Planning New Brunswick Public Health Services: from Incrementalism & Segmentation to Comprehensiveness & Integration

Presentation to the NB Coalition of Concerned Citizens

by

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Planning

'A method of doing or proceeding with something formulated beforehand .....

……..proceeding with a definite purpose'

From: The Random House Dictionary, NY, 1978

Over 60 Years of Incrementalism = Current Set of Services

- *1957- (federal* **Hospital Insurance & Diagnostic Services Act)** *publicly funded hospital services in private/community owned & operated installations*

- *Pre 1966 - multiple local non-profit organizations & individual doctors' offices responsible to provide health care. Health care funded locally & by users (except hospitals since 1957). No provincial planning of services or funding*

- *Starting 1966 (NB 1968) Medical Care Act -Provincial government now pays same local organizations & doctors' offices to provide services (public health care insurance & E O kicked in). 100% public funding without provincial program/service planning*

- *1980s- CHA (coverage of all – undefined- medically necessary services, 1st hospital services master plan articulated. Beginning of (bottom-up) infrastructure & program planning*

- *1990s- Start of service consolidation & of province – wide sectoral planning (from 52 hospital and health centre boards to 8, strengthened hospital master plan, provincial physician resources plan, Extra-mural services plan completed, as well as ambulance plan)*

- *Early 2000s- Further consolidation of services/devolution of program responsibilities (from 8 regional hospital boards to 2 Regional Health Authorities, NBHC, Facilicorp, MH, PH)*

- *Today- Still no comprehensive/ province-wide health services plan*

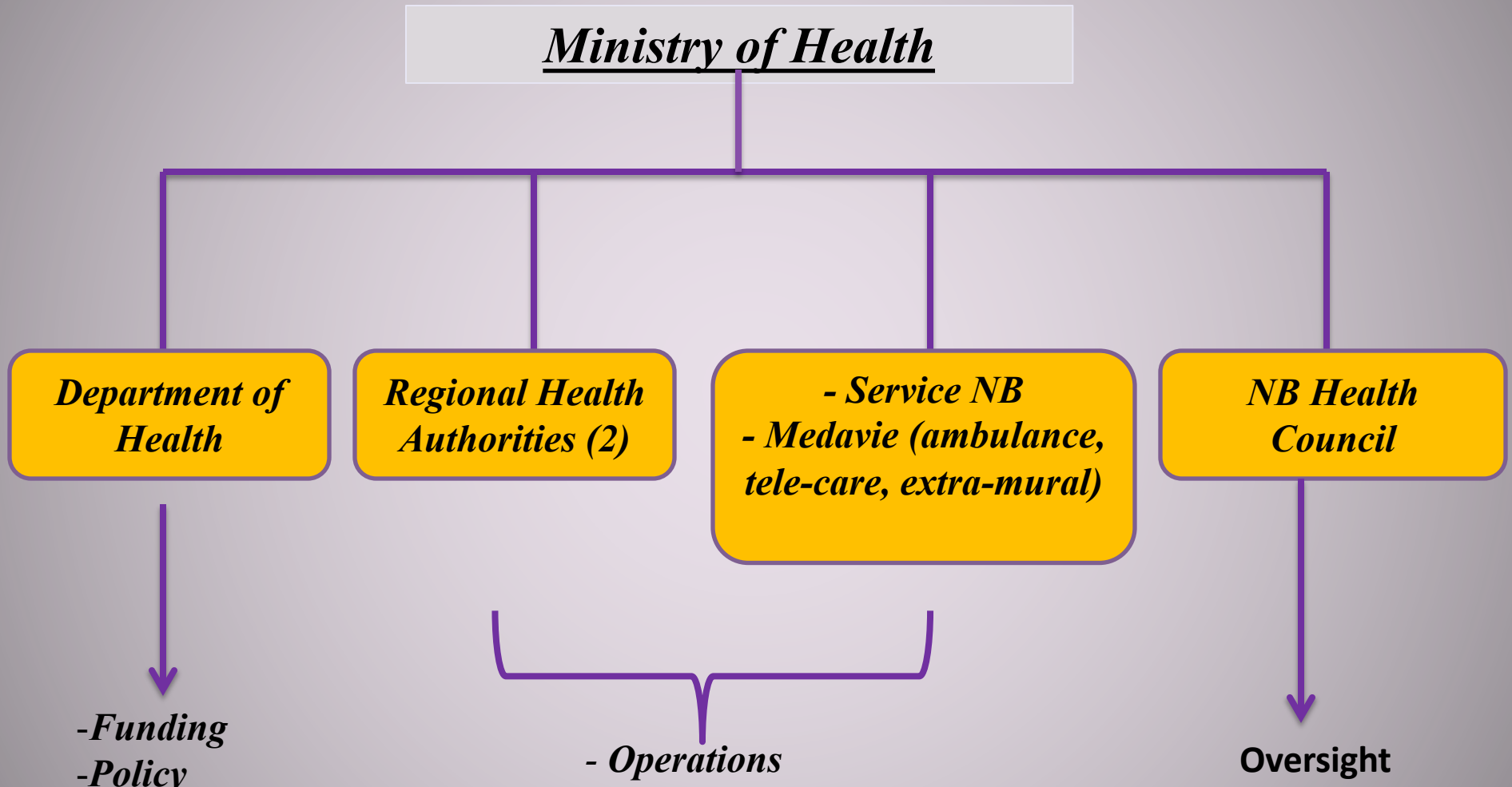
Funding vs. Service Delivery: the Great Disconnect

- ***1967- Sharing (50/50) of program costs guaranteed. Province assumes only half of services cost. Incentive for program expansion by province.***
- ***1968- Provincial funding vs. local programming and delivery***
- ***1977 – Federal block-funding. Limits federal health care expenditures. Provincial governments now responsible for a growing share of health care expenditures***
- ***1984- CHA, 1st dollar coverage of all- undefined -medically necessary services/prohibition of user fees, including deductibles. Guaranteed public health care, no charge at point of service. Federal government pays smaller share but imposes stricter program criteria***
- ***1992- Regional Hospital Boards (provincial funding/regional program responsibility)***
- ***2002- 2008 Regional Health Authorities (devolution- more services go regional, funding remains central)***
- ***Individual services- providers & health care professionals decide, provincial government pays***

Note: Key public finance principle: the one (or organization)who spends- or causes spending- should be responsible to raise corresponding resources. Health care funding rules as we know them in Canada violate this principle

New Brunswick Ministry of Health (NBMOH)

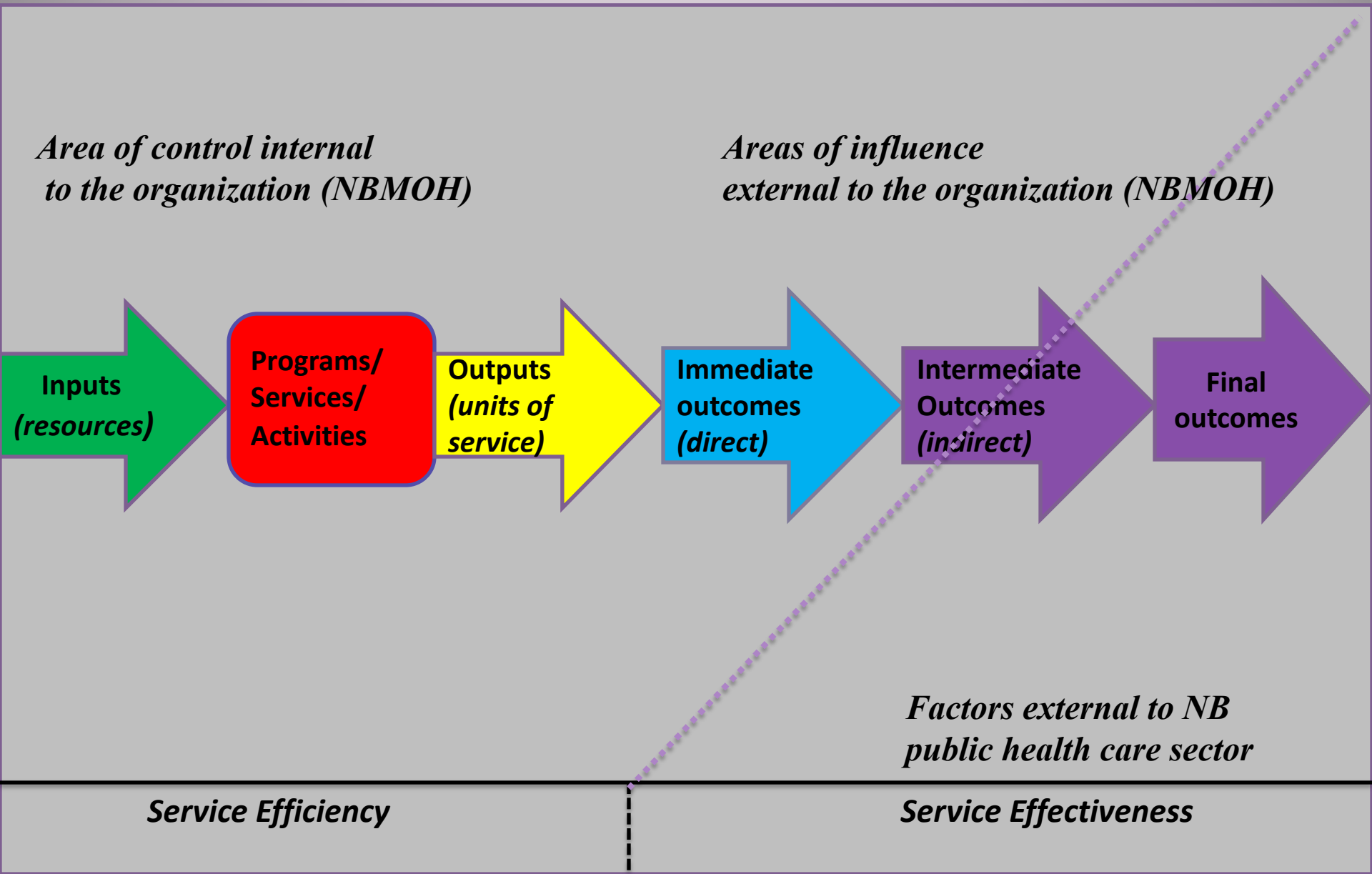
(configuration Spring 2018)



Note: nursing homes (LTC) reside in another department

Planning Framework: A Results-based Logic Model

(adapted from Treasury Board Secretariat Guidelines
Government of Canada -August 2001)



Results-based Logic Model (RBLM)
What the Framework Does

- ***Ensures clear & logical design that ties resources to expected outputs & outcomes** – logical sequence of activities, outputs & a chain of outcomes for policy, program or initiative*
- ***Tells how well (efficiently)resources are deployed**- input/output relationship*
- ***Distinguishes service outputs from health outcomes** – clarifies role of health care in improving health of population*
- ***Outlines appropriate performance measures** -allows managers to track progress, measure outputs & outcomes, support subsequent evaluation work, learn and, make adjustments to improve on an ongoing basis*
- ***Sets out evaluation work** - expected to be done over the lifecycle of a policy, program or initiative*
- ***Ensures adequate public reporting** - on both service outputs & health outcomes*

Planning Parameters

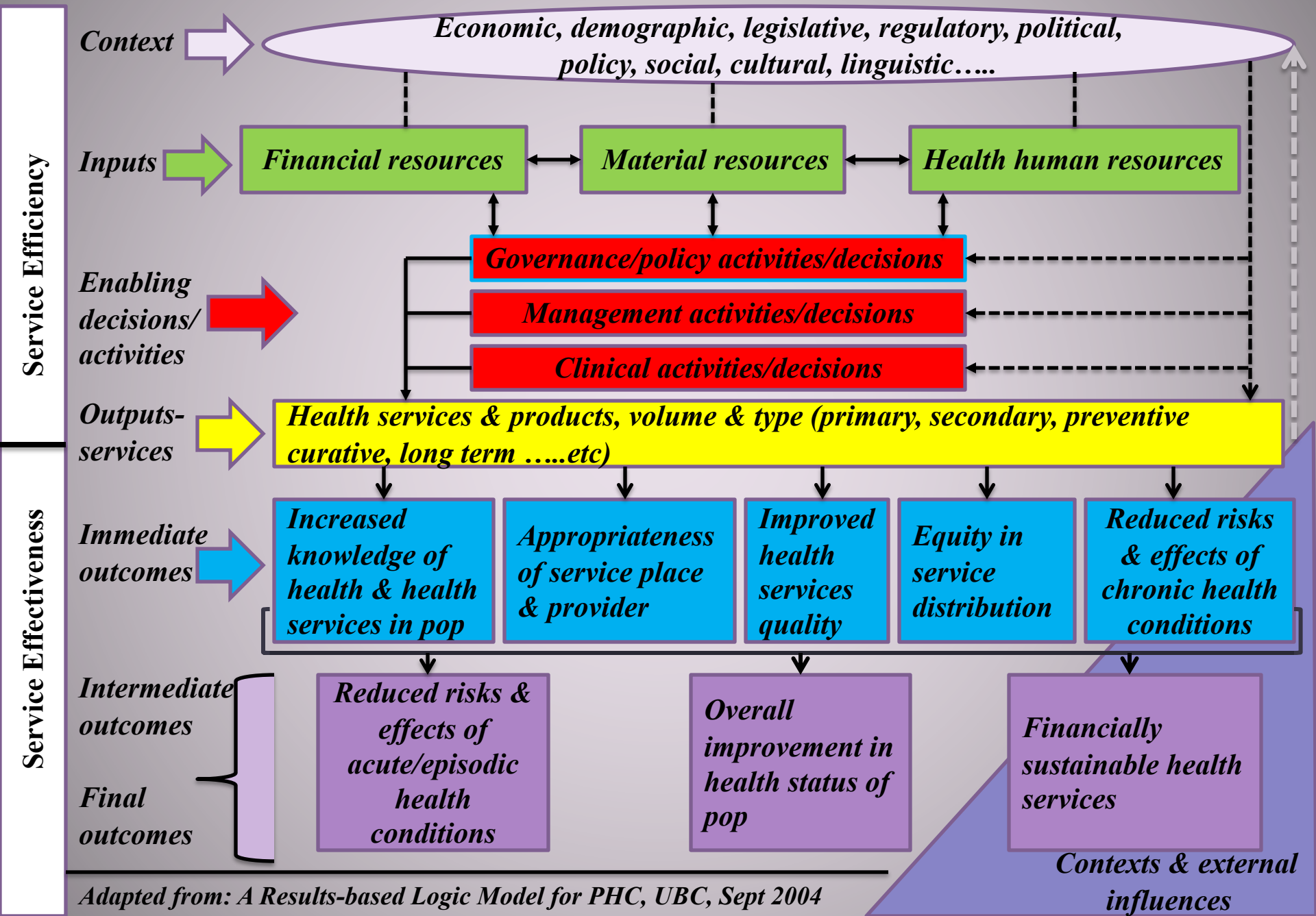
- ***Population based services*** *- service organization & distribution based mainly on* ***objective*** *demographic data*

- ***Inputs (financial, material, human) allocated on the basis of accepted resource to population ratios*** *- explicit sector specific (primary care, secondary care, long term care) ratios established*

- ***Units of service targets outlined for each key resource category*** *- ex: each community health centre serves so many people, each family physician sees so many patients, each nurse serves so many patients, each MRI generates so many diagnostic images*

- ***Explicit system & health outcome targets established*** *- ex: more equitable service distribution, reduction in number of chronic diseases, reduced effects of episodic & acute health conditions, more financially sustainable health services*

A Results-based Logic Model Applied to Health Services



Other Variables to Consider in Developing NB Health Services Plan

- ***Canada Health Act (CHA) requirements*** *- particularly regarding accessibility*
- ***Demographics*** *- geographic & age distribution*
- ***Need for critical mass*** *- required in order to achieve efficiency & quality of service*
- ***Language of service*** *- availability of service in language of choice of user (NB Official Languages Act)*
- ***Distribution of health services between the two linguistic communities*** *– interpretation of Section 16.1 of the Canadian Charter (1993)*

Developing NB Health Services Plan: Steps & Sequence

- ***Ministry's acceptance of planning framework/parameters***
- ***Creation of small internal (to Ministry) experts panel*** *- clinical & planning experts*
- ***Literature/best practices review*** *- search for standards (resource/population ratios, resource/output indicators & outcomes targets)*
- ***Check current service volumes & distribution against above standards*** *- using existing data*
- ***Draw preliminary service plan*** *- outlining desired inputs allocation against resource/population ratios as well as output targets (units of service) against allocated resources & outcome targets*
- ***Validate service plan with key stakeholders/providers*** *- seek general endorsement*
- ***Government approval of service plan*** *- both Cabinet & government caucus*
- ***Document/articulate service plan for public consumption*** *- emphasis on evidence, simple vocabulary & clinical/professions' support*
- ***Legislature support -*** *all political parties*
- ***Take service plan to the public (Premier, Minister)***

Strategic & Tactical Considerations

- ***Be selective in the choice of markers/benchmarks** - choose those for which you have reliable data & which matter for most of the consuming public, those relating to primary & long-term care for example (pick quality over number)*

- ***Focus mainly on areas where the actions of NBMOH are likely to have an undisputable impact (quick wins) - i.e., inputs, outputs & some immediate outcomes (1 to 5 years)***

- ***Avoid focusing on areas out of NBMOH control – i.e., do not emphasize intermediate (5 to 10 years) or final (10 to 25 years) outcomes, such outcomes are only partially influenced by actions of the Ministry***

- ***In order to be meaningful, service plan needs to be relatively specific - make sure it is specific enough to be operationalized (too general a 'flight plan' not useable)***

- ***Make sure that this population based service plan is used as main guide/tool for allocation of resources - as a result of the existence of this plan, what counts in resource allocation process should be explicit***

- ***Ensure that service plan will be adapted in future to reflect demographic & technological changes - outlines rules for future service adjustments- services adjusted based on objective criteria, not in response to the strongest lobby***