

If it Ain't Broke Don't Fix It: Bill-6 – *The Regional Health Authorities Amendment Act (Improved Fiscal Responsibility and Community Involvement)*

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I think that there is another direction, a better direction, and in this case the minister has chosen the wrong direction. -Dr. Jon Gerrard

I. WHAT IT IS, AND WHY IT WAS NEEDED

A. Introduction

In Friday, April 20 2012, approximately mid-way through the 2nd session of the 40th legislature of Manitoba, the NDP government tabled Bill-6. Its name, *The Regional Health Authorities Amendment Act (Improved Fiscal Responsibility and Community Involvement)*,² spoke loudly to the putative government objectives. Notably, many of the criticisms levelled against the legislation actually agreed in principle with financial transparency and sound stewardship of collective resources.³

The objectives of this Bill were generally purported to be the reduction of complexity through regional health authority (RHA)

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² Bill 6, *The Regional Health Authorities Amendment Act (Improved Fiscal Responsibility and Community Involvement)*, 1st Sess, 40th Leg, Manitoba, 2012 (assented to 9 November 2012), SM 2012 c 8, CCSM c R34 [RHA Amendment Act]. Will also be referred to as "Bill-6" and "the Act".

³ The healthcare system accounts for approximately 42% of the provincial budget. See Manitoba Health, *Achieving Health System Accountability 2009: Getting There Together*, (Winnipeg: Manitoba Publications, 2009) online: Manitoba Health <http://www.gov.mb.ca/health/rha/docs/ahsa_2009.pdf> at 2 [Achieving Accountability].

amalgamation; increased community involvement and ownership of health care service delivery; and increased accountability and fiscal transparency. These are admirable, *prima facie* unassailable goals, but vexing questions lie with their substance and implications.

Bill-6's amendments proved controversial, and were thoroughly excoriated for being out of touch with current agreements, unduly interfering, and bereft of proactive consultation. The Bill was lambasted both in committee and during debates as an exercise in power for the purpose of appearing to act, and a marked departure from the previous methods of health care administration in this province.

This paper will examine the Bill's development conditions and purported rationale, outline changes to the existing *Regional Health Authorities Act*,⁴ then consider the Bill's passage through the legislature and legacy. The Bill itself is fairly complex, necessitating glossing over some nuances in order to provide a comprehensive picture of the background, process, and a consideration of the policy implications. Interested readers can look to previous versions of the *RHA Act* as well as the legislature's informational services to further educate themselves. In addition to providing a legislative overview, this paper will advance the conclusion that, the criticisms of this piece of legislation were soundly warranted. Bill-6 represents a disappointingly broad attempt to increase transparency and accountability while increasing government control over private health care actors. There is a duality to this Bill which extends government control over healthcare in two directions; one public and the other private in a manner possibly neither warranted nor desired.

B. Development Conditions

The *Regional Health Authorities Act* was enacted on April 1, 1997 under the PC government of Gary Filmon, specifying governance and administrative procedures for 13 initial regional health authorities.⁵ Their

⁴ *Regional Health Authorities Act*, SM 1996 c 53, CCSM c R 34 [RHA Act].

⁵ Manitoba Health, *Report of the Manitoba Regional Health Authorities External Review Committee* (Winnipeg: RHA Review Committee, 2008) at 1, online: Manitoba Health <<http://www.gov.mb.ca/health/rha/docs/report0208.pdf>> [RHA Report]. The City of Winnipeg was initially split into two regions, and Marquette and South Westman RHA amalgamated in 2002 to form the now current Assiniboine RHA. Additionally, in 2012 after the enactment of Bill-6, 6 more RHAs were wound down and others renamed leaving the Northern, Prairie Mountain, Interlake-Eastern, Southern and

raison d'être was echoed by similar initiatives across the country, and included increased communication, improved efficiencies in health care delivery, and cost reduction.⁶

While an external audit conducted in 2008 concluded that "to varying degrees, the benefits...have been achieved",⁷ this could be viewed by some as charmingly optimistic.⁸ It is beyond the scope of this paper to properly consider the effectiveness and foibles of the regionalization system, but the theme of dubious merit shall re-emerge below.

Legislative changes are never enacted in vacuums, entirely bereft of rationality. They are a response to market conditions, an identification of and solution to a new problem, or updating existing legislation to avoid obsolescence. They take place within a cultural and historical legislative context; properly reviewed the reader can begin to appreciate the tapestry woven by disparate reports, complaints and government policies.

Without any claim to completeness, the conditions that gave rise to Bill-6 include several notable examples. Proponents of transparency did not have to look very far, as particularly in the municipal context, this past year had seen plain examples of corruptions and misuse of public funds,⁹ as well as controversial government actions to improve transparency.¹⁰ The concepts and their importance were nothing if not in the public consciousness.

Winnipeg RHAs.

⁶ RHA Report, *supra* note 5 at 1,10.

⁷ *Ibid* at 13.

⁸ Bryan Schwartz & Kyle B Lamothe, "Stifling Innovation in Health Care: The Regional Health Authority System and Restriction on Private Actors" 2010 34:3 Man LJ 95 at 96 [Stifling Innovation].

⁹ Igor Bonifacic, "Winnipeg's Sam Katz Joins List of Canadian Mayors Facing Legal Trouble", *The Toronto Standard* (11 December 2012) online: Toronto Standard <<http://www.torontostandard.com/the-sprawl/sam-katz-joins-ford-in-list-the-list-of-canadian-mayors-facing-legal-trouble>>.

¹⁰ Legislation proposed to increase the transparency for both unions and First Nations' have managed to get the federal government embroiled in controversy. See Lori Theresa Waller, "Bill C-377: Costs, constitutional concerns raised in opposition to legislation targeting unions", (29 November 2012) online: Rabble.ca <<http://rabble.ca/news/2012/11/costs-constitutional-concerns-create-rocky-path-ahead-union-disclosure-bill-government>> ;see also Gloria Galloway, "Chiefs deride native transparency act", *The Globe and Mail* (15 October 2012) online: The Globe and Mail <<http://www.theglobeandmail.com/news/politics/chiefs-deride-native-transparency-act/article4614583/>>.

The next thread of Bill-6 finds a reader considering the Throne Speech and the opening of the first session of the Fortieth Legislature of the province of Manitoba. Lieutenant Governor Phillip S Lee noted the government's objectives would focus on the "key priorities that were presented to Manitobans during the election" including "making healthcare even better".¹¹ Notably absent, however, was an explicit reference of an imminent desire to lessen the number of RHAs. An oblique reference to efficiency improvements creating conditions favourable to amalgamation foreshadowed this desire and echoed language present in the recommendations of a 2008 RHA Report.¹²

These goals of improving health care were to be achieved by acting on several fronts, including improving wait times and cancer treatment, expanding and improving facilities including the acquisition of capital equipment, and hiring 2000 new nurses, 200 doctors, 50 physician's assistants and 22 residency positions.¹³ These improvements to a system proclaimed as "world class" were heralded as making the "system more efficient and effective", with the improvements saving "close to 1,000 patient trips to and from Winnipeg every year".¹⁴

The budget speech on April 17, 2012 spoke of reducing the number of regional health authorities to streamline services. Finance Minister Stan Struthers claimed that "Manitoba has gone from the second-highest hospital administrative costs in the country to the second-lowest".¹⁵ The stage was certainly set for some change in the administration of health care in Manitoba.

¹¹ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol LXIV No 1b (20 October 2011) at 5 (Hon Philip S Lee) [Throne Speech].

¹² RHA External Report, *supra* note 5 at 38.

¹³ Throne Speech, *supra* note 11.

¹⁴ *Ibid.* Interestingly, criticisms from political opposition regarding this bill suggested that these efficiencies, even if attained, would be countered by increased travel costs for larger amalgamated RHAs.

¹⁵ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol 16 (17 April 2012) at 320 (Hon Stan Struthers) [Budget 2012]. The quote above is from the text of the speech at 2, reproduced online with additional material at <<http://www.gov.mb.ca/finance/budget12/speech12.pdf>>.

C. The 2008 External RHA Report

Five years before these recent events, the Ministers of Health and Healthy Living commissioned an external committee to assess the RHA system and recommend areas of improvement. This report was released in February of 2008, a 139 page document which made several recommendations, and concluded the 1997 RHAs establishment had provided "...Manitobans with benefits that probably would not otherwise have materialized."¹⁶

The report made 35 recommendations and conclusions, including the following:

1. Regionalization had generally provided for and achieved the intended benefits to Manitobans.
2. Regionalization's effectiveness would be improved if MB Health were to delegate more authority and accountability to the RHAs, and set specific RHA outcomes.
3. RHA governance would improve with better methods of board appointment, equitable compensation levels and enhanced accountability.
4. The actual effective level of community involvement varies between regions, though RHAs are not held accountable for ongoing input.
5. Comparisons with regionalization models in other provinces and regions is problematic due to the nature of reporting and the data.¹⁷

Interestingly, it did not recommend amalgamation, instead observing that stability of RHA boundaries was important to improve community involvement. Yet, the report did acknowledged that amalgamation was something that might yet emerge through evolution of the RHA model.¹⁸ The report is an interesting addition to the story of Bill-6, given the opposition's strident claims consultation was sorely lacking, and that these changes essentially sprang fully-formed from the ether. Its very existence may have served to provide notice that official attention had been directed towards RHA reform in some fashion within the province.¹⁹ On the other

¹⁶ RHA External Report, *supra* note 5 at v.

¹⁷ *Ibid* at vi-viii.

¹⁸ *Ibid* at 26.

¹⁹ The Canadian Taxpayers Federation, certainly not an uncritical observer, had

hand, some critics point out that the composition of the three person committee and the identity of the respondents conspire to make a mockery of the external moniker.²⁰ Despite these criticisms, the report was relied upon by the government in the creation and shaping of this Bill in some instances. In others, plain recommendations seemed to be completely ignored.

D. Criticisms

The bill saw blowback from two fronts: from the Official Opposition as well as the Liberal Party, and from stakeholders who saw the legislation as partially problematic with amendments running counter to established contracts and Memorandums of Understanding (MOUs). It is difficult to conclusively determine the effects of some amendments before they come into force, or regulations are promulgated. For example, it is too early to determine if the amalgamation provisions have effected their purported positive changes, fiscal or otherwise. Notwithstanding these provisos, many of the criticisms leveled against the bill still stand compelling.

While addressing the entirety of the changes to the *RHA Act* is beyond the scope of this paper, focus is placed upon three elements that have elicited the greatest debate: (i) the amalgamation of RHA's; (ii) Control of CEOs and leaders of health corporations; and (iii) regulation making powers regarding control over surplus monies, including those derived from ancillary services.

E. Changes to the Legislation - The Amendments

In response to the external report and the conditions outlined above, the NDP government tabled a bill that made several changes to the existing *Act*, innocuous and sweeping alike. Changes important for the

welcomed a similar indicator in a 2007 Throne Speech that the government would reconsider RHAs noting it was a "welcome departure" from an "unapologetic defence of the regionalization model", Adrienne Batra, "Reviewing the Review" (11 January 2007) online: taxpayer.com <<http://www.taxpayer.com /commentaries/reviewing-the-review>>. They proffered 5 suggestions for improving health care, including p3's and private services.

²⁰ Stifling Innovation, *supra* note 8 at 100-1. If many, or most of the respondents were internal to the RHA bureaucracy, then the report's conclusions and recommendations would be made without extensive representation by communities and private health corporations. If the committee was not as non-partisan as it was purported to be, then the credibility of the conclusions may be cause for question.

paper's analysis are noted below, before an examining Bill-6's passage through the legislature and consideration of substance and process.

The *RHA Amendment Act* provided for changes can be grouped broadly into two categories: (1) fiscal transparency and improvement (including accountability); and (2) community involvement.

1. Fiscal Transparency and Improvement:

(i) The government is given authority to amalgamate regional health authorities (RHAs) whether or not it has received a request to amalgamate from the affected authorities. Sections 51(1) - (4) are repealed, and 51(5) is amended to remove "that have submitted a proposal under subsection (1)." This change allowed the government to act upon their budgetary promise and reduce the number of RHAs from 11 to the current 5.²¹

(ii) The government may set a policy to standardize the employment contracts for senior managers of RHAs. The policy can deal with all aspects of such contracts, including compensation. In addition, RHAs may set a compensation policy for senior managers of health facilities within their region. Contract provisions that do not comply with a such policy are void.²²

(iii) Restrictions are placed on the re-hiring of former senior managers by RHAs and health facilities.²³

(iv) RHAs may give directions to health facilities within their region about the process they use to hire senior managers.²⁴

(v) New regulation-making powers allow the government to establish rules respecting the way in which RHAs and health facilities use budgetary

²¹ Bill-6 amends s 51(5)(a)&(b) to remove reference to subsection (1) and repeals subsections 51(1)-(4) which concern proposals submitted by RHAs to the province requesting amalgamation. The effect is to take away the voluntary nature and place the discretionary, and final, authority in the hands of the Health Minister. On June 1, 2012, the 11 RHAs were amalgamated into five larger regions pursuant to this power. The Bill also repealed former subsection 8(1.), which previously allowed for 2 RHAs in the city of Winnipeg].

²² Division 5.1, including ss 51.1-51.3. This entire division of the Act is new and includes many of the controversial provisions relating to contracts. Notably, it stands outside the protections afforded under s 29 of the Act.

²³ S 51.4(1). See section III(B)(1)(b), *infra* for a consideration of the impact of this provision in light of recent government actions.

²⁴ S 29.1(2)(a).

surpluses and revenue they receive from providing ancillary services, such as parking.²⁵

(vi) In provisions of the current Act not yet in effect, RHAs are required to post the expenses of their chief executive officer. This Bill extends that requirement to the heads of health facilities.²⁶

2. Community Involvement:

(vii) RHAs must have local health involvement groups, which replace the existing advisory councils. Such groups will advise RHAs about health issues in the region.²⁷

This list is not exhaustive, but covers provisions sown in the most fertile ground for controversy and debate. The amendments will be considered and analyzed below and their apparent impact discussed at length in comparison to previous government activity, comparators, and policy grounds. The nature of the controversy is also illuminatingly framed by the passage of the bill through the legislature itself.

II. PASSAGE OF BILL-6 THROUGH THE LEGISLATURE²⁸

The bill, considered a significant change in the delivery of health care in Manitoba spent eight weeks (from its 1st reading on April 20 until its 3rd reading June 14, 2012) in the legislature, in process that at times was tense and combative.

This bill faced substantial opposition from both political opposition and from the public themselves at second reading, committee stage, and third reading. Opposition parties took shots not at the objectives but the expected outcomes of the bill, including projected pecuniary savings. Additionally, they repeated stakeholder concerns about sparse

²⁵ S 59 (k.1-2). k.1 deals with surplus funds under the control of an RHA, k.2 empowers the cabinet to craft regulations affecting other health corporations as well.

²⁶ S 38.1(1)-38.1(4).

²⁷ S 1 (definitions), S 32 of the Act.

²⁸ The rationale for the extensive treatment of the legislative process is manifold: I believe it is beneficial to provide a summary of events for pedagogical as well as rhetorical reasons. Both supporters and detractors of the bill can be seen to speak through their words and actions in the pages of the Hansard. As well, I did not wish to present some of the analytical opposition as purely my own when identical concerns had been voiced by both opposition party members and stakeholders.

consultation and unneeded expansion of government power in the face of previous contrary agreements, and without evidentiary backing.

A. 1st Reading

On Friday, April 20 2012, the Minister of Health, the Honourable Theresa Oswald moved the first reading of Bill-6, seconded by Minister for Conservation and Water Stewardship, Mr. Gord Mackintosh.²⁹ As debate is not permitted at this stage, the minister presented a brief statement; she explained the Bill would support the RHA mergers announced as part of the 2012 budget, reducing them from 11 to 5 and allowing "administrative savings redirected into supporting front-line care."³⁰ Additionally, she claimed the legislation would make the "RHA's more responsive to the patients and local communities they serve" and noted the legislation included several fiscal transparency and accountability provisions.³¹

B. 2nd Reading

The crisp afternoon of Monday, May 28 saw the advent of some heated debate concerning Bill-6 upon its second reading. Minister Oswald further expounded the Bill's virtues before moving that it be referred to a committee of the house.³² In it, she highlighted the multi-faceted approach of the Bill: the reduction of RHA numbers, improved financial responsibility, and engagement of local communities in health care delivery.³³

She claimed the Bill would require RHAs to consult with residents of their health regions, thus "informing the planning and delivery of health services".³⁴ The creation of local health involvement groups was highlighted, although no explanation of their differentiation from previous health advisory councils was proffered.

²⁹ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1stSess, Vol 19 (20 April 2012) at 407 (Hon Theresa Oswald) [1st Reading].

³⁰ *Ibid*; Budget 2012, *supra* note 15 at 2.

³¹ 1st Reading, *supra* note 29 at 407.

³² Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1stSess, Vol LXIV No 40 (28 May 2012) at 1800 (Hon Theresa Oswald) [2nd Reading].

³³ *Ibid*.

³⁴ *Ibid*.

Oswald then focused on the fiscal responsibility portions of the bill, including controls on executive compensation structures and oversight in RHAs, hospitals and health corporations, concluding with this:

We believe Bill-6 will support our efforts to streamline administration, redirect resources to support front-line care, improve financial responsibility and avoid the financial issues we've seen in other jurisdictions, and give patients and families and local communities an even stronger voice in the delivery of health care.³⁵

Subsequently, the Honourable Jon Gerrard for the Liberal party rose to speak. His would be the first in a series of strident voices attacking many aspects of the Bill. Gerrard articulated the Liberal Party's clear intention to vote against the passage of the amendments to the RHA Act for a number of reasons.³⁶

He claimed the savings were illusory and the bill was the product of a government only appearing to act.³⁷ There was no evidence, he opined, that this bill would improve fiscal responsibility, community involvement, or the delivery of services to patients.³⁸ The 2002 amalgamation of South Westman and Marquette RHA, provided a concrete example of cost increases rather than savings. This was a line of questioning that would be picked up and carried by the Official Opposition at length.³⁹

Additionally, Gerrard focused on the concern that increased geographical boundaries would result in both increased travel expenses, and people ending up in personal care homes "PCHs" further away from previous residences and relations.⁴⁰

On issue of community involvement and responsiveness, he suggested that increased size, centralization of services, and reduction of autonomy would increase a sense of isolation rather than reduce it.⁴¹ Gerrard

³⁵ *Ibid.*

³⁶ 2nd Reading, *supra* note 32 at 1800 (Hon Jon Gerrard).

³⁷ *Ibid* at 1801.

³⁸ *Ibid* at 1804.

³⁹ *Ibid* at 1801; This criticism was reiterated by PC Member Myrna Driedger, where she compared the \$10 million savings claim to the identical savings projection prior to the amalgamation of a school board. Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol 41a (29 May 2012) at 1841.

⁴⁰ 2nd Reading, *supra* note 32 at 1801.

⁴¹ *Ibid* at 1801.

criticized the change from advisory councils to local health involvement groups as meaningless exercise with no credible reason to suggest community involvement would improve. On the change he asked: "Isn't that what the advisory councils were supposed to be doing?"⁴²

Closing, Gerrard claimed that amalgamating also will divert resources from the task at hand, which is to delivery health care, as perversely provide incentives to avoid transparency and accountability.⁴³

C. Further Debate: The Saga Continues...

Resuming on June 6, 2012, the debate on second reading of the Bill-6 began in earnest. Four MLAs from the Official Opposition rose to speak to the Bill, with two commencing their criticism in question period. They expressed disbelief in the efficacy of Bill-6 and decried a lack of consultation prior to its introduction.

Wayne Ewasko (Lac Du Bonnet), and Myrna Driedger (Charleswood) sallied forth on questions WRHA's administrative costs,⁴⁴ the potential closure of the Pinawa Hospital, a dearth of meaningful consultation, and the anxiety surrounding the RHA amalgamation announcement.⁴⁵ These brief, yet tense exchanges including a government response were in large part to foreshadow the tenor of the debate to shortly follow, with two other MLAs additionally criticizing the proposed amendments.⁴⁶

Generally speaking, the opposition centred around three categories (i) no cost savings will be seen by amalgamation; (ii) there was no consultation regarding the changes to the RHA Act by Bill-6; and (iii) the legislation will have the effect of decreasing transparency and responsiveness by extending the control and power of the government.

⁴² *Ibid* at 1802.

⁴³ *Ibid.*

⁴⁴ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol LXIV No 46 (6 June 2012) at 2173-2174 [Debate on 2nd Reading].

⁴⁵ *Ibid* at 2176.

⁴⁶ These exchanges included Driedger accusing Oswald of "more than enough spin" and failing "Manitoba patients on a daily basis" at 2174 and Oswald acknowledging that "the member opposite doesn't let the facts get in the way of a good question." The Minister of Health further claimed the WRHA corporate costs were holding at 2.99%, that they had been given the task this year of finding \$14 million in admin and corporate savings, and CIHI stats showed Manitoba trending downwards on administrative costs in opposition to the rest of the country at 2174.

Myna Driedger (Charleswood), expressing Official Opposition support for the Bill's intent, stated while they had been "...great champions of asking for greater accountability and transparency within the health-care system," they lacked confidence the government would deliver on its promises or achieve its objectives.⁴⁷ She argued that costs had "skyrocketed" in a process that was put together with "absolutely no consultation with the public"; it was a policy that was crafted "on a napkin".⁴⁸

Support for Bill-6's intent was to be reiterated later by MLA Wayne Ewasko, who highlighted purportedly increased, scandal-reducing oversight resulting from publication of CEO compensation levels and regulation of surplus funds from ancillary fees.⁴⁹

Driedger criticized the government for the lack of financial oversight over RHAs, pointing to the misuse of public funds in the Burntwood and NOR-MAN RHAs.⁵⁰ At the same time, she noted CEOs with employment control placed in the government's hands may work to silence any criticism they may harbour concerning policies or direction of the government.⁵¹ Driedger finished by asserting the legislation was "watering down" health advisory councils and replacing them with local health involvement groups, although the import of this statement is difficult to discern.⁵²

Mr. Reg Helwer (Brandon West) questioned whether the RHA mergers would reduce wait times, and advanced a common concern with the larger health regions: the possibility that seniors may find themselves

⁴⁷ Debate on 2nd Reading, *supra* note 44 at 2179 (Myrna Driedger). To buttress her assertions, she noted WRHA Admin costs rose from \$6 to \$105 Million from 1999-2012 after merging 2 Winnipeg RHAs. MLA Wayne Ewasko later observed RHA admin costs as a whole had risen 842% since 1999 at 2187. This figure was probably selected for its impact, and would include increases attributable to increased complexity of service delivery, aging populations, and other factors. The true percentage attributable to negative ramifications correlated with amalgamation is unknown.

⁴⁸ *Ibid* at 2180 (Myrna Driedger).

⁴⁹ *Ibid* at 2187.

⁵⁰ *Ibid* at 2181.

⁵¹ *Ibid* at 2183. See also Stifling Innovation, *supra* note 8 at 98-99. RHA ties to government could lead to increasingly constrictive attempts to control criticism especially if aimed at the hand that feeds.

⁵² Debate on 2nd Reading, *supra* note 44 at 2184 (Myrna Driedger).

in a personal care home far away from their loved ones whilst remaining within the regions technical boundaries.⁵³

Wayne Ewasko (Lac du Bonnet) advanced the argument that Bill-6 would create opacity, not transparency. RHA CEOs' diminished autonomy would effectively silence them in the face of the power conveyed to the deputy.⁵⁴ This concern was picked up in a modified form by Mr. Cliff Cullen (Spruce Woods) when he suggested that increased centralization and control would inhibit the ability of service providers to make local decisions.⁵⁵ While recapitulating concerns about timing and consultation, Mr. Cullen adopting an earlier pejorative and skewered the Bill as "developed on a napkin"⁵⁶ when it purported to alter delivery of a service that consumes close to 45% of the provincial budget without meaningful consultation.⁵⁷

D. Committee Stage – Human Resources Committee

On June 11, 2012, the Standing Committee on Human Resources met, with seven bills on the agenda. The 11 members of the committee devoted more than an hour to considering presentations on the bill and the resulting clause by clause vote, which passed the amending legislation in its entirety.⁵⁸

The committee stage presents interested stakeholders the opportunity to engage in the democratic process by expressing concern and suggesting changes to impending legislation.⁵⁹ Four stakeholder groups prepared presentations, including a private health corporation, Personal Care Homes (PCHs) and faith-based healthcare services. Finally, the Association of Manitoba Municipalities forwarded a written submission. The community presenters intervening at this stage counseled removing

⁵³ *Ibid* at 2185-2186 (Reg Helwer).

⁵⁴ *Ibid* at 2186.

⁵⁵ *Ibid* at 2190.

⁵⁶ *Ibid* at 2189 (Cliff Cullen).

⁵⁷ *Ibid*.

⁵⁸ Manitoba Legislative Assembly, *Standing Committee on Human Resources*, vol LXIV No 3 (11 June 2012) at 129 [Committee]. The committee was composed of 4 PC and 7 NDP MLAs, making the conclusion in many respects foregone.

⁵⁹ "Fact Sheet No 5: How Standing Committees Operate" online: The Legislative Assembly of Manitoba <<http://www.gov.mb.ca/legislature/committees/>>.

provisions of Bill-6 respecting compensation and direction of executives and surplus funds of health care corporations. Bill-6 was cast as dangerously vague, contravening duly negotiated agreements, and unnecessarily interfering with private organizations.

Mr. John Friesen from the Eden Mental Health Centre, indicated that both the appointment of CEOs and the control over use of surplus funds specifically concerned him.⁶⁰ Nonetheless, he described a silver lining in the increased geographical boundaries of the amalgamated RHAs: the quality of care delivered would likely improve in the face of reduced red tape between RHAs and the attendant logistical improvements.⁶¹

However, describing their working relationship in positive terms, he stated that the feeling would be that "the proposed legislation would be unnecessary to solve problems" and concluded by suggesting that "if it ain't broke, don't fix it".⁶²

Mr. Gerald Pronyk, from the Manitoba Association of Residential and Community Care Homes for the Elderly (MARCHE), communicated their severe reservations over provisions of the bill that would

...unilaterally enhance bureaucratic control in several areas that our members believe are crucial to the autonomy of private organizations and their ultimate ability to carry out their mission, including resident care.⁶³

Mr. Pronyk stated that it was unfortunate that the government appeared to view the private health corporations as an extension of government.⁶⁴ MARCHE took umbrage with provisions that would control both executives of their members and usage of surplus funds. In a lengthy oral submission, he pilloried Bill-6, whose lack of consultation left them "blindsided"⁶⁵, and contravened both service purchase agreements (SPAs) for personal care homes (PCHs) as well as the faith based agreement of 1999.⁶⁶ He observed Bill-6's failure to define ancillary

⁶⁰ Committee, *supra* note 58 at 78-79.

⁶¹ *Ibid* at 79-80.

⁶² *Ibid* at 79. Mr. Friesen noted the close and harmonious working relationship his health corporation had with the RHA, including during the appointment of staff.

⁶³ *Ibid* at 80.

⁶⁴ *Ibid*.

⁶⁵ *Ibid* at 83.

⁶⁶ *Ibid* at 80. Mr. Pronyk outlined several articles of the SPA that whose language was in sharp contrast to the rights established in Bill-6.

services might be used to extend the control over surpluses to fundraising arms of the PCHs. He questioned why surplus funds derived from efficiencies should be placed into the hands of the RHAs, noting this could create disincentives for efficient operations.⁶⁷

MARCHE took no issue with the government's attempts to streamline its own operations, and concluded with the following statement:

There's been no demonstration whatever that this unprecedented and unprincipled attack on private autonomy is justified by any practical need. The government already has many tools to address any particular problems that may arise. We are aware of no incidents which could not be addressed within the existing array of government authority where a private corporation declined to co-operate with government in addressing real problems.⁶⁸

Ms. Julie Turenne-Maynard, of the Interfaith Health Care Association of Manitoba (IHCAM), affirmed this, asserting the offending provisions should be excised. Characterizing Bill-6 as "tantamount to a breach of trust", she stated that "[t]he bureaucratic supervision of the employment contracts is an unprecedented intrusion into the internal management of private health health-care corporations."⁶⁹ Management of the employment contracts would not be subject to the controls in section 29 of the *RHA Act*, she claimed, including consultation requirements and arbitration dispute resolution mechanisms.⁷⁰

Finally Mr. Daniel Lussier, from the Catholic Health Association of Manitoba (CHAM) presented to the committee the association's concerns over portions of the bill allowing for the selection and compensation of leaders. He interpreted those portions to allow a government to claw back unused surpluses at the end of the year.⁷¹

Concluding incidents of mismanagement and corruption were not endemic; he urged a targeted response that is appropriate to the level of change required:

surely the best approach is one that is finely focused on whatever change is needed to address a particular problem, not to create sweeping new powers for

⁶⁷ *Ibid* at 81.

⁶⁸ *Ibid* at 82.

⁶⁹ *Ibid* at 84.

⁷⁰ *Ibid* at 85. For more discussion, see analysis section III(B)(1)(b), *infra*.

⁷¹ *Ibid* at 87.

bureaucracy that expends—at the expense of fundamental principles of long-standing agreements.⁷²

The Association of Manitoba Municipalities' written submission expressed their concern that "the larger RHAs would be less responsive local needs."⁷³ They stressed the need for appropriate geographic representation to counteract the isolationist effect, proposing that RHA boards be comprised of participants elected under a ward system.⁷⁴ The association did, however, support the controversial provisions regarding surpluses and revenues derived from ancillary services, as well the replacement of advisory councils.⁷⁵

E. Amendments at the Report Stage

On June 14, 2012, Bill-6 was considered by the House in its un-amended form. It was to see opposition again with regard to the proposed amendment and at the concurrence and 3rd reading stage.

With respect to this bill, a single amendment was proposed by the Minister of Health, Theresa Oswald. In it, Clause 16(2) was altered to include several other sections in a list of provisions to come into force on a date fixed by proclamation.⁷⁶

In respect of the previous iteration, the former section 16(2) did not have sections 8, and parts of sections 12 and 13 in the list of sections to come into force on a date fixed by proclamation. This had the effect of delaying (potentially indefinitely) the effective operation of controversial clauses concerning health advisory groups, contract control provisions, and regulation-making powers over surplus funds of private health care corporations. Despite adamant requests, no substantive amendments were proposed or accepted; the net effect was to delay the application of the controversial provisions, but keep their character unaltered.

⁷² *Ibid* at 89.

⁷³ *Ibid* at 133. The AMM submission was the single written submission on Bill-6.

⁷⁴ *Ibid* at 134.

⁷⁵ *Ibid*.

⁷⁶ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol 51b (14 June 2012) at 2501 [Report Amendments].

F. Third Reading

Bill-6 was given its third reading later that evening, facing its final legislative opposition as Mr. Jon Gerrard again protested its passing. The changes would not save money, they would alienate those already isolated, and decrease community involvement. There was no evidence that the Bill was required, or that it would improve the quality of care in the province. These were the charges leveled against the *Regional Health Authorities Amendment Act*, and yet moments later, the question was called and the motion was carried.⁷⁷

Bill-6 was given Royal Assent on November 9, 2012, with several provisions including those permitting amalgamation of RHAs, thus becoming part of the law of Manitoba. Cabinet's new regulation-making powers regarding surplus funds additionally became law, though at the time of writing those powers have not yet been extended to health corporations.

III. ANALYSIS

A. Public Reaction and Media Coverage

Reaction to Bill-6 was a muted affair initially. A day after the legislation was tabled in the House, the Winnipeg Free Press ran a story providing a quick overview of some of the proposed changes, and nothing more was forthcoming until a month after the Human Resources Committee had met.⁷⁸

Following this, representatives from CHAM and MARCHE approached the media to further protest what they viewed as legislation that would negatively affect the delivery of health care in the province of Manitoba, with little resulting furor.⁷⁹ Despite indicating that this

⁷⁷ *Ibid* at 2518.

⁷⁸ Larry Kusch "Law will make health execs' expenses public", *Winnipeg Free Press* (21 April 2012) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/local/law-will-make-health-execs-expenses-public-148365845.html>>. Online comments were generally positively focused on the objectives of Bill-6, especially on salary caps and financial accountability. What appears to be action to reign in what appears to be highly inflated compensation levels wouldn't be likely culprits for popular uprisings.

⁷⁹ Larry Kusch "Changes alarm health centres", *Winnipeg Free Press* (18 July 2012) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/local/changes-alarm-health-centres-162833836.html>>. Though anecdotal and not a proper sample size, the mere

legislation would potentially impact some of the larger health centres in the city of Winnipeg, including St. Boniface Hospital and the Misericordia Health Centre, little controversy ensued.

B. Analysis of the Bill Itself

This bill raises sweeping questions about the nature of government intervention, innovation, and regionalization in health care delivery. Within its facially singular structure, Bill-6 extends government control over public sector and private sector health care services. Manitoba Health extends control over RHAs, who in turn extend control over their facilities in both sectors. Inasmuch as they yield similar policy or practical concerns, private and public sector will be examined together. But, as will be seen, there are further objections particular to the private sector on top of those relating to the public. Despite these controversial elements, the compelling rationale behind some provisions of this new version of the *RHA Act* is plainly apparent. Indeed, on one view, the legislation was subject to vigorous scrutiny and the exercise of the democratic process, and should be lauded when judged by the robust and impassioned debate. On another view, however, this legislation is one that ought not to have been enacted so swiftly or in such an indiscriminate manner. Bill-6 has been characterized quite plausibly by opponents as a bill whose central defining feature is the expansion of government control. Three areas stand out as particularly controversial or troubling: (a) the amalgamation of RHAs; (b) Control of CEOs and leaders of health corporations (including regulation making powers regarding control over surplus monies); and (c) expansion of community involvement.

The legislative methods, purportedly to increase accountability measures, have amalgamated more than regional health authorities, in a manner many claim will be to the detriment of health care delivery in this province. Authority previously dispersed is now concentrated in fewer hands: in this case, the RHAs or the Health Minister.

1. Amalgamation

Though the *RHA Amendment Act* also repealed section 8(1.1) of the *RHA Act* allowing for two RHAs in the city of Winnipeg, it was the

21 comments posted online pales rather instructively in comparison to the dozens posted on most stories regarding local sports, including the Winnipeg Jets.

change to section 51(1-5) that is the lodestone for critics. Subsequent to the coming into force of these amendments, a voluntary amalgamation was undertaken, without using the power to force the RHAs to combine.⁸⁰ Given the government's purported plan of action and the newfound power invested in them, the voluntary outcome is not especially surprising.

There are perhaps two major questions confronting this part of the legislation. Firstly, will it save money? Secondly, is increased centralization a good thing? Empowering the government to force amalgamations in light of opposition could be considered a questionable, but arguably necessary step to maximize efficient use of collective resources.

The short answer to the first question is that it is neither simple nor clear. Fully addressing the issue of cost savings is well beyond the scope of this paper, given the analysis' complexity and required information. Regional differences in service delivery, analysis complexity, lack of data, and elimination of non-regionalization causal factors conspire to obfuscate a clear picture.⁸¹

However, some comments are warranted. As noted, RHA amalgamation should create gains in the form of standardized procedures and reduced red tape.⁸² This should theoretically improve service delivery and correspondingly reduce administrative costs.

Pointing to CIHI statistics, Finance Minister Stan Struthers noted that Manitoba has gone from the second highest to second lowest level of hospital administrative expenditures in the country.⁸³ Although the CPWC (cost per weighted case) indicators have actually increased from 2007-2009, administrative costs were lower than the national average and have decreased as a percentage of total costs, from 5.6% in 2005 to 4.4% in 2009.⁸⁴ Political opponents point out, however, that overall costs have

⁸⁰ Manitoba, Legislative Assembly, *Debates and Proceedings*, 40th Leg, 1st Sess, Vol LXIV No 21 (24 April 2012) at 485 (Hon Theresa Oswald).

⁸¹ RHA Report, *supra* note 4 at 12. Nonetheless, Minister Oswald noted that the \$10 million in projected savings was to be acquired over three years, by cutting between 30 and 40 *executive* positions, Committee, *supra* note 58 at 126.

⁸² Committee, *supra* note 58 at 79-80 (John Friesen).

⁸³ Budget 2012, *supra* note 15 at 2.

⁸⁴ Canadian Institute for Health Information, "Canadian Hospital Reporting Project" *Canadian Institute for Health Information*, online: CIHI <<http://www.cihi.ca/CIHI-external/internet/EN/TabbedContent/health+system+performance/indicators/performance/cihi010657>> at Financial Indicator Trending [CIHI

increased as well as individual patient treatment costs, and previous school board and RHA amalgamations had not seen cost decreases.

Two points have to be made about these figures. One issue with them and conclusions that follow was ably noted by the Official Opposition: while the ratio of administrative to overall spending may have decreased, the total expenditures have soared.⁸⁵ The complex causality of this belays adequate treatment here; yet, while some of this can be explained by aging populations, and inflationary increases for services, wages, and transportation, the increase remains significant.

In Alberta, administrative expenditures as a proportion of total spending decreased subsequent to moving to a single region health authority, although absolute costs have increased. In 2010-2011 they sat at \$354 million, an \$83 million increase from 2006-2007 when the province had multiple health regions.⁸⁶ This increase is partially comprised of one-time costs, including severance payouts, and affected by inflation, but there is a much greater issue with using administrative costs as a success indicator: the data is inherently suspect.⁸⁷

Online].

⁸⁵ Committee, *supra* note 58 at 2187. The term cost-per-weighted case refers to a financial indicator used to track the treatment cost for a standard hospital patient. The cost is "a relative, average cost calculated by summing the weights assigned to all cases treated by a hospital, and dividing this number into the hospital's total inpatient expenditure", Manitoba Centre for Health Policy "Glossary, Term: Cost Per Weighted Case (CPWC or CWC)" online: University of Manitoba <<http://mchp-appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=102491>>.

⁸⁶ Jodie Sinnema, "Alberta's health superboard hasn't reduced administration costs - yet," *Edmonton Journal* (20 January 2011), online: *Edmonton Journal* <<http://www.edmontonjournal.com/health/Alberta+health+superboard+hasn+reduced+administration+costs/4140924/story.html>>; CIHI Alberta indicators - from 2007-2009 expenditures have similarly decreased, as they have for all provinces.

⁸⁷ Further speaking to use of statistics in assessing changes to the highly politicized health care sector in a general sense, provincial decisions to focus on 5 priority areas for wait-time reductions have led to improvements focused on those key areas at the expense of others not identified as a priority. This has led to a distorted picture of the entire edifice as noted by Chris Simpson, chairman of the Wait Time Alliance: "The focus on the big five priority areas made for some very nice report cards for governments, but while we were making progress in those areas, everything else got left behind", *Healthy Debate Weekly*, "Waiting and waiting for surgery: Wait-time strategies had some success, but led to distortions in priorities," *Winnipeg Free Press* (8 July 2013) online: *Winnipeg Free Press* <<http://www.winnipegfreepress.com/opinion/analysis/waiting-and-waiting-for->

The Review Committee has concerns about the comparability of this particular indicator across regions throughout Canada. CIHI does not conduct comprehensive audits of the appropriate coding of expenditures to MIS accounts for measuring administrative costs. Public scrutiny is causing regions across Canada to make this percentage appear to be as small as possible.⁸⁸

Using administrative costs to assess system efficiency may not be helpful because the comparative value is uncertain. If simple accounting gymnastics can result in lower public costs, a comparison's worth is immediately devalued. The metric is not completely worthless, but for purposes of concluding the Health Minister made the appropriate decision, it is deeply flawed. Statistics available from the Canadian Institute of Health Information actually show these costs diminishing between 2007-2009 in provinces with single and multi-region health authorities.⁸⁹ Taking into account the number of variables contributing to these figures, diminishing figures for both models at least presents the possibility that amalgamation was not responsible for the reduction. Arguably, a comment from the external report suggests that better tracking and setting performance targets will serve the cause of cost reduction better than simply amalgamating. The lack of developed targets for "efficiency, costs and outcomes" is one of the "critical issues that needs to be addressed."⁹⁰

The RHA External report consistently recommended creating or clarifying targets and evaluating performance indicators. Better understanding amalgamation's efficacy would inform the answer concerning its desirability as well as improve its effectiveness. Though cost reduction may have been the chief motivating factor for the process, the methodology raises the spectre of the apparent aggressive expansion of government control over health care delivery, flying in the face of existing agreements and contrary recommendations. Central control does not lead automatically to transparency nor to accountability, let alone cost savings. In regard to each objective of Bill-6, creating targets, tracking outcomes,

surgery-214571081.html>. This article additionally notes the historical global budget funded model of Canadian Hospitals, arguably taking an opposing position to any argument for decentralization or devolution of decision making powers.

⁸⁸ RHA Report, *supra* note 5 at 43-44.

⁸⁹ CIHI Online, *supra* note 84.

⁹⁰ RHA Report, *supra* note 5 at 14.

and adjusting procedures or processes seem far more likely to be successful.

Indeed, the RHA External report actually recommended stable boundaries to facilitate community involvement and improvements to service delivery.⁹¹ It is puzzling in the face of this observation that the government would seek to destabilize those selfsame boundaries in pursuit of, among other goals, community involvement. In fact, those boundaries and slight variances in programs were not noted as a barrier to effective collaboration between RHAs.

Some commentators have derided the Manitoban RHAs for taking on "some of the worst habits of old fashioned bureaucratic government" since their creation, and they have aggressively expanded their control.⁹² With Bill-6, the government has done the same in a potentially intrusive fashion. What are the drawbacks of increasingly centralized control? Perhaps the most troubling could be the cessation of an ability to innovate or be responsive to local conditions. Standardized processes can enhance efficient service delivery, but straightjacket procedures stymie responsiveness. In fact, one commentator argues that indicia of burgeoning control in the health sector is part of a wider negative system of stagnation and micromanagement.⁹³

Recommendation 6.1 of the 2008 External Report suggested increased devolution of authority to allow local authorities to make "critical resource allocation and service planning decisions."⁹⁴ The report was not arguing for a central element of control, but a dispersion of control, with commensurately increased accountability:

since the implementation of regionalization, the distinction between the role of the RHAs and the role of government has become less clear as the government has assumed more of the responsibility for decisions in the regions. The feedback from the RHAs was that the major decisions, such as the types and capacities of services that will be provided in each community, are made by government, leaving the less consequential (and less controversial) decisions to the RHAs. If

⁹¹ *Ibid* at 26.

⁹² Stifling Innovation, *supra* note 8 at 97.

⁹³ Bryan Schwartz, *Revitalizing Manitoba: From Suppliant Society to Diversity & Dynamism* 2ed (Winnipeg, Frontier Centre for Public Policy 2011) at 3-4. This author further argues that this stagnation crushes innovation crucial to the effective delivery of health care in a publically funded system.

⁹⁴ RHA Report, *supra* note 5 at 30.

regionalization is to achieve its maximum potential, increased devolution of decision-making authority to the regions must occur. However, the devolution can only be effective if proper accountability processes are implemented as well. In other words, increased authority in the RHAs must be accompanied by increased accountability.⁹⁵

Again, some commentators note that other centralized jurisdictions have sought to not increase centralized control in the face of similar conclusions, arguing this desirability question can be answered negatively as well.⁹⁶

However, in my view, devolution of control and increased autonomy can still take place with fewer health authorities, even a single region. Standardized processes and reporting mechanisms make a lot of sense, and they are not conceptually beholden to a negatively centralized control. Furthermore, fears concerning local responsiveness and negatively displaced residents (in regard to PCHs) can be countered by appropriated drafted and administered guidelines and regulations. Nonetheless, further amalgamation without a concomitant dispersion of authority, and legislative protection for autonomy would be an unwelcome move. The non-fiscal human costs resulting from patients living far removed from family support structures will never be comprehensively tracked, and grasping the full effect of these larger boundaries may be difficult.

Additionally, patients and their families are not the only ones who will potentially be affected by amalgamation vis a vis widened borders. If one of the goals of the amalgamations is to reduce the number of administrative positions, those remaining staffers will, of necessity, be forced to oversee a larger geographical region. An individual on the road cannot be said to be effectively delivering or administering health care, and the reduction in efficiency and the costs associated with burgeoning travel might be innocuous but significantly deleterious.⁹⁷

⁹⁵ RHA Report, *supra* note 5 at 29.

⁹⁶ Stifling Innovation, *supra* note 8 at 97, citing United Kingdom Department of Health, Equity and excellence: Liberating the NHS (London, UK: Her Majesty's Government, 2010). The United Kingdom report noted that an increased level of autonomy would allow health care providers to "...be freed from government control to shape their services around the needs and choices of patients" at 27.

⁹⁷ A discussion of efficiency and cost does not address any negative ramifications for morale stemming from excessive travel commitments, whose deleterious effects will never be adequately measured. For a discussion on the interaction of loyalty and organizational commitment with workplace productivity, see Sarah Brown et al,

As a further corollary to the argument against centralization, it seems just as likely that accountability and dispersed authority are not the enemies they may seem, either. If you provide clear and adequate expectations, then track those expectations and engage in corrective measures as necessary, authority to make resource allocation or service delivery decisions can be very widely dispersed indeed.⁹⁸

2. Control over CEOs, Compensation, Contracts, and Surpluses

The insertion and amendment of provisions purporting to improve fiscal transparency and accountability represent the most controversial portions of Bill-6. The insertion of an entire division (Division 5.1) into the *Act*, as well as the alteration of section 29.1 (2) of the *Act*, dramatically changes the locus of control over RHAs and private health corporations.

Under the new *Act*, government could standardize employment contracts for senior managers of RHAs, and would empower RHAs to do the same for health corporations. The policy can deal with all aspects of such contracts, including compensation. Despite permissive language (policies may be put in place), failing to use the ability to regulate contracts is highly unlikely, given the government objective with the bill. Once the policy is in effect, adherence becomes mandatory under section 51.2(2) of the amended *RHA Act*.

Additionally, health authorities may give directions to health facilities within their region about the process they use to hire senior managers. A direction given to a health corporation formerly could only relate to matters of a regional nature; Bill-6 expanded this to allow a direction concerning the process for hiring a CEO or any designated senior officer.⁹⁹

Finally, in an amendment that caused significant consternation, Bill-6 saw the inclusion in section 59 of the *Act* new regulation-making powers allowing the government to establish rules respecting the way in which

"Workplace Performance, Worker Commitment and Loyalty" (2011) 20:3 J of Econ & Management Strategy 925.

⁹⁸ On a similar note, see John Braithwaite, "The Essence of Responsive Regulation" (2011) 44 UBC L Rev 475. Braithwaite argues that a system of escalating corrective sanctions allows actual regulations to be about collaborative consensus building, combining a dispersed authority in an accountable framework.

⁹⁹ *RHA Amendment Act*, *supra* note 2, s 29.1(2). Designated is defined as by regulation.

RHAs and health facilities use budgetary surpluses and revenue they receive from providing ancillary services, such as parking.¹⁰⁰

These changes are problematic for the following interrelated reasons:

1. They contravene existing agreements with private sector health care corporations with both practical and policy issues to contend with as a result.
2. The controls over executives and surplus funds exist outside of the restrictions on direction-giving to health corporations by RHAs in section 29 of the Act these jeopardize protection afforded to autonomy of health corporations.
3. They represent a two-tiered expansion of government control in the face of recommendations to the contrary and limited evidence to support them. They may serve to stifle innovation and provide disincentives for efficiency, or restrict the operation of the private health corporations especially in avenues of faith-based operation. These provisions represent a two tiered expansion of control, of the government over RHAs and of the RHAs over private health corporations.

The consideration of expansion can be considered a meta-issue, in that the first two exist as evidence of a larger contextual morass whose boundaries are drawn by the third issue.

The MARCHE representative observed at committee that existing agreements in place allowed for private organizations to "retain and apply, at their own discretion, savings resulting in operational surpluses" as well as control over selection of CEO.¹⁰¹ The concern is that the final decision of the appointment of a private health care corporation would now potentially be in the hands of the RHA. Control over compensation could be used, as noted in committee, to pressure corporations to fall into line on other government or RHA policies. In the absence of compelling reasons to enact changes which contravene existing agreements, a minimal level of consultation prior to legislative amendment should have been afforded to RHAs and other health corporations. Contracts are put in place to ensure reasonable levels of certainty and finality. If a particular

¹⁰⁰ *Ibid*, ss k.1-2. Ancillary services are not defined, leading to questions about the scope of this provision, including one presenter at committee who questioned if the definition could include fundraising activities as well. See Committee, *supra* note 58 at 81.

¹⁰¹ *Ibid* at 80 (Gerald Pronyk).

contract is not satisfactory, then renegotiation ought to take place. In a private contractual relationship, unilateral withdrawal from an obligation is labeled a breach and material modifications to contract terms require agreement from the parties. While a MOU may have less formal force than a contract, neither them nor SPAs in force should be effectively discarded without a compelling rationale. Evidence should be presented that existing agreements fail to achieve objectives, and speculative dangers should be carefully considered.

The government need not be restricted to solely reactive legislation; in the face of a likely issue the legislature has a duty and ability to act for the benefit of Manitobans. But agreements were drafted with particular terms for a reason. If control was previously in the hands of the private sector actors there was a reason for this, and to treat the private sector as a branch of government is to act in error if there are relevant differences between them. Some may argue that treating private sector entities as a branch or extension of government is always in error. However, these private health care corporations deliver government programs with significant funding and regulatory integration. Some control and oversight is both desirable and necessary over areas of public safety or funding. Yet, discarding or unilaterally amending a contract shows little respect for the autonomy of the other party in an agreement, and jettisons the certainty sought by contracting in the first place. The status of private health care corporations in relation to the public is particular; in providing services that are publically funded to a greater or lesser degree they ought to be regulated. Yet, unilaterally curtailing the autonomy of these organizations in such a fashion is damaging to the trust integral to the contracting process and inimical to predictable and stable interrelationships between government and non-government entities tasked with carrying out public programs.

One example of this conflict between the existing SPAs and the new RHA Act is the provision for dealing with surplus funds as identified as by Mr. Pronyk.¹⁰² Though some examples (including the NOR-MAN and Burntwood RHA scandals) afford some reasons for increasing the control over compensation levels, the government was, at the time, unable to provide an example for smaller or faith-based health corporations. Why

¹⁰² *Ibid* at 81. Mr. Pronyk referred to Article 11.6 of the Service Purchase Agreement, which was publically unavailable at the time of writing.

then, does the legislation purport to extend to PCHs and other faith-based organizations in this fashion? These agreements were effectively discarded with dearth of evidence despite the 2008 report noting "no reason to believe financial controls in the existing system are lacking."¹⁰³ If the current controls are not actually lacking, either there is no reason to actually change them, or the application is what is lacking. Even in the face of some irregularities, if the misuse or misappropriation of funds is not stemming from these surplus funds but from use of normal expenditures, or in violation of existing policies,¹⁰⁴ this provision is likely to have little to no practical effect. If a putatively independent report is unable to suggest that financial controls are lacking for fully public sector entities, it is difficult to see the logic in increasing regulatory control over public, let alone private, entities. Changing the control regime if the application is the issue may have no practical effects.

Again, it is important to note the legislative objectives are both reasonable and laudatory. Scandals in Ontario and other regions in Manitoba militate in favour of aggressive protection of public funds in an area consuming such a large part of the provincial budget. There may be a visceral reaction that demands that a CEO of an 80 bed PCH not be compensated to the same degree as the CEO of HSC, but this fails to consider important nuances. If, for example, the PCH executive has

¹⁰³ RHA Report, *supra* note 5 at 28; See also Committee, *supra* note 58 at 124. Defending Bill-6's purpose, Minister Oswald asserted the provisions in the bill so impugned by the presenters were there for some "very, very good reasons" inspired by both local events and those in other jurisdictions, including the Ontario Ornge helicopter operations. This referred to the Ontario provincial air ambulance service which came under intense scrutiny for questionable contracts, excessive spending and significant misuses of public funds. Tanya Talaga, "Sex, money and helicopters: ORNGE probe wraps up for summer," *The Toronto Star* (2 August 2012) online: Toronto Star <<http://www.thestar.com/news/canada/politics/article/1236422-ornge-sex-money-and-helicopters-ornge-probe-wraps-up-for-summer>>. For a more recent local example, see Bill Redekop, "Care home fires director after damning investigation," *Winnipeg Free Press* (23 March 2013) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/local/care-home-fires-director-after-damning-investigation-197725921.html>>. This situation is discussed in greater detail below.

¹⁰⁴ Policies in place with the WRHA and a Personal Care Home were allegedly disregarded during a recent firing of a PCH CEO for financial mismanagement. "Middlechurch care home mismanaged public money: report" *CBC News* (29 October 2012) online: CBC News <<http://www.cbc.ca/news/canada/manitoba/story/2012/10/29/mb-middlechurch-home-interim-manager.html#content>>.

particular skills, the nature of the job is more demanding, or requirements for fund-raising more stringent, perhaps they do deserve greater compensation.¹⁰⁵

A second issue with Bill-6 relates to changes to the Act empowering the government to enact policies concerning executives and surplus funds drafted to fit outside of protections for faith-based organizations and other health corporations found in section 29. The RHA Act had several provisions which restricted the level of control RHAs had over health corporations operations by limiting when directions could be given, and on what subject matter. Consider the following:

"Old" 29.1(2) (Subject matter of a direction)

A direction given to a health corporation may relate only to matters that have a region-wide impact on the regional health authority's responsibility to coordinate and integrate health services and facilities in its health region, including planning, standards, and the allocation of financial and other resources.

"New" 29.1(2)

A direction given to a health corporation may relate to

(a) the process for hiring a chief executive officer, or any senior officer of the corporation designated for the purpose of Division 5.1 of Part 4; or

(b) any matter that has a region-wide impact on the regional health authority's responsibility to coordinate and integrate health services and facilities in its health region, including planning, standards, and the allocation of financial and other resources.

The wording of the previous version of this clause restricts the subject matter of directions provided to any health corporation. Obvious in the new section is the insertion of the ability to provide directions on process for hiring executives and senior officers designated under Division 5.1 of the RHA Act. This power would not cause the same stir if it were limited, as it might appear to be, by the same limitations as all directions given under section 29. However, actions by the Health Minister recently cast doubt upon that interpretation. Finally, the word "only" has been removed from the clause, which widens the scope of the list and suggests the

¹⁰⁵ See Colleen Coates, "How much salary is too much?," *Winnipeg Free Press* (23 March 2013) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/business/how-much-salary-is-too-much-199658591.html>>. Ms. Coates urges moderation in the public reaction to salaries, especially in the non-profit sector and councils consideration of nuances.

examples provided may not be exhaustive, or may be added to in a future amendment. Limitation on directions is further provided by current subsections 29.1(3) and (5):

Limitation on direction

29.1(3) A direction given to a health corporation may not

- (a) relate to aspects of the health corporation's activities for which the regional health authority does not provide funds;

...

- (d) require a change in the composition of the board of directors of the health corporation.

Consultation required before direction may be given

29.1(5) A direction under this section may be given only if

- (a) the normal processes contemplated by any agreement under Division 3.1, including consultation and cooperation, fail to resolve the issue that is the subject matter of the potential direction; and
- (b) the regional health authority has made reasonable efforts to consider and accommodate the position of the health corporation on the matter.

Finally, current subsection 29.3(1) of the *Regional Health Authorities Act* has further control mechanisms in place for directions given to faith-based health corporations, and states:

A direction given under section 29.1 to a health corporation that is owned and operated by a religious organization must

- (a) not be inconsistent with any agreement that the health corporation has entered into under subsection 5(2); and
- (b) be consistent with the following principles:

1. The health corporation may continue to respond to the spiritual and religious needs of its residents or patients, and to provide care and services in a manner that is consistent with the fundamental principles of the religion or faith to which it adheres.

2. The health corporation may continue

- (i) to own and operate its facilities,
- (ii) to retain the identity of the facilities as faith-sponsored facilities, and
- (iii) to be governed by a board of directors appointed or elected by the religious organization.¹⁰⁶

The (untouched) current wording of the Act in that section unequivocally extends protection to the autonomy of private health care corporations, while ensuring harmonization between legislation and existing agreements. However, those protections exist for agreements

¹⁰⁶ RHA Act, *supra* note 4.

entered into pursuant to section 5(2) and directions provided under section 29.1, and not for regulations pursuant to section 59(k.1-2) or policies under section 51.1.

Recall that Division 5.1 provides powers to government over RHAs and RHAs over health corporations to regulate or restrict employment contracts and policies of executives and senior officers. This includes section 51.4(1), a restriction on re-hiring executives within a year of employment cessation, not tied to any stated policy and existing as a blanket provision subject only to the discretionary decision of the Health Minister. Despite strong opposition from private health organizations and political opposition, these new powers exist outside of the controls in section 29 of the *RHA Act*, and have remained complete and unaltered in the Bill's final iteration.

RHAs under section 29.1(5) may only issue directions when collaborative endeavours (including mediation requirements under Division 3.1) have failed. However, it is not clear how these requirements restrict controls over employment contracts, appointment of executives, or limitations on re-hiring. When a hiring policy is put into place, for example, the final approval transfers to the CFO of Manitoba health. To provide force and effect to Division 5.1, it cannot be the case that application of their contract controls would be constrained by section 29. The wording requires consultation from the RHA, but does not include the same for MB Health. If this were not the case, provisions such as subsection 29.3(1)(a) would appear to have no real force, given existing SPAs that allow for PCHs to control the process and hiring of executives.

Directions concerning surplus funds and control over executives are or will be given to health corporations despite possibly conflicting existing agreements. A direction under section 29 cannot (according to subsection 29.3(1)) be in conflict with other agreements signed under 5(2). Thus, the recent instruction to fire Bethania Care Home's CEO (discussed below) and control over surplus funds cannot be restrained by section 29 if they are both to be considered legitimate. And if section 51.4(1) under Division 5.1 is not restrained by Section 29 restrictions, then it must be the case the entire division (not to mention the surplus fund regulation powers) must lie outside of section 29.

It is perhaps uncontested that adequate accountability is required for any publically funded institution or service, but the vague language of the legislation leaves open the possibility of more negative outcomes. These

changes may be justified for the government to clear up their own house, as it were, but the provisions could have included other protections or express support for increased autonomy and innovation. The receipt of government funding should not be taken to create *de facto* government entities. The existence of SPAs, MOUs, and section 29 of the Act all point to the realization and affirmation that this is the case. Accountability does not have to be coexistent with direct managerial control if adequate objectives are clearly articulated and tracked and significant remedial (including punitive) measures are in place to control for failures.

A third issue lies with the aggressive expansion of centralized control, the evidence of which can be seen within Bill-6 and resulting controversy. This can have a variety of consequences, including some negative and unintended ones. Knowledge that surplus funds acquired by hard work or innovation might be reallocated to another facility is galling for a fully public entity, let alone for a private corporation. This sort of pervasive, unneeded control can act to significantly dis-incentivize finding efficiencies as a reaction a freeloader problem, real or perceived. Why work harder or smarter if the fruits of your labour will be transferred to a lazier or less efficient jurisdiction? There is little rational debate on the proposition that accountability and transparency are virtues, or that the public deserves to know and have a say in where public funds are used. However, this legislation is very widely crafted, and accountability does not have to stem from centralized control.

Consider this statement from the 2008 External Report:

Increased accountability in the RHAs involves increased accountability for board chairs, CEOs and their management organization and for board members. The specifics of how this can be done are detailed in several sections of this report. Authority in any organization is delegated within limits. Discretion (authority) can never be unbounded. ... Effective delegation requires clear and consistent limits to authority. Inconsistent application of limits has the effect of reducing the limits to a narrow range in which decision-makers will only make risk-free decisions. The Review Committee's recommendation relates to implementing greater empowerment of the RHAs by increasing the delegation of authority.¹⁰⁷

In response to objections both in light of existing agreements and pushing back against this expansion of control, Minister Oswald claimed the inclusion of subsections k.1-3 in section 59 should be interpreted as only requiring a report and plan for surplus funds, and that faith-based

¹⁰⁷ RHA External Report, *supra* note 5 at 29.

organizations will not be required to give back the funds.¹⁰⁸ However, the wording of the provision is much wider than that and allows regulation, prohibition and restriction of surplus monies. While the current government may only require a report, the language of the change supports a much wider variety of orders. This suggests either sloppy drafting or a wider purpose to the clause than the official government position, and in fact the wording allows more or less complete control by the cabinet over any acquired surpluses. The legislation is internally inconsistent in that it restricts RHA's ability to provide directions in 29.1(3)(a) where it does not provide funds, but allows cabinet to regulate areas relating to ancillary services in 59(k.1-2). With one hand the Act restricts control by one branch of government, and with the other it extends that control.

However, despite these and other reassurances, no adequate answer was proffered to address the rationale of enacting legislative changes that conflicted with existing agreements or principles of agreements. If there was no reason to believe financial controls were lacking, and no evidence of misuse of surplus funds, why exert control over surplus funds? Would being able to veto the appointment of senior management prevent corrupt decisions from being made, or would this just stifle any criticism? I submit that the latter is more likely as those with positions angle to keep them, and engage in those risk-free decisions. This scheme of central control arguably will "almost certainly lead to compounding existing inefficiencies"¹⁰⁹ at the same time potentially precluding beneficial 'risky' decisions or serving to keep organizations or individuals in line.

The government has claimed to this end, that the power to appoint CEOs to PCHs would stay with the homes themselves and their boards, their contracts would only have to be consistent with the contract policy drawn up by the RHA, and PCHs and their faith-based concerns would be considered when developing regulations.¹¹⁰ The general sense provided by the government was that the respect enshrined into law in 2001, and

¹⁰⁸ See Committee, *supra* note 58 at 86 (Hon Theresa Oswald). Jon Gerrard, who observed that a promise by a current government to not claw back the funds would not necessarily fetter any subsequent administration with no strictures on government powers, dubiously considered this claim in committee.

¹⁰⁹ Michael Kirby and Wilbert Keon, "Why Competition is Essential in the Delivery of Publicly Funded Health Care Services," (2004) 5:8 Policy Matters at 4.

¹¹⁰ Committee, *supra* note 58 at 126-127.

indicated by subsection 29.3(1), would be honoured and the ability of these organizations to set their own fates would mostly undisturbed. In fact, Minister Oswald opined that this respect leads to a reality where

any directive an RHA may give a health corporation must respect the unique role of faith-based facilities by ensuring three essential things, in my view: that they can respond to the spiritual and religious needs of their residents and patients; that they can provide care in a way that is consistent with the fundamental principles of their religion and faith; and that reaffirms that religious organizations can continue to own and operate their facilities, retain their identity and be governed by a board of directors.¹¹¹

It is, however, difficult to reconcile the Minister's sense with legislative indicia discussed above, and actions subsequently undertaken with respect to two personal care homes in the province. Neither of these stories are examples of unfettered bureaucratic interference, but is the unambiguous affirmation of the *RHA Amendment Act*.

One change brought about by Bill-6 recently came under fire when it was used by the government to order a PCH to fire its CEO who fell afoul of restrictions now embodied in subsection 51.4(1).¹¹² The PCH had allowed their CEO to retire, and then re-hired him the following day at an increased salary, skirting around a salary freeze, while collecting a retiring allowance.¹¹³

¹¹¹ *Ibid* at 82-83 (Hon Theresa Oswald).

¹¹² Larry Kusch, "CEO's contract illegal: province," *Winnipeg Free Press* (22 March 2013) online: *Winnipeg Free Press* <<http://www.winnipegfreepress.com/local/ceos-contract-illegal-province-199490511.html>> [Illegal Contract]. Subsequently, the CEO was placed on administrative leave pending investigation into allegations surfacing after a financial audit was conducted. Larry Kusch, "Bethania CEO put on leave during investigation," *Winnipeg Free Press* (17 May 2013) online: *Winnipeg Free Press* <<http://www.winnipegfreepress.com/breakingnews/Bethania-CEO-put-on-leave-during-investigation-207870821.html?device=mobile>>. Patient care at the facilities was still noting as meeting provincial standards, however.

¹¹³ "Care Home CEO given money under 'illegal' contract: Manitoba Government," *The Canadian Press* (21 March 2013) online: *The Canadian Press* <<http://www.winnipegfreepress.com/arts-and-life/life/health/care-home-ceo-given-money-under-illegal-contract-manitoba-government-199382801.html>>. Interestingly enough, the practice of retirement allowances, a public sector payment plan indefensible in any industry has become the focus of further controversy, and despite being part of the current furor has nothing to do with the Act or Bill-6. Nonetheless, it has become part of the general sense of dissatisfaction aimed at public spending: Tom Brodbeck, "WRHA employees got \$4.6 million in retirement bonuses last year," *Winnipeg Free Press* (27 March 2013) online: *Winnipeg Free Press*

The care home's board of directors defended their actions by claiming that taxpayers were saved \$16,000/yr in pension contributions and leave allowance, that the practice is allowable even under the new law with prior approval. Additionally, they contended the putatively "illegal" contract was common practice throughout the province, and that the province was attacking the move based on the faith-based nature of their home, and the controversy over Bill-6.¹¹⁴ Probably most strongly, they contended the contract had been formed prior to the legislative amendments and thus should not be targeted under the RHA Act as amended by Bill-6.

The Manitoba Health audit document, subsequently released, noted the new contract was for oversight over two PCHs rather than the single one before.¹¹⁵ The care home's board expressed disappointment with the government's decision to engage in a public dispute over this, claiming they hoped they could return to "mutually respectful discussions ... respecting the privacy rights of all concerned".¹¹⁶

This optically disadvantageous situation could be heralded as a victory for Bill-6, and an affirmation of the rightness of the legislative amendments to protect taxpayers, but determinations should not be made on the backs of jealousy or resentment. If the new contract was for the same level of services it would be difficult to justify, but even then could have been approved by the Health Minister. However, if the contract was for an increased level of services, which it appears to be, was cemented prior to legislative changes, and provides substantial annual savings, this change should be celebrated rather than decried. The inclusion of the retiring allowance in reports of this situation do nothing but serve to inflame public opinion but are not restricted to PCHs and bear little on any justification for Bill-6's changes. Additionally, suggestions that the province may request or change the care home's board if they do not

<<http://www.winnipegsun.com/2013/03/27/wrha-employees-got-46-million-in-retirement-bonuses-last-year>>.

¹¹⁴ Illegal Contract, *supra* note 112.

¹¹⁵ Manitoba Health, News Release, "Manitoba Health releases audit of Bethania Group Personal Care Homes" (21 March 2013) online: <<http://www.wrha.mb.ca/healthinfo/news/2013/130321-bethania.php>>.

¹¹⁶ Nick Martin, "Care home's board upset with publicity," *Winnipeg Free Press* (25 March 2013) online: [Winnipeg Free Press](http://www.winnipegfreepress.com/local/care-homes-board-upset-with-publicity-199809201.html) <<http://www.winnipegfreepress.com/local/care-homes-board-upset-with-publicity-199809201.html>>.

remove the executive run contrary to legislative intent in section 29 of the Act.

A second and potentially damning rebuttal to the critics of Bill-6 emerged prior to the Royal Assent of Bill-6 when the executive director of Middlechurch Care Home was fired amidst allegations and of financial mismanagement of public funds. A report from the provincial ombudsman cited "gross mismanagement" of public funds, and Minister Oswald was quick to affirm that Manitobans expected accountability for their tax dollars, including those funding independent care homes.¹¹⁷ Admittedly, the optics here are terrible for those concerned with the wider impact of this legislation, and disregarding proper tendering practices and policies is neither intelligent nor appropriate.¹¹⁸ Nonetheless, despite these labels of mismanagement, "no specific provincial or federal laws were broken"¹¹⁹ during the vilified CEO's tenure, the home had paid down a debt of \$1.5 million while undertaking refurbishing work with no alleged negative impact upon resident care.¹²⁰ It is difficult to conclude what these two situations indicate, with supporters of Bill-6 pointing to the rightness of their cause, and opponents seeing only witch hunts. What is clear is that the situations are not as transparently scandalous as they initially seem, and that in the latter case any changes to legislation would have been ineffective at preventing any misdemeanour. Notably, the Bethania contract was designated as "illegal" and reported as such, yet if it were signed prior to the legislation taking effect, it would not be, for example. The pair of incidents do, however, provide public relations support for the

¹¹⁷ See Manitoba, News Release, "Province Announces Interim Manager Appointed to Oversee Administration of Middlechurch Home of Winnipeg" (29 October 2012) online: <<http://www.documentcloud.org/documents/491788-ombudsman-report-into-middlechurch-home.html#document/p2atp4>>; Manitoba, Ombudsman, *Report on Investigations of Allegations of Wrongdoing at Middlechurch Home of Winnipeg Inc.* (Winnipeg: Manitoba Ombudsman, 2012) online: <<http://news.gov.mb.ca/news/print/index.html?item=15508>>.

¹¹⁸ Bill Redekop, "Care home fires director after damning investigation," *Winnipeg Free Press* (13 March 2013) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/local/care-home-fires-director-after-damning-investigation-197725921.htm>> [Investigation].

¹¹⁹ Larry Kusch, "Interim manager installed at care home," *Winnipeg Free Press* (30 October 2012) online: Winnipeg Free Press <<http://www.winnipegfreepress.com/local/interim-manager-installed-at-care-home-176373691.html>>.

¹²⁰ Investigation, *supra* note 118.

extension of government control over health care delivery in all sectors. Yet, the cost of this extension is something that may be obscured in the haze of indignation and disbelief.

Manitoba Health has produced documentation to improve accountability¹²¹ and so is perhaps moving in the right direction, but the size of the teeth in Bill-6 and the direction of the bite generate worry. Enacting measures such as simply posting expenses, as subsections 38.1(1)-38.1(4) will eventually require, has in no way reigned in what some have termed excessive salaries under the WRHA.¹²² Accountability measures do need to have some teeth, but they should be targeted and drafted in accordance with stakeholder interests and suggestions. This Bill was supposed to increase transparency and yet it seems to have been created without the knowledge of major stakeholders. And its accountability provisions appear to be premised upon an assumption that accountability only follows from top down control that treat all players in the health care service delivery world as extensions of government.

3. Improvement of Community Involvement

Finally, in a provision to improve community involvement, the *RHA Amendment Act*'s replaces DHACs with LHIGs as noted above. RHAs must have local health involvement groups, which replace the existing advisory councils. Such groups will advise RHAs about health issues in the region.

However, regulations provided that previous DHACs were composed of health care providers from various disciplines, though the RHA board

¹²¹ Achieving Accountability, *supra* note 3; Manitoba Health, *The Accountability Cycle: Making it Work*, Winnipeg, Regional Health Authorities in Manitoba Publications, 2012, online: Manitoba Health <<http://www.gov.mb.ca/health/rha/docs/acmw.pdf>>.

¹²² While the RHA External Report, *supra* note 5, proposed limited salary increases at recommendation 7.4, it concomitantly recommended external audits on executive salaries & accountability measures. Even with the current WRHA practice of posting salaries in excess of \$50,000 annually, criticism abounds: see "Senior WRHA execs salaries surge," *Winnipeg Sun* (30 June 2012) online: *Winnipeg Sun* <<http://www.winnipegsun.com/2012/06/30/senior-wrha-execs-salaries-surge>>; For a recent listing see online: <<http://taxpayer.com/sites/default/files/2010%20PSCDA%20Audited.pdf>>. Bill-6 extended public salary disclosure requirements to the heads of health facilities. Simply publically posting salaries and relying upon public uproar to regulate them seems to be of limited merit. Public scrutiny and outrage sometimes fail to accomplish anything in the face of concerted special interest groups, massive power differentials, or an ineffective political process.

could appoint non-providers if they deemed it appropriate.¹²³ Section 32(1) of the Act previously defined the role of these groups as to "advise and assist the board of the regional health authority."¹²⁴

The exact nature and rationale of this change is opaque in the face of an un-enacted provision and subsequent lack of regulatory evidence, or RHA practice guidelines. Though the DHACs had been noted as having inconsistent success *vis a vis* community involvement, this inconsistency could be blamed on a variety of factors including personal, compositional or situational.¹²⁵ Indeed, in some cases the DHACs had been replaced if the RHAs provided a functionally isomorphic input process or mechanism and others had created procedures that "create an increased feeling of ownership in the region and constitute a best practice."¹²⁶

Indeed, the external report on the RHAs recommended that Manitoba Health increase RHA accountability and report on the effectiveness of their methods of obtaining community input through what they termed "other community engagement methods ... to engage and empower their communities and districts".¹²⁷

It is clear that local involvement with the delivery of health services is an admirable goal, and should positively affect that delivery by ensuring that appropriate care is provided and that local delivery is responsive to local conditions. However, what is far from clear is what difference a mere name change will make, or if there is more than a name change. Arguably the application of existing policies is to blame for creating issues with community involvement, not the enabling or subordinate legislation. Simply changing a name only is puzzling when performance metrics, accountability reviews, and accurate assessment of outcomes might all improve the quality of service delivery more effectively.

¹²³ Man Reg 169/88 at s 6(2).

¹²⁴ *The Regional Health Authorities Act*, *supra* note 4 s 32(1) as amended by RHA Amendment Act, *supra* note 2.

¹²⁵ RHA External Report, *supra* note 6 at 49.

¹²⁶ *Ibid* at 51. Bill-6 also introduced, s 26.1(3), which imposes a consultation requirement on RHAs when engaging in a list of various health service delivery activities. Inasmuch as this imperative is used to provide teeth to accountability measures and does not require overly onerous procedures, it is a welcome addition.

¹²⁷ *Ibid* at 51-52. These suggestions are found at Recommendations 10.1 and 10.2.

After all, the new LHIGs' purpose is to "provide advice to the board of the authority on issues that impact the delivery of local health services"¹²⁸, something the DHACs were already supposed to be doing. Substituting functionally equivalent processes' accomplishes nothing, so logically the conclusion that must follow is a disjunctive one: either this truly is as toothless a change as it *prima facie* appears to be, or the promulgation of regulations will reveal the efficacy and rational behind this change.

IV. CONCLUSION

Ultimately, the *Regional Health Authority Amendment Act* represents a significant change in the level of control the government exerts over RHAs. With publically digestible objectives and compelling logic at first glance, it is hardly a shock that its introduction and passage failed to cause serious ripples in the general public. Despite stiff political opposition and impassioned committee presentations, the Bill survived completely unscathed. And though the most contentious of sections are not yet in force, simply delaying their effects may not obviate them. The Bill lacked crucial safeguards and is based upon some questionable assumptions. Bereft of experience or fleshed-out regulations, concrete conclusions are restricted, yet substantial skeletons of government expansion lurk in this particular closet.

The Bill additionally opened the door to more centralized control, which may very well hinder the application of innovative solutions while simultaneously not providing the level of responsiveness required by patients and taxpayers. This is, perhaps, the exercise of government power for the sake of being seen. The most truly mystifying alteration is the creation of new powers unfettered by accountability measures in a bill putatively drafted to improve accountability and trust coupled with amendments that seek only to delay implementation rather than address the concerns voiced.

Not all is rotten with this particular apple; however some measures for accountability and transparency make at least conceptual sense and will hopefully generate improvement. One thing is certain: the *Regional Health Authorities Amendment Act* may have initially slipped under the radar of the public for the most part, but its real effects have yet to be felt.

¹²⁸ *RHA Amendment Act*, *supra* note 2 s 32.