers where prevention and public education will form a major component of their mandate.

26. That Government harness all areas of policy in support of good health in a coordinated way through a Deputy Ministers Committee that will be mandated to continuously monitor the impact that new and continuing policies have on the determinants of health.

27. That Government give a higher profile to public education and health promotion, by increasing the resources applied to these areas.

28. That Government encourage good health through measuring health outputs rather than inputs.

29. That a variety of Community Care Centers be developed in New Brunswick. The structure of the local primary health care service should not be restricted, but should follow local needs.

30. That the Department of Health and Community Services encourage effective management of chronic diseases in a Community Care Center format where clinics, public education and clinical practice guidelines will be employed.

31. That the Department of Health and Community Services, and community-based health services utilize the knowledge and enthusiasm of those in individual support groups for chronic illnesses to assist the self-management of chronic diseases.

32. That the Department of Health and Community Services develop a plan to transfer the responsibility for primary health care out of hospitals to the communities.

33. That the Department of Health and Community Services ensure that the Extra-Mural Hospital be a vital component of Community Care Centers.

34. That the Department of Health and Community Services take steps to ensure that hospital care is specifically targeted to the delivery of specialized and highly specialized diagnostic procedures and treatment.

35. That the Department of Health and Community Services take active measures to support the use of technologies and innovative drug therapies that enable people to remain in their communities or to return to them as quickly as possible.

36. That the Department of Health and Community Services reinvest savings generated from the redefinition of roles towards the development of Community Care Centers.

37. That the Department of Health and Community Services revise its Master Plan to reflect the change in paradigm.

38. That the development of tertiary care service be permitted only where the principles of evidence-based decision-making, critical mass, and linguistic service are met.

39. That the Department of Health and Community Services educate the public on the use of Community Care Centers where appropriate.

Beginning at recommendation 40, concerns relate to services currently offered and their perceived problems. Recommendations are made that could be adopted to improve access to client/patients, improve efficiency, and/or to make better use of existing resources by having care provided at a less expensive location.

8.2 Short Term Care

Health Services Review Recommendations

40. That Regional Health Authorities strengthen discharge planning, and inter-regional discharge planning so that appropriate service is available for patients requiring short term care on leaving an acute care facility.

41. That the Department of Health and Community Services establish a protocol for a short term care support system.

Short Term Home Care complements the delivery of acute care in the home through the Extra Mural Program. The Extra-Mural service allows earlier discharge from hospital and for some persons, the provision of some hotel services like housekeeping or meal preparation are required in addition to the health service.

Council continued to have concerns about the availability of support services simply because long term care demands absorb so much available capacity. Council agrees that Regional Health Authorities must strengthen the home care service. Where inter-regional discharges occur, communication back to the home community should be addressed.

Home services should be extended to assist individuals who as a result of a temporary health crisis need non-medical assistance in the home but currently do not qualify for assistance because the incident will last less than 3 months.

8.3 Long Term Care

Health Services Review Recommendations

42. That the Department of Health and Community Services simplify and streamline the Single Entry Point (SEP) assessment process, while ensuring that the appropriate health care workers are consulted. The process should be fair, be seen to be fair, and be consistent across the Province.

43. That the Department of Health and Community Services build in a re-evaluation or reassessment process as part of SEP since the condition of elderly patients and those with chronic conditions are expected to deteriorate through time.

44. That the Department of Health and Community Services actually measure the work required to care adequately for patients in Nursing Homes, Special Care Homes and Community Residences, and pay for the level of service required.

45. That the Department of Health and Community Services review the amount allowed for the comfort and clothing allowance so that the amount meets the basic needs of the residents.

46. That the Department of Health and Community Services examine the appropriate funding level for "grandfathered" residents of Special Care Homes and pay what is required for adequate care.

47. That the Department of Health and Community Services pay an adequate wage for homemakers, one that, at the very least, permits them to achieve an annual income above the poverty line in the Province.

Much has happened with Long Term Care since the Health Services Review.

Action has also been taken by the Department of Family and Community Services with respect to the Single Entry Point Assessment Tools. A shorter, simpler tool has been under trial in the Moncton area and is expected to become universal across the province this fiscal year.

No changes have been made to the amount of comfort and clothing allowance for persons in Special Care Homes (the rate is $110.00 per month) or nursing homes (the rate is $ 88.00 per month). Council understands the issues surrounding resident preference versus what is supplied by the homes and agrees residents who want a different option should pay. At the same time, allowances based on placement location fail to recognize the varied types of residents (which can include seniors, the disabled but mentally competent, the mentally ill) and their varying need to have cash for family visits, for participation in activities the homes offer or for outings when opportunity permits. At $88 a month, there is too often nothing left for basic clothing, let alone those types of comforts. Council recommends continued review and increased support to meet resident needs appropriately, while recognizing the need for health care to be affordable.

Action on Recommendation 46 saw a rate of $ 36.00 per day became effective April 1, 1999. Further action is included in the findings of the Long Term Care Review conducted by the Department of Health and Community Services.

A dollar-per-hour increase of the rate paid to home care agencies was granted in 1999, raising the rate from $9.50 to $10.50 an hour. Of this increase, at least 85 cents was expected to be passed on to the home care workers.

The transfer of responsibility for the Long Term Care Program from Health and Wellness to Family and Community Services signalled recognition that some citizens require both health and social services. The Department of Family and Community Services was directed to look at new policies which recognize the distinction between the needs of persons with disabilities, the needs of seniors and the needs of the mentally ill. Council sees this as a positive step. Further, Council recognises that Home Care and Nursing Care are very much a part of the continuum of health services. To reflect the shared responsibility, Council recommends that policy development, funding and certain central functions remain with the Department of Family and Community Services, but that delivery of services become part of the on-going responsibility of the Regional Health Authorities. In this way each person can move quickly and easily from institutional treatment to at-home or nursing-home care where care can be readily accommodated. In order to ensure timely, seamless care through efficient assessment and transfer, long term care resources at the local level must be managed by the same health care team that manages other primary health care services.

Council recommends that because Long Term Care, Home Care and the care component of Nursing Home Services are a critical part of the health system, they should become insured services.

This recommendation will be reinforced by the findings of the nursing homes staffing needs study conducted by management and labour to address capacity and level of care difficulties. Council further recommends an immediate 30 minutes increase of patient care time from 2.5 hrs to 3 hrs per day. Additional increases should be made based on the findings of the study.

Further to the direction taken to date by the Department of Family and Community Services, Council puts forth additional suggestions that should be considered while integrating long term care services within the new health system.

Council recommends that:

- Regional managers have the flexibility to approve funding of services over the $2040 ceiling to assist individuals in need through a crisis period, preventing possible premature movement to a nursing home; and

- All residential facilities be mandated to provide not only high quality care but also opportunities for residents to access programming activities conducive to their social, spiritual, physical and emotional well-being.

For nursing homes, Council recommends that:

- The current funding formula in relation to the nursing staffing standards of hours of care be reviewed so that the requirement under the Nursing Home Act stating that a registered nurse be on site 24 hours per day can be met without unrealistic and impractical disruptions to work schedules;
- A plan to recruit nurses and expand their roles in nursing homes be developed and feature the following:
  - Emphasis on the challenges and opportunities for registered nurses in gerontology and long term care nursing, particularly in nursing homes.
  - A co-op program between the nursing home sector and the universities to increase student clinical experiences in nursing homes.
  - A formal summer employment program be established for first and second-year nursing students.
  - Financial support and flexibility in work schedules for nurses working in nursing homes to obtain additional education required to take on expanded roles.
  - Strategic hiring of nurse practitioners;
- The Department of Health and Wellness, in cooperation with regional health authorities and nursing homes, develop a physician coverage strategy to ensure appropriate on-site medical care for nursing homes; and
- The provincial government clarify the mandate of the nursing homes, recognizing them as the primary provider for individuals requiring nursing care at levels 3 and 4. Consequently, nursing homes must be funded at levels required to provide the physical environment and necessary staffing to adequately deliver this highly complex care.

In making the above recommendation, Council appreciates the need for flexibility. Some individuals residing in special care homes whose health conditions deteriorate after placement may prefer to stay in these surroundings due to the relationship with other residents and the operator. Reasonable measures should be undertaken to accommodate the wish of the resident.

Council recommends that:

- The financial portion of the assessment process be initiated from the onset of the care assessment and include an early notice to families regarding necessary documentation. The Department of Family and Community Services should also identify other measures that could be introduced to alleviate the financial burden placed on nursing homes in situations where the financial evaluation is still in progress after the individual has been approved for placement; and
- Inspection visits for the licensing of a nursing home be coordinated in advance with the nursing home and the licensing evaluation consider accreditation requirements successfully achieved by the nursing home.

8.4 Ambulance Services

Health Services Review Recommendations

48. That the Department of Health and Community Services establish performance indicators for ambulance service providers in order to ensure adequate and consistent levels of service to all residents of the Province.
49. That the Department of Health and Community Services increase the standards for ambulance services so that an Emergency Medical Technician 2 (EMT2) be present on all emergency calls.
50. That charges for ambulance services be related to the income of the recipient of the service through an income-tested co-pay methodology.

This service is a crucial part of a new system and has been discussed in some detail in the chapter on the Proposed Health System.

8.5 Pharmaceuticals

Health Services Review Recommendations

51. That the Health Card Policy be reviewed in order that access to a health card does not act as a disincentive to gainful employment.

52. That the low-income cut-off be used as a benchmark for the working poor to have access to a health card.

53. That the Prescription Drug Program Policy be reviewed so that those with limited income faced with a chronic illness resulting in high pharmaceutical costs be given access to client-specific coverage, which includes all supplies required to manage their illness.

54. That the Department of Health and Community Services give consideration to the future development of the role of the pharmacist.

55. That hospitals focus on seamless pharmaceutical care through the provision of discharge counseling to patients/clients and discharge information to health care providers outside the hospital, including community pharmacists.

56. That the Department of Health and Community Services in collaboration with the College of Physicians and Surgeons and the New Brunswick Pharmacists Association establish a means of dealing with polypharmacy issues.

Access to specific pharmaceuticals which at that time were not listed in the Provincial Formulary for treatment of Multiple Sclerosis was a primary issue discussed. This was addressed. Since, New Brunswick has been a lead player in trying to create a common pharmaceutical approval process for all Canadians or at least among the Atlantic Provinces. Council sees this as a positive and constructive move and encourages the government to continue.

Health Card access is again under review by the Department of Family and Community Services, as they examine disincentives to work. Council encourages government to further explore the needs of all the working poor not only those still on assistance in order to expand current coverage, resources permitting.

When establishing the electronic health record, priority should be placed on medications (i.e. one person – one medication profile) across all health care delivery sites. The success and benefits of such systems have been demonstrated in other provinces and countries.

Council recommends that the approval process for the addition of drugs to both the Regional Health Authority and Provincial Prescription Drug Program Formularies, be a collaborative process.

People remain in hospitals rather than moving to other care sites or home in order to continue to receive drugs that are not covered by various formularies. This unnecessary expense is a consequence of decisions being made within isolated programs and does not take into consideration patient needs and the impact on the total system. Similar issues exist due to the lack of approvals for newer antipsychotic drugs for the treatment of mental illnesses and for symptomatic treatment of Alzheimer's Disease and other dementias.

In addition to fully supporting the recommendations on pharmaceuticals, Council further recommends that:

- Mechanisms be instituted between the Prescription Drug Program and the Regional Health Authorities, to harmonize formularies in order to avoid gaps in drug coverage as the patient moves from one service site to another or home (e.g. from the hospital to the nursing home); and

- The Department of Health and Wellness identify groups of citizens who do not have pharmaceutical coverage at the present time (approximately 18 per cent of the population) and explore the feasibility of extending coverage, ensuring citizens have access to prescription drugs when required. Evidence supports the role of medications in maintaining or restoring health and in the reduction in the use of more expensive health services.

8.6 First Nation Services

Health Services Review Recommendations

57. That health care services actually available on each New Brunswick reserve be reviewed so that adequate and consistent health programs, provided by all levels of government, are available to all. Once the review is completed, all levels of government must address service needs where necessary and consider implementing new delivery systems through establishing service delivery through community-based care.

58. That the Federal/Provincial/First Nation relationship be improved to foster partnership in the delivery of and access to health programs with the New Brunswick Government taking a leadership role.

59. That the appropriate provincial health officials meet with the appropriate band staff and set up a process that permits First Nation people to retain their Medicare cards in spite of the transitory nature of their life styles. Using the current structures such as band offices to co-ordinate this administration has proved workable in the past.

Aboriginal people in New Brunswick have access to insured health care services. In most First Nation communities, services are also available but there is concern about maintenance because of the Federal government's decision to withdraw from direct delivery. Regional Health Authorities need to explore how they can assist or complement what is being delivered.

The Federal Government transfers health dollars specifically for every First Nations person but the services provided are not consistent across the Province. Responsibilities of the Federal Government, Provincial Government and First Nations communities are not clearly defined.

Council recommends that:

- The present Tripartite Committee, consisting of the Federal Government, Provincial Government and First Nations people should meet quarterly. The committee should assist in defining the roles of Federal, Provincial and First Nations in the provision of health care to First Nation People.

Positive changes have taken place in the provision of health services to First Nation people during the past few years, which include:

- Regarding the Extra-Mural Program as a service that brings expertise to clients;
- The establishment of First Nation Liaison Committees with most Regional Hospital Corporations, alleviating barriers and concerns;
- Cross-cultural awareness sessions in some Health Regions. Many health care providers are unaware of services located within the First Nation communities for aftercare or discharge planning purposes. Communication aimed at physicians, nurses and pharmacists is paying some dividends, however more can and should be done; and
- Sharing of expertise in the area of housekeeping and food services, home care and management services, between the Regional Hospital Corporations and First Nation Health Centres has enhanced accountability and strengthened service delivery within some First Nation Health Centres.

The provincial government provides a Medicare card to all residents of New Brunswick, including aboriginal people living in First Nation communities. Native persons in New Brunswick have dual citizenship and move back and forth across the American/ and Canadian boarder at will. The retention of a Medicare card requires continuity of residence in New Brunswick. Therefore, the card tends to be cancelled every time an aboriginal person leaves the province for an extended period of time. The process for the re-instatement of the card is cumbersome. A permanent address is required and sometimes aboriginal people do not have a fixed address.

Council recommends that:

- A mechanism be developed to address the issue of Medicare cards for all New Brunswickers who do not have a permanent address in New Brunswick; and
- The Department of Health and Community Services through the Tripartite Committee work with Band Councils to address the issue of Medicare Cards for those persons returning to First Nation communities from outside the province.

The First Nation Liaison committees have had positive outcomes for the health care of First Natives people. However the scope has been limited to hospital care and emergency services. Regional Health Authorities, with their broader scope of programs and services, would provide the opportunity to broaden the discussion to include all primary health care.

Council recommends that:

- First Nation Liaison committees be established between First Nation communities and Regional Health Authorities and meet regularly. These committees must have a higher forum (at the provincial level) to bring their common concerns and to address provincial related issues. In addition to the Medicare card, some of the more critical issues include health care statistics pertaining to aboriginal people, mental health services, prescription drug misuse, an increase in non-aboriginal people living in some First Nation communities and access to rehabilitative services such as physiotherapy and occupational therapy.

8.7 Public Health Services

Council acknowledges the important contribution of Public Health Services to the health of New Brunswickers. To strengthen these services, Council recommends that:

- Regional Health Authorities receive funding from the Department of Health and Wellness for community development and targeted programs which assist children, adults and seniors in widening lifestyles choices to include physically activity, healthy eating habits, proper use of medications, community involvement, reduction of cigarette and alcohol use, establishment of safe home environments for children and seniors, encouraging age-appropriate use of motorized vehicles, and using protective gear for sporting activities;
- Regional Health Authorities receive funding from the Department of Health and Wellness to provide comprehensive child health services including:
  - pre-natal and post natal-care
  - home assessment of all new-born within three (3) days of discharge from hospital
  - breastfeeding counselling and support
  - early childhood development and school readiness
  - school health
  - vision, hearing and speech screening services and dental health
  - parenting and life skills training
  - nutritional assessment and counselling
  - immunization, well-baby and pre-school clinics
  - cognitive assessment for pre-school children
  - adequate financial assistance to support the basic needs of children

- adequate financial assistance to support the participation of parent(s) in care plans; and

- Sexual health services provided by the Department's sexual health centres be available to all adults regardless of age and marital status. At the present time services are limited to adolescents and single adults aged 20-24.

A reliable supply of safe drinking water is vital to the health of all New Brunswickers. The recent water quality disaster in Walkerton, Ontario is a dramatic reminder that unsafe drinking water can lead to serious health risk and death. Approximately 40 per cent of New Brunswickers living in small towns and rural areas rely on domestic wells as their primary source of water. The minimum cost for well water testing during the summer of 2001 was $40, an amount not all New Brunswickers can afford. A domestic well water testing project carried out during the summer of 2001, sponsored by the Department of the Environment and Local Government revealed that a very small percentage of home owners availed themselves of the service, even those with the ability to pay.

Council recommends that:

- The Department of the Environment and Local Government and the Department of Health and Wellness develop program options for government consideration aimed at ensuring that all domestic wells are tested at least once a year. New Brunswickers with the ability to pay would do so.

8.8 Mental Health Services

Health Services Review Recommendations

60. That the Department of Health and Community Services and Local Advisory Committees pursue public awareness campaigns to increase the knowledge of the public about mental illness.

61. That the Department of Health and Community Services take steps to educate all front-line workers who interact with the mentally ill or their families on the nature of mental illness and associated needs.

62. That the Department of Health and Community Services ensure that the Physician Resource Plan include strategies to attract and retain the number of psychiatrists to meet the needs of the Province.

63. That Regional Health Authorities ensure that their Emergency Room staff have ready access to Mental Health services to deal with patients/clients presenting in a crisis.

64. That the Department of Health and Community Services ensure that rural communities have adequate access to Mental Health services.

65. That the Department of Health and Community Services consider the feasibility of extending Medicare coverage to include psychological counseling.

66. That the Department of Health and Community Services adjust the drug formularies to include the new generation of antipsychotic drugs.

67. That the Department of Health and Community Services initiate discussions with the Department of Human Resources Development NB to explore the feasibility of modifying the use of the Health Card.

68. That the Department of Health and Community Services reduce the caseload of mental health workers to allow for more active case management of at-risk clients.

69. That the Department of Health and Community Services explore the role of pharmacists in local communities as part of the case management team.

70. That the Department of Health and Community Services initiate discussions with the Department of Municipalities and Housing to review the availability and standard of housing for the mentally ill.

71. That the Department of Health and Community Services take steps to increase the availability of vocational programs and supportive employment opportunities.

72. That the Department of Health and Community Services undertake a review of the Single Entry Point (SEP) assessment tool and process to ensure its appropriateness for the mentally ill.

73. That the Department of Health and Community Services explore ways and means of expanding the current range of respite services.

74. That the Department of Health and Community Services ensure that consumers and stakeholders are consulted on a regular and scheduled basis.

75. That the Department of Health and Community Services investigate the apparent disconnect between its view on the status of Mental Health Services and that of the people in the field.

Mental health services play a crucial role in the overall health and well-being of the population. In many aspects, those who work in the mental health field are faced with larger problems than the presenting problem, so their solutions must be holistic. This requires a service delivery approach which considers the broad environment that surrounds the individual.

Once accessed, New Brunswickers say services are of good quality and supportive. However, the challenge for many is getting access in a timely manner. Due to limited resources, the focus lies with the most acute health problems, leaving little emphasis on early intervention, or prevention. In addition, there is great disparity among locales regarding the range and quantity of services available. The current Mental Health Program is deemed to be the only publicly funded mechanism from which New Brunswickers can access needed support and services to prevent, treat and manage emotional problems or mental illness.

Based on discussions with providers and stakeholders Council recommends that:

8.8.1 Access

The prevention/promotion/education focus be enhanced, as well as diagnosis. Work practices be based on a clear and consistent direction. Work load measurements and time allocated to the intervention plan should fall within established provincial standards, case planning and management approaches should also be monitored utilising best practices to ensure highest and best use of those resources. Expanded roles for clinicians should be explored, as well as more community support options for clients needing assistance between visits and a consistent and holistic approach to intervention be developed.

Council recognizes that some of these areas are already under examination and that some standards are already in place. However, in light of the proposed broader integration of health services and a new service delivery model, a comprehensive analysis of the provision of mental health services should be conducted. Council recommends that implementation of the new service delivery approach provides opportunities to streamline and refine the provision of these services. In particular the length of treatment, caseload size and access (waiting times) seem to vary across the province. These should be more consistent in all areas of the province. Council also recognizes that treatment of mental illness is complex and pre-established recipes for treatment cannot always be applied. However, some measures and approaches can be consistently applied to ensure the best outcomes.

8.8.2 Networks and Partnerships

Mental health experts should be involved in the development and refinement of 'healthy public policy' in all areas that are considered an extension of mental health services. For example when improving residential services and options, mental health experts should be included in the planning and determination of type and need for residential facilities to ensure adequate and quality options for mentally/emotionally disabled individuals. They should also be included when addressing policies that contribute to disincentives to participate in job/educational programs geared at increasing self-reliance and independence such as loss of a health card.

It is time to review the processes involved for making referrals and follow-up for mental health services by other government departments whose work impacts on utilization of mental health services. For example, the legal and correctional systems rely on these services to conduct assessments and/or to provide court mandated treatment. Council has heard that improvements could be gained by reviewing existing protocols for referral and follow-up.

8.8.3 Use of Technology

Serving rural and remote areas of the province is a challenge. Creative and innovative methods must be utilized to ensure needs are met consistently. Such methods are currently available through the use of tele-psychiatry and should be broadly applied to address the limited availability of expert resources.

8.8.4 Crisis Intervention

Health professionals must also be able to refer individuals in crisis in a timely fashion. There are several effective models in place throughout the province. However, some regions do not have crucial 24 hours a day, 7 days a week, access. Council strongly emphasizes the need to implement crisis intervention best practices consistently across the province to ensure all areas have consistent and effective access when needed.

8.8.5 Linkages between addictions and mental health

Currently mental health services and addiction services are delivered under separate mechanisms. Mental health falls under the responsibility of the Department of Health and Wellness while addiction services are housed within Regional Hospital Corporations. Council recommends the two services be brought together under the proposed Regional Health Authorities to facilitate supportive approaches when working with common clients.

Council further suggests:

- Expanded linkages between addiction services and mental health services to facilitate the cross-training of professionals and innovation in prevention and promotion strategies targeting individuals who would access both services;
- Continued expansion of the Youth Treatment Model for Addiction Services to ensure availability throughout the province and in all schools. There may be opportunities to expand the reach of all current prevention and promotion strategies targeted at youth by joint planning and maximizing the use of existing resources between Addiction Services strategies and those of Mental Health.

8.8.6 Recent Changes

Recent direction by government to create a separate policy framework for persons with disabilities accessing services through the Long Term Care program will have a positive impact for the chronically mentally ill. This change will allow for a better assessment tool that factors in the special needs and abilities of individuals with mental illness.

8.8.7 Involving Community-based Organizations

Regional Health Authorities must work closely with the volunteer service organizations for the mentally ill, as well as Mental Health staff. A wealth of effort and potential can be found within these community-based agencies that needs to be supported.

8.9 Rehabilitation Services

Health Services Review Recommendations

76. That the Department of Health and Community Services mandate audiologists to serve the nursing home population.

77. That the Department of Health and Community Services mandate audiologists to offer rehabilitative services as part of their ongoing practice.

78. That the Department of Health and Community Services take steps to enable audiologists to carry out more preventive and educational services.

79. That the Department of Health and Community Services mandate selected sites to offer specialized diagnostic services such as Central Auditory Processing Disorder (CAPD) on a provincial basis.

80. That the Department of Health and Community Services adjust the Rehabilitation Services Resource Plan to reflect these needs.

81. That the Rehabilitation Services Plan be adjusted to enable speech language pathologists to deliver more education and prevention services.

82. That the Department of Health and Community Services take steps to ensure that wherever possible speech language pathologists are able to practice within their area of specialty.

83. That the Department of Health and Community Services take action to ensure that an adequate supply of up-to-date equipment to support rehabilitative activities is available.

84. That the Department of Health and Community Services take steps to ensure that the Rehabilitation Services Plan identify the number of occupational therapists to reflect the need for their services.

85. That the Department of Health and Community Services take steps to ensure that the Rehabilitation Services Plan reflects the number of physiotherapists needed to provide adequate service coverage.

86. That the Department of Health and Community Services reassess the Rehabilitation Services Plan and take steps to implement any outstanding strategies.

87. That the Department of Health and Community Services take corrective action with respect to the provision of administrative support for rehabilitative services.

88. That the Department of Health and Community Services acknowledge the work of the Rehabilitation Advisory Committee and take appropriate actions to respond to their proposals.

The renewal of the health system calls for a much different approach to the delivery of service than exists today. Therefore, the delivery of rehabilitation services will need to be adjusted at the primary, secondary and tertiary levels in order to be fully integrated in a seamless system of care.

In its assessment, Council made the distinction between rehabilitation services required to restore function lost as a result of a disability or injury and support services required in order to maximize their daily living abilities or vocational training needs. Council focused on the former.

In an adjusted rehabilitation services system, Council recommends that:

- Hospital setting be resourced with appropriate and adequate rehabilitation professionals to provide any immediate interventions required on site; and
- One of two options be possible depending on the extent and complexity of restoration activities necessary for the individual to reach maximum potential:
  - When discharged, the individual can access the primary care system in the Community Health Centres which will ensure an appropriate rehabilitation plan is carried out. Ambulatory rehabilitation services now delivered in hospitals would become part of the primary care system. The Community Health Centres would meet the needs of the school population, nursing home population, special care home population and those discharged from secondary or tertiary facilities.
  - When the individual has complex and multiple requirements resulting from severe injury or disability, a provincial tertiary rehabilitation facility will meet his or her needs. Council recognizes the need for a modernized provincial tertiary rehabilitation facility and commends government for its indication that such a facility will receive priority attention. This facility must have specialized resources with the capacity to provide outreach services and support to the primary and secondary care settings.

Those delivering rehabilitation services recognize that early interventions lead to better outcomes. Currently, there are growing waiting lists at all levels of the system. In addition, there are significant unmet rehabilitation needs for a number of client groups such as seniors in nursing homes. Addressing these needs will ease the burden on other parts of the system. For example: meeting the rehabilitation needs of nursing home residents would reduce the number of care hours required for nursing home residents by preventing the deterioration of their daily living capabilities.

Rehabilitation services go beyond the services traditionally delivered by physiotherapists, occupational therapists, audiologists and speech language pathologists. All health professionals play a role in rehabilitation, including: respiratory therapists, dietitians, psychologists, social workers and nurses. Council acknowledges the Department of Health and Wellness' Rehabilitation Services Master Plan, released in 1994. The Health Services Review identified the need to update the plan.

Council recommends that:

- A comprehensive review of the Rehabilitation Services Master Plan be undertaken by Department of Health and Wellness, in light of adjustments required as a result of the renewed health system proposed by Council.
- As part of the Rehabilitation Master Plan review, possible linkages with the Workers' Compensation Centre in Grand Bay should be explored.

Council recognizes the current and projected shortages of rehabilitation personnel. Council recommends that:

- The Department of Health and Wellness initiate immediate steps to develop and implement a Recruitment and Retention Strategy.

Rehabilitation providers are not utilised in the most effective manner. The rehabilitation plans include a number of functions that could be performed by a Rehabilitation Assistant, freeing valuable time to address other unmet needs.

In this regard, Council recommends that:

- The creation of the Rehabilitation Assistant position. The training should consist of the basic RNA program with a rehabilitation module. Additional on the job practicums would occur. At the service site, the role of the Rehabilitation Assistant could be generic or specific to a rehabilitation specialty.

Council reiterates the Health Services Review Recommendations relating specifically to audiologists. In addition, Council sees a role for audiology services in the primary care system. This will require further assessment in a revisited Rehabilitation Services Master Plan.

Council identified the need to incorporate more clinical practice experience with paediatric patients be required in order to better prepare these providers to meet the needs of New Brunswickers.

Other recommendations emerged from Council's assessment of rehabilitation services, that:

- Clinical expertise in rehabilitation specialty areas be enhanced provincially and regionally to assist both managers and providers;
- Regional Health Authorities explore options with key stakeholders on how best to meet the needs of under-serviced groups (such as the deaf and hard-of-hearing);
- A provincially coordinated rehabilitation equipment program with a centrally-managed registry be established and integrated with the expansion of the existing equipment recycling program run by the Department of Family and Community Services;
- Rehabilitation professionals be given an education and prevention mandate at all levels, i.e. client-specific, groups of clients and the population at large; and
- Government pursue public policy initiatives targeted at reducing injury during recreational, workplace and domestic activities.

As with all services, on-going work will be required to develop appropriate service standards.

8.10 Physician Services

Health Services Review Recommendations

89. That the Department of Health and Community Services, in collaboration with other levels of government, PRAC, the NB Medical Society, Regional Health Authorities, Municipalities, Professional Groups and Business develop a coordinated comprehensive strategy for the recruitment and retention of physicians.

90. That the Department of Health and Community Services investigate the perception amongst medical school students that New Brunswick is "closed" to new physicians and take appropriate steps to change this situation.

91. That the Department of Health and Community Services expand specialty residency training to hospitals outside of Saint John, Fredericton and Moncton, as their infrastructure permits, in order to offer residencies in more rural settings.

92. That the Department of Health and Community Services look more closely into the various types of remuneration for doctors.

Since 1999, the Department of Health and Wellness has taken steps to increase the number of seats in medical schools. It also hired a provincial recruitment officer to work with New Brunswick medical students. Continued attention will be required.

Health providers are the most significant asset in our system today. Family physicians were involved in the dialogue on primary health care renewal and the challenges and opportunities this may represent for physicians. The feedback from these sessions has been shared with the Department of Health and Wellness. It is only with the full participation of these professionals that the changes proposed by Council will actually become reality.

The relationship between the province and its physicians is shadowed by the stresses and decisions of the last ten years. Shortages of physician resources have increased the burden. Open and frank dialogue between the two parties must be re-established in order to move forward. Implementation of primary care renewal must not be coercive. While many family physicians welcome the change, others do not. The system must find a way to work with both groups.

To rebuild this relationship, and to move ahead with primary care renewal Council recommends that:

- The Department of Health and Wellness establish a structured committee process involving the New Brunswick College of Family Physicians, the New Brunswick College of Physicians and Surgeons and the New Brunswick Medical Society to identify barriers and solutions in the implementation of primary care renewal; and
- The Province explore and implement alternative means of compensating physicians. The fee-for-service mechanism will continue to be an option chosen by some physicians. In this regard, the fee-schedule must be realigned to financially compensate a more holistic approach to family medicine.

There are many models of collaborative and group practice that exist across the province where physicians, nurses, and other health professional are working together to better meet the needs of New Brunswickers. In these models, the traditional roles of the various providers have been modified to varying degrees. However, these models did not include evaluation plans when initiated. Therefore, valid and reliable data is not available for evaluation and credible findings related to the outcomes of these models are unavailable. Council urges the Department of Health and Wellness to adopt a policy of including an evaluation plan in all new initiatives concerning primary care renewal.

8.11 Nursing Services

Health Services Review Recommendations

93. That the Department of Health and Community Services update and implement the Nursing Services and Resource Management plan to match increased patient needs with increased staffing levels.

94. That the Department of Health and Community Services address the casualization of nurses in hospitals.

95. That the Department of Health and Community Services give consideration to the removal of administrative and legislative barriers which restrict the ability of the system from expanding the role and making more efficient use of nurses.

96. That, in keeping with the proposed vision for health care delivery, the Department of Health and Community Services considers the development and implementation of provincial projects employing Advanced Practice Nurses in contexts such as emergency departments and Community Care Centers.

97. That the Department of Health and Community Services explore the office based nursing model for doctor's offices in New Brunswick with consideration given to salaries or fee for service being paid.

Government is to be commended for establishing 300 full-time nursing positions in 1999 to address nurse casualization. Both Council and the Department of Health and Wellness have been looking at the barriers preventing nurses from practicing the full scope of the profession for which they were educated. Also being explored are the expansion of nursing roles and the legitimization of extended activities. This work will be further developed through the auspices of the Nursing Utilization Stakeholder Committee recently established by the Department of Health and Wellness. This Committee has been mandated to offer advice and strategies pertaining to the introduction of the Nurse Practitioner as well as addressing barriers to full scope of practice for both nurses and Registered Nursing Assistants.

Council supports the advent of the Nurse Practitioner into the system as a member of the delivery team and urges that Nurse Practitioner programs be available to nurses in both official languages. Financial support and leave for practicing nurses who wish to pursue full-time study to become Nurse Practitioners are necessary. The Department of Health and Wellness has identified preliminary service sites for possible introduction of this new nursing role. They include Emergency Rooms, Nursing Homes and Community Health Centres. Practice sites will likely evolve over time. Nurse Practitioners are not physician replacements; they will work in partnership with all other members of the service delivery team. Council strongly urges the Department of Health and Wellness to ensure the proper evaluation strategies are in place to accompany the introduction of the Nurse Practitioner into the system.

When looking at the broad scope of nursing, Council recognizes that a significant number of nurses currently practicing in the system have the skills, training, ability and desire to work within the full scope of practice. Yet, there exists legislative, administrative and protectionism barriers that prevent their full contribution to patient care. Addressing these barriers is as important as the introduction of the Nurse Practitioner because their removal has the potential of making the greatest impact on service delivery. The same arguments and rationale apply to expanding the scope of Registered Nursing Assistants.

The renewal of primary care will provide opportunities and requirements for experienced nurses to enhance their scope by adding to their skill set through additional preparation in specific areas (e.g. assessment, pharmacology, etc.). Opportunities and support for such preparation must be integrated in the system, such as flexibility in shift scheduling and tuition support.

Council assessed the issue of Registered Nursing Assistants being utilized in practice settings that have not traditionally been seen as a role for these providers. Larger community health centres may indeed have a series of tasks that can appropriately be carried out by the Registered Nursing Assistant. The expansion of the Registered Nursing Assistant role into a Rehabilitation Assistant has been put forward in the previous section on rehabilitation services. Council would suggest that a Registered Nursing Assistant role in home care might have positive impacts on service delivery. This would need to be further studied by the Department of Health and Wellness and the Regional Health Authorities, possibly through the means of two test projects, one conducted in an urban area and the other in a rural community.

Collaborative practice, physicians and nurses working together to maximize their contribution to patient care, is an important building block in a renewed primary care system. The Proposed Health System chapter further expands this element.

8.12 Other Health Service Providers

Health Services Review Recommendations

98. That the Department of Human Resource Development NB consider allowing the small additional sum required to make fittings for dentures and doing so in a timely fashion so that the clients can actually make use of the dentures.

99. That the Department of Health and Community Services continuously monitor the legislated responsibilities of those who provide technical support services so that adjustments can be made as additional training and hence areas of expertise are added to the qualifications of these practitioners.

Council has been advised that changes to the contract with denturists have corrected the problem of dentures fitting.

Council recommends that all health professionals and para-professionals should be able to function within the health system within the full scope of their training. While a number of health professions were examined, it was not feasible to conduct a comprehensive review of all health professional groups within the timeframe available to Council. Council urges the Department of Health and Wellness to continue the work in collaboration with health professional groups on this issue.

Council did have preliminary discussions with respect to two providers: home support workers and midwives.

Home support workers are a key in the provision of short-term and long-term home care and appropriate early discharge from the hospital setting. These providers currently feel undervalued in the system. Council is concerned with the lack of standardized training in the province and the lack of standards governing the work in various service sites.

Council recommends that:

- A task force be established to develop a provincial strategy for home support workers, made up of the Departments of Health and Wellness and Family and Community Services, the Regional Health Authorities and the various service agencies;
- Perspectives of the home support workers and the clients they serve inform the development of the provincial strategy.

Midwives are not a recognized service provider in New Brunswick, though they are a regulated profession in some Provinces (e.g. Ontario, British Columbia). In these jurisdictions, midwives are an integral part of the primary care team providing pre/post-natal care as well as actually performing low-risk deliveries. In countries such as Great Britain, midwifery is a long-standing and respected practice.

Council supports the introduction of midwives in New Brunswick to assist physicians with low-risk pregnancies and deliveries. This is particularly relevant in view of the shortage of obstetricians, the average age of obstetricians, the decreasing number of family physicians who choose to deliver babies and the support women themselves have given to the concept.

Council recommends that:

- The Department of Health and Wellness undertake a feasibility study on the introduction of midwifery to New Brunswick.

8.13 Professional Education

Health Services Review Recommendations

100. That the Department of Health and Community Services look into the possibility of re-establishing the practice of purchasing seats in the Faculty of Medicine at Memorial University.

101. That the number of places purchased in the Faculty of Medicine at Dalhousie University be reduced if the University is not willing to consider changing its training program to better respond to the needs of New Brunswick.

102. That consideration be given by the university Faculties of Medicine to a proactive selection of medical students with rural origins.

103. That both the University of New Brunswick (UNB) and the Université de Moncton (U. de M.) continue their efforts to offer Advanced Practice Nursing training, especially to the level of Nurse Practitioner.

104. That both UNB and U. de M. look into the possibility of offering or co-ordinating specialty courses for New Brunswick nurses who want to access enhanced training programs without leaving the Province.

105. That the Department of Health and Community Services re-establish budgets for continuing education and retraining opportunities for health care professionals, with involvement and co-operation from the various health professional associations.

106. That continuing education programs needs be co-ordinated and aligned with the expectations and needs of the health care system as they relate to the future role of health care professionals.

107. That adequate RNA training be offered where there is a need, especially in Francophone areas of the Province.

108. That the Department of Health and Community Services consider subsidizing the cost of training for homemakers.

Council supports the on-going training of all health care professionals in order to maintain currency within the field of work or to advance capacity, both of which are critical to meeting the health care needs of New Brunswick.

With respect to medical education, Council notes government's initiatives in purchasing additional seats at Memorial University and Sherbrooke University. In view of the current shortage of physicians in the province, Council urges the government to increase its number of seats. The province must also ensure that New Brunswick medical students receive training that reflects the needs and realities of New Brunswick. Concerns were expressed in the Health Services Review (recommendation 101) with respect to the Faculty of Medicine at Dalhousie University. These concerns continue. Council urges government to take the necessary steps to ensure that New Brunswick is getting value for its investment. This may require the purchase of seats in other medical schools.

With respect to nursing education Council recommends that:

- Nurse Practitioner education be available through the Université de Moncton as quickly as possible.
- Resources be made available to both Université de Moncton and the University of New Brunswick to allow the initiation of full-time Nurse Practitioner Programs.

A key element to the on-going education of nurses and other health professional groups is mentorship at the work site. With the workloads experienced by most professionals due to the lack of staff, mentorship has become increasingly difficult. Moreover, orientation for new staff is shrinking. This results in gaps in transfer of knowledge. Council's vision of the health system is one where providers are valued and treated as assets. It is therefore important for the Regional Health Authorities to create a comprehensive orientation plan for recent graduates in all health disciplines.

Staff shortages are becoming increasingly critical in certain professions, such as physicians, nurses and pharmacists. Council acknowledges the initiatives undertaken in the development of recruitment and retention strategies for physicians and nurses.

Council recommends that:

- The Department of Health and Wellness establish recruitment and retention programs for other health professions in which shortages are of concern; and
- The Department of Health and Wellness take immediate steps to develop an education strategy to increase access for New Brunswick students in the health profession training programs where shortages are anticipated.

It is important to establish strong and effective communication links between employers, professional associations, academic institutions and the province, to facilitate the preparation, training and maintenance of health professionals.

Educational institutions must become partners in health renewal. Council believes the province should promote a more interdisciplinary model of education that would facilitate a team approach in the delivery of service.

8.14 Technology

Health Services Review Recommendations

109. That the Department of Health and Community Services consult with key stakeholders to determine information needs, standards and priorities.

110. That the Department of Health and Community Services, based on the information coming out of the consultations, co-ordinate the planning and implementation of a fully integrated information system.

111. That the Department of Health and Community Services establish in collaboration with appropriate stakeholders, including experts from the field, a decision-making provincial framework for the acquisition of innovative medical technologies.

112. That the Department of Health and Community Services establish a strategy for the maintenance or replacement of existing technologies.

113. That the Department of Health and Community Services revise its plan for the installation of Magnetic Resonance Imaging (MRIs) and agree to install a fixed MRI in both Saint John and Moncton. Mobile MRI units should be made available to service the needs of the other regions.

114. That the Department of Health and Community Services encourage the expansion of radiologic imaging and intervention in the health care system.

115. That the Department of Health and Community Services actively promote the implementation of digital imaging across the system.

116. That the Department of Health and Community Services actively promote telemedecine and teleradiology and that strategies to remove barriers to their use be developed and implemented.

A single electronic patient record should be available within the Province. The record must maintain confidentiality of patient information but be accessible to providers of care as needed. The patient record is the stimulus for creating an information system that will also provide management capabilities and the tools to evaluate the system and its parts, compare performances, provide feedback to stakeholders through the report card, and therefore ensure New Brunswickers can get necessary services anywhere in the province.

An integrated information system plan has the potential to facilitate partnerships with organizations that can provide the infrastructure and technological expertise. This new system will improve the existing telemedicine and telehealth services.

8.15 Funding

Health Services Review Recommendations

117. That the Department of Health and Community Services implement a multi-year planning and budgeting system. As part of this system any savings achieved by the Regional Health Authorities, if the agreed-upon service levels are achieved, should be retained by the Regional Health Authorities. Common cost accounting and consistent data collection are both required in order to continuously improve the management of the Regional Health Authorities.

118. That prior to introducing a multi-year budgeting and planning system, balanced budgets be re-established. Boards must exercise control, and concurrently be responsible for overall spending.

119. That concomitant with this re-organized system, a simplified reporting system be put in place. Benchmarks and management indicators must be agreed to so those service levels are defined, and accountability and financial control are respected. Such indicators are the foundation of any reporting system.

120. That there be flexibility in handling monies. If Regional Health Authorities achieve savings, they should be allowed to carry this amount forward, and movement between budget categories, and between operating and capital budgets should be permitted. The flow of resources from community-based services to hospitals should be prohibited and the transfer of resources from hospital to community-based services encouraged.

121. That funds be available centrally in order to support the introduction of innovative methods in the health care system.

Council recommendations with respect to funding, management of funds, the priority of community-based services versus institution based services, and the need for support to innovative ideas and research have been clearly stated in the Chapters on Accountability and Report Card and throughout this report.

Health Services Review Recommendations

122. That the political component of decision-making be acknowledged and compensating trade-offs made between regions affected by consolidation of services to achieve lower unit cost. The transfer of jobs from a given area should be offset by locating a different service in the affected area, while at all times using the lowest cost service provider

Appendix A - Council

Members and Staff

The Council members are:

Michel C. Leger (Chair)	Shédiac	Lawyer and Former Beauséjour Hospital Corporation Board Member
Donna Johnston	Red Bank	V.O.N.
Myrna Richards	Hampton	Lawyer and former chair of the New Brunswick Advisory Council on the Status of Women
Mary E. Jarratt	Fredericton	Family Physician, member of active medical staff at Dr. Everett Chalmers Hospital
Michelle Tolszczuk	Edmundston	Medical Director at Fraser Papers, a member of Region 4 Hospital Corporation medical personnel
Nancy Roberts	Moncton	Director of Regional Pharmacy Services, South East Health Care Corporation
Peter Jollymore	Saint John	Retired, formerly Acting Dean, Faculty of Business, UNBSJ
Heather Erb Campbell	Saint John	Executive Director, Heart and Stroke Foundation of New Brunswick
Warren Davidson	Moncton	Consultant in Geriatric Medicine, South East Health Care Corporation
Lynn Kelly de Groot	Dalhousie Junction	Physician Recruitment Officer
Norma McGraw	Tracadie-Sheila	Director of Extra-Mural Program, Northeast Health Network
Gilbert St.-Onge	Edmundston	Formerly CEO, Region 4 Hospital Corporation
Judith Wuest	Stanley	Professor, UNB Faculty of Nursing
Barbara Gagnon-Thériault	Fredericton	Acting manager, Canada/New Brunswick Business Services Center, mother of a special needs child (withdrew mid 2000)

The Staff:

Mavis Hurley	Deputy Minister
Étienne Thériault	Policy Advisor
Norma Dubé	Policy Advisor
Jean Finn	Policy Advisor
Lise Bellefleur	Policy Advisor
Nancy Campbell	Administrative Support