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Case Study

Public Health System Financing in Nova Scotia

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

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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

CMOH	Chief Medical Officer of Health
DHA	District Health Authority
DHW	Department of Health and Wellness
IWK	Izaak Walton Killam Health Centre
MOH	Medical Officer of Health
NS	Nova Scotia
NSH	Nova Scotia Health
SARS	Severe Acute Respiratory Syndrome

About the Study

This case study of Nova Scotia is part of a multi-province comparative study aiming to shed light on public health system financing processes and uncover potential strategies for supporting stable public health funding. The study builds on previous research led by 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, University of Toronto), with the support of a team of researchers, advisors, knowledge users, and trainees from across Canada.

Executive Summary

This summary report provides an overview of the public health system budget-setting processes in Nova Scotia, and uncovers some of the key factors influencing public health system resource allocation decisions. We interviewed 12 key informants from Nova Scotia with current and past positions in public health and health system leadership roles across the Department of Health and Wellness (DHW) and NS Health (NSH) between June 2023–January 2024. This document summarizes what we heard from these interviews, supplemented by documents identified through a jurisdictional review and shared by local experts and knowledge users. These results shed light on the processes and challenges of financing public health systems, including planning and decision-making, and provides a foundation for discussions around future policy directions for strengthening public health financing in Nova Scotia and across Canada.

Key Takeaways

- Nova Scotia's public health system has recently benefitted from alignment with overall health system investment as a political priority.
- The NSH public health budget ensures funds are spent on public health programs and enables redistribution of unused funds within the public health system.
- Nova Scotia's public health leadership governance structure supports close collaboration among public health leaders to coordinate system-wide priorities and bring them to the attention of top government decision-makers.
- To help ensure the sustainability of public health funding, key informants raised several considerations. One such consideration was to include a provincial responsibility for funding public health programs in the development of new public health legislation.

Introduction & Background

Following the COVID-19 pandemic, many public health experts 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; Naylor et al., 2003; Raine, 2015; Tam, 2021). However, there has been limited research focusing on public health financing, particularly examining how public health systems are financed in Canada (Fiset-Laniel et al., 2020; Graham & Sibbald, 2021; Jacques et al., 2023). 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 sought to uncover the factors that influence these processes throughout this case study of Nova Scotia.

Methods

We conducted a case study of the Nova Scotia 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 4 academic papers and 23 grey literature documents. The second step involved conducting in-depth qualitative interviews with 12 key informants who are influential in public health budget-setting, including medical officers of health (MOHs), public health directors, and senior executive roles from the DHW and NSH. Participants were recruited through a combination of theoretical, snowball, and respondent-driven sampling. Taking an inductive and deductive analytical approach, we synthesized data from the literature and interviews to describe the funding status and budget-setting process of the public health system at the local and provincial levels, identify factors that influence public health financing decisions, and propose policy considerations for improving public health financing. This report was reviewed by three key informants, helping to validate our findings and analysis.

This study received ethics approval from the University of Toronto Ethics Board (REB# 44620).

Analytic Overview

This section presents our findings regarding the Nova Scotia public health budget-setting process and funding status, followed by an analysis of the factors that influence decision-making during budget-setting and concluding with policy considerations for improving public health financing.

Budget-Setting Process

The DHW is the primary funder public health programs in Nova Scotia, and allocates funding to the NSH and Izaak Walton Killam Health Centre (IWK) (Smith et al., 2022). The health authorities (NSH and IWK) are responsible for allocating resources across health services (*Health Authorities Act*, 2014). Budget-setting for the public health system is thus centralized at the provincial level.

In summer and fall, leading up to the budget submission process, NSH public health leadership (Director of Public Health, Senior Medical Officer of Health (MOH), VP responsible for Public Health) and DHW's public health branch executives (Associate Deputy Minister, Director of Public Health, Chief Medical Officer of Health [CMOH], Deputy CMOH) collaboratively develop business cases for top-up program funding. These are informed by population need, programming gaps, and cost pressures, and are strategically aligned with government priorities. The NSH Executive Leadership team evaluates business cases based on measurable impact, and advances select cases to the DHW for consideration.

NSH and IWK are required to submit a health services business plan to the Minister of Health by November 1. They are not allowed to run a deficit budget, as prescribed by the *Health Authorities Act* (2014). The DHW's public health branch executives develop the public health budget based on historical funding and government directives regarding budget limitations, and incorporate the approved business cases. The DHW's health leadership team, which includes the CEO of NSH, the Deputy Minister of Health, the Deputy Minister to the Premier, and other representatives, ranks the priority of budget asks across program areas and submits the health budget to the Treasury Board. The five divisions of the DHW collaborate to decide on funding allocations, supported by evidence and analyses from the Division of Investment and Decision Support (Government of Nova Scotia, 2017). In December, the Finance and Treasury Board announces the opening of pre-budget consultation with the public (Finance and Treasury Board, 2022). The Fiscal Policy, Economics and Budgetary Planning Branch of the Department of Finance works with the Treasury Board to develop the provincial budget (Government of Nova Scotia, 2018). By March 31, the Minister of Health informs the health authorities whether their health services business plans are approved or require revisions (*Health Authorities Act*, 2014). By April 1, the provincial budget estimates, compiled by the Minister of Finance, is voted on and passed by the Legislature as the yearly *Appropriations Act* (*Finance Act*, 2010).

Community Health Boards are volunteer-run and advocate on behalf of communities to address social determinants of health by collaborating with NSH and IWK (Nova Scotia Community Health Boards, n.d.). Every three years, Community Health Boards submit Community Health Plans to be incorporated into the NSH and IWK health services plans, consisting of recommendations for health promotion priorities and initiatives established through community consultation (*Health Authorities Act*, 2014).

Some key informants expressed concern that the low percentage of the overall health budget allocated to the public health system[1] is insufficient for fulfilling the full breadth of public health functions. Key informants noted that many public health functions are conducted in collaboration with other government actors; thus, aspects of public health activities in the province extend beyond the dedicated public health budget. Some key informants shared that when certain public health functions (and funding) were transferred to other departments in the past (such as the Department of Environment), public health expertise was diminished. Nevertheless, several key informants noted that public health system has benefited from new investments in recent years due to a provincial commitment to public health renewal in alignment with the government's *Action for Health* plan (Standing Committee on Health, 2023).

Factors Influencing Financial Decision-Making

Drawing on a conceptual framework developed in our earlier work (Seabrook, 2024), we consider the following intersecting factors that influence budgetary decision-making for public health programs and services:

1. **External factors**, consisting of system-wide impacts from outside the public health system such as economic shocks, public health emergencies or other contextual influences,
2. **Structural factors**, including the way the public health system is organized, as well as the laws and policies that guide their decision-making processes, and
3. **Political factors**, including the values and relationships between key stakeholders that influence decision-making.

Timelines of influential external and structural factors are presented in **Appendices B** and **C**.

External factors

Many key informants described the way that **public health crises,** such as the SARS epidemic and the COVID-19 pandemic, put a spotlight on the critical role of the public health system (Naylor et al., 2003; Province of Nova Scotia, 2022). This spotlight was said to open a window of opportunity for new investment through greater awareness and appreciation of the public health system, though some note attention wanes over time. They further explain that post-crisis investments tend to focus solely on infectious diseases, rather than the full breadth of public health functions.

Political factors

Key informants agreed that the government's **political agenda** is the most important determinant of the provincial public health budget, overpowering all other influential forces. Since political agendas work to bolster re-election chances within a 4-year cycle, it was said that they rarely focus on long-term preventative policy such as public health strategies. Public health budgets are also impacted by broader government restructuring agendas, such as the shift of public health programs and resources, including health inspectors, to the Department of the Environment. However, it was noted that since healthcare has been a top priority for recent NS governments across political parties, public health leaders have been able to draw

[1] According to our calculations based on Nova Scotia provincial budget estimates, public health received 1.3% of the health budget in 2019, which increased to a budgeted 3.4% in 2023.

benefit from this political attention by aligning with strategic health planning. Most recently, the inclusion of public health in the provincial *Action for Health* plan has led to new public health investments and programs such as the launch of the Nurse-Family Partnership (Government of Nova Scotia, 2022a).

The political agenda was said to be highly influenced by **public pressure**, which tends to focus on challenges with accessing healthcare services. However, a key informant found that the response to the COVID-19 pandemic portrayed the public health system in a positive light and garnered public support. Public health issues tend to be lower on the political agenda than healthcare services, where for instance key informants reported health human resources are sometimes redirected from public health to meet more urgent healthcare needs. However, key informants also reported that elected officials can be influenced by **strong leadership in public health**, particularly the well-respected CMOH Dr. Strang, in the role since 2007. **Good relationships between public health officials and decision makers** facilitate policy alignment. Such relationships help increase **decision-makers' understanding** of public health programs and services and thus the value they attribute to it.

Key informants discussed the most effective **framing strategies** for accessing new provincial public health investments through business cases. Specifically, they suggested aligning business cases with government priorities and emphasizing that current health system spending is unsustainable and that preventive public health programs can help relieve pressure on the healthcare system. The **close collaboration between public health actors**, such as the NSH public health leadership and the DHW Public Health branch, has helped communicate the priorities of decision-makers to public health leadership, which in turn has informed the framing of business cases. However, a **lack of transparency** around budget decision-making at the Ministry level, which excludes most public health officials, was thought to limit informed public health budget and business case planning.

Structural factors

The **health system reform** that amalgamated Nova Scotia's 9 District Health Authorities (DHAs) into a single provincial health authority (NSH) was noted to have mixed effects on public health funding trends. The reform centralized authority in decision-making and resource allocation, leading to an increase in political influence over budget-setting (Fierlbeck, 2019). It also consolidated the 9 public health budgets into a provincial budget overseen by NSH senior leadership and allocated to the four zones (Fierlbeck, 2018a; Nova Scotia Health Authority, 2015). Key informants described this as creating a "closed" **public health budget structure**, whereby unused funds are pooled provincially and redistributed within public health line items, as opposed to being reallocated to non-public health activities, as had reportedly occurred prior to the amalgamation despite being designated as "non-portable".

Public health system decision-making, including budget-setting, occurs primarily at the Public Health Steering Committee level, bringing together the DHW Senior Executive Director of Public Health, Associate Deputy Minister, CMOH, Deputy CMOH, and the NSH Vice President of Public Health, Senior Director of Public Health, and Senior MOH. This **governance structure** was said to allow close collaboration between public health leaders at the DHW and NSH levels but the involvement of zonal public health officials, such as regional public health directors and MOHs was reportedly limited to developing and advocating for business cases to NSH.

Nova Scotia's government has undertaken two phases of **public health system renewal** in the past two decades. The first renewal was triggered by multiple reports post-SARS that highlighted vulnerabilities of

public health systems across Canada, such as the *Naylor Report* (Moloughney, 2006; Naylor et al., 2003). This renewal involved a significant new investment in the public health system from 2006-2010, and the development of Public Health Standards (Nova Scotia Department of Health and Wellness, 2011b, 2012b), though budget cuts followed in 2010-12 (Standing Committee on Health, 2023). A key informant reported that the **public health standards** can guide decision-making by defining core system functions and performance indicators. However, others commented that their power is limited since they are outdated and unlegislated. The COVID-19 pandemic accelerated the second public health system renewal that led to a 3-year investment to bolster public health system capacity (Government of Nova Scotia, 2022a; Standing Committee on Health, 2023).

Key informants explained that limited **health surveillance capacity** has challenged data-informed decision-making. Finally, key informants discussed the **challenge of maintaining a skilled workforce** in public health practice, facing a lack of public health professionals such as health promoters, as well as MOH turnover. Workforce vacancies lead to unspent public health budgets, which was said to risk future budget allocations being reduced. To address this challenge, public health leadership is considering recruiting other professions into public health and making agreements with the provincial government on multi-year targeted investments to phase in a new workforce.

Policy Considerations

Long-Term Funding Model

Key informants brought up fiscal uncertainty as a key challenge in public health system financing, and called for greater funding predictability. For instance, it was suggested to index public health system allocations to inflation and increase permanent funding rather than allocating term-based funds. Some key informants mentioned that they are already seeing more permanent funding allocated in recent years, particularly through transitioning business cases to permanent funding.

Specifying Provincial Funding in Legislation

Key informants highlighted the fluctuation of public health budgets with electoral cycles. A key informant suggested that a legislated mandate for provincial funding for public health programs could promote funding stability. As of 2024, public health leaders were developing legislation to cover all public health functions as part of the public health system renewal process, offering an opportunity to incorporate a provincial funding mandate.

Including MOHs in Decision-Making

Key informants suggested that meaningfully including MOHs in budget decision-making would enable the breadth of their public health expertise to inform resource allocation and help link funding with improving health outcomes.

Investment in Public Health System Infrastructure

Key informants indicated a need for investment in public health system infrastructure, particularly in surveillance systems, which would bolster needs-based and equitable budget-setting as well as overall health system planning. Some reported that efforts to build surveillance capacity were underway as of 2024.

Improved Communication on Budget-Setting Processes

Some key informants discussed a lack of clarity around budget-setting and business case processes; they called for improved decision-making transparency and communications regarding funding request processes so that public health leadership can adequately plan short and long-term programs.

Increasing Public Health Visibility

Key informants shared that demonstrating public health impacts more effectively will be key to sustaining public health system funding over time. Some support the development of standard performance indicators across the province and a reporting system that could monitor the impact of public health programs. Standard indicators can be guided by provincial public health standards and incorporate indicators that capture structure, process and outcome measures.

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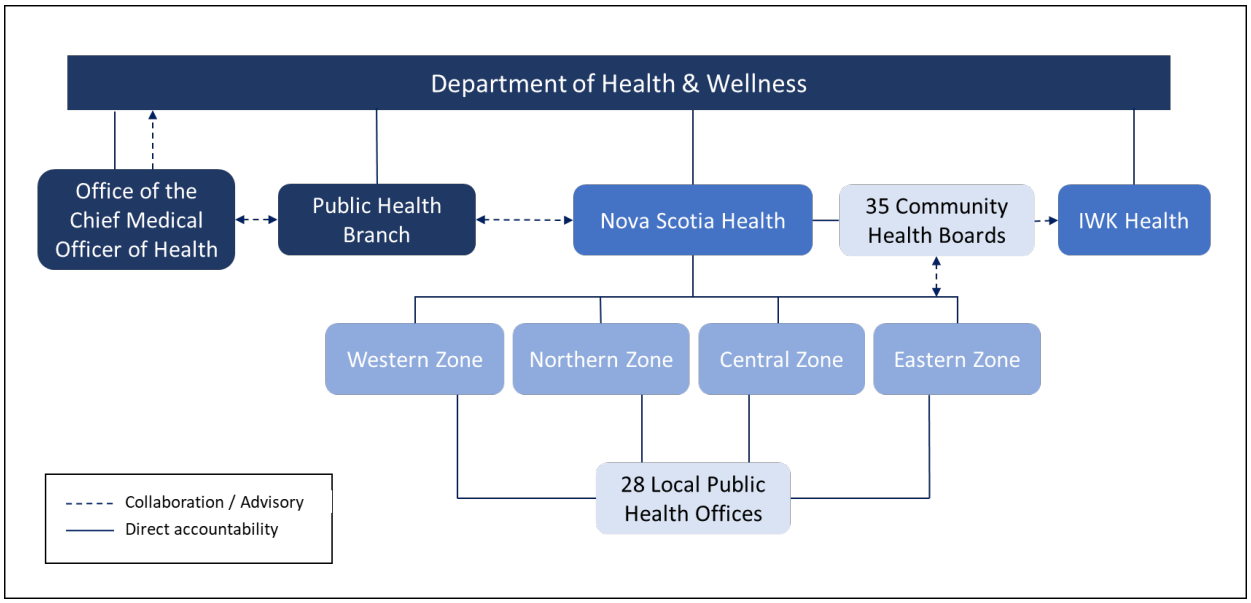
Appendix A. Nova Scotia's Public Health System Financing Structure

Figure A1. Structure of Nova Scotia's public health financing system



The Department of Health & Wellness's (DHW) Public Health Branch and CMOH are jointly responsible for setting strategic directions and providing guidance for public health activities (Smith et al., 2022). Nova Scotia Health (NSH) is responsible for overseeing most health services including public health (Fierlbeck, 2018b; Smith et al., 2022). The IWK Health Centre is a health authority separate from NSH, and specializes in women and children's healthcare, delivering some health prevention services (*Health Authorities Act*, 2014; Smith et al., 2022). NSH is divided into 4 geographical management zones, each with a public health director and regional MOH, as well as 28 local Public Health Offices in total across the province (Nova Scotia Health, n.d.; Smith et al., 2022). 35 local Community Health Boards advise NSH and IWK on community needs and programs to inform provincial priority setting, and provide grants to local health promotion projects *(Health Authorities Act*, 2014; Nova Scotia Community Health Boards, n.d.).

Appendix B. Impact of Major Events on Public Health Funding

Date range	Major event	Impact on public health funding
2003	SARS outbreak	• The outbreak triggered an external review of the public health system in NS (Moloughney, 2006; Nova Scotia Department of Health and Wellness, 2012a). • Led to the first targeted federal funding transfer to support provincial public health systems in 2004 (Moloughney, 2006).
2008-2010	Great recession	• The provincial government cited austerity pressures as a barrier to continued investment in the public health system (Nova Scotia Department of Health and Wellness, 2012b).
2009	H1N1 outbreak	• The mobilization of public health resources to conduct the largest immunization program in the province's history (Nova Scotia Department of Health and Wellness, 2011a). • Highlighted public health system improvements since SARS but also emphasized continued public health system weaknesses (Nova Scotia Department of Health and Wellness, 2012b).
2016-present	Opioid overdose crisis	• In October 2016, CMOH Dr. Strang launched an opioid strategy, including securing sustained funding for harm reduction (Tutton, 2016). • In 2017, the gobernment of Nova Scotia released an *Opioid Use and Overdose Framework* and invested $4.67 million into harm reduction and overdose prevention by 2022 (Government of Nova Scotia, 2022b).
2020	Mass casualty	• Nova Scotia experienced a mass casualty in April 2020 resulting in the deaths of 22 people (Mass Casualty Commission, 2023). • The Mass Casualty's final report recommended a public health approach to preventing future violence, involving an investment of over $10.5 million in public health and community safety strategies (Government of Nova Scotia, n.d.; Mass Casualty Commission, 2023).
2020-2023	COVID-19 pandemic	• NSH surged its public health capacity by more than 330% (Nova Scotia Health Authority, 2021). • Triggered a three-year investment across core public health functions starting in 2022 (Province of Nova Scotia, 2022).

Appendix C. Impact of Public Health System Structural Changes on Financing

Date range	Structural change	Impact on public health system and financing
2000	*Health Authorities Act*	Localized public health services through the creation of 9 District Health Authorities (DHAs), from the previous 4 health boards (Smith et al., 2022). Also legislated the role of Community Health Boards (*Health Authorities Act*, 2000).
2002	Creation of the Office of Health Promotion (also known as Nova Scotia Health Promotion)	The creation of the Office of Health Promotion gave the public health system a voice in cabinet as well as a dedicated budget (Fierlbeck, 2018a).
2003	National Advisory Committee: Learning from SARS	Recommended increasing public health funding ($300M in annual federal transfers to the provinces/territories) (Naylor et al., 2003).
2004	*Health Protection Act*	Legislates health protection functions including medical officers of health (MOHs), health hazards, outbreaks, and food safety, but excludes other public health functions (Health Protection Act, 2004; Moloughney, 2006).
2001-2005	The 9 DHAs grouped into 4 "shared service areas"	Regionalized public health administration while maintaining funding and governance at the local DHA level (Moloughney, 2006).
2006	The renewal of the Public Health System	A government-initiated public health system renewal analysis recommended a minimum doubling of public health system investment as a proportion of health spending (1.2% at the time) over a multi-year period (Moloughney, 2006). This commitment was implemented with new investments from 2006/07 to 2009/10, but followed by budget cuts in 2010/11 and 2011/12 (Nova Scotia Department of Health and Wellness, 2012b; Standing Committee on Health, 2023).
2006	Public Health Funding Approach	A funding task team was commissioned to develop a formal approach for allocating new funding for the public health system. The resulting approach consisted of a flexible model allocating 70% of new public health funding to the DHAs and 30% to the province, taking base budget expenses, population, and local needs into account (Fitzgerald, 2006).
2006-2011	Creation and merging of the Department of Health Promotion & Protection	The Office of Health Promotion, the Department of Health Public Health branch and the CMOH are combined to create the Department of Health Promotion & Protection (Auditor General, 2008; Nova Scotia Department of Health and Wellness, 2012a). The Department of Health Promotion & Protection invested in preschool speech-language treatment, as well as various health promotion programs targeting families, schools, and communities (d'Entremont & Barnet, 2006). The Department of Health and Department of Health Promotion & Protection merged to create the Department of Health & Wellness (DHW) in 2011 (Fierlbeck, 2018b; Smith et al., 2022).

2011	Nova Scotia Public Health Standards	Public health standards are published as part of the public health system renewal process, with the aim of providing a basis for public health planning, reporting, and funding (Nova Scotia Department of Health and Wellness, 2011b).
2012	The renewal of public health in Nova Scotia mid-course review	Highlighted continued lack of public health system capacity, and recommended investment in IT systems, assessment and surveillance functionality, environmental health, and workforce development (Nova Scotia Department of Health and Wellness, 2012b). An Auditor General report backed many of the public health renewal mid-course review recommendations (Auditor General, 2013).
2014-2015	*Health Authorities Act*	9 Health Authorities merged into one Nova Scotia Health Authority (NSH), launched in 2015 (*Health Authorities Act*, 2014). Public health organizational structure was maintained in 4 regionalized zones (Fierlbeck, 2018a; Nova Scotia Health Authority, 2015). The goal of the reform was to constrain health system spending, and specifically health administration costs, although this was not achieved (Fierlbeck, 2019). The first NSH business plan announces a review of resources dedicated to health promotion and a commitment to increase capacity (Nova Scotia Health Authority, 2015).
2022	Action for Health: Strategic Plan	The provincial government's *Action for Health* plan included commitments to build health promotion capacity through a 3-year investment across core public health functions (Government of Nova Scotia, 2022a; Province of Nova Scotia, 2022; Standing Committee on Health, 2023): • Approximately $12 million was invested in the public health system in 2021-22 (Standing Committee on Health, 2023). • The DHW invested in surveillance, MOHs, and towards establishing a new emergency preparedness program (Standing Committee on Health, 2023). • NSH invested in health protection core functions, particularly regarding effective pandemic response, as well as in Early Years and Healthy Communities (Standing Committee on Health, 2023), which included rolling out a new province-wide Nurse-Family Partnership Program supported by a multi-million dollar investment.