Settling for Mediocrity: Aging and Health Care in New Brunswick

Ken McGeorge and Thomas M.J. Bateman

Abstract

Demographic aging is a social, economic, and political condition that will soon affect most parts of the world. Some jurisdictions, like New Brunswick, are already experiencing it. The province's health care system should be adjusting to take account of the aging population, but it is instead stuck in mediocrity, posting poor health outcomes while occupying greater and greater shares of provincial program spending. This essay examines some of the circumstances associated with the province's mediocre health performance, with particular attention to the aging challenge; it suggests some steps to improve the system and the health of New Brunswickers as demographic aging proceeds.

Résumé

Le vieillissement de la population constitue une condition sociale, économique et politique qui touchera bientôt la plupart des régions du monde. Certaines provinces, comme le Nouveau-Brunswick, le constatent déjà. Le système de soins de santé de la province devrait s'adapter afin de tenir compte de la population vieillissante, mais il s'enlise plutôt dans la médiocrité : il affiche de piètres bilans de santé et occupe une part de plus en plus importante des dépenses de programmes de la province. Le présent article porte sur certaines des circonstances liées aux résultats médiocres de la province en matière de santé, accorde une attention particulière aux défis liés à la vieillesse et propose certaines mesures pour améliorer le système et la santé des gens du Nouveau-Brunswick au fur et à mesure que le vieillissement de la population se poursuit.

Introduction

In New Brunswick, health care is a bit like the weather: everyone talks about it, but no one does anything about it. Health matters touch everyone, and health policy, accordingly, touches everyone. Some 400 million contacts are made with the system annually (Simpson 1). On health questions, everyone has an opinion. Canadians in opinion polls consistently rate health care at or near the top of key issues in election campaigns. In Canadian political debate more generally, health care is tied to comparisons to health-care politics to the south, and we generally boast that our system is far superior and in no need of change. This is unfortunate because while Canada may perform well against the United States, it is at best a mediocre performer in comparison to other health-care systems in the developed economies. In 2012, Jeffrey Simpson put it thus:

> Canada ranks well above the OECD average in per capita spending on health care but slightly below average for administrative spending. Those who blame high administrative costs for Medicare's sustainability challenge are wrong, according to OECD data. The Canadian system is characterized by above-average overall costs, average health-care outcomes, less high-tech equipment and fewer acute-care beds, fewer doctors and

> medical students per capita, less choice among providers and patients, less regulation on prices for everything outside the basic Medicare services and a weak setting of priorities by payers, namely governments. (Simpson 162)

In other words, according to Simpson, we have a Chevrolet system at Cadillac prices.

In fact, Canada does not have a health care "system" as such. Health care is largely a provincial jurisdiction and the federal government's ability to set national standards of care is limited to its spending power. This means that ten provincial systems operate in Canada, all loosely held to the five principles of Medicare contained in the *Canada Health Act*, which the federal government enforces by moral suasion and slowly diminishing transfers of money for health services to the provinces. Decades ago, federal transfers for health were significant shares of provincial spending; that share is now more modest, and federal government leverage has declined accordingly (Saillant, *A Tale* 129).

Some deplore the fragmenting effects of federalism. On the other hand, provinces experience different circumstances, and their governments may be ideally placed to respond to those local circumstances nimbly and appropriately. Ten provincial health care systems can be understood as ten laboratories in which experiments can be tried and lessons learned. A healthy competition is implicit in the co-existence of public policy systems vying for the support of persons inside and outside their borders (Breton 457–502).

New Brunswick is one such laboratory. More intensely than other provinces, New Brunswick is aging. Twenty per cent of its population is over 65 years of age and, since 2015, deaths have outnumbered births. For the economy and society in general, and for the health care system in particular, this is significant. Given its relatively unique situation, New Brunswick can be a leader in the development of policies and approaches to adjust to and care for an aging population. While there has been a lot of talk, New Brunswick is in fact a case study in mediocre performance: we have struck an awkward equilibrium of high spending, dysfunction, and mediocrity whose combined effect is to resist change. Even a report on primary health care by the provincial government of David Alward confessed that the province is among Canada's biggest spenders on health but produces outcomes that are among the lowest (New Brunswick Health Council 10).

This article is the product of the experience of a long-time health care administrator with expertise in care for the elderly and the observations of an academic student of politics and public policy. It is borne of the frustration of seeing opportunities missed, lapses not avoided, and resources misallocated. Our thesis is that New Brunswick has settled for mediocrity in health care, particularly with respect to population aging. Instead of facing its unique demographic situation to become a leader in the management of population aging, the province's health system has failed to go much further than acknowledging the demographic facts on the ground. This is an unsustainable posture. The well-being of the people of this province is increasingly at stake.

Development of Health Care in New Brunswick

In one respect, New Brunswick was a historical leader in health care. In 1918, a minister of health for the province was appointed—the first in the British Empire (Cleary 4). In other respects, the province's system developed along conventional lines. Hospitals grew as not-for-profit organizations in thirty-five communities, with health clinics in several others across the province. The sponsoring bodies

were either religious or community non-profit organizations. Non-profit boards typically comprised town council officials, local community leaders, and a local physician.

Operating revenue usually came from insurance claims, donated funds, or direct charges. In the post-WW2 era, the financial viability of hospitals increasingly became an issue. As costs continued to rise, bad debts grew, and cash flow became an issue. This was true across the country. Blue Cross was formed by hospitals as a cooperative insurance organization that helped to relieve the cost burden for patients while getting operating cash to hospitals (Medavie Blue Cross, "History"). By the early 1960s, the struggle intensified and people deferred care for non-emergent situations while hospitals struggled to pay bills. After some foot-dragging, New Brunswick signed on to the federal government's offer of assistance for provincially administered hospital insurance. Even with this assistance, the province was poor and left the delivery of social services to local governments with highly variable fiscal capacities. This patchwork became the impetus for a policy revolution.

In 1965, Premier Louis Robichaud, who himself had grown up in a poor, rural Acadian community, proposed a program of Equal Opportunity. This sweeping program, based on recommendations of the "Byrne Commission" that reported in 1963 (New Brunswick, Royal Commission on Finance and Municipal Taxation), consolidated power in the provincial government and dissolved county councils that until then had the responsibility of caring for the disadvantaged. The intent of this restructuring was to ensure that all residents have equal access to a similar level of essential service regardless of place of residence or language (Robichaud 1–11; Young 95–98).

As Marchildon and O'Byrne indicate, broader health care developments in Canada dovetailed nicely with Robichaud's provincial policy revolution. "Equal opportunity" of the 1960s was all about increasing the capacity of the provincial government to equalize residents' access to quality health care and other services (Marchildon and O'Byrne 153–6).

Equal Opportunity meant that the provincial government assumed control over the hospitals. Strictly speaking, title was retained by a local non-profit organization, but actual control became vested in the province in a number of ways. The province had members appointed to the boards and asserted control through legislation, regulations, and the budget process. The centralization and rationalization of taxation and policy making meant that the province took over the debts of local bodies, including hospital boards. But it also took control of their assets, while leaving undisturbed their ostensibly private status (Stanley 141). Beneath the veneer of local governance was prodigious policy control from Fredericton. Notably, the Byrne Commission recommended the creation of administrative commissions to regulate the operations of schools, hospitals and other services to be placed in the hands of the provincial government. Rejecting this, "Louis jealously treasured the power of his office to build roads, hospitals, and schools, wherever his government thought they would be of the greatest benefit, politically and economically" (Stanley 142). Modernization was married to the New Brunswick politics of patronage.

According to a former provincial Department of Health official, care of the elderly was not part of Equal Opportunity, and each community was left to figure out its own strategy. In the 1960s and '70s nursing homes gradually sprang up, owned and operated by service clubs, churches or religious organizations, and other non-profit organizations. Unlike other provinces, the private sector was excluded from nursing home ownership and operation. In the development of long-term care, this feature alone has presented significant social and operating challenges. In the global growth and

development of excellence in long-term care, the combination of leadership, culture, and private enterprise has been critical. The exclusion of the private sector in this field in New Brunswick may have forestalled a good deal of innovation and funding.

In 1972 eleven nursing homes formed the Association of New Brunswick Nursing Homes to develop and maintain a system of employee benefits, develop a common approach to union collective bargaining (CUPE was the major union organizing nursing home staff), and present a voice to government on matters of mutual concern.

Nursing homes were initially regulated by the Department of Health (later Health and Community Services) through the Nursing Home Services Branch. A formula was devised to govern the allocation of operating budgets to nursing homes and, for the most part, nursing homes did not depart from the staffing allocations in the budgets. The formula laid out precisely the rates of compensation for all personnel—unionized staff as well as administrative officers.

In the early 1980s, New Brunswick had introduced the popular Extra-Mural Program to provide a range of active treatment services at home, based on the model developed in New Zealand. The purpose was to improve service access and reduce the pressure on hospital-based services. Still, in the late 1980s, there were more nursing home beds per capita in New Brunswick than in other provinces, access to admission to hospital beds was almost without limit, and wait lists were short. It was a costly "on demand" system in which hospitals absorbed demand that nursing homes could not supply. Rural communities, in particular, treasured their small hospitals. Many nursing homes were small (30–40 beds) and could not support full-time management teams. Consequently, some shared services arrangements were established that enabled small homes and community boards to have access to trained and experienced management personnel.

In 1988, the provincial government became concerned about the rapid growth in cost of the hospital and nursing home sector and established the Commission on Selected Health Care Programs (called the McKelvey-Levesque Commission after its co-chairs) to create a plan. McKelvey-Levesque examined the ways in which hospitals and nursing homes functioned, and concluded that for a small province there was too much infrastructure. It recommended that health services be regionalized as a means of streamlining decision-making and governance (New Brunswick, Commission on Selected Health Care Programs 47–48).

This report's proposals were too significant to be implemented in haste. In 1991 the McKenna government, with a large legislative majority and a mandate to make tough decisions, commissioned a small working group (made up of staff from the Medical Society, Hospital Association, Nurses Association, Department of Health) to recommend hospital system efficiencies. This group quickly concluded that system improvements were not possible in the absence of a regional hospital structure, and that the recommendations of the McKelvey-Levesque Commission should be implemented. In March 1992, Dr. Russell King, Minister of Health and Community Services, announced in the legislature, in the context of the province's capital budget, the regionalization of New Brunswick hospitals. All hospital boards were disbanded by the end of the month, and replaced by a one-person board for the period 1 April–30 June 1992, that one person being the Minister of Health and Community Services. Eight regional hospital boards were created.

Regionalization was implemented before all the details were worked out, so the first several months were difficult for managers and the government. Once the jobs and beds were reduced and hundreds of people reassigned, the regional organizations turned their attention to trying to operate systematically. After two years had passed, staff in the regions were able to identify benefits of the new scheme:

- more efficient use of health facilities;
- better access to specialty services by those in rural communities;
- management of some quality practices;
- leadership/management training made consistent; and
- beginnings of standardization of key practices both managerially and clinically.

In preparing for the provincial election of 1995, government was, understandably, becoming concerned. Regionalization of hospitals had taken a toll, with the electorate in some communities showing signs of serious angst. This was particularly true in Region 3, which houses the provincial capital and which was a lightning rod for much anger. Region 3 had the largest concentration of small communities combined with the provincial capital. It had four small community hospitals with independent medical staffs, all fighting for survival, a situation that made the Hospital Corporation and its leadership easy targets.

In the years that followed, health care cost reduction dominated government thinking. This led to further consolidation. Eventually, dealing with two boards seemed to be more desirable than dealing with eight, so there was a consolidation into Vitalité, the francophone health authority, and Horizon, its anglophone counterpart. The policy of consolidation had much merit, but the government pursued it as a complete answer to stresses in health care, while other issues affecting service excellence and good outcomes were largely ignored.

Two conclusions can be drawn from this brief post-war history. First, New Brunswick has been able to innovate. While regionalization of health services had been discussed in the health literature for thirty years (Ellis 953–957), no province had had the courage to move in that direction. Provinces had merely flirted with regionalization by encouraging health facilities to work together. New Brunswick was the first jurisdiction to restructure the hospital system (though Saskatchewan simultaneously initiated a series of rural hospital closures [MacKinnon 228–256]).

The second conclusion is that the regionalization-consolidation dynamic has amounted to almost all of the government's health care reform agenda. Very little policy attention has been paid to emerging issues in health care, among the most important of which is population aging. New Brunswick ignores this and other emerging issues at its peril.

The Context for Crisis and Change

Whatever its mythic status, health care in Canada is under stress and must change in order to be a sustainable system that fosters the health and well-being of Canadians. Aging and new thinking about human health are high on the list. But change does not come easily in Maritime health care.

Aging

In 2011 the first baby boomer cohort reached retirement age. In 2015 in New Brunswick, deaths outnumbered births. Demographic aging may not be a tsunami that will engulf the developed world, but it is a glacier whose slow, inexorable movement will pose challenges for health care.

It is not just us. "We are in the midst of an unprecedented transition in global demography" (Bloom et al. 80). Three changes are afoot: decreasing fertility, increasing longevity, and the aging of large birth cohorts. In 2002 the United Nations produced the Madrid International Plan of Action on Population Aging and noted that the "remarkable demographic transition under way will result in the old and the young representing an equal share of the world's population by mid-century. Globally, the proportion of persons aged 60 years and older is expected to double between 2000 and 2050, from 10 to 21 per cent, whereas the proportion of children is projected to drop by a third, from 30 to 21 per cent" (United Nations para 3). More recently the UN's Department of Economic and Social Affairs reiterated the point, asserting that "population aging is a universal phenomenon; every country or area with at least 90,000 inhabitants in 2017 is projected to see an increase in the proportion aged 60 years or over by 2050" (United Nations, Department of Economic and Social Affairs 1).

What the world will face is what this province currently experiences. Almost 20% of New Brunswick's population is over 65 years of age compared to 16.5% of Canada's population. Over four in 10 New Brunswick seniors are over 75 years of age. Fertility in this province is low because young people tend to out-migrate while the province experiences a net gain of seniors in-migration from year to year.

Several consequences follow from demographic aging. The first is that aging will produce 1% annual increases in health spending in Canada (CIHI, *National Health Expenditure*, 25). Per capita spending on health care varies with age. In 2014, "the cost for Canadians younger than age 1 was an estimated $10,800 per person, on average. For youths age 1 to 14, per-person average spending on health was $1,423; the equivalent for those age 15 to 64 was $2,663, and the average was $11,635 for those 65 and older" (CIHI, *National Health Expenditure* 22). For those over 90 years of age, the cost leaps to almost $30,000 per year. A critical caveat is that health care costs are high for everyone at the end of life. "For most people, the vast majority of all the health care they'll ever get comes near the hour of death" (Reid). Health care costs are high for the elderly, in part, because more deaths occur in this age group than in others.

In addition to this, health conditions for seniors are different from those in other age groups:

> Nations with swiftly aging populations may find themselves with a growing disease burden on their hands: nearly one quarter of the world's burden of disease is attributable to illness in adults aged sixty and over. In turn, the majority (nearly 70 percent) of the older-adult disease burden is due to non-communicable diseases (ncds) such as heart disease, cancer, chronic respiratory disease, musculo-skeletal conditions, and mental disorders such as Alzheimer's and dementia. Adding to and significantly complicating the concerns posed by ncds is the issue of multi-morbidity, which affects a majority of older adults with ncds. (Bloom et al. 82–4)

To put the point crudely, younger people get sick or injured, are treated, and then return to health. For seniors the story is often different. Many suffer not merely from discrete illnesses but from

chronic conditions that require long-term management rather than curative treatment. In New Brunswick, 39% of seniors suffer from three or more chronic conditions such as diabetes or chronic obstructive pulmonary disease (New Brunswick Council on Aging 5). Cancers are also primarily a disease of the aged (Hadler 65). "The number of chronic conditions—not age—accounts for the greater use of primary health care services among seniors. Chronic disease management will therefore become increasingly important as the number and proportion of Canada's seniors grow over the next 25 years" (CIHI, *Health Care in Canada* 51).

A second consequence of aging is that economic growth will slow. Demographic aging means declines in labour force participation and tax revenues (Saillant, *A Tale* 41–43). The baby boomers were a large employment and consumption machine that fueled the economics of the developed world until the first part of this century. As noted, in 2011 the first cohort of baby boomers reached retirement age, and the effects on the economy will increasingly be felt. When declines in economic growth and increases in health spending are combined, the net effect is that government revenues will be pressured precisely at the time charges on the health care system will increase. Governments in recent years have shown notable restraint in health care spending. In real dollar terms, since 2010, health spending has increased only 0.1% per year. But the sustainability of such restraint under current structures of health care is called into question. How low, for example, can doctors' salaries go before other provinces will draw doctors away (Saillant, *Over the Cliff* 75–94)? The question is whether health care policy-makers and practitioners are doing more with less or whether the system is under increasing stress as fewer resources are being allocated for the same responsibilities and functions as before.

Health versus Treatment; Relationships versus Heroism

The Canadian health care system is the product of mid-twentieth-century movements to ensure that everyone, regardless of ability to pay, has access to necessary medical care. Universality was achievable in part because it was generally understood to be affordable, as well as just. At that time, the dominant health concern was access to good care to treat discrete illness or injury. Its symbolic centre was the hospital. Such were the limits of medical science and the needs of a demographically young population. "Existing health care delivery systems and organizations were developed to meet acute-care needs. Adept at handling these one-time, episodic conditions, these same systems are now facing issues such as fragmentation, inefficiency and poor outcomes (particularly for those with chronic conditions)" (CIHI, *Health Care in Canada* 129). In other words, the system was not structured for challenges posed by an aging population.

But the challenge goes beyond the need to rejig the system to handle chronic conditions. As our understanding of the determinants of health deepens, observers have noted that conventional health institutions and practices do not have the influence we once thought. One authoritative American study suggests that

> health is influenced by factors in five domains—genetics, social circumstances, environmental exposures, behavioural patterns, and health care. When it comes to reducing early deaths, medical care has a relatively minor role. Even if the entire U.S. population had access to excellent medical care—which it does not—only a small fraction of these deaths could be prevented. The single greatest opportunity to improve health and reduce premature deaths lies in personal behaviour. In fact, behavioural causes account for nearly 40% of all deaths in the United States. Although there has been

> disagreement over the actual number of deaths that can be attributed to obesity and physical inactivity combined, it is clear that this pair of factors and smoking are the top two behavioural causes of premature death. (Schroeder 1221–1222)

A New Brunswick government report makes the same point. The health care system accounts for 10% of one's overall health (New Brunswick, *Rebuilding Health Care Together* 8). A rich literature indicates that social networks, friendships, family bonds, and civic engagement all conduce to health and a subjective sense of well-being. It is not just that someone notices when you slip in the bath and miss an appointment; rather, humans thrive on social interaction and derive much satisfaction and support from it (Putnam 326–335).

Note the perceptual disconnect. "We have a certain heroic expectation of how medicine works," argues Atul Gawande (39), yet our formal systems that deliver health care are struggling to keep up. After the Second World War, medicine made stunning leaps in the battle against disease. "A single generation experienced a transformation in the treatment of human illness as no generation had before. It was like discovering that water could put out fire. We built our health care system, accordingly, to deploy firefighters. Doctors became saviors" (Gawande 39). Hospitals became the citadels of medical progress. They are the sites of our technical prowess and we expect heroic feats to be performed on the sickest patients. Surgeons and specialists became miracle workers. "Fields like primary-care medicine, seemed, by comparison, squishy and uncertain" (39). In like manner, the pharmaceutical industry has revolutionized health care and we accordingly look to the silver bullet to treat our ailments. Drugs now constitutes the second highest category of health spending after hospitals themselves. Yet the sources of health and well-being are predominantly found elsewhere.

Observers increasingly believe that the magic-bullet view of health care is making us sicker, not better. First is the problem of overtreatment. Evidence increasingly abounds that people are being given too many medications—many of them with harmful interactions with one another—and too many unnecessary and even harmful diagnostic procedures (CIHI, *Unnecessary Care* 9–10; Picard 115–117). The second is that the pressure to do something at the insistence of the patient may trump the benefit of listening to the patient, inquiring into his or her history and suggesting alterations and remedies other than tests, pills, and procedures. "Don't just do something, stand there!" is the quip to shake us into realizing that waiting is sometimes better than acting (Martin 124). National health care expert Danielle Martin counsels a move away from the default "procedure" and toward a more relational approach to care—toward "slow medicine"—wherein the medical practitioner develops a deep understanding of the whole person and his or her needs, not all of which are treatable by medical technique (Martin, 121–145; see also Cleary 3; Gawande 41).

The relational approach to care is, needless to say, well suited to the aging context.

Entrenched Interests and Gridlock

A critical issue is how change can be achieved in a massive, complex system staffed by articulate, highly paid professionals able to defend their interests, serving a citizenry wedded to free, locally available comprehensive acute-care services.

Several factors are involved. First, doctors are obviously central to the health care system and have enjoyed a great deal of autonomy, even after single-payer insurance was instituted in Canada in the

mid-twentieth century. However, medical societies, descendants of medieval guilds, jealously guard their prerogatives (Taylor 258–266). Other health care workers are unionized and enjoy substantial job and compensation security. These factors introduce a great deal of rigidity into the health planning and reform process. This form of interest-group politics is familiar to all students of public policy. But in health care, there is also a broad Canadian commitment to Medicare as a cultural value, not just a functioning system. Opponents of reform invoke the values of Medicare to block change. It often works. This is what Jeffrey Simpson has defined as Canada's "third-rail problem" (366).

Second, and partly following from the first point, politicians see little benefit in disturbing the policy status quo. Ministers come and go, and members of the Legislative Assembly hear less from their constituents about the cost of care or its ineffectiveness and more about lack of resources, poorly equipped hospitals, and the need for more doctors. Everyone has a health-care experience and thus an opinion. In a single-payer model of health care, people easily assume health care is free, or at least paid for by someone else. This, of course, is one of the virtues of the Canadian model—medical care on the basis of need, rather than ability to pay—but it distances people from the opportunity costs associated with deploying resources for this or that form of health care. Most people have no idea what a medical procedure costs and the system does nothing to enlighten them. One may be led to speculate that our system is mediocre partly because people conclude that mediocrity is good enough for materials and services that are free.

In Canada, the problem with health care is exacerbated by federalism. The federal government transfers dollars to the provinces for health care though health care is pre-eminently a provincial jurisdiction. So the province gets credit for spending federal dollars. Democratic accountability generally means that the government that spends money on people raises tax revenues from those same people and accounts to them for both activities. These relationships of accountability are misaligned in Canada, and were seen from the beginning as an unfortunate consequence of the federal role in health care (Taylor 36).

Third, to the extent that changes have been made, changes have usually taken the form of deployment of new resources. This has been easy to do and often politically expedient; it has satisfied the actors within the health care system. For example, the federal government in the Harper years responded to lengthening wait times for certain procedures like joint replacements by offering the provinces dedicated monies to speed them up. The provinces took the money, reduced times for those procedures, and watched as wait times for others lengthened. When more money is poured into the system, it is largely absorbed in salary increases rather than in process and system improvements. And salaries constitute the greatest share of health care costs.

Fourth, old habits die hard. Canadians still equate good health care with the infrastructure of acute care. As Andre Picard notes, "A community without a hospital is viewed as a place without a heart or soul" (24). In New Brunswick, half of seniors live in rural areas, compared to 20% in Canada as a whole. Seniors are understandably reluctant to see their hospitals close. The magic-bullet view of drugs and the demands that doctors "do something" remain entrenched, abetted by fee-for-service billing models that encourage the performance of discrete procedures and the ordering of myriad diagnostics. Evidence that the system resists change is that existing facilities are being used for purposes for which they were not designed. For example, 20% of hospital beds in the province are occupied by persons who do not require acute care (New Brunswick Council on Aging 6). Reflecting on the Maritimes and the

resistance to policy and economic change, one Cape Breton entrepreneur captured the dilemma perfectly: "People are for progress but are opposed to change" (qtd. in Savoie 322).

The days of dealing with health care challenges by spending more money are coming to an end. Governments cannot afford the 6% annual increases in health care spending that were the norm until 2010. Reduced economic growth in the future will put more pressure on spending budgets. Will that reduced growth also diminish demand for health care, or alter the nature of demand? Economic growth to date has been associated with increased utilization of health care services, other things being equal. If "health" is so elastic a concept, it may be responsive to more austere conditions in public finance. On the other hand, "health" is a container into which we put our highest aspirations for longevity, performance, and emotional well-being. Can anyone have too much health? Probably not, not least because the health care industry has as big an interest in making us consider ourselves sick—thus in need of medical care—as it does in making us better. And the "worried well" themselves seek to medicalize their conditions (Hadler 128–145). The challenge for health care policy in the future will be to reconcile available resources with highly expansive notions of what it means to be well and live well.

Generational change in the medical profession may stimulate change. The medical profession is increasingly female-dominated, and new doctors do not want to run solo practices; nor are they inclined to the fee-for-service model and the long hours required to make a lot of money.

For New Brunswick, public finances will not get better in the foreseeable future. An argument can be made that under-spending for health is not actually the problem: the province spends more per capita on health than the Canadian average and has more doctors per 100,000 population than the Canadian average (New Brunswick, *Rebuilding Health Care* 7). The population will continue to age; the rural north will continue to depopulate; the pressure for change will continue to mount. Is the province up to informed, constructive change to meet the challenge? What will it take to prompt the change that is required?

The Political Trap in Health Care

New Brunswick is a small province and a large share of its population is rural. Furthermore, a large proportion of the province's seniors live in rural areas. These demographic features alone make the delivery of care expensive. As indicated above, a critical dynamic in health care policy has been the integration of province-wide standards and regionalized management and delivery. This has not worked as well as possible. Provincial governments have been unable to resist the temptation to meddle in affairs that could be left to regional authorities. Put differently, elected politicians have failed to insulate themselves from appeals from residents when regional authorities make difficult decisions. Two examples illustrate the point.

Consider, first, Waterville Hospital. When hospitals were regionalized in 1992, there were four small hospitals operating in Carleton and Victoria Counties. With a declining and aging population, the four could work together to share resources and programs. Each hospital was really struggling to maintain quality and volume of service. While geography presented some challenges, the facilities were only a twenty-minute drive from each other. The Region 3 Hospital Corporation created a plan to convert the two smallest facilities to largely community health centres with emergency care capacity and to develop the other two as facilities that could maintain basic obstetrics and general surgical capacity. The Hospital Corporation's plan was based on what was happening in rural communities across North

America—and as close as fifteen miles away in the state of Maine. But a seat in the legislature was at stake and doctors in one community were not in support of the regional plan, so they proposed, during the 1995 provincial election campaign, the creation of one hospital to replace the four smaller facilities. The Hospital Corporation averred based on the evidence that this would never work. The Liberals lost the seat but went ahead with a plan for one hospital located in a compromise location that was, in the opinion of some critics, in the middle of nowhere. The Hospital Corporation had a soft estimate of $17 million for execution of its four-site plan; the proposed single hospital was estimated to cost $85 million. It was eventually completed at a cost of $115 million, and of the four other facilities, one is a community health centre, one continues to operate with limited surgery, and one has been empty for six years with the province paying the overhead and upkeep for five of those years. The Waterville Hospital is a beautiful facility, but half of its beds are closed, and most of the open beds are occupied by seniors awaiting nursing home placements; surgical activity is limited to some general and endoscopic procedures. The hospital in Woodstock, for a $17 million modernization, could have been retained to perform all of that with fewer staffing requirements.

Surgical facilities in St. Stephen provide a second example. In this small community hospital, the surgeon was coming up for retirement, and the hospital had insufficient volume to maintain one surgeon, much less surgical support. With the retiring surgeon's consent, the Horizon Health Authority in 2016 proposed to replace the surgical program with non-surgical services. Some members of the community waged a campaign to retain surgery and threatened to pull the hospital out of the Horizon network (even though that would be legally impossible). The premier, perhaps conscious of the need to maintain his narrow majority in the legislature, announced that surgery would remain in St. Stephen. The local people understandably mobilized to defend a convenient local health service. But no independent body helped them understand that that is not a good idea for the public as a whole. The government intervened to prevent a restructuring, not remain to the side and permit Horizon to push it through.

These cases illustrate the policy gridlock occasioned by political meddling in management matters best left to regional authorities. The lesson for New Brunswickers is that when a decision is made to rationalize the system, close a rural hospital, and consolidate services in a more efficient manner, just call up an MLA or minister or the media and the government will undercut the regional authority and preserve the status quo or adopt a costlier alternative. In so doing, the politicians communicate the message that they are in fact in control of the system and will accede to local wishes. The public naturally makes more demands of the politicians, many of them too expensive to implement. When the politicians judge that the demand is too expensive or disruptive, they create an expectation of action. This means appointing a commission, asking for a report, promising action, then, after the lapse of an appropriate period, repeat.

The Road to Better Performance

Empower the New Brunswick Health Council

Because of its demographic characteristics, New Brunswick can be a Canadian leader in providing the sort of care appropriate to new conditions of demographic change and fiscal scarcity. The outlines of a plan are relatively well known. As the old administrative science maxim goes, you cannot manage what you cannot measure. The absence of evidence-based advice for government on matters of service organization, appropriateness, and disease strategies leaves health service providers in a type of

limbo. Yet the New Brunswick Health Council has staff, budget, and research capacity. It can function as a source of sober second thought on health authority service plans, providing government with advice that is nonpartisan and aimed at ensuring the highest quality of sustainable health care.

Develop a Rural Health Strategy

A rural health strategy is particularly critical when we consider that almost half of seniors in the province live in rural areas. In a properly executed rural health care plan, persons in small communities have efficient access to the services required to help them live safely at home. There are models in Canada, and other provinces have jumped ahead of New Brunswick. Some of the elements of a good rural health strategy include strong clinical leadership in the regional centres that recognizes the duty to provide the same great care to rural areas as would be experienced in the regional centres. This can be done, but not without a strong commitment to satellite clinics, telemedicine, and all the potential of electronic communication.

Remove Partisanship from Key Appointments

Strong leadership and culture must also be priorities. Appointments to positions of leadership must be based on essential standards for education, training, and prior experience. Managing in a health care environment is every bit as unique as managing in the nuclear industry, and one would not appoint an executive in that industry who did not have progressively increasing responsibility and training in the nuclear energy field. Leadership starts at the top and permeates through the organization: board members, executive team members, department heads, supervisors, union officers, and medical staff.

A recent performance audit of the Department of Social Development conducted by New Brunswick's Office of the Auditor General speaks to this need. The department sought advice for improving productivity and realizing savings in several of its areas of service delivery, including seniors' homes and long-term care. Its relations with the consultant who eventually billed for $13 million broke a host of policies and regulations, including those pertaining to procurement, contract compliance, and expense reimbursement. In the end, the department realized just $10 million in savings. The report is damning. In her summary of the audit, the auditor general declared that a major reason for the violations is the "culture of complacency" pervading the department (Office of the Auditor-General 5).

Adopt Flexible Strategies for Health Care Workers

As mentioned above, the face of family medicine has changed across the continent; many younger doctors opt for shorter work weeks, reduced caseload, and a more relational approach to their interaction with patients. Other jurisdictions have seen the development of alternative models of primary care that do not leave elders without proper care. An integrated primary care model of practice has physicians, nurse practitioners, nurses, social workers, and other professionals function as a team in managing care. Recently announced changes to primary care delivery are a step in the right direction. The New Brunswick Medical Society is providing incentives for doctors to move into team practices and sharing patients to reduce wait times (Pruss). Hospital-based urgent care centres take much of the volume of non-emergent cases from emergency departments while creating an approach to care that is integrated with the health system.

Physician compensation models can make a difference. The fee-for-service model encourages quick, one-off visits to the doctor's office. Doctors crowd their schedules to get in as many appointments as possible. They then bill for discrete services rendered. But waits lengthen and the quality of care may suffer. Compensation based on salary or capitation facilitates a "slower medicine" approach in which doctors can spend more time with patients with co-morbidities and complex family-care situations. Currently, too many people end up in hospital emergency departments because they lack a family physician or cannot see one in a timely fashion. This is a costly and ultimately unhealthy way to deliver care, especially in a context of demographic aging (Martin 80–84).

Develop a Dementia Strategy

As New Brunswickers age, dementia will become an increasingly important health care challenge. Dementia affects 750,000 Canadians at present and that number will double by 2031. (Senate of Canada 3). Dementia is neither mental illness nor simply aging, as many mistakenly assume. Dementia is one of the major health issues of this century, and models of treatment must include improved awareness and additional training on the part of all professionals (nurses, physicians, therapists, receptionists). This disease is best dealt with early, in partnership with the Alzheimer Society of Canada, which runs educational programs, support networks, memory cafes, and other social activities that are all aimed at maintaining normal life for sufferers and providing respite for caregivers.

Conventional primary care does not work well for persons with dementia. The Linda Lee Clinics that are springing up in Ontario show that dementia patients are best managed on a case management basis by a team of professionals. Through a day program or primary care office a case manager coordinates all elements of the support required by the patient and the caregiver, including primary care, home support, and home care essential in preventing the crisis that eventually will take place in the absence of support.

Such a dementia strategy would also recognize that a large proportion of seniors suffer from co-morbid conditions. Familiar combinations are Alzheimer's and Parkinson's; arthritis and high blood pressure; and diabetes and circulatory problems. Once diagnosed, many of these chronic conditions should be managed through integrated primary care clinics in which best-practice information is readily available.

Develop a Health Education Strategy that is Socially Informed

Acute health care accounts for only a small portion of one's overall health. Health promotion and prevention of disease must be emphasized and must commence early in life. Unhealthy lifestyles, unfortunately, follow the poverty cycle, so a complete program aimed at healthy living and disease prevention must be linked to poverty reduction. Most of the diseases that require long-term care are not preventable; but for those that are preventable, there are several options to consider, including public education on the social determinants of health, and tax and policy measures to "nudge" people to make healthy choices and discourage unhealthy ones (Thaler and Sunstein 159–184).

Establish Centres of Excellence

With a population of 750,000 there just is not enough caseload or fiscal room in New Brunswick to sustain multiple thoracic surgery units or multiple heart centres; continued attempts to duplicate, triplicate, and quadruplicate will yield marginal quality results and will place unnecessary fiscal pressure

on the health budgets. With technology now available, centres of excellence can be established, concentrating expertise, caseload, and consequential efficiencies in one location. Such centres would facilitate sub-specialization and reduce waiting times. The goal would be to establish specialty services that maximize best practices, minimize access issues, and improve overall quality. The trade-off is that patients would be less likely to have local access to specialized procedures.

Develop an Integrated Management System for Long-Term Care

Finally, because the long-term care system is a major choke point for New Brunswick health care, improved management methods for such care should be developed. Long-term care should be administered at arm's length from government, with licensing and inspection based on proven risk-management principles and accreditation standards. The existing stock of special care homes, nursing homes, and Home First initiatives can provide care for New Brunswick seniors that is the envy of the country. Small community facilities can do better when part of an integrated system in which best-practice guidelines are used, leadership is consistent, and labour relations are effectively managed. This requires initiatives on several levels, including the following: correcting longstanding problems with the assessment and single entry point systems, fixing system navigation challenges, improving the licensing and inspection process at all levels of the system, insisting on consistent training standards, and attending to the recommendations in the Aging Council Report, especially those concerning person-centred care.

Conclusion

This essay has argued that, while it can and should be a leader in addressing the health needs of an aging population, New Brunswick health care is stuck in a path-dependent equilibrium in which a large share of public spending is devoted to an increasingly outdated acute-care model. Academic public policy studies suggest that at critical junctures, a crisis or shock can disrupt a stable equilibrium and inject a fluidity that leaders can exploit to fashion a new model (Hogan). In the circumstances described in this essay, it is hard to know what a sudden crisis would look like. Aging, to take one example, is a slow-drip development that escapes the notice of most people, and whose solution falls outside the planning horizon of the four-year political election cycle. In the absence of foresight and the willingness of leaders to incur some bad press and the ire of affected interests and communities, the system will continue to become increasingly unsustainable.

Elected officials either know little about the character of contemporary health care and stay aloof from emerging issues (given the constraints of office), or they are propelled by short-term political imperatives into micro-management of particular issues with consequences they do not contemplate. In both cases, the real underlying issues do not get a fair hearing. The creation of the Waterville Hospital is one major illustration of this feature in which the debate was strictly along party lines with the real public policy issues drowned out in the debate. Health policy in New Brunswick is either made on the fly or left in a state of paralysis while pressure on the system slowly mounts. New Brunswick can do better.

Ken McGeorge spent his career as a health executive giving leadership to major teaching hospitals in Nova Scotia, New Brunswick, and Ontario. He was part of the leadership team in health care restructuring in New Brunswick in the 1990s. He is Co-Chair of the New Brunswick Council on Aging.

Thomas M.J. Bateman is Associate Professor of Political Science at St Thomas University in Fredericton.

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