First Report of the Standing Committee on Health Care

Second Session

Fifty-seventh Legislative Assembly
of the
Province of New Brunswick

November 2011

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Members of the Committee

Hon. Madeleine Dubé, Chair
M.L.A., Edmundston–Saint-Basile

Sherry Wilson, Vice-Chair
M.L.A., Petitcodiac

Dorothy Shephard
M.L.A., Saint John Lancaster

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Donald Arseneault
M.L.A., Dalhousie-Restigouche East

November 2011

To The Honourable
The Legislative Assembly of
The Province of New Brunswick

Mr. Speaker:

I have the pleasure to present herewith the First Report of the Standing Committee on Health Care. The Report is the result of your Committee's public consultations and deliberations on Regional Health Authority boundaries, Regional Health electoral boundaries, and election rules.

On behalf of the Committee, I wish to thank the presenters who appeared at the public hearings and those individuals and groups who submitted written briefs. In addition, I would like to express my appreciation to the members of the Committee for their contribution in carrying out our mandate.

And your Committee begs leave to make a further report.

Respectfully submitted,

Hon. Madeleine Dubé, M.L.A.
Chair

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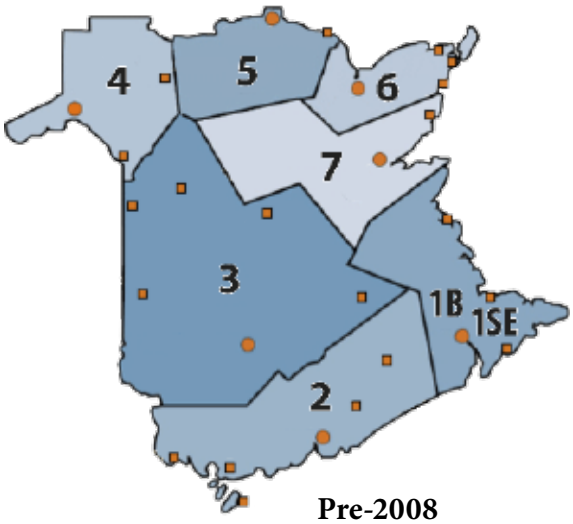
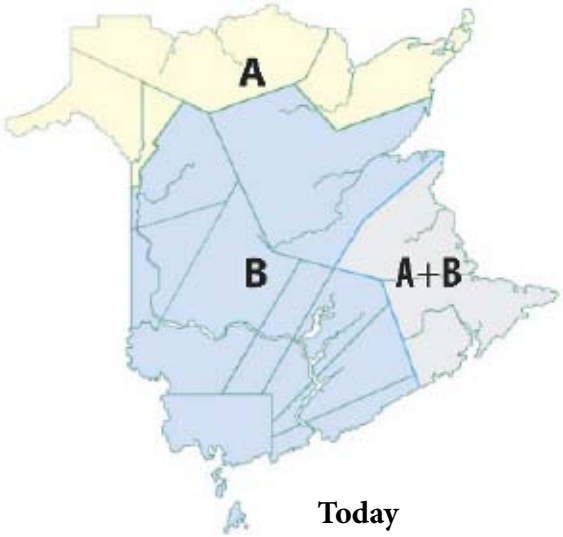
History and Background

In 2008, the New Brunswick government reorganized the former 8 health authorities to two RHAs, or Regional Health Authorities:

RHA A (now operating as Vitalité Health Network) and RHA B (now operating as Horizon Health Network).



Pre-2008



Today

The boundaries of the 8 former health authorities continue to be referred to as "zones". Legislative amendments to the *Regional Health Authorities Act* set out the territorial boundaries of the two new RHAs using the old zone descriptions. As set out in Schedule A of the *Regional Health Authorities Act*, RHA A is composed of zones 4, 5, 6, and zone 1 Beauséjour. RHA B is composed of zones 2, 3, 7, and zone 1 Southeast.

The 2008 reorganization of the RHAs gave rise to concern that the government had not sufficiently met its obligation to promote the cultural, economic and social development of New Brunswick's official linguistic communities. In particular, legal action was commenced by the Francophone interest group Égalité santé en français N.-B. inc. Consultation with members of the Francophone community on ways to improve health care services and health care governance for Francophone residents resulted in a report entitled *Toward an Improved Health Care System in French in New Brunswick*. In response, legislative changes were made to the *Regional Health Authorities Act* and the *New Brunswick Health Council Act*. At that time, government also committed to a review of the geographic areas assigned to each Health Authority in consultation with local communities.

Elected hospital boards were replaced with appointed boards as part of the 2008 reforms. By 2010, consensus had arisen amongst all of the province's major political parties to reinstate elected members to the RHA boards.

On June 7, 2011, the Legislative Assembly of the Province of New Brunswick passed Motion 93, a copy of which is attached to this Report as Appendix A.

Motion 93 mandated the Legislative Assembly's Standing Committee on Health Care to provide recommendations in preparation for the reinstatement of elected members on the boards of the province's two RHAs in conjunction with the May 2012 Municipal and District Education Council elections.

To assist the Committee with its mandate, the Department of Health published a Discussion Paper in July 2011. The Committee reviewed the Discussion Paper and agreed to solicit public input by internet, by written submission, and by appearance before one of 7 public hearings scheduled to be held around the province. In total, 33 submissions were received from New Brunswickers in various forms and locations, as listed in Appendix B.

Based on the Discussion Paper and its consultations, the Committee divided its work into three major sets of questions:

1. How, if at all, should the boundary line between RHA A and RHA B be altered?
2. Given that each RHA will elect 8 board members, how should these new ridings ("sub-zones") be organized?
3. What rules should govern the eligibility of candidates for election to those positions, and how should vacancies be filled?

While the Committee's mandate in this consultation was limited in scope and under a tight timeline in order to make recommendations in time for implementation in spring 2012, the public hearings did provide New Brunswickers with the opportunity to express their opinions on broader issues concerning health care. Some of those submissions related directly to work arising from Motion 93. In other cases, the Committee members met informally with New Brunswickers after the official hearings had adjourned for the day. Regardless of the forum, the message of interest and commitment to quality health care in the province was encouraging and helpful to the Committee in its ongoing work. The members are grateful to those who took their time to write, e-mail, telephone, and attend the public hearings.

One of the clear underlying messages of many of the public submissions was that while the mechanics of elections have some importance, the greater dialogue must be about the actual health care system itself, and the practical realities of delivering health care must be kept in mind when reforms like these are discussed and implemented. The Committee is unanimous in its desire to keep such priorities foremost, both in this report's recommendations and in its ongoing work. At the same time, however, it was evident to the Committee that there was a fundamental misconception on the part of some of the presenters as to where individuals can obtain health care services. Specifically, there is confusion among some people that the language of work of the RHAs also determines the language of service. The clear mandate of both RHAs is to provide services in both official languages, to ensure that all New Brunswickers can receive health services anywhere in the province in the official language of their choice. When this important fact is overlooked, discussion of health issues prompts unnecessary anxiety and conflict. Accordingly, the Committee wishes to emphasize this point, congratulate the efforts which have been made to improve bilingual service throughout the province, and encourage both RHAs to continue to progress in this way.

Summary of Recommendations

The Committee's recommendations are as follows:

Part I: Recommendations as to boundaries between RHA A and RHA B

1. The present boundaries which delineate RHA A and RHA B should not be altered in any way.
2. The essential nature and integrity of RHAs as regional entities should be respected.
3. Medical Centres and local linguistic communities which are served by such Centres should remain attached to the RHA in which they are geographically located.

Part II: Recommendations as to sub-zones within the RHAs

4. Each RHA should be divided into 8 sub-zones, created by dividing the 4 zones within it into two sub-zones.
5. Eligibility to vote and to be a candidate in each of the sub-zones should be limited to persons whose primary residence is within that sub-zone.
6. Persons residing in zone 1 (Beauséjour/Southeast), should be given the choice of RHA in which they cast their ballot.

Part III: Recommendations relating to rules governing elections and vacancies

7. a. Candidates for seats on RHA boards should be required to have and maintain their primary residence within the sub-zone they represent.

   b. Board members who transfer their primary residence outside their sub-zone or who are otherwise unable or unwilling to perform their duties as board members should have their seats vacated.

   c. Vacant seats should be filled by appointment of the Minister of Health with an individual whose primary residence is in the vacated sub-zone.

   d. Employees of RHAs, employees of the Department of Health, members and employees of the New Brunswick Health Council, persons holding privileges at a hospital within New Brunswick, Senators, Members of Parliament, and Members of the Legislative Assembly should not be permitted to be candidates for RHA boards.

Part I: Recommendations as to boundaries between RHA A and RHA B

1. **The present boundaries which delineate RHA A and RHA B should not be altered in any way.**

More than any other issue the Committee examined, the matter of the boundary line between the two RHAs touched on the sensitive issue of language.

The discussion of where the boundaries should be drawn sprang directly from the settlement of the legal challenge raised by Égalité santé. In 2008, when government reformed the system of health care governance, compressing 8 RHAs into 2, concerns were raised that the adoption of the former zone boundaries had been done without sufficient consultation or sufficient attention to the needs of the province's Francophones. A report by Gino LeBlanc, entitled *Toward an Improved Health Care System in French in New Brunswick*, was commissioned and led to the former Minister of Health Schryer's statement in the New Brunswick Legislature on April 8, 2010. This statement, accompanied by amendments to the *Regional Health Authorities Act* and *New Brunswick Health Council Act*, included this commitment:

> *A review of the geographic areas currently assigned to each health authority will also be conducted, in consultation with local communities served.*
>
> Minister Mary Schryer, Ministerial Statement in New Brunswick Legislative Assembly, 8 April 2010

Discussion on this issue brought into sharp relief the differing views among the province's Francophones as to the emphasis which RHA A should give to its role as a Francophone cultural institution, rather than solely as a provider of health care. A few advocates called for the boundaries between the RHAs to be eliminated, and the construction of a dual health system modeled upon that used in education. A strong majority rejected this view.

The Committee observed communities which were united in their desire for quality health care. The views of most presenters were nuanced, complex, and realistic, recognizing the dynamic interchange between language and health care. Presenters from both linguistic communities supported the enhancement of institutions which gave their communities more direct control over the decisions which impact on their health care. Everyone understands the importance of being able to obtain service in their official language as part of quality health care. Accordingly, presenters advocated strongly for improved bilingualism at all points of patient care.

Naturally, there is not unanimity in every aspect as to how best to balance the intertwined roles which RHAs perform as providers of health care, and as centres of community. To a large degree, there is consensus that both roles are very important. Balance is to be achieved through a spirit of reasonableness, accommodation, and recognition of the province's fiscal realities.

One of the words I will not use today, absolutely not, is "division." Every time the notion of linguistic division is put forward, it is misrepresented, and untruths are spread. The words that interest me the most are "convergence" and "cooperation." [Translation]

Jean-Marie Nadeau, Président de la Société de l'Acadie du Nouveau-Brunswick, Campbellton, 14 September 2011

The issue of boundary changes was most closely connected to the suggestion by Égalité santé that Neguac, Rogersville, and Baie-Sainte-Anne should be part of the Vitalité Health Network. This position was in part based on Égalité santé's belief that bringing these communities into RHA A was the best way to ensure Francophone control of their services, and thus improve provision of health care for Francophones. However, representatives from those communities were vehemently opposed to any suggestion that they be moved from RHA B. Their substantial concern was that such a move would inevitably lead to decreasing the catchment area of the Miramichi Regional Hospital, and thus weaken the level of care provided there. In contrast with the suggestion that they as Francophones were unlikely to receive quality health care from an RHA B facility, they reported pride and satisfaction in the successes which had been achieved in providing such services. They were strongly of the view that a transfer to RHA A would be a move backwards in terms of health outcomes for their communities.

The Committee considers it significant that not a single representative of a geographic community asked to be transferred to the other RHA. Instead, presenters expressed an overarching loyalty to their region based, not on language, but on their place in the community as a geographic entity. To these New Brunswickers, repeatedly raising the spectre of transfer to another RHA created uncertainty and threatened to divide a community which was united across linguistic lines.

The majority of presenters strongly believed that quality health care delivery should trump organizational structure. They equated quality health care with provision of local bilingual services rather than dual delivery models.

New Brunswickers do not identify themselves as residents of one or the other RHA. They support improved co-operation between RHAs and between local care and centres of specialized care.

We think that it is time to foster a global vision of health system delivery based on values such as those promoted by the World Health Organization (WHO) under their Towards Unity for Health strategy. These values are quality of services, equity of services, pertinence and cost-effectiveness.

Aurel Schofield, Centre de formation médicale du Nouveau-Brunswick, written submission

The Committee also recognizes the advantage that maintaining the present boundaries provides in terms of lessening confusion, facilitating elections, tracking population health statistics over time, and promoting stability in the organization and ability to manage and improve health services.

2. **The essential nature and integrity of RHAs as regional entities should be respected.**

The importance of linguistic rights is well known and acknowledged, enshrined in statute and in some cases constitutionally, and intertwined in the unique fabric of New Brunswick society. The 2010 reforms further reiterated this, providing greater clarity and assurance as to the working language of the RHAs. What the Committee heard was the substantial over-arching commitment of New Brunswickers to the place they call home, beginning with a fierce love for the local community in which they live, work, and raise their families and radiating outward into a strong sense of ownership and community with the province as a whole. New Brunswickers understand the important role which health services play in the viability of their communities. While they understand that New Brunswick's population and resources are limited, they know that local services are accessible services.

Their clear preference was that RHAs be organized in ways which understand and support a strong regional focus in health care delivery.

3. **Medical Centres and local linguistic communities which are served by such Centres should remain attached to the RHA in which they are geographically located.**

There was a suggestion by Égalité santé that it might be preferable to transfer Centre communautaire Sainte-Anne in Fredericton, Centre Communautaire Samuel de Champlain in Saint John, and Conseil communautaire Beausoleil in Miramichi from RHA B to RHA A. However, representatives from those health centres felt that would be a step backward.

> *Since its inception, we have been working with the Horizon Health Network in this cooperative spirit to improve health services for Francophones in our respective regions. Moreover, the presence of Francophones on the authority's board of directors means that senior managers are well aware of the needs that exist and the responsibilities they have toward Francophone citizens. This board presence and the team spirit that characterizes our relationship with the authority have enabled us to improve the health services offered to Francophone communities...*
>
> *the executive directors of the three community centres are pleased to be part of the Horizon health authority liaison committee, which ensures implementation of the strategic plan on official languages.* [Translation]
>
> Thierry Arseneau, Executive Director of the Centre communautaire Sainte-Anne, Fredericton, 7 September 2011

Efforts should be focused upon integrating centres like Medisanté fully into the RHA of which they are geographically a part, strengthening the interchanges and the involvement of the patients and administrators of these facilities within the heart of the RHA which provides them with their extended services. This also supports a more efficient acquisition of resources and allocation of staff in these community health centres.

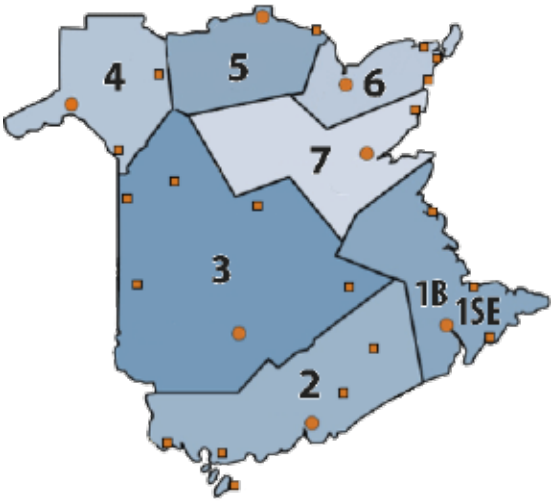
The clear advantages of simple borders for both clarity and organizational efficiency were seen as far outweighing the possible benefits of a "honeycombed" or "swiss-cheesed" boundaries map under which Anglophone communities currently within RHA A would be transferred to RHA B and Francophone communities in RHA B would be transferred to RHA A.

In addition to the weakening of regional ties which would result, there was the additional fact that New Brunswick's increasingly bilingual population expects both RHAs to provide bilingual service and does not wish to divide themselves from their neighbours on the basis of language. In addition, any time boundaries are altered the new division also creates a group within it which has now become a localized minority. The reality of New Brunswick is that our population is vibrant, intertwined, and mobile. Effort is better spent on strengthening co-operation between RHAs, rather than endlessly redrawing lines on a map which by their very nature will inevitably be arbitrary to some degree.

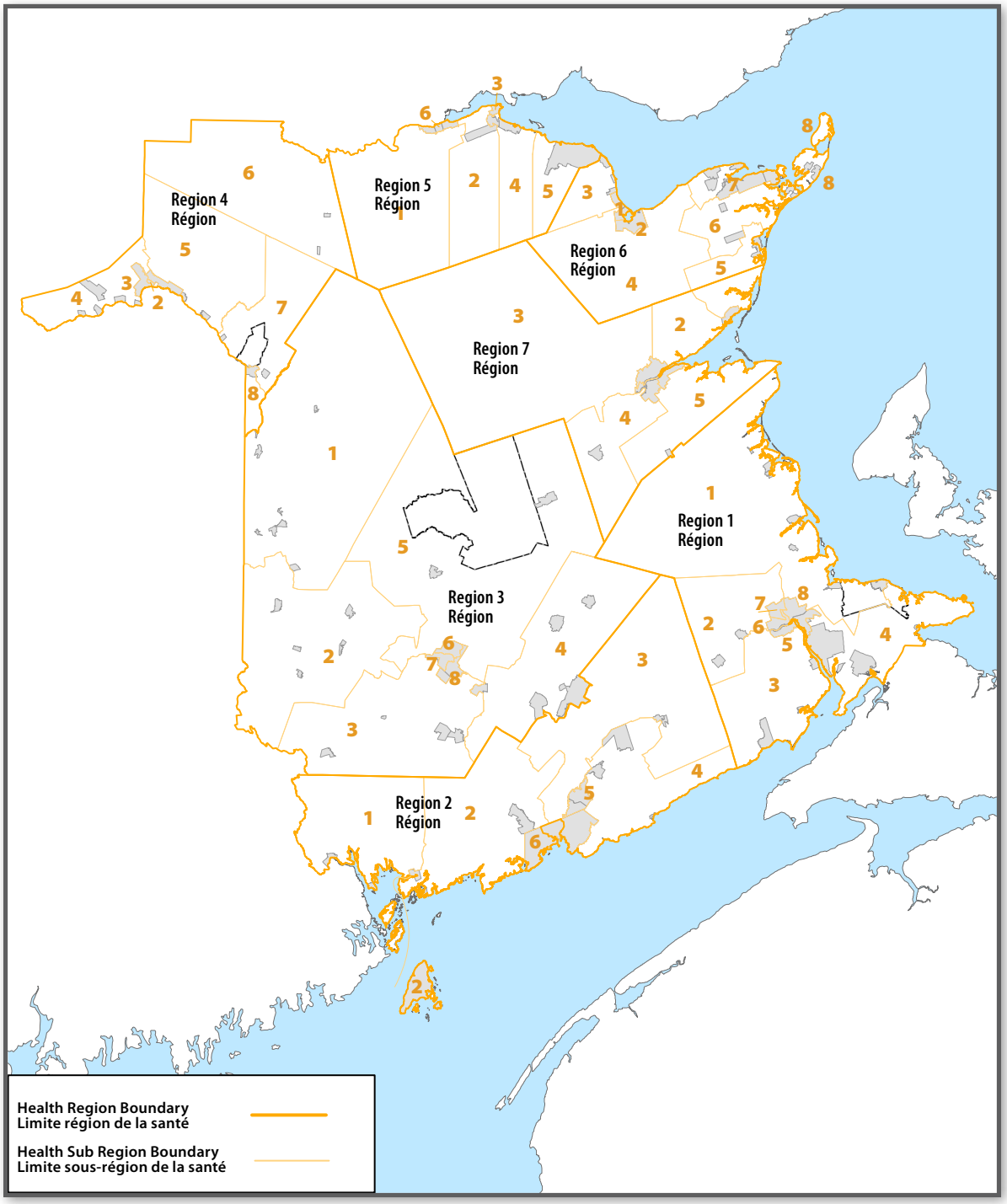
Part II: Recommendations as to sub-zones within the RHAs

4. **Each RHA should be divided into 8 sub-zones, created by dividing the 4 zones within it into two sub-zones.**

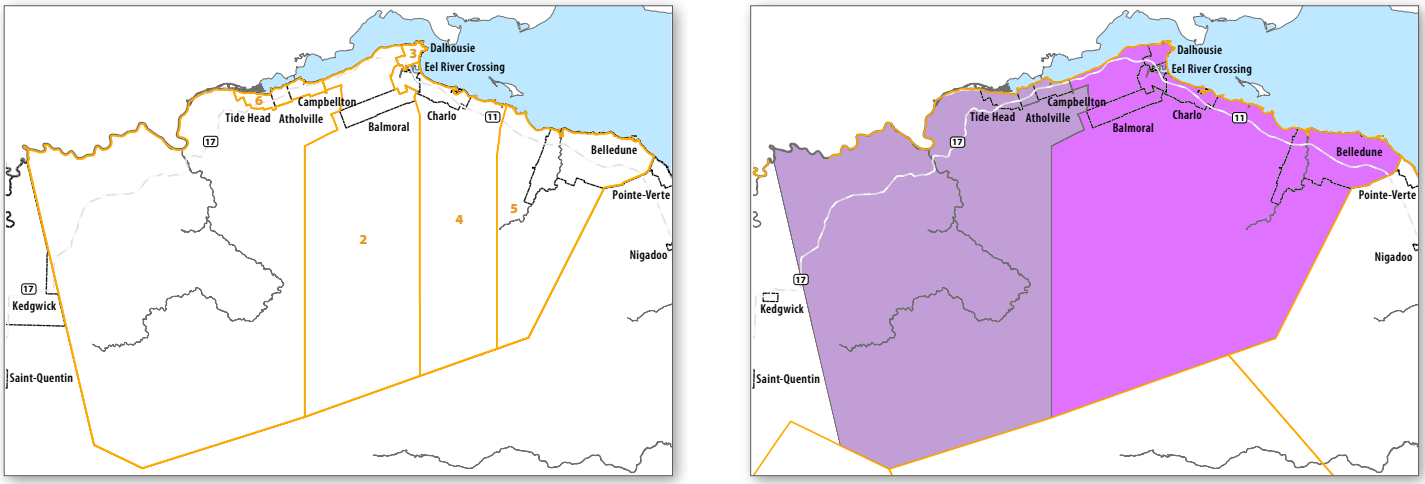
Prior to the 2008 reforms, the province's health care system was managed by 8 regional health authorities:



Members were elected to the boards of these 8 authorities from geographic sub-zones within them:



Reinstating elections to the RHAs means that where New Brunswickers formerly elected members to 8 boards, they will now elect members to 2. The constituencies for these board members are created by combining the former sub-zones from the pre-2008 system into new larger sub-zones. The result is that each zone is sub-divided into two contiguous sub-zones of roughly equal population.



Having heard of the importance which New Brunswickers attach to their geographic communities, it is natural to seek a way of structuring the board that ensures strong regional representation. Keeping in mind the impending May 2012 date for the next elections, the Committee recommends an equal division of 2 representatives to each zone.

It must be acknowledged that organizing the constituencies geographically in this way, based on equal representation per zone, results in population variances. The reinstatement of elections removes some responsibilities from the Minister and returns them to the general public. The people of New Brunswick will once again elect the majority of the board. If this is to succeed, communities must take an active interest in ensuring that their representatives are active, informed, and qualified to undertake their duties as board members.

Elections will strengthen regional representation, but even the most committed of regional advocates understands the need for our health care system to be an integrated and efficient one, run for the benefit of New Brunswickers as a whole. We have confidence in New Brunswickers that they will exercise good judgment to elect those whose interest in the health care system does not end at the boundary of their sub-zone.

The Minister will strive to incorporate the voices of minority groups and reflect the balance and diversity of the province on each board, albeit with only 7 appointments on each board instead of 17 under the former system.

> *It will be up to the Minister of Health to choose the seven non-elected members in order to restore regional representativeness and also the gender balance, the age balance, and that of ethnic and Native communities.* [Translation]
>
> Dr. Hubert Dupuis, Égalité santé en français N.-B. inc., Moncton, 26 August 2011

While electing or appointing representatives, I think special attention should be placed on having the rural areas and linguistic minority groups well-represented on each board. If you want both the Horizon and Vitalité boards to provide bilingual services, you need members from the other linguistic community to work on them.

Georges R. Savoie, Miramichi, 8 September 2011

A map showing proposed boundaries for the sub-zones is included in this Report as Appendix C.

5. **Eligibility to vote and to be a candidate in each of the sub-zones should be limited to persons whose primary residence is within that sub-zone.**

A minority of presenters supported allowing voters a choice of whether to vote geographically, based on where they live, or linguistically, based on their official language of choice. Other presenters pointed out the pitfalls of such a proposal. To begin with the most basic: while the two RHAs have different working languages, both have an absolute commitment to provide services to patients in their official language of choice.

It was clear to the Committee that more effort needs to be made to communicate the bilingual reality of health care to New Brunswickers. Some presenters expressed concern that, for example, an Anglophone living in Bathurst would be encouraged or even required to drive past their local hospital to reach Miramichi and an RHA B hospital. In fact, the bilingual nature of our health system is explicitly designed to avoid such a situation.

(I)t is important to remember that anyone can receive health services from either RHA, regardless of where one lives, and that RHAs must provide services in one's official language of choice.

Jennifer O'Donnell, President, New Brunswick Association of Speech-Language Pathologists and Audiologists, Bathurst, 9 September 2011

(A) health authority is not a private club. All the services in New Brunswick are for all the citizens in New Brunswick.

Jean-Marie Nadeau, Président de la Société de l'Acadie du Nouveau-Brunswick, Campbellton, 14 September 2011

The goal is obtain for the patient the twin advantages of local care and specialized care within an efficient province-wide system. Since the local RHA is the primary care giver, that is where the patient should cast their ballot.

Too much emphasis on the linguistic differences between the RHAs obscures the reality of our integrated, bilingual health care system, and pulls against the reality of the province as an increasingly intertwined, bilingual community. With so much goodwill and so much progress to provide services in the patient's language of choice, it would be a step backward to suggest voters separate themselves from their neighbours based upon the difference in the two RHAs internal language of work. Whatever the RHAs are internally, externally they are bilingual care providers, and it is that care which concerns the voter.

There is a commitment to foster and provide proper support to localized language minorities. Central to this is a desire that such groups are not marginalized but are integrated into their regional health system. If we allowed voting across geographic boundaries, the indications we received are that most would not take that option. Some would, however, dividing that minority community against itself and weakening its influence in their home region.

A system of voting across regional boundaries would also add significant costs and complexity to the system of voting and counting ballots on election day. It would also create the possibility that a number of electors, perhaps even a determinative group, would find themselves located outside the board member's sub-zone, creating issues around travel costs, accountability, and representation. For all these reasons, it is felt that the best way to foster a viable system of representation is to have both those who vote and those who are voted for from the same contiguous geographic area.

New Brunswickers have many attributes and there are innumerable ways in which they could be grouped and represented, including language, gender, age, and occupation. The selection of geographic criteria reflects practical considerations in the organizing of elections and management of health care, as well as the public's interest in local services.

It is not a denigration of other important factors to recognize that geographic alignment of constituencies is ultimately more practical than the alternatives. For example, the Committee notes that the new board members will represent areas so large that all will contain both urban and rural populations. This does not reflect a disparaging of either group's identity as such, or negate the importance of both receiving services. Rather, it is a reflection of the reality of modern New Brunswick life. Our cities are not so large as to have lost emotional contact with the countryside which surrounds them. Our rural areas are not so remote that the citizens do not regularly have contact with the urban centres to shop, work, and socialize. Life in New Brunswick should incorporate the best of both worlds by integrating the best features of each. Our governing system should understand that pitting one group against another serves neither.

The Committee understands the value of a board which is representative of our province's diversity, and the strength that a multitude of backgrounds will bring to the RHA boards. It recommends that the government encourage all New Brunswickers to become involved in the reinstated elections process, both as voters and as candidates. Every effort should be made to encourage wide participation of a diverse pool of New Brunswickers in terms of language, gender, interest and background.

In summary, the Committee does not recommend allowing persons to vote in the RHA outside their regional area. We feel the possible value in providing such a choice would be outweighed by the confusion, additional expense, and physical disconnect between voters and their representatives which may result.

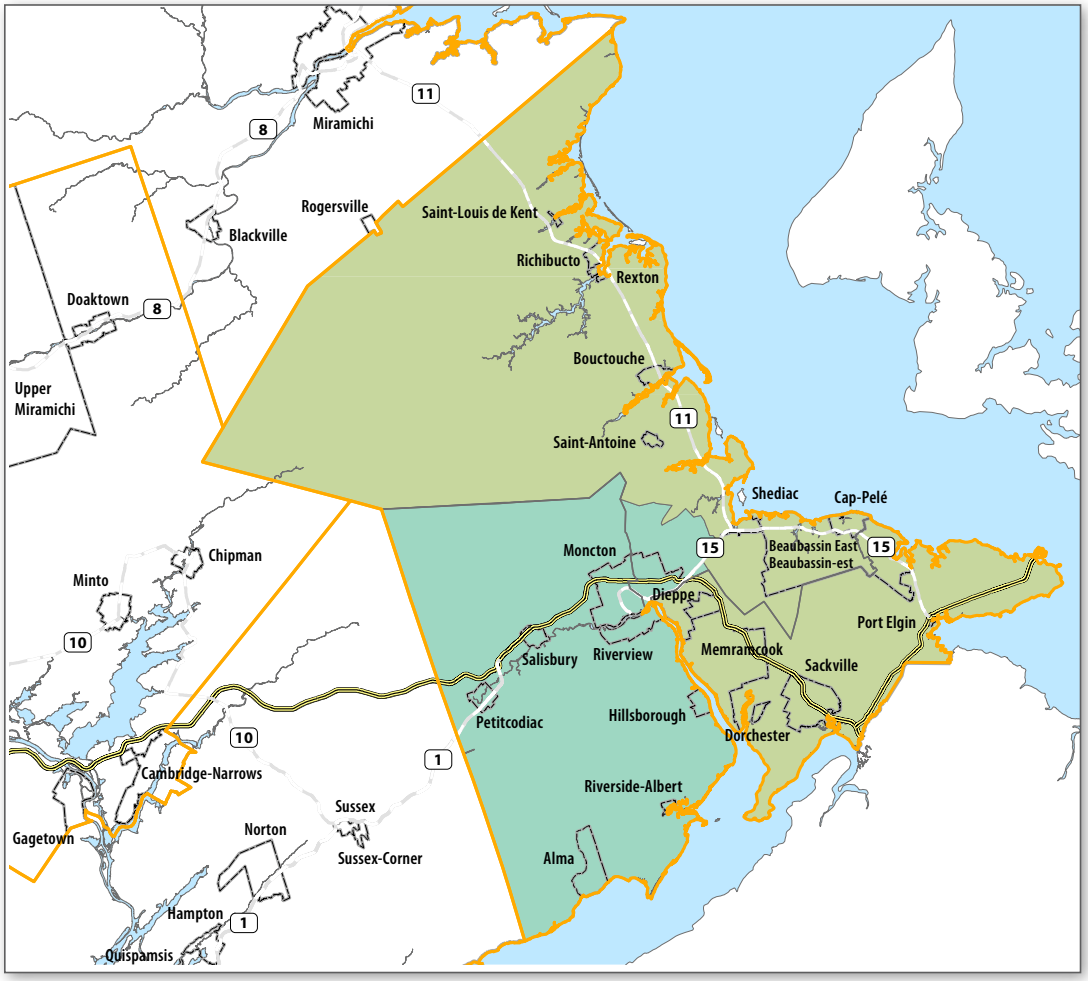
(I)f they are to represent the members of that community they need to be present and available to that community. They would have firsthand knowledge of how health care is run in that region, the accessibility issues that may be occurring and the specific needs of that community by being a resident.

Pauline Watt, New Brunswick Association of Dietitians, Written Submission

6. **Persons residing in zone 1 (Beauséjour/Southeast), should be given the choice of RHA in which they cast their ballot.**

The overlapping jurisdiction of the RHAs in zone 1 is a reflection of the history and present reality of settlement patterns within the region. Just as we do not feel that it would be successful to attempt to extend the overlapping pattern of zone 1 across the province, neither do we feel it would be advisable to attempt to separate out the various parts of zone 1 in a dubious effort to force its conformity with the pattern elsewhere. Both RHAs operate Regional Hospitals within zone 1, and the reports we receive are that there is exemplary co-operation between the two. Patients quite properly move between facilities managed by different authorities as their health needs dictate, receiving service in their official language of choice.

To avoid double-voting, the residents of zone 1 would make a selection of ballot as they did before the 2008 health reforms.



Part III: Recommendations relating to rules governing elections and vacancies

7. **a. Candidates for seats on RHA boards should be required to have and maintain their primary residence within the sub-zone they represent.**

   b. Board members who transfer their primary residence outside their sub-zone or who are otherwise unable or unwilling to perform their duties as board members should have their seats vacated.

   c. Vacant seats should be filled by appointment of the Minister of Health with an individual whose primary residence is in the vacated sub-zone.

   d. Employees of RHAs, employees of the Department of Health, members and employees of the New Brunswick Health Council, persons holding privileges at a hospital within New Brunswick, Senators, Members of Parliament, and Members of the Legislative Assembly should not be permitted to be candidates for RHA boards.

In general, this section of the work drew the least comment from presenters.

There is an obvious advantage in having a common set of rules for elections which are being held simultaneously. At the same time, there is no need to feel obligated to have the same rules where a difference would work better for the RHAs. Common sense should prevail.

The Committee heard repeatedly of the important role of board members as points of contact for the general public, to bring their concerns and interests into the centre of the decision-making process. While everyone understands that RHA sub-zones will of necessity be large and diverse, the public still sees great value and takes reassurance from having a specific person designated as their representative on the board.

For this reason, the physical separation of the board member from his or her sub-zone would lead to immediate concerns as to their availability and contact with the people they are tasked to represent. It is recommended that this aspect of the requirements be made explicit so that it is understood in advance by would-be candidates.

Naturally, there is a desire to replace vacancies in elected positions by by-election. Unlike municipalities, however, the large area of the RHA board sub-zones would require much greater expense and effort – so much so as to make by-elections impractical. Rather than have a position sit vacant, the Committee recommends it be filled by appointment with an individual whose primary residence is within that sub-zone. The Committee notes that should there be an opportunity to fill the vacated position by by-election due to some other simultaneous event (e.g., a referendum) without substantial increased costs, it would expect the government to provide the electors with that opportunity.

Finally, there was a plurality of support to limit eligibility for candidates to RHAs in order to both avoid conflicts of interest, and to minimize partisanship within the board elections process.

Appendix A: Motion 93

WHEREAS the current administration committed in its election platform to "reinstate elected members to Regional Health Authorities in time for the 2012 election and create options for local communities to have real input into health care management"; and

WHEREAS legislative amendments to the *Regional Health Authorities Act* are currently being considered by this Assembly which would alter the composition of Regional Health Authority Boards such that eight members would be elected and seven members appointed by the Minister of Health taking the interests of our residents into account; and

WHEREAS the Government of New Brunswick is required to consult and wishes to ensure opportunities for input on the issues of Regional Health Authority electoral boundaries and the electoral process, as well as a geographic area review, so that the views of New Brunswickers are taken into consideration;

THEREFORE BE IT RESOLVED that pursuant to Standing Rule 89(d), this House appoint a Standing Committee on Health Care and that the question of Regional Health Authority electoral boundaries and process and the review of the geographic areas currently assigned to each health authority be referred to the Committee, to report back to this Assembly with recommendations by September 30th 2011.

In addition to the powers traditionally conferred upon the said Committee by the Standing Rules, the Committee shall have the following additional powers, namely:

- to meet during sittings of the House and during the recess after prorogation until the next following Session;
- to adjourn from place to place as may be convenient;
- to retain such personnel as may be required to assist the Committee.

BE IT FURTHER RESOLVED that during a period when the Legislative Assembly is adjourned or prorogued, the Committee may release a report by depositing a copy with the Clerk of the Legislative Assembly, and upon the resumption of the sittings of the House, the Chair shall present the report to the Legislative Assembly;

BE IT FURTHER RESOLVED that the said Committee be composed of Hon. Ms. Dubé, Ms. Shephard, Mr. Riordon, Ms. Wilson, Mr. S. Robichaud, Mr. Lifford, Mr. Fraser and Mr. Arseneault.

Appendix B: List of Presenters and Submissions Received

Association Acadienne et Francophone des aînées et aînés du Nouveau-Brunswick inc., Jean-Luc Bélanger

Blanchard, Louise

Bourque, Claude

Bowes, Elizabeth

Canadian Union of Public Employees, Local 865, Claudette Cavanagh

Centre communautaire Sainte-Anne de Fredericton, Thierry Arseneau

Centre de formation médicale du Nouveau-Brunswick, Aurel Schofield

City of Miramichi, Mayor Gerry Cormier

College of Psychologists of New Brunswick, Éric Grandmaison

Conseil communautaire Beausoleil Inc., Sylvain Melançon

Diotte, Pauline

Égalité santé en français N.-B. inc., Dr. Hubert Dupuis, Jacques Verge, and William Laplante

Foran, John

Jackson, Mitch

Jules, Widler

Losier, Dr. Gerard

Manuel, Mirielle

McKay, John

Michaud, Nelson

Miramichi Chamber of Commerce, Mike Hill

New Brunswick Association of Dietitians, Pauline Watt

New Brunswick Association of Social Workers, Miguel LeBlanc

New Brunswick Association of Speech-Language Pathologists and Audiologists, Jennifer O'Donnell and Annie Giasson

New Brunswick Chiropractors' Association, Dr. Norm Skjonsberg

Robinson, Norma

Savoie, Georges R.

Shannon, Paul

Siddhartha, Dr. Sanjay

Société de l'Acadie du Nouveau-Brunswick, Jean-Marie Nadeau, Patrick Clarke, and Bruno Godin

Sokolowski, Wlodzimierz

Thibault, Louise

Village of Neguac, Mayor Roger Ward, Jr.

Village of Rogersville, Mayor Pierrette Robichaud

Appendix C: Recommended RHA Board Sub-zones Map