Report on the Statutory Review

of

Hospitals and Health Services Act 1927

Minister for Health

1. ***Introduction***

The *Hospitals and Health Services Act* 1927 ("the Act") was promulgated to govern the activities of the local hospital board. Like all legislation enacted since that time the Act has undergone numerous amendments to accommodate the changing landscape of hospital and health service delivery plus the inclusion of the regulation of private facilities. One of the amendments to the Act[1], requires that the Minister carry out a review of the operation of the Act as soon as is practicable after 1 January 1991 and every fifth anniversary after that date. Section 38(1) requires that such a review have regard for:

> ***"(a) the attainment of the objects of this Act;***
> ***(b) the administration of this Act;***
> ***(c) the effectiveness of the operations of the Minister, the boards of the public hospitals under this Act, the Department, the CEO, the Executive Director and authorized persons under this Act;***
> ***(d) the need for the continuation of the boards of public hospitals and any other committee or body established or constituted under or for the purposes of this Act; and***
> ***(e) such other matters as appear to the Minister to be relevant.[2]"***

The Act further requires that the Minister shall have prepared a report based on the review that he will present to both houses as soon as practicable[3].

According to Parliamentary Records no such report has ever been tabled.

This report fulfils the requirements of s 38 highlighting the major aspects of a review conducted over the last twelve months summarises the existing provisions of the Act in the light of present (and future) requirements while incorporating a number of recommendations from the Government's health reform agenda set out in the *Reid Report*[4] as well as others that became evident during the review process.

The review used as its basic structure, the primary objectives of an ideal hospital and health services act; that of providing an efficient and effective legislative framework for the delivery, maintenance and monitoring of a state-wide health system. From that base, the present components of the Act were examined for their continued relevance, the recommendations from a number of consultative reviews[5] incorporated, models from other states researched and legal opinions on various sections of the Act supplied by the State Solicitor's Office accommodated. This material is then informed with additional discussion from key stakeholders before making recommendations for possible inclusion in a new bill.

The report is divided into a number of sections including, the objectives of the Act, the administrative and legal structures, the responsibilities of the Minister, the board(s), the various statutory positions and importantly the mechanisms to regulate the private health sector and concludes each section with the major recommendations from the review. Primary amongst these recommendations were for a new *Health*

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[1] Inserted into the *Hospitals and Health Services Act* in 1985
[2] Section 38 *Hospitals and Health Services Act* 1927
[3] Section 38 (2) *Hospitals and Health Services Act* 1927
[4] Department of Health 2004 *A Healthy Future for Western Australians –report of the health reform committee – (the "Reid Report")*
[5] 2001 Report of the Health Administrative Review Committee; 2003 Country Health Services Review; 2004 A Healthy Future for Western Australians; 1999 Oceana Report

Services bill and the removal of the board structure to ensure the legislation reflects current practice and is in line with the *Reid Report's* desire for a "single unified public health system".

2. Background

The genesis for the present legislation was a bill to make provision for the "Establishment, Maintenance and Management" [6] of public hospitals to be managed by a 'hospital board'. The Act at that time lists forty- seven public hospitals ranging from the comparatively large Perth and Fremantle Public Hospitals to those situated in now extinct communities like East Kirrup and Youanmi. As a result, subsequent amendments were restricted by the original intent of establishing, maintaining and managing from a board based management structure, rather than on the delivery of services using a global approach.

The emphasis for Government, and most modern public hospital systems, is now on having a holistic approach to the delivery of a broad range of health services within geographical areas, integrating the services of all levels of government (Federal, State and local) and private facilities (private and not for profit) in order to maintain and improve the health of Western Australians.

To accommodate this state-wide approach has meant the adaptation of the basic legislation that focussed on the 'establishment, maintenance and management of public hospitals' with a local board providing for the entire hospital needs of the local area. The shift has been towards the delivery of health services for the State centred around hubs of tertiary hospitals. While this shift has been underway for some 20 years, recent reviews and reform processes conducted by Government has brought into stark relief the limitation of the present legislation structure of autonomous local boards to the development of a 'single unified Government health system'. The most recent amongst these reviews was the 2004 *Reid Report* that specifically recommended that to bring about the desired efficiencies in the public health system there would need to be legislative change.

3. Objects of this Act

While the Act does not have an Objects provision the long title states it is to "provide for the establishment, maintenance and management of public hospitals and for the control and regulation of private hospitals and private psychiatric hostels, (and) for the provision of other health services". Despite the limitations of the basic legislation mentioned above, the objects of the Act have been attained in that:

- The State Government presently spend in excess of $3.6b in managing and maintaining some five tertiary hospitals, twelve public secondary metropolitan hospitals, six major regional resource centres/hospitals, plus purchasing of hospital and health services from two private hospitals, more than 300 community based and mental health facilities; and more than 250 non-government organisations.

[6] Long title of the *Hospitals and Health Services Act* 1927

- The *Reid Report* recommended the establishment of a single management structure, the adoption of hospital and health services delivery model based on geographical areas or 'area health services', new State-wide IT systems and shared corporate services for all hospital boards. This manifests itself in the form of three Area Health Services centred around primary (tertiary) hospitals offering residential medical care along with associated ancillary or allied health services (mental health, Indigenous health, dental health, child health, substance abuse and population health[7]) to the community within their area. The shared corporate service has been achieved through the creation of the Health Corporate Network.

- The State Government is in the process of expanding the Joondalup Health Campus, Swan Districts, Armadale/Kelmscott Memorial and Rockingham/Kwinana District hospitals to 300 bed general hospitals and increasing the range of clinical services offered by these hospitals as well as the expanding and refurbishing of country hospitals to enable them to deliver (as much as possible) the acute care needs of their regional communities.

- The State Government has also committed to the expansion of the provision of hospital and health services to patients in the home involving the delivery of acute and chronic care services through ambulatory care initiatives such Hospital in the Home and Chronic Disease management teams which provide direct medical assistance, educational programmes and support services.

- More than nine per cent of the total health budget has been committed to the provision of mental health services, including the expansion of the Bunbury Acute, Psychiatric Unit and the Armadale Health Service campus, building of 200 beds in supported community residential cluster accommodation in metropolitan locations, and regional areas. Three new integrated services that of the North and South Community Mental Health Emergency Services plus a 24-hour Mental Health Emergency Response Line (MHERL) will replace the current Psychiatric Emergency Team (PET).

- The Licensing and Review Unit of the Department of Health, as the delegate of the Chief Executive Officer, controls and regulates 22 private hospitals, 128 licensed nursing homes, 14 nursing posts, 13 day surgeries plus 5 Disability Service nursing homes and 28 private psychiatric hostels.

[7] Rec 63 *Reid Report*

4. Administrative and Legal Structures of the Act

The general administration of the Act is "under the control of the Minister"[8] who will provide, to such an "extent as he considers necessary to meet all reasonable requirements"[9], hospital accommodation, and hospital and health services within a public hospital setting or elsewhere. This control and management of public hospitals is vested in the (local) hospital board who:

(a) "is responsible for –

i) the control, management, and maintenance of the public hospital or hospitals for which it is or has been appointed;

ii) providing health services under any agreement entered into by the Commonwealth with the State under the Commonwealth Act that relates to that hospital or those hospitals; and

iii) providing any other health service approved by the Minister; and

(b) may perform or exercise such other duties, powers and functions for the purposes of this Act as may be prescribed".[10]

Over the last 10 years the presence of a 'local' board have been dismantled to a circumstance where the boards of the numerous hospitals have been (except for the Peel Health Services Board and Quadriplegic Centre) amalgamated and the membership dissolved, centralising all the functions and powers of the board[11] with the Minister. In July 2002 the Minister delegated his authority to act to the Director General of the Department of Health ("the DG"), thus enabling him to use the delegated board authority from the Minister, his capacity as the Commissioner for Health/Chief Executive Officer in addition to his authority under the *Public Sector Management Act* to manage and direct the public hospital and health services of the State. This has created a circumstance whereby public health in Western Australia functions administratively as one entity – *WAHealth* and legally as four entities. These are the Metropolitan Health Services, the WA Country Health Service, Peel Health Services Board, the Quadriplegic Centre Board, plus the Department of Health with an overlay of the Area Health Services[12] to deliver the hospital and health services plus the departmental divisions[13] providing policy and administrative support. The policy and administrative support groups while providing administrative and policy assistance to the functions of the Act, are administered under a separate act, the *Public Sector Management Act* 1994.

At an operational level the present arrangements under the Act are working well, however, difficulties arise in the area of delegations, the contracting with external agencies, court proceedings and to some extent in the implementation of whole of Health policy initiatives. As a result of these difficulties and in line with the *Reid Report's* advocacy for legislative change, it is recommended that a new bill be drafted to alleviate the uncertainties to these arrangements under the legislation and provide for an efficient, flexible legal and administrative structure for the deliver of hospital and health services across the State.

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[8] Sec 5 *Hospitals and Health Services Act* 1927
[9] Sec 5A *Hospitals and Health Services Act* 1927
[10] Sec 18 (1) *Hospitals and Health Services Act* 1927
[11] Sec 7 *Hospitals and Health Services Act* 1927
[12] North Metropolitan Area Health Service, South Metropolitan Area Health Service, Child & Adolescent Health Service and WA Country Health Services (WACHS is also a legal entity).
[13] Health System Support, Health Reform, Health Finance, Mental Health, HRIT

Recommendation 1: A new *Health Services* bill be drafted to reflect current thinking and practice in the establishment, maintenance, financing and management of hospital and health services delivery within the State.

Recommendation 2: Provision be made in the new bill for the inclusion of the administration and delivery of public hospital and health service as well as monitoring of private sector facilities.

5. Effectiveness of the Operations of the "authorized officers"

The Act attributes powers to the Minister, the board and three statutory officers, namely the Executive Director (Personal Health Services) ("the ED(PH)"), Chief Executive Officer ("the CEO") and the Chief Psychiatrist. The statutory officers and their objectives are identified in the *Health Legislation Administration Act* 1984 ("*the HLAA*")[14]. The objectives of the *HLAA* are to facilitate the coordination of the administration of all Health acts and as such names the above statutory officers and their power of delegation. This legislation was necessary because prior to 1984, there was no single authority delivering hospital and health services and policy, rather three separate departments responsible for Hospital and Allied Services, Mental Health Services and Public Health plus the statutory authority of the individual boards. To that extent, the *HLAA* has achieved its objectives; however the statutory officers identified under that act no longer function in those roles within the *Hospitals and Health Services Act* and as such need amendment in the new bill.

The Act also attributes powers and/or responsibilities upon a number of these statutory positions that are no longer relevant. Two examples are at s 7A(1)(e) which allows the Minister to subsidise "patients who are unable to afford the payment of reasonable fees" and the provision that allows for the levying of a fee upon the owner or agent for the treatment of seamen "injured in the service of a ship[15]" (though it is void if his injury is self inflicted or a venereal disease).

The powers of the statutory officers in a public hospital are similar to those of a Royal Commissioner. In other jurisdictions the Minister or CEO may conduct investigations but instead of specifying a particular statutory title makes provision for 'authorised officers' or designated 'investigators'.

In addition to the diminution of the authority and/or importance of these statutory officers, the Machinery of Government Taskforce ("MoG") made a number of recommendations for streamlining management processes to ensure public sector agencies are responsive to government policy. These include the standardization of administrative bodies and nomenclatures for agency heads plus the removal of the duality of roles some CEO's have in taking instruction from the Minister while being responsible to a board. Clearly, the public hospital and health service sector with its

[14] Sec 6 *Health Legislation Administration Act* 1984
[15] Sec 31A *Hospitals and Health Services Act* 1927

board structure[16], the complicated CEO and ministerial responsibilities plus the three statutory officers fits into this category.

5.1. The Minister

As mentioned earlier, the Minister is responsible for the general administration of the Act. Under s 5A the Minister's duties are to provide; subject to Treasury allocation, all reasonable requirement for the provision of public hospitals and health services by way of accommodation, equipment and staffing.

Section 7A gives the Minister many general powers that would ordinarily be given to a CEO of a department. These powers (along with those in s 5A) introduced in 1972, gave the Minister some "control over the management of public hospitals generally throughout the State"[17] due to the autonomous nature of the majority of public hospitals of the State at that time. Such things as the "establish(ment of) depots and the supply of equipment" [18], the maintenance of "an exchange"[19], the power to "conduct training and instruction"[20] or subsidize "the accommodation of any frail aged person"[21] are more appropriately either removed from the Act or included in the responsibilities of the CEO.

Section 18(2) was similarly introduced in order that "the Minister may, after consultation with a hospital board, give to it (the board) directions as to the exercise of its functions".

In a modern context, the Minister has a responsibility to formulate policies to promote, protect, maintain, develop and improve the health and well being of the people of Western Australia, through the provision and monitoring of hospital and health services. The Minister should retain his/her authority to enter contracts on behalf of the Crown[22] (including Commonwealth/State Health Agreements), to conduct investigations in the public interest[23], and issue written directions to the CEO on any matter in relation to public hospitals and health services that s/he considers necessary or expedient in order to give efficacy to the Act.

Recommendation 3: The new bill to include provisions that grant the Minister all the powers necessary to effectively administer the health system of the State.

[16] Chief Executives appointed by the board have the potential to be responsible to the board, the DG and the Minister.
[17] Western Australia *Parliamentary Debate* Legislative Assembly 27 April 1972 pp1064 (Mr R Davies, Minister for Health)
[18] Sec 7A(1)(a) *Hospitals and Health Services Act* 1927
[19] Sec 7A(1)(b) *Hospitals and Health Services Act* 1927
[20] Sec 7A(1)(bc) *Hospitals and Health Services Act* 1927
[21] Sec 7A(1)(d) *Hospitals and Health Services Act* 1927
[22] Sec 7A(2) *Hospitals and Health Services Act* 1927
[23] Sec 9 *Hospitals and Health Services Act* 1927

5.2. The Chief Executive Officer

The authority of the Chief Executive Officer[24] within the Act is restricted to provisions within Parts IIIA, IIIB, and IIIC as well as in the power to restrain a patient under regulation[25]. Parts IIIA and B pertain to the regulation and monitoring of private health facilities, Part IIIC allows for him/her to direct hospital service providers to supply him/her with certain health information on individuals using their services.

The CEO has no capacity to direct the activities of the boards of public hospitals that deliver the State's hospital and health services. His current capacity to direct is by way of his delegated capacity from the Minister. The inability of the senior public servant of the Health portfolio to direct the activities of public health facilities is anachronistic.

This application of the Act is not ideal in the long term and adds weight to the need for legislative reform.

Recommendation 4: The new bill to empower the CEO to:

a) advise the Minister on all aspects of hospital and health policy and delivery;
b) assist the Minister in the planning, provision, coordination and review of accommodation and services of public health facilities;
c) perform and exercise the functions, powers and duties vested in the Minister by the act; and
d) direct the performance of public health divisional executives.

As mentioned above, the role of the CEO in relation to Part IIIA & IIIB is that of licensing and monitoring of private hospitals and private psychiatric hostels respectively. Before an individual (or body corporate) can obtain a licence s/he must satisfy the CEO that;

"(a) that he or she has attained the age of 18 years;

6. ***that he or she is a person of good character and repute and a fit and proper person to conduct a private hospital***
7. ***that he or she has sufficient material and financial resources available to him or her to comply with the requirements of this Act; and***
8. ***that he or she understands fully the duties and obligations imposed on him or her in relation to the conduct of a private hospital under this Act and otherwise."***[26]

The CEO shall not grant a licence unless he is satisfied –

"(***a) that the proposed premises are suitable to be approved as a private hospital; and***

(b) that arrangements for the management, equipment and staffing of the private hospital are satisfactory."[27]

[24] Until July 2006 referred to as the Commissioner for Health and now defined as "the chief executive officer of the Department" under s 3 of the *HLAA*

[25] Sec 37 (2f)(d) *Hospitals and Health Services Act* 1927

[26] Sec 26B *Hospitals and Health Services Act* 1927

In addition s/he may impose certain conditions upon the licence, including such things as the maximum number of patients (or class of patients) that may be treated at any one time[28] and/or the number and the categories of nursing and other staff.[29] This results in the primary focus of licensing being on the character of the licensee, the construction, establishment and maintenance of premises and the management, equipment and staffing of the facility, not the standard of care or services delivered to the client/patient within these facilities. This is contrary to other jurisdictions, other sectors[30] and community expectations that expect the level or standard of care delivered to patients to be monitored in both private and public facilities.

In some jurisdictions[31] the monitoring of private facilities is covered under a separate act. Research for the review found very little evidence of a sector-wide push for such a division in the legislative processes. In addition, with the increasing integration of public and private facilities and the expansion of the services that are delivered beyond the four walls of a traditional "hospital" facility incorporating both sectors in the one bill with the CEO having overall responsibility for standards maintains a holistic approach to servicing the health care needs of the entire community.

Recommendation 5: The new bill to retain provisions for CEO of the Health portfolio to monitor, evaluate and regulate private health service providers.

The power exercised by the CEO under Part IIIC[32] requires hospitals and health services to supply him/her with certain information to assist in:-

(a) "the management of public hospitals
(b) the regulation of private hospitals and private psychiatric hostels
(c) the planning for and evaluation of hospital and health services; and
(d) the conduct of epidemiological analysis and health research."

This statistical information is vital for both the long and short-term viability of hospital and health service delivery and the advancement of community health and well being at a State and national level. With the increasing mobility of the community and the expectations of individuals to immediate access to the most advanced medical technology it is imperative that the CEO's power to collect, use and disclose this information be maintained.

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[27] Sec 26C *Hospitals and Health Services Act* 1927
[28] Sec 26D(2)(a) *Hospitals and Health Services Act* 1927
[29] Sec 26D(2)(b) *Hospitals and Health Services Act* 1927
[30] Commonwealth aged care facilities accreditation requires the achievement of forty-four care standards.
[31] Queensland and NSW
[32] Sections 26R-T *Hospitals and Health Services Act* 1927

Recommendation 6: The new bill to retain the power for the CEO to collect, use and disclose health information for the planning, research and the advancement of long term public good.

5.3. The Executive Director (Personal Health Services)

The ED(PH)'s authority manifests itself within the Act at s 3(2) in recommending to the Minister the proclamation of a public hospital and at s 10 in authorising persons to visit and or inspect hospitals[33] and medically examine any patient[34]. In addition, the authority of the ED(PH) may be used in court proceedings to certify a person was the subject of detention under regulation[35] and the transfer of patients from one public hospital to another[36].

While the majority of functions of this statutory officer occur under the *Health Act*[37], the DG or his delegate could carry out those few functions performed under this Act. The authority to declare an institution a public hospital is perhaps no longer necessary and the designating of a "senior medical officer" to medically examine any patient and or conduct investigations could be the responsibility of the DG.

5.4. The Chief Psychiatrist

The Chief Psychiatrist has authority under ss 4, 26DA and Part IIIB. Section 4 gives him/her authority to act in "authorized hospitals"[38] in the interest of patients with a mental illness. Section 26DA extends this authority to private facilities. The third provision is through regulations[39] under s 26Q(d)(ii) of Part IIIB, whereby s/he can require the reporting of certain information on residents under the care of a supervisor in a private psychiatric hostel. This 'information' manifests itself as the fulfilment of a set of care standards for residents of these establishments.

The role of this statutory officer in overseeing the monitoring and delivery of hospital and health services to people with a mental illness has also been examined under the review of the *Mental Health Act*[40] and similarly recommends that the position be retained.

Recommendation 7: The powers of the Chief Psychiatrist to monitor the care and treatment of peoples with mental illness be retained (and if necessary expanded) within the new bill.

[33] Under certain conditions in private facilities.
[34] Provided they are a medical practitioner
[35] Sec 37(2g) *Hospitals and Health Services Act* 1927
[36] Sec 37(2)(b) *Hospitals and Health Services Act* 1927
[37] *Health Act* 1911
[38] "authorised hospital" at s 21 *Mental Health Act* 1996 means a hospital (public or private) that can receive involuntary patients
[39] Hospital (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997 Reg 13
[40] *Mental Health Act* 1996

6. Delegating Authority

A flow-on from the powers of the statutory officers is that of their authority to delegate (or sub delegate) in the administration and management of the organisation(s). The Act presently makes few provisions for delegating authority; rather it relies on the powers conveyed through the *HLAA* to facilitate the administration of the functions under the Act. The three instances in the Act where the authority to delegate may be exercised is by the ED(PH) in his/her power to delegate to "authorised officers",[41] the CEO in the licensing process of private facilities may be 'read down' to make use of delegated officers to undertake the activities involved in licensing[42] and under regulation[43] the CEO is able to delegate a medical practitioner or any other person authorized to control any patient whose conduct is detrimental to his own condition or that of any other patient.

The board(s) has no power to delegate.

There has been limited discussion within Health as to the continued relevance of the HLAA. Should this discussion progress, it may be appropriate to incorporate into the new *Health Services Bill*, a capacity for the CEO[44] and any other necessary statutory officers to be authorised to delegate (or sub-delegate) his/her power and functions to appropriate officers.

Recommendation 8: Appropriate delegation powers to be incorporated into the new bill.

7. Effectiveness of the public hospitals boards

The Act allows for two structures, namely the hospital board run by elected/appointed members[45] or by the Minister in place of the board[46]and that of agencies created by the Governor[47]. Neither structure functions as the Act originally intended. As mentioned already, the power of the boards has been vested in the Minister. The only agency formed under s 7A, the Pathcentre, has been incorporated into the administrative division of North Metropolitan Area Health Service. Organisationally, the boards have been replaced by an area health services model of delivery with three primary geographical areas - North Metropolitan Health Service, South Metropolitan Health Service, Western Australian Country Health Service, plus a number of specialist operational areas.

In addition to the complexities of the present legal and administrative structure, the functions of the board(s) as stated earlier are no longer applicable in a modern health service. Examples of this include no provision within the Act for the disbursement of consolidated revenue funding to the board(s), though it does make mention of how the

[41] Sec 10 *H&HSA*
[42] Part III A&B *H&HSA*
[43] Sec 37 (2f)(d) *Hospitals and Health Services Act* 1927
[44] Mentioned at Section 2.5.3
[45] Sec 15 *Hospitals and Health Services Act* 1927
[46] Sec 7 *Hospitals and Health Services Act* 1927
[47] Sec 7B *Hospitals and Health Services Act* 1927

board(s) can allocate those funds. It does however stipulate the purposes for which boards can apply the monies under their control including the maintenance of public hospitals, the equipping of (hospital) buildings, ambulance services, hospital and health services and the control and isolation of persons suffering from any infectious diseases.

The emphasis should be on a State wide approach with an "increased focus on health promotion, improved interface between general practice and the public health system and enhanced community–based aged care, mental health and Aboriginal health services' to improve the health status of Western Australians and reduce the growth in demand for hospital emergency care and beds"[48].

The review envisages the replacement of the redundant board structure and the formalisation of the present administrative arrangements. This would mean the creation of a legal entity (*WAHealth*) under the new legislation. A flow-on from this would be that the CEO able to appoint the senior administrators to the administrative divisions and distribute (subject to government policy) the funding allocation to health service divisions according to current Government policy directives. The CE's of each division would, under the direction of the CEO be responsible for the management of funds and personnel allocated to their divisions.

At present the employment landscape of *WAHealth* is fragmented and complex with the 30,000+ staff having the potential to be employed under one of the 40 different awards or contract types, by one of six employing authorities, under three different acts or in the case of the *Hospitals and Health Services Act*, one of three separate provisions under that act. This fragmentation of the workforce, employment conditions and policies plus the incompatibility of human resource data inhibits workforce planning, the career paths of employees and the achievement of efficiencies in the transfer of staff to areas of need. The future employment model needs to be suitably flexible as to allow for the CEO to appoint accountable senior staff, offer contracts for service, transfer staff across the sector, discipline staff to the point of termination and prescribe sector wide HR standards and conditions.

The ideal would be for *WAHealth* to create one employing entity structure for the delivery of public hospital and health services. Reducing the number of employing authorities will increase the efficiencies of HR data, reduce the diversity of the policies and practice and may facilitate flexibility in the movement of staff across the sector and reduce the 'intellectual' silos of the historical 'hospital based' organisational structures.

This particular facet of the proposed new bill and in the delivery of hospital and health services may be superseded by Government action elsewhere in the form of legislation to make all government employees servants of the State.

[48] *Reid Report* 2004 pp v

Recommendation 9: The new bill to remove the board structure and adopt one legal entity for the delivery of hospital and health services with the Director General/CEO having the power to create whatever administrative divisions s/he so wishes, to perform and exercise the functions, powers and duties vested in the Minister by the Act, and importantly to direct the performance of Chief Executive's of Area Health Services

9. The Department of Health

The Department of Health (the "DoH") is established under a separate act, that of s 35 of the *Public Sector Management Act* 1994. As the State's principal health authority, its key objective is to secure the greatest possible improvement in the health and quality of life for all Western Australians. Its major functions are to:

- ***understand the health status of the community, purchase relevant health services for the people, and monitor the appropriateness and quality of the services provided; develop and review health policy and legislation, and ensure compliance with policy, quality standards, and statutory obligation within its area of responsibility***
- ***acquire and maintain resources and encourage research to improve health outcomes***
- ***provide support and advice to the minister for Health; and***
- ***deliver health services to the community, clients and patients."***[49]

Three specific Health reports commissioned by Government since 2001[50] have recommended streamlining of the structures within the Health portfolio. These included the *Report of the Health Administrative Review Committee*[51] (HARC), the *Country Health Services Review*[52] (CSR) and the *Health Reform Committee Report*[53] (the *Reid Report*). The CSR reinforced the need for legislative reform to aid in the development of future strategies for rural public health, while the *Reid Report* further refined the HARC recommendations on:

- a single management structure;
- the restructuring of human resources systems;
- staffing arrangements;
- the centralising of supply mechanisms; and
- the reorientation of accountability of chief executives ("the CE's") of area health services to the Director General for Health ("the DG").

Revision of the legislation underpinning these recommendations continues to be undertaken. A new *Health Services* bill will enhance the re-alignment sought earlier.

At Section 5.2 mention is made of the CEO's powers to license private health facilities. This function has been delegated to officers in the Licensing Standards and

[49] Hicks S. 2001 *Government Structures for Better Results* pp 145 ("MoG" Taskforce)
[50] In line with the MoG Taskforce
[51] Department of Health. 2001 *Report of the Health Administrative Review Committee,* Government of Western Australia
[52] Department of Health 2003 *Country Health Services Review,* Government of Western Australia
[53] Department of Health. 2004 *A Healthy Future for Western Australians* Government of Western Australia

Review Unit (the "LSRU")[54]. Other sectors of DoH are also involved in the monitoring and regulating of the private health facilities including the Office of the Chief Psychiatrist (under ss 26DA and 26Q(d) of the Act), Mental Health Services, Aged Care and other sections of the divisions of Health Protection as well as Health Policy & Clinical Reform.

However, given the narrowness of the licensing provisions there is no integration between the standards required of the other sections of DoH (mentioned above) and the granting of a license. This is particularly true in the maintenance of care standards within aged care facilities and services for people with mental illnesses.

Recommendation 10: The criteria for licensing private health facilities be broadened to include care standards and compliance with DoH service agreements.

[54] Part of the Health Protection Division of Department of Health