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Amalgamating Provincial Health Authorities: Assessing the Experience of Nova Scotia

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Abstract

Reflecting the shift away from regionalized health governance in Canada's provinces, the Nova Scotia government consolidated its nine Distinct Health Authorities into the single Nova Scotia Health Authority as of 1 April 2015. Regionalized health administration had originally been expected to produce economic efficiencies but, after two decades, a fragmented system of health governance was increasingly perceived as inflexible, uneven, and expensive. A more centralized system was presented as a means of reducing administrative costs, promoting scale economies, allowing greater flexibility, and facilitating standardization, which would in turn lead to significant savings. Five years on, however, the expected cost savings have not materialized. While there has been more success in standardization of services, not all attempts at standardization have led to greater efficiency. Evidence for greater flexibility is mixed. Problems with amalgamating health authorities include opportunity costs incurred by thoroughgoing reform, ambiguous and diminished accountability, administrative bottlenecks, decreased responsiveness, and poor working relationships with health care professionals leading to issues of access to health care services.

Suivant le mouvement de dé-régionalisation amorcé dans d'autres provinces canadiennes, le gouvernement de Nouvelle Écosse a consolidé ses neuf Autorités de Santé Distinctes en une seule autorité sanitaire le 1er avril 2015. Initialement, l'attente était que la régionalisation de l'administration sanitaire apporterait des gains d'efficacité, mais, après deux décennies, les systèmes fragmentés de gouvernance de la santé ont été perçus comme rigides, injustes et coûteux. Recentraliser le système a été présenté comme un moyen de réduire les coûts administratifs, de promouvoir des économies d'échelle, de permettre une plus grande flexibilité, et de faciliter la standardisation pour générer des économies substantielles. Après cinq années, cependant, les économies attendues ne se sont pas matérialisées. Même si la standardisation des services a été plus réussie, il n'en reste pas moins que la standardisation n'a pas toujours amélioré l'efficacité. L'évidence empirique sur l'amélioration de la flexibilité est tiède. Parmi les problèmes liés à la consolidation des autorités sanitaires, on peut citer des coûts d'opportunité liés à la mise en place de la réforme, une moindre transparence comptable, des goulots d'étranglement administratifs, une moindre attention aux attentes des usagers, et des relations détériorées avec les professionnels de santé amenant des problèmes d'accès aux soins.

Key Messages

- There has been no clear correlation between the consolidation of health authorities and reduction in either health administration costs or overall health costs in Nova Scotia.
- In a consolidated health authority undergoing extensive restructuring and the reduction of middle managers, especially within an environment of hostility to the public sector and limited public sector resources capable of meeting public demand, serious problems (such as diminished responsiveness) can arise that may contribute to a worsening cycle of governance.

Messages-clés

- *Aucune corrélation claire ne peut être établie entre la consolidation des autorités sanitaires et la réduction des coûts, totaux ou administratifs, en Nouvelle-Ecosse.*
- *Dans une autorité sanitaire consolidée subissant une restructuration profonde et une diminution du nombre de cadres intermédiaires, des problèmes sérieux (tels qu'une diminution de la réponse aux attentes des usagers) peuvent se manifester, particulièrement dans un climat hostile au secteur public et quand celui-ci n'a pas les ressources suffisantes pour répondre à la demande du public. Ces problèmes peuvent contribuer à entamer une spirale négative de gouvernance.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

The 1990s were notable for the wave of reorganization in health governance that swept across the Canadian provinces. Driven in part by principles set out in the school of New Public Management, most provinces adopted a regional structure of health governance that both centralized local authority for health administration at a regional level, and decentralized (at the same regional level) several functions that had previously been under the direct purview of provinces' departments of health. The beginning of the twenty-first century has been no less notable for the move away from this regionalized structure of health governance: by 2019 most provinces had either dramatically reduced the number of regional health authorities, or had consolidated all regional units into single provincial entities that were distinct from, though answerable to, provincial health departments (Marchildon 2016).

On 1 April 2015, the Nova Scotia Health Authority (NSHA) was created. The new body amalgamated nine existing District Health Authorities (DHAs) into a single governance structure. The IWK Health Centre, a facility for women and children in Halifax, was not part of this amalgamation, and remains a separate corporate entity. Both authorities are governed by boards of directors, which are in turn responsible to the Nova Scotia Department of Health and Wellness (DHW). While operational decision-making is now centralized within the NSHA, the authority has created four regional zones (Central, Northern, Eastern, and Western), each with two executive directors (medical and operational).

The amalgamation of the DHAs into one centralized body was supported by a reorganization of the DHW that came into effect on 1 April 2016. This restructuring transferred a number of functions from the DHW to the NSHA, including acute and tertiary care, mental health and addictions, primary care, and public health care. Programs focusing on cancer care, diabetes care, cardiovascular health, organ donation, renal care, and blood coordination also became the responsibility of the NSHA. Long-term care and health IT systems remained under the auspices of the DHW. Formally, the roles and responsibilities of the NSHA and DHW are set out in the *Health Authorities Act*. Specifically, the NSHA is responsible for “governing, managing and providing health services in the province and implementing the strategic direction set out in the provincial health plan” and “engaging with the communities they serve through the community health boards.” The DHW, in turn, is responsible for “providing leadership for the health system by setting the strategic policy direction, priorities and standards for the health system, ensuring appropriate access to quality care through the establishment of public funding for health services that are of high value to the population, and ensuring accountability for funding and for the measuring and monitoring of health-system performance” (Nova Scotia Health Authority 2019).

2 HISTORY AND CONTEXT

Like many other provinces, Nova Scotia regionalized its health authorities in the 1990s. While blueprints for a regionalized system of health care had been articulated in provincial reports written in 1972, 1989, and 1992, the implementation of a regionalized system only occurred in 1994. The four regional health authorities were subsequently expanded into nine DHAs in 1999. The expected cost savings of regionalized health governance never did materialize, and the timing of the restructuring—concurrent with federal restraint on health transfers—was clearly not propitious. Over the same time period, the province lost several major industries (mining, cod, steel) and the exodus of working-age persons to western provinces exacerbated the ratio of older to younger individuals. Both fiscal and demographic trends put severe cost pressures on the province. In 2013 a new Liberal government was elected and, influenced by the experience of Alberta (which had recently amalgamated its own regional health authorities), the formation of a single health authority became a priority.

3 GOALS OF THE REFORM

The principal goal of the new reforms was to constrain spending on health care, and particularly spending on health administration. Nova Scotia was consistently spending more than most other provinces on health administration (both per capita and as a percentage of total provincial health expenditure). This was not simply a case of a smaller jurisdiction enjoying fewer scale economies, as other smaller provinces routinely spent less on health administration. The rhetoric was on moving health dollars to the “frontline,” and the new government suggested that the reorganization would lead to savings of \$13M per year (Gorman 2014). A related, though less explicit, economic goal was the containment of public sector labour costs. The health sector in Nova Scotia employed a significant proportion of public sector workers and, as noted below, specific unions were perceived to be particularly responsible for winning wage increases that were then used as leverage by other unions to increase wages across the public sector (see Fierlbeck 2018, Chapter 7).

Secondary objectives were greater flexibility and uniformity within the health care system. While at first glance these goals may seem contradictory, both were seen as instruments for a more efficient functioning of the overall health system. A system of health management based on very small administrative jurisdictions limited the movement of supplies, services, and patients across DHAs. Information systems were based on DHA geography, complicating record-keeping for individuals travelling across DHA boundaries. Personnel travelling to meet counterparts in other DHAs might require permission to do so even if the distance was only a few kilometres. Each DHA was responsible for measurements and outcomes, and lack of standardization made it difficult to compare performance across regions. Moreover, each region had over time established different services, as well as varied paths of access to these services, which confused and perplexed patients moving across regions.

4 HOW THE REFORM WAS IMPLEMENTED

As Lazar *et al.* (2013) note, substantive health reform is most likely to succeed when implemented as a signature policy initiative by a new government. But underlying tensions contributing to the decision to amalgamate had, in Nova Scotia, been percolating for a few years. External factors, including the recession that began in 2008, highlighted the need for economic sustainability. Structural problems were highlighted by the H1N1 pandemic in 2009, which revealed serious issues underlying both vertical governance (lack of coordination between DHAs and the Department of Health) and horizontal governance (many public health functions were overseen by the Department of Health Promotion, which was a discrete provincial department distinct from the Department of Health). A report by the Auditor General, released at the height of the H1N1 outbreak, was critical of the lack of hierarchical coordination and accountability in provincial health care governance (Office of the Auditor General 2009).

A key precipitating factor was a wage settlement negotiated by a scrappy and well-organized nurses' union under the New Democratic Party (NDP) government in 2012. This settlement, made to forestall a potential strike, was deeply divisive even within the NDP government (Steele 2014). It convinced the incoming Liberal government in 2013 that a strong stance would have to be taken against public sector health care workers. Soon after coming to office, the new government passed legislation requiring striking home care workers to go back to work. This was followed by another piece of legislation limiting the ability of nurses and other health care workers to strike. A third bill, the Public Services Sustainability Act, legislated a wage pattern over the entire public sector. This piece of legislation directly affected physician salaries, keeping them the lowest in Canada.

5 EVALUATION

Five years after the event, what has been the effect of reorganization of the DHAs into a single health authority? One primary objective was the containment of health care costs. Overall, however, health care expenditure in Nova Scotia has steadily increased from \$4393.5M in 2013 to a projection of \$4814.4M in 2018 (Canadian Institute for Health Information 2018, Table D.4.3.3). Moreover, the percentage of provincial government expenditure used only for health administration in 2018-19 is projected to be 1.3%, exactly what it was in 2013-14, the year before the NSHA was established (Canadian Institute for Health Information 2018, Table F.3.3.2). This is similar to most other Canadian provinces, where the percentage of provincial government health expenditure on administration fluctuated no more than 0.1-0.2% over the past decade. A more subtle issue is the extent to which administrative costs were the result of the number of highly paid administrators. CEO positions for the DHAs were eliminated under amalgamation, but were replaced by a wide array of VPs, Chiefs, and Executive Directors for the consolidated NSHA (see Fierlbeck 2018, Fig 2.1). Considerable debate exists regarding the precise level of bureaucratization

within the NSHA, from 10-14 levels of management and 3.25 workers per manager (Surette 2019) to five levels of management and 29 employees reporting to a direct supervisor (Knox 2019).

There has been more success in the standardization of services (such as a single entry point of access for mental health and addictions services). At the same time, not all standardization has led to greater efficiency. Hiring practices, for example, have been standardized using a new human resources system, but managers report that this has led to very lengthy hiring processes (Accreditation Canada 2017, 98). In terms of performance measurement, indicators have been standardized across regions and institutions. However, the format of publicly-accessible performance indicators has changed so that it is not possible easily to compare outcomes between 2015 and 2018. The centralization of physician hiring within the NSHA, which caused opaque processing delays, was also perceived as a significant obstacle to the recruitment of both new physicians and locum replacements (West 2016).

Evidence for greater flexibility is mixed. For certain specific procedures, such as access to diagnostic tests (such as MRIs), being able to move across regional boundaries more nimbly has slightly lowered wait lists for these services. However, it is difficult to assess progress in access to services, as the data made public since 2015 are in varying formats and cannot be evaluated longitudinally. Moreover, it is difficult to distinguish structural advantages and disadvantages that are inherent to a centralized system of governance from problems that arise from the process of large-scale system change per se. A wholesale reorganization of health governance systems means change and uncertainty in roles, relationships, and responsibilities. Much time and energy are spent initially on determining the demarcation of authority and decision-making competence; managers must learn to work with different individuals within new reporting structures. The NSHA's CEO has admitted that "growing pains from the amalgamation of the province's health boards mean change is happening slower than some may wish" (Ray 2017). In itself this presents an opportunity cost, as the bureaucratic capacity to address specific programs (primary care, mental health care, long-term care, etc.) is diminished when so many resources are used to adjust to new processes and relationships. The 2017 Accreditation Canada report of the NSHA, for example, noted the existence of "pressure and demand on the front-line managers because of the many changes that have occurred in building the new NSHA, such as the implementation of new policies, procedures, and processes" (Accreditation Canada 2017, 30).

A second problem with the new bivalent governance structure is the determination of accountability between the province's health department and the new health authority. While the broad parameters of responsibility may specify that the province addresses overarching policy directions, and that the health authority is responsible for implementation, in practice it can be difficult to sort out complex lines of responsibilities. An Auditor General's report in December 2018, for example, noted that the development and implementation of IT programs such as Panorama, Drug Information System, and Personal Health Records was compromised because the DHW and NSHA could not agree on who had authority over

these applications (Office of the Auditor General 2018). Moreover, the implementation of the new governance system did not include a formal and transparent assessment and feedback mechanism.

A third problem with the rationalization of health authorities has been the development of administrative bottlenecks. A centralized structure of health care governance means that the decisions that were once dispersed across several regional DHAs are all consolidated within one decision-making structure. While some administrative decisions can be applicable simultaneously across all jurisdictions under a centralized system, decision-making authorities still must respond to local input. This is much more time- and labour-intensive than a more decentralized system, where these decisions are made concurrently by discrete administrative bodies across the province. The process of rationalization thus produces an administrative bottleneck where one centralized authority must respond to local concerns across the province, especially where local voices had previously expected timely feedback from managers at a regional level. In Nova Scotia, “[s]ince the government merged the district health authorities into a single entity, there has been persistent criticism from some people about a loss of local input” (Gorman 2019). In March 2019, the Auditor General took the NSHA to task for failing to communicate to Nova Scotians “what they should expect from their health care system” (Office of the Auditor General 2019, 13). Where a centralized authority is attempting to familiarize itself with new processes, the ability to respond promptly to local input is already compromised as it must attend first to internal issues of organization and communication. Where middle management positions are eliminated as part of the process of streamlining a perceived “top-heavy” bureaucratic structure, the capacity to respond expeditiously is further constricted. And, where this structural reduction in responsiveness occurs within an environment of both hostility to the public sector and limited public sector resources capable of meeting public demand, serious political problems arise that contribute to a worsening cycle of governance.

The political tensions underlying amalgamation were most obvious in the public response to physician supply. Nova Scotia is characterized by an interesting paradox: while the lack of family doctors is a highly-charged issue, the province appears to have one of the best GP-patient ratios in Canada. Nonetheless, these statistics are misleading. In the first place, the patient population in Nova Scotia is older and sicker than that in most provinces, and so the number of treatment hours per patient is much higher. According to Statistics Canada (2019), for example, the prevalence of diabetes in Nova Scotia is 8.3% (compared to a Canadian average of 7.3%); that of chronic obstructive pulmonary disease (COPD) is 6.4% (4.3% in Canada); and that of high blood pressure is 21.6% (17.6% in Canada). In the second place, GPs in Nova Scotia work amongst the lowest number of hours per week (Canadian Medical Association 2017), though (at 49.18 hours per week) it is still above the standard 40-hour work week. The lower number of physician hours in Nova Scotia can likely be explained by looking at the demographic characteristics of the physician workforce in the province, which is both the oldest in Canada (Scott’s Medical Database 2019) and one with a higher number of female physicians than many other provinces (Canadian Medical

Association 2017): both of which are indicators of working fewer hours on average.

Certainly, Nova Scotia faces challenging circumstances, including a population older and sicker than that of most provinces, as well as limited fiscal resources to meet the additional demand from this demographic. But this is true of all eastern provinces. In Nova Scotia, the process of amalgamation facilitated political decisions that exacerbated an already difficult situation. For example, an unpublicized centralized physician resource plan attempted to discourage physician recruitment in urban areas in favour of rural ones; but the net result was a serious decline of family doctors in central Nova Scotia with little uptake in remote areas (West 2016, Weeks 2017). Rather than relocating to remote areas, physicians eschewed the province entirely; a decision no doubt made easier by the province's uncompetitive salary structure relative to other provinces. At the same time, the province's College of Physicians and Surgeons cancelled the Clinician Assessment for Practice Program, which assessed internationally-trained doctors for family practice in Nova Scotia, leading to the reduction of around 30 family doctors (McPhee 2018). A new Practice Ready Assessment program was implemented in 2018.

The inability of the province to replace physicians as they retired or left the province meant greater burnout of existing physicians, who in turn became more likely to leave their positions (Schneiderei 2019). This leads to further problems with recruitment and retention, as GPs prefer working where they are well-supported by specialists, and specialists prefer having access to other specialists in cognate areas (Weeks 2017). As the centralized system became increasingly perceived as poorly responsive to the concerns of health care workers, the level of mistrust and resentment against the health authority rose as well: a survey commissioned by Doctors Nova Scotia in August 2018 confirmed that a substantial majority of respondents did not trust the NSHA "to work effectively to enact meaningful changes" and did not feel well-informed "about wider organizational change and strategic planning" (McPhee 2019). In some areas that were particularly affected by the exodus of physicians, such as Cape Breton, the new tensions were exacerbated because they fell on existing political fault lines (i.e., the traditional political acrimony between Cape Breton and the "urban elites" in Halifax).

To the extent that physicians are independent contractors in the health care system who enjoy a significant level of professional mobility, a heightened perception of mistrust and lack of responsiveness affects their willingness to engage with officials to develop innovative and creative solutions to issues of access for Nova Scotians. This is also true of other health care workers, who have felt a disproportionate impact from the strategy to achieve overall fiscal sustainability in the province. The structural limitations of a centralized system of health governance (reduced responsiveness, diminished transparency, disputes over jurisdiction) did not cause the current stressors on the provincial health care system. But it is arguable that it facilitated and exacerbated them. Structural administrative changes always take place within a rich and nuanced context of local political and social relationships; and the ability of administrative reorganization to achieve its objectives may rest as much in this context as in the structures themselves.

6 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

A summary of the assessment of Nova Scotia's experience with the consolidation of health authorities is presented in Table 1.

Table 1: Amalgamation of health authorities: strengths, weaknesses, opportunities, and threats

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ● Province-wide standardization can facilitate better performance measurement, make navigation of services easier for patients, and promote the implementation of best practices. Some functions can be performed less frequently when executed at a provincial level. ● Equipment and personnel can be moved more expeditiously across the province. ● Patients can more readily move across regions to access services. ● Better scale economies can be achieved in the provision of goods and services. ● Greater overall coordination is possible (regions are less likely to be operating at cross-purposes). 	<ul style="list-style-type: none"> ● Focusing resources on administrative reorganization can result in opportunity costs for program development. ● Requiring processes that were previously executed at a regional level to be implemented through a centralized mechanism may result in administrative bottlenecks. ● A centralized administrative system can be less responsive. ● The existence of two large administrative units (department of health and health authority) can lead to disputes over responsibility. ● A hierarchical system of governance can be less transparent.

OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • A single health authority that is able to address issues of responsiveness and accountability may be able to capitalize on opportunities for better coordination and nimbleness within the system. 	<ul style="list-style-type: none"> • A single health authority that is not able to address issues of responsiveness and accountability may cause distrust, resentment, and exit by health care workers, leading to more problems with access to health care services.

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8 FOR MORE DETAIL

8.1 General information

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