

Rapid Review 10

Province-Wide Services

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Table of Contents

Introduction and Background	2
Methods	4
Scope	4
Search Strategy	4
Key findings: Common themes and points of divergence	5
Stated rationale for centralization	5
Approaches to organizing province-wide services	6
Evaluation of the impacts of centralization	9
Limitations & future work	9
Conclusion	10
Appendix 1: Summary of province-wide services	11
References	33

Introduction and Background

Provincial governments face the challenge of striking the right balance between centralized and decentralized (or regionalized) health care planning, management and delivery. In pursuit of efficiency, governments may decide to decentralize health care planning and administration to the local level,¹ while at the same time centralize some clinical and administrative functions in arm's-length organizations to gain economies of scale and scope, and reduce transaction costs. The variety of approaches to regionalize health care that we see across the country, and over time, underscores this persistent challenge (Bergevin et al., 2016; Boychuk, 2009; Lewis & Kouri, 2004; Lomas, 1997; Marchildon, 2005, 2015, 2016, 2017).

An emerging trend in recent years can be seen as a reversal of regionalization, with the consolidation of smaller geographically defined structures into a single body (Barker & Church, 2017).² In 2008, Alberta became the first province to create a single arm's-length organization. Since then, four additional jurisdictions eliminated regional bodies in favour of a single centralized administrative authority—Prince Edward Island, Nova Scotia, Northwest Territories, and Saskatchewan. In addition, several provinces have recently established, or are currently in the process of establishing, new province-wide organizations to provide specific clinical and administrative services and functions.³

Economic theory in support of centralization suggests larger organizations can lower costs of production by better absorbing high fixed costs, and gaining economies of scale and scope.⁴ Economies of scale refer to the reduced average costs achieved with increased volume. Centralization in health care increases volume and, thus, may allow for the achievement of economies of scale. For example, centralizing back office functions including human resources, finance and information technology functions needed to support health regions and delivery organizations can yield economies of scale (Duckett, 2016), as can centralized procurement due to improved purchasing power and larger order sizes (Duckett, 2015). Finally, economies of scope may be gained since broadening the scope of services provided can spread fixed costs, and clinical or managerial expertise, which may be shared across different types of services. Additional arguments can be made for centralization that relate to the

¹ Economic theory of fiscal decentralization suggests efficiency gains with decentralized authority. Since local level preferences and costs of local goods and services are likely to vary, decentralized authority to decide how those goods and services should be allocated would increase economic welfare (Oates, 1972). Put another way, local governments or delegated authorities (e.g., health regions) have access to better information about their local population than do central governments and thus can respond by tailoring the service delivery and spending to meet local needs (Hurley et al., 1995). In contrast, central governments lack the local knowledge and faces political constraints in making efficient allocation decisions.

² While Quebec maintains a regionalized structure, it is interesting to note that when Bill 25 replaced locally elected boards with politically appointed agencies in 2003, it arguably strengthened the government's "centralized control" over the health system (Martin et al., 2010).

³ An early scan for the Canadian Agency for Drugs and Technologies in Health (CADTH) in 2011 found that Ontario, British Columbia in collaboration with Alberta, and New Brunswick have introduced some form of shared service models with the aim of improving efficiency and containing costs (Hanrahan, 2011).

⁴ Specialized academic health centres, for example, have both high fixed capital costs and highly skilled human capital that cannot easily be shifted. Therefore, these centres operate almost as "natural monopolies" because it is prohibitively costly to have multiple centres.

potential to eliminate duplicated functions, and reducing the size of the bureaucracy (Duckett, 2015, 2016).

While there are economic arguments supporting centralization, these need to be balanced with the potential efficiency gains from decentralization. This rapid review describes the current landscape of province-wide services in Canada, including the following two, often distinct, categories of services: 1) health and clinical services; and (2) shared back-office administrative services, including information technology, payroll and some human resources (HR) functions. We aim to shed light on the approaches provincial governments have taken to centralize health services and administrative functions in provincial arm's-length organizations.

Methods

Scope

We define a centralized arm's-length organization as ones that provides health services to the population, including clinical services, public health services and functions, and/or shared back-office administrative services and functions.⁵ The following organizations and programs are beyond the scope of this review: sub-provincial regional authorities;⁶ provincial/territorial quality councils;⁷ specialized agencies serving specific subpopulations; e-Health; federal government services; and pan-Canadian agencies, organizations, and alliances.

Search Strategy

We conducted an open search in Google along with targeted searches of websites of provincial ministries of health, centralized health authorities, and agencies to find information on province/territory-wide services. We explored different combinations of search terms that included "[jurisdiction name]", "province-wide", "health services", "clinical services", "centralized", "shared services", "procurement", "capital planning", "back-office services", "supply chain", and "non-clinical services". We retrieved additional sources using search terms that described services that were commonly centralized (and not detailed in the mandate or service provision of another agency) such as "[jurisdiction] cancer agency". All searches were performed between September 18 and 25, 2018.

We completed a template for each province based on publicly available information, which we sent to local experts to review and fill in informational gaps.⁸

⁵ We focus on arm's-length bodies because provincial governments have in large part adopted the central tenet of New Public Management, since the 1990s, which is to "steer and not row," in other words, to make policy but not to deliver public services (Hood, 1991). In the steering role, the service delivery can be more efficient by being de-politicized; decision makers can consider long-term interests of their populations. Thus, implicit in the choice of centralization vs decentralization is the separation of the service delivery role from the policy role of government through the creation of arms-length delegated structures.

⁶ Please see Peckham, Ho and Marchildon (2018), Appendix C "Provincial/Territorial Health Authorities and Regional Health Authorities by Jurisdiction", for details on the regulations, roles and responsibilities of regional authorities.

⁷ Please see Milligan, Peckham and Marchildon (Forthcoming) for a comprehensive review of provincial quality councils in Canada including their mandate, scope, etc.

⁸ We received reviews from the following jurisdictions: British Columbia, Manitoba, and Québec.

Key findings: Common themes and points of divergence

The clinical services and administrative functions that governments have decided to organize centrally vary across the country. We include all 10 provinces in this review; however, we discuss in more detail the larger provinces as they have more options for organizing services as a function of population size and density. Table 1 summarizes the degree to which provincial governments have centralized clinical services and administrative functions an arm's-length from ministries of health.

Table 1. Degree of centralization of clinical and administrative services into a provincial arms-length organization: Low, Medium and High

Province	Clinical services	Administrative/back-office functions
British Columbia	Medium	High
Alberta	High	High
Saskatchewan	High	High
Manitoba	Medium	High
Ontario	Low	High
Québec	Low	High
New Brunswick	Medium	Medium
Nova Scotia	High	Medium
Prince Edward Island	High	High
Newfoundland & Labrador	Low	Medium

Notes: This categorization provides a high-level assessment of the state of centralization of services in arm's length organizations. Some provinces categorized as "High" administratively, such as British Columbia and Quebec could possibly be categorized as "Medium", because it is unclear how consistently administrative functions are provided centrally versus regionally. New Brunswick and Nova Scotia are categorized as "Medium" administratively because of the limited range of services offered by the centralizing body to other health agencies (e.g., limited to capital spending over \$1 million, for Nova Scotia, only laundry, facility engineering, and power for New Brunswick).

Stated rationale for centralization

The most common rationale used for the centralization of services and functions was cost savings. This is consistent with results from other studies of the reforms in Alberta (Donaldson, 2010; Duckett, 2011) and Nova Scotia (Fierlbeck, 2018; CIHI, 2016). Many of these province-wide agencies aimed to gain economies of scale and scope, share best practices across the province (such as with Alberta Health Services; Duckett, 2011), and leverage existing infrastructure and resources (such as Cancer Care Ontario).

Additionally, there were common themes around consistency and equity in service delivery, particularly in reference to all residents being able to get the same level of services regardless of where they live in their jurisdiction. There was a consistent use of the terms "right care, right time, right place" in the mandates and/or mission statements of province-wide organizations in Saskatchewan, Manitoba, and

Prince Edward Island. Centralization also aimed to better coordinate the delivery of health care services with the provincial health authorities in Alberta, Saskatchewan, Nova Scotia and British Columbia.

Approaches to organizing province-wide services

The results of the rapid review reveal considerable variation in the approach governments have taken to centralize clinical and administrative services. Also, there are variations in the breadth of services within the mandates of provincial-level agencies operating at an arm's length from ministries of health. Table 2 summarizes the range of services included in centralized organizations across the provinces.

Scope of provincial health authorities

Alberta Health Services and Health PEI have broad mandates, including a wide range of clinical and non-clinical services. Nova Scotia has taken a different approach, as it maintains an organization responsible for children and women's health (IWK) that is separate from the central health authority (Nova Scotia Health Authority). Also, there appears to be some non-clinical shared services managed by a government department entirely outside of the health ministry in Nova Scotia. Detail on the extent of the Shared Services Initiative, introduced prior to the establishment of a single health authority in the province, is also unclear. For example, it is unclear if non-clinical services outside of the Shared Services Initiative (such as clinical IT applications) are centralized between Nova Scotia Health Authority and IWK or if they each manage independent programs and systems.

Saskatchewan appears to be slowly making the transition from a regional structure to a centralized Health Authority. Clinically this authority will be responsible for all service delivery with the exception of cancer services, which are operated by the Saskatchewan Cancer Agency. Responsibility for non-clinical services are less clear. 3sHealth was an organization established to leverage economies of scale across the province, particularly for the smaller, more rural health regions. However, 3sHealth's role becomes less clear in a province-wide authority where such administrative operations would be de facto centralized within the organization itself.

Specialized clinical services

Our review also uncovered several other centralized arms-length agencies providing specialized care at the province level, mostly overseeing cancer care. While economic theory suggests why there is often greater specialization in areas of high fixed costs (rare skills plus expensive medical equipment and infrastructure), public statements on the rationale for these agencies broadly reflect quality and service delivery goals. Provinces vary in the extent to which some specialized services, e.g., teachings hospitals, are overseen and managed centrally (e.g., in British Columbia's Provincial Health Services Authority, and the newly established organization, Shared Health, in Manitoba), regionally (e.g., New Brunswick), or by the hospitals themselves (e.g., in Ontario).

Cancer services are managed centrally in Manitoba (Cancer Care Manitoba). This is also the case in Saskatchewan in spite of the consolidation of the previous health regions into the single authority in

2017. Manitoba (Cancer Care Manitoba) and Saskatchewan (Saskatchewan Cancer Agency) have established single cancer agencies that are responsible for delivery of cancer care services, while in Ontario (Cancer Care Ontario) there is no centralized delivery of services. Yet all three agencies report on incidence and survival rates, and provide support and information to patients and clinics, and perform research functions. Similarly, cancer care is one of the several specialised programs or agencies that are embedded within British Columbia's Provincial Health Services Authority.

In addition to these arms-length agencies, there are many specialized services with province-wide mandates, which we do not include in this review. The province-wide mandate of these specialized services is likely the result of a low volume of patient demand turning a centre which provides a service into a de facto province-wide deliverer (e.g. Rainbow Health Ontario (RHO), a province-wide program for LGBT+ health services at Sherbourne Health in Ontario, and the Québec Heart and Lung Institute at the Université Laval).

Public health

In most provinces, public health services (immunization, disease/infection control, environmental health, etc.) are a branch of the ministry of health, with some domain under the Chief Medical Officer (CMO). There is some sharing between ministries and regional health authorities. For example, in Saskatchewan, planning and disease monitoring are done centrally, but the administration of vaccines is handled in clinics by nursing staff employed by the Health Authority.

Ontario is unique in having a crown corporation devoted to public health as an arms-length agency (Public Health Ontario) responsible for the entire province, providing laboratory services in addition to surveillance and population health assessments. In Québec, the Institut national de santé publique du Québec (INSPQ) centralizes research, training, and specialized lab services for region level public health services. In British Columbia there is shared responsibility of public health between the Provincial Health Services Authority and the regional authorities due to its unique dual health authority (provincial and regional) structure.

The rationale to centralize public health services in an arms-length agency (e.g., Public Health Ontario, INSPQ, etc.) appears to be motivated in part by the economies of scale with regard to specialized lab testing, but also to the economies of expertise within these organizations thus allowing a sharing of expertise and best practices across the provinces.

Administrative (back-office) services and functions

There appears to be a trend across the country toward the centralization of administrative, back-office services. Centralization of province-wide shared administrative services is seen in provinces with a single delegated authority where these services are explicitly integrated (e.g., in Alberta Health Services) as well as in provinces with a more regionalized structure such as in Québec (Centre de service partagé du Québec [CSPQ], and more recently in Ontario (Health Shared Services Ontario [HSSOntario])). These agencies are often justified on the basis of cost savings: their websites and annual reports regularly attempt to estimate costs saved.

Table 2. Summary of arms-length organizations providing clinical, public health and administrative (back-office) services

Province	Clinical services			Public health	Administrative/ back-office functions
	Health services	Specialized acute care	Cancer		
British Columbia	First Nations Health Authority*	Provincial Health Services Authority			
Alberta	Alberta Health Services				
Saskatchewan	Saskatchewan Health Authority		Saskatchewan Cancer Agency	Saskatchewan Health Authority*	Saskatchewan Health Authority & 3sHealth
Manitoba	Shared Health†	Addictions Foundation of Manitoba	Cancer Care Manitoba		Shared Health†
Ontario			Cancer Care Ontario°	Public Health Ontario*	HSSOntario
Québec				INSPQ	CSPQ+
New Brunswick		Réseau de Santé Horizon Health Network			Service New Brunswick+
Nova Scotia	Nova Scotia Health Authority	IWK & Nova Scotia Health Authority	Nova Scotia Health Authority		
Prince Edward Island	Health PEI				
Newfoundland & Labrador					

Notes: Empty (grey) cells indicate responsibility is held by regional authorities or within provincial government. In some cases, e.g., public health, it is difficult to separate regional from central services since there tends to be a strong role for both. While it is a centralized agency, the Institut national d'excellence en santé et en services sociaux (INESSS) was not included here, as it provides neither clinical services, public health, nor administrative functions.

* Denotes shared responsibility with the ministry of health and/or regional authorities. Note that First Nations Health Authority also includes some public health functions in their mandate.

† Service New Brunswick and CSPQ are joint initiatives between the ministry of health and other government ministries (in their respective provinces).

° Cancer Care Ontario does not deliver cancer services.

† Shared Health's scope is currently evolving as a part of the larger ongoing transformation of Manitoba's health system.

Evaluation of the impacts of centralization

We were not able to identify any evaluations of the impacts of these system reforms. Even after 10 years with a single delegated authority in Alberta there is little known about the extent to which the objectives of centralization were met. Recently, the provincial auditor noted that the integration of administrative support functions has contributed to lower administrative costs in Alberta,⁹ yet they also identified the challenges faced in integrating “clinical processes and frontline care” (Office of the Auditor General of Alberta (2017)).

The organizations we include in our review all publish annual reports including financial statements, as required by public sector organizations. Many also include performance metrics outlining their work and achievements. Some, such as the Addictions Foundation of Manitoba, report the volume of their service delivery and demographics about their clients.

In the case of shared administrative service organizations, such as Service New Brunswick or Centre de service partagé du Québec, there are often estimates of the costs saved through centralization. There is little formal evaluation, but the First Nations Health Authority in British Columbia has engaged an external consultant to provide a complete evaluation of its work since the transfer of federal and provincial service delivery. As part of this work they will also publish a framework for evaluation so such evaluations can be replicated in future.

Limitations and future work

This review aimed to provide a snapshot of the approaches to province-wide services in Canada and is limited to publicly available information. We excluded the territories because of their unique challenges owing to the small populations as well as their models of shared governance; however, future work could examine the structural reforms in Northwest Territories to learn from their recent move to centralization.

One of the challenges faced with comparative assessments across jurisdictions is often one of inconsistent terminology. Thus, it is not always clear what services are being provided province-wide by arm’s-length organizations. Nor is there always clarity in the governance arrangements of the agencies providing services. Furthermore, given that our source documents were largely press releases, annual reports, and websites, it was difficult to ascertain the nature of the relationship between a given ministry of health and these centralized organizations. The practical level of autonomy may differ from

⁹ CIHI data for 2017 forecast administration to make up 2.3% of total health spending, or \$170.15 per capita in Alberta, which is lower than some provinces (e.g., British Columbia, Manitoba, and Saskatchewan) but higher than Ontario and Québec (CIHI, 2017). However, it is difficult to compare these costs across provinces where administration of hospitals is by hospital boards (as in Ontario) with those administered centrally (e.g., in Alberta). The CIHI definition of administrative costs include expenditures related to the cost of providing health insurance programs by the government and all costs for the infrastructure to operate health departments but not costs of running hospitals, long-term care programs, etc., (CIHI, 2017). Allocating a central or regional health authority’s administrative costs to the system as a whole vs to hospitals and other facilities is thus not straightforward.

what is reported within these documents. For example, eHealth Saskatchewan, while not subject to this review, is interesting in that it is fully autonomous from the provincial ministry in law, regulation, and mission but currently has the deputy minister of health acting as the interim Chief Executive Officer.

Similarly, it is not always clear to what degree services are centralized in practice. For example, Alberta Health Services is organized into geographically based zones that have their own executives and medical officers. Also, the Saskatchewan Health Authority still directs service searches to the websites of the regions it was to replace. It will take a more thorough investigation to draw meaningful inferences about the true level of centralization that occurs in frontline service delivery. Finally, we provide a snapshot of the extent of centralization in Canada at this point in time; the emerging centralization in Manitoba could prove to be an interesting case for future analysis.

Conclusion

Provincial governments appear to be moving toward greater centralization of health services and administrative functions at the province level to achieve economies of scale and scope, and to reduce geographical variations in care. The relatively rapid pace of structural change we see in Canada reflects the challenge governments face in striking a balance between economies of scale through centralization and efficiency gains from decentralized planning and delivery.

While there is an emerging trend toward reverse regionalization under way in Canada, there is variation in the approaches taken to centralize services. Alberta Health Services was the first province-wide agency to be established and it has among the broadest scope of services within its mandate. On the other hand, the exclusion of IWK from the centralization of clinical health services within the Nova Scotia Health Authority, and the separation of clinical from non-clinical services centrally in the recent Saskatchewan reform, distinguish Nova Scotia and Saskatchewan from Alberta and Prince Edward Island where the operation of health centres is fully centralized. Yet, there are no clear differences in rationale for embedding all clinical and administrative functions within a single organization as opposed to having highly specialized agencies providing province-wide back-office or clinical services. As this time, there is almost no empirical evidence supporting one approach over the other. This in part reflects the limited evaluation of these reforms as well as the politicized nature of these decisions.

Appendix 1: Summary of province-wide services

British Columbia

Clinical and Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Provincial Health Services Authority (PHSA) (2001) ¹	<p>"To ensure that BC residents have access to a coordinated provincial network of high-quality specialized health-care services."²</p> <p>Goals:³</p> <ol style="list-style-type: none"> 1. To administer and deliver high-quality specialized health services that produce the expected results; 2. To administer and support province-wide health care programs and services in collaboration with the health authorities (HA); 3. To foster and develop health promotion and prevention in the province; 4. To integrate and co-ordinate efforts within the PHSA and with provincial and community partners to develop appropriate 	<p>Clinical Services:</p> <p>BC Autism Assessment Network BC Cancer BC Centre for Disease Control BC Children's Hospital & Sunny Hill Health Centre for Children BC Early Hearing Program BC Emergency Health Services (with programs BC Ambulance Service and the BC Patient Transfer Network) BC Mental Health & Substance Use Services BC Renal Agency BC Surgical Patient Registry BC Transplant BC Women's Hospital + Health Centre Cardiac Services BC Health Emergency Management BC Indigenous Health Lower Mainland Pathology & Laboratory Medicine</p>	<p>"PHSA operates under The Society Act and is accountable to the Ministry of Health [MOH] through a twelve-member Board of Directors appointed by the Minister of Health. The composition of the board is intended to be geographically representative of the population of BC, with board members living in all regions of the province.</p> <p>"As a public sector organization, the PHSA is mandated to meet the needs of the people we serve. The Governance policies and practices of the PHSA are compliant with the Governance and Disclosure Guidelines for Governing Boards of British Columbia Public Sector Organizations (Best Practice Guidelines) issued by the Board Resourcing and Development Office, Office of the Premier of BC. These guidelines define how the Board carries out its duties of stewardship and accountability." ¹</p>	<p>Some performance measurements can be found in the PHSA Service Plans (e.g., in the 2015/16 – 2017/18 PHSA Service Plan, there are performance measurements regarding breast cancer screening, independent dialysis, complex paediatric surgeries, among others).¹</p> <p>The PHSA also publishes annual PHSA Research Metrics Reports which looks at different indicators and spending for each one.⁶</p> <p>Evaluation: The PHSA has Service Plans (based on fiscal years) that present performance measures, consistent with the MOH's mandate and goals, and focus on aspects critical to the organization's</p>

	<p>research methodologies and systems, knowledge and innovation;</p> <p>5. To integrate and coordinate efforts within the PHSA and with provincial and community partners to improve efficiency and service;</p> <p>6. To create a sustainable, affordable public health care system through sound financial stewardship;</p> <p>7. To respect and value our employees (as a vital component of the health care system) through recognition and support;</p> <p>8. To commit to health reform and system performance improvements</p>	<p>Mobile Medical Unit Perinatal Services BC Provincial Infection Control Network of BC Provincial Language Service Services Francophones Stroke Services BC Trans Care BC Trauma Services BC</p> <p>Non-Clinical Services: (note that the PHSA absorbed the previously centralized BC Clinical and Support Services [BCCSS]): Employee Records & Benefits Payroll Revenue Services Technology Services Accounts Payable Supply Chain</p>	<p>The PHSA has a Board of Directors (12 members) and an Executive Team (PHSA Executive – 12 members).⁴</p> <p>It works with BC's 5 regional health authorities, the First Nations Health Authority (FNHA) and the BC Ministry of Health.</p> <p>"Corporate Governance addresses the Board of Directors and the role the Board plays in ensuring the organization's short and long-term success consistent with its mandate and mission. The Governance policies and practices of the PHSA are compliant with the Governance and Disclosure Guidelines for Governing Boards of BC Public Sector Organizations (Best Practice Guidelines) February 2005 issued by the Board Resourcing and Development Office (BRDO)*, Office of the Premier of British Columbia."⁵</p>	<p>performance.¹</p> <p>"The targets in this plan have been determined based on an assessment of Provincial Health Services Authority operating environment, forecast conditions, risk assessment and past performance."⁷</p> <p>Thus, although no external review/evaluation can be found for the PHSA, the organization itself publishes these Service Plans which evaluates the PHSA as a whole.</p>
<p>First Nations Health Authority (FNHA) (2013)</p>	<p>"The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region."⁸</p> <p>"The FNHA works with BC</p>	<p>Clinical Services: Maternal, Child, and Family Health Mental Wellness and Substance Use Traditional Healing Nursing Services</p> <p>Non-Clinical Services: Healthy Living Communicable Disease Control eHealth Environmental Health</p>	<p>"The First Nations Health Authority is part of a unique health governance structure ('Tripartite Framework Agreement on First Nation Health Governance') that includes political representation and advocacy through the First Nations Health Council, and technical support and capacity development through the First Nations Health Directors Association. Collectively, this First Nations health governing structure works in partnership with BC First Nations to improve the health and well-being of</p>	<p>Performance measures for different goals are highlighted in the Annual Reports. Two examples from the FNHA Annual Report 2017/18 for Goal 1: Measuring Progress includes "First Nations health governance effectiveness" and "Governance partnership effectiveness."¹⁴</p> <p>"FNHA is committed to a</p>

	<p>First Nations, government partners and others to improve health outcomes for BC First Nations people. Mandated by a number of health agreements (Transformative Change Accord: First Nations Health Plan [2006], Tripartite First Nations Health Plan [2007], and Tripartite Framework Agreement on First Nations Health Governance – collectively ‘the Health Plans’), and direction given by BC First Nations leadership.</p> <p>The Health Plans envision a First Nations Health Authority that would take over administration of Health for federal health programs for First Nations in BC. The FNHA mission ‘Supporting BC First Nations to implement the Tripartite First Nations Health Plan’ has received unprecedented support from First Nations leaders in BC and is well on the way to the transfer of First Nations Inuit Health Branch Pacific Region.”⁹</p>	<p>Health Human Resources Research, Knowledge Exchange, and Evaluation Health and Wellness Planning</p> <p>Funding Arrangements Health Emergency Management</p> <p>Note: "This work does not replace the role or services of the Ministry of Health and health authorities. The First Nations Health Authority collaborates, co-ordinates, and integrates their respective health programs and services to achieve better health outcomes for B.C. First Nations and Aboriginal people.”¹⁰</p>	<p>First Nations and Aboriginal people in British Columbia.”¹⁰</p> <p>"The Board of Directors includes members nominated by First Nations in our five regions and as well as members at large. The Board continues to collectively work and make decisions for the benefit of all BC First Nations, regardless of residence. At the same time, the structure makes space for regional and other relevant experiences and perspectives. The appointments to the FNHA Board of Directors are made by the members of the FNHA.”¹¹ Note there are 9 board members.</p> <p>"In 2016/2017, the FNHA signed its Annual Letter of Mutual Accountability (LMA) with the BC Ministry of Health (MOH) for the 2016/2017 fiscal year. The LMA is an annual joint letter describing how the FNHA and MOH will work to support one another’s mandates and sets out a series of collective priorities for the year.”¹²</p> <p>"A key focus for this relationship is the Ministry of Health’s implementation of a new system of primary and community care in BC.”¹³</p>	<p>high standard of accountability and transparency. Each year, we publish Annual Reports which include independently audited financial statements. We are pleased to share these reports”¹⁵</p> <p>Not only does FNHA release their Annual Reports, they also share FNHA, FNHC and FNHDA remuneration, as well as, their FNHA audited financial statements.¹³</p> <p>Evaluation: A consultant is currently (September 2018) doing an evaluation of FNHA.</p>
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Notes: The Health Employers Association of BC (HEABC) could also be considered to provide administrative services such as physician recruitment (through Health Match BC) and other HR functions such as labour relations and contract negotiations. The 1993 Korbin Commission’s Inquiry into the public sector recommended the creation of single

employer bargaining agents in the public sector. As a result of this review, the HEABC was formed on December 1, 1993 under the Society Act to represent employers in the health sector.¹⁶

¹ Provincial Health Services Authority. (2015). 2015/16 - 2017/18 PHSA Service Plan. Retrieved from http://www.phsa.ca/about-site/Documents/2015-16_PHSa_Service_Plan_FINAL.pdf

² Provincial Health Services Authority. (n.d.). Our Unique Role. Retrieved from <http://www.phsa.ca/about/who-we-are/our-unique-role>

³ Provincial Health Services Authority. (2003). PHSA Health Services Design Plan. Retrieved from <http://www.phsa.ca/Documents/PHSAhealthservicesdesignplan.pdf>

⁴ Provincial Health Services Authority. (n.d.). Leadership. Retrieved from <http://www.phsa.ca/about/leadership>

⁵ Provincial Health Services Authority. (n.d.). Corporate Governance. Retrieved from <http://www.phsa.ca/about/leadership/corporate-governance>

⁶ Chesney, & Palacios. (n.d.). PHSA Research Metrics Report - 9th Annual Report Fiscal Year 2016-17. Retrieved from <http://www.phsa.ca/research/Documents/RM-report-2016-17-v3-public.pdf>

⁷ Provincial Health Services Authority. (n.d.). 2017/18-2019/20 Service Plan. Retrieved from http://www.phsa.ca/about-site/Documents/2017-18_PHSa_Service_Plan.pdf

⁸ First Nations Health Council. (n.d.). About the FNHA. Retrieved from <http://www.fnha.ca/about/fnha-overview>

⁹ First Nations Health Council. (n.d.). Mandate. Retrieved from <http://www.fnha.ca/about/fnha-overview/mandate>

¹⁰ Ministry of Health. (2017, August 02). First Nations Health Authority. Retrieved from <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/first-nations-health-authority>

¹¹ First Nations Health Council. (n.d.). FNHA Board of Directors. Retrieved from <http://www.fnha.ca/about/governance-and-accountability/fnha-board-of-directors>

¹² First Nations Health Authority. (2018). 2017-2018 Annual Report. Retrieved from <http://www.fnha.ca/Documents/FNHA-Annual-Report-2017-2018.pdf>

¹³ First Nations Health Authority. (2017). Annual Report 2016/2017. Retrieved from <http://www.fnha.ca/Documents/FNHA-Annual-Report-2016-2017.pdf>

¹⁴ First Nations Health Authority. (2017). Annual Report 2016/2017. Retrieved from <http://www.fnha.ca/Documents/FNHA-Annual-Report-2016-2017.pdf>

¹⁵ First Nations Health Authority. (n.d.). Annual Report. Retrieved from <http://www.fnha.ca/about/governance-and-accountability/annual-reports>

¹⁶ Health Employers Association of BC. (n.d.). About Us. Retrieved from <http://www.heabc.bc.ca/page49.aspx#.W64rphNKh0t>

Alberta

Clinical and Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Alberta Health Services (2008)	<p>"Canada's first province-wide, fully integrated health system"¹</p> <p>"...great opportunities for patients to be even better served in the future with the changes that will occur as part of the restructuring. The plan is to have one approach to health care that integrates health services across the province and standardizes care so that all patients receive the same quality of care."²</p> <p>"Where once separate staff, rules and processes created barriers, today we have significant co-operation and sharing of best practices between health care providers and sectors. This allows us to look across the province to find the best way of doing things."³</p>	<p>Clinical Services: Administering hospitals, health centres, long-term care, public health services (immunizations /vaccinations), mental health and addictions services.</p> <p>Non-Clinical Services: Human resources (including recruitment and retention), supply chain management, procurement, security services</p>	<p>The Alberta Health Services Board was "re-introduced effective November 27, 2015...."⁴</p> <p>"The board is responsible for the governance of AHS, working in partnership with Alberta Health to ensure all Albertans have access to high quality health services across the province. The Board is accountable to the Minister of Health."</p> <p>"It is a regional health authority governed by the Regional Health Authorities Act, RSA 2000, c. R-10 (RHAA) and is responsible for administering the Alberta Health Region, which covers the entire province.... 'The scope of AHS' responsibilities under the above mandate is subject to the direction of, and the resources provided by, the Minister of Health (Minister)."⁵</p>	<p>Consolidated financials are audited by the Auditor General of Alberta each year in the Annual Report. Performance metrics are reported in the annual reports as well as in topic-specific reports.</p>

¹ Alberta Health Services. (n.d.). About AHS. Retrieved from <https://www.albertahealthservices.ca/about/about.aspx>

² Alberta Health Services. (2008). News Release: Alberta Health Services moves toward one provincial health system to increase patient access and enhance care. Retrieved from <https://www.albertahealthservices.ca/news/releases/2008/Page485.aspx>

³ Raedle, J. (2017, January 17). A Single Provincial Health Care System is the Best Way Forward. Retrieved from <https://leaderpost.com/opinion/columnists/a-single-provincial-health-care-system-is-the-best-way-forward>

⁴ Alberta Health Services. (n.d.). AHS Board. Retrieved from <https://www.albertahealthservices.ca/about/Page12825.aspx>

⁵ Alberta Health Services. (n.d.). Alberta Health Services - Mandate and Roles <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-mandate-roles.pdf>

Saskatchewan

Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Saskatchewan Health Authority (SHA) (2017)	<p>"The Advisory Panel on Health System Structure report recommends system-wide transformation to better coordinate health care services across the province, and improve access to high quality, timely services for Saskatchewan people."¹</p> <p>[Note: The Advisory Panel was given a mandate to recommend fewer regions to "achieve administrative efficiencies as well as improvements to patient care".]¹</p>	<p>Clinical Services: Administering hospitals, health centres, long-term care, public health services (immunizations/vaccinations), mental health and addictions services.</p> <p>Non-Clinical Services: Human resources (including recruitment and retention), supply chain management, and procurement.</p>	SHA is governed by the Saskatchewan Health Authority Board of Directors, 10 members appointed to 3-year terms by the MOH. ²	<p>The Provincial Auditor of Saskatchewan provides financial audits and the SHA Annual Report "demonstrates the Saskatchewan Health Authority's commitment to transparency, accountability and public reporting of performance."³</p> <p>Act: The Provincial Health Authority Act</p> <p>Evaluation: None at this time.</p>
Saskatchewan Cancer Agency (SCA) (2006)	<p>"In 2007-08, the Agency [SCA] entered its second year of operation under a provincial model of care."⁴ The SCA was established with "The Cancer Agency Act" in 2006.⁵</p> <p>No specific rationale could be found. Likely due to the low population density of Saskatchewan, the high capital (fixed) costs of cancer treatment, and the economies of scale of centralization.</p>	<p>Clinical Services: Provision of radiotherapy and chemotherapy services for patients diagnosed with cancer, follow-up and treatment planning, as well as support for the "social, emotional and economic needs of patients" and lodges for patients who live outside of the two major centres where treatment services are provided.⁶</p> <p>Non-Clinical Services: The SCA also monitors and</p>	The SCA has a board of directors appointed by the Lieutenant Governor in Council. ⁷ They work with the SHA (as defined within the Cancer Agency Act) with respect to patient care.	<p>The SCA releases annual cancer control reports as well as financial reports audited by the Provincial Auditor of Saskatchewan.</p> <p>Act: The Cancer Agency Act</p> <p>Evaluation: Peer-reviewed evaluations focus on the efficacy of oncology methods (diagnosis, reporting, and treatment) rather than on efficacy of the agency itself.</p>

		reports on cancer incidence, prevalence, survival rates for the province.		
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Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
3sHealth (Shared Services Saskatchewan) (2012)⁸	"This is an important step in the transformation of the Saskatchewan health system and demonstrates the commitment of stakeholders to moving towards a more efficient, high quality and sustainable health care experience for the people of this province." ⁸	"3sHealth provides payroll and scheduling services, employee benefits, dictation and transcription services, linen services, provincial contracting, and transformation services to the Saskatchewan health system." ⁹	"3sHealth is governed by the 3sHealth Board, which is appointed by Governing Council." ¹⁰	The accounting and consulting firm MNP has done an audited statement of cumulative savings. ¹¹ 3sHealth also produces an Annual Report which contains financial statements.

Notes: During the 2010-11 fiscal year, the Treasury Board Crown Corporation, previously known as the Saskatchewan Health Information Network (SHIN), transformed into eHealth Saskatchewan,¹² which is an arm's-length autonomous agency to procure, implement, own, and manage the electronic health records (EHR) for Saskatchewan as well as other health information technology, such as hospital and radiology systems,¹³ but was ruled out of scope for purposes of this review.

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- ¹ Abrametz, B., Bragg, T., & Kendel, D. (2016, December). Saskatchewan Advisory Panel on Health System Structure Report - Publications Centre. Retrieved from <http://www.publications.gov.sk.ca/details.cfm?p=88433>
- ² Government of Saskatchewan. (n.d.). Governance. Retrieved from <https://www.saskhealthauthority.ca/about/pages/governance.aspx>
- ³ Government of Saskatchewan. (2018, July). Saskatchewan Health Authority Annual Report 2017-2018. Retrieved from <https://www.saskhealthauthority.ca/about/Documents/2017-18-SHA-Annual-Report-Web.pdf>
- ⁴ Saskatchewan Cancer Agency. (2008). Annual Report 2007/08. Retrieved from <http://www.saskcancer.ca/adx/asp/adxGetMedia.aspx?DocID=481,91,6,1,Documents&MediaID=1628&Filename=2007-08> Saskatchewan Cancer Agency Annual Report.pdf
- ⁵ Government of Saskatchewan. (2017). The Cancer Agency Act. Retrieved from <http://www.publications.gov.sk.ca/freelaw/documents/English/Statutes/Statutes/C1-1.pdf>
- ⁶ Saskatchewan Cancer Agency. (2018). Our Facilities. Retrieved from <http://www.saskcancer.ca/Default.aspx?DN=a465a33f-2312-4fc8-8a6f-5a2e084f3d9c>
- ⁷ Saskatchewan Cancer Agency. (2018). Board of Directors. Retrieved from <http://www.saskcancer.ca/Default.aspx?DN=1a943152-c55c-4c60-9aaf-32075cac306c>
- ⁸ 3shealth. (2012, April). 3sHealth organization confirmed. Retrieved from <http://www.3shealth.ca/newsreleases/3shealth-organization-confirmed>
- ⁹ 3shealth. (2014). Corporate Profile. Retrieved from <http://www.3shealth.ca/about-3shealth/corporate-profile>
- ¹⁰ 3shealth. (2014). 3sHealth Governance. Retrieved from <http://www.3shealth.ca/about-3shealth/3shealth-governance>
- ¹¹ 3shealth. (2014). Health System Savings. Retrieved from <http://www.3shealth.ca/about-3shealth/health-system-savings>
- ¹² Government of Saskatchewan. (2011). 2010-11 Annual Report - eHealth Saskatchewan. Retrieved from <https://www.ehealthsask.ca/about/Annual%20Reports/2010-11%20Annual%20Report.pdf>
- ¹³ Government of Saskatchewan. (2018). 2017-18 Annual Report - eHealth Saskatchewan. Retrieved from https://www.ehealthsask.ca/about/Annual%20Reports/2017-18%20Annual_Report.pdf

Manitoba

Clinical and Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
CancerCare Manitoba (CCMB) (1997)	The provincially mandated cancer agency responsible for setting strategic priorities and long-term planning for cancer and blood disorders. The CCMB provides clinical services to both children and adults. ¹	The cancer services the organization provides to Manitobans include prevention, early detection, multidisciplinary cancer treatment, supportive and end-of-life care. The CCMB is also responsible for radiation protection throughout the province. In addition, the Research Institute at the CCMB investigates all aspects of cancer and blood disorders, including research to improve the patient's experience while at the CCMB. ¹	"The CCMB Board of Directors is responsible for the strategic vision and planning at CCMB." ² The board is appointed by the Minister and approved by the Lieutenant Governor in Council. ²	The CCMB has recently published the 2016-2021 Manitoba Cancer Plan where several metrics/performance measures were highlighted. The third strategic direction was entitled "Toward Enhanced Reporting on Performance, Quality and Safety" and includes different measures and indicators. It is important to note that the framework for this was developed by Manitoba Health, Healthy Living and Seniors. Corporate publications include: CCMB Annual Progress Reports, Community Health Assessments and Accreditation with Exemplary Standing. ³
Shared Health (2018) ⁴	Creation of a provincial health organization. "Manitobans deserve the right care, in the right place, at the right time, whether they live in a city, a town, or in a rural or remote community."	Clinical Services: Diagnostic Services Other Services Non-Clinical Services: This will include the provision of business services for the regional health authorities, the CCMB and	"Our interim board of directors reports to the Minister of Health, Seniors and Active Living. Each board member brings significant experience in health care and provides governance to the organization through this time	None at this time.

	<p>Shared Health brings together clinical experts from across the province to deliver a patient-centred, accessible, responsive health system that people can count on. Shared Health plans clinical and preventive services across the entire province, supported by centralized administrative functions that use human, capital and financial resources in the best way possible. We work collaboratively with communities to make sure we meet people's health care needs, compassionately, effectively and as close to home as possible."⁵</p> <p>"Shared Health is leading and coordinating the development of Manitoba's first provincial clinical and preventive services plan.</p> <p>"This approach has been recommended by a number of external, expert reviews of Manitoba's health system... This strategic focus will reduce duplication and ensure people are able to access the right care at the right time in the right place."⁷</p>	<p>the Addictions Foundation of Manitoba.</p> <p>"Shared Health's scope and services will continue to evolve throughout 2018 and 2019, as part of a larger transformation of Manitoba's health system currently under way."⁵</p>	<p>of transformation. Once Shared Health is fully established in 2019, a permanent board of directors will be appointed.</p> <p>The executive is responsible for the day-to-day leadership and administration of Shared Health. It reports to the board of directors."⁶</p> <p>"Shared Health supports the delivery of patient-focused care across Manitoba. This will include the coordination of some business services for the regional health authorities, CancerCare Manitoba and the Addictions Foundation of Manitoba."⁷</p>	
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Addictions Foundation of Manitoba (AFM) (1956)	<p>"AFM is a Crown agency that is committed to being a foundation of excellence in providing addictions services and supporting healthy behaviours. AFM employs over 400 staff and provides a wide range of addictions services to Manitobans through 28 locations across the province."⁸</p>	<p>Addictions Programs and Services: For Adults For Family For Youth For Communities and Schools Manitoba Opioid Support and Treatment Impaired Driver Program Problem Gambling Rapid Access to Addictions Medicine (RAAM)</p> <p>"AFM provides Manitobans with a range of services and supports relating to alcohol, substance use and problem gambling."⁹</p>	<p>The AFM is accountable to the Province of Manitoba (Manitoba Healthy Living and Seniors) through its Board of Governors. The Board directs the AFM's affairs in accordance with The Addictions Foundation Act. The membership consists of 9 to 15 governors appointed by the Lieutenant Governor in Council. The Board's function is to establish organizational direction and vision, set broad policy, provide leadership and ensure the organization attains its objectives.¹⁰</p>	<p>AFM Reports and Expenses are available to the public online.</p> <p>Progress on the Strategic Priorities (i.e., data), as well as financial statements can be found in the AFM Annual Reports.</p> <p>While some of the AFM programs have undergone external evaluation, we were not able to find any evaluations of the AFM as a whole.</p>
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Notes: We exclude the process of accreditation from the review of performance measurement, but it is interesting to note that "In December 2015, Accreditation Canada conducted extensive surveys at all CancerCare Manitoba locations. CCMB met an exceptional 97.7% of the indicators used in the accreditation process, and awarded Accreditation with Exemplary Standing, the highest designation available."¹¹

The origin of the AFM dates back to 1956 when the Alcoholism Foundation of Manitoba Act was passed, authorizing the provision of facilities and services for treatment of alcohol addiction, counselling, education, prevention, and research. In 1993, to more accurately reflect the services offered by the AFM, Bill 44 was enacted and the AFM's name was changed to The Addictions Foundation of Manitoba.⁸

¹ CancerCare Manitoba. (n.d.). Who we are. Retrieved from <https://www.cancercare.mb.ca/About-Us/who-we-are>

² CancerCare Manitoba. (n.d.). Board of Directors. Retrieved from <https://www.cancercare.mb.ca/About-Us/board-of-directors>

³ CancerCare Manitoba. (n.d.). Corporate Publications. Retrieved from <https://www.cancercare.mb.ca/About-Us/corporate-publications>

⁴ Shared Health Manitoba. (n.d.). Organizational Structure. Retrieved from <http://sharedhealthmb.ca/organizational-structure>

⁵ Shared Health Manitoba. (n.d.). About Shared Health. Retrieved from <http://sharedhealthmb.ca/about>

⁶ Shared Health Manitoba. (n.d.). Leadership Team. Retrieved from <http://sharedhealthmb.ca/leadership-team>

⁷ Shared Health Manitoba. (n.d.). Organizational Structure. Retrieved from <http://sharedhealthmb.ca/organizational-structure>

⁸ Addictions Foundation Manitoba. (2015, June 23). About AFM. Retrieved from <https://afm.mb.ca/about-afm/>

⁹ Addictions Foundation Manitoba. (n.d.). Programs and Services. Retrieved from <https://afm.mb.ca/programs-and-services/>

¹⁰ Addictions Foundation Manitoba. (2017, December 06). Board of Governors. Retrieved from <https://afm.mb.ca/about-afm/board-of-governors/>

¹¹ CancerCare Manitoba. (n.d.). Corporate Publications. Retrieved from <https://www.cancercare.mb.ca/About-Us/corporate-publications>

Ontario

Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Cancer Care Ontario (1997)	"Cancer Care Ontario and the Ontario Renal Network are divisions of CCO. These parts of our business use CCO's infrastructure, assets and models to improve the quality and performance of Ontario's cancer and chronic kidney disease systems." ¹	<p>The CCO encompasses Cancer Care Ontario and the Ontario Renal network. This includes the clinical services for cancers and kidney disease, but also non-clinical services in terms of oversight and direction of "approximately \$1.9 billion in funding for hospitals and other cancer and chronic kidney disease healthcare providers."²</p> <p>The CCO also oversees programs to work with the Ministry of Health and Long-Term Care, hospitals, local health integration networks (LINHs), and other agencies in: chronic disease prevention; integrated care; P Scans Ontario; Person-Centred Care Program; Access to Care (ATC); clinical and continuing education.³</p>	Overseen by a board of directors appointed by the Lieutenant Governor in Council. ³	The CCO releases annual cancer control reports as well as financial reports audited by the Auditor General of Ontario.
Public Health Ontario (PHO) (2008)	The PHO was established by the Ontario Agency for Health Protection and Promotion Act of 2007 as a response to an increased number of virulent outbreaks (notably SARS in 2003), which were deemed beyond the capacity of existing public health operations. ^{4,5}	The PHO absorbed the Ontario Provincial Lab and was mandated to provide the following clinical and non-clinical services: advice, consultation and interpretation; continuing education and professional development; health emergency preparedness; information management; knowledge and best practices generation; laboratory services; library services; research, ethics and evaluation; support to	Overseen by a board of up to 13 directors appointed by the Lieutenant Governor in Council. ⁵	The PHO releases an annual report with metrics on services provided and financial reports audited by Ernst & Young. ⁵

		policy and program development; surveillance and population health assessment. ⁵		
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Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Health Shared Services Ontario (HSSOntario) (2017)	<p>"In December 2016, the Legislative Assembly of Ontario passed the Patients First Act, 2016, which resulted in the amalgamation of three discrete shared services entities—the Ontario Association of Community Care Access Centres (OACCAC), the LHIN Shared Services Office (LSSO) and the LHIN Collaborative (LHINC)—to form a new shared services entity, HSSOntario....</p> <p>"... emphasis for HSSOntario in the coming year will be to:</p> <ul style="list-style-type: none"> • harmonize the service offering to the LHINs, which historically, was provided by a number of discrete entities; • ensure that services evolve to support the broader mandate of the LHINs; and • identify and realize opportunities for effectiveness and efficiencies across the sector."⁶ 	<p>HSSOntario provides the following shared services⁷ to LHINs and other health entities:⁸</p> <p>Development and oversight of patient-care digital health platforms, information technology, and data management; Home and community care program support and implementation, including support for policy development and quality improvement; Finance and administration, including accounts payable and inventory management; Procurement; Human resource management, including employee benefits and assistance; Labour relations and collective bargaining; Communications and public relations support.</p>	<p>Overseen by a board of directors, the chair of which is an Assistant Deputy Minister in the Ministry of Health and Long-Term Care (MOHLTC).</p>	<p>As they have absorbed the OACCAC, they report (by LHIN) on wait times for home care and long-term care.</p> <p>Financial statements, audited by PWC, are available annually.⁹</p> <p>No other evaluations could be found.</p>

Notes: Ontario Agency for Health Protection and Promotion operates under the name Public Health Ontario.

eHealth Ontario, established in 2008 as a merger between the Ministry electronic health program and Smart Systems for Health Agency (SSHA),¹⁰ is an arm's-length autonomous body¹¹ to centralize electronic health records (EHRs) and to facilitate record sharing, but was ruled out of scope for this review.

There are additional centralized agencies that are not included in this table because it was unclear whether they were operating autonomously. For example, HealthForceOntario Marketing and Recruitment Agency (HFO MRA) was established in 2007 collaboratively between the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Training, Colleges and Universities (MTCU) to address concerns around physician shortages.¹² It is responsible for recruitment and retention of health professionals in Ontario, but was not included here due to issues around incomplete centralization – the Niagara LINH, for example, runs their own competing recruitment agency and there have been complaints about HFO MRA pushing back too much work onto the community.¹³

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- ¹ Cancer Care Ontario. (2017, October 05). What We Do. Retrieved from <https://www.ccohealth.ca/en/what-we-do>
- ² Cancer Care Ontario. (2018, July 31). Who We Are. Retrieved from <https://www.ccohealth.ca/en/who-we-are>
- ³ Cancer Care Ontario. (2018, January 18). General Health – CCO. Retrieved from <https://www.ccohealth.ca/en/general-health>
- ⁴ Population Health Improvement Research Network. (2011). Ontario Agency for Health Protection and Promotion is now Operating as Public Health Ontario. Retrieved from http://www.rrasp-phirn.ca/index.php?option=com_content&view=article&id=210%3Aontario-agency-for-health-protection-and-promotion-is-now-operating-as-public-health-ontario&catid=6%3Alatest-news&Itemid=17&lang=en
- ⁵ Public Health Ontario. (n.d.) Annual Report 2008-09. Retrieved from https://www.publichealthontario.ca/en/eRepository/Annual_Report_2008-2009_English.pdf
- ⁶ Health Shared Services Ontario. (2018). Health Shared Services Ontario Annual Business Plan FY2018/19. Retrieved from <http://hssontario.ca/Quality/Documents1/Health-Shared-Services-Ontario-Annual-Business-Plan-FY2018.pdf>
- ⁷ Health Shared Services Ontario. (n.d.). What We Do. Retrieved from <http://hssontario.ca/who-we-are/what-we-do>
- ⁸ Ministry of Government and Consumer Services. (n.d.). ServiceOntario - Government of Ontario, Canada. Retrieved from <https://www.ontariocanada.com/registry/view.do?postingId=26826&language=en>
- ⁹ HSSOntario. (n.d.). Annual Reports and Financial Statements. Retrieved from: <http://hssontario.ca/Who/Pages/Archived-Annual-Reports-and-Financial-Statements.aspx>
- ¹⁰ EHealth Ontario. (n.d.). What We Do. Retrieved from <https://www.ehealthontario.on.ca/en/about-us/about-us>
- ¹¹ EHealth Ontario. (n.d.). Disclosure. Retrieved from <https://www.ehealthontario.on.ca/en/about-us/governance-documents>
- ¹² Health Force and Recruitment Agency. (n.d.). About Us. Retrieved from [http://www.healthforceontario.ca/en/M1/About_Us/HealthForceOntario_Marketing_and_Recruitment_Agency_\(HFO_MRA\)](http://www.healthforceontario.ca/en/M1/About_Us/HealthForceOntario_Marketing_and_Recruitment_Agency_(HFO_MRA))
- ¹³ Morgan, James. (2018). Doctor Brings Attention To Physician Shortage in Casselman. *The Review*. Retrieved from <https://thereview.ca/2018/06/18/doctor-brings-attention-to-physician-shortage-in-casselman/>

Québec

Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
National Public Health Institute of Quebec (INSPQ) (1998)	None provided. Likely due to the high capital cost of laboratory facilities and equipment, as well as optics for independent analysis and quality assurance.	Clinical Services: Laboratory Testing; Disease monitoring; toxicology; public health services. Non-Clinical Services: Specialty and expertise; training; scientific opinion; consultation; quality assurance; confirmation testing. ¹	Governed by a board of directors, one of whom must be a representative of the deputy minister (DM) of the Ministère de la Santé et des Services sociaux (MSSS). ²	None found.
Héma-Québec (1998)	Héma-Québec replaced the Canadian Red Cross Service on the recommendation of the Krever Report. ³	Héma-Québec is the “expert in all biological products of human origin,” managing blood supplies and banks for provincial hospitals, as well as managing the Québec Mother’s Milk Bank, tissue repositories and Système d’information intégré sur les activités transfusionnelles et d’hémovigilance (SIIATH). ³	Governed by a board of directors.	Annual reports detail some activity measures as well as financial statements audited by Vérification Générale du Québec.

Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Centre de Services Partagés du Québec (CSPQ) (2005)	To provide or make accessible services to all public services while leveraging scale to reduce costs. ⁴	Provides procurement; communications; finance; HR; printing and publishing; IT and web services to government branches, institutions in the health and social services network, and health regions. ⁵	Governed by a board, but as a non-health specific agency, there is no specific relationship with the MSSS.	Annual reports/business plans estimate cost savings and performance metrics on service delivery.

The Institut national d'excellence en santé et en services sociaux (INESSS) (2011)	It replaced the Conseil du médicament and the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS). ⁶ It operates in space similar to the pan-Canadian (excluding Québec) agency Canadian Agency for Drugs and Technologies in Health (CADTH).	“INESSS’s mission is to promote clinical excellence and the efficient use of resources in the health and social services sector. At the heart of the mission, INESSS assesses, in particular, the clinical advantages and the costs of the technologies, medications and interventions used in health care and personal social services. It issues recommendations concerning their adoption, use and coverage by the public plan, and develops guides to clinical practice in order to ensure their optimal use.” ⁶	Governed by a board of 11 members appointed by the provincial government.	The INESSS provides annual reports on their service delivery and management, including financial statements which have been reviewed by the président-directeur générale and directrice des services administratifs of the Secrétariat Générale of Quebec.
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Notes: While it is a centralized agency, the Institut national d'excellence en santé et en services sociaux (INESSS) does not provides clinical services, public health, or administrative functions as defined in this report.

¹ INSPQ. (n.d.). About Us. Retrieved from <https://www.inspq.qc.ca/en/institute/about-us>

² Government of Quebec. (n.d.). Legis Quebec. Retrieved from <http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/l-13.1.1>

³ Héma-Québec (n.d.). From Provider of Blood to Expert in Biological Products of Human Origin. Retrieved from <https://www.hema-quebec.qc.ca/hema-quebec/profil/historique-temps.en.html>

⁴ Government of Quebec. (2015). Plan de Transformation. Retrieved from https://www.cspq.gouv.qc.ca/fileadmin/Fichiers_client/Centre_documentaire/A_propos/PTO/PT-Plan_Theorique-vfW.pdf

⁵ Government of Quebec. (n.d.). Centre de Services Partagés du Québec. Retrieved from <http://www.cspq.gouv.qc.ca/>

⁶ INESSS. (n.d.). About the Institut. Retrieved from <https://www.inesss.qc.ca/en/about-us/about-the-institut.html>

New Brunswick

Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Réseau de Santé Horizon Health Network (Horizon) (2008)	"In order to ensure clinical care is delivered uniformly, effectively and efficiently the Government of New Brunswick has transitioned to two Regional Health Authorities (RHAs) from the previous eight RHAs." ¹ There was no justification given for province-wide services only being provided at one of the RHAs.	Province-wide programs: New Brunswick Heart Centre; NB Organ and Tissue Program; NB Perinatal Health Program; NB Stem Cell Transplantation Program; New Brunswick Trauma Program; Operational Stress Injury Clinic; Stan Cassidy Centre for Rehabilitation; Child and Adolescent Psychiatry Unit. ²	"Horizon Health Network's Board of Directors is comprised of 8 elected members and 7 members who are appointed by the Minister of Health. There are also 3 non-voting members: the President and Chief Executive Officer (who acts as Secretary), the Chairperson of the Regional Medical Advisory Committee and the Chairperson of the Regional Professional Advisory Committee." ³	Performance measures posted on their website (by service and/or service area), ⁴ audited financials provided by KPMG for the annual report. ⁵

Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Service New Brunswick (2016)	The 2014 provincial Liberal platform vowed to "eliminate duplication by centralizing functions that are common across all departments of government, including: communications, financial, human resources, information technology and policy development services and save \$30 million a year" ⁶	FacilicorpNB was responsible for clinical engineering and laundry services, ⁷ but Service New Brunswick also reports on providing energy management and "strategic procurement health and supply chain." ⁸	Service New Brunswick is a provincial crown corporation with clients outside the Ministry of Health so there is no formal relationship outside of the one with government in general.	Performance metrics and audited financials (from the Auditor General of New Brunswick) are included in the annual report. ⁸

Rapid Review No. 10

Notes: FacilicorpNB, a crown corporation providing shared services to health authorities and facilities was merged (along with other shared services) under the Service New Brunswick masthead as a result of the Common Services Review. The act was proclaimed October 1, 2015 but full transfer didn't occur until April 1, 2016.

¹ Government of New Brunswick, Canada. (2018, January 17). Regional Health Authorities. Retrieved from

https://www2.gnb.ca/content/gnb/en/services/services_renderer.9435.Regional_Health_Authorities.html

² Horizon Health Network. (n.d.). Provincial Programs. Retrieved from <http://en.horizonnb.ca/home/facilities-and-services/provincial-programs.aspx>

³ Horizon Health Network. (n.d.). Board. Retrieved from <http://en.horizonnb.ca/home/about-us/board.aspx>

⁴ Horizon Health Network. (n.d.). Performance Indicators. Retrieved from <http://en.horizonnb.ca/home/about-us/performance-indicators.aspx>

⁵ Horizon Health Network. (n.d.). 2017-2018 Annual Report. Retrieved from http://en.horizonnb.ca/media/950440/annualreport2017-18_web.pdf

⁶ Service New Brunswick. (n.d.). 2015-2016 Annual Report. Retrieved from <https://www2.snb.ca/content/dam/snb/publications/AR-15-16-E.pdf>

⁷ FacilicorpNB. (n.d.). INFOEvolution. Retrieved from http://facilicorpnb.ca/files/Info_Evolution_summer_2015.pdf

⁸ Service New Brunswick. (2017). 2016-2017 Annual Report. Retrieved from <https://www2.snb.ca/content/dam/snb/publications/AR-16-17-E.pdf>

Nova Scotia

Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Nova Scotia Health Authority (NSHA) (2015)	"This new provincial approach will better co-ordinate health resources and expertise in a way that helps us turn the tide toward better health." ¹	Clinical Services: Administering hospitals, health centres (except IWK), cancer care, long-term care, public health services (immunizations/vaccinations), mental health and addictions services, IT clinical applications. Non-Clinical Services: Human resources (including recruitment and retention), supply chain warehousing, procurement (under \$1 million). ²	The NSHA is governed by a board of directors, but there are 37 Community Health Boards (CHBs) that inform local planning and direction. ³	Financials audited by the Auditor General of Nova Scotia annually in the Annual Report. ⁴
IWK Health Centre (1996)	IWK began as a pediatric hospital in 1909 but in 1996 merged with the adjacent Grace Maternity Hospital.	Clinical services for children, women, and families. It also provides addictions and mental health treatments, as well as research and primary care services. ⁵	The IWK is governed by a board of directors and receives funding from the NS Ministry of Health.	Audited financial statements are done annually by Grant Thornton LLP. ⁶

Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Shared Services Initiative (2014) ⁷	"It is focused on identifying savings and more consistent delivery of services." ⁷	Although it provides shared services in the five key areas of finance and payroll, human resource services, supply chain services/procurement, information and communications technology services, and building infrastructure and asset management, only procurement over \$1	The Shared Services Initiative is part of the Internal Services Department of the Government of Nova Scotia.	None found.

		million and non-clinical IT are provided to the IWK/health authority. ²		
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¹ Government of Nova Scotia. (n.d.). Site Sections. Retrieved from <https://novascotia.ca/dhw/about/nova-scotia-health-authority.asp>

² Government of Nova Scotia. (2014). Shared Services Update. Retrieved from <https://novascotia.ca/is/programs-and-services/documents/SharedServices-ProjectUpdate-Dec11-2014.pdf>

³ Community Health boards. (n.d.). Find Your CHB. Retrieved from <https://www.communityhealthboards.ns.ca/find-your-chb/>

⁴ Nova Scotia Health Authority. (2018). Consolidated Financial Statements. Retrieved from <http://www.nshealth.ca/AnnualReport2017-18/FINAL> - NSHA Consolidated 2017-18 Financial Statements.pdf

⁵ IWK Health Centre. (2018). Service Directory. Retrieved from <http://www.iwk.nshealth.ca/services>

⁶ IWK Health Centre. (2018). Financial Statements. Retrieved from http://www.iwk.nshealth.ca/sites/default/files/public-accountability/2018_IWK_Financial_Statements.pdf

⁷ Government of Nova Scotia. (2014, October 20). Government of Nova Scotia. Retrieved from <https://novascotia.ca/is/programs-and-services/shared-services.asp>

Prince Edward Island

Clinical & Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Health PEI (2010)	Created to move closer towards realizing a 'One Island Health System' that provides Islanders with the right care, by the right provider, in the right place. ¹	<p>Clinical Services: Full range of clinical, public health, mental health and addictions, telehealth, home care, organ donation, palliative care, reproductive care, walk-in clinics and diagnostics.</p> <p>Non-Clinical Services: Strategic planning and evaluation; risk management; quality and safety; human resource management; financial planning and analysis; financial accounting and reporting; materials management; health information management.</p>	<p>"The Health PEI Board of Directors governs the agency, is accountable to the Minister of Health and Wellness and works collectively on behalf of all Islanders to ensure the management and delivery of safe, quality health care. The board also oversees the Chief Executive Officer."¹</p> <p>"Health PEI Board members represent various community perspectives and bring together a broad combination of skills, knowledge and experience necessary to govern our health system. The Minister of Health and Wellness appoints each board member for a three-year term."²</p>	<p>The board of directors' committee on Audit, Compliance and Monitoring, "monitors Health PEI's compliance with the Health Services Act in the areas of finance and audit, property, personnel, and strategic direction."²</p> <p>The board of directors' committee on public engagement's primary focus is on enhancing public awareness and understanding of health matters and ensuring confidence in the PEI health system.²</p> <p>Documents such as strategic plans, business plans and annual reports are all publicly available. Performance measures can be found in the business plans for different strategic priorities under goals.</p>

¹ Government of Prince Edward Island. (n.d.). Health PEI. Retrieved from <https://www.princeedwardisland.ca/en/topic/health-pe>

² Government of Prince Edward Island. (2018, September 28). Health PEI Board. Retrieved from <https://www.princeedwardisland.ca/en/information/health-pe/health-pe-board>

Newfoundland & Labrador

Non-Clinical Services

Org. Name (Established)	Rationale for Centralization	Province-Wide Services Provided	Governance Structure & Relationship with the Ministry of Health	Auditing & Evaluation
Newfoundland and Labrador Centre for Health Information (1996)	<p>Established following the recommendation of the Health System Information Task Force (1995).¹</p> <p>"... responsible for developing and implementing the province's confidential and secure electronic health record (EHR).</p> <p>"The Centre also works to improve the health of all Newfoundlanders and Labradorians by providing quality health information to health professionals, the public, researchers and health system decision-makers."²</p>	<p>"The Centre is creating a network of eHealth systems to securely connect and share health information with authorized care providers across the province."³</p> <ol style="list-style-type: none"> 1. HEALThe NL – provincial electronic health record 2. TELEHEALTH – videoconferencing technology 3. TELEPATHOLOGY 4. eDOCSNL – provincial electronic medical record program for physicians 	<p>"A statutory corporation created by the Centre for Health Information Act and governed by a Board of Directors appointed by the Lieutenant-Governor in Council and reporting to the Minister of Health and Community Services. It is managed by a Chief Executive Officer."^{1,2}</p>	<p>The Centre has business plans and annual reports that are publicly available.</p> <p>There is a section entitled "Report on Performance" that "focuses on progress on goals and objectives related to the three strategic issues identified in the 2014/2017 Business Plan, including the initiatives and activities undertaken in 2016/2017."⁴ It also lists goals, measures and indicators.</p>

Notes: Clinical Services are under the jurisdiction of the four regions, with oversight by the Department of Health and Community Services, such as through the use of Committees (e.g., a Provincial Cancer Control Advisory Committee). Newfoundland & Labrador also established the Health Research Ethics Authority in 2011⁵ as an arm's-length body to oversee and review all health research done in Newfoundland & Labrador. It was not included here as there did not appear to be any direct clinical or non-clinical services.)

¹ The Centre for Health Information. (2018). About the Centre for Health Information. Retrieved from <https://www.careerbeacon.com/corpprof/nlcentre/index.html>

² The Centre for Health Information. (n.d.). About Us. Retrieved from <https://www.nlchi.nl.ca/index.php/about-us>

³ The Centre for Health Information. (n.d.). eHealth Systems. Retrieved from <https://www.nlchi.nl.ca/index.php/ehealth-systems>

⁴ The Centre for Health Information. (2017). Annual Business Report 2016/2017. Retrieved from 2016/17 Annual Report - https://www.nlchi.nl.ca/images/FINAL_NLCHI_Annual_Report_Sept_26_2017.pdf

⁵ Health Research Ethics Authority. (n.d.). Health Research Ethics Authority. About. Retrieved from <https://www.hrea.ca/about/>

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