

Health Care in New Brunswick: The Elephant in the Room (as if we needed another elephant)

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Context is always necessary for understanding, perhaps especially in the non-spatial and atemporal spheres that digital journals occupy. Providing some context to this special issue on health care in New Brunswick is therefore necessary for a fuller appreciation of the stakes and the issues for residents of one of Canada's smallest and poorest provinces.

The Canadian Context

In Canada, health care is the shared responsibility of both federal and provincial/territorial governments. Canadians pay taxes, the federal government collects and redistributes those to provinces and territories, who in turn deliver health and other social services. And while that explanation is overly simple, it points to a paradox in our health system that is both strength and weakness: the banker and lawmaker (the fed) has a very limited role in service delivery. That is the responsibility of provinces and territories.

That paradox aside, health care in Canada is mostly “public” in that it is accessed on the basis of need rather than locale, status, or ability to pay. Citizenship is the requisite for service, from which came the idea of “universality”: from coast to coast to coast, uniformity would be the core value that governed wait times, human resource expertise, infrastructure, and other aspects of the system. The quality of one's health care and maintenance, it was thought, should not be dependent on the province or territory in which you lived, nor on your income or status, but on the simple fact that you were Canadian. All else being equal, universality of care was the goal.

“All else being equal,” however, exists only in theory. Not only are there regional differences in Canada that affect the delivery of health services—and provincial differences within regions that affect that delivery—but there are also differences of demography, population density, income distribution, and literacy within each province that affect health and health services. In other words, Canada's uneven social, economic, political, and cultural landscapes are determining factors in the provision of health services to citizens.

Universality of service may be the goal, but Canadians know that it is more accurately an ideal—and they live accordingly, choosing, if they can, to reside in areas of better care, better hospitals, and more physicians, and making employment, higher education, and career decisions on the basis of the wider realm of public health livability indices (recreational infrastructure, childcare, safe neighbourhoods, fiscal stability, good schools, and progressive health policy).

Politicians know this, too, which is why our health system is under almost-constant negotiation between users and service providers and between federal and provincial/territorial governments. To call the system complex is to understate the matter. It is intricate, difficult to navigate, and multiform, employing upwards of 6 per cent of the entire Canadian workforce and costing 11.7 per cent of Canada's annual GDP (2006, 2010 numbers from the Government of Canada). That it works at all to trickle down

to delivery occupies that area of faith that lifts planes off runways. But it does work, most of the time well, especially in delivering acute and emergency services.

The New Brunswick Context

New Brunswick's status as a "have-not" province—a province that receives equalization payments from wealthier "have" provinces to offset its fiscal incapacities—means that its ability to meet the goal of universality as outlined in the *Canada Health Act* is especially challenging. While wealth transfers exist to level the playing field, so exists the expectation of uniformity of service *regardless* of fiscal inequality. By crude analogy, the extension of the logic that governs that expectation would hold that the houses of those who receive welfare should be no different than the houses of those who provide it. And while that analogy is admittedly ridiculous, the assumption that underlies it informs our country's definition of uniformity in universality.

The implications of this fact in New Brunswick and other have-not provinces for physician and medical staffing, infrastructure and equipment costs, health education and research, and other aspects of health, widely defined, are staggering. Provinces with the fewest resources are expected to deliver services that are the equivalent of provinces with the most. That is the Canadian contract.

The rhetoric that comes from some quarters of "have" provinces makes the challenges that "have-not" provinces face even more difficult, for that rhetoric employs either-or absolutes that limit the choices poorer provinces can make. What is to be done, then, when uniformity remains both law and assumption, but transfer payments from rich to poor provinces are contested or reduced?

The current government in New Brunswick has responded in the following ways. First, and most controversially, it began in August 2017 to disassemble its office of the Chief Medical Officer of Health, claiming in language that we are now (unfortunately) accustomed to, that such a move would "enhance" public health in New Brunswick by transferring functions of the office to departments of cognate function. Roughly a hundred personnel responsible for public health inspections, agri-food, population health, and other health enforcement functions now reside in the departments of Justice and Public Safety, Social Development, and Environment and Local Government.

Tellingly, provincial Deputy Minister of Health Tom Maston said the reorganization reflected the fact that New Brunswick is "'challenged' as a small province [because it] lacks the resources to set up a full public health agency such as exist in Ontario and British Columbia." In other words, New Brunswick can no longer afford to do what "have" provinces can. Those provinces "have much larger staffs," Maston said. "It's a straight resource issue for us" (qtd. in Poitras).

So, what is the consequence of dismantling a team of public health professionals to provide a facsimile of service under other departmental configurations? The expertise, though scattered, remains, but without the same capacity to anticipate, plan a response, and work as a unit to manage the kind of major health crises we've seen in other parts of Canada and the world. As the deputy minister himself admitted, Ontario and British Columbia residents have a health service that New Brunswickers can no longer afford but must struggle with reduced capacity to provide.

(New Brunswickers will know, of course, that the wider context of this change involves the still-mysterious firing of the province's chief medical officer in December 2015. In that instance, and in the

subsequent dismantling of her office, communications personnel have seemed unable to understand that forthrightness is always superior to spin: Maston's admission, then, should have preceded the attempt to try to convince an already-skeptical public that reduction was enhancement. But that is a secondary if aggravating issue.)

Similar streamlining affected other health services in New Brunswick. In September 2017, the provincial government announced that Medavie Health Services New Brunswick, a private not-for-profit corporation, would be awarded a ten-year (untendered) contract to manage a new health entity that combined Ambulance New Brunswick, the flagship Extra-Mural [Nursing] Program, and Tele-Care 811. The change effectively privatizes the management of those services in the province while taking authority away from New Brunswick's two "public" health networks, Horizon and Vitalité.

At this time it is too early to know if such consolidation of public health services under the management of a private company will deliver the outcomes promised; however, concerns about staffing and transparency are already mounting. Stories of chronically low numbers of paramedics, slow deployment of ambulances, and family members taking sick relatives to hospitals in the back of trucks and SUVs have been circulating, as have worries about the fact that, as a private company, Medavie does not have to provide an accounting of its operational outcomes. These are troubling signs for New Brunswickers.

Beneath the always-heated debates about health care privatization, however, is the larger issue facing have-not provinces like New Brunswick. In an age of increasing costs and the growing appeal of austerity—not to mention the continued (and reasonable) expectation of uniformity in the delivery of health care to Canadians—how does a small, structurally poor province like New Brunswick provide health services? Short of becoming an open site for nuclear waste disposal, thus bowing to the pull-up-your-socks crowd who accuse us of living off the hard work and environmental risks of others, the choices we have are limited.

Two of those choices—accepting second-class health care or moving to richer parts of the country to receive it—contravene the spirit of both Canada and the *Canada Health Act*. Whatever the outcomes are, the foregoing is the context within which we will have to make them.

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Works Cited

Poitras, Jacques. "Top Health Bureaucrat Calls Overhaul of Public Health a 'Straight Resource Issue.'" CBC Online. 13 October 2017. <http://www.cbc.ca/news/canada/new-brunswick/public-health-office-overhauled-1.4353800>