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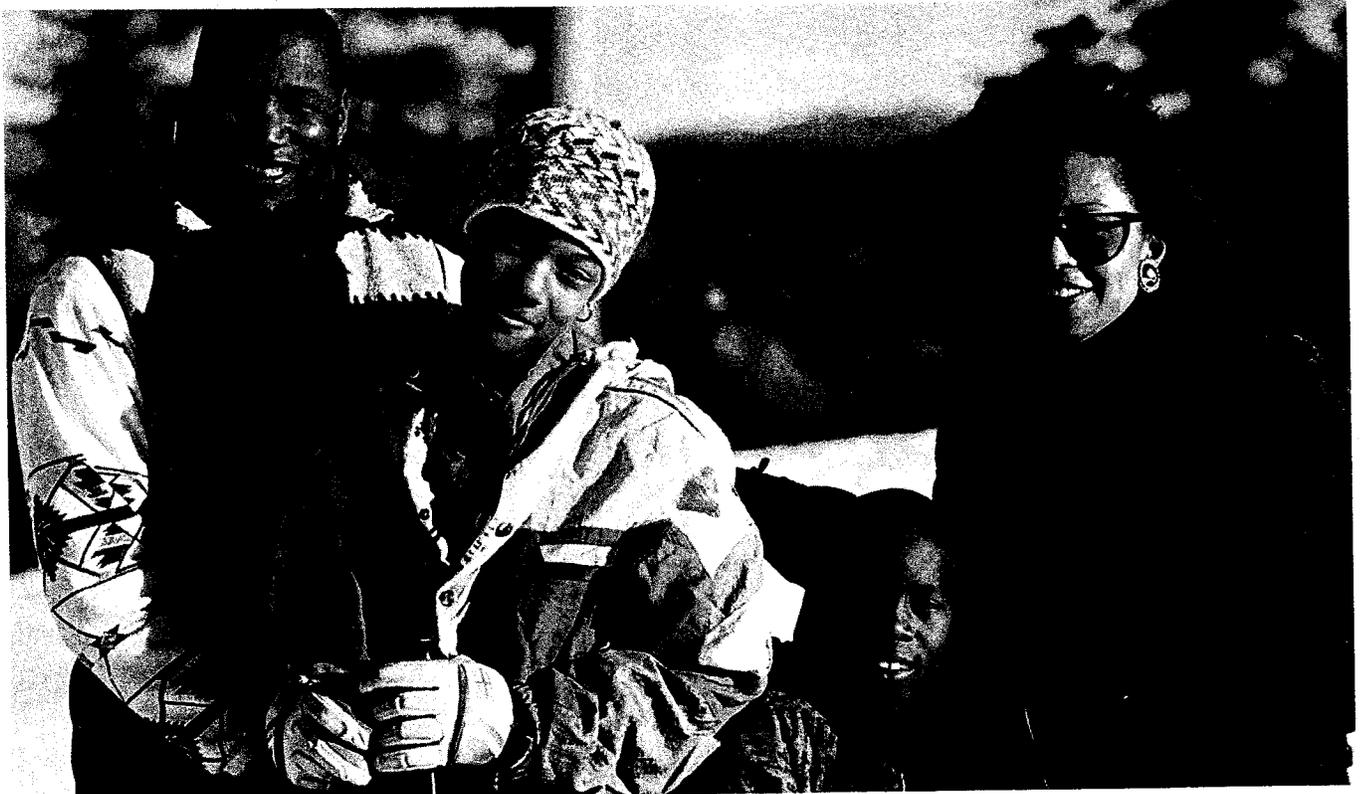
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Bill No. SB330



Achieving Accountability

Manitoba
Health



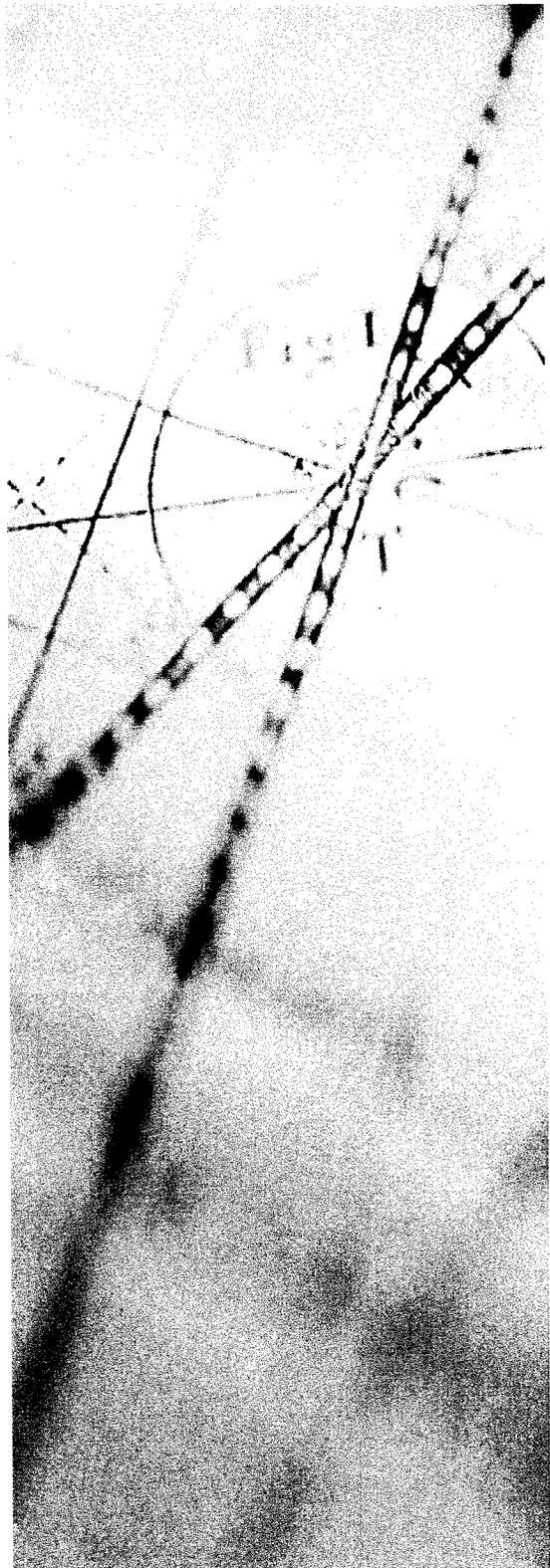


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Achieving Accountability

Introduction

The decision to regionalize the operation and administration of health in Manitoba is a major change in the way that health care is planned and delivered. The Regional Health Authorities (RHAs) are responsible within the context of broad provincial policy direction, for assessing and prioritizing needs and health goals, and developing and managing an integrated approach to their own health care system.¹

Improvement in the overall quality of Manitoba's health care system requires a new focus on accountability. Responsibilities need to be clearly assigned, expectations set, and performance of the system reported on and monitored.

The Regional Health Authorities Act legislation came into force in 1997. It was amended in June of 1997 by the Regional Health Authorities Amendment Act. It sets out the conditions under which the RHAs are incorporated, as well as defining duties and responsibilities of the RHAs and the Minister of Health. Although both parties are responsible for policy, assessment of health status and ensuring effective health planning and delivery, the focus of these responsibilities are different.

The purpose of this discussion document is to define accountability relationships within Manitoba's health care system. The primary relationship is between the Minister of Health and the RHAs. Other relationships that flow from this primary relationship, although identified in this document, are not fully outlined.

I What is Accountability?

The Manitoba Government is committed to results-oriented, open, accountable government. The people of Manitoba have the right to know what health services are being delivered and what results are being achieved. This is known as accountability. The following definition of accountability is used extensively in health care literature.

Accountability is the obligation to answer for a responsibility that has been conferred.

To be accountable implies a formal relationship and...it also implies a prior act of delegation direct from one party to another.² For an accountability framework, it is important to focus on formal lines of authority, areas where responsibilities have been developed, expectations are clear, reporting is required and performance is evaluated

¹ Manitoba Health. *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, 1996.

² Timothy W. Plumptre. *Beyond the Bottom Line Management in Government*, Institute for Research on Public Policy, Halifax, Nova Scotia. 1988.

II What is the Accountability Process?

Figure 1 illustrates a conceptual model depicting the key elements in an accountability relationship. Together these elements form a "wheel" providing for a continuous feedback loop of accountability.

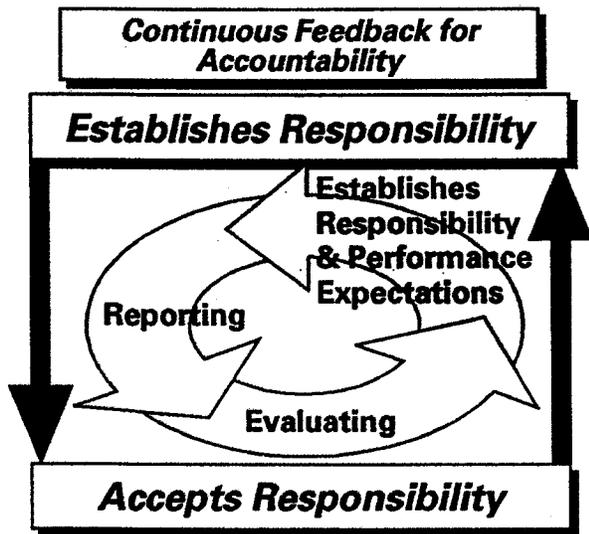


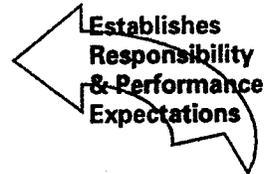
Figure 1

Several important elements underlie effective accountability relationships:

- roles and responsibilities are understood;
- performance expectations' are explicit;
- resources are provided, including spending authority for same;
- review and feedback are carried out, and, . follow-up actions, including rewards and sanctions, can be used to improve future performance.

Establishing Responsibilities/ Expectations

In any accountability relationship, the process will usually begin by establishing the responsibilities and expectations of the relationship.



Reporting

This phase involves some method of measuring outcomes, performance or progress toward meeting the defined responsibilities and expectations.



Evaluating

This phase involves analyzing the information and performance reports received during the reporting phase and making decisions based on that information.



III How Does Accountability Work

The purpose of this section is to outline the accountability relationships in Manitoba's health care system and, more specifically, between the Minister of Health and the RHAs. Figure 2 outlines the flow of accountability and relationships.

Legislative Assembly

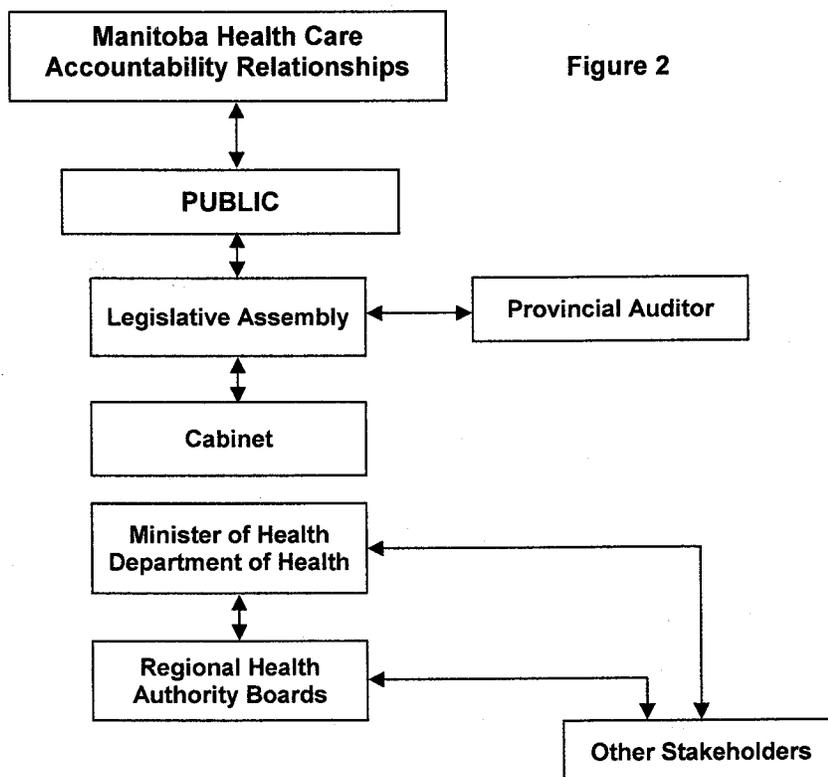
The Regional Health Authority Act passed by the *Legislative Assembly* authorizes the delegation of responsibility and defines the limits, under which actions can be taken or services provided. All other procedures that delegate powers and responsibilities to RHAs (such as provincial policy and/or guidelines) operate within limits of this legislation. Ensuring accountability and effective management in government departments such as Manitoba Health is the function of the office of the independent Provincial Auditor who reports to the Legislative Assembly.

Cabinet

Cabinet confers on the *Minister of Health* the final accountability and overall responsibility for the health care system. The Minister is accountable to Cabinet while also being accountable to the people of Manitoba through the Legislative Assembly. Through election of Members of the legislative Assembly (MLAs) the public has access to the Legislature and lawmaking.

The Minister is responsible for planning and implementing strategic direction and provincial policy, prescribing health services that must be provided or made available, developing standards, monitoring and evaluating, and funding the provincial health care system.

The Minister has responsibility and authority to establish the expectations related to the Minister's delegation of responsibility and authority to the RHAs, and to ensure that those expectations are effectively communicated to all RHAs.



Different methods are used by the Minister to identify responsibilities and expectations of the RHAs, such as legislation, regulations, ministerial directions, policy and guidelines. The Minister also provides the necessary information and support that the RHAs need to meet the Minister's expectations.

Manitoba Health exists to act as an agent of the Minister to assist the Minister in performing the responsibilities conferred on him by the Legislature and to support the Minister in all his duties.

Regional Health Authorities

Regional Health Authorities have been given the legislated responsibility and authority to plan, manage, deliver, monitor and evaluate health services within their regions. They will have input into the development of provincial policy and planning direction, as well as into standards development. They are responsible for implementing and establishing a sustainable, integrated system of health services.

RHAs have an obligation to be aware of and carry out all expectations and responsibilities

that have been established, seek clarification: if they are unclear, and recommend changes where they feel necessary.

As the relationship between the Minister and the RHAs evolves, it will be necessary to jointly review the responsibilities and expectations on an ongoing basis to ensure that they are increasingly focused on outcomes.

The joint development process will be carried out through forums such as the RHA Council of Chairs, which advises to the Minister and has an ongoing dialogue with the Minister regarding RHA board issues.

Other Stakeholders

Other stakeholders in health including the many non-governmental organizations, foundations, charitable groups, providers, consumers, volunteers and individuals who are recognized for the essential contributions they make to the effective functioning of the health care system and the resulting health of Manitobans. They are not discussed in this document due to its specific focus on public-sector accountability.



Cross-References

Adoption and publication of rules. Title 2, ch. 4, part 3.

Part 5

Montana Older Americans Act

Part Cross-References

Montana Access to Food and Nutrition Act, Title 50, ch. 49, part 1.

52-3-501. Short title. This part may be cited as the "Montana Older Americans Act"

History: En. Sec. 1, Ch. 67, L. 1987; Sec. 53-5-701, MCA 1989; redes. 52-3-501 by Code Commissioner, 1991.

52-3-502. Definitions. In this part, the following definitions apply:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Older Montanan" means a resident of this state who is at least 60 years of age.

History: En. Sec. 2, Ch. 67, L. 1987; amd. Sec. 64, Ch. 83, L. 1989; Sec. 53-5-702, MCA 1989; redes. 52-3-502 by Code Commissioner, 1991; amd. Sec. 360, Ch. 546, L. 1995.

52-3-503. Purpose and policy. (1) The legislature finds that older Montanans constitute a valuable resource of this state and that their competence, experience, and wisdom must be used more effectively for the benefit of all Montanans.

(2) The legislature further finds that a complete range of services is not available in all areas of the state and that many Montanans lack access to the services that are available.

(3) The legislature declares that it is the policy of this state, subject to available funding, to provide a wide range of coordinated services to enable older Montanans to maintain an independent lifestyle, avoid unnecessary institutional care, and live in dignity.

(4) It is the intent of the legislature that available federal, state, regional, and local resources be used to strengthen the economic, social, and general well-being of older Montanans and that the state:

(a) develop appropriate programs for older Montanans;

(b) coordinate and integrate all levels of service, with emphasis on the whole person; and

(c) promote alternative forms of service that will create options for older Montanans.

History: En. Sec. 3, Ch. 67, L. 1987; Sec. 53-5-703, MCA 1989; redes. 52-3-503 by Code Commissioner, 1991; amd. Sec. 3, Ch. 435, L. 1999.

52-3-504. Services to be provided. Subject to available funding, the department, in conjunction with other state, local, and private agencies and organizations, shall identify and may provide for older Montanans, in addition to existing services:

(1) a directory of available services;

(2) transportation that provides access to services;

(3) housing, nutrition, education, homemaker, escort, respite, hospice, and other programs that facilitate self-care;

(4) physical and mental health care, including inpatient and outpatient services, screening, appliances and supplies, and home health care;

(5) placement in adult day care, foster care, personal care, supervisory care, and nursing homes;

(6) protective advocacy and legal programs;

(7) job training, job development, and income maintenance;

(8) adult education; and

(9) training and research in aging.

History: En. Sec. 4, Ch. 67, L. 1987; Sec. 53-5-704, MCA 1989; redes. 52-3-504 by Code Commissioner, 1991; amd. Sec. 4, Ch. 435, L. 1999.

52-3-505. Role of department. The department shall develop a plan to coordinate the services identified in 52-3-504, facilitate cooperation among agencies, avoid duplication, and increase efficiency.

History: En. Sec. 5, Ch. 67, L. 1987; Sec. 53-5-705, MCA 1989; redes. 52-3-505 by Code Commissioner, 1991.

52-3-506. Coordination with federal legislation. Nothing in this part shall be construed to prevent the department from complying with the rules and regulations