SUMMARY PAPER
RECOMMENDATIONS OF THE HEALTH REFORM COMMITTEE
IMPLEMENTATION OF RECOMMENDATIONS

Note: This paper is a subjective review of the implementation of recommendations of the Health Reform Committee (HRC; "Reid Review") to assist the Sustainable Health Review (SHR) Panel in identifying lessons relevant to the SHR. Information was gathered from a variety of sources, many not directly involved in implementing the HRC recommendations. The paper assesses implementation of HRC recommendations at five years from the report's release; the HRC did not itself recommend implementation occur within a specific timeframe.

1. THE HEALTH REFORM COMMITTEE

- In March 2003 the State Government appointed a Health Reform Committee (HRC), which it tasked with developing a vision for the Western Australian health system. The HRC was chaired by Professor Mick Reid, a former Director General of NSW Health.
- The HRC terms of reference required it to develop a plan to improve the quality of health services and manage costs of the health system, with a focus on strategies which would:
  - improve health and health outcomes;
  - ensure quality of care;
  - increase effectiveness and efficiency of clinical services;
  - ensure transparency and accountability of the health sector;
  - enhance management and information systems; and
  - address State/Commonwealth issues.
- In March 2004 the HRC presented its final report, *A Healthy Future for Western Australians.* The then Government endorsed 85 of the 86 recommendations.

2. HEALTH REFORM IMPLEMENTATION TASKFORCE

- In August 2004 a Health Reform Implementation Taskforce (HRIT) was created to have overall carriage of the reform agenda and responsibility for implementing the 85 endorsed recommendations; it was operated independently of the Department of Health and reported directly to the Minister for Health.
- The HRIT workplan created 91 health reform projects to pursue the recommendations, with the projects organised into 10 chapters:
  1. Population health, primary and community care
  2. Mental health
  3. Infrastructure
  4. Country services
  5. Clinical services
  6. System efficiencies
  7. Workforce
  8. Organisation and governance
  9. Information management/information technology
  10. Research and training.
- The implementation program was designed to be over four years.
- The HRIT produced a workplan which outlined agreed priorities, timeframes and key milestones for each recommendation.
- From November 2005 the review of the reform agenda's progress was assessed by the Health Reform Implementation Steering Committee. From 2005 through 2008 six-monthly reports on the progress of the health reform agenda were submitted to the Expenditure Review Committee of State Cabinet.
- Public reporting on progress initially was via "community report cards". The first community report card, based on the HRIT workplan was published in August 2006. In April 2007, the quarterly community report cards were replaced by an ongoing series of community newspaper advertorials that presented information to the public on a variety of health services such as elective surgery, emergency departments, after hours GP clinics and the health call centres.
- After a period of approximately six months the HRIT function was absorbed into the Department of Health. Over a further period of several years actions in response to the Reid Review were progressively became part of into the "regular business" of the Department rather than implementation being pursued as a stand-alone project.

3. ASSESSMENT OF IMPLEMENTATION OF RECOMMENDATIONS

- Attachment A provides an assessment of the implementation of the *Reid Review* recommendations. It considers the progress in implementing recommendations at 5 years after the finalisation of the Review.
- The SHR has assigned a green, amber or red rating for each recommendation:
  - A green assessment was given if at 5 years the recommendation was either implemented or considered on track to be achieved in line with the review's vision.
  - An amber assessment was given if:
    - Partial / reasonable level of progress had been made; or
    - the recommendation had been considered and some variation had been made relative to what was proposed (policy/priority change).
  - A red assessment was given if there had been no or unsatisfactory progress towards implementing the recommendation, particularly on a system-wide basis.
- In the assessment, officers in the Sustainable Health Review Secretariat have sourced information from:
  - past Department of Health briefing notes and a 2011 Department of Health report on the implementation of recommendations;
  - information on the implementation of recommendations supplied by health services;
  - a 2014 report to the Transition and Reconfiguration Steering Committee on the Implementation of the Reid Report
  - information from the November 2017 Clinical Senate session 'Destination: Sustainability';
  - information supplied in 2017 by Health Service Providers, the Department of Health, and selected officers who were involved in the Health Reform Implementation Team.
- Assessment of the progress in implementing recommendations is highly subjective. There is likely to be conflicting views whether a number of the recommendations were progressed satisfactorily.
- Green/amber/red ratings are summarized in the table below:

Green	Amber	Red
39	**31**	**16**

4. OBSERVATIONS

Consideration of the implementation of the *Reid Review* recommendations needs to recognise that the review presented a plan in response to the circumstances at a point in time. The recommendations it made tended to be very specific rather than just providing broad directions. Some were capable of being implemented quickly, while others would obviously take significant time to progress. Some might become outdated with the passage of time or with changes to State or Commonwealth policies.

5.1 Recommendations that have been implemented (green)

- A number of the *Reid Review* recommendations were readily able to be actioned in the short term precisely as recommended in the review, eg.
  - Recommendation 1 proposed a set of objectives for the WA health system. These were reflected in a WA Statement of Strategic Intent published in 2005 and have featured in subsequent Statements of Strategic Intent.
  - A number of recommendations (eg. recommendations 21, 24, 26 and 27) proposed the construction of new or upgrades to existing hospital infrastructure. A plan was developed to construct/expand hospital facilities in line with these recommendations.
  - Recommendation 57 proposed the appointment of a senior advisor on allied health. This was followed by the creation of a Chief Health Professions Officer position.
  - Recommendation 77 proposed that the Department of Health produce a quarterly report card to provide easy access to key health performance statistics. The first report card was published in August 2006.
- A number of the recommendations requiring longer term actions required sustained effort, and good progress was made, eg.
  - Recommendation 20 proposed that multipurpose services and integrated district health services should continue to be developed. In the period since the *Reid Review* there has been a substantial increase in the number of these services.
  - Recommendation 22 proposed the continued increase in the provision of telehealth services. There has since been substantial ongoing expansion of telehealth as a mode of service delivery.

5.2 Recommendations either partially implemented or where there has since been variation from what was proposed (amber)

- In some cases it became apparent that there were barriers to implementing the recommendations precisely as they had been presented. This led to variation between what was recommended and what was ultimately implemented, although the flavour of the Reid recommendations was retained. In some other cases further consideration of issues

led to decisions to pursue alternatives to what the review recommended. In some instances it was not possible to resource the implementation of commitments. Some examples are:

- In 2008 a Coalition Government was elected, with part of its election platform being a commitment to retain Royal Perth Hospital (RPH) as a tertiary hospital. This overtook the plan to close RPH when Fiona Stanley Hospital opened, which had been a logical consequence of the *Reid Review's* recommendation 29.
- Recommendation 30 proposed to have a single management structure for SCGH and RPH. For a brief period SCGH and RPH were brought under a single management structure as per the recommendation. However, a decision was taken to assign RPH to the south metropolitan area, and as a consequence the proposed change in management arrangements was reversed. It is understand this decision was taken in the face of strong resistance by staff to having the hospitals under a single management structure.
- Recommendation 15 was for the development of an Aboriginal primary care strategy with emphasis on the continued roll-out of the Commonwealth Primary Health Care Access Program (PHCAP). Unfortunately, not long after the *Reid Review* was finalised, the Commonwealth decided to discontinue its support for PHCAP.
- Recommendation 38 proposed that existing renal transplant units should be merged into a single integrated service, but it was subsequently decided to maintain to maintain the then status quo of two units.

5.3 Recommendations where no or unsatisfactory progress was made towards implementing the recommendation, particularly on a system-wide basis (red)

- Despite efforts to pursue some recommendations, the envisaged reforms were not achieved on a systemwide basis. Some examples are:
  - Recommendation 32 proposed that a medi hotel facility be established in conjunction with a tertiary hospital. It is understood that tertiary hospitals were asked to assess the feasibility of locating a medi hotel on their sites. . While it is now not clear, it is possible that the hospitals were unenthusiastic or that it was not given priority in the Health capital works programs, or both. It is noteworthy that a key election commitment by the current Government is that medi hotels will be constructed. This commitment is now being pursued as a high priority.
  - Recommendation 79 proposed that there be reforms in a number of identified areas to improve efficiency in service provision and reduce growth in health expenditures in the five years following the review. This either did not occur or efforts proved ineffective.
  - Recommendation 82 pre-supposed that capital investment in new or upgraded infrastructure would lead to more efficient service delivery and a reduced need to grow recurrent expenditures. This did not prove to be the case, wither because the new buildings were used to deliver increased activity or because there was not sustained effort to drive service delivery to become more efficient.

6. CONCLUSIONS

- Implementing the 85 endorsed recommendations of the *Reid Review* was an incredibly large and complex task.
- A number of recommendations were readily implemented in the early period following the review and some longer term recommendations were also implemented in the precise terms presented in the review.
- As time progressed it became apparent that there were major hurdles in pursuing some recommendations; and alternative approaches were often pursued that sought to retain the flavour of what the review had recommended.
- There were some explicit political policy decisions to pursue alternatives to some key recommendations.
- An obsession with infrastructure consumed focus and drew quality resources away from more sustainable and community-focused changes.
- The transition from "reform projects" to "business as usual" failed.
- There weren't robust systems and governance foundations such as ABF to sustain the commitment to change. Stamina in pursuing reforms faded over time, with the shift from an implementation team to a business as usual approach and changes in economic conditions both being key factors.
- A number of recommendations were not implemented on a system-wide basis or what has been pursued is quite different to what the *Reid Review* envisaged. In most of these cases there was an assessment that recommendations have been impractical to implement or it was too difficult to obtain the resources necessary for their implementation. Sometimes this has been because implementation has relied on cooperation from external parties (eg. the Commonwealth), but this has not been forthcoming. In a relatively few cases, there has either been a failure by WA Health to commit to their implementation or efforts at implementation have been made but failed.

ATTACHMENT A - HEAT MAP – IMPLEMENTATION STATUS OF THE REID REVIEW RECOMMENDATIONS

No	Recommendation	RAG
1	The health system of Western Australia should: - promote and protect the health of the people of Western Australia - reduce inequities in health status - provide safe, high quality, evidence-based health care - promote a patient centred continuum of care - ensure value for money - be transparent and accountable - optimise the public/private mix - be financially sustainable, and have a sustainable workforce.	
2	A major, coordinated, long-term health promotion program which has an integrated lifestyle approach to prevent cardiovascular disease, cancer and diabetes should be implemented. This program should include a particular focus on Aboriginal communities. This approach should entail close cooperation with non-government organisations and groups such as the Western Australian Divisions of General Practice network.	
3	In view of the high utilisation of hospital beds by people who suffer falls, there should be a targeted health promotion and prevention program in this area.	
4	A summit of primary care practitioners should be held to identify and develop opportunities for improved interface between GPs and community health personnel in both the public and non-government sectors. The summit should be jointly sponsored by the Department of Health, the Australian Government Department of Health and Ageing, and the Western Australian Divisions of General Practice network.	
5	The technology and infrastructure available through the Health Call Centre should be used to: - support the interface between GPs, community-based services and hospital care, and - enable better monitoring and support of patients with chronic and complex conditions.	
6	Western Australia should support the national call centre framework, and work with the Australian Government to use Western Australia's current call centre infrastructure as part of the national call centre network.	
7	Hospital discharge summaries should be sent to the treating GP either by fax or email within 12 hours of a patient's discharge. This should become standard practice in all hospitals. As electronic patient record systems are developed across the public hospital system, there should be collaboration with GPs to develop standardised electronic discharge summaries.	
8	Early discharge programs which organise and coordinate self-management, home care, and community health support programs, should be extended and involve the non-government and GP sectors.	
9	The Department of Health and the Western Australian Divisions of General Practice network should work collaboratively with the Australian Government to develop and implement comprehensive GP services at, or adjacent to, hospital sites in the metropolitan area.	
10	Programs such as transitional care, post-acute home care packages, intermittent care and the residential care line should be expanded to reduce unnecessary hospital and residential care for older people. These programs should be implemented as soon as possible once hospitalised older people have been assessed as requiring these services	
11	The Department of Health should continue to develop, with the Australian Government, alternative funding options, which enhance flexible packages of care for the older person.	
12	Recognising the importance of mental health and the projected growth in mental illness, a whole of government approach to mental health and mental illness is needed to provide a framework for action by government departments, the non-government sector and the community.	
13	A major focus in the treatment of mental health should be in prevention and early intervention programs and services.	
14	Initiatives aimed at improving community-based mental health care and the integration of these services with the hospital, mental health hostel and supported accommodation sector should be pursued.	
15	A primary care strategy for Aboriginal people should be developed and implemented according to the informed preferences of the communities themselves and in collaboration with the Office of Aboriginal and Torres Strait Islander Health in the Australian Government Department of Health and Ageing. This strategy should emphasise the continued roll out of the Primary Health Care Access Program.	
16	Recognising the need for coordination to improve child and maternal health, an inter-agency working group should be established to drive a new approach.	
17	Evidence-based clinical guidelines should be developed and implemented, focusing in the first instance on the needs of patients with chronic and complex conditions. This development should involve a multi-disciplinary clinical team, both hospital and community-based, and consumers.	

18	The Department of Health should progressively implement a system-wide clinical information system which incorporates the public and private hospital, community health, primary care and mental health sectors. This system would include electronic patient records, unique medical record numbers, and provider identification.	
19	The vision for country health services as outlined in The Country Health Services Review is endorsed.	
20	Multi purpose services and integrated district health services should continue to be developed in collaboration with local service providers and the Australian Government to provide more comprehensive, accessible and sustainable	
21	The proposal to develop regional hospitals into regional resource centres in Geraldton, Broome, Port Hedland, Kalgoorlie, Bunbury and Albany to provide more locally accessible hospital care, where clinically appropriate, is endorsed.	
22	Opportunities for telehealth to be a component of the integrated care system should continue to be explored. Further development will rely on clinical leadership and the availability of appropriate bandwidth and other infrastructure.	
23	The planning and provision of hospital and community-based services in the metropolitan area should be based upon integrated models of care for both north and south of the river. This north/south model is reflected in the recommended changes to the Department of Health's organisational structure (refer to Recommendation 69).	
24	Rockingham/Kwinana District, Joondalup Health Campus, Swan District and Armadale Kelmscott Memorial hospitals should be expanded over the next 10 years to approximately 300 bed general hospitals. This development will improve access to hospital care in high-growth metropolitan areas and reduce demands on the tertiary hospitals for general care.	
25	Conjoint clinical staff appointments within Area Health Services will enable appointments to both a tertiary and general hospital. Such appointments will allow for additional capacity and complexity in general hospitals.	
26	Other metropolitan hospitals should be reconfigured in the following manner: - Osborne Park and Bentley hospitals - dedicated sub-acute, aged care, rehabilitation and mental health facilities. - Royal Perth Rehabilitation Hospital, Shenton Park Campus - to be closed, with the acute rehabilitation services moved to the Northern Tertiary Hospital site and the non-acute rehabilitation services moved to Osborne Park, Fremantle and Bentley hospitals. - Woodside Maternity Hospital - to be closed once an appropriate replacement facility south of the river has been identified. - Graylands Selby-Lemnos Hospital - continues current role as the major mental health facility. - Kalamunda Hospital - sub-acute, aged care, rehabilitation, day surgery and support for community-based palliative care.	
27	A new major tertiary hospital should be constructed to service the south of Perth and incorporate the tertiary clinical services of Fremantle Hospital together with designated clinical groups from Royal Perth and Sir Charles Gairdner hospitals. The preferred location for this hospital is at Murdoch, and planning should commence immediately.	
28	With the development of the new Southern Tertiary Hospital, Fremantle Hospital should be reconfigured to provide rehabilitation, mental health and aged care services and primary/community care.	
29	There should be one tertiary hospital in the Northern Area Health Service. This should be located on one site. While there are strong arguments for consolidation to either the Royal Perth Hospital or the Queen Elizabeth II Medical Centre site, the preference is for this hospital to be located on the Queen Elizabeth II Medical Centre site. A focused and time limited community and clinical consultative process should occur and a detailed business case developed by September 2004, before the final decision is made.	
30	To assist with the development of the new Northern Tertiary Hospital, a single management and clinical staffing structure across Royal Perth and Sir Charles Gairdner hospitals should be implemented along with the formal establishment of the Northern and Southern Area Health Services.	
31	King Edward Memorial and Princess Margaret hospitals should be rebuilt and co-located with an adult tertiary hospital to gain significant clinical benefits. King Edward Memorial Hospital should be relocated within the medium term, and Princess Margaret Hospital rebuilt as part of a second phase, together with the Telethon Institute for Child Health Research. The Women's and Children's Health Service should remain a separate and independent Area Health Service, and the two relocated hospitals should retain their current names.	
32	A Medi-hotel facility should be established in conjunction with a tertiary hospital with an evaluation of its effectiveness undertaken.	
33	The Northern Tertiary Hospital should be designated as the State centre for major adult trauma, and Princess Margaret Hospital as the State centre for major paediatric trauma. Emergency departments should be expanded in each of the four general hospitals to accommodate emergency adult and paediatric care, excluding only major trauma.	

34	Cardiothoracic services should operate as an integrated service, reporting to a single head of department with common management and audit protocols and integrated on-call rosters. This approach should be reviewed once the new Southern Tertiary Hospital is operational. The statewide Paediatric Cardiac Surgical Unit at Princess Margaret Hospital should continue	
35	The decision by the Department of Health to move to a single neurosurgery service is endorsed.	
36	One tertiary hospital should be designated as the main tertiary site for haemodialysis services and act as the centre of excellence for the State.	
37	Home and community-based renal haemodialysis should be expanded across the State, and satellite haemodialysis services should be provided in metropolitan and country centres. These services should be developed under the umbrella of a statewide plan for renal haemodialysis services, which particularly addresses poor access by Aboriginal communities in rural and remote areas.	
38	Pending the establishment of a single renal transplant service at the Northern Tertiary Hospital, the two existing transplant units should be merged into a single integrated service that reports to a single head of department with common management and audit protocols, and integrated on-call rosters.	
39	Transplantation services for liver, heart and lung should continue as at present.	
40	The proposal to establish a State Centre for Cancer Care to integrate and coordinate delivery of cancer care across the State is fully endorsed.	
41	Purpose built facilities to provide for inpatient, day and ambulatory palliative care hospice services should be incorporated into the four designated general hospitals. These services should form an integrated network with existing community-based palliative care services, including supporting end of life care in residential aged care facilities.	
42	The recommendations of the 'Western Australian Statewide Obstetric Services Review' are supported and should be implemented as part of the overall implementation of this report. These recommendations include: - recognising King Edward Memorial Hospital as a centre of excellence that provides a statewide service, including policy advice, clinical guidelines and service coordination, and - providing gynaecological and obstetrics care services at the four designated general hospitals.	
43	Both the Northern and Southern Tertiary Hospitals, and Princess Margaret Hospital will need to be reconfigured with increased adult and paediatric ventilated intensive care beds, as recommended in the 'Development of a Five to Ten Year Plan for Intensive Care Services in Western Australia' review.	
44	The level of outpatient services in the State's tertiary hospitals should be progressively decreased, with enhanced roles for the non-tertiary hospitals and private practice.	
45	Routine elective surgery such as orthopaedics should be accommodated in the four general hospitals with strong links to the associated tertiary hospital.	
46	Strategies to reduce the average length of stay for targeted hospital patient groups should be implemented. These strategies should focus on the key areas of chronic disease management, rehabilitation, aged care, mental health, and short stay surgical and non-surgical acute services, and be fully implemented within five years.	
47	Targets should be established for improving rates of day of surgery admission and day procedures.	
48	The recommendations and approaches outlined in the pathology, pharmacy and food services reviews are endorsed.	
49	A single pathology service should be created within the metropolitan health services by 2005. This new service, headed by a Chief Executive, should deliver efficiencies while enabling the planned development of specialist services. A Western Australian system-wide drug formulary and drug bar coding should be developed and implemented. Hospital food services should be reformed by implementing system-wide standards and performance indicators, and introducing a computerised food service system.	
50	A dedicated group within HealthSupply WA in the Department of Health should be established to drive procurement reform. This group should include clinician involvement, and focus on key areas of product rationalisation and consolidation of contracting, tendering, distribution and warehousing services.	
51	Oncology and sterile manufacturing should be reviewed within 12 months to improve efficiency in these services by realising economies of scale in production and distribution.	
52	Staff throughout the public health sector should be offered opportunities to contribute to the development of a State health strategic plan	
53	The Western Australian public health system should support and reward innovation and continuous improvement. Mechanisms to achieve this should include development of a dedicated innovations website and the establishment of both an innovations fund and an innovation awards program.	
54	The Department of Health should develop its workforce planning tools and capacity in collaboration with the universities, colleges of TAFE, the Department of Education and Training and the Australian Government.	
55	A healthy workforce strategic plan should be developed which aligns with the State health strategic plan.	
56	Discussions should occur between the Department of Health, major private hospitals, clinicians, medical colleges	

	and universities to consider new approaches to under-graduate and postgraduate medical training. This will ensure greater involvement of the non-tertiary public hospitals, private hospitals, and the primary care sector.	
57	A senior adviser on allied health should be appointed to the Department of Health initially to assist with the development of a comprehensive strategy addressing allied health workforce issues.	
58	Increased numbers of Aboriginal health professionals should be employed in the Western Australian public health system. Employment targets should be set in area performance agreements to achieve this (refer Recommendation 73).	
59	Western Australia should establish a Strategic Medical and Health Research Policy Council and associated Research Development Unit to allow for a more collaborative and strategic approach to medical research in this State.	
60	Clinical leadership in the change process should be appropriately recognised and supported. Cross-institutional clinical collaboratives should facilitate this leadership role.	
61	The concept of Area Health Services should be retained and further developed. Attention needs to be given to: - better role definition between Area Health Services and the Royal Street office - improving links between metropolitan and country Areas - reconfiguring the metropolitan Area Health Services to a north/south Area model, and enhancing the Area Health Services responsibilities for the health of the population within their catchment Area.	
62	The Department of Health's Royal Street office should be responsible for coordinating system wide policy and planning, allocating resources, managing the system's regulatory framework, monitoring and evaluating performance, and ensuring the State Government's financial, social and environmental aims for health are met.	
63	The service delivery components of population health, aged care, dental health, mental health and Aboriginal health programs, which are currently provided by the Royal Street office, should as far as possible be devolved to the Area Health Services. The associated budgets allocated to these programs should also be devolved.	
64	The role of Area Chief Executives should be focused on improving and maintaining the health of the Areas population and the management of all health services.	
65	To clarify its role as an advisory body to the Director General of Health, the State Health Management Team should be renamed the State Health Executive Forum.	
66	Formal links between the country and metropolitan Area Health Services, which ensure regional patients have timely access to tertiary health care and up to date professional expertise, should be clearly described. The performance agreements of the metropolitan Area Chief Executives should explicitly include these linkages.	
67	Community advisory committees should be established in the metropolitan and South West Area Health Services to enable local communities to contribute to decisions about service priorities and plans.	
68	The Health Consumers' Council (WA) should be asked to provide regular feedback on health system performance and major health system issues.	
69	The Area Health Service structure should be modified as soon as possible to include only three metropolitan Area Health Services: - a North Metropolitan Area Health Service responsible for the health needs of the population north of the Swan River - a South Metropolitan Area Health Service responsible for the health needs of the population south of the Swan River, and - a Women's and Children's Health Service.	
70	The Women's and Children's Health Service should be responsible for coordinating and integrating a statewide service for the health needs of the State's women and children. This will involve collaboration and consultation with a range of service providers in order to provide for the health needs of women and children from prevention and early intervention all the way through to tertiary care.	
71	The Department of Health should work to improve joint Australian/State Government planning and service provision, integrated models of care and pooled funding. The newly established Bilateral Working Group should be used as a vehicle to achieve this.	
72	The Department of Health should adopt a funding model of annually allocating health resources to Area Health Services which is population and output based. The model should: - be based on the principle of fairness - recognise the needs of specific population groups - be transparent, and - quarantine funds for designated services/programs such as Aboriginal health, mental health and population health. This funding model should be developed throughout 2004 and implemented in 2005/06.	
73	Comprehensive annual performance agreements between the Director General of Health and Area Chief Executives which specify targets for designated service priorities and financial outcomes should be implemented	

	in 2004/05. The same discipline should operate internally within the Royal Street office.	
74	A statewide Clinical Governance Framework which involves the following four pillars should be implemented within two years: - clinical audit - clinical risk - consumer values, and - professional development and management.	
75	A culture of continuous performance improvement that focuses on regular performance monitoring and benchmarking should be promoted	
76	An improved outcome statement, output structure and key efficiency and effectiveness indicators should be developed and used in the 2005/06 State budget. These indicators should address clinical outcomes, quality, safety, equity, financial performance and workforce utilisation.	
77	The Department of Health should produce a quarterly report card which gives the community and other stakeholders easy access to key statistics on health system performance.	
78	The public health system's data and information should be: - consolidated into a central repository, to be managed by the Royal Street office. A review of the system's current data sources and management should be undertaken within 12 months to achieve this, and - enhanced to improve integrity, consistency and reliability as a matter of priority.	
79	Reforms in the following areas should be implemented to reduce the growth in the health expenditure over the next five years: - avoiding unnecessary hospital admission by providing better integrated primary care services, and community and home-based care, particularly for older people and for people with chronic and complex conditions - providing health care in the most appropriate setting including building the capacity of Perth's general hospitals, and providing dedicated sub-acute facilities to redirect non-tertiary work away from the tertiary hospitals - reducing the average length of stay in hospitals to national benchmark levels in areas where this has currently not been achieved - achieving national benchmarks in relation to rates of day surgery procedures and rates of day surgery admissions - reducing the cost structure of hospital services through increasing efficiencies via better management, and - increasing operational efficiency by providing modern, well designed hospital facilities.	
80	There should be an ongoing program of analysis to identify cost drivers within hospitals, to: - support managers in analysing costs and delivering improved efficiency, and - enable the Royal Street office to undertake system-wide analysis of major areas of expenditure and cost growth.	
81	The Department of Health should pursue revenue raising initiatives, which will increase the State health system's per capita 'own-source' revenue to the national average by 2006/07. This will include setting revenue targets for Area Health Services.	
82	The capital investment required to achieve an average two percentage points per annum reduction in recurrent expenditure growth should be planned and developed with robust business cases for investment. In turn, the State health system must plan and manage its service provision and reform agenda to meet this aim.	
83	A Health Reform Action Plan and Communication Strategy should be developed by the Director General of Health for consideration by the Minister for Health and Expenditure Review Committee by 31 May 2004.	
84	An external reference group with an independent chair should be established that reports to both the Minister for Health and the Treasurer, and externally monitors and reports on implementation of the reform agenda. There should be a consumer representative on this group.	
85	A Health Reform Implementation Coordination Unit that reports directly to the Director General of Health should be created to encourage and have overall carriage of the reform implementation of this report. Designated implementation teams should be formed around specific report recommendations.	
86	For the clinical reform strategies the principal advisory group to the Health Reform Implementation Coordination Unit should be the Clinical Senate.	