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Case Study

Public Health System Financing in British Columbia

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June 2024

The views expressed by the authors are not intended to represent the views of the North American Observatory on Health Systems and Policies.

Suggested citation

Seabrook, M., Ammi, M., Guyon, A., Pinto, A., Wotherspoon, H., & Allin, S. (2024). A Case Study of Public Health System Financing in British Columbia. Toronto: North American Observatory on Health Systems and Policies.

Acknowledgements

We would like to thank the key informants and advisors who participated and contributed to this research. We are grateful for the research coordination and editing support of Monika Roerig, and copyediting support of Patrick Farrell.

This report consists of a summarized synthesis of Melanie Seabrook's Master's thesis titled "Public Health Financing in British Columbia: A Case Study Investigating Factors Influencing Decision-Making." Part of this work was supported through Seabrook's Graduate Fellowship from the Institute of Health Policy, Management and Evaluation, University of Toronto and Canada Graduate Scholarship – Master from the Canadian Institutes of Health Research.

This work was also supported by the Canadian Institutes of Health Research through a Catalyst Grant Award for the project "Sustainable financing to transform Canada's public health systems" (#PO5-187041).

About

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision-making.

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List of Abbreviations

BC	British Columbia
BCCDC	British Columbia Centre for Disease Control
MLA	Member of the Legislative Assembly
NGO	Non-Governmental Organization
PHSA	Provincial Health Services Authority
SARS	severe acute respiratory syndrome

About the Study

This case study of British Columbia is the first of four planned case studies of public health financing in Canadian provinces, a comparative study aiming to shed light on public health financing processes and uncover potential strategies for supporting stable public health funding. The study builds on previous research from the North American Observatory on Health Systems and Policies (NAO) that profiled various provincial public health systems (Smith et al., 2022). It also supports the Chief Public Health Officer's call for sufficient and stable public health funding (Tam, 2021). The study is led by Dr. Sara Allin (NAO), with the support of a team of researchers, advisors, knowledge users, and trainees from across Canada.

Executive Summary

This study examined factors related to the stability of public health funding in Canada. Our objectives were: 1) to describe public health budget-setting processes in British Columbia (BC); and 2) to identify the factors influencing decision-making for public health resource allocation. We conducted a case study consisting of a literature review of two decades of public health financing processes, trends, and contextual influences in BC, and semi-structured interviews with 14 key informants influential in budget-setting for the province's public health system. Taking an inductive analytical approach, we synthesized data from the literature and interviews according to political, structural, and external factor categories influencing public health financing decisions. We identified policy considerations with the potential to promote stable public health funding, such as including public health experts in financial decision-making, and strengthening partnerships with external public health organizations.

Key Takeaways

- Budget-setting for public health in BC is **largely based on historical spending**; funding was maintained between 2000–2020.
- **External factors** such as crises and major events **open windows of opportunity for new political engagement** with public health issues, creating avenues for new funding for public health.
- **Including public health leaders in financial decision-making processes** helps build strong relationships with other decision-makers, which then **promotes public health investment**.
- **Partnerships** between government and public health non-governmental organizations (NGOs) such as the BC Ministry of Health's partnership with the BC Healthy Living Alliance **enables effective public health advocacy to promote new and long-lasting public health investments**.

Introduction & Background

In the aftermath of the COVID-19 pandemic, many public health experts have renewed calls to strengthen Canada's public health systems and financing, building on recommendations throughout the past two decades, including after the Walkerton and severe acute respiratory syndrome (SARS) outbreaks (CIHR, 2021; Denis et al., 2020; Guyon et al., 2017; Moloughney, 2006; Naylor et al., 2003; Raine, 2015; Tam, 2021). However, there has been limited research focusing on public health financing (Fiset-Laniel et al., 2020; Graham & Sibbald, 2017, 2021; Jacques & Noël, 2022). Specifically, there have been few efforts to examine how public health is financed in the Canadian context.

Our study aims to shed light on public health financing systems and inform ongoing efforts to bolster public health financing in Canada. We examined the process of decision-making for public health resource allocation and identified and investigated the factors that influence these processes through a case study of British Columbia (BC).

Methods

We conducted a case study of the BC public health financing system in two steps. The first step involved a jurisdictional review of academic and grey literature to collect relevant documents on budget-setting processes, policies, political shifts, major events, and reforms in the province between 2000–2023. We included 15 academic papers and 36 grey literature documents. The second step involved conducting in-depth qualitative interviews with 14 key informants who are influential in public health budget-setting, including senior executives, public health leadership, financial officers, and NGO representatives, recruited from all levels of the BC public health system. Participants were recruited through a combination of theoretical, snowball, and respondent-driven sampling. Due to challenges connecting with stakeholders, our analysis is missing certain perspectives such as from the First Nations Health Authority, private sector, politician, and general public perspectives, consisting of the main limitation of this case study. Taking an inductive analytical approach, we synthesized data from the literature and interviews according to political, structural, and external factor categories influencing public health financing decisions, presented in the next section. We also identified policy considerations for improving public health financing from analyzing key challenges and recommendations discussed by the key informants.

This study received ethics approval from the University of Toronto Ethics Board (REB# 43336).

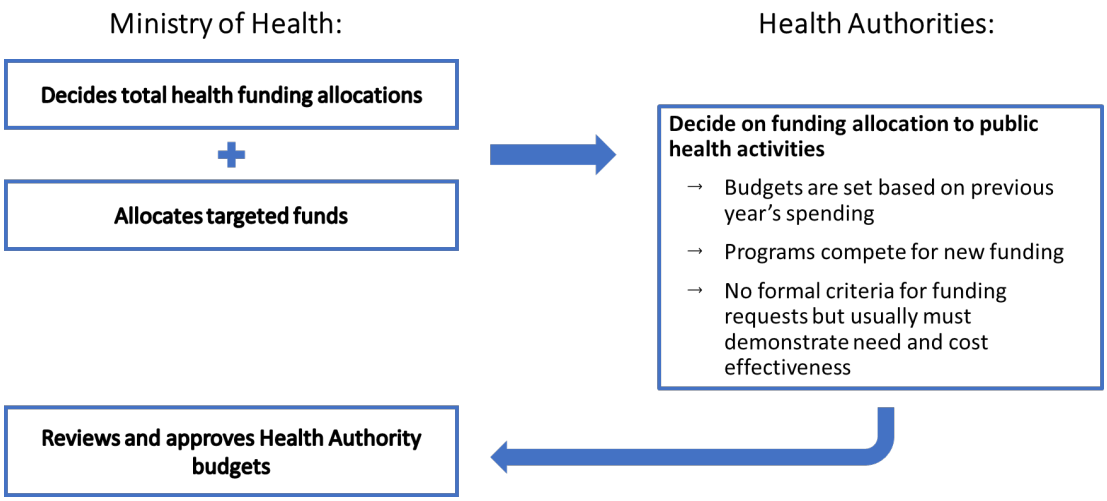
Analytic Overview

This section presents our findings regarding the BC public health budget-setting process, followed by an analysis of the factors that influence decision-making during budget-setting. The final section concludes with policy considerations based on this analysis.

Budget-Setting Process

This section provides a detailed description of the budget-setting process for the BC public health system (see **Appendix A** for the system structure). In broad summary, the majority of BC public health programs and services are funded by the Ministry of Health budget (Province of British Columbia, n.d.). The Ministry of Health decides on the total health funds to be allocated to health authorities (approved by the Treasury Board & Legislative Assembly), and approves health authority budgets that specify the amount of funding to be allocated to "Population Health & Wellness." The Ministry of Health also allocates funds to partner organizations such as NGOs through its Population & Public Health division. The following section describes yearly budget-setting processes for public health at the Government of BC and health authority levels.

FIGURE 1. Summary of budget-setting for health programs in BC



Government of British Columbia

From May to September each year, the Legislative Assembly Select Standing Committee on Finance and Government Services conducts consultations with the public as well as various interested parties such as NGOs.

Ministry of Health staff develop a health budget proposal, which is reviewed by the Deputy Minister and recommended to the Minister of Health. The Minister then submits their budget recommendation to the Treasury Board. The Ministry of Health determines health authority allocations by starting with the previous year's spending, accounting for new government commitments (e.g., new programs), adjusting for previous one-time expenditures and unallocated funds, and allocating the remaining funds using the Population Needs-Based Funding tool, activity-based funding, or other methods (Bellringer et al., 2017).

The Treasury Board compiles all Ministry budgets into the provincial budget, per the *Financial Administration Act* (1996), aligning them with provincial government priorities. The Committee of Supply, consisting of all MLAs, debates and approves the annual *Supply Act* to authorize budgeted expenditures (Bellringer et al., 2017).

The Ministry of Health monitors needs throughout the year and adjusts program or health authority funding accordingly (e.g., for new programs or cost pressures) (Bellringer et al., 2017). At the end of the fiscal year, if the Ministry of Health has a surplus, departments, agencies, and partner organizations can apply to receive "end-of-year" funding.

Provincial Health Services Authority (PHSA)

PHSA agencies submit a budget package to the corporate business planning team by early December. In the BC Centre for Disease Control (BCCDC), the senior executive team, made up of the Chief Strategy Officer, the Chief Operating Officer, and the Chief Medical Officer, develops the BCCDC budget proposal (BCCDC, n.d.). The corporate business planning team then consolidates the PHSA budget and allocates new funding across PHSA agencies, aligning with the Ministry of Health's strategic priorities and adjusting for cost pressures and union salary increases.

Regional Health Authorities

The Ministry of Health provides individualized mandate letters to each health authority, outlining strategic priorities to be addressed in the upcoming year (Van Roode et al., 2020; Wong et al., 2010). The broad mandate for "Population Health & Wellness" is to implement the Guiding Framework for Public Health. The Ministry also provides funding letters with total health fund allocations and targeted funds to each health authority. Targeted funds are sometimes a result of proposals put forward by health authority public health leadership in collaboration with the Ministry's Population & Public Health division, often working through the policy advisory committees (**Appendix A**).

Budget-setting processes within regional health authorities are led by the Chief Financial Officer and their finance staff (Dionne et al., 2009; Interior Health Authority, 2019; Island Health Authority, 2022; Northern Health Authority, 2022; Vancouver Coastal Health Authority, 2016). Health authority budgets tend to change minimally from year to year. Most health authority budget-setting starts with the previous year's budget, adjusts for inflation, and allocates any remaining additional funds across programs to address program budget enhancement proposals. Chief Medical Health Officers and VPs of Public Health work with their senior executive teams to secure funding for public health program needs and shortfalls. Key informants reported that health authority and Ministry strategic priorities and population health data may be taken into account in allocating additional funds. Health authorities also factor in any funds they may receive from other Ministries and partner municipalities through Healthy Living plans. As explained by key informants, the senior executive team deliberates until a balanced budget proposal is agreed upon and approved by the health authority's Board of Directors by April 1. The Ministry of Health reviews the health authority budget plans and provides an assessment within a month (Strelioff, 2003). When shortfalls are experienced during the year, program areas can submit a business case to the health authority senior executive team to request additional funds, which must describe the need, the anticipated impact, and the return on investment.

Factors Influencing Public Health Financial Decision-Making

While the previous section details the decision-making process and identifies the key actors and decision points in public health budget-setting, this section outlines the factors influencing public health funding decisions. The factors are grouped into three layers of influence: external, structural, and political. The factors are highly interconnected, in that they do not act independently but rather act on each other to influence funding decisions.

External factors

External factors consist of phenomena occurring outside of the health system with wide-reaching impacts. These can manifest as major social or economic events, or as public health crises, such as epidemics (**Appendix B**). Such events lead to increased pressure on governments to engage and respond, which was reported to have caused potential changes in funding for public health.

Public health crises are seen as one of the most impactful factors influencing public health funding, with many resulting in large investments. However, crises also tend to concentrate public health resources on crisis response, which redirects resources from other public health functions. Furthermore, public health crises bring to light vulnerabilities in the system, which has prompted public health system renewal in the past, such as following the SARS outbreak in 2003 (Ministry of Health Services, 2005b), and currently in response to COVID-19. Understanding and appreciation for the public health system among the general public and decision-makers is increased following public health crises, which can lead to support for new investment.

> *"The sad thing is that an epidemic of any kind, whether it was SARS, or H1N1, or in this case COVID-19, increases attention on public health. … But it narrows the vision of public health to infectious disease management, and it's so much more than that." (Key informant)*

In addition to public health crises, other major events can also have an important external influence on public health funding. For example, public health gained attention in BC when Vancouver won the bid to host the 2010 Olympics, becoming the most impactful social event leading to investments in public health in the province since 2000. The event opened a window of opportunity for a new public health campaign, which was propelled by a collaboration between public health officials and advocates and facilitated by political buy-in (Derom & Lee, 2014; Public Health Agency of Canada, 2009).

Structural factors

Structural factors consist of health system organization, policies, and processes that shape decision-making (**Appendix C**). Key informants reported how consolidating public health budgets under public health management prevented the reallocation of funds to non-public health activities at the regional health authority level. Key informants found that including Chief Medical Health Officers and VPs of Public Health on senior executive teams allows for deeper public health expertise to inform funding decisions and enables public health leaders to advocate for new public health funding directly to other decision-makers.

> *"I think those positions are really key to educate and share about the value of public health. … So just having [the Chief Medical Health Officer's] perspective at the table, it's been really important. The questions they ask, their thinking, their experience is unique, and I think*

they're invaluable. Now I think back and I can't even imagine why they weren't here before." (Key informant)

They also reported that public health frameworks can be useful for providing performance measures to guide resource allocation. Finally, many highlighted challenges with workforce availability in the public health system. Consequences of constant vacancies are exacerbated by the complex processes involved in approving repurposed funds, leading to yearly public health budget surpluses.

Political factors

Political factors refer to the value judgements that influence decision-making and the power dynamics involved in stakeholder interactions and relationships (**Appendix D**). The political agendas of elected officials are influenced by the public's priorities and by public health advocacy. Key informants reported that public health is rarely on the political agenda, except in times of crisis such as epidemics. However, advocacy in BC has been successful in bringing public health issues to the attention of senior decision-makers. In budget-setting for health, programs compete for new funding, and our key informants agreed that curative health services are usually prioritized over public health. This balance is moderated to some extent by how well decision-makers understand public health, which in turn is often determined by relationships between public health system leaders and decision-makers, through which public health leaders aim to demonstrate the value of funding public health. To do so, they make strategic use of evidence in funding proposals, finding that alignment with political priorities and providing economic rationales is most likely to lead to funding approvals.

"I believe that the informal channels—where you have good government relations, where you have warm relationships, and where you are making the case that what you're trying to advance actually aligns with government frameworks and government priorities—that's where you have the best success in making changes." (Key informant)

Policy Considerations

While the implications we can draw from a single case study are limited, we present policy considerations that outline effective factors in protecting and promoting stable public health funding in BC, potential areas for improvement, as well as lessons to inform change in other jurisdictions.

- Key informants highlighted that **including public health leaders in financial decision-making** had a protective effect on public health budgets. Relatedly, they found that **consolidating public health budgets** under public health management seems to prevent the reallocation of public health funds to other services.
- Key informants called for **greater transparency** in decision-making, both publicly and within health system leadership, which they believe would help create a more equitable allocation process and improve long-term planning.
- This case study demonstrated the way that **partnerships between external public health organizations and the health system** led to more effective advocacy for new and long-lasting investments in public health.
- Key informants voiced the importance of **basing funding requests in evidence** of population needs and program effectiveness and called for dedicated **resources for health surveillance,** which could inform health system-wide decision-making. Relatedly, they pointed to the need for developing **standard performance indicators** and a reporting system that could help demonstrate the impact of public health programming to decision-makers as well as identify areas in need of more resources.
- Key informants identified the lack of **legislated public health standards** in BC as a vulnerability, as there are no minimum standards that may help ensure core funding.

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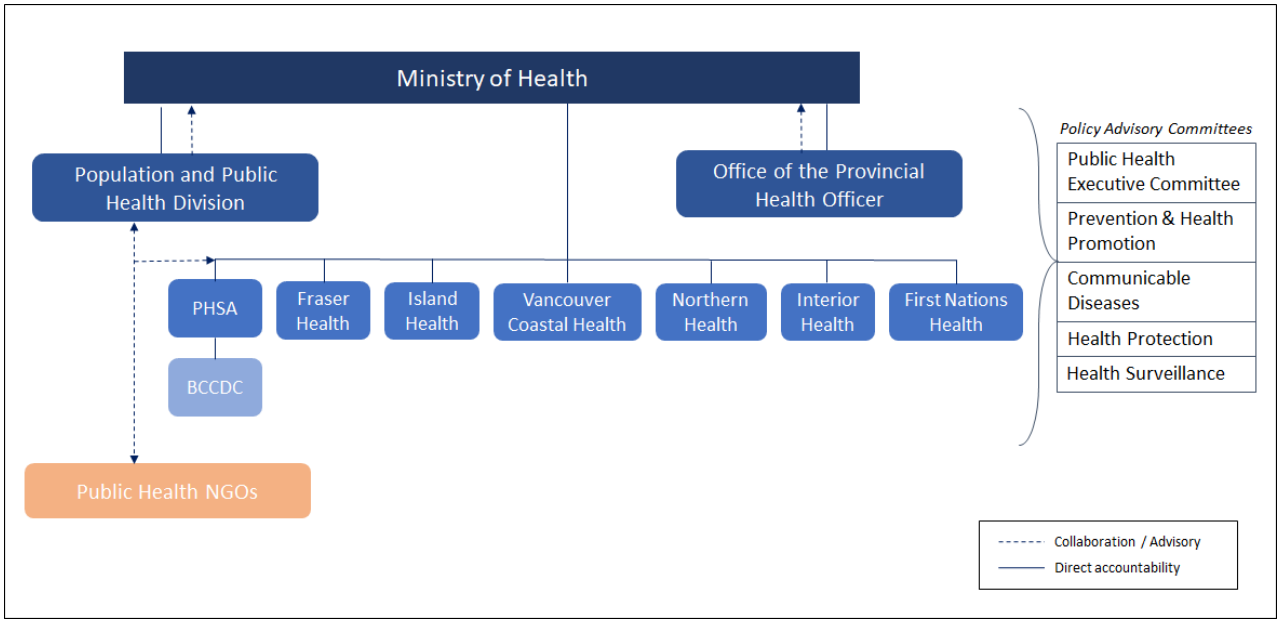
Appendix A. British Columbia's Public Health System Structure

Figure A1. Structure of BC's public health system



(Bellringer et al., 2017; Province of British Columbia, n.d.; Smith et al., 2022; with input from key informants.)

Abbreviations: PHSA (Provincial Health Services Authority); BCCDC (British Columbia Centre for Disease Control); NGO (Non-Governmental Organization).

The Ministry of Health is responsible for the strategic direction of the public health system and allocates funding for all health programs, including public health, to the various health authorities. The regional health authorities, the Provincial Health Services Authority housing the BC Centre for Disease Control, and the First Nations Health Authority are responsible for delivering public health services. Various public health NGOs, such as the BC Alliance for Healthy Living, also receive funding from the Ministry to organize public health programs. Public health policy advisory committees coordinate public health system planning, including preparing funding proposals.

Appendix B. External Factors Impacting Public Health Funding

Date range	External factor	Potential or actual impact on public health funding
2000	Walkerton waterborne disease outbreak (ON)	Highlighted the importance of effective public health oversight of water systems (Provincial Health Officer, 2019), triggering investments in BC water system upgrades totaling $109 million in 2002 (Select Standing Committee on Health, 2002).
2003	SARS outbreak	Revealed a lack of epidemiologic investigation processes and lack of health system surge capacity (Provincial Health Officer, 2019). Initiated renewal of public health systems across Canada (Ministry of Health Services, 2005b). Prompted federal investment in public health of $400 million over 3 years, with $51 million allocated to BC (Ministry of Health Services, 2005a).
2004–2010	2010 Olympics hosted in BC	Triggered the development of the ActNow strategy, involving cross-sectoral collaboration and many major investments in public health between 2005–2010 (Kendall, 2010; Select Standing Committee on Health, 2004), including $25 million to the BC Healthy Living Alliance in 2006, $5 million to the Union of BC municipalities in 2005, and $15 million over 3 years for cross-ministry collaboration (Foster et al., 2011). $8 million, $16 million, and $24 million was allocated for public health to regional health authorities in the 3 consecutive years leading up to the Olympics.
2008–2010	Economic Recession	Austerity pressures led to major cuts in government spending, including a direction from the Minister of Health to cut health authority public health budgets by 10% in 2010 (Canadian Press, 2010).
2009	H1N1 pandemic	Provision of 2 million antiviral treatments and 1.8 million vaccinations, though no specific investment amounts were reported (Provincial Health Officer, 2010).
2016–present	Opioid overdose crisis	Commitment of $322 million over 3 years by the BC government to respond to the crisis (Province of British Columbia, 2018).
2020–2023	COVID-19 pandemic	Led to unrestricted spending on pandemic response.

Appendix C. Structural Factors Influencing Public Health Funding

Date	Structural factor	Potential or actual impact on public health financing
2000	*Budget Transparency & Accountability Act*	Requires ministries and other government entities publish yearly service plans and budgets (Budget Transparency and Accountability Act, 2000).
Dec 2001	Consolidation of the 52 regional health authorities into 5 and establishment of the PHSA under the *Health Authorities Act*	Centralized public health organization and resources and set the original health authority base budgets.
2005	BC Framework for Core Functions in Public Health	Meant to act as a baseline of public health services to be delivered and inform resource allocation (Ministry of Health Services, 2005b). Recommends investments in public health capacity (Ministry of Health Services, 2005a).
2008	*Public Health Act*	Lays out responsible actors and their powers to fulfil public health functions (Public Health Act, 2008), primarily regarding health protection functions.
2008–2010	Creation & dissolution of the Ministry of Healthy Living & Sport	Took up the implementation of the ActNow strategy and public health functions more broadly (Public Health Agency of Canada, 2009; Wong et al., 2010). Separated some public health funds from the larger Ministry of Health budget.
2013	Establishment of the First Nations Health Authority (FNHA)	Responsibility for the delivery of health services (including public health) for First Nations was transferred from the federal government to the FNHA (Smith et al., 2022).
2013 (updated in 2017)	BC Guiding Framework for Public Health	Aimed to guide public health resource allocation by providing performance measures for public health programs (Ministry of Health, 2013).

Appendix D. Political Factors Influencing Public Health Funding

Political factor	Potential or actual impact on public health funding
Competition with curative healthcare sector	Curative services are often prioritized for funding over public health, and public health funds have sometimes been redirected to address healthcare deficits in the past.
Political agendas	Public health seldom reaches the political agendas of elected officials.
Public pressure	The public tends to pressure government to address healthcare issues that they interact with directly, such as wait times for curative services.
Public health advocacy	Public health advocacy helps bring public health issues to the attention of decision-makers.
Decision-maker expertise	Decision-maker level of understanding of public health influences their prioritization of public health for funding.
Relationships between public health and decision-makers	Developing relationships between public health actors and decision-makers leads to more informed decision-making around resource allocation to public health.
Relationships across public health actors	Public health actors collaborate across the Ministry of Health, health authorities, and NGOs to coordinate efforts around funding requests and advocacy.
Transparency in decision-making	Transparency around decision-making for public health budget-setting is limited, which leads to distrust and barriers to effective planning.
Use and framing of evidence	Framing evidence in alignment with political and economic priorities in funding proposals increases their likelihood of being approved.

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