Government of **Western Australia**
Department of **Health**

Department of Health
Annual Report 2015–16





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Department of Health
Annual Report 2015–16

Department of Health

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Statement of compliance

HON MR JOHN DAY BSc BDSc MLA
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Department of Health for the financial year ended 30 June 2016.

The Annual Report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

15 September 2016

Contents

Overview of agency

Vision statement

Vision

To deliver a safe, high quality, sustainable health system for all Western Australians.

Values

WA Health's Code of Conduct identifies the values that we hold as fundamental in our work and describes how these values translate into action.

Our values are:

Priorities

Our strategic priorities are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.

Ensuring people in Western Australia receive safe, high quality and accessible health services underpins our strategic priorities. This includes delivering health services that are patient centred, based on evidence and within a culture of continuous improvement.

WA Health's strategic priorities are:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services.

Executive summary

The 2015–16 financial year marked the end of an era for WA Health, as the health system made preparations to move away from a centralised governance structure and embrace a devolved structure as of 1 July 2016.

Guided by the *WA Health Reform Program 2015–2020*, WA Health spent 2015–16 planning for the transition to the new governance arrangements, which will support the ongoing sustainability and performance of the health system, and make it more responsive to local communities.

Central to the new structure was the passing of the *Health Services Act 2016*, which received Royal Assent on 26 May 2016.

The new legislation allowed for the creation of five Health Service Providers as separate statutory authorities, governed by Boards, which are legally responsible and accountable for the oversight of hospital and health service delivery in their area. This included the creation of the new East Metropolitan Health Service.

The Health Information Network, Health Corporate Network and Health Supply Network were also amalgamated as Health Support Services, which from 1 July 2016 was created as a non-Board governed Health Service Provider.

The legislation also established the Department of Health as the 'System Manager', responsible for the overall management, performance and strategic direction of WA Health.

Also in 2015–16, the *Mental Health Act 2014* was enacted and the long-awaited *Public Health Bill 2014* passed through Parliament, replacing 100-year-old legislation and introducing a contemporary approach to managing public health.

In addition, the State's $7 billion infrastructure program continued its success, with the opening of the 307-bed St John of God Midland Public Hospital, which replaced the outdated Swan District Hospital.

Significant headway was also made in preparation for the opening of the new Perth Children's Hospital in the coming months.

In country Western Australia, new emergency departments opened in Esperance and Carnarvon and extensive upgrades were made to the emergency department at Broome Health Campus; Exmouth Health Service upgrade was completed; and clinical works at Kalgoorlie Health Campus were finalised.

Information and Communications Technology (ICT) service delivery was also improved with the upgrade of more than 90 per cent of WA Health's computer fleet and the establishment of an Incident Management Triage team to provide a 24-hour-a-day, seven-day-a-week, on-call facility for hospital staff requiring assistance with an ICT issue.

Roll-out of core clinical applications continued and the Psychiatric Online Information System was upgraded to support the implementation of changes to the *Mental Health Act 2014*. A contract was also awarded for the implementation of a new Laboratory Information System to support the delivery of pathology services.

The most notable achievement of 2015–16, however, was the way in which WA Health's professional, 42,000-strong workforce continued to excel at its core business of delivering world-class health care to the people of Western Australia, while also meeting increasing demand on the system.

In 2015–16 WA Health managed:

- more than 562,000 inpatient separations, an increase of 25,000 on the previous year
- more than one million emergency department attendances, an increase of 20,000 on the previous year
- more than 2.4 million outpatient occasions of service – an increase of 145,000 on the previous year.

WA Health also performed well for the community against the four strategic priorities outlined in the *WA Health Strategic Intent 2015–2020*: Prevention and Community Care Services; Health Services; Chronic Disease Services; and Aboriginal Health Services.

Prevention and Community Care Services

The passing of the new *Public Health Bill 2014* through Parliament on 30 June 2016 was the culmination of a significant regulatory reform project led by the Department of Health.

The new Bill repeals much of the outdated *Health Act 1911* and strengthens Western Australia's capacity to deal with contemporary public health issues such as preventable diseases and emerging risks from new industries, as well as emergencies including global epidemics.


WA Health

In 2015–16, the Department of Health's public health team implemented the State Government ban on commercial solaria, established a framework to address Zika virus, and consolidated the State Health Emergency Management Policy. It also implemented a new program to provide free pertussis vaccine to pregnant women and ran the statewide mosquito control campaign 'Fight the Bite'.

This year also saw the launch of the *WA Rare Diseases Strategic Framework and Implementation Plan 2015–2018*. The first of its kind in Australia, this Framework is a comprehensive plan for improving the health and wellbeing of people living with a rare disease, enabling more timely diagnosis and better integrated care.

In 2015–16, the Department's Office of Mental Health undertook an extensive implementation program for the *Mental Health Act 2014*, which commenced on 30 November 2015. This included training more than 3,500 mental health staff, clinical and administrative system redesign, and a coordinated communication strategy across the public health system. An impact study was also undertaken to examine the initial changes of the new legislation on mental health services.

The Department completed 95 per cent (72) of its 76 endorsed recommendations from the 'Stokes Review' – which reviewed the admission or referral to, and the discharge and transfer practices of, public mental health facilities and services in Western Australia. The remaining four recommendations are due for completion in 2016–17.

Work began on the *State Oral Health Plan 2016–2020*, which will be the first of its kind in Western Australia. The State Oral Health Advisory Council was also established in November 2015.

Health Services

The Department of Health is a key part of the broader health system, responsible for health sector planning, providing advice to Government and supporting the health services to provide world-class health care to nearly 2.6 million people.

In 2015–16, the Department launched the *WA Health Workforce Strategy 2016–2020* to ensure the adequate supply of an appropriately skilled, diverse and flexible workforce.

On 1 April 2016, the Department introduced the new WA Elective Services Target (WEST) and a new statewide WA Emergency Access Target (WEAT) to replace the discontinued national targets. The WEST measures the percentage of over boundary cases (those waiting longer than the clinically recommended time) on the waiting list, with a target of 0 per cent. The WEAT requires that 90 per cent of all patients presenting to a public hospital emergency department will be seen and admitted, transferred or discharged within four hours.

These new initiatives continue to drive local improvement and maintain Western Australia's positon as one of the best performing States in terms of elective surgery wait times, and access to emergency care.

Other initiatives to improve access to, and the function of, health services in 2015–16 include:

- the *WA Adult Gastrointestinal Endoscopy Services Strategy 2015–2020* to address waiting lists, improve referral processes and develop care pathways for endoscopy patients
- the Theatre Efficiency Reform Program to deliver efficiency improvements in hospital operating theatres
- a model for ambulance distribution which provides ambulance officers with enhanced clinical services information so the patient arrives at the right hospital, as well as a mechanism to trigger changes to distribution based on ambulance thresholds per site.
- a policy outlining a change in practice in tertiary adult hospitals whereby ambulance officers handover patients to hospital staff within 30 minutes.
- a statewide, Acute Stroke Pathway to improve access for regional stroke patients requiring treatment in specialist metropolitan stroke units
- a Steering Committee to oversee the implementation of the recommendations from the Review of Maternity Services in Metropolitan non-tertiary hospitals.

Work also continued to progress the *WA Health Clinical Services Framework 2014–2024* through the establishment of specialty action groups for priority areas. For example, the Statewide Paediatric Reconfiguration Steering Committee was formed to determine the expected volume and appropriate distribution of paediatric activity across WA.

The WA Health Central Referral Service continued to manage first specialist outpatient referrals into the WA health system, distributing outpatient activity in a strategic, consistent and documented manner to improve patient access to care. As at July 2016, the service had received approximately 379,000 referrals since its establishment in February 2014.

Significant reform was also undertaken to achieve greater efficiency in the delivery and management of health resources including the implementation of key national Activity Based Funding reform initiatives. A number of Activity Based Management (ABM) Business Intelligence Tools were trialled and the Department hosted a major ABM conference to improve the knowledge of frontline staff on clinical performance and service delivery cost.

In procurement, a new contract management model for whole-of-Health contracts strengthened oversight of contracts, improved contract compliance and clinical engagement, and delivered savings of more than $6.6 million.

In 2015–16, WA Health's inaugural Strategic Procurement Program moved into its second phase, focusing on improving capacity, compliance and capability in procurement management practices and processes.

Key achievements and activities in 2015–16 included:

- the development of a binding Procurement Policy Framework to ensure consistent processes and governance for Health Service Providers undertaking procurement activity
- the development of a comprehensive register of WA Health contracts and procurement processes through the Procurement Development and Management System
- the incorporation of consistent procurement authorisations within in each Health Service
- the launch of tailored contract management training and education initiatives across WA Health.

The Department of Health also continued to deliver leadership programs and master classes aimed at improving the quality of leadership in the public health system. It assisted in the design and commission of a range of staff development and strategic organisational development initiatives focused on team building, culture and service improvement.

In addition, approximately $18 million was provided in support of health and medical research through core Department of Health programs and the FutureHealth WA (FHWA) initiative. Core Department programs include the Clinician Research Fellowships, Research Translation Projects, Medical and Health Research Infrastructure Fund and the Research Institute Support scheme.

FHWA supported a number of initiatives in 2015–16 including the Telethon–Perth Children's Hospital Research Fund, Merit Awards for emerging WA researchers, the development of a Research Governance Service IT System, and the enhancement of research capacity at Fiona Stanley Hospital. A three-year, $1.3 million FHWA grant was also announced for the development of a Clinical Trials and Data Centre by the WA Health Translation Network (WAHTN).

The WAHTN, which was supported by a FHWA grant in 2014–15, is a consortium of the WA universities, research institutes and public sector hospitals. It aims to accelerate collaboration in the WA health and medical research sector, and facilitate the rapid translation of research outcomes to improved patient care and community health.

Chronic Disease Services

In 2015–16, the Department of Health maintained its investment in high quality, evidence-based, population-wide health promotion programs. These programs target the common, modifiable risk factors for developing chronic disease including smoking, poor nutrition, obesity and insufficient physical activity.

Focus on reducing health conditions linked to excess body mass has continued via the innovative 'LiveLighter' campaign, a flagship initiative for WA Health, run by the National Heart Foundation WA in partnership with the Cancer Council WA. Following its success in Western Australia, this campaign has now been taken up by Departments of Health in Victoria, Queensland and the Australian Capital Territory (ACT).

In partnership with the Heart Foundation (WA Division), the Department's Chronic Disease Prevention Directorate (CDPD) won the Institute of Public Administration Australia WA's 2015 Achievement Award for 'Best Practice in Health and Wellbeing Award' for its WA Healthy Workers Initiative. This suite of government-funded workplace health services aims to address poor diet, physical inactivity, smoking and harmful alcohol consumption.

The CDPD uses targeted approaches to reach those in need. In partnership with the Departments of Education and Regional Development, the CDPD-funded Foodbank WA provides the School Breakfast and Nutrition Program to approximately 17,000 children in more than 400 schools in low socioeconomic status areas, regional and remote Aboriginal communities, and metropolitan schools with high Aboriginal, Culturally and Linguistically-Diverse (CALD) or other nutritionally vulnerable groups.

An increase in the proportion of people who are ageing combined with increased levels of chronic disease and co-morbidities, has required expansion of sub-acute and community care services. In response the Department of Health has:

- expanded the South West Subacute Care Program
- employed a geriatrician to service the Great Southern Region, based at the Albany Hospital Campus
- commenced a trial of a two-year integrated care program via a public-private partnership, with direct involvement of the patient's GP.

Changing health behaviours and building a healthier State takes a multi-sectoral approach. The Department of Health places a high priority on initiating, growing and maintaining partnerships through networking with Government, industry and community services organisations.

Aboriginal Health Services

The Department of Health continues to support and invest in the delivery of services and programs that seek to close the gaps in the health and wellbeing of Aboriginal people.

In 2015–16, a comprehensive statewide consultation process was undertaken to inform the development of an implementation guide to support the *WA Aboriginal Health and Wellbeing Framework 2015–2030*.

The Framework, which guides WA Health and other agencies in their approach to Aboriginal health, was the first of its kind in more than a decade and the first to highlight the importance of prevention and culture in improving health outcomes for Aboriginal people.

A key priority of the Framework is to ensure that WA Health employees are equipped to serve the needs of Aboriginal people and to ensure services are provided in a culturally appropriate manner. In line with this, cultural education and training opportunities have been introduced for all WA Health staff. A mandatory, Aboriginal Cultural eLearning course for all staff was successfully implemented across the health system, with more 65 per cent of WA Health employees completing the training within the first year.

A strong, skilled and growing Aboriginal health workforce across WA Health – including clinical, non-clinical and leadership roles – is vital for a culturally appropriate workforce. In 2015–16, a variety of career pathways and employment opportunities for Aboriginal people were used to increase the number of Aboriginal Health Workers in the system. Training is being conducted to improve the numbers of Aboriginal Allied Health Assistants in rural and remote communities. A pilot to introduce Aboriginal Health Practitioners to the health system has commenced, and cadetships are in place for Aboriginal students studying health and health-related courses.

In addition, the Aboriginal Health Policy Directorate delivered the inaugural WA Health Aboriginal Leadership Excellence and Development Program, which is a talent management and succession planning initiative for Aboriginal staff across the health system.

The *WA Aboriginal Health and Wellbeing Framework 2015–2030* also supports prevention and promotion activities. In 2015–16, WA Health has been working to address the higher rates of vaccine preventable diseases and the lower rates of immunisation coverage of Aboriginal children at 12 months and 2 years, compared to non-Aboriginal children. An Aboriginal Health Workers Immunisation Competency Training Program is now underway to train Aboriginal Health Workers in how to vaccinate children.

The implementation of the *WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2015–18* has begun to combat the high rates of sexually transmitted infections, and blood-borne viruses such as HIV, hepatitis B and hepatitis C amongst Aboriginal people in WA. Developed in consultation with key stakeholder organisations, the Strategy highlights the importance of the partnerships between non-government organisations and government agencies.

In 2015–16 the Department of Health's Communications Directorate partnered with Noongar radio to produce a radio segment called 'Health Matters', which focuses on positive promotion of health matters to an Aboriginal audience, with input from Aboriginal and other health professionals. The program has received positive feedback, and also runs weekly on a prison radio program.

In addition, a comprehensive evaluation of the statewide Specialised Aboriginal Mental Health Service (SSAMHS) is underway, to give consideration to extending funding beyond June 2017. The SSAMHS helps to address the mental health needs of Aboriginal people throughout Western Australia.

The Department of Health is also in partnership with the WA Country Health Service to implement a Fluoride Varnish Program as part of the State Government's Improving Ear, Eye and Oral health of Children in Aboriginal, Rural and Remote Communities Program.

WA Health enters the new financial year keen to consolidate and build upon the reforms and achievements of 2015–16. Key to this will be a smooth transition to the new governance arrangements introduced on 1 July 2016.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

WA at a glance

22,793
babies were born in a WA public hospital in 2015

WA males are expected to live to **81.2** years of age and females to **85.8** years of age

1,708
deaths in WA are caused by coronary heart disease

12,364
people in WA were diagnosed with cancer in 2014

44.2%
of all potentially preventable hospitalisations in WA were due to chronic conditions

24.5%
of 16–24 year olds in WA consume alcohol at high risk of short-term harm

12.3%
of adults living in WA in 2014 were current smokers

59.9%
of WA children do not undertake sufficient physical activity

27.5%
of adults living in WA are obese

92.7%
of adults in WA do not eat 2 serves of fruit and 5 serves of vegetables daily

13.8%
of adults in WA reported being diagnosed with a mental health condition in the last 12 months

74.3%
of Year 8 students were fully immunised against Human Papillomavirus during 2015

Operational structure

Enabling legislation

The Department of Health was established by the Governor under section 35 of the *Public Sector Management Act 1994*. The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 25 Acts and 73 sets of subsidiary legislation.

Administered legislation

Acts administered as at June 2016

- *Anatomy Act 1930*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cremation Act 1929*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Practitioners Regulations National Law (WA) Act 2010*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Quality Improvement) Act 1994*
- *Hospitals and Health Services Act 1927*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medicines and Poisons Act 2014*
- *National Health Funding Pool Act 2012*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Pharmacy Act 2010*
- *Poisons Act 1964*
- *Prostitution Act 2000 (other than section 62 and Part 5)*
- *Radiation Safety Act 1975*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *Western Australia Health Promotion Foundation Act 2016*
- *White Phosphorus Matches Prohibition Act 1912.*

Acts passed during 2015–16

- *Western Australia Health Promotion Foundation Act 2016* was assented on 21 March 2016
- *Health Services Act 2016* was passed on 26 May 2016
- *Public Health Bill 2014* was passed on 30 June 2016.

Bills in Parliament as at June 2016

- *Public Health (Consequential Provisions) Bill 2014.*

Amalgamation and establishment of Boards

There were no Boards amalgamated or established in 2015–16.

Accountable authority

The Director General of Health, Dr David Russell-Weisz, was the accountable authority for the Department of Health in 2015–16.

Responsible Minister

The Department of Health is responsible to the Minister for Health, the Hon. John Day.

WA Health structure

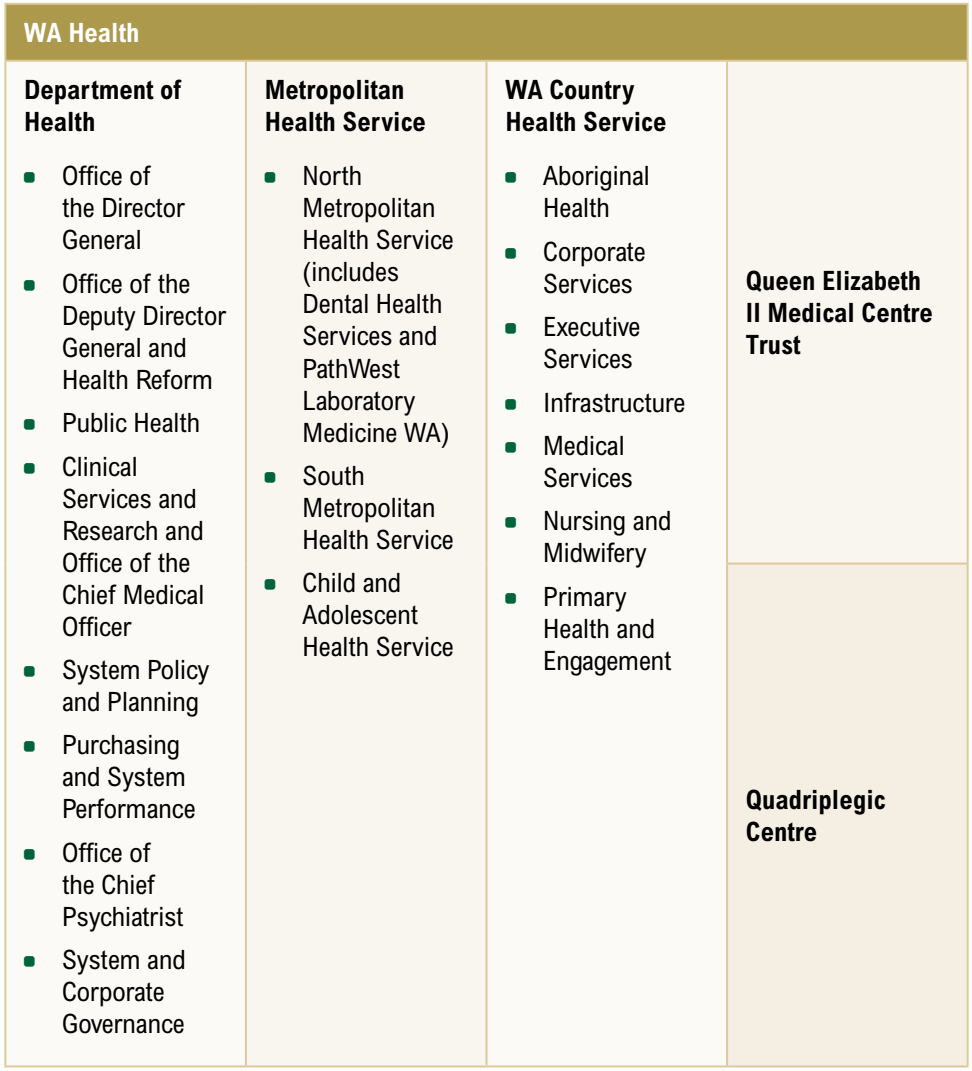
WA Health encompasses five health service areas:

1. Department of Health
2. Metropolitan Health Service
3. WA Country Health Service
4. Quadriplegic Centre
5. Queen Elizabeth II Medical Centre Trust.

Each service area is composed of health service providers and/or support service providers. The Quadriplegic Centre and the Queen Elizabeth II Medical Centre Trust are responsible for submitting their own annual reports.

The WA Health structure is displayed in Figure 1.

Figure 1: **WA Health structure**



WA Health management structure

The State Health Executive Forum is the highest decision making body within the Department of Health, and advises the Director General. This advisory group includes the Chief Executives from the Metropolitan Health Service and the WA Country Health Service as well as Senior Executives from within the Department of Health. Further information on the management structure of the Metropolitan Health Service and the WA Country Health Service is available in the Metropolitan Health Service and the WA Country Health Service Annual Reports, 2015–16.

Figure 2: **State Health Executive Forum management structure**

Minister for Health

Director General

Deputy Director General Department of Health	**Assistant Director General** Public Health	**Assistant Director General** Clinical Services and Research and Office of the Chief Medical Officer
Assistant Director General System Policy and Planning	**Assistant Director General** Purchasing and System Performance	**Assistant Director General** System and Corporate Governance
Director Office of the Director General	**Chief Executive** South Metropolitan Health Service	**Chief Executive** North Metropolitan Health Service
Chief Executive Child and Adolescent Health Service	**Chief Executive** WA Country Health Service	

Senior officers

Senior officers and their area of responsibility for the Department of Health are listed in Table 1.

Table 1: **Department of Health senior officers**

Area of responsibility	Title	Name	Basis of appointment
Department of Health	Director General	Dr David Russell-Weisz	Term Contract
Department of Health	Deputy Director General	Rebecca Brown	Term Contract
Office of the Director General	Director	Patsy Turner	Term Contract
System Policy and Planning	Assistant Director General	Gail Milner	Term Contract
Clinical Services and Research and Office of the Chief Medical Officer	Assistant Director General	Prof. Gary Geelhoed	Term Contract
Public Health	Assistant Director General	Prof. Tarun Weeramanthri	Term Contract
Purchasing and System Performance	Assistant Director General	Angela Kelly	Term Contract
System and Corporate Governance	Assistant Director General	Kylie Towie	Term Contract

The Department of Health's senior officer structure displayed above was in place from July 2015 to June 2016. The senior officer structure includes all officers who were members of the Department Executive for a period greater than three months.

Roles and responsibilities

The Department of Health:

- establishes the strategic direction for the WA Health system to improve health outcomes for all Western Australians
- provides policy oversight and high level advice in relation to a range of clinical and related issues across WA Health and the broader community
- manages resourcing, finance and performance issues with all budget holders including Health Services and the Department of Health Executive
- ensures leadership in innovation, advice, information and guidance on health services for mental health patients, older people and Aboriginal people
- develops, coordinates and delivers a wide range of statewide public health policy and programs.

Office of the Director General

Supports the Director General in both the role as the head of the Department of Health and as the delegate of the Health Service Board by:

- establishing and managing processes, guidelines and communications to ensure that the WA health system meets all ministerial, parliamentary and inter-agency requirements
- providing business support services (Human Resources, Corporate Governance, and Communications Directorate) to the Department of Health divisions
- providing secretariat for key coordination meetings and the Health Service Board meetings.

Office of the Deputy Director General and Health Reform

Supports the Director General of Health by:

- providing overall Health Reform Program management and program communications and implementation support
- supporting the recruitment and establishment of Health Service Boards and delivery of induction for new Board members
- developing an Interim and Statutory Board Operations Framework and supporting its implementation by Health Service Boards. This includes coordinating a System Manager review of Board performance
- supporting the WA Health Information and Communications Technology governance structure and overseeing implementation of the *WA Health Health Information and Communications Technology Strategy 2015–2018*
- reforming WA Health's support services, including the development of a costing and pricing model and Service Level Agreements for Health Support Services and its clients
- overseeing the development and implementation of a functional review of non-clinical functions across WA Health
- implementing system-wide and entity-based transition plans to ensure that the system is able to transition to new governance arrangements while maintaining excellence in clinical care, training, research, policy and planning
- supporting the implementation of binding policy frameworks that are issued by the Director General who will become the System Manager following the enactment of the *Health Services Act 2016*
- setting the WA Health framework for employment and ethical conduct under the *Health Services Act 2016*, and the industrial framework for the WA health system
- providing expert commercial, medical, litigation and general legal advice to WA Health on a broad range of legal matters
- overseeing the delivery of support services to the Department of Health and WA Health Services.

Clinical Services and Research and Office of the Chief Medical Officer

Has responsibility for:

- policy and funding support to Western Australia's health and medical research community, including hospitals, universities and research institutes
- supporting clinical and health research
- providing support, advice and the development of policy concerning blood, therapeutics and health technology
- providing fertility-related information and resources to the community and overseeing the regulation of assisted reproductive technology in WA
- conducting strategic research, planning and projects concerning the speciality medical workforce
- managing recruitment, accreditation, and monitoring of medical pre-vocational training positions
- contributing to the development and achievement of the strategic aims and objectives of WA Health in dental and related activities
- providing high level dental advice to the Director General and Minister for Health, and liaising and communicating actively with dental professional groups, specialist colleges, universities and research agencies
- overseeing the development and fulfilment of strategies to meet the WA public health system's oral health workforce needs in the short, medium and long term
- providing high level advice on issues and trends in the delivery of allied health and health science services across the health system
- ensuring the provision of leadership and strategic direction to the various allied health and health science professions
- developing and coordinating the implementation of policy associated with the development and delivery of allied health and health science services
- providing strategic direction and policy advice for nursing and midwifery professional leadership, workforce and clinical services
- establishing safety and quality policy, guidelines and programs
- licensing and regulation of non-government healthcare providers, and regulation of the Australian Health Service Safety and Quality Accreditation Scheme in WA
- provision of a statewide reporting and monitoring function for clinical incidents including sentinel events and health service complaints.

Office of the Chief Psychiatrist

Has responsibility for ensuring patients' rights are protected through the administration of the *Mental Health Act 2014*, and in supporting clinicians in applying the provisions of the mental health legislation appropriately. Key responsibilities include:

- monitoring of standards of mental health care throughout the state
- participation in a range of state and national committees, working groups and advisory groups relating to matters pertaining to the delivery of high quality mental health care throughout the State
- managing complaints and concerns, including those regarding the standards of psychiatric care and physical care in mental health services and monitoring actions against coronial recommendations
- providing clinical practitioner training and education sessions regarding new medications and adverse reactions, and the mental health legislation
- statutory oversight of any agency that seeks to influence treatment and care of mentally unwell people across WA.

System Policy and Planning Division

Has responsibility for:

- system-wide policy and statewide planning to deliver service improvements and innovative and cost effective programs to enable the best achievable health and wellbeing outcomes for the WA community
- setting the strategic direction across the WA Health's public health system to improve health outcomes for all Aboriginal people living in WA
- developing system-wide policy in accordance with the strategic direction and priorities of the WA Health Networks
- strategic workforce planning and the delivery of workforce development activities
- leading and influencing equitable access to cancer control and end-of-life care in WA through a system of supporting, guiding and delivering high quality cancer prevention, screening, early detection, cancer treatment and palliative care activities and initiatives
- leading the strategic planning, coordination, review and reform of public mental health services.

Public Health

Ensures comprehensive and coordinated leadership, policy, and delivery of public health services through:

- advice and advocacy on public health, pharmaceutical issues and genomics
- regulatory support associated with public health and pharmaceuticals
- surveillance, control and prevention of communicable diseases
- assessment, correction, control and prevention of environmental factors affecting health
- disaster preparedness and management
- prevention of chronic disease and injury
- provision of linked data and epidemiological information and advice.

Purchasing and System Performance

Manages the critical enablers of the health system, performance monitoring, financial management and infrastructure by:

- ensuring that the allocation of resources, the purchasing and performance monitoring of publicly-funded health services, and WA Health's infrastructure planning align with WA Health strategic priorities and policy settings
- administering economic modelling tools, resource allocation methodologies and performance management processes required for the purchase of publicly funded health services
- providing strategic leadership and advice on the operation of WA Health's financial management framework and budget strategy
- undertaking financial accounting and cash management for WA Health, including financial reporting
- Maintaining statewide patient data collections and development of information management policy to support planning, resource allocation, performance reporting and research
- planning and developing WA Health's infrastructure including monitoring of the Capital Works Program, and advice on the purchase, disposal and leasing of land and property
- Developing annual Service Agreements with each Health Service Provider to establish purchasing priorities and ensure a transparent resource allocation process for WA Health in accordance with the *Health Services Act 2016*.

System and Corporate Governance

Management of frameworks and policies that promote system-wide corporate governance, transparency and accountability by:

- assuring that there are appropriate provisions and outcomes for legislative compliance through statutory interpretation, drafting and provision of legal advice to the WA health system
- ensuring that there is a centrally-coordinated environment to manage the legislative portfolio administered by the Minister for Health
- management of policy and practice controls to provide confidence in the transparency and integrity of the WA Health procurement and contracting environment
- monitoring procurement processes within WA Health to ensure that they are efficient, effective and responsive to achieving departmental outcomes
- provision of advisory services on complex and sensitive industrial relations and workforce management issues, central coordination and representation responding to, and negotiating, industrial agreements for WA Health
- maintaining corporate governance practices through auditing and reporting on the internal environments across WA Health on matters of workplace activity
- management of misconduct complaints and promoting awareness about codes of conduct, standards and ethical behaviours expected to be delivered by WA Health staff.

Performance management framework

To comply with its legislative obligation as a WA government agency, WA Health operates under the Outcome Based Management performance management framework. This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. WA Health's key performance indicators measure the effectiveness and efficiency of the health services provided by WA Health in achieving the stated desired health outcomes.

All WA Health reporting entities contribute to the achievement of the outcomes through health services delivered either directly by the entities or indirectly through contracts with non-government organisations.

WA Health's outcomes and key performance indicators for 2015–16 are aligned to the State Government goal of 'greater focus on achieving results in key service delivery areas for the benefit of all Western Australians' (see Figure 3).

The WA Health outcomes for achievement in 2015–16 are as follows:

Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness

Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care

The health service activities that are aligned to Outcome 1 and 2 are cited below (Figures 3 and 4).

Activities related to Outcome 1 aim to:

1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury
2. Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible
3. Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child
4. Provide appropriate care and support for patients and their families during terminal illness.

Activities related to Outcome 2 aim to:

1. Increase the likelihood of optimal health and wellbeing by:
   - providing programs which support the optimal physical, social and emotional development of infants and children
   - encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury through:
   - immunisation programs
   - safety programs.
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - programs for early detection of developmental issues in children and appropriate referral for intervention
   - early identification and intervention of disease and disabling conditions (e.g. breast and cervical cancer screening; screening of newborns) with appropriate referrals
   - programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education)
   - monitoring the incidence of disease in the population to determine the effectiveness of primary health measures.
4. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability, enabling people with chronic illness or disability to maintain as much independence in their everyday life as their illness or disability permits, supporting people in their homes for as long as possible and providing extra care when long-term residential care is required. Services and programs are delivered to:
   - ensure that people experience the minimum of pain and discomfort from their chronic illness or disability
   - maintain the optimal level of physical and social functioning
   - prevent or slow down the progression of the illness or disability
   - enable people to live, as long as possible, in the place of their choice supported by, for example, home care services or home delivery of meals
   - support families and carers in their roles
   - provide access to recreation, education and employment opportunities.

Performance against these activities and outcomes are summarised in the Agency Performance section and described in detail under Key Performance Indicators in the Disclosure and Compliance section of this report.

Figure 3: **Outcomes and key effectiveness indicators aligned to the State Government goal for the Department of Health**

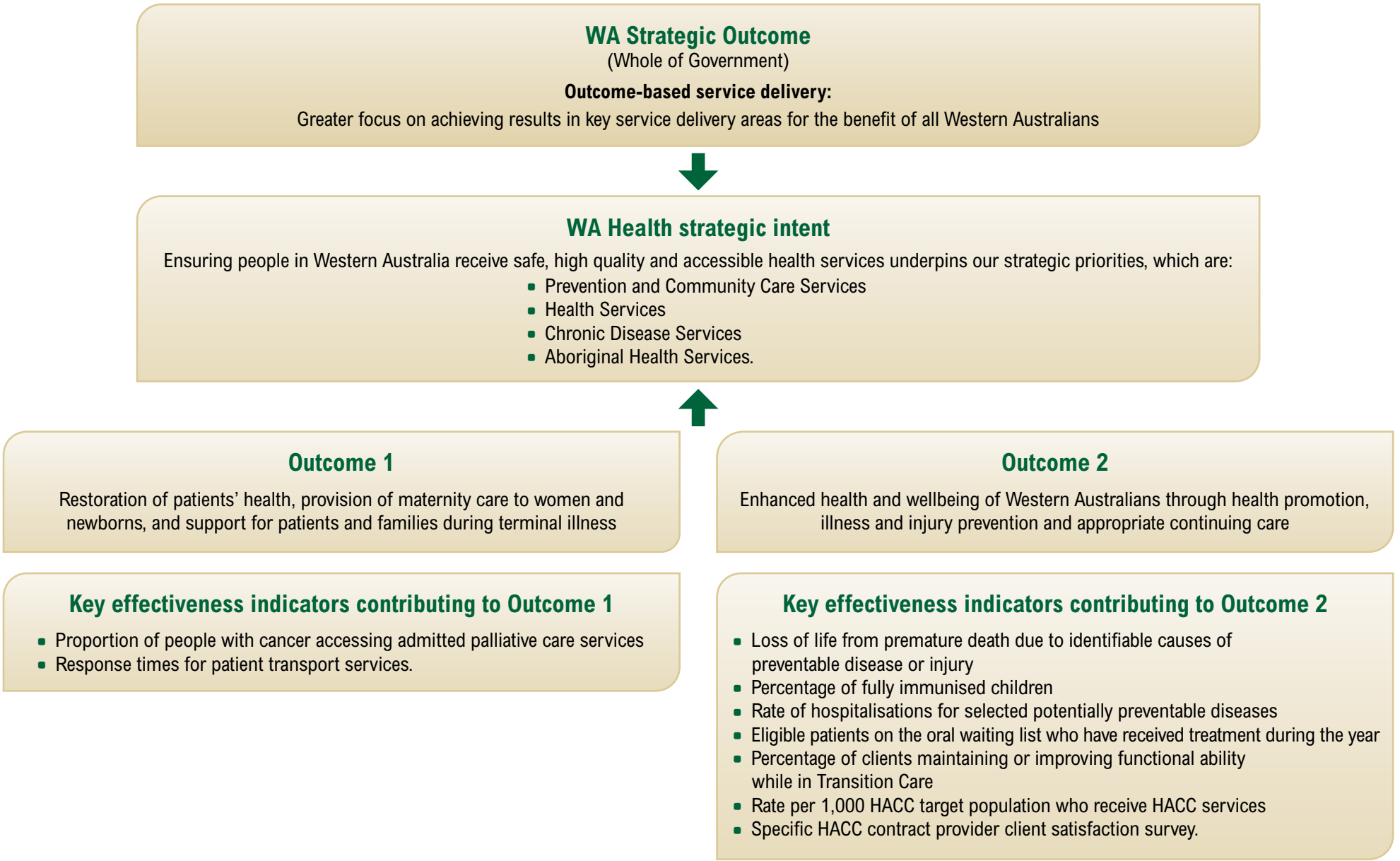


Figure 4: **Services delivered to achieve WA Health outcomes and key efficiency indicators for the Department of Health**

Outcome 1

Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness

Outcome 2

Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care

Services delivered to achieve Outcome 1

1. Public hospital admitted patients
2. Home based hospital programs
3. Palliative care
4. Emergency department
5. Public hospital non-admitted patients
6. Patient transport.

Services delivered to achieve Outcome 2

7. Prevention, promotion and protection
8. Dental health
9. Continuing care
10. Contracted mental health.

Key efficiency indicators for services within Outcome 1

- Cost per capita of supporting treatment of patients in public hospitals
- Average cost per Home-based Hospital day of care and occasion of service
- Average cost per client receiving contracted palliative care services
- Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – WA Ambulance Service Agreements.

Key efficiency indicators for services within Outcome 2

- Cost per capita of providing preventive interventions, health promotion and health protection activities
- Average cost per dental service provided by the Oral Health Centre of WA
- Average cost per person of HACC services delivered to people with long-term disability
- Average cost per transition care day
- Average cost per day of care for non-acute admitted continuing care
- Average cost to support patients who suffer specific chronic illness and other clients who require continuing care.

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Agency performance

Financial

The total cost of providing health services to WA in 2015–16 was $8.4 billion. Results for 2015–16 against agreed financial targets (based on Budget statements) are presented in Table 2.

Full details of the Department of Health's financial performance during 2015–16 are provided in the Financial statements.

Table 2: **Actual results versus budget targets for WA Health**

Financial	2015–16 Target $'000	2015–16 Actual $'000	Variation $ +/–
Total cost of service	8,149,524	8,420,946	271,422
Net cost of service	4,799,867	4,933,295	133,428
Total equity	10,119,720	9,576,838	-542,882
Net increase/decrease in cash held	(107,948)	(325,300)	(217,352)
Approved full time equivalent staff level (salary associated with FTE)	4,686,045	4,703,263	17,218

Note: 2015–16 targets are specified in the 2015–16 Budget statements.

Data sources: Budget Strategy Branch, Health Corporate Network.

Summary of key performance indicators

Key performance indicators assist the Department of Health to assess and monitor the extent to which Government outcomes are being achieved. Effectiveness indicators provide information that aid with assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service. Key performance indicators also provide a means to communicate to the community how the Department of Health is performing.

A summary of the Department of Health key performance indicators and variation from the 2015–16 targets is provided in Table 3.

Note: Table 3 should be read in conjunction with detailed information on each key performance indicator found in the Disclosure and Compliance section of this report.

Table 3: **Actual results versus KPI targets**

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Key effectiveness indicators:			
Proportion of people with cancer accessing admitted palliative care services	49.4%	42.6%	-6.8%
Response times for patient transport services: Priority 1 calls attended within 15 minutes by St John Ambulance	90.0%	93.8%	3.8%
Inter-hospital transfers for Priority 1 calls meeting the target contract patient response time by the Royal Flying Doctors Service	80.0%	83.3%	3.3%

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Key efficiency indicators:			
Cost per capita of supporting treatment of patients in public hospitals	$32	$26	-$6
Average cost per home based hospital day of care	$353	$312	-$41
Average cost per home based occasion of service	$125	$129	$4
Average cost per client receiving contracted palliative care services	$4,919	$4,941	$22
Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Western Australia Service Agreements	$65	$65	$0
Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Key effectiveness indicators:			
Loss of life from premature death due to identifiable causes of preventable disease or injury:			
Lung Cancer	1.8	1.6	-0.2
Ischaemic heart disease	2.5	2.5	0.0
Falls	0.2	0.2	0.0
Melanoma	0.5	0.5	0.0
Percentage of fully immunised children	≥90%	90.4%	0.4%
Rate of hospitalisations for selected potentially preventable diseases (per 100,000)			
Pertussis	No hospitalisation	3.9	N/A
Measles		0.0	
Mumps		1.6	
Hepatitis B		0.0	
Rubella		0.0	
Diptheria		0.0	
Poliomyelitis		0.0	
Tetanus		0.0	

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Eligible patients on the oral waiting list who have received treatment during the year:			
General practice	1,580	639	-941
Oral surgery	910	1,206	296
Orthodontics	2,100	1,248	-852
Paedodontics	790	349	-441
Periodontics	480	575	95
Other	780	3,637	2,857
Total	6,640	7,654	1,014
Percentage of clients maintaining or improving functional ability while in transition care	65%	70%	5%
Rate per 1,000 Home and Community Care target population who receive Home and Community Care services	350	349	-1
Specific Home and Community Care contract provider client satisfaction survey:			
Helps them to be independent	85%	80.8%	-4.2%
Improves the quality of life	85%	86.1%	1.1%
Key efficiency indicators:			
Cost per capita of providing preventive interventions, health promotion and health protection activities	$55	$49	-$6
Average cost per dental service provided by the Oral Health Centre of WA	$162	$144	-$18
Average cost per person of Home and Community Care services delivered to people with long-term disability	$4,082	$3,991	-$91
Average cost per transition care day	$300	$316	$16
Average cost per day of care for non-acute admitted continuing care	$769	$764	-$5
Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	$51	$40	-$11

Patient Evaluation of Health Services

Background

The Patient Evaluation of Health Services survey is conducted annually to gauge patient satisfaction levels with the WA health system. In 2015–16, WA Health surveyed approximately 8,000 people asking them about their health care experiences during their stay in hospital or attendance at an emergency department.

Patient satisfaction is influenced by seven stable aspects of health care:

1. Access – getting into hospital
2. Time and care – the time and attention directed to patient care
3. Consistency – continuity of care
4. Needs – meeting the patient's personal needs
5. Informed – information and communication
6. Involvement – involvement in decisions about care and treatment
7. Residential – residential aspects of the hospital.

The relative importance placed on each of these aspects can vary over time and across patient groups. At the beginning of each Patient Evaluation of Health Services survey, patients are asked to rank these seven aspects of health care from most important (7) to least important (1). This helps determine the relative importance the patients place on each aspect of care. Patients are then asked a series of questions that relate to these seven aspects of health care. Responses from these questions are used to calculate the:

- mean (average) satisfaction score – represents how patients in WA hospitals rate each of the seven aspects of the health service, presented as a score out of 100[1]
- overall indicator of satisfaction – determined by the average of the seven aspect scores, weighted by their importance as ranked by patients
- outcome score – reflects how patients rate the outcome of their hospital stay (i.e. the impact on physical health and wellbeing).

[1] The mean scores do not represent the percentage of people who are satisfied with the service; rather they represent how patients in WA hospitals rated a particular aspect of health service. If all the patients thought the service was average and that some improvements could be made, the score would be 50, and if they were totally satisfied with the service the score would be 100.

Results

In 2015–16, results are presented from the following WA patient groups:

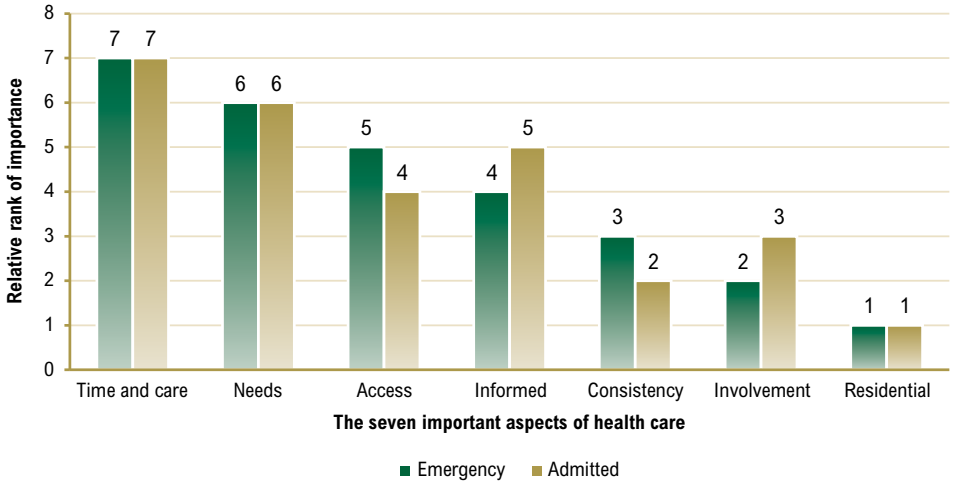
- emergency department patients, aged 16–74 years
- admitted patients, aged 16–74 years who were in hospital from 0–34 nights.

The survey participation rate was 95 per cent, and comprised of 1,267 adult emergency department patients and 4,112 adult admitted patients.

Ranked importance of the aspects of health care

In 2015–16, both patient groups ranked time and care as the most important aspect of health care, followed by needs. For the remaining aspects, emergency department attendees ranked access as the third most important followed by informed, consistency and then involvement. Admitted patients ranked the importance of informed above access and the importance of involvement above consistency. The least important aspect of care for both patient groups was residential (see Figure 5).

Figure 5: **The seven aspects of health care ranked by patient groups from most important (7) to least important (1), 2015–16**



Satisfaction with the aspects of health care

To determine if patient satisfaction with each aspect of health care is increasing, decreasing, or remaining the same over time, comparisons are made with results from previous years by patient group.

In 2015–16, mean satisfaction scores rated by emergency department patients were highest for the time and care aspect and lowest for the involvement aspect (see Table 4). Patient rated satisfaction with the residential aspect was significantly higher in 2015–16 compared with previous years.

Table 4: **Emergency department patients' mean scores, by aspect of health care, 2013–14 to 2015–16**

Emergency department patients (16–74 years)			
Aspect	**2013–14**	**2014–15**	**2015–16**
Time and care	88.6	86.8	88.8
Informed	83.7	82.2	83.9
Needs	83.2	82.2	83.5
Consistency	77.8	76.2	78.4
Access	69.8	69.0	70.8
Residential	61.8↑	61.3↑	65.1
Involvement	61.3	60.4	61.6

Admitted patients' mean satisfaction scores in 2015–16 were highest for the needs aspect and lowest for the residential aspect. The 2015–16 needs, access and residential scores were significantly higher compared with 2013–14. There were no other significant differences (Table 5).

Table 5: **Admitted patients' mean scores, by aspect of health care, 2013–14 to 2015–16**

Admitted patients (16–74 years)			
Aspect	**2013–14**	**2014–15**	**2015–16**
Needs	90.5↑	91.3	91.9
Time and care	87.9	88.7	88.6
Informed	83.9	84.0	84.3
Involvement	74.5	75.2	75.6
Access	70.3↑	71.8	72.7
Consistency	72.2	72.0	71.9
Residential	63.4↑	64.8	65.1

Notes:

↑ Indicates that the mean score for 2015–16 is significantly higher than the comparison score.

The mean satisfaction scores for patients admitted to a metropolitan or country hospital in WA in 2015–16 were highest for the needs, time and care aspects. The score for access was significantly lower for patients attending metropolitan hospitals compared with the State and significantly higher for patients attending country hospitals compared with the State (see Table 6).

Table 6: **Admitted patients' mean scores, by location, 2015–16**

Aspect	State	Metropolitan	Country
Needs	91.9	91.5	92.3
Time and Care	88.6	88.3	89.0
Informed	84.3	83.9	84.7
Involvement	75.6	75.0	76.2
Access	72.7	70.4↑	75.1↑
Consistency	71.9	70.8	73.2
Residential	65.1	63.9	66.5

Notes:

↑ Indicates that the location mean score for 2015–16 is significantly higher than the State comparison score.

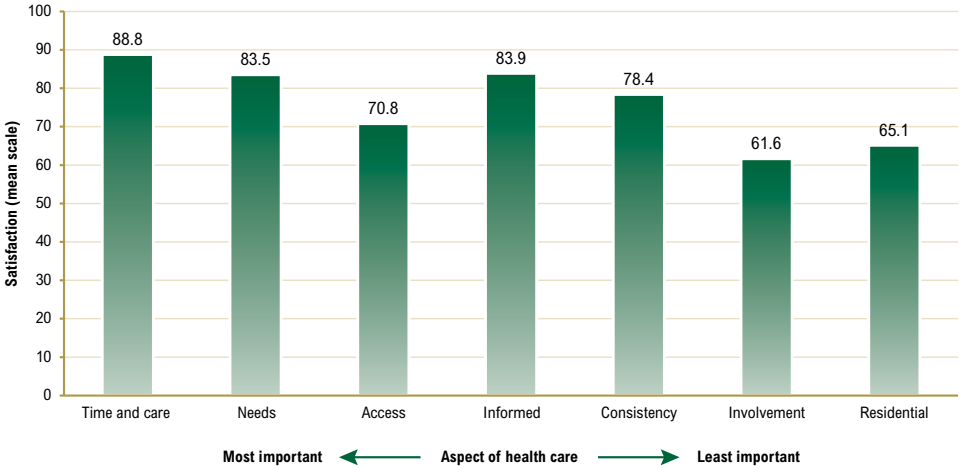
Comparing importance with the satisfaction of aspects of health care

Areas where changes or improvements might be most beneficial and appreciated by patients can be identified by comparing the relationship between how patients rank the importance of the aspects of health care and their satisfaction with those aspects.

In 2015–16, emergency department patients ranked time and care as the most important aspect of health care followed by needs. Both aspects were also rated highest and second highest respectively in terms of satisfaction.

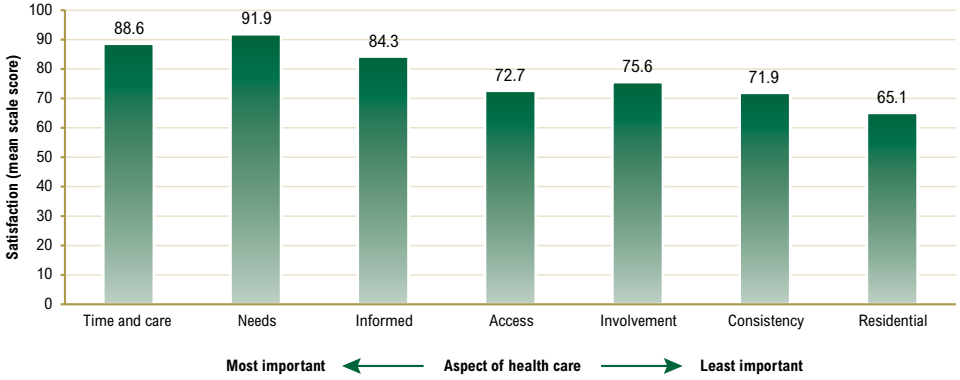
This patient group ranked access as the third most important aspect of health care however, access was rated fifth in terms of satisfaction. Residential was ranked as the least important aspect of health care among emergency department patients, and this patient group was least satisfied with involvement in decisions about their care and treatment (see Figure 6).

Figure 6: **Satisfaction with the aspects of health care by rank of importance, emergency department patients, 16–74 years, 2015–16**



In 2015–16, admitted patients ranked time and care as the most important aspect of health care, however, in terms of satisfaction, this aspect was rated second. Admitted patients ranked residential as the least important aspect of health care and it was also associated with the least satisfied (see Figure 7).

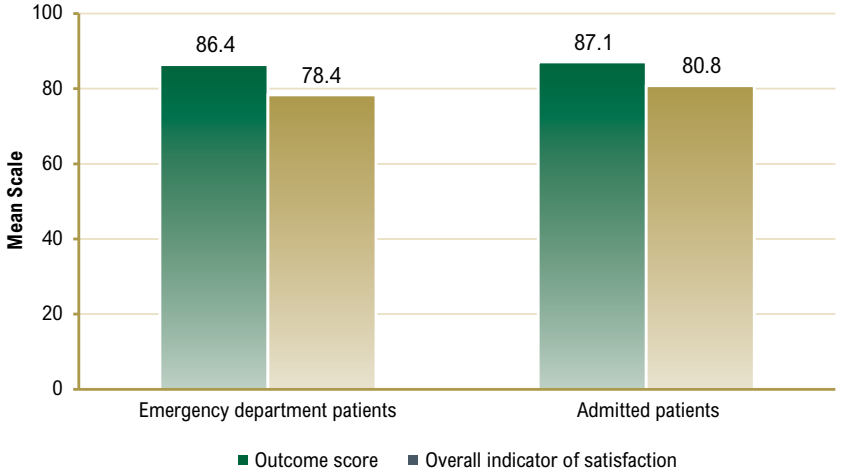
Figure 7: **Satisfaction with the aspects of health care by rank of importance, admitted patients, 16–74 years, 2015–16**



Comparing overall satisfaction with patient rated outcomes

There is a relationship between patients' overall satisfaction with health care and how patients rate the outcome of their hospital visit. Figure 8 shows that emergency department patients and admitted patients rated the outcome of their visit higher than their overall indicator of satisfaction. This suggests that although patients were satisfied with their experience in WA hospitals, they were more satisfied with the outcome of their hospital visit and the improvement in their condition.

Figure 8: **Patient-rated overall satisfaction with health care compared to their satisfaction of the outcome, emergency department and admitted patients, 2015–16**



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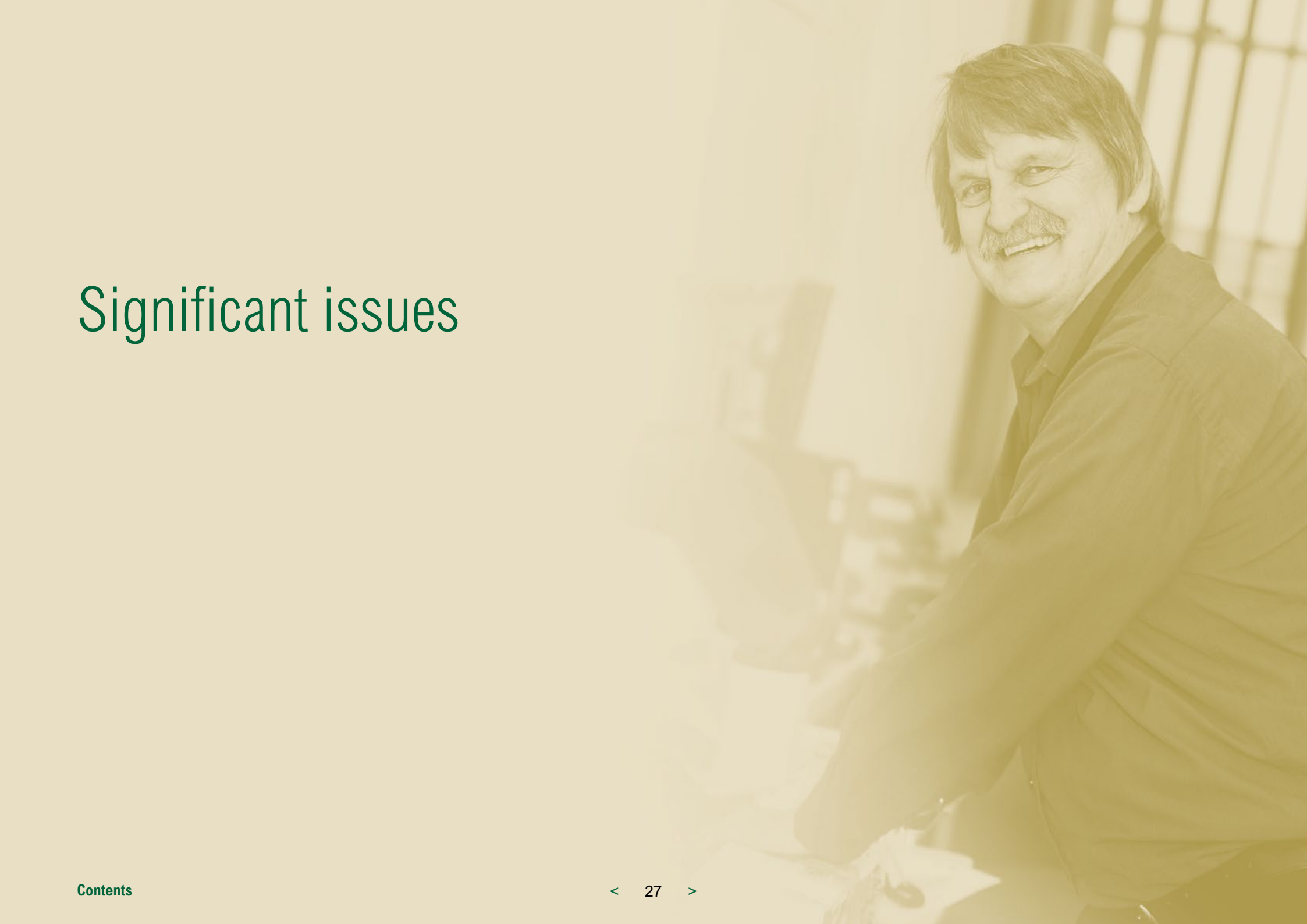
Significant issues



The *WA Health Strategic Intent 2015–2020* underpins the requirement for people in Western Australia to receive safe, high quality and accessible health services. The Strategic Intent outlines the key direction that the health system will undertake. It aims to support operational planning that will take into account necessary health service demand management, sustainability and improvement, with a key focus on:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services.

The *WA Health Reform Program 2015–2020* is an integrated program of work aligned to the Strategic Intent. It comprises a series of projects across four key areas of reform:

1. Governance
2. Performance
3. Support Services
4. Procurement.

The reform will enable decision-making and health service delivery that supports local community needs. It will also allow policy and standards to be aligned to national and international best practice. This will ensure the quality and safety of health services is maintained.

WA Health reform

In 2015–16, the governance of WA Health was concentrated centrally, with all authority and accountability resting with the Director General of the Department of Health. With an annual budget of more than $8.6 billion, approximately 42,000 staff and more than 90 hospitals, WA Health has been deemed too large and complex to operate under this model of governance. For WA Health to be more responsive and innovative in meeting the health needs of local communities, changes to the governance of WA Health were necessary.

On 1 July 2016, the *Health Services Act 2016* will replace the *Hospital and Health Services Act 1927*. This will allow for the implementation of WA Health governance reform to support the ongoing sustainability and performance of the health system.

The establishment of WA Health Service Boards is part of the governance reform. There are five Health Service Boards – North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service and WA Country Health Service. Each will be legally responsible and accountable for the oversight of hospital and health service delivery by Health Service Providers in their geographical area. Health Support Services will also exist as a Health Service Provider, accountable for the delivery of technology, supply, workforce and finance services to support staff in improving patient care.

The *Health Services Act 2016* also establishes the Department of Health, led by the Director General, as the System Manager. The System Manager will be responsible for the overall management, performance and strategic direction of WA Health.

Clear delineation of roles and responsibilities will enable decision-making at a service delivery and patient care level. It will also allow for more robust systemwide policy and standards that will be aligned to national and international best practice. This will ensure the quality and safety of health services and reduced duplication of resources.

In 2015–16, to support implementation of the *WA Health Reform Program 2015–2020* including the transition to the new governance arrangements, the Department of Health:

- progressed the *Health Services Act 2016* to be passed by WA Parliament
- created five Board-governed Health Service Providers
- appointed Interim Boards made up of Chairs and Members selected following an open, skills-based recruitment process
- amalgamated the Health Corporate Network, Health Information Network and Health Support Network under the banner of Health Support Services
- completed a Functional Review and Readiness Assessment of non-clinical functions
- implemented the *WA Health Information and Communications Technology Annual Implementation Plan 2015–2016*, to support the improvement of information and communication technology across WA Health
- implemented the *Procurement Development and Management System* and *Procurement Policy Framework* to support Health Services Providers in the acquisition of good and services and the contracting of health providers
- developed the *Performance Management Policy 2016–17* to support transparent and accountable reporting of health care system performance.

Demand and activity

The Department of Health supports health services in addressing the challenges of health service inpatient, emergency and outpatient demand and activity. This has included the development and implementation of innovative strategies to:

- improve patient flow through specific service areas to reduce patient wait times
- develop more targeted performance measures for emergency and elective activity
- encourage patients to seek appropriate treatment in the primary care sector rather than in hospital emergency departments.

With the advancement in medical technology coupled with an increase in consumer expectations, the demand for health technologies has increased. To ensure that new and high cost health technologies are safe and cost effective, governance processes have been established. Also in 2015–16 the development of a 10-year system-wide plan for medical imaging technology was completed.

The demand for advanced technological genetic testing has increased. Detection of rare diseases acts to support accurate and early diagnosis that can improve health outcomes for patients and reduce unnecessary hospital admissions and specialist care. The *WA Rare Diseases Strategic Framework and Implementation Plan 2015–2018*, the first in Australia, was developed to aid the coordination of WA Health initiatives for rare diseases. Under the Framework, a new patient-centric diagnostic pipeline has been implemented to support the patient's journey to diagnosis. This has resulted in a threefold increase in molecular disease confirmation.

The demand for health services can be managed through the prevention, promotion and implementation of public health initiatives to improve the overall health and wellbeing of Western Australians. The Department of Health has continued to purchase the delivery of evidence-based population-wide health promotion programs, and contributed to the development of effective and strategic state and national policy.

The Department of Health is active in communicable disease control. For new and emerging infectious disease threats, such as Zika virus, there is a need to maintain effective response frameworks and programs. This also applies to re-emerging infectious disease threats including drug resistant tuberculosis, pertussis (whooping cough) and pandemic influenza. In 2015–16, a public health response framework for Zika virus was developed. Also, a new state-funded program to provide pertussis vaccine to pregnant women is now available to protect infants from whooping cough in the first months of their lives.

More than 9,500 Western Australians are hospitalised each year for preventable dental conditions. In addition, there has been an increase in demand at hospital emergency departments for preventable dental conditions. In response the:

- Chief Dental Officer led the development of the *National Oral Health Plan 2015–2024*, which was approved by Australian Health Ministers Advisory Council and publicly released in February 2016
- *State Oral Health Plan 2016–2020* is in its final stages of development
- State Oral Health Advisory Council was established in November 2015.

Workforce challenges

A key priority for the Department of Health is to identify, monitor and manage workforce issues that may affect health care service delivery. This incorporates workforce planning, development and reform. In 2015–16, the *WA Health Workforce Strategy 2016–2020* was completed to ensure the adequate supply of an appropriately skilled, diverse and flexible workforce.

While there has been an incremental increase in medical graduates entering the workforce, it has not been sufficient to meet growing health care service requirements. WA is also experiencing a shortage of suitably trained and experienced doctors. By 2015–25 it is expected that there will be a shortfall in some specialist doctors that will not be able to meet demand in those specialties. To address these workforce shortages:

- *The Specialist Workforce Capacity Program* continues to map the medical specialty workforce to inform strategic statewide medical workforce planning
- commencement of the *Integrated Registrar Reform Project* to identify the vocational and non-vocational medical registrar workforce, identify gaps in education and training, and streamline recruitment and selection
- implementation of the *Competent Authority Pathway* to recruit suitably qualified junior doctors from overseas
- provision of community rotations for junior doctors in metropolitan and in rural WA.

Increased demand for hospital, primary and preventative health care has created challenges in providing an adequately skilled nursing and midwifery workforce. Programs and strategies to accelerate nurses and midwives to transition to areas of need have included:

- a *Perioperative Intensive Graduate Nurse Transition Program*
- refresher pathways for experienced nurses and midwives transitioning back to acute care practice
- upskilling programs for nurses to move into new areas of speciality practice
- continued transition support funding for graduate nurses and midwives entering the workforce including mental health services.

A strong, skilled and growing Aboriginal health workforce across WA Health including clinical, non-clinical and leadership roles is important. A variety of career pathways and employment opportunities for Aboriginal people will be used to increase Aboriginal health workers. Currently, training is being conducted to improve the numbers of Aboriginal allied health assistants in rural and remote communities. A pilot to introduce Aboriginal health practitioners to the health system has commenced, and cadetships are in place to support Aboriginal nursing and midwifery students.

Recruitment and retention of a well-trained and rural-ready workforce are key requirements of sustainable and effective health care services in rural and remote communities. The Department of Health is currently collaborating with the health and education sector to support health students to seek employment in rural areas following graduation. Planning for ongoing skill development training for rural and remote allied health generalists.

Managing funding reform and cost efficiencies

The WA health system provides high quality health services to almost 2.6 million people and leads innovative reforms to enhance the health and wellbeing of our population. However, influencing factors such as changing community health needs and expectations, and increasing health care costs are placing more complex demands on the WA health system. Continued reform and innovation by WA Health are essential to ensure the quality and performance of our health system is sustained.

In response to the impact of these factors, WA Health is undergoing a significant reform to achieve greater efficiency in the delivery of services and the management of health resources including:

- health service reconfiguration
- movement towards a more devolved governance model
- increasing transparent resource allocation and setting performance expectations in relation to funds provided to the Health Service Providers
- implementation of key national Activity Based Funding reform initiatives.

In 2015–16, the Department of Health achieved the following funding reform initiatives:

- implementation of phase one of the *WA Health Strategic Asset Plan 2015–25* that outlines outputs and future priorities concerning WA Health infrastructure requirements
- completion of the *WA Health Funding and Purchasing Policy Guidelines 2015–16* that provides information on budget development, resource allocation and service performance and accountability
- active engagement with the Mental Health Commission in examining and implementing strategies for managing funding reform
- commencement of a two-year initiative focusing on the licensing of private health care facilities to enable licensing fees to more closely align to the cost of the provision of services
- provision of a costing Quality Assurance and reasonability analysis tool to improve the quality, consistency, and timeliness of data related to Activity Based Funding
- implementation of ongoing strategies to efficiently manage costs associated with procurement and contract management, including a coordinated approach to health service pharmaceutical procurement and post-hospital care for older people.

Health inequalities

WA Health is actively involved in addressing inequities through targeted interventions to prevent and manage disease, and the provision of, and accessibility to, appropriate health services.

The Department of Health continues to support and invest in the delivery of services and programs that seek to close the gaps in the health and wellbeing of Aboriginal people. The *Aboriginal Health and Wellbeing Framework 2015–2020* aims to ensure Aboriginal people in WA have access to high quality health care and services, while assisting the community to make good health a priority through a focus on prevention.

A key priority of the Framework is to ensure WA Health employees are equipped to serve the needs of Aboriginal people and to ensure services are provided in a culturally appropriate manner. Cultural education and training opportunities have been introduced for all WA Health staff.

The Framework also supports prevention and promotion activities. One area in which this is occurring is to address the higher rates of vaccine preventable diseases and the lower rates of immunisation coverage of Aboriginal children immunised at 12 months and two years, compared to non-Aboriginal children. To address this Aboriginal health workers are being trained to vaccinate via the Aboriginal Health Workers Immunisation Competency Training Program.

To combat the high rates of communicable diseases among Aboriginal people in WA, the Department of Health has commenced the implementation of the *WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2015–18*.

The Department of Health, in partnership with the WA Country Health Service, is also planning to implement a Fluoride Varnish Program as part of the State Government's Improving Ear, Eye and Oral health of Children in Aboriginal, Rural and Remote Communities Program.

Chronic disease prevention among Aboriginal, and culturally and linguistically diverse populations and rural and remote population groups is supported by the Department of Health via policy development and purchasing of community services.

An increase in the proportion of people who are ageing combined with increased levels of chronic disease and co-morbidities, has required expansion of sub-acute and community care services. In response the Department of Health has:

- expanded the South West Subacute Care Program
- employed a geriatrician to service the Great Southern Region based at the Albany Hospital Campus
- commenced a trial of a two-year integrated care program via a public-private partnership, with direct involvement of the patient's GP.

Under the *Mental Health Act 2014*, established standards and a series of eight statutory guidelines have been improved to enhance the treatment, care, support and protection of people who have a mental illness and are consumers of mental health services.

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Disclosure and compliance

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

DEPARTMENT OF HEALTH

Report on the Financial Statements

I have audited the accounts and financial statements of the Department of Health.

The financial statements comprise the Statement of Financial Position as at 30 June 2016, the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information, including Administered transactions and balances.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the Department of Health at 30 June 2016 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

Director General's Responsibility for the Financial Statements
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards and the Treasurer's Instructions, and for such internal control as the Director General determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Department's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Director General, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

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Report on Controls
I have audited the controls exercised by the Department of Health during the year ended 30 June 2016.

Controls exercised by the Department of Health are those policies and procedures established by the Director General to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

Opinion
In my opinion, in all material respects, the controls exercised by the Department of Health are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2016.

Director General's Responsibility for Controls
The Director General is responsible for maintaining an adequate system of internal control to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities are in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

Auditor's Responsibility for the Audit of Controls
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the Department of Health based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the adequacy of controls to ensure that the Department complies with the legislative provisions. The procedures selected depend on the auditor's judgement and include an evaluation of the design and implementation of relevant controls.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Report on the Key Performance Indicators

I have audited the key performance indicators of the Department of Health for the year ended 30 June 2016.

The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide information on outcome achievement and service provision.

Opinion
In my opinion, in all material respects, the key performance indicators of the Department of Health are relevant and appropriate to assist users to assess the Department's performance and fairly represent indicated performance for the year ended 30 June 2016.

Director General's Responsibility for the Key Performance Indicators
The Director General is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such controls as the Director General determines necessary to ensure that the key performance indicators fairly represent indicated performance.

Auditor's Responsibility for the Audit of Key Performance Indicators
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the key performance indicators based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the key performance indicators. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments the auditor considers internal control relevant to the Director General's preparation and fair presentation of the key performance indicators in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the relevance and appropriateness of the key performance indicators for measuring the extent of outcome achievement and service provision.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence
In conducting the above audits, I have complied with the independence requirements of the Auditor General Act 2006 and Australian Auditing and Assurance Standards, and other relevant ethical requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the Department of Health for the year ended 30 June 2016 included on the Department's website. The Department's management is responsible for the integrity of the Department's website. This audit does not provide assurance on the integrity of the Department's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
21 September 2016

Certification of financial statements

DEPARTMENT OF HEALTH

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

The accompanying financial statements of the Department of Health have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2016 and financial position as at 30 June 2016.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

Peter May
A/CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

15 September 2016

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

15 September 2016

Financial statements

Department of Health

Statement of Comprehensive Income

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	6	111,542	96,418
Contracts for services	7	648,525	624,410
Supplies and services	8	53,487	53,839
Grants and subsidies	9	6,381,354	5,940,013
Depreciation expense	10	574	577
Loss on disposal of non-current assets	11	10	7
Contribution to Capital Works Fund	12	2,414	42,352
Other expenses	13	22,754	24,116
Total cost of services		**7,220,660**	**6,781,732**
INCOME			
Revenue			
User charges and fees		14,708	5,781
Commonwealth grants and contributions	14	2,070,404	1,951,838
Other grants and contributions	15	7,415	9,210
Finance income	16	1,961	2,024
Donation revenue	17	2,107	1,000
Other revenue		1,029	800
Total revenue		**2,097,624**	**1,970,653**
Total income other than income from State Government		**2,097,624**	**1,970,653**
NET COST OF SERVICES		**5,123,036**	**4,811,079**
INCOME FROM STATE GOVERNMENT	18		
Service appropriations		4,853,583	4,726,672
Assets (transferred)/assumed		1,055	11,243
Services received free of charge		1,947	2,377
Royalties for Regions Fund		51,921	57,438
Total income from State Government		**4,908,506**	**4,797,730**
(DEFICIT)/SURPLUS FOR THE PERIOD		**(214,530)**	**(13,349)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	31	957	2,579
Total other comprehensive income		**957**	**2,579**
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE PERIOD		**(213,573)**	**(10,770)**

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.
Refer also the 'Schedule of Income and Expenses by Service'.

Department of Health

Statement of Financial Position

As at 30 June 2016

	Note	2016 $000	2015 $000
ASSETS			
Current Assets			
Cash and cash equivalents	32	8,706	93,030
Restricted cash and cash equivalents	19, 32	202,067	339,108
Inventories	20	15,723	16,163
Receivables	21	41,032	34,418
Other current assets	26	3,902	813
Total Current Assets		271,430	483,532
Non-Current Assets			
Amounts receivable for services	22	36,858	100,417
Finance lease receivable	23	4,942	2,981
Property, plant and equipment	24	27,226	26,744
Other non-current assets	26	9,237	4,201
Total Non-Current Assets		78,263	134,343
Total Assets		**349,693**	**617,875**
LIABILITIES			
Current Liabilities			
Payables	28	61,645	46,712
Provisions	29	20,287	21,846
Other current liabilities	30	778	197
Total Current Liabilities		82,710	68,755
Non-Current Liabilities			
Provisions	29	5,235	3,627
Total Non-Current Liabilities		5,235	3,627
Total Liabilities		**87,945**	**72,382**
NET ASSETS		**261,748**	**545,493**
EQUITY	31		
Contributed equity		(213,341)	(143,169)
Reserves		306,647	305,690
Accumulated surplus		168,442	382,972
TOTAL EQUITY		**261,748**	**545,493**

The Statement of Financial Position should be read in conjunction with the accompanying notes.
Refer also the 'Schedule of Assets and Liabilities by Service'.

Department of Health

Statement of Changes in Equity

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
CONTRIBUTED EQUITY	31		
Balance at start of period		(143,169)	(143,169)
Transactions with owners in their capacity as owners:			
Distributions to owners		(70,172)	-
Balance at end of period		**(213,341)**	**(143,169)**
RESERVES	31		
Asset Revaluation Reserve			
Balance at start of period		305,690	303,111
Other comprehensive income for the period		957	2,579
Balance at end of period		**306,647**	**305,690**
ACCUMULATED SURPLUS	31		
Balance at start of period		382,972	396,321
(Deficit)/Surplus for the period		(214,530)	(13,349)
Balance at end of period		**168,442**	**382,972**
TOTAL EQUITY			
Balance at start of period		545,493	556,263
Total comprehensive income/(loss) for the year		(213,573)	(10,770)
Transactions with owners in their capacity as owners		(70,172)	-
Balance at end of period		**261,748**	**545,493**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Department of Health

Statement of Cash Flows

For the year ended 30 June 2016

	Note	2016 $000 Inflows (Outflows)	2015 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		4,475,422	4,360,257
Royalties for Regions Fund	18	51,921	57,438
Assets transferred	18	1,132	11,254
Net cash provided by State Government		4,528,475	4,428,949
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(112,176)	(92,459)
Supplies and services		(689,523)	(708,026)
Grants and subsidies		(6,009,806)	(5,575,055)
Contribution to Capital Works Fund		(2,414)	(42,352)
GST payments on purchases		(382,154)	(374,202)
Receipts			
User charges and fees		14,694	5,779
Commonwealth grants and contributions		2,045,404	1,940,814
GST receipts on sales		23,707	22,074
GST refunds from taxation authority		357,940	355,174
Other receipts		4,580	10,915
Net cash used in operating activities	32	(4,749,748)	(4,457,338)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(92)	(285)
Net cash used in investing activities		(92)	(285)
Net decrease in cash and cash equivalents		(221,365)	(28,674)
Cash and cash equivalents at the beginning of the period		432,138	460,812
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	32	210,773	432,138

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Department of Health

Schedule of Income and Expenses by Service

For the year ended 30 June 2016

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	22,668	20,980	2,268	1,290	3,057	2,479	-	-
Contracts for services	34,491	38,215	30,128	21,927	23,582	24,612	-	278
Supplies and services	1,901	1,732	610	232	1,098	465	-	-
Grants and subsidies	4,125,129	3,808,640	1,774	5,115	1,837	8,629	769,962	664,644
Depreciation expense	71	74	9	6	10	12	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Contribution to Capital Works Fund	248	3,780	111	1,013	115	1,867	-	-
Other expenses	12,586	12,803	234	196	320	517	-	-
Total cost of services	4,197,094	3,886,224	35,134	29,779	30,019	38,581	769,962	664,922
Income								
User charges and fees	8,538	333	86	30	89	55	-	-
Commonwealth grants and contributions	1,224,039	1,137,086	1,270	4,909	2,202	2,174	191,685	154,720
Other grants and contributions	-	-	-	-	-	-	-	-
Finance income (a)	1,377	1,395	2	9	-	-	218	197
Donation revenue	2,001	1,000	-	-	-	-	-	-
Other revenue	78	141	37	7	41	12	-	-
Total income other than income from State Government	1,236,033	1,139,955	1,395	4,955	2,332	2,241	191,903	154,917
NET COST OF SERVICES	2,961,061	2,746,269	33,739	24,824	27,687	36,340	578,059	510,005
Income from State Government								
Service appropriations	2,802,217	2,698,690	32,167	24,378	26,451	35,669	546,942	501,115
Assets (transferred)/assumed	52	-	42	-	38	-	-	-
Services received free of charge	162	209	72	56	75	103	-	-
Royalties for Regions Fund	4,734	9,147	-	-	678	3,332	17,790	7,765
Total income from State Government	2,807,165	2,708,046	32,281	24,434	27,242	39,104	564,732	508,880
(DEFICIT)/SURPLUS FOR THE PERIOD	(153,896)	(38,223)	(1,458)	(390)	(445)	2,764	(13,327)	(1,125)

(a) 2014/15 restated in accordance with a change in allocation methodology adopted in 2015/16.

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

Schedule of Income and Expenses by Service (continued)

For the year ended 30 June 2016

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	-	-	11,121	8,549	42,177	38,046	911	715
Contracts for services	-	-	133,360	122,253	46,012	55,475	14,529	10,624
Supplies and services	-	-	1,946	1,964	43,389	41,832	159	2,996
Grants and subsidies	805,114	804,556	107,135	86,026	399,594	386,519	74,245	67,397
Depreciation expense	-	-	49	47	315	311	4	4
Loss on disposal of non-current assets	-	-	-	-	-	7	-	-
Contribution to Capital Works Fund	-	-	614	8,570	464	7,312	50	717
Other expenses	-	-	1,287	1,692	5,271	4,844	105	138
Total cost of services	805,114	804,556	255,512	229,101	537,222	534,346	90,003	82,591
Income								
User charges and fees	-	-	477	255	4,408	4,500	39	21
Commonwealth grants and contributions	248,649	224,180	3,593	3,545	153,452	168,390	12,041	21,964
Other grants and contributions	-	-	-	-	7,415	9,062	-	-
Finance income (a)	269	289	-	-	83	85	-	43
Donation revenue	-	-	3	-	97	-	-	-
Other revenue	-	-	200	430	210	75	16	5
Total income other than income from State Government	248,918	224,469	4,273	4,230	165,665	182,112	12,096	22,033
NET COST OF SERVICES	556,196	580,087	251,239	224,871	371,557	352,234	77,907	60,558
Income from State Government								
Service appropriations	526,257	570,041	239,082	220,759	352,584	345,954	73,825	59,513
Assets (transferred)/assumed	-	-	235	-	176	11,243	19	-
Services received free of charge	-	-	402	475	303	405	33	40
Royalties for Regions Fund	3,321	1,596	20,372	28,407	4,247	4,689	-	220
Total income from State Government	529,578	571,637	260,091	249,641	357,310	362,291	73,877	59,773
(DEFICIT)/SURPLUS FOR THE PERIOD	(26,618)	(8,450)	8,852	24,770	(14,247)	10,057	(4,030)	(785)

(a) 2014/15 restated in accordance with a change in allocation methodology adopted in 2015/16.

The Schedule of Income and Expenses by Service should be read in conjunction with the accompanying notes.

Department of Health

Schedule of Income and Expenses by Service (continued)

For the year ended 30 June 2016

	Continuing Care		Mental Health (b)		TOTAL	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	29,340	24,359	-	-	111,542	96,418
Contracts for services	366,101	350,686	322	340	648,525	624,410
Supplies and services	4,384	4,618	-	-	53,487	53,839
Grants and subsidies	96,564	108,487	-	-	6,381,354	5,940,013
Depreciation expense	116	123	-	-	574	577
Loss on disposal of non-current assets	10	-	-	-	10	7
Contribution to Capital Works Fund	812	19,093	-	-	2,414	42,352
Other expenses	2,951	3,926	-	-	22,754	24,116
Total cost of services	500,278	511,292	322	340	7,220,660	6,781,732
Income						
User charges and fees	1,071	587	-	-	14,708	5,781
Commonwealth grants and contributions	233,473	234,870	-	-	2,070,404	1,951,838
Other grants and contributions	-	-	-	148	7,415	9,210
Finance income (a)	-	-	12	6	1,961	2,024
Donation revenue	6	-	-	-	2,107	1,000
Other revenue	447	130	-	-	1,029	800
Total income other than income from State Government	234,997	235,587	12	154	2,097,624	1,970,653
NET COST OF SERVICES	265,281	275,705	310	186	5,123,036	4,811,079
Income from State Government						
Service appropriations	254,058	270,553	-	-	4,853,583	4,726,672
Assets (transferred)/assumed	493	-	-	-	1,055	11,243
Services received free of charge	900	1,089	-	-	1,947	2,377
Royalties for Regions Fund	779	2,282	-	-	51,921	57,438
Total income from State Government	256,230	273,924	-	-	4,908,506	4,797,730
(DEFICIT)/SURPLUS FOR THE PERIOD	(9,051)	(1,781)	(310)	(186)	(214,530)	(13,349)

(a) 2014/15 restated in accordance with a change in allocation methodology adopted in 2015/16.

(b) Include services in addition to those provided by the Health Services under agreement with the Mental Health Commission for specialised admitted and community mental

Department of Health

Schedule of Assets and Liabilities by Service

As at 30 June 2016

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
Assets								
Current assets	48,648	120,251	4,570	5,420	2,711	9,792	113,417	159,414
Non-current assets (a)	28,174	25,680	766	2,154	4,342	7,948	549	295
Total Assets	76,822	145,931	5,336	7,574	7,053	17,740	113,966	159,709
Liabilities								
Current liabilities	12,567	10,179	2,104	1,310	2,260	3,293	-	46
Non-current liabilities	1,005	895	113	34	123	79	-	-
Total Liabilities	13,572	11,074	2,217	1,344	2,383	3,372	-	46
NET ASSETS	63,250	134,857	3,119	6,230	4,670	14,368	113,966	159,663

(a) *2014/15 includes restatement of finance lease receivable, in accordance with a change in allocation methodology adopted in 2015/16.*

The Schedule of Assets and Liabilities by Service should be read in conjunction with the accompanying notes.

Department of Health

Schedule of Assets and Liabilities by Service (continued)

As at 30 June 2016

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
Assets								
Current assets	-	11,086	11,325	21,774	39,737	70,749	13,412	8,982
Non-current assets (a)	677	435	3,178	16,811	27,239	34,927	260	1,406
Total Assets	677	11,521	14,503	38,585	66,976	105,676	13,672	10,388
Liabilities								
Current liabilities	-	-	14,045	9,401	19,109	19,905	4,548	1,543
Non-current liabilities	-	-	518	280	2,103	1,512	42	23
Total Liabilities	-	-	14,563	9,681	21,212	21,417	4,590	1,566
NET ASSETS	677	11,521	(60)	28,904	45,764	84,259	9,082	8,822

(a) 2014/15 includes restatement of finance lease receivable, in accordance with a change in allocation methodology adopted in 2015/16.

The Schedule of Assets and Liabilities by Service should be read in conjunction with the accompanying notes.

Department of Health

Schedule of Assets and Liabilities by Service (continued)

As at 30 June 2016

	Continuing Care		Mental Health		TOTAL	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
Assets						
Current assets	37,610	76,064	-	-	271,430	483,532
Non-current assets (a)	13,048	44,678	30	9	78,263	134,343
Total Assets	50,658	120,742	30	9	349,693	617,875
Liabilities						
Current liabilities	28,077	23,078	-	-	82,710	68,755
Non-current liabilities	1,331	804	-	-	5,235	3,627
Total Liabilities	29,408	23,882	-	-	87,945	72,382
NET ASSETS	21,250	96,860	30	9	261,748	545,493

(a) 2014/15 includes restatement of finance lease receivable, in accordance with a change in allocation methodology adopted in 2015/16.

The Schedule of Assets and Liabilities by Service should be read in conjunction with the accompanying notes.

Summary of Consolidated Account Appropriations and Income Estimates

For the year ended 30 June 2016

	2016 Estimate $000	2016 Actual $000	Variance $000	2016 Actual $000	2015 Actual $000	Variance $000
Delivery of Services						
Item 13 Net amount appropriated to deliver services	4,692,820	4,723,889	31,069	4,723,889	4,597,359	126,530
Section 25 transfer of service appropriation		(754)	(754)	(754)	7,133	(7,887)
Amount Authorised by Other Statutes						
- Salaries and Allowances Act 1975	697	697	-	697	680	17
- Lotteries Commission Act 1990	129,536	129,750	214	129,750	121,500	8,250
Total appropriations provided to deliver services	4,823,053	4,853,582	30,529	4,853,582	4,726,672	126,910
Capital						
Item 118 Capital appropriations	213,940	146,494	(67,446)	146,494	245,284	(98,790)
GRAND TOTAL	5,036,993	5,000,076	(36,917)	5,000,076	4,971,956	28,120
Details of Expenses by Service						
Public Hospital Admitted Patients	4,366,127	4,562,408	196,281	4,562,408	4,332,761	229,647
Home-Based Hospital Programs	44,833	36,735	(8,098)	36,735	39,936	(3,201)
Palliative Care	32,227	33,199	972	33,199	36,910	(3,711)
Emergency Department	740,513	807,760	67,247	807,760	722,379	85,381
Public Hospital Non-Admitted Patients	940,919	961,045	20,126	961,045	965,384	(4,339)
Patient Transport	212,197	218,084	5,887	218,084	207,033	11,051
Prevention, Promotion & Protection	596,272	547,230	(49,042)	547,230	544,923	2,307
Dental Health	115,495	103,623	(11,872)	103,623	99,175	4,448
Continuing Care	488,900	472,650	(16,250)	472,650	459,711	12,939
Mental Health	612,041	721,415	109,374	721,415	663,642	57,773
Total Cost of Services	8,149,524	8,464,149	314,625	8,464,149	8,071,854	392,295
Less Total income	(3,349,657)	(3,487,651)	(137,994)	(3,487,651)	(3,249,851)	(237,800)
Net Cost of Services	4,799,867	4,976,498	176,631	4,976,498	4,822,003	154,495
Adjustments (a)	23,186	(122,916)	(146,102)	(122,916)	(95,331)	(27,585)
Total appropriations provided to deliver services	4,823,053	4,853,582	30,529	4,853,582	4,726,672	126,910
Capital Expenditure						
Purchase of non-current physical assets	474,875	399,404	(75,471)	399,404	587,991	(188,587)
Repayment of borrowings	79,351	68,815	(10,536)	68,815	59,185	9,630
Adjustments for other funding sources (b)	(340,286)	(321,725)	18,561	(321,725)	(401,892)	80,167
Capital appropriations	213,940	146,494	(67,446)	146,494	245,284	(98,790)

The Summary of Consolidated Account Appropriations and Income Estimates comprises the Department and Statutory Authorities within WA Health which are Metropolitan Health Service, WA Country Health Service, Queen Elizabeth II Medical Centre Trust and Quadriplegic Centre Board.

(a) Adjustments comprise movements in cash balances, movements in accrual items such as receivables and payables, Royalties for Regions funding and resources received free of charge from other state government agencies.

(b) Adjustments for the ($321.725 million) comprise $108.9 million funding for New Children's Hospital, $41.441 million funding for Royalties for Regions, $31.782 million CWP Treasury Administered funding and include movements in cash balances and other accrual items such as receivables and payables.

Note 37 'Explanatory statement' provides details of any significant variations between estimates and actual results for 2016 and between actual results for 2016 and 2015.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2016

Note 1 Australian Accounting Standards

General

The Department's financial statements for the year ended 30 June 2016 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Department has adopted any applicable new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Department cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. Partial exemption permitting early adoption of AASB 2015-7 '*Amendments to Australian Accounting Standards - Fair Value Disclosures of Non-for-Profit Public Sector Entities*' has been granted. Aside from AASB 2015-7, there has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Department for the annual reporting period ended 30 June 2016.

Note 2 Summary of significant accounting policies

(a) General statement

The Department is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

The Financial Management Act 2006 and the Treasurer's Instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for land, buildings and site infrastructure which have been measured at fair value.

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000).

Note 3 'Judgements made by management in applying accounting policies' discloses judgements that have been made in the process of applying the Department's accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 'Key sources of estimation uncertainty' discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(c) Reporting entity

The reporting entity comprises the Department only and is based on the control exercised by the Department over Metropolitan Health Service and WA Country Health Service.

The Department has received an exemption from the application of paragraph 4(iv) of Treasurer's Instruction 1105, allowing the Department to elect not to prepare consolidated financial statements. To give full effect to this exemption, the Department has also been granted an exemption from paragraph 7(ix) of Treasurer's Instructions 1101, allowing the Department to present separate financial statements. These exemptions apply to the 2014/15 and 2015/16 reporting periods.

As from 1 July 2012, the Department of Health administers two agency special purpose accounts, the State Pool Account and the State Managed Fund Account, established and maintained pursuant to section 16(1)(d) of the Financial Management Act 2006. The purposes of the special purpose accounts are outlined at note 44 'Special purpose accounts'. The new funding arrangement established under the National Health Reform Agreement requires the Commonwealth Government to make payments of activity based funding and block grant funding to the State Pool Account, from which the block grant funding is subsequently paid to the State Managed Fund Account. The State is required to make payments of activity based funding to the State Pool Account and the block grant funding to the State Managed Fund Account.

Note 2 Summary of significant accounting policies (continued)

(c) Reporting entity (continued)

The Department administers assets, liabilities, income and expenses on behalf of Government which are not controlled by, nor integral to the function of the Department. These administered balances and transactions are not recognised in the principal financial statements of the Department but schedules are prepared using the same basis as the financial statements and are presented at note 45 'Administered assets and liabilities' and note 46 'Disclosure of administered income and expenses by service'.

Mission

The mission of the Department is to improve, promote and protect the health of Western Australians by:

* Caring for individuals and the community;
* Caring for those who need it most;
* Making best use of funds and resources;
* Supporting our team.

The Department is predominantly funded by Parliamentary appropriations.

Services

Income, expenses, assets and liabilities attributable to the Department's services are set out in the 'Schedule of Income and Expenses by Service' and the 'Schedule of Assets and Liabilities by Service'.

The Summary of Consolidated Account Appropriations and Income Estimates comprises the Department and Statutory Authorities within WA Health which are Metropolitan Health Service, WA Country Health Service, Queen Elizabeth II Medical Centre Trust and Quadriplegic Centre Board.

The Department and Statutory Authorities within WA Health provide the following services:

Public Hospital Admitted Patients

Public hospital admitted patient services describe the care services provided to inpatients in public hospitals (excluding specialised mental health wards) and to public patients treated in private facilities under contract to WA Health. An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, renal dialysis, oncology services and obstetric care.

Home-Based Hospital Programs

The 'Hospital in the Home' (HITH) and 'Mental Health in the Home' (MITH) programs provide short-term acute care in the patient's home for those who can be safely cared for without constant monitoring for conditions that traditionally required hospital admission and inpatient treatment. These services involve daily home visits by nurses, with medical governance usually by a hospital-based doctor. This service also includes the 'Friends-in-Need-Emergency' (FINE) program which delivers similar care interventions for older and chronically ill patients who have a range of short-term clinical care requirements.

Palliative Care

Palliative care services describe contracted inpatient and home-based multi-disciplinary care and support for terminally ill people and their families and carers. Education and advisory services are also available to assist professionals, particularly those in rural areas.

Emergency Department

Emergency department services describe the treatment provided in metropolitan and major rural hospitals to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. An emergency department can provide a range of services and may result in admission to hospital or in treatment without admission. Not all public hospitals provide emergency care services. Privately provided contracted emergency services are included.

Public Hospital Non-admitted Patients

Medical officers, nurses and allied health staff provide non-admitted (out-patient) care services and include clinics for pre and post surgical care, allied health care and medical care as well as emergency services provided in the remainder of rural hospitals not included under the Emergency Department service.

Patient Transport

Patient transport services are those services provided by St John Ambulance Australia, the Royal Flying Doctor Service (RFDS) Western Operations and the Patient Assisted Travel Scheme (PATS). These services assist people in need of urgent medical treatment to reach the nearest appropriate medical facility or assist people living in rural or remote locations to access specialist services.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(c) Reporting entity (continued)

Prevention, Promotion and Protection

Prevention, promotion and protection services describe programs implemented to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness and disability with early detection and developmental interventions, or monitor the incidence of disease in the population to determine the effectiveness of health measures and provide direction for new policies and programs. Specific areas of service include genomics, the management and development of health information, Aboriginal health, breast screening services, child and community health, health promotion, communicable disease control, environmental health, disaster planning and management, statutory medical notifications and services provided by the Office of the Chief Medical Officer.

Dental Health

Dental Health Services (DHS) is State funded and governed by North Metropolitan Health Service to provide free, universal public general dental services to school aged children and subsidised public general dental services to eligible adults (Health Care/ Pensioner Concession Card holders). This is provided though government dental clinics, mobile services and private dentists who participate in metropolitan and country patient dental subsidy schemes. The Oral Health Centre of Western Australia (OHCWA) is contracted by Department of Health to provide subsidised public specialist dental services to eligible patients (Health Care/ Pensioner Concession Card holders).

Continuing Care

Aged and continuing care services include:

the Home and Community Care (HACC) program providing services such as domestic assistance, social support, nursing care, respite, food and meal services, transport and home maintenance. These services aim to support people to stay at home where their capacity for independent living is at risk of premature admission to long-term residential care;

the Transition Care Program aims to help older people's independence and confidence at the end of a hospital stay by assisting them to maintain or improve their functional ability. This program provides the person with more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and assists them and their family to access longer term care arrangements;

non-government continuing care programs that offer residential care type services for frail aged or younger disabled persons who are unable to access a permanent care placement in a Commonwealth Government funded residential aged care facility, or where their care needs exceed what can be provided in a normal home environment;

residential care in rural areas provided for people assessed as no longer being able to live at home and include nursing home care provided by the State, nursing home type care provided in public hospitals and hostel care; and

chronic illness support services providing people with a chronic condition with treatment and preventive care to enable them to remain healthy at home. Services include chronic disease support initiatives which aim to improve the life of those with chronic conditions, reduce avoidable hospital admissions and inpatient length-of-stay, emergency department attendance, and not-for-profit sector contracts that provide community members with services and support for a range of chronic conditions and illnesses.

Mental Health

Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by Health Services under an agreement with the Mental Health Commission for specialised admitted and community mental health.

(d) Contributed equity

AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*' requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by Treasurer's Instruction 955 '*Contributions by Owners made to Wholly Owned Public Sector Entities*' and have been credited directly to Contributed Equity.

The transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. Refer also to note 31 'Equity'.

Note 2 Summary of significant accounting policies (continued)

(e) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership are transferred to the purchaser and can be measured reliably.

Provision of services
Revenue is recognised by reference to the stage of completion of the transaction.

Service appropriations
Service Appropriations are recognised as revenues at fair value in the period in which the Department gains control of the appropriated funds. The Department gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury. Refer to note 18 'Income from State Government' for further information.

Net appropriation determination
The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the Department. In accordance with the determination specified in the 2015-2016 Budget Statements, the Department retained $401million in 2016 ($394 million in 2015) from the following:

. proceeds from fees and charges;
· sale of goods;
· Commonwealth specific purpose grants and contributions; and
· other departmental revenue.

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Department obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Royalties for Regions funds are recognised as revenue at fair value in the period in which the Department obtains control over the funds. The Department obtains control of the funds at the time the funds are deposited into the Department's bank account.

Gains

Realised and unrealised gains are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(f) Property, plant and equipment

Site infrastructure

In 2015-16, the Department has created a new asset class for site infrastructure and reclassified amounts which were previously included within buildings. Site infrastructure includes roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables. Site infrastructure is measured at fair value.

Capitalisation/expensing of assets

Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed directly to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement

Property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is the fair value at the date of acquisition.

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land, buildings and site infrastructure and historical cost for all other property, plant and equipment. Land, buildings and site infrastructure are carried at fair value less accumulated depreciation (buildings and site infrastructure) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

Where market-based evidence is available, the fair value of land and buildings is determined on the basis of current market values determined by reference to recent market transactions.

In the absence of market-based evidence, fair value of land, buildings and site infrastructure (clinical sites) is determined on the basis of existing use. This normally applies where buildings and site infrastructure are specialised or where land use is restricted. Fair value for existing use buildings and site infrastructure is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

When buildings and site infrastructure are revalued, the accumulated depreciation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period. Site infrastructure on properties that the Department shares with Metropolitan Health Service were revalued as at 1 July 2015 by Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor).The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016, and the fair value determined on the basis of depreciated replacement cost.

The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

Refer also to note 24 'Property, plant and equipment' and note 25 'Fair value measurements' for further information on revaluations.

Derecognition

Upon disposal or derecognition of an item of property, plant and equipment and infrastructure, any revaluation surplus relating to that asset is retained in the asset revaluation reserve.

Asset revaluation reserve

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets as described in note 24 'Property, plant & equipment'.

Depreciation

All non-current assets having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

In order to apply this policy, the following methods are utilised:
* Land - not depreciated
* Buildings - diminishing value
* Site Infrastructure - diminishing value
* Plant and equipment - straight line

The depreciation method for plant and equipment was changed to straight line on 1 July 2014. Up to 30 June 2014, plant and equipment were depreciated using the diminishing value with a straight line switch method under which the cost amounts of the assets are allocated on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed, and adjusted if appropriate, annually. Estimated useful lives for each class of depreciable asset are:

Buildings	50 years
Site Infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 10 years
Furniture and fittings	10 to 20 years
Other plant and equipment	4 to 15 years

Artworks controlled by the Department are classified as property, plant and equipment, which are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

(g) Impairment of assets

Property, plant and equipment and infrastructure are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised as expense in the statement of comprehensive income. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Department is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

Note 2 Summary of significant accounting policies (continued)

(g) Impairment of assets (continued)

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairments at the end of each reporting period.

Refer to note 27 'Impairment of Assets' for the outcome of impairment reviews and testing.

Refer also to note 2(o) 'Receivables' and note 21 'Receivables' for impairment of receivables.

(h) Non-current assets classified as held for sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are disclosed separately from other assets in the Statement of Financial Position. Assets classified as held for sale are not depreciated or amortised.

All Crown land holdings are vested in the Department by the Government. The Department of Lands (DOL) is the only agency with the power to sell Crown land. The Department transfers the Crown land and any attaching buildings to DOL when the land becomes available for sale.

(i) Leases

Leases of property, plant and equipment, where the lessee has substantially all of the risks and rewards of ownership, are classified as finance leases.

The Department as lessee

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments determined at the inception of the lease. The assets are disclosed as leased property, plant and equipment, and are depreciated over the period during which the Department is expected to benefit from their use. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

The Department as lessor

The finance lease asset is recognised as a receivable at an amount equal to the net investment in the lease. The recognition of finance income is based on a pattern reflecting a constant periodic rate of return of the lessor's net investment in the finance lease. The finance lease asset has been prepaid as described below.

To establish the pre-paid lease structure for the multi-deck car park at the Queen Elizabeth II Medical Centre site , the State and the Capella Parking Pty Limited exchanged invoices for equal amounts in January 2014 for the Construction Payment and Rental Prepayment as outlined in the Project Agreement. The pre-paid lease structure is an in-substance finance lease arrangement between the State and Capella, as Capella as the lessee has taken on the majority of risks and rewards of ownership of the multi-deck car park. The Project Agreement has a term of 26 years. The Department of Health, as representative of the State, recognises the accretion of the residual interest in the asset (multi-deck car park) over the term of the arrangement as income to gradually build the value of the asset on the statement of financial position over time.

(j) Financial Instruments

In addition to cash, the Department has two categories of financial instrument:
• Loans and receivables; and
• Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

Financial Assets
• Cash and cash equivalents;
• Restricted cash and cash equivalents;
• Receivables;
• Amounts receivable for services; and
• Finance Lease Receivables.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(j) Financial Instruments (continued)

Financial Liabilities
• Payables

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(k) Cash and cash equivalents

For the purpose of the Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand, cash at bank and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(l) Accrued salaries

Accrued salaries (refer note 28 'Payables') represent the amount due to employees but unpaid at the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Department considers the carrying amount of accrued salaries to be equivalent to its fair value.

The accrued salaries suspense account (refer note 19 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur instead of the normal 26. No interest is received on this account. The 2015/16 financial year includes 27 pays and the amount previously held in Accrued Salaries Suspense Account was used for the purpose of meeting the 27th pay.

(m) Amounts receivable for services (holding account)

The Department receives service appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

Refer to note 22 'Amounts receivable for services' and note 18 'Income from State Government'.

(n) Inventories

Inventories are measured on a weighted average cost basis at the lower of cost and net realisable value.

Inventories not held for resale are valued at cost unless they are no longer required, in which case they are measured at net realisable value.

Refer also to note 20 'Inventories'.

(o) Receivables

Receivables are recognised at original invoice amount less an allowance for uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Department will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.

Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payments for GST have been assigned to the Department of Health. This accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Service) was the NGR in previous financial years. The entities in the GST group include the Department of Health, Mental Health Commission, Metropolitan Health Service, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health. Additionally, the Department recognises GST receivables on its own accrued expenses.

Refer also to note 2(j) 'Financial instruments' and note 21 'Receivables'.

(p) Payables

Payables are recognised when the Department becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as they are generally settled within 30 days.

Refer also to note 2(j) 'Financial instruments' and note 28 'Payables'.

Note 2 Summary of significant accounting policies (continued)

(q) Provisions

Provisions are liabilities of uncertain timing or amount, and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of obligation. Provisions are reviewed at end of each reporting period.

Provisions - employee benefits

All annual leave and long service leave provisions are in respect of employees' services up to the end of the reporting period.

Annual leave

Annual leave is not expected to be settled wholly within 12 months after the end of the reporting period and is therefore considered to be 'other long-term employee benefits'. The annual leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

The provision for annual leave is classified as a current liability as the Department does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Long service leave

Long service leave is not expected to be settled wholly within 12 months after the end of the reporting period. The long service leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Unconditional long service leave provisions are classified as current liabilities as the Department does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Department has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income for this leave as it is taken.

Deferred Salary Scheme

The provision for deferred salary scheme relates to the Department's employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability is measured on the same basis as annual leave. It is reported as a current provision as employees can leave the scheme at their discretion at any time.

Superannuation

The Government Employees Superannuation Board (GESB) and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). From 30 March 2012, existing members of the WSS or GESBS and new employees have been able to choose their preferred superannuation fund provider. The Department makes contributions to GESB or other fund providers on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. Contributions to these accumulation schemes extinguish the Department's liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(q) Provisions (continued)

The GSS is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the Department to GESB extinguishes the Department's obligations to the related superannuation liability.

The Department has no liabilities under the Pension Scheme or the GSS. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Department to the GESB.

The GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits, and is recouped from the Treasurer for the employer's share.

Refer to note 2(r) 'Superannuation Expense'.

Employment on-costs (workers' compensation insurance)

Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Department's 'Employee benefits expense'.

Refer to note 13 'Other expenses'

(r) Superannuation expense

Superannuation expense is recognised in the Statement of Comprehensive Income and comprises of employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBS or other superannuation funds.

(s) Services received free of charge or for nominal cost

Services received free of charge or for nominal cost, that the Department would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured. A corresponding expense is recognised for services received.

Services received from other State Government agencies are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(t) Assets transferred between government agencies

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are measured at the fair value of those net assets that the Department would otherwise pay for, and are reported under Income from State Government when received by the Department. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions*' in respect of the net assets transferred.

(u) Comparative figures

Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

Note 3 Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Department evaluates these judgements regularly.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Department believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful lives.

Note 4 Key sources of estimation uncertainty

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

Employee benefits provision

In estimating the non-current long service leave provision, employees are assumed to leave the Department each year on account of resignation or retirement at 7.5%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Other estimations and assumptions used in calculating the Department's long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Department has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2015 that impacted on the Department.

Title		
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part C of this Standard defers the application of AASB 9 to 1 January 2017. The application date of AASB 9 was subsequently deferred to 1 January 2018 by AASB 2014-1. The Department has not yet determined the application or the potential impact of AASB 9.	
AASB 2014-8	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]* This Standard makes amendments to AASB 9 Financial Instruments (December 2009) and AASB 9 Financial Instruments (December 2010), arising from the issuance of AASB 9 Financial Instruments in December 2014. The Department has not yet determined the application or the potential impact of AASB 9.	
AASB 2015-3	*Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality* This Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing that Standard to effectively be withdrawn. There is no financial impact.	

Future impact of Australian Accounting Standards not yet operative

The Department cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 1101. By virtue of a limited exemption, the Department has early adopted AASB 2015-7 *Amendments to Australian Accounting Standard - Fair Value Disclosures of Not-for-Profit Public Sector Entities*. Where applicable, the Department plans to apply the following Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supercedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Department shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 1057	*Application of Australian Accounting Standards* This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.	1 Jan 2016
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Department to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-4	*Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]* The adoption of this Standard has no financial impact for the Department as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.	1 Jan 2016
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-1	*Amendments to Australian Accounting Standards – Annual Improvements to Australian Accounting Standards 2012–2014 Cycle [AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140]* These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012–2014 Cycle in September 2014, and editorial corrections. The Department has determined that the application of the Standard has no financial impact.	1 Jan 2016
AASB 2015-2	*Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, 101, 134 & 1049]* This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.	1 Jan 2016
AASB 2015-6	*Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities [AASB 10, 124 & 1049]* The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.	1 Jul 2016
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. The Department has not yet determined the application or the potential impact of AASB 15.	1 Jan 2017

Note 5 Disclosure of changes in accounting policy and estimates (continued)

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 2016-2	*Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107* This Standard amends AASB 107 Statement of Cash Flows (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Department has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Department has not yet determined the application or the potential impact.	1 Jan 2017

Note 6 Employee benefits expense

	2016 $000	2015 $000
Salaries and wages (a)	102,569	88,438
Superannuation - defined contribution plans (b)	8,973	7,980
	111,542	96,418

(a) Includes the value of fringe benefits to employees plus the fringe benefits tax component and the value of superannuation contribution component for leave entitlements.

(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.

(c) Redundancy expenses of $6.274 million were incurred in 2015/16 ($0.928 million in 2014/15).

Employment on-costs (workers' compensation insurance) are included at note 13 'Other expenses'.

Note 7 Contracts for services

Public patients services	-	719
Home and community care	276,809	268,716
Patient transport service	129,607	119,512
Other aged care services	105,879	107,954
Mental health	322	340
Blood and organs	24,326	31,085
Aboriginal health	8,484	10,194
Palliative care	22,639	4,699
Oral health	14,127	10,231
Other contracts	66,332	70,960
	648,525	624,410

Note 8 Supplies and services

Medical supplies	42,602	42,581
Other consumables	1,420	1,798
Operating lease rentals	9,465	9,460
	53,487	53,839

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 9 Grants and subsidies

	2016 $000	2015 $000
Recurrent		
Funding for the Delivery of Health Services by Autonomous Statutory Authorities (a):		
Metropolitan Health Service	4,943,622	4,540,200
WA Country Health Service	1,405,873	1,358,568
Quadriplegic Centre Board	9,980	11,304
Queen Elizabeth II Medical Centre Trust	231	258
Research and development grants	17,861	20,017
Spectacle subsidy scheme (b)	68	2,533
Other	3,719	7,133
	6,381,354	5,940,013

(a) Includes the non-cash component of service appropriations. Refer to note 2(e) 'Service appropriations'.

(b) The management of the Spectacle Subside Scheme was transferred from Department of Health to the Metropolitan Health Service in 2015/16.

Note 10 Depreciation expense

Buildings	349	350
Site infrastructure	75	75
Computer equipment	22	26
Furniture and fittings	9	3
Other plant and equipment	119	123
	574	577

Note 11 Loss on disposal of non-current assets

Carrying amount of non-current assets disposed:		
Property, plant and equipment	10	7
Net loss	10	7

Refer to note 24 'Property, plant and equipment'.

Note 12 Contribution to Capital Works Fund 2,414 42,352

$2.414 million was paid to the Capital Works Fund during the 2015/16 financial year, an administered trust account of the Department, to fund the capital works program for the Health Services.

Note 13 Other expenses

Advertising	1,217	1,410
Act of Grace and ex-gratia payments (b)	8,865	8,380
Communication	987	933
Computer related expenses	1,777	1,761
Insurance	200	179
Legal expenses	1,051	1,549
Other employee related expenses	2,273	2,530
Promotional expenses	358	1
Repairs and maintenance	900	735
Scholarships	1,772	2,149
Travel related expenses	493	568
Workers' compensation insurance (a)	228	992
Freight and cartage	683	771
Special functions	538	438
Other	1,412	1,720
	22,754	24,116

(a) The employment on-costs include workers' compensation insurance only. Superannuation contributions accrued as part of the provision for leave entitlements are employee benefits and are not included in employment on-costs.

(b) In 2014/15, $8.380 million of Act of Grace payments were made to the Metropolitan Health Service and WA Country Health Service for patient fee debts. Under the Private Patient Scheme approved by the State Government, the Department has commenced the ex-gratia payments towards patient fee debts in July 2015. The total amounts of ex-gratia payments is $8.865 million for 2015/16 ($6.410 million for Metropolitan Health Service and $2.455 million for WA Country Health Service).

		2016 $000	2015 $000
Note 14	**Commonwealth grants and contributions**		
	Cash Grants - Recurrent		
	National Health Reform Agreement (NHRA) (a):		
	Local Hospital Networks	1,638,623	1,539,891
	Public Health	38,528	37,154
	Specific Purpose Grants:		
	Home and Community Care	178,285	174,802
	Department of Veterans' Affairs	73,403	72,451
	Public Health Programs	6,948	3,438
	Aged Care Programs	41,273	28,952
	Multi-Purpose Services Sites	27,823	27,434
	Public Health Outcome Funding Agreement - Vaccines	17,894	22,886
	Other Public Health Programs	-	3,438
	Treating More Public Dental Patients	12,041	21,964
	Other programs	10,587	8,403
	Non-Cash Contributions		
	Vaccine inventories received free of charge	24,999	11,025
		2,070,404	1,951,838

(a) As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement (NHRA) for services, health teaching, training and research provided by local hospital networks or other organisations, and any other matter that under that Agreement is to be funded through the National Health Funding Pool, the State Managed Fund (Health) Account and the State Managed Fund (Mental Health) Account. The new funding arrangement established under the Agreement requires the Commonwealth to make funding payments to the State Pool Account from which distributions to the local hospital networks are made by the Department of Health and Mental Health Commission. All moneys in the State Pool Account and in the State Managed Fund (Health) Account are fully allocated to local hospital networks in each financial year (refer note 44 'Special Purpose Accounts'). Under the National Health Reform Agreement, the Commonwealth Government also provides public health funding to the Department of Health.

Note 15	**Other grants and contributions**		
	Department of Education - Health services for students at public schools	7,415	7,062
	Mental Health Commission - Mandatory Program	-	148
	Main Roads WA - Neurotrauma Research Program	-	2,000
		7,415	9,210

Both the Mental Health Commission - Mandatory program and Main Roads WA - Neurotrauma program were fully paid during 2014/15.

Note 16	**Finance income**		
	Finance lease income	1,961	2,024
Note 17	**Donation revenue**		
	General public contributions	2,107	1,000
Note 18	**Income from State Government**		
	Service appropriations (a)		
	Appropriations received to deliver services	4,723,136	4,604,492
	Amount authorised by other statutes:		
	Salaries and Allowances Act 1975	697	680
	Lotteries Commission Act 1990	129,750	121,500
		4,853,583	4,726,672

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

		2016 $000	2015 $000
Note 18	**Income from State Government (continued)**		
	Assets (transferred)/assumed (b)		
	The following assets have been transferred from/(to) other state government agencies during the period:		
	Assets transferred in:		
	Cash from Metropolitan Health Services in relation to surplus interest and facility charges held in the specific purpose accounts for private practice income of medical practitioners	1,132	11,254
	Assets transferred out:		
	Medical equipment to Metropolitan Health Services	(42)	-
	Other plant & equipment to Metropolitan Health Service	(35)	(11)
		1,055	11,243
	Services received free of charge (c)		
	Determined on the basis of the following estimates provided by agencies:		
	Department of Education - accommodation	898	887
	Landgate - valuation services and land information	174	272
	State Solicitor's Office - legal service	874	1,218
	Department of Finance - accommodation management fees		-
		1,947	2,377
	Royalties for Regions Fund (d)		
	Regional Community Services Account (d):		
	Regional Workers Incentives	8,941	13,550
	Royal Flying Doctor Service	16,476	4,000
	Pilbara Health Partnership	1,472	9,242
	St John Ambulance	8,000	7,790
	Rural Generalist Pathways	82	2,400
	Fitzroy Kids Health	150	200
	Improving Ear, Eye & Oral Health Child Aboriginal	1,500	1,500
	Rural Palliative Care Program	1,250	1,000
	Rural In-Reach Program-Women (Women's Support Health Care)	1	250
	Patient Assisted Travel Scheme	10,480	10,080
	Pilbara Cardiovascular Screen Program	-	123
	Renal Dialysis Service Expansion program	-	496
	Busselton ICT	-	2,806
	SIHI - Regional Infrastructure and Headworks Fund - Residential Aged & Dementia Care		
	Regional (Kalgoorlie Esperance) Telehealth	3,569	-
		51,921	53,438
	Regional Infrastructure and Headworks Fund (d):		
	SIHI Residential Aged & Dementia Care	-	4,000
		51,921	57,438

(a) Service appropriations fund the net cost of services delivered. Appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the budgeted depreciation expense for the year and any agreed increase in leave liability during the year.

(b) Discretionary transfers of assets and liabilities between State Government agencies are reported under Income from State Government. Transfers of assets and liabilities (including grants) in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 'Contributions' in respect of the net assets transferred. Other non-discretionary non-reciprocal transfers of assets and liabilities designated as contributions by owners under TI 955 are also recognised directly to equity.

(c) Services received free of charge or for nominal cost are recognised as revenues at the fair value of those services if it can be reliably measured and if they would have been purchased if they were not donated.

(d) This is a sub-fund within the over-arching 'Royalties for Regions Fund' established under the Royalties for Regions Act 2009. The recurrent funds are committed to projects and programs in WA regional areas.

		2016 $000	2015 $000
Note 19	**Restricted cash and cash equivalents**		
	Current		
	Commonwealth Specific Purpose Grants (a)	90,624	104,170
	Royalties for Regions Fund (b)	105,044	146,976
	Telethon - Perth Children's Hospital Research Fund (c)	6,399	4,792
	Accrued Salaries Suspense Account (d)	-	83,170
		202,067	339,108

(a) Funds held for the specific purposes stipulated by Commonwealth Government for Public Health Outcome Funding Agreement (PHOFA) and Vaccines ($7.2 million), Subacute Care ($24.3 million), Emergency Department ($18.2 million), Aged Care programs ($12.6 million), NPA Adult Public Dental Services ($10.4 million) and other initiatives and programs ($17.9 million).

(b) Unspent funds are committed to projects and programs in WA regional areas.

(c) Funds received from the Channel 7 Telethon Trust, the Department of Health and other donors to fund and promote child and adolescent health research in Western Australia. Refer to note 44 'Special Purpose Accounts'.

(d) The 2015/16 financial year has 27 pay periods for payments of salaries and wages instead of the normal 26 pay periods. Amounts accumulated over the last 10 financial years in the Accrued Salaries Suspense Account have been used for the purpose of meeting the 27th pay for the Department and Statutory Authorities within WA Health.

Note 20	**Inventories**		
	Current		
	Drug supplies (at cost)	8,909	6,828
	State Distribution Centre - supply stores (at cost)	6,814	9,335
		15,723	16,163

The financial responsibility for the supply inventory stores has been transferred from Metropolitan Health Service to the Department of Health since the opening of the State Distribution Centre at Jandakot in the 2013/14 financial year.

Refer to note 2(n) 'Inventories'.

Note 21	**Receivables**		
	Current		
	Receivables	6,605	1,099
	Allowance for impairment of receivables	(6)	(20)
	Accrued revenue	4,139	3,188
		10,738	4,267
	GST receivable	30,294	30,151
		41,032	34,418
	Reconciliation of changes in the allowance for impairment of receivables:		
	Balance at start of period	20	22
	Doubtful debts expense	-	-
	Amounts written off during the period	(14)	(2)
	Balance at end of period	6	20

The rights to collect GST receivable from the Australian Taxation Office have been assigned to the Department of Health from 1 July 2012. The Department of Health has become the Nominated Group Representative (NGR) for the GST Group as from this date. The entities in this group include the Department of Health, Mental Health Commission, Metropolitan Health Service, WA Country Health Service, Queen Elizabeth II Medical Centre Trust, and the Health and Disability Services Complaints Office. Metropolitan Health Service was the NGR in the previous financial years.

Refer to note 2(o) 'Receivables' and note 47 'Financial instruments'.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

		2016 $000	2015 $000
Note 22	**Amounts receivable for services (Holding Account)**		
	Non-current	36,858	100,417
		36,858	100,417

Represents the non-cash component of service appropriations (refer to note 2(m) 'Amounts receivable for services (holding account)'. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Amounts receivable for services ($70.171 million) relating to Joondalup and Peel Health Campuses have been transferred from the Department to Metropolitan Health Service in 2015/16. See also Note 31 (c) 'Equity' for further information on the transfer.

Note 23	**Finance lease receivable**		
	Non-current	4,942	2,981

Refer to note 2(i) 'Leases' .

Note 24	**Property, plant and equipment**		
	Land		
	At fair value (a)	12,577	11,609
	Buildings		
	At fair value (a)	11,341	12,685
		11,341	12,685
	Site infrastructure		
	At fair value (b)	2,352	1,444
		2,352	1,444
	Computer equipment		
	At cost	157	192
	Accumulated depreciation	(138)	(151)
		19	41
	Furniture and fittings		
	At cost	84	48
	Accumulated depreciation	(24)	(15)
		60	34
	Other plant and equipment		
	At cost	2,757	2,850
	Accumulated depreciation	(1,965)	(2,004)
		792	846
	Artworks		
	At cost	85	85
	Total property, plant and equipment	27,226	26,744

(a) Land and buildings were revalued as at 1 July 2015 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016. In undertaking the revaluation, fair value was determined by reference to market values for land: $3,825,700 (2015: $3,857,000). For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). Refer also to note 2(f) 'Property, plant and equipment'.

(b) Site infrastructure on properties that the Department shares with Metropolitan Health Service were revalued as at 1 July 2015 by Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor).The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016, and the fair value determined on the basis of depreciated replacement cost. See note 2 (f) 'Property, plant and equipment'.

Site infrastructure include roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

(c) Information on fair value measurements is provided in Note 25.

	2016 $000	2015 $000
Note 24 Property, plant and equipment (continued)		
Reconciliations		
Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below.		
Land		
Carrying amount at the start of year	11,609	9,404
Transfer to Department of Lands	(2)	-
Revaluation increments / (decrements)	969	2,205
Carrying amount at the end of year	12,576	11,609
Buildings		
Carrying amount at the start of year	12,684	12,661
Transfers between asset classes	(1,055)	-
Revaluation increments/(decrements)	61	372
Depreciation	(349)	(349)
Carrying amount at the end of year	11,341	12,684
Site Infrastructure		
Carrying amount at the start	1,445	1,520
Transfers between asset classes	1,055	-
Revaluation increments/(decrements)	(73)	-
Depreciation	(75)	(75)
Carrying amount at the end of year	2,352	1,445
Computer Equipment		
Carrying amount at the start of year	41	54
Depreciation	(22)	(26)
Carrying amount at the end of year	19	41
Furniture & fittings		
Carrying amount at the start of year	34	16
Additions	36	27
Transfers to Metropolitan Health Service	-	(6)
Depreciation	(9)	(3)
Carrying amount at the end of year	60	34
Other Plant & equipment		
Carrying amount at the start of year	846	736
Additions	152	245
Transfers to Metropolitan Health Service	(77)	(5)
Other disposals	(10)	(7)
Depreciation	(119)	(123)
Carrying amount at the end of year	792	846
Artworks		
Carrying amount at the start of year	85	85
Carrying amount at the end of year	85	85
Total property, plant and equipment		
Carrying amount at the start of year	26,744	24,476
Additions	188	285
Transfer to the Department of Lands	(2)	-
Transfers to Metropolitan Health Service	(77)	(11)
Other disposals	(10)	(7)
Revaluation increments/(decrements)	957	2,577
Depreciation	(574)	(576)
Carrying amount at the end of year	27,226	26,744

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 25 Fair value measurements

(a) Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) Quoted prices (unadjusted) in active markets for identical assets (level 1).
2) Inputs other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2);
3) Inputs for the asset that are not based on observable market data (unobservable input) (level 3).

The following table represents the Department's assets measured at fair value at 30 June 2016.

Assets measured at fair value:	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Total $000**
Land				
Vacant land	-	3,826	-	3,826
Specialised	-	-	8,751	8,751
Buildings				
Specialised	-	-	11,341	11,341
Site Infrastructure	-	-	2,352	2,352
	-	3,826	22,444	26,270

There were no transfers between Levels 1, 2, or 3 during the period.

The following table represents the Department's assets measured at fair value at 30 June 2015.

Assets measured at fair value:	**Level 1 $000**	**Level 2 $000**	**Level 3 $000**	**Total $000**
Land				
Vacant land	-	3,857	1	3,858
Specialised	-	-	7,751	7,751
Buildings				
Specialised	-	-	12,685	12,685
Site Infrastructure	-	-	1,445	1,445
	-	3,857	21,882	25,739

There were no transfers between Levels 1, 2, or 3 during the period.

(b) Valuation techniques used to derive level 2 and level 3 fair values

The Department obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services) annually. Two principal valuation techniques are applied to the measurement of fair values:

Market value type assets - level 2 valuations

The Department's vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Landgate Valuation Services considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjusts the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

Current use type assets - level 3 valuations

Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio political restrictions on a land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

Note 25 Fair value measurements (continued)

(b) Valuation techniques used to derive level 2 and level 3 fair values (continued)

Current use type assets - level 3 valuations

The Department's community health centres throughout the State and public health buildings located on hospital sites are specialised buildings and site infrastructure valued under the cost approach. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings and site infrastructure, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The actual construction cost, with adjustment of the annual movement in building cost index, is an approximation of current replacement cost in the first three years. The building cost index is published by the Department of Finance's Building Management and Works.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation;
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   • Community Health Centres
   • Buildings on hospital sites utilised for Public Health
c) Measurement of the general floor areas;
d) Application of the BUC cost rates per square meter of general floor areas;
e) Application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

The maximum effective age used in the valuation of specialised buildings and site infrastructure is 50 years. The effective age of buildings and site infrastructure is initially calculated from the commissioning date, and is reviewed after the building and site infrastructure have undergone substantial renewal, upgrade or expansion.

The straight line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings and site infrastructure are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a current use basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to annual revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the Statement of Comprehensive Income as depreciation expenses over their remaining useful life.

(c) Fair value measurements using significant unobservable inputs

The following table represents the changes in level 3 items for the period ended 30 June 2016:

	Site Infrastructure	Land	Buildings
2016	**$000**	**$000**	**$000**
Fair value at start of period	1,445	7,751	12,684
Revaluation increments/(decrements)	(73)	1,000	61
Transfers from/(to) other asset classes	1,055	-	(1,055)
Depreciation Expense	(75)	-	(349)
Fair value at end of period	2,352	8,751	11,341

The following table represents the changes in level 3 items for the period ended 30 June 2015:

	Site Infrastructure	Land	Buildings
	$000	**$000**	**$000**
2015			
Fair value at start of period	1,520	5,711	12,661
Revaluation increments/(decrements)	-	2,040	373
Depreciation Expense	(75)	-	(350)
Fair value at end of period	1,445	7,751	12,684

(d) Valuation processes

The Department manages the valuation processes. These include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

Landgate Valuation Service determines the fair values of the Department's land and buildings, and prior to 1 July 2014, also determined the fair values of site infrastructure. A quantity surveyor is engaged by the Department to provide an update of the current replacement costs for specialised buildings and site infrastructure. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor and calculates the depreciated replacement costs.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

		2016 $000	2015 $000
Note 26	**Other assets**		
	Current		
	Prepayments (a)	3,902	813
		3,902	813
	Non-current		
	Prepayments (a)	9,237	4,201
		13,139	5,014

(a) Includes (i) prepayment for palliative care services in 2011/12, to be received over the next ten financial years; and (ii) prepayments to the National Blood Authority under the National Blood Agreement.

Note 27 Impairment of Assets

There were no indications of impairment to property, plant and equipment at 30 June 2016.

The Department held no goodwill during the reporting period.

Note 28 Payables

	2016 $000	2015 $000
Current		
Trade payables	24,206	18,889
Accrued salaries	2,941	3,625
Accrued expenses	34,498	24,198
Total current	61,645	46,712

Refer to note 2(p) 'Payables' and note 47 'Financial Instruments'.

Note 29 Provisions

	2016 $000	2015 $000
Current		
Employee benefits provision		
Annual leave (a)	9,661	9,097
Long service leave (b)	10,358	12,522
Deferred salary scheme (c)	268	227
	20,287	21,846
Non-current		
Employee benefits provision		
Long service leave (b)	5,235	3,627
	25,522	25,473

(a) Annual leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	6,841	6,388
More than 12 months after the end of the reporting period	2,820	2,709
	9,661	9,097

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	2,072	2,615
More than 12 months after the end of the reporting period	13,522	13,534
	15,594	16,149

(c) Deferred salary scheme liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	-	-
More than 12 months after the end of the reporting period	268	227
	268	227

Note 30 Other current liabilities

Unearned Income	778	197

		2016 $000	2015 $000
Note 31	**Equity**		
	The Western Australian Government holds the equity interest in the Department on behalf of the community. Equity represents the residual interest in the net assets of the Department. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.		
	Contributed equity		
	Balance at the start of period	(143,169)	(143,169)
	Distributions to owner		
	Transfer of assets to Metropolitan Health Service (c)	(70,170)	-
	Transfer land to Department of Lands	(2)	-
	Balance at the end of period	(213,341)	(143,169)
	(a) Treasurer's Instruction 955 '*Contributions by Owners Made to Wholly Owned Public Sector Entities*' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*'.		
	(b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.		
	Under Treasurer's Instruction 955 non-discretionary and non-reciprocal transfers of net assets between state government agencies have been designated as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.		
	(c) In accordance with the Minister's direction, the assets (Amounts Receivable for Services) relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred to Metropolitan Health Service on 1 June 2016. This transfer of assets has been formally designated as a contributions by owner for the Metropolitan Health Service and a distribution to owners for the Department.		
	Reserves		
	Asset revaluation reserve		
	Balance at the start of period	305,690	303,111
	Net revaluation increments/(decrements):		
	Land	969	2,205
	Buildings	61	374
	Site infrastructure	(73)	-
		957	2,579
	Balance at the end of period	306,647	305,690
	Accumulated surplus		
	Balance at the start of period	382,972	396,321
	Result for the period	(214,530)	(13,349)
	Balance at the end of period	168,442	382,972
Note 32	**Notes to the Statement of Cash Flows**		
	Reconciliation of cash		
	Cash at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
	Cash and cash equivalents	8,706	93,030
	Restricted cash and cash equivalents (refer to note 19)	202,067	339,108
		210,773	432,138

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

		2016 $000	2015 $000
Note 32	**Notes to the Statement of Cash Flows (continued)**		
	Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities		
	Net cost of services	(5,123,036)	(4,811,079)
	Non-cash items:		
	Depreciation expense	574	577
	Services received free of charge	1,947	2,377
	Loss on disposal of non current assets	11	7
	Transfer of non-cash funding to Health entities	371,549	364,958
	Donation of non-current assets	(94)	-
	Adjustments for other non-cash items	(4)	-
	(Increase)/decrease in assets:		
	Inventories	440	(3,478)
	Receivables	(6,614)	4,970
	Finance lease receivable	(1,961)	(2,024)
	Other assets	(8,125)	437
	Increase/(decrease) in liabilities:		
	Payables	14,934	(16,435)
	Provisions	50	3,255
	Other liabilities	581	(903)
	Net cash provided by/(used in) operating activities	(4,749,748)	(4,457,338)
	At the end of the reporting period, the Department had fully drawn on all financing facilities, details of which are disclosed in the financial statements.		
Note 33	**Services provided free of charge**		
	During the period the following services were provided to other W.A. agencies free of charge for functions outside the normal operations of the Department:		
	Contiguous Local Authorities Group	1,453	1,687
	Department of Corrective Services	119	116
	Department of Education	-	4
	Department of Planning & Infrastructure	143	139
	Town of Port Headland	-	18
	Water Corporation	181	171
	Department of Fire & Emergency Services	38	37
	Department of Housing & Works	50	49
	Department of Water	31	54
	Others	146	130
		2,161	2,405
Note 34	**Commitments**		
	The commitments below are inclusive of GST:		
	Non-cancellable operating lease commitments		
	Commitments in relation to non-cancellable operating leases are payable as follows:		
	Within 1 year (a)	9,470	9,429
	Later than 1 year and not later than 5 years (a)	19,077	517
		28,547	9,946
	The leases are non-cancellable, with rent payable monthly in advance. Operating leases relating to government owned buildings have contingent rental obligations based upon current property valuations. There are no restrictions imposed by these leasing arrangements on other financing transactions.		
	(a) includes new 3 year lease term for 189 Royal St $28 million		
	Private sector contracts for the provision of health services		
	Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
	Within 1 year	597,453	578,282
	Later than 1 year and not later than 5 years	571,736	904,816
	Later than 5 years and not later than 10 years	15,532	54,640
		1,184,720	1,537,738
	Other expenditure commitments		
	Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
	Within 1 year	7,612	3,021
	Later than 1 year and not later than 5 years	320	480
		7,932	3,501

		2016 $000	2015 $000
Note 35	**Contingent liabilities and contingent assets**		
	Contingent liabilities		
	The following contingent liabilities are additional to the liabilities included in the financial statements:		
	Interstate charging for patients transferred to hospitals outside of Western Australia (final liability dependent on finalisation of activity with other States)	1,568	-
	Contingent assets		
	At the reporting date, the Department is not aware of any contingent assets.		
Note 36	**Events occurring after the end of the reporting period**		
	There were no events occurring after the reporting period which had significant financial effects on these financial statements.		
Note 37	**Explanatory statement**		
	Significant variations between estimates and actual results, and between the actual results for 2016 and 2015, for income and expenses as presented in the financial statement titled 'Summary of Consolidated Account Appropriations and Income Estimates' are shown below. Significant variations are considered to be those greater than 10%.		

	2016 Estimate $000	2016 Actual $000	Variance $000
Significant variances between estimates and actual for 2016 - Total appropriations to deliver services:			
(a) Total cost of services			
Home-Based Hospital Programs	44,833	36,735	(8,098)
The variance is due to efficiencies gained by the redirection of Hospital in the Home services, now contracted out to a non government organisation.			
Dental Health	115,495	103,623	(11,872)
The Commonwealth National Partnership Agreement for Treating More Adult Public Dental Patients has enabled better than expected service delivery efficiencies to a larger number of patients being treated.			
Mental Health	612,041	721,415	109,374
The budget was based on the Service Level Agreement with the Mental Health Commission. Actual costs during 2015/16 included expenditure above the budgeted value, mainly due to the provision of additional mental health services outside the agreed scope of service agreement with the Mental Health Commission.			
(b) Adjustments	23,186	(122,916)	(146,102)
Adjustments comprise movements in cash balances, movements in accrual items such as receivables and payables, Royalties for Regions funding and resources received free of charge from other state government agencies.			
Significant variances between estimates and actual for 2016 - Capital appropriations:			
(a) Capital Appropriations	213,940	146,494	(67,446)
During 2015/16, a lesser amount of capital appropriation funding was provided towards the Asset Investment Program (AIP) compared to budget. This was reflective of major projects within AIP having been reallocated to 2016/17.			
Significant variances between estimates and actual for 2016 - Capital expenditure:			
(a) Purchase of non-current physical assets	474,875	399,404	(75,471)
The decrease is mainly due to variations in the timelines of projects within the Asset Investment Program (Renal Dialysis and Support Services $23.5 million; Royal Perth Hospital - Development Stage 1 $18.4 million; Onslow Hospital $14.9 million; Replacement of PathWest's Laboratory Information System $10.9 million; Improving Public Hospital Services (NPA) $10.7 million.)			
(b) Repayment of borrowings	79,351	68,815	(10,536)
The decrease in repayment of borrowings compared to budget is mainly due to the reallocation in the available lease facility of $10.1 million from 2015/16 to 2016-17. This is part of the substantial rationalisation process carried out in conjunction with Serco in relation to the remaining assets to be acquired for the Fiona Stanley Hospital.			
(c) Adjustments for other funding sources	(340,286)	(321,725)	18,561
The reduction represents lesser amounts of capital funding provided towards the Asset Investment Program (AIP) in 2015/16 compared with 2014/15 as a result of a number of project delays and the reallocation of budget to the next two years.			

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

Note 37 Explanatory statement (continued)

	2016 Actual $000	2015 Actual $000	Variance $000
Significant variances between actual for 2016 and 2015 - Total appropriation to deliver services			
(a) Total Cost of Services			
Palliative Care	33,199	36,910	(3,710)
The decrease in actual expenditure is due to variations in end of life decisions, and the associated costs of care.			
Emergency Department	807,760	722,379	85,381
The variance is due to increased expenditure from the opening of St John of God Midland Public Hospital, the first full year of operation of the Fiona Stanley Hospital's Emergency Department, and the closure of the Swan Districts Hospital.			
Significant variances between actual for 2016 and 2015 - Capital appropriations:			
(a) Capital appropriations	146,494	245,284	(98,790)
Less capital funding has been provided towards the Asset Investment Program (AIP) in 2015/16, compared with the previous year. This is reflective of the fact that many of the major projects in the AIP have reached completion stage, such as the Midland Health Campus ($36 million), Busselton Health Campus ($16 million), Fiona Stanley Hospital Information Communication and Technology ($27.5 million) and Sir Charles Gairdner Mental Health Unit ($10 million). In addition, project delays have further reduced the capital appropriation requirements in 2015/16.			
Significant variances between actual for 2016 and 2015 - Capital expenditure:			
(a) Purchase of non-current physical assets	399,404	587,991	(188,587)
Construction activities for several projects peaked in 2014/15 (Perth Children's Hospital - Development $114.3 million). A number of large projects achieved practical completion during 2015/16, including St John of God Midland Public Hospital ($79.6 million).			
(b) Repayment of borrowings	68,815	59,185	9,630
The increase in repayment of borrowings is mainly due to new borrowings under the Fiona Stanley Hospital finance leases resulting in additional lease repayments in 2015/16.			
(c) Adjustments for other funding sources	(321,725)	(401,892)	80,167
The difference is mainly due to a reduction in Treasury Administered funding ($93.2 million) and funding for Perth Children Hospital ($147.5 million), with an increase in Royalties for Regions funding ($14.7 million) and Capital Contribution ($141.0 million).			

	2016	2015
Note 38 Remuneration of senior officers		
The number of senior officers whose total fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:		
$120,001 - $130,000	-	1
$180,001 - $190,000	-	2
$210,001 - $220,000	-	1
$220,001 - $230,000	-	2
$280,001 - $290,000	1	1
$330,001 - $340,000		-
$340,001 - $350,000	1	-
$350,001 - $360,000	2	-
$390,001 - $400,000	-	1
$450,001 - $460,000	-	1
$490,001 - $500,000	-	1
$520,001 - $530,000	1	1
$550,001 - $560,000	1	-
$580,001 - $590,000	1	-
$650,001 - $660,000	-	1
	7	12

	$000	$000
Base remuneration and superannuation	2,899	3,638
Annual leave and long service leave accruals	19	249
Other benefits	75	69
Total remuneration of senior officers	2,993	3,956

The total remuneration includes the superannuation expense incurred by the Department in respect of senior officers.

		2016 $000	2015 $000
Note 39	**Remuneration of auditor**		
	Remuneration paid or payable to the Auditor General in respect of the audit for the current financial year is as follows:		
	Auditing the accounts, financial statements and key performance indicators	345	341
Note 40	**Supplementary financial information**		
	Write-offs		
	During the financial year, the Department has written off debts and inventory under the authority of:		
	The Accountable Authority	49	-
		49	-
Note 41	**Related bodies**		
	A related body is a body which receives more than half its funding and resources from the Department and is subject to operational control by the Department.		
	The Department had no related bodies during the financial year.		
Note 42	**Affiliated bodies**		
	An affiliated body is a body which receives more than half its funding and resources from the Department but is not subject to operational control by the Department.		
	The nature of assistance provided in the form of grants and subsidies to all non-government agencies (whether affiliated or not) during the year are outlined below:		
	Research and development	20,342	20,044
	Public health	1,199	7,104
		21,541	27,148
Note 43	**Other statement of receipts and payments**		
	Commonwealth Grant - Christmas and Cocos Island		
	Balance at the start of period	-	-
	Receipts		
	Commonwealth grant	2,906	2,273
	Payments		
	Purchase of WA Health Services	(2,940)	(2,273)
		(2,940)	(2,273)
	Balance at the end of period	(34)	-
Note 44	**Special Purpose Accounts**		
	State Pool Account		
	The purpose of the special purpose account is to hold money paid by the Commonwealth, the State or another State under the National Health Reform Agreement for funding health services.		
	Balance at the start of period	-	-
	Controlled by Department		
	Receipts:		
	Commonwealth activity based funding for local hospital networks	1,410,406	1,297,338
	Commonwealth activity based funding for Department of Health	36,719	26,848
	Commonwealth block funding for local hospital networks	191,498	215,705
	Commonwealth public health funding for Department of Health	38,528	37,154
	State activity based funding from Department of Health	2,498,987	1,725,211
	Payments:		
	Commonwealth activity based funding to local hospital networks	(1,410,406)	(1,297,338)
	Commonwealth activity based funding to Department of Health	(36,719)	(26,848)
	Commonwealth block funding to State Managed Fund (Health) Account	(191,498)	(215,705)
	Commonwealth public health funding to Department of Health	(38,528)	(37,154)
	State activity based funding to local hospital networks	(2,498,987)	(1,725,211)
		-	-

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2016

		2016 $000	2015 $000
Note 44	**Special Purpose Accounts (continued)**		
	State Pool Account (continued)		
	Administered by Department of Health		
	Receipts:		
	Commonwealth activity based funding for Mental Health Commission (MHC)	92,040	101,288
	Commonwealth block funding for Mental Health Commission	73,580	72,024
	State activity based funding from Mental Health Commission	157,463	160,452
	Payments:		
	MHC Commonwealth activity based funding to local hospital networks	(90,617)	(99,677)
	MHC Commonwealth activity based funding to non-government organisation (NGO)	(1,423)	(1,611)
	Commonwealth block funding to Mental Health Commission	(73,580)	(72,024)
	MHC State activity based funding to local hospital networks	(157,463)	(160,452)
		-	-
	Balance at the end of period	-	-
	State Managed Fund (Health) Account		
	The purpose of the special purpose account is to hold money received by the Department of Health for the purposes of health funding under the National Health Reform Agreement that is required to be undertaken in the State through a State Managed Fund.		
	Balance at the start of period	-	-
	Controlled by Department		
	Receipts:		
	Commonwealth block funding from State Pool Account	191,498	215,705
	State block funding from Department of Health	349,227	261,250
	Payments:		
	Commonwealth block funding to local hospital networks	(191,498)	(215,705)
	State block funding to local hospital networks	(349,227)	(261,250)
		-	-
	Administered by Department of Health		
	Receipts:		
	Mental Health Commission - Commonwealth block funding	72,539	70,387
	Mental Health Commission - State block funding	176,434	167,341
	Payments:		
	Mental Health Commission - Commonwealth block funding to local hospital networks	(72,539)	(70,387)
	Mental Health Commission - State block funding to local hospital networks	(176,434)	(167,341)
		-	-
	Balance at the end of period	-	-
	Southern Inland Health Initiative Special Purpose Account		
	The purpose of the special purpose account is to hold capital and recurrent funds for expenditure on approved Southern Inland Health Initiative projects as authorised by the Treasurer and the Minister, pursuant to section 9(1) of the *Royalties for Regions Act 2009* to be charged to the Royalties for Regions Fund and credited to the Account.		
	Recurrent		
	Balance at the start of period	146,550	178,367
	Receipts		
	Aged & Dementia Program	-	4,000
	Payments to WA Country Health Service		
	District Medical Workforce Investment	(32,626)	(26,499)
	District Hospital Investment Program	(5,310)	(5,431)
	Telehealth Investment Program	(3,960)	(3,734)
	Aged & Dementia Program	(839)	(153)
	Payments to Metropolitan Health Service		
	Southern Inland Health Initiatives - Stream 5	(200)	-
	Payments to Department of Health		
	Sliver Chain	(215)	-
	Diabetic Assocation of WA	(350)	-
		103,050	146,550

		2016 $000	2015 $000
Note 44	**Special Purpose Accounts (continued)**		
	Southern Inland Health Initiative Special Purpose Account (continued)		
	Capital		
	Balance at the start of period	72,235	94,918
	Receipts		
	Telehealth Investment Program	2,707	-
	Payments		
	District Hospital Investment Program - Stream 2	(10,000)	(4,734)
	Primary Health Centres Demonstration Program - Stream 3	(500)	(775)
	Small Hospital and Nursing Post Refurbishment Program - Stream 4	(9,000)	(17,174)
	Telehealth Investment Program	(2,707)	-
		52,735	72,235
	Balance at the end of period	**155,785**	**218,785**
	Telethon - Perth Children's Hospital Research Fund		
	The purpose of the special purpose account is to receive funds from the Channel 7 Telethon Trust, the Department of Health and other donors to fund and promote child and adolescent health research in Western Australia.		
	Controlled by Department of Health		
	Balance at the start of period	4,792	4,036
	Receipts	4,119	3,114
	Payments	(2,511)	(2,358)
	Balance at the end of period	6,400	4,792
Note 45	**Administered assets and liabilities**		
	Current Assets		
	Cash and cash equivalents	226,132	334,907
	Receivables	-	1,949
	Total administered current assets	226,132	336,856
	Current Liabilities		
	Payables	-	-
	Total administered current liabilities	-	-
	The Department administers the Capital Works Fund for the Asset Investment Program on behalf of State Government which are not controlled by, nor integral to the function of the Department. The administered assets, liabilities, income and expenses are not recognised in the principal statements of the Department but are presented at note 45 "Administered assets and liabilities' and note 46 'Disclosure of administered income and expenses by service' using the same basis as the financial statements.		

Notes to the Financial Statements

For the year ended 30 June 2016

Note 46 Disclosure of administered income and expenses by service

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Metropolitan Health Service	243,911	340,902	1,002	1,381	1,110	1,540	40,941	60,398
WA Country Health Service	62,215	68,201	17	-	141	103	11,871	18,074
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to local hospital networks	-	-	-	-	-	-	-	-
Transfer of block funding to local hospital networks	-	-	-	-	-	-	-	-
Transfer of Commonwealth block funding to Mental Health Commission								
Total administered expenses	306,126	409,103	1,019	1,381	1,251	1,643	52,812	78,472
Income								
Administered for Capital Works Fund:								
Capital appropriations	211,846	455,328	788	1,240	921	1,383	30,079	70,259
Royalties for Regions Fund	22,602	10,071	-	-	45	36	4,981	6,527
Commonwealth grants and contributions		-	-	-	-	-		-
Contribution from Department of Health	1,865	29,486	1	-	12	-	35	4,231
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	-	-
Commonwealth block funding for MHC	-	-	-	-	-	-	-	-
State activity based funding from MHC	-	-	-	-	-	-	-	-
State block funding from MHC	-	-	-	-	-	-	-	-
Total administered income	236,313	494,885	789	1,240	978	1,419	35,095	81,017

Notes to the Financial Statements

For the year ended 30 June 2016

Note 46 Disclosure of administered income and expenses by service (continued)

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Metropolitan Health Service	29,101	43,784	5,508	7,556	6,067	9,351	498	671
WA Country Health Service	14,805	16,461	1,039	292	3,069	1,799	8	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to local hospital networks	-	-	-	-	-	-	-	-
Transfer of block funding to local hospital networks	-	-	-	-	-	-	-	-
Transfer of Commonwealth block funding to Mental Health Commission								
Total administered expenses	43,906	60,245	6,547	7,848	9,136	11,150	506	671
Income								
Administered for Capital Works Fund:								
Capital appropriations	20,273	51,513	3,646	6,249	3,418	7,232	401	597
Royalties for Regions Fund	11,122	7,956	508	401	1,339	1,055	-	-
Commonwealth grants and contributions	-	-	-	-	1,602	-	-	-
Contribution from Department of Health	4	-	-	-	114	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	-	-
Commonwealth block funding for MHC	-	-	-	-	-	-	-	-
State activity based funding from MHC	-	-	-	-	-	-	-	-
State block funding from MHC	-	-	-	-	-	-	-	-
Total administered income	31,399	59,469	4,154	6,650	6,473	8,287	401	597

Note 46 Disclosure of administered income and expenses by service (continued)

	Continuing Care		Mental Health		TOTAL	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES						
Expenses						
Funding for Capital Works Fund transferred to:						
Metropolitan Health Service	14,641	23,178	3,373	16,500	346,152	505,261
WA Country Health Service	3,726	7,235	386	448	97,277	112,613
State Pool Account and State Managed Fund Account administered for Mental Health Commission						
Transfer of activity based funding to local hospital networks	-	-	249,503	261,740	249,503	261,740
Transfer of block funding to local hospital networks	-	-	248,973	237,728	248,973	237,728
Transfer of Commonwealth block funding to Mental Health Commission			1,041	1,637	1,041	1,637
Total administered expenses	18,367	30,413	503,276	518,053	942,946	1,118,979
Income						
Administered for Capital Works Fund:						
Capital appropriations	15,550	17,688	268	15,237	287,190	626,726
Royalties for Regions Fund	880	693	51	40	41,528	26,779
Commonwealth grants and contributions	-	-	-	-	1,602	-
Contribution from Department of Health	380	8,635	3	-	2,414	42,352
State Pool Account and State Managed Fund Account administered for Mental Health Commission						
Commonwealth activity based funding for MHC	-	-	92,040	101,288	92,040	101,288
Commonwealth block funding for MHC	-	-	73,580	72,024	73,580	72,024
State activity based funding from MHC	-	-	157,463	160,452	157,463	160,452
State block funding from MHC	-	-	176,434	167,341	176,434	167,341
Total administered income	16,810	27,016	499,839	516,382	832,251	1,196,962

Note 47 Financial instruments

a) **Financial risk management objectives and policies**

Financial instruments held by the Department are cash and cash equivalents, restricted cash and cash equivalents, finance leases, receivables and payables. The Department has limited exposure to financial risks. The Department's overall risk management program focuses on managing the risks identified below.

Credit risk
Credit risk arises when there is the possibility of the Department's receivables defaulting on their contractual obligations resulting in financial loss to the Department.

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment, as shown in the table at Note 47(c) 'Financial Instruments Disclosures' and Note 21 'Receivables'.

Credit risk associated with the Department's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, the Department trades only with recognised, creditworthy third parties. The Department has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Department's exposure to bad debts is minimal. At the end of the reporting period there are no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the account being raised.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating client credit ratings. For financial assets that are either past due or impaired, refer to Note 47(c) 'Financial Instrument Disclosures'.

Liquidity risk
Liquidity risk arises when the Department is unable to meet its financial obligations as they fall due. The Department is exposed to liquidity risk through its normal course of operations.

The Department has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Department's income or the value of its holdings of financial instruments. The Department does not trade in foreign currency and is not materially exposed to other price risks. All cash and cash equivalents and restricted cash and cash equivalents are non-interest bearing.

b) **Categories of financial instruments**

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2016 $000	2015 $000
Financial Assets		
Cash and cash equivalents	8,706	93,030
Restricted cash and cash equivalents	202,067	339,108
Loans and receivables (a)	52,538	107,665
Financial Liabilities		
Financial liabilities measured at amortised cost	61,645	46,712

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

c) **Financial instrument disclosures**

Credit risk

The following table details the Department's maximum exposure to credit risk and the ageing analysis of financial assets. The Department's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Department.

The Department does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

Ageing analysis of financial assets

			Past due but not impaired				
	Carrying amount	Not past due and not impaired	up to 3 months	3-12 months	1-5 years	> 5 years	Impaired financial assets
	$000	$000	$000	$000	$000	$000	$000
2016							
Cash and cash equivalents	8,706	8,706	-	-	-	-	-
Restricted cash and cash equivalents	202,067	202,067	-	-	-	-	-
Receivables (a)	10,738	10,384	36	253	64	-	-
Finance lease receivable	4,942	4,942	-	-	-	-	-
Amounts receivable for services	36,858	36,858	-	-	-	-	-
	263,312	262,958	36	253	64	-	-
2015							
Cash and cash equivalents	93,030	93,030	-	-	-	-	-
Restricted cash and cash equivalents	339,108	339,108	-	-	-	-	-
Receivables (a)	4,267	4,049	27	185	2	4	-
Finance lease receivable	2,981	2,981	-	-	-	-	-
Amounts receivable for services	100,417	100,417	-	-	-	-	-
	539,803	539,585	27	185	2	4	-

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

c) **Financial instrument disclosures (continued)**

Liquidity risk and interest rate exposure

The following table details the Department's interest rated exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposures and maturity analysis of financial assets and financial liabilities

			Interest rate exposure				Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months - 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000		$000
2016										
Financial Assets										
Cash and cash equivalents		8,706	-	-	8,706	8,706	8,706	-	-	-
Restricted cash and cash equivalents		202,067	-	-	202,067	202,067	202,067	-	-	-
Receivables (a)		10,738	-	-	10,738	10,738	10,738	-	-	-
Finance lease receivable		4,942	-	-	4,942	4,942	-		-	4,942
Amounts receivable for services		36,858	-	-	36,858	36,858	-	-	-	36,858
		263,312	-	-	263,312	263,312	221,511	-	-	41,801
Financial Liabilities										
Payables		61,645	-	-	61,645	61,645	61,645	-	-	-
		61,645	-	-	61,645	61,645	61,645	-	-	-

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

c) **Financial instrument disclosures (continued)**

Liquidity risk and interest rate exposure (continued)

Interest rate exposures and maturity analysis of financial assets and financial liabilities

			Interest rate exposure				Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 3 months	3 months - 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000		$000
2015										
Financial Assets										
Cash and cash equivalents		93,030	-	-	93,030	93,030	93,030	-	-	-
Restricted cash and cash equivalents		339,108	-	-	339,108	339,108	339,108	-	-	-
Receivables (a)		4,267	-	-	4,267	4,267	4,267	-	-	-
Finance lease receivable		2,981			2,981	2,981	-		-	2,981
Amounts receivable for services		100,417	-	-	100,417	100,417	-	-	-	100,417
		539,803	-	-	539,803	539,803	436,405	-	-	103,399
Financial Liabilities										
Payables		46,712	-	-	46,712	46,712	46,712	-	-	-
		46,712	-	-	46,712	46,712	46,712	-	-	-

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

Fair values
All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

Certification of key performance indicators

DEPARTMENT OF HEALTH

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2016

I hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Department of Health's performance and fairly represent the performance of the Department for the financial year ended 30 June 2016.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

15 September 2016

Key performance indicators

Outcome 1

Outcome 2

Proportion of people with cancer accessing admitted palliative care services

Outcome 1
Effectiveness KPI

Rationale

The World Health Organization defines palliative care as care that improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

In Australia and many other parts of the world, the demand for palliative care services is increasing due to the ageing of the population and the increases in the prevalence of cancer and other chronic diseases that accompany ageing. State and territory governments and the Australian Government have committed to improving the palliative care needs of Australians through the *National Palliative Care Strategy 2010: supporting Australians to live well at the end of life*.

Effective palliative care requires a broad multidisciplinary approach and may be provided in hospital or at home. Hospital based palliative care services aim to improve the quality of life of patients and families through the provision of symptom management, respite care and terminal care.

Monitoring this indicator's changes over time can facilitate the identification of the demand for palliative care services that can enable the development of evidence-based programs and management strategies. This will ensure accessible and effective palliative care services for Western Australians.

Target

The 2014 target is 49.4 per cent.

The target is based on the average of the previous five years.

Results

In 2014, the percentage of people with cancer accessing palliative care services as a public patient in a public hospital or private hospital was 42.6 per cent. The result was below the target of 49.4 per cent (see Table 7) associated with a change in calculation method. Accessibility for patients requiring admitted palliative care services has increased 20% since 2012.

Table 7: **Percentage of public patients with cancer accessing palliative care services, 2012–2014**

	2012	2013	2014	Target
Percentage of patients (%)	35.9	35.1	**42.6**	**49.4**

Notes:

1. This KPI measure is based on:
   a. the number of people who received palliative care services as a patient in a WA public hospital, or a public patient in a WA private hospital
   b. cancer mortality rates.
2. Cancer is defined as a principal diagnosis of an invasive malignant neoplasm.
3. The number of cancer related deaths is a nationally accepted proxy for potentially needed palliative care services.
4. A lag period of 12 months is due to delays related to Coroner's cases.
5. In 2016, the calculation of this KPI was changed to correct a miscalculation. The count of privately insured patients who receive care in a WA private hospital are now excluded from the total number of public patients admitted for care to a WA palliative care service. As a result:
   a. results from 2013–14 to 2015–16 have been reinstated for comparability purposes
   b. previously reported results that have been restated as per the below table, are no longer considered applicable nor comparable:

	2012	2013
Percentage of patients (%)	52.7	53.1

Data sources: WA Cancer Registry, Hospital Morbidity Data System.

Response times for patient transport services

Outcome 1
Effectiveness KPI

Rationale

To ensure Western Australians receive the care they need, when they need it, strong partnerships have been forged within the health care community through collaboration between St John Ambulance Australia – Western Australia Ambulance Service, the Royal Flying Doctor Service and the Western Australian Department of Health. This collaboration ensures that patients have access to an effective ambulance and Royal Flying Doctor Service to ensure the best possible health outcomes for patients requiring urgent medical treatment through rapid response.

Response times for patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and provide a good indication of the efficiency and effectiveness of patient transport services. It is believed that adverse effects on patients and the community are reduced if response times are reduced.

This indicator measures the response of patient transport services provided within the metropolitan and rural areas of WA to patients with the highest need of urgent medical treatment Priority 1. Through surveillance of this measure over time, the effectiveness and efficiency of patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of urgent medical care.

Target

a) St John Ambulance Australia – Western Australia Ambulance Service:
   - Attend 90 per cent of Priority 1 calls within 15 minutes in the metropolitan area.

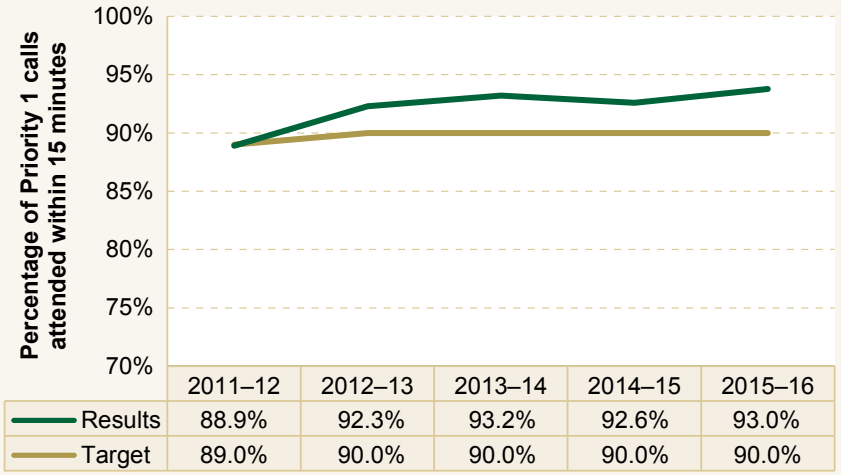
b) Royal Flying Doctors Service:
   - 80 per cent of inter-hospital transfers for Priority 1 calls (excluding regional resource centres) meeting the Target Contract Patient Response Time.

Results

a) St John Ambulance Australia – Western Australia Ambulance Service:

In 2015–16, 93.0 per cent of Priority 1 calls in the metropolitan area were attended within 15 minutes, above the target (see Figure 9).

Figure 9: **Percentage of Priority 1 calls attended within 15 minutes in the metropolitan area by St John Ambulance Australia – Western Australia Ambulance Service, 2011–12 to 2015–16**



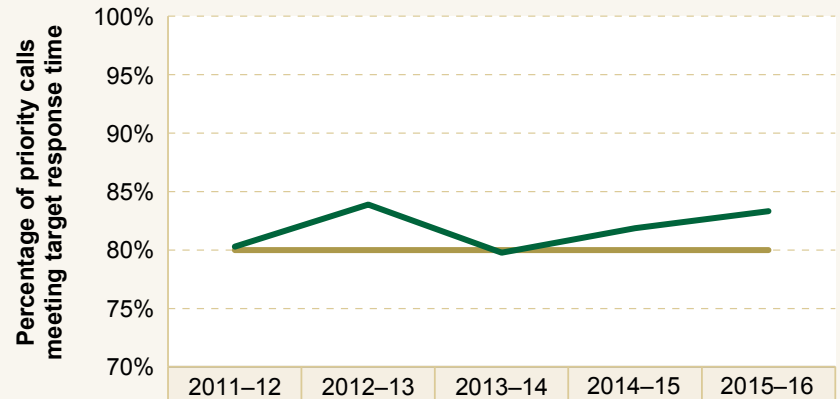
	2011–12	2012–13	2013–14	2014–15	2015–16
Results	88.9%	92.3%	93.2%	92.6%	93.0%
Target	89.0%	90.0%	90.0%	90.0%	90.0%

Data source: Department of Health unpublished data.

b) Royal Flying Doctors Service:

The Royal Flying Doctor Service achieved 83.3 per cent of inter-hospital transfers for priority 1 calls in 2015–16. This result was above the Target Contract Patient Response Time of 80 per cent (see Figure 10).

Figure 10: **Percentage of Royal Flying Doctor Service inter-hospital transfers meeting the Contract Target Response Time within each agreed geographical area of patient origin for Priority 1 calls, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Results	80.3%	83.9%	79.8%	81.9%	83.3%
Target	80.0%	80.0%	80.0%	80.0%	80.0%

Data source: Department of Health unpublished data.

Cost per capita of supporting treatment of patients in public hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

This indicator is a measure of the cost of providing care in hospital to patients by the number of people who reside in WA. It accounts for specific expenses incurred by the Department of Health contributing to hospital services, including, improving clinical practice and medical workforce via the development and implementation of policies and models of care.

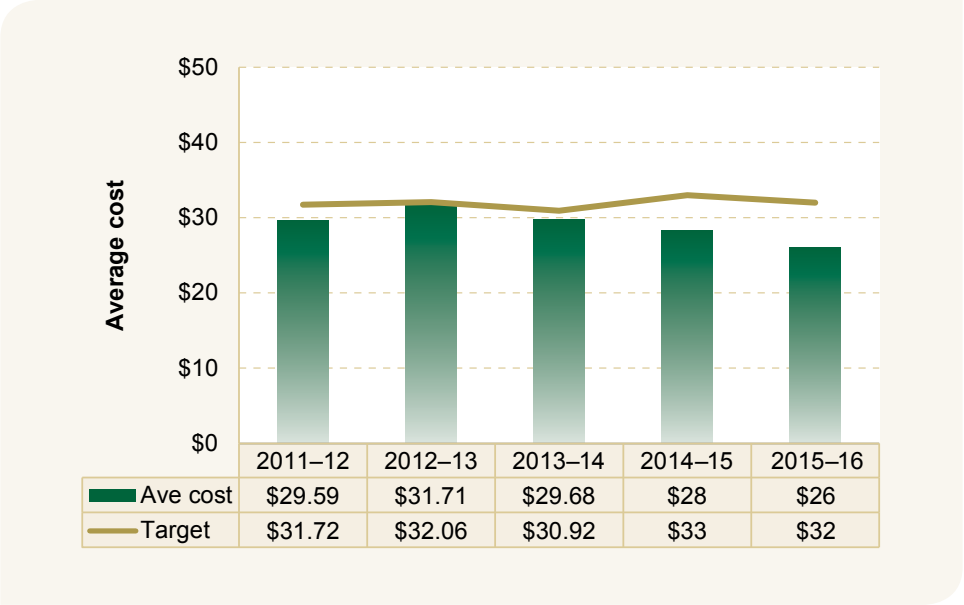
Target

The 2015–16 target unit cost is $32 per capita of supporting the treatment of patients in public hospitals. A result below the target is desirable.

Results

In 2015–16, the average cost of providing care to patients in public hospitals was $26, this is below the target of $32 (see Figure 11). The lower expenditure to target is attributable to Department of Health contract variations below that estimated at the time of budget allocation.

Figure 11: **Cost per capita of supporting treatment of patients in public hospitals, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$29.59	$31.71	$29.68	$28	$26
Target	$31.72	$32.06	$30.92	$33	$32

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.

Data source: Department of Health unpublished data.

Average cost per home based hospital day of care and occasion of service

Outcome 1
Efficiency KPI
Service 2: Home-based hospital programs

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Home Based Hospital Programs have been implemented as a means of ensuring all Western Australian's have timely access to effective health care. These programs aim to provide safe and effective medical care for patients in their home that would otherwise require a hospital admission. In addition to the Home Based Hospital Programs that are delivered by the public health system, the WA Government has entered a collaborative agreement with the non-government sector to provide these programs for suitable patients. The home based hospital service may be delivered as in-home admitted acute medical care, measured by days of care, or as post-discharge or sub-acute medical intervention, delivered as occasions of service.

Target

Target unit costs for:

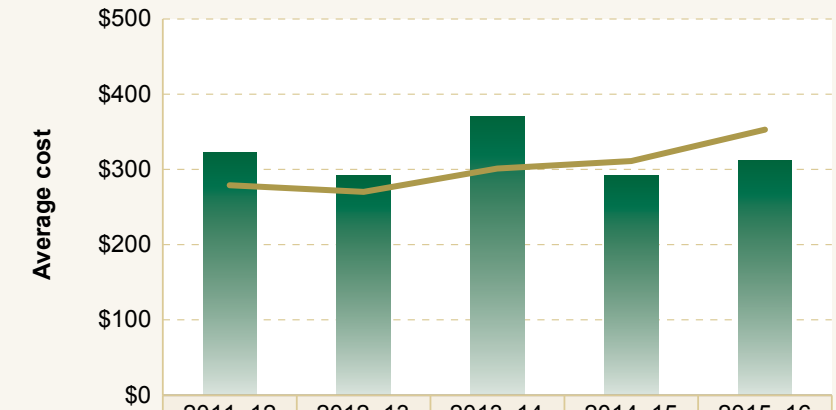
a) Home based hospital day of care is $353
b) Home based hospital occasion of service is $125.

Results

a) Home based hospital day of care

In 2015–16, the average cost of home based hospital day of care was $312, below the target of $353 (see Figure 12). The variance to target is due to the increase in expenditure and activity attributable to an increase in home based hospital programs provided by Department of Health contracted service providers.

Figure 12: **Average cost per home based hospital day of care, 2011–12 to 2015–16**

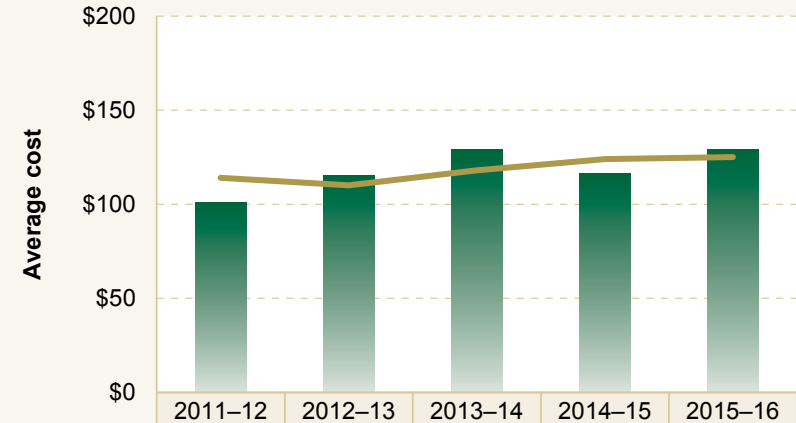


	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$323	$291	$371	$292	$312
Target	$279	$270	$301	$311	$353

b) Home-based hospital occasion of service

In 2015–16, the average cost of home based hospital occasion of service was $129, slightly above the target of $125 (see Figure 13). The variance to target is due to the increase in expenditure and activity attributable to an increase in home based hospital programs provided by Department of Health contracted service providers.

Figure 13: **Average cost per home based hospital occasion of service, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$101	$115	$129	$117	$129
Target	$114	$110	$118	$124	$125

Data source: Department of Health unpublished data.

Average cost per client receiving contracted palliative care services

Outcome 1
Efficiency KPI
Service 3: Palliative care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Palliative care is aimed at improving the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement. In addition to palliative care services that are provided through the public health system, the WA Government has entered into collaborative agreement with private sector health providers to provide palliative care services for those in need.

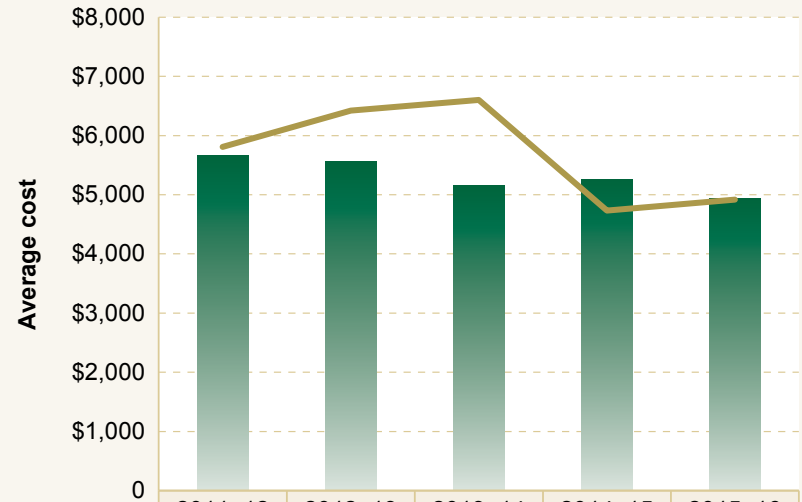
Target

The 2015–16 target unit cost is $4,919 per client receiving contracted palliative care services. A result below the target is desirable.

Results

In 2015–16, the average cost for a client receiving contracted palliative care services was $4,941, slightly above the target of $4,919 (see Figure 14).

Figure 14: **Average cost per client receiving contracted palliative care services, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$5,663	$5,560	$5,153	$5,265	$4,941
Target	$5,810	$6,423	$6,599	$4,734	$4,919

Data source: Department of Health unpublished data.

Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements

Outcome 1
Efficiency KPI
Service 6: Patient transport

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

To ensure Western Australians receive the care they need, when they need it, strong partnerships have been forged within the health care community through collaborative agreements with St John Ambulance Australia – Western Australia Ambulance Service, the Royal Flying Doctor Service and the Western Australian Department of Health. This collaboration ensures that patients have access to an effective ambulance and Royal Flying Doctor Service that aims to ensure the best possible health outcomes for patients requiring urgent medical treatment.

Target

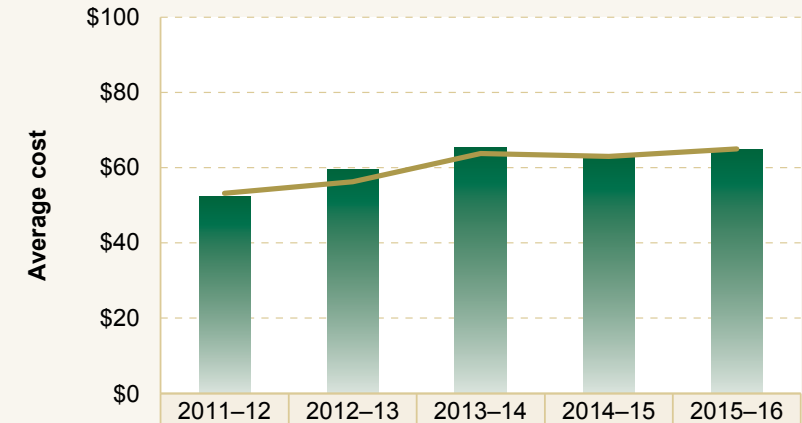
The target unit cost for 2015–16 is $65 per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements.

A result below the target was desirable.

Results

The average unit cost for 2015–16 is $65 per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements. This meets the target of $65 (see Figure 15).

Figure 15: **Cost per capita of Royal Flying Doctors Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$52.32	$59.38	$65.25	$63	$65
Target	$53.16	$56.23	$63.75	$63	$65

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.

Data source: Department of Health unpublished data.

Loss of life from premature death due to identifiable causes of preventable disease or injury

Outcome 2
Effectiveness KPI

Rationale

Loss of life from preventable disease or injury refers to premature deaths from conditions considered to be potentially avoidable through the application of existing public health or medical interventions. These are unnecessary, untimely deaths.

Measuring potential years of life lost and the cause of these premature deaths is one of the most important means of monitoring and evaluating the effectiveness, quality and productivity of health systems.

The potential years of life lost from premature death are measured for specified conditions, which include falls, ischaemic heart disease, melanoma and lung cancer. These conditions contribute significantly to the burden of disease and injury within the community and are considered National Health Priority Areas.

The data obtained from this indicator can assist health system managers to best determine targeted promotion and prevention initiatives, such as the WA Health Promotion Strategic Framework 2012–2016, that are required in order to reduce the loss of life from these preventable conditions by improving the effectiveness and quality of health care delivery.

Target

The 2014 target per preventable disease is based on the 2013 National Person Years of Life Lost per 1,000 population:

Preventable disease	Target (in years)
Lung cancer	1.8
Ischaemic heart disease	2.5
Falls	0.2
Melanoma	0.5

Improved or maintained performance will be demonstrated by a result below or equal to the target.

Results

The potential years of life lost due to lung cancer among Western Australians was 1.6, below the target of 1.8. The years of life lost from premature death due to ischaemic heart disease, melanoma and falls met the target. Since 2005, ischaemic heart disease, lung cancer and melanoma have all shown decreases in the potential years of life lost (see Table 8).

Table 8: **Person years of life lost due to premature death associated with preventable conditions, 2005–2014**

Condition	Calendar years										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Target
Lung cancer	1.9	2.0	2.0	1.8	2.2	1.7	1.8	1.8	1.6	**1.6**	**1.8**
Ischaemic heart disease	3.3	3.3	3.6	3.3	3.2	3.0	3.1	2.5	2.6	**2.5**	**2.5**
Falls	0.4	0.3	0.5	0.4	0.7	0.5	0.4	0.3	0.5	**0.2**	**0.2**
Melanoma	0.8	0.6	0.6	0.4	0.7	0.4	0.6	0.7	0.4	**0.5**	**0.5**

Notes:

1. Age-standardised PYLLs per 1,000 population.
2. 2005–2012 deaths are final, 2013 deaths are revised and 2014 deaths are preliminary.
3. Minor methodological improvements and updates to death data mean that figures are not directly comparable with previous reports.
4. The following ICD 10 Codes were used:
   - Lung cancer C33 to C34.9
   - Ischaemic Heart Disease I20 to I25.9
   - Falls W00. to W19.9 or X59. to X59.9 (with any multiple cause codes of: S02. to S02.9 or S12. to S12.9 or S22. to S22.9 or S32 to S32.9 or S42. to S42.9 or S52. to S52.9 or S62. to S62.9 or S72. to S72.9 or S82. to S82.9 or S92. to S92.9 or T02. to T02.9 or T08. to T08.9 or T10. to T10.9 or T12. to T12.9 or T14.2)
   - Melanoma C43 to C43.9.

Data sources: Mortality database, Epidemiology Branch, Department of Health, Australia Bureau of Statistics.

Percentage of fully immunised children

Outcome 2
Effectiveness KPI

Rationale

In accordance with the National Partnership Agreement on Essential Vaccines, WA Health aims to minimise the incidence of major vaccine preventable diseases in Australia by achieving or sustaining high levels of immunisation coverage across WA, and equity of access to vaccines and immunisation services.

Immunisation is a simple, safe and effective way of protecting people against harmful diseases before they come into contact with them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease. Without access to immunisation, the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

This indicator measures the percentage of fully immunised children that have received age appropriate immunisations in order to facilitate the effectiveness of health promotion strategies that aim to reduce the overall incidence of potentially serious disease.

Target

The agreed target in the National Childhood Immunisation Program is ≥90 per cent of children fully immunised at 12 months, two years and five years of age.

Results

WA is a large, diverse and unevenly populated area, and this contributes to the complexity of delivering immunisation services statewide. As a result this requires multifaceted strategies to deliver services to communities that have special requirements because of remote location or socio-cultural or economic factors.

In 2015, the immunisation rate among Aboriginal children was lower than their non-Aboriginal counterparts. The exception to this is children aged 5 years living in WA regional areas, who had coverage of 94.6 per cent (compared to 92.5 per cent of non-Aboriginal children) (see Table 9).

Immunisation coverage of Aboriginal children aged 1 year residing in the metropolitan area was 77.6 per cent in comparison to non-Aboriginal children at 92.4 per cent. Overall, immunisation rates in 1 year old Aboriginal children was lowest in metropolitan Perth while some metropolitan regions had immunisation coverage above the national average of 88.7 per cent*. Access to flexible and culturally appropriate services in the metropolitan area has contributed to a delay in the vaccination of at-risk Aboriginal children at 12 months.

The percentage of children immunised at 2 years was below target across metropolitan and country areas. This is attributed to a change in the definition of ‘fully immunised’ for 2 year olds that occurred on 31 December 2014 with the inclusion of three additional vaccines.

Immunisation rates in 5 year olds are higher in Aboriginal children than non-Aboriginal children at a state level and for those living in the country. Full immunisation coverage of Aboriginal children in the metropolitan area has remained below target.

The Department of Health has developed targeted strategies to improve immunisation rates including:

- improving the capture of child immunisation records
- increasing immunisation services at hospitals and paediatric outpatient clinics
- increasing the availability of culturally appropriate services
- addressing overdue vaccinations through active follow-up of at risk children.

Table 9: **Percentage of children fully immunised, by selected age cohort, by Aboriginality, 2011–2015**

Children immunised		2011	2012	2013	2014	2015
12 months (%)						
State	Aboriginal	81.1	79.1	82.5	84.0	**83.4**
	Non-Aboriginal	90.6	91.3	90.3	91.5	**92.6**
Metropolitan	Aboriginal	82.4	73.3	75.7	76.6	**77.6**
	Non-Aboriginal	90.3	91.0	90.2	91.3	**92.4**
Country	Aboriginal	86.1	82.8	87.0	88.8	**87.4**
	Non-Aboriginal	91.4	92.4	91.1	92.4	**93.6**
2 years (%)						
State	Aboriginal	91.2	92.7	90.4	85.7	**83.2**
	Non-Aboriginal	90.7	90.3	90.7	89.0	**88.4**
Metropolitan	Aboriginal	74.1	89.1	85.7	80.7	**77.8**
	Non-Aboriginal	90.3	89.7	90.2	88.6	**88.0**
Country	Aboriginal	93.4	94.8	93.6	89.2	**87.0**
	Non-Aboriginal	92.2	92.4	92.9	90.8	**90.1**
5 years (%)						
State	Aboriginal	81.6	90.5	90.3	92.3	**92.0**
	Non-Aboriginal	87.5	89.2	89.6	90.4	**91.0**
Metropolitan	Aboriginal	74.1	86.6	84.6	87.7	**88.2**
	Non-Aboriginal	87.0	88.7	89.0	90.1	**90.7**
Country	Aboriginal	87.2	93.0	94.1	95.2	**94.6**
	Non-Aboriginal	89.5	91.2	91.6	91.8	**92.5**

Note:

Data based on children aged 12 ≤ 15 months, 24 ≤ 27 months and 60 ≤ 63 months between 1 January 2015 – 31 December 2015.

* National data for immunisation coverage for 2015 of cohort aged 12 ≤ 15 months can be accessed at www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-hist-data-ATSI-child.htm

Data source: Australian Childhood Immunisation Register.

Rate of hospitalisations for selected potentially preventable diseases

Outcome 2
Effectiveness KPI

Rationale

In accordance with the National Partnership Agreement on Essential Vaccines, WA Health aims to minimise the incidence of major vaccine preventable diseases in Australia by achieving or sustaining high levels of immunisation coverage across WA, and equity of access to vaccines and immunisation services.

Immunisation is a simple, safe and effective way of protecting people against preventable disease before they come into contact with them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease and likelihood of hospitalisation.

The hospitalisations for vaccine preventable diseases amongst children are measured for specified infectious conditions that include rubella, diphtheria, poliomyelitis, measles, mumps, pertussis, hepatitis B and tetanus, which form part of the National Immunisation Program and can pose a significant burden on health care in Australia.

The surveillance of hospitalisations for vaccine preventable conditions amongst children can support the further development and delivery of targeted health promotion initiatives and prevention strategies, such as the National Immunisation Strategy 2013–18 that aims to reduce the impact of these conditions on individuals and the community. This ensures enhanced health and well-being of Western Australians, while supporting the sustainability of the public health system.

Target

The target for 2015 is no reported hospitalisation in any category.

Results

In 2015, WA hospitalisations for pertussis were the lowest since 2011 with 3.9 per 100,000 and nil per 100,000 hospitalisations for non-Aboriginal and Aboriginal children aged 0–12 years respectively. In March 2015, pertussis vaccinations became freely available for all WA pregnant women. Vaccination during pregnancy has been shown to be effective in reducing the risk of pertussis in young infants.

Hospitalisation rates for mumps was 0.8 per 100,000 and 19.6 per 100,000 for non-Aboriginal and Aboriginal children respectively. The increase in hospitalisation rates in comparison to prior years is associated with a mumps outbreak in 2015. Additional measures were implemented to efficiently provide prophylactic immunisation in affected communities to assist in controlling the spread of the disease.

The rate of hospitalisation for measles and hepatitis B in 2015 were nil (see Table 10). In the past five years no hospitalisations for rubella, diphtheria, poliomyelitis and tetanus have been reported.

The *Western Australian Immunisation Strategy 2016–2020*, provides a vision for building on improvements in immunisation services realised under the previous strategy to protect individuals and populations from vaccine-preventable diseases.

Table 10: **Rate of hospitalisation for potentially preventable diseases (per 100,000), 2011–2015**

Preventable disease		2011	2012	2013	2014	2015
Whooping Cough (Pertussis): 0–12 year olds						
State	Aboriginal	86.16	59.63	23.0	36.9	0.0
	Non-Aboriginal	19.33	14.76	9.3	4.3	3.9
Metropolitan	Aboriginal	145.12	63.00	24.8	33.5	0.0
	Non-Aboriginal	17.28	15.49	8.6	3.4	3.6
Country	Aboriginal	50.79	57.71	21.9	39.5	0.0
	Non-Aboriginal	26.47	12.15	12.1	10.4	5.9
Measles: 0–17 year olds						
State	Aboriginal	0.00	0.00	0.0	0.0	0.0
	Non-Aboriginal	0.18	0.00	0.0	0.0	0.0
Metropolitan	Aboriginal	0.00	0.00	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.00	0.0	0.5	0.0
Country	Aboriginal	0.00	0.00	0.0	0.0	0.0
	Non-Aboriginal	0.76	0.00	0.0	0.0	0.0
Mumps: 0–17 year olds						
State	Aboriginal	0.00	0.00	0.0	0.0	19.6
	Non-Aboriginal	0.00	0.19	0.2	0.0	0.8
Metropolitan	Aboriginal	0.00	0.00	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.24	0.0	0.5	0.4
Country	Aboriginal	0.00	0.00	0.0	0.0	19.6
	Non-Aboriginal	0.00	0.00	0.9	0.0	10.2
Hepatitis B: 0–12 year olds						
State	Aboriginal	0.00	0.00	4.6	0.0	0.0
	Non-Aboriginal	0.00	0.00	0.3	0.0	0.0
Metropolitan	Aboriginal	0.00	0.00	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.00	0.0	0.0	0.0
Country	Aboriginal	0.00	0.00	7.3	0.0	0.0
	Non-Aboriginal	0.00	0.00	1.2	0.0	0.0

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.
2. Care should be taken in the interpretation of the results due to the small number of hospitalisations of children aged 0–17 for all preventable diseases, and the overall number of Aboriginal children living within the Metropolitan and WA Country area.
3. Hospitalisations are based on patient records where by a preventable disease is recorded as the principal disgnosis.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Eligible patients on the oral waiting list who have received treatment during the year

Outcome 2
Effectiveness KPI

Rationale

Oral health, including dental health, is fundamental to overall health, wellbeing and quality of life, with poor oral health likely to exist when general health is poor and vice versa. This makes access to timely oral treatment services critical in reducing the burden of oral disease on individuals and communities, as it can enable early detection and diagnosis with the use of preventative interventions rather than extensive restorative or emergency treatments.

To facilitate the equity of access to dental healthcare for all Western Australians, specialised dental and oral treatment services are provided through State Government subsidised dental care for Health Care card holders and general dental care to eligible patients within their local catchment area by the Oral Health Centre of Western Australia.

Costly treatment and high demand on public general, specialist dental and oral healthcare emphasises the need for a focus on prevention and health promotion.

This indicator measures access to public specialist dental services by monitoring the number of all eligible patients on the oral waiting list who have received treatment during the year. Through monitoring specialised dental and oral treatment services received by eligible patients, the areas of greatest need can be identified, which can aid in facilitating the development of more effective targeted programs to ensure improved oral care for Western Australians.

Target

The 2015–16 target by dental speciality:

Dental speciality	Number
General practice	1,580
Oral surgery	910
Orthodontics	2,100
Paedodontics	790
Periodontics	480
Other	780
Total	**6,640**

Results

In 2015–16, the number of eligible patients receiving treatment through the Oral Health Centre of Western Australia was 7,654, above that of the previous year (see Table 11).

The number of eligible patients receiving treatment was above the set targets for the specialities oral surgery, periodontics and ‘other’. Patients receiving general practice, orthodontics and paedodontics treatment were below the target.

In 2015–16, general dental restorative treatment was introduced as a new dental speciality (see category ‘other’). General practice waitlist patients were redirected to this area to receive prescribed and comprehensive dental treatment. This resulted in fewer patients receiving general dental care under the speciality of general practice.

Table 11: **Number of eligible patients on the Oral Health Centre of Western Australia dental waiting list who received treatment in the financial year, 2011–12 to 2015–16**

Dental speciality	Year			
	2013–14	2014–15	2015–16	Target
General practice	1,106	1,179	639	**1,580**
Oral Surgery	1,418	762	1,206	**910**
Orthodontics	1,372	1,034	1,248	**2,100**
Paedodontics	498	385	349	**790**
Periodontics	604	334	575	**480**
Other	1,092	2,169	3,637	**780**
Total	**6,090**	**5,863**	**7,654**	**6,640**

Notes:

1. 'Other' includes the specialities of Endodontics, Oral Pathology, Restorative Care (including general restorative care treatment) and Temporomandibular Joint.
2. In 2015–16, general restorative care treatment was made available to student patients.
3. In a full financial year patient waitlists are influenced by:
   a. a constant supply of dental specialists
   b. the number of patient referrals to the Oral Health Centre of Western Australia.
4. In 2016, an improved methodological counting rule of wait list patients was introduced. The results from 2013–14 to 2015–16 have been reinstated for comparability purposes. Previously reported results as follows are no longer considered applicable nor directly comparable. In 2015–16, speciality targets were not recalculated using the new method:

Number of eligible patients on the Oral Health Centre of Western Australia dental waiting list who received treatment in the financial year, 2011–12 to 2014–15

Dental Speciality	2013–14		2014–15	
	Number	Target	Number	Target
General Practice	1,264	1,541	1,718	1,725
Oral Surgery	2,544	2,116	918	1,510
Orthodontics	2,076	2,429	1,288	2,310
Paedodontics	781	670	574	780
Periodontics	534	604	286	530
Other	1,200	790	1,131	830
Total	**8,399**	**8,150**	**5,915**	**7,685**

Data source: Oral Health Centre of Western Australia.

Percentage of clients maintaining or improving functional ability while in transition care

Outcome 2
Effectiveness KPI

Rationale

The Transition Care Program is a joint Commonwealth, State and Territory initiative that aims to optimise the functioning and independence of older people after a hospital stay and enable them to return home rather than prematurely enter residential care.

This program is tailored to meet the needs of the individual and aims to facilitate a continuum of care for older people in a non-hospital environment while giving them more time and support to make a decision on their longer term care arrangements.

The effectiveness of a Transition Care program can be assessed by measuring functional ability improvements in clients utilising the Transition Care program. Monitoring the success of this indicator can enable improvements in service planning and the development of targeted strategies and interventions that focus on improving the program's effectiveness, ensuring the provision of the most appropriate care to those in need. This enhances the health and wellbeing of older Western Australians.

Target

The 2015–16 target for the percentage of clients maintaining or improving functional ability is 65 per cent.

Results

In 2015–16, the percentage of clients maintaining or improving functional ability was 70 per cent (see Table 12).

Table 12: **Percentage of clients maintaining or improving functional ability while in transition care, 2011–12 to 2015–16**

Indicator	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)
Clients maintaining or improving functional ability	67	69	68	69	**70**
Target	65	65	65	65	**65**

Data sources: Aged and Continuing Care Directorate, Department of Health unpublished data.

Rate per 1,000 Home and Community Care target population who receive Home and Community Care services

Outcome 2
Effectiveness KPI

Rationale

The Home and Community Care Program is a joint Commonwealth, State and Territory initiative under the *Home and Community Care Act 1985* aimed at providing basic support services to older people, people with a disability, and their carers to assist them to continue living at home and be more independent in the community. The program aims to reduce the use of residential and acute care, reduce the risk of premature or inappropriate long-term residential care, improve functioning and support independence in the community, support carers and enhance the quality of life for these Western Australians in need.

The reach and effectiveness of the Home and Community Care Program can be determined through monitoring the number of people in the target population who have received Home and Community Care services. This in turn can support the development of targeted strategies that aim to ensure that the people with the greatest need have access to the services they require and are provided with the care they need in the most appropriate setting – ensuring the well-being and quality of life for Western Australians in need.

Target

For 2015–16, the target is 350 per 1,000 home and community care target population.

Results

In 2015–16, the rate per 1,000 target population receiving home and community care services was 349, slightly below the target of 350 (see Table 13).

Table 13: **Rate per 1,000 home and community care target population receiving HACC services, 2011–12 to 2015–16**

Indicator	2011–12	2012–13	2013–14	2014–15	2015–16
HACC target population (per 1,000)	371	368	362	370	**349**
Target (per 1,000)	-	-	347	343	**350**

Notes:

1. In 2013–14, to align with national reporting requirements the calculation of the rate per 1,000 target population receiving home and community care was changed. As a result prior year results are no longer comparable.
2. The calculation of this KPI is based on:
   a. ABS population projections applied to the 2012 ABS Survey of Disability, Ageing and Carers (SDAC) rates.
   b. estimated proportion of people living in the community who have a profound, severe or moderate disability.

Data sources: Home and Community Care Minimum Data Set Database, Department of Health and Ageing.

Specific Home and Community Care contract provider client satisfaction survey

Outcome 2
Effectiveness KPI

Rationale

The Home and Community Care Program is a joint Commonwealth, State and Territory initiative under the *Home and Community Care Act 1985* aimed at providing basic support services to older people, people with a disability and their carers to assist them to continue living at home and be more independent in the community. The program aims to reduce the use of residential and acute care, reduce the risk of premature or inappropriate long-term residential care, improve functioning and support independence in the community, support carers and enhance the quality of life for these Western Australians in need.

To drive the continuous improvement of the Home and Community Care Program, the Home and Community Care Client Quality of Life Survey has been developed. This survey obtains feedback from clients about the effectiveness of the program in supporting them to remain living independently in the community.

Through measuring client satisfaction on the Home and Community Care Program's success of supporting clients to be independent and in improving their quality of life, areas of improvement can be identified. This enables improvements in service planning and the development of targeted strategies and interventions that focus on improving the program's effectiveness and ensuring the provision of the most appropriate care to those in need. This enhances the well-being and quality of life for Western Australians in need.

Target

The target for 2015–16 is:

a) 85 per cent of Home and Community Care clients believe home and community care helps them to be independent.

b) 85 per cent of Home and Community Care clients believe home and community care improves their quality of life.

Results

In 2015–16, 1,049 Home and Community Care clients were involved in the Home and Community Care Program, Quality of Life Client Survey. This equates to a participation rate of 80.8 per cent. The overall satisfaction rate of clients receiving HACC support was 93.4 per cent. Of all survey respondents 80.8 per cent believed the Home and Community Care Program helped them to be independent, while 86.1 per cent stated it improved their quality of life (see Table 14).

The proportion of clients who reported that HACC services significantly improved their overall quality of life and/or helped them to become more independent was lower when compared to prior year results. Perceived unmet need by clients receiving HACC support is associated with quality and flexibility of services, and staff capacity.

Table 14: **Home and Community Care Program, Quality of Life Client Survey results, 2011–12 to 2015–16**

	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)	Target (%)
Percentage of clients that believe the Home and Community Care program helps them to become independent	92.8	88.0	89.0	82.9	80.8	**85.0**
Percentage of clients that believe the Home and Community Care program improves their quality of life	94.8	92.5	93.9	92.0	86.1	**85.0**

Notes:

1. Results exclude clients who chose not to answer that particular question, or who felt the service/s they received from the Home and Community Care Program were not applicable to the question.
2. The survey sampling error at a confidence interval of 95 per cent for KPI (a) [78.31, 83.28] and (b) [83.95, 88.25].

Data source: The University of Western Australia Aged Care Research and Evaluation Unit - Home and Community Care Program, Quality of Life Client Survey.

Cost per capita of providing preventive interventions, health promotion and health protection activities

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion & protection

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The delivery of effective targeted preventative interventions, health promotion and health protection activities aims at reducing disease, disability and injury within the community, fostering the ongoing health and wellbeing of Western Australians.

Target

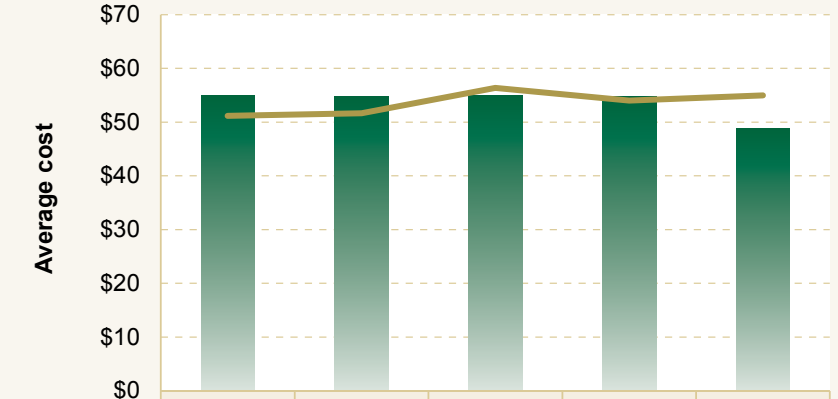
The target unit cost for 2015–16 is $55 per capita to provide preventative interventions, health promotion and health protection activities.

A result below the target is desirable.

Results

In 2015–16, the average cost to provide public health interventions and programs was $49 (see Figure 16). The lower expenditure to target is attributable to Department of Health contract variations below that estimated at the time of budget allocation.

Figure 16: **Cost per capita of providing preventive interventions, health promotion and health protection activities, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$54.94	$54.81	$55.01	$55	$49
Target	$51.16	$51.63	$56.37	$54	$55

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014, as defined by the Australian Statistical Geography Standard.

Data sources: Department of Health unpublished data, Australian Bureau of Statistics, Oracle Financial Systems.

Average cost per dental service provided by the Oral Health Centre of WA

Outcome 2
Efficiency KPI
Service 8:
Dental health

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Specialised dental and oral treatment services are provided through State Government subsidised dental care for Health Care Card Holders and general dental care to eligible patients within their local catchment area, through a collaborative agreement with the Oral Health Centre of Western Australia.

Target

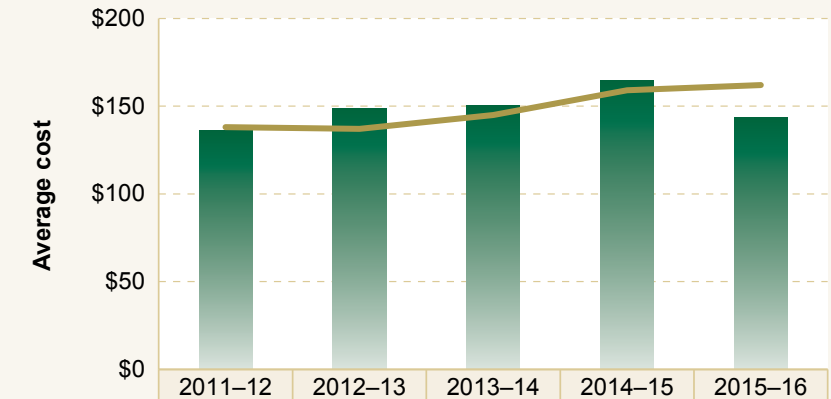
The 2015–16 target unit cost is $162 per subsidised public specialist dental service, provided by the Oral Health Centre of Western Australia. A result below the target is desirable.

Results

The average cost per subsidised public specialist dental services provided by the Oral Health Centre of Western Australia in 2015–16 was $144, below the target of $162 (see Figure 17).

The expenditure variation to target is attributable to increased activity levels.

Figure 17: **Average cost per specialist dental service provided by the Oral Health Centre of Western Australia, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$136	$149	$150	$165	$144
Target	$138	$137	$145	$159	$162

Data sources: Department of Health unpublished data, Oral Health Centre WA, Oracle Financial Systems.

Average cost per person of Home and Community Care services delivered to people with long term disability

Outcome 2
Efficiency KPI
Service 9:
Continuing care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The Home and Community Care Program (the Program) is a joint Commonwealth, State and Territory initiative under the *Home and Community Care Act 1985*. The Program provides basic support services to frail older people, people with a disability, and carers to assist them to continue living at home and be more independent in the community. The Program aims to reduce the use of residential and acute care; reduce the risk of premature or inappropriate long-term residential care; improve functioning and support independence in the community; support carers and enhance the quality of life for these Western Australians in need.

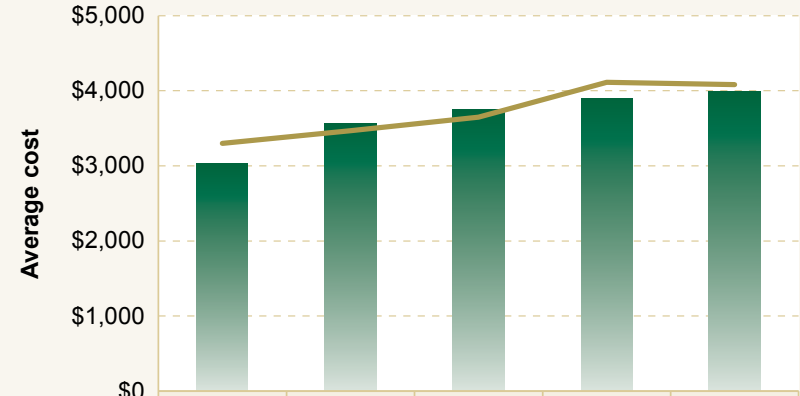
Target

The 2015–16 target unit cost is $4,082 per person of Home and Community Care services to people with a long term disability. A result below the target is desirable.

Results

In 2015–16, the average cost per person to provide Home and Community Care services to people with a long term disability was $3,991, below the target of $4,082 (see Figure 18).

Figure 18: **Average cost per person of Home and Community Care services delivered to people with long term disability, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$3,030	$3,569	$3,745	$3,901	$3,991
Target	$3,299	$3,468	$3,649	$4,111	$4,082

Notes:

1. The calculation of this KPI includes clients who receive Home and Community Care funded services and who have agreed for their personal information to be captured in the Home and Community Care Minimum data set.
2. The financial figures include the total allocation of Home and Community Care funding. This consists of funding to community based, non-government and local government organisations, and funding allocated to the WA Department of Health and WA Country Health Service.

Data sources: Department of Health unpublished data, Home and Community Care Minimum Data Set Database.

Average cost per transition care day

Outcome 2
Efficiency KPI
Service 9: Continuing care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The Transition Care Program is a joint Commonwealth and State and Territory initiative that aims to optimise the functioning and independence of older people and enable them to return home after a hospital stay rather than prematurely enter residential care. The Transition Care Program is tailored to meet the needs of the individual and aims to facilitate a continuum of care for older people in a non-hospital environment, while giving them more time and support to make a decision on their longer term care arrangements.

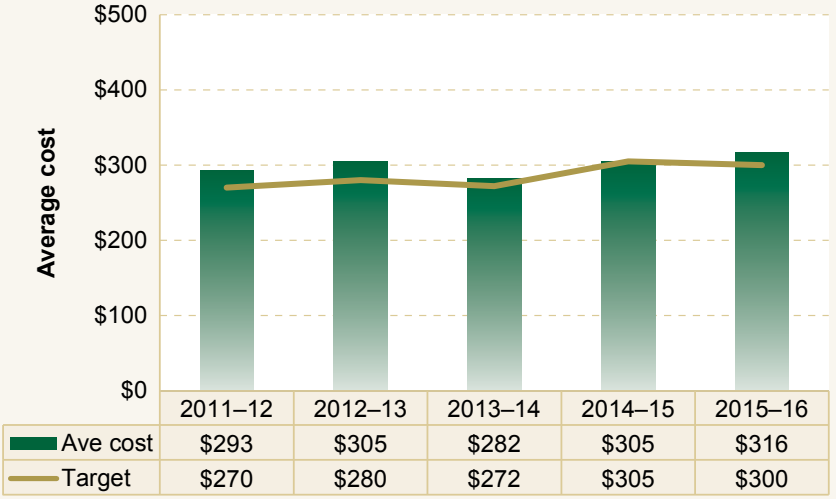
Target

The 2015–16 target unit cost is $300 per transition care day. A result below the target is desirable.

Results

The average cost per transition care day in 2015–16 was $316 slightly above the target of $300 (see Figure 19).

Figure 19: **Average cost per transition care day, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$293	$305	$282	$305	$316
Target	$270	$280	$272	$305	$300

Data source: Department of Health unpublished data.

Average cost per day of care for non-acute admitted continuing care

Outcome 2
Efficiency KPI
Service 9:
Continuing care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The goal of non-acute care is the prevention of deterioration in the functional and current health status of patients, such as frail older people or younger people with a disability. Non-acute care is usually provided in a hospital while patients are awaiting placement into residential care, waiting for the services they will need at home to be organised, vital modifications to be made to their homes, or when requiring respite care.

In addition to the non-acute admitted continuing care services that are delivered by the public health system, the Western Australian Government has entered into collaborative agreements with private providers to provide continuing care for non-acute patients.

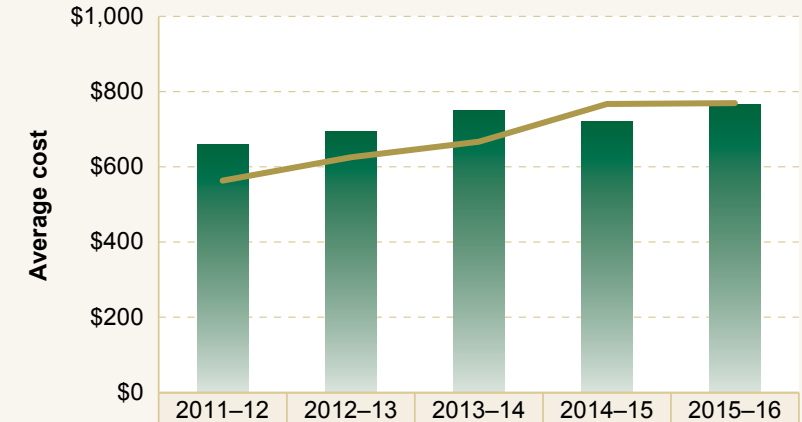
Target

The 2015–16 target unit cost is $769 per day of care for non-acute admitted continuing care. A result below the target is desirable.

Results

In 2015–16, the average cost per day to provide non-acute admitted continuing care was $764, below the target of $769 (see Figure 20).

Figure 20: **Average cost per day of care for non-acute admitted continuing care, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$661	$694	$751	$721	$764
Target	$563	$625	$667	$767	$769

Data source: Department of Health unpublished data.

Average cost to support patients who suffer specific chronic illness and other clients who require continuing care

Outcome 2
Efficiency KPI
Service 9:
Continuing care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians, it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

Chronic conditions pose a significant burden on health care in WA. Most chronic conditions do not resolve spontaneously, and are generally not cured – require ongoing care and support. As such, the State Government has identified several chronic conditions, e.g. diabetes, which requires special health services to improve quality of life. In addition to chronic diseases, for those who have permanent disabilities, ongoing care and support aims to enhance their health and wellbeing. This care is provided through residential, community or respite care through organisations that have collaborative agreements with the WA Government.

Target

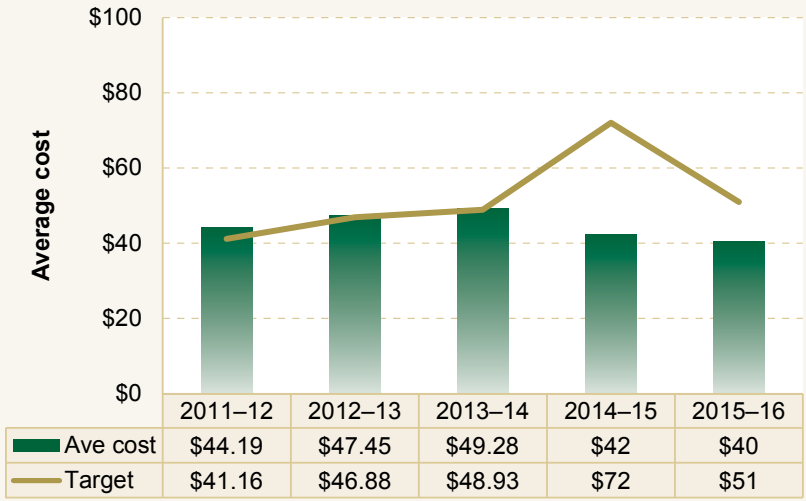
The 2015–16 target unit cost is $51 to support patients who suffer specific chronic illness and other clients who require continuing care. A result below the target is desirable.

Results

For 2015–16, the average cost to support patients who suffer specific chronic illness and clients who require continuing care was $40 and below target (see Figure 21).

The expenditure variance to target is attributable to an overestimation of activity in the calculation of the target for contracted services.

Figure 21: **Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$44.19	$47.45	$49.28	$42	$40
Target	$41.16	$46.88	$48.93	$72	$51

Data sources: Department of Health unpublished data, Australian Bureau of Statistics 2012 Survey of Disability, Ageing and Carers (Cat. No. 4430.0), Oracle Financial Systems.

Ministerial directives

Treasurer's Instructions 902 (12) requires disclosing information on any Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

WA Health has received no Ministerial directives related to this requirement.

Summary of board and committee remuneration

The total annual remuneration for each board or committee is listed below (see Table 15). For details of individual board or committee members please refer to Appendix 1.

Table 15: **Summary of State Government boards and committees within the Department of Health, 2015–16**

Board/Committee name	Total remuneration
Animal Resources Authority Board	$5,900
Cardiovascular Health Network Executive Advisory Group	$60
Department of Health WA Human Research Ethics Committee	$53,320
Diabetes and Endocrine Health Network Executive Advisory Group	$1,020
Falls Prevention Health Network Executive Advisory Group	$0
Fluoridation of Public Water Supplies Advisory Committee	$0
Interim Child and Adolescent Health Service Board	$80,898
Interim East Metropolitan Health Service Board	$75,221
Interim North Metropolitan Health Service Board	$69,544
Interim South Metropolitan Health Service Board	$86,575
Interim WA Country Health Service Board	$63,867
Local Health Authorities Analytical Committee	$1,387
Musculoskeletal Health Network Executive Advisory Group	$180
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia	$28,803
Pharmacy Registration Board of Western Australia	$16,558
Radiological Council	$7,520
Renal Health Network Executive Advisory Group	$840
Respiratory Health Network Executive Advisory Group	$1,560
Stimulant Assessment Panel	$1,372
Western Australian Aged Care Advisory Council	$1,363
Western Australian Board of the Medical Board of Australia	$56,182
Western Australian Board of the Nursing and Midwifery Board of Australia	$24,003
Western Australian Child and Youth Health Network Executive Advisory Group	$60
WA Health Transition and Reconfiguration Steering Committee	$0
WA Reproductive Technology Council	$14,193
WA Reproductive Technology Counselling Committee	$2,059
WA Reproductive Technology Counselling Embryo Storage Committee	$0
WA Reproductive Technology Counselling Licensing and Administration Advisory Committee	$369
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee	$355
WA Reproductive Technology Counselling Scientific Advisory Committee	$497
Womens and Newborns Health Network Executive Advisory Group	$180

Other financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Hospitals and Health Services Act 1927 (WA)*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Hospitals (Services Charges) Regulations 1984 and the Hospitals (Services Charges for Compensable Patients) Determination 2005* and are reviewed annually. The following informs WA public hospital patient fees and charges for:

- **Nursing Home Type Patients**

  The State charges public patients who require nursing care and/or accommodation after the 35th day of their stay in hospital, providing they no longer need acute care and they are deemed to be Nursing Home Type Patients. The total daily amount charged is no greater than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

- **Compensable or ineligible patients**

  Patients who are either 'private' or 'compensable' and Medicare ineligible (overseas residents) may be charged an amount for public hospital services as determined by the State. The setting of compensable and ineligible hospital accommodation fees is set close to, or at, full cost recovery.

- **Private patients (Medicare eligible Australian residents)**

  The Commonwealth Department of Health regulates the Minimum Benefit payable by health funds to privately insured patients for private shared ward and same day accommodation. The Commonwealth also regulates the Nursing Home Type Patient 'contribution' based on March and September Pension increases. To achieve consistency with the *Commonwealth Private Health Insurance Act 2007*, the State sets these fees at a level equivalent to the Commonwealth Minimum Benefit.

- **Veterans**

  Hospital charges of eligible war service veterans are determined under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement, the Department of Health does not charge medical treatment to eligible war service veteran patients. Instead, medical charges are fully recouped from the Department of Veterans' Affairs.

The following fees and charges also apply:

- The Pharmaceutical Benefits Scheme regulates and sets the price of pharmaceuticals supplied to outpatients, patients on discharge and for day admitted chemotherapy patients. Inpatient medications are supplied free of charge.
- The Dental Health Service charges to eligible patients for dental treatment are based on the Department of Veterans' Affairs Fee Schedule of dental services for dentists and dental specialists. Eligible patients are charged the following co-payment rates:
  - 50 per cent of the treatment fee if the patient holds a current Health Care Card or Pensioner Concession Card
  - 25 per cent of the treatment fee if the patient is the current holder of one of the above cards and receives a near full pension or an allowance from Centrelink or the Department of Veterans Affairs.
- There are other categories of fees specified under Health Regulations through Determinations, which include the supply of surgically implanted prostheses, Magnetic Resonance Imaging services and pathology services. The pricing for these hospital services is determined according to their cost of service.

Capital works

WA Health has a substantial Asset Investment Program that facilitates re-modelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure metropolitan general and tertiary hospitals, and significant investment in regional hospital infrastructure (see Table 16).

Table 16: **Major Asset Investment Program works completed in 2015–16**

Initiative	Estimated total cost in 2015–16 $`000
Metropolitan Health Service	
Capital Works (including major redevelopments and equipment)	
FSH – Development	1,595,566
Graylands Hospital – Redevelopment Planning	600
King Edward Memorial Hospital (KEMH) Holding	1,380
King Edward Memorial Hospital (KEMH) Maternal Fetal Assessment	5,500
PMH – Interim Holding Works at Existing PMH Site	2,824
QEIIMC Electrical Switchgear Upgrade	2,290
RPH Medical Oncology Redevelopment	2,447
RPH Plastics Clinics Relocation	4,440
SCGH – G Block Lift Upgrade	6,092
South Metropolitan Health Service Reconfiguration (FSH link)	145
Subtotal	**1,621,284**
WA Country Health Service	
Capital Works (including major redevelopments and equipment)	
Broome Mental Health – 14-Bed Unit	9,169
Broome Paediatrics Facility	7,833
Broome Regional Resource Centre – Redevelopment Stage 1	42,000
Country Staff Accommodation Stage 3	27,019
Denmark Multipurpose Centre – Replacement	18,041
Derby Community Mental Health Refurbishment	1,201
East Kimberley Development Package	39,244
Hedland Regional Resource Centre Stage 2	136,327
Kalgoorlie Regional Resource Centre – Redevelopment Stage	57,989
Kimberley – Various Health Project Developments	45,300
Nickol Bay Hospital Roof Replacement	2,500
Regional Health Administrative Accommodation	2,179
South West Health Campus – Critical Care Unit	14,518
Western Australia Country Health Service Picture Archiving and Communication System (PACS) – Regional Resource Centre	6,307
Subtotal	**409,627**

Initiative	Estimated total cost in 2015–16 $`000
Statewide	
Clinical Training Fund	3,289
Community Mental Health Initiatives	5,788
ICT Bunbury BreastScreen Clinic	500
ICT Equipment and Infrastructure – Clinical Incident Management System	3,343
ICT Equipment and Infrastructure – FSH ICT – Anaesthetics Alert Management	1,200
ICT Equipment and Infrastructure – ICT	235,011
ICT Equipment and Infrastructure – Upgrade of PABX infrastructure at SCGH and KEMH	3,000
Junior Doctors – Simulated Learning Environments	1,004
State Rehabilitation Service – Development	225,689
Subtotal	**478,824**

Table 17: **Major capital works in progress during 2015–16**

Initiative	Estimated Total Cost in 2015–16 ($'000)[a) i]	Reported in 2014–15 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Metropolitan Health Service				
Armadale Kelmscott Hospital – Development[4]	15,403	15,970	-567	TBA
Fiona Stanley Hospital (FSH) ICT Commissioning[1]	32,114	20,400	11,714	Completed
Fremantle Hospital and Health Service Reconfiguration[1]	5,221	0	5,221	Jun 16
FSH ICT – Intensive Care Clinical Information Systems	4,200	4,200	0	Completed
FSH ICT – Pharmacy Automation	9,600	9,600	0	Completed
Joondalup Health Campus – Development Stage 1[1]	215,152	218,152	-3,000	Completed
Joondalup Health Campus Telethon Paediatric Ward[4]	14,718	15,018	-300	May 16
Kalamunda Hospital – Redevelopment Stage 2[1,4]	8,147	9,761	-1,614	TBA
Midland Health Campus – Development Stage 1[5]	359,680	360,200	-520	Completed
Osborne Park Hospital Additional Parking Facility[4]	3,330	3,500	-170	Dec 16
Osborne Park Hospital Reconfiguration Stage 1	26,301	26,301	0	TBA

Initiative	Estimated Total Cost in 2015–16 ($'000)[a) i]	Reported in 2014–15 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Perth Children's Hospital Information Communication Technology[5]	179,152	187,980	-8,828	TBA
Peel Health Campus – Development Stage 1[4]	2,333	2,464	-131	Jun 17
Perth Children's Hospital (PCH) – Development	1,162,668	1,162,668	0	TBA
Princess Margaret Hospital (PMH) – Holding[4]	6,245	6,462	-217	Various
QEIIMC – New Central Plant Facility[5]	221,523	221,562	-39	Completed
RPH Redevelopment Stage 1[3,5]	19,371	8,000	11,371	Jun 17
SCGH – Catheter Laboratory 2 Upgrade[1]	835	0	835	Completed
SCGH – Redevelopment Stage 1[1,4]	48,028	51,730	-3,702	Various
SCGH – Mental Health Unit	28,926	28,926	0	Completed

Initiative	Estimated Total Cost in 2015–16 ($'000)[a) i]	Reported in 2014–15 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
WA Country Health Service				
Bunbury, Narrogin and Collie Hospitals – Pathology Laboratories Redevelopment[6]	6,960	0	6,960	Sep 18
Busselton Health Campus[5]	117,510	120,227	-2,717	Completed
Carnarvon Health Campus Redevelopment[5]	25,937	26,191	-254	Completed
Country – Staff Accommodation Stage 4[4]	8,514	8,889	-375	Aug 16
Eastern Wheatbelt District (Including Merredin) Stage 1[4]	8,280	9,000	-720	Sep 18
Enhancing Health Services for the Pilbara in Partnership With Industry[5]	8,276	8,483	-207	Completed
Esperance Health Campus Redevelopment[5]	32,619	32,743	-124	Nov 16
Exmouth Multipurpose Service Redevelopment[2,5]	7,900	7,684	216	Completed
Harvey Health Campus Redevelopment[2,5]	12,968	13,879	-911	Dec 16
Karratha Health Campus – Development[5]	206,900	207,142	-242	Jun 18
Onslow Hospital[1]	41,800	0	41,800	Jul 18

Initiative	Estimated Total Cost in 2015–16 ($'000)[a) i]	Reported in 2014–15 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Point of Care Network for Pathology Testing[6]	776	0	776	Dec 16
Remote Indigenous Health[5]	20,326	21,156	-830	Aug 18
Renal Dialysis and Support Services[6]	44,753	0	44,753	May 17
Southern Inland Health Initiative – Integrated District Health Campuses Stream 2[2,4,5]	127,432	145,436	-18,004	Aug 18
Southern Inland Health Initiative – Primary Health Centres[2,4,5]	39,312	43,314	-4,002	Aug 18
Southern Inland Health Initiative – Small Hospitals and Nursing Posts[2,4,5]	102,615	108,718	-6,103	Jul 17
Southern Inland Health Initiative – Telehealth[2]	5,522	5,496	26	Dec 17
St John's Ambulance (Regional Western Australia)[5]	1,825	1,838	-13	Completed
Strengthening Cancer Services – Regional Cancer Patient Accommodation[5]	4,517	4,507	10	Sep 17
Upper Great Southern District (including Narrogin) Stage 1[2,4,6]	11,029	9,000	2,029	Sep 18
Wheatbelt Renal Dialysis[2,5]	1,967	2,000	-33	Sep 18

Initiative	Estimated Total Cost in 2015–16 ($'000)[a) i]	Reported in 2014–15 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Statewide				
BreastScreen WA – Digital Mammography Technology[5]	12,666	12,998	-332	May 17
Equipment Replacement Program[4,5]	433,864	441,040	-7,176	Ongoing
Health Services Development Fund[4]	3,992	4,312	-320	TBA
ICT – Corporate and Shared Services Reform – Health Corporate Network[5] (HCN)	9,441	9,824	-383	Completed
Land Acquisition[1,4]	4,873	5,750	-877	N/A
Minor Buildings Works[4,5]	157,198	145,423	11,775	Ongoing
NPA – Improving Public Hospital Services[5]	89,126	89,397	-271	Dec 17
PathWest – Laboratory Equipment and Asset Replacement/Maintenance[3]	1,500	0	1,500	Dec 18
Replacement of PathWest's Laboratory Information Systems[4,5]	25,023	27,581	-2,558	Jun 18
Stabilising Existing ICT Platform[4,5]	12,705	17,268	-4,563	Completed

Notes:

1. The information above is based upon the:
   i) 2015–16 published budget papers.
   ii) 2014–15 published budget papers.
2. Completion timeframes are based upon a combination of known dates at the time of reporting.
3. Projects listed above as 'complete' may still be in the defects period.
4. Projects variations above were due to the following:
   i) Transfer of funding between projects.
   ii) Royalties for Regions Funding changes.
   iii) Additional State Funding.
   iv) Impacted as part of Whole of Government Capital Audit.
5. 2015–16 Budget excludes amounts that will not be capitalised, therefore the estimated total cost may vary from that reported in the 2014–15 Budget.
   i) Additional Commonwealth funding.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 18 shows the number of Department of Health full-time equivalent employees for 2014–15 and 2015–16 as at June 2016.

Table 18: **Department of Health total full-time employees by category**

Category	Definition	2014–15	2015–16
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff	813	876
Agency	Includes FTE associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	32	39
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest	0	0
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care	0	0
Dental nursing	Includes registered dental nurses and dental clinic assistants	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations	0	0
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners	14	13
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis	3	2

Category	Definition	2014–15	2015–16
Medical support	Includes all allied health and scientific/ technical related occupations	37	37
Nursing	Includes all nursing occupations. Does not include agency nurses	31	31
Site services	Includes engineering, garden and security-based occupations	0	0
Other categories	Includes Aboriginal and ethnic health worker related occupations	1	3
	Total	**931**	**1,001**

Notes:

1. The number of full-time equivalent employees was calculated as the monthly average full-time equivalent employees and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, time off in lieu, and workers compensation.
2. Full-time equivalent employee figures provided are based on Actual (Paid) month-to-date full-time equivalent employees.
3. Full-time equivalent staff at the Drug and Alcohol Office, Mental Health Commission WA, Office of Health Review, Peel Health Campus and Joondalup Health Campus have been excluded.

Data source: Human Resource Data Warehouse.

Staff development

The Department of Health is committed to the provision of ongoing staff development and recognises that this is an essential contributing factor to quality service delivery, employee engagement, performance and retention.

The Department of Health proactively supports a performance development approach focused on mutual discussion and assessment of employee capability. This is achieved through personal development plans that form part of the annual performance development cycle. Training and development opportunities for staff at all levels are supported and include:

- up-skilling through practical 'on-the-job' training and opportunities to temporarily perform duties of a higher classification level or secondment
- formal development opportunities and study to meet relevant accredited and professional competency requirements supported both within work time and external to the work environment
- in-house training that provides legislative and public sector compliance, safety and quality, and a range of leadership, management and interpersonal skills development
- opportunities to participate both internally and externally in information and education sessions, forums and relevant skills training and professional development.

Industrial relations

The WA Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations. Additionally, the service also supports significant workforce management issues for the metropolitan, country and other health services comprising WA Health.

Key activities in 2015–16 included:

- conclusion of new industrial agreements for hospital support workers
- renegotiating industrial agreements for registered nurses and allied health employees that expire 30 June 2016
- renegotiating industrial agreements for medical practitioner agreements that expire 30 September 2016.

Workers' compensation

The WA Workers' Compensation system is a scheme set up by the State Government and exists under the statute of the *Workers' Compensation & Injury Management Act 1981*.

The Department of Health is committed to providing staff with a safe and healthy work environment in order to deliver effective and efficient health care services. In 2015–16 a total of six workers' compensation claims were made (see Table 19).

Table 19: **Number of Department of Health workers' compensation claims in 2015–16**

Employee category	Number
Nursing Services/Dental Care Assistants	0
Administration and Clerical	6
Medical Support	0
Hotel Services	0
Maintenance	0
Medical (salaried)	0
Total	**6**

Note: For the purposes of the annual report employee categories are defined as:

- Administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff
- Medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers
- Hotel services – includes cleaners, caterers and patient service assistants.

For further details on the Department of Health's occupational safety and health and injury management processes, please see the Occupational Safety, Health and Injury section of this report.

Unauthorised use of credit cards

WA Health uses Purchasing Cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The Purchasing Card is a personalised credit card that provides a clear audit trail for management.

WA Health credit cards are provided to employees who require it as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for a personal purpose, they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

Despite being made aware of obligations pertaining to the use of credit cards, one Department of Health cardholder used their card for personal purposes. The full amount ($235) was refunded before the end of the reporting period (see Table 20).

Table 20: **Personal use expenditure by Department of Health cardholders, January to June 2016**

Credit card personal use expenditure	January to June 2016
Aggregate amount of personal use expenditure for the reporting period	$235
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$0
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$235
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Government Building Contracts

The Government Building Training Policy applies to State Government building, construction and maintenance contracts that have a labour component of $2 million and over. All tenders issued from 1 October 2015 are in scope of this policy.

The Department of Health supports the Government Building Training Policy and is committed to developing a strong training culture and sustained commitment to training through employment of apprentices and trainees within the building and construction industry.

As at 30 June 2016, no contracts subject to the Government Building Training Policy were awarded.

Governance requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

In 2015–16, the Deputy Director General, Rebecca Brown, declared that a significant family member was an employee of and holds shares in Telstra from whom the Department of Health procures services. Administration arrangements are in place within WA Health to ensure that a conflict of interest does not occur.

Other legal disclosures

Advertising

In 2015–16, in accordance with section 175Z of the *Electoral Act 1907*, the Department of Health incurred a total advertising expenditure of $2,750,380 (see Table 21). A total of 87 per cent of all advertising expenditure was through the procurement of media advertising and market research.

Table 21: **Summary of Department of Health advertising in 2015–16**

Summary of advertising	Amount ($)
Advertising agencies	284,353
Market research organisations	1,093,195
Polling organisations	0
Direct mail organisations	77,841
Media advertising organisations	1,294,991
Total advertising expenditure	**2,750,380**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 22.

Table 22: **Department of Health advertising, by class of expenditure, 2015–16**

Recipient/organisations	Amount ($)
Advertising agencies	
The Brand Agency	252,819
Cooch Creative	3,185
Longtail	28,349
Total	**284,353**
Market research organisations	
Painted dog	99,811
Metrix	45,897
Edith Cowan University	947,487
Total	**1,093,195**
Polling organisations	
	0
Total	**0**
Direct mail organisations	
Quickmail	49,777
Zipform	28,064
Total	**77,841**

Recipient/organisations	Amount ($)
Media advertising organisations	
OMD	441,098
Carat	578,953
Adcorp	18,831
Facebook	79,418
International recruitment	176,691
Total	**1,294,991**
Total advertising expenditure	**2,750,380**

Disability access and inclusion plan

The *Disability Services Act 1993* was introduced to ensure that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation regarding WA Health services. As at June 2014, amendments to the Act now require public authorities to ensure that people with disability have equal opportunities to employment.

WA Health ensures compliance with this and all other principles through the implementation of the *WA Health Disability Access and Inclusion Plan 2010–15*. Current initiatives and programs being implemented in accordance with the Plan are outlined below.

Access to service

The Department of Health is committed to the development and implementation of a system-wide framework to ensure equitable access to all services for people with disability. Requirements of people with disability are considered and accommodated in the planning of any events and/or services. This includes choosing appropriate venues that are compliant with recommended access guidelines in relation to access, ease of movement within the building, parking arrangements, transport and travel to and from the building. Translators are available for people with disability if required and all communication materials can be provided in alternate formats.

The provision of services provided by non-government organisations on behalf of the Department of Health must conduct their business in a manner consistent with the *WA Health Disability Access and Inclusion Plan 2010–15*.

Access to buildings

All Department of Health buildings and facilities are accessible to people with disability. Public areas of the Department of Health are accessible to wheelchairs and modified vehicles, with access ramps and lifts available to all levels of the building. Concierge services and dedicated ACROD parking bays are available to people with disability. General access areas are on the ground floor level and these areas include motion-activated and timed access doors.

In 2015–16, work undertaken on buildings or facilities were compliant with the Building Code of Australia and the Advisory Notes on Access to Premises prepared by the *Human Rights and Equal Rights Commission Act 1986* and the *Disability Discrimination Act 1992*. Improvements have been undertaken at Grace Vaughan House with the aim of providing universal access. The WA Cancer and Palliative Care Network continue to ensure that health services adhere to the guidelines to ensure accessibility to people with disability.

Access to information

The Department of Health is committed to ensuring that people with disabilities, their families and carers are able to fully access information in the public health system. The WA Health website has been designed to meet the State Government's *Web Content Accessibility Guidelines* to AA level. All public-related information complies with the *WA Health Communications Policy*.

Information provided by non-government organisations on behalf of the Department of Health must ensure web-based information meets disability access guidelines, and where practicable, closed captioning is applied to television advertising.

Quality of service by staff

Information and services are delivered in accordance with the *State Government Access Policy* and the *Disability Access and Inclusion Policy 2010–15*. A new Department of Health Disability Access and Inclusion Policy will be effective from 2016–21. Staff and community consultation was undertaken to inform the development of this new policy and to ensure a consistent level of service is available to all staff and members of the public.

The Department of Health continues to provide training and educate staff about disability and to encourage and support the employment of more people with disability.

Opportunity to provide feedback

The Department of Health's Complaint Management Policy outlines the processes for consumers, patients and carers to lodge a complaint about the care received in a State public hospital.

People with a disability are provided with the same access to a complaints management process. Complaints can be lodged via written correspondence, telephone or in person. All complaints are fully investigated and the outcome provided to the complainant in a relevant and accessible format.

Participation in public consultation

Public consultation with consumer groups, inclusive of individuals and groups representing specific disability areas, their families and carers is undertaken to ensure that barriers to inclusion or participation are addressed. To ensure a range of stakeholders representing patients/consumers are included in public consultations, media advertising is used. Facilitated focus groups are generally used to learn about opinions and to guide future action.

Initiatives and programs provided by the Department of Health are assessed for any potential impact on people with disability.

Opportunities to obtain and maintain employment

The Department of Health complies with the WA Health Recruitment, Selection and Appointment Policy and associated procedures. This ensures recruitment and selection is undertaken in a consistent, inclusive and open and transparent manner. Training is provided to those participating in selection processes to ensure full understanding of the relevant public sector standards, legislation and regulations, including those that relate to disability discrimination.

Department of Health employees with a disability are supported via regular reviews of workplace accessibility and adjustments to the work environment as required. Co-workers are required to adapt their work practices including tailoring their methods of delegation and giving instruction to staff members with learning disabilities.

Compliance with public sector standards

The WA Health Code of Conduct has been developed to comply with the principles of appropriate behaviour outlined in the WA Public Sector Commission's Code of Ethics.

All WA Health employees are responsible for ensuring their behaviour reflects the standards of conduct embodied in the WA Health Code of Conduct. In 2015–16, the Department of Health published and updated an enhanced WA Health Code of Conduct.

The revised WA Health Code of Conduct was implemented as part of the Employment Policy Framework. The Framework specifies employment governance requirements that all health service providers and the Department of Health must comply with in order to ensure an effective and consistent approach to:

- industrial relations
- human resource management
- ethics and integrity.

To assist staff to understand and comply with the principles of workplace behaviour and conduct, the Department of Health induct, inform and educate their employees through various online communications, e-learning and face-to-face program training. The mandatory Accountable and Ethical Decision Making Program is an integral part of all employee training in this area and is designed to communicate expectations of workplace conduct through internal discussions on real ethical dilemmas. In 2015–16, a total of 7,180 WA Health employees undertook the Accountable and Ethical Decision Making training through the online training platform or face-to-face training.

Employee compliance with the WA Health Code of Conduct is monitored via reports of breaches of discipline. WA Health is required to review and investigate all complaints alleging non-compliance with the Code of Ethics or Code of Conduct. In 2015–16, a total of eight matters were lodged and investigated internally.

Compliance to the principles of the Public Sector Commission's Standards in Human Resource Management is maintained by the Department of Health through:

- centralised management of a standardised recruitment and selection process
- implementation of employee performance management processes.

In 2015–16, no new Breach of Standard claims were lodged regarding the recruitment, selection, and appointment process, or the process of the management of an employee's performance. Two claims were finalised from the previous year, one sent to the Public Sector Commission for review, the other finalised internally. There are no matters outstanding.

Freedom of Information

The Western Australian *Freedom of Information Act 1992* gives all Western Australians a right of access to information held by the Department of Health.

The types of information held by the Department of Health include:

- reports on health programs and projects
- briefings for Minister and executive staff
- health circulars, policies, standards and guidelines
- health articles and discussion papers
- departmental magazines, bulletins and pamphlets
- health research and evaluation reports
- epidemiological, survey and statistical data/information
- publications relating to health planning and management
- committee meeting minutes
- general administrative correspondence
- financial and budget reports
- staff personnel records.

The public can access this information from the WA Health website (ww2.health.wa.gov.au). Links to other health-related websites are also available. Members of the public who do not have internet access can obtain hard copy documents for free or at nominal cost. General enquires can be made to the Senior Policy Officer on 9222 6412.

Access to information can also be made through a Freedom of Information application that involves the lodgement of a written request. The written request must provide sufficient detail to enable the application to be processed, including contact details and an Australian address for correspondence. In the case of an application for amendment or annotation of personal information it is required that the request include:

- detail of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out-of-date or misleading
- the applicant's reasons for holding that belief
- detail of the amendment that the applicant wishes to have made.

Applications should be addressed to the Freedom of Information Office, and may be lodged by:

Person	Department of Health Legal and Legislative Services 189 Royal Street EAST PERTH WA 6004
Mail	Department of Health, Western Australia PO Box 8172 Perth Business Centre WA 6849
Fax	(08) 9222 4355
Email	FOI.DOH@health.wa.gov.au

All requests for information can be granted, partially granted or may be refused in accordance with the Western Australian *Freedom of Information Act 1992*. The applicant can appeal if dissatisfied with the process or the reasons provided and in the event of an adverse access decision.

For the year ending 30 June 2016, the Department of Health dealt with 68 applications for information, of which 38 applications were granted full or partial access and 11 were refused (see Table 23).

Table 23: **Freedom of Information applications to the Department of Health in 2015–16**

Summary of number of applications	Number
Applications carried over from 2014–15	1
Applications received in 2015–16	67
Total number of applications active in 2015–16	**68**
Applications granted – full access	21
Applications granted – partial or edited access	17
Applications withdrawn by applicant	4
Applications refused	11
Applications in progress	3
Other applications	12
Total number of applications dealt with in 2015–16	**68**

Notes:

1. Partial or edited access to information includes the number of applications accessed in accordance with section s28 of the *Freedom of Information Act 1992* (WA).
2. Other applications include exemptions, deferments or transfers to other departments/agencies.

Recordkeeping plans

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

The Department of Health continues to progress its compliance with the *State Records Act 2000* through the Department of Health Recordkeeping Plan. The Plan provides an accurate reflection of the recordkeeping program within the organisation, including information regarding recordkeeping system(s), disposal arrangements, policies, practices and processes. In 2015–16, the following was achieved:

- review of the Business Classification System
- review of the Retention and Disposal Schedule for Administrative and Functional (Non Patient) Records
- completion of the draft Digitisation of Administrative and Functional (Non Patient) Records
- formation of an Electronic Document Records Management System Business Advisory Group.

Strategies to ensure that employees are aware and comply with the Department of Health Recordkeeping Plan include online recordkeeping awareness and systems training, and communication via the intranet and newsletters.

In 2015–16, over 390 Department of Health employees completed the Online Recordkeeping Awareness training. Feedback from 81 per cent of participants described the program as informative, essential or stimulating, and 86 per cent agreed that their knowledge improved as a consequence of the training.

Within the Department of Health, more than 138,000 records were captured into the Electronic Documents and Records Management Systems during 2015–16.

Substantive equality

WA Health continues to contribute towards substantive equality for all Western Australians through the implementation of the Policy Framework for Substantive Equality. The framework provides a clear direction for all persons employed in WA Health by addressing the diverse needs and sensitivities of the communities.

In 2015–16, the Department of Health introduced the WA Health Aboriginal Cultural Learning Package that comprises online tools and resources designed to support the development of a culturally respectful and non-discriminatory health system. Since commencement of the training, 90 per cent of WA Health employees enrolled in Cultural e-Learning, with 58 per cent completing the training.

Additionally, the following activities occurred:

- a study day for health services on Towards Social Cohesion Through Improving Migrant Health and Wellbeing
- a series of Being Culturally Responsive cultural competency training for Child and Adolescent Health Service
- Let's Talk Culture seminars that covered forced migration, culture and mental health and domestic violence
- ongoing advice and support for implementation of the WA Health Language Services Policy 2011, which included refreshment of web-based resources for consumers and health services to assist with promotion and application of the policy
- audit of health service provision of language services to non-English speaking and hearing impaired consumers. This has informed improvements in service delivery and policy.

Occupational safety, health and injury management

WA Health is committed to occupational safety, health and injury management systems in line with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*.

Commitment to occupational safety, health and injury management

The Department of Health adopts a continuous improvement approach to occupational safety, health and injury management. Safety and health at the Department of Health is the responsibility of operational line managers and executives with functional support provided by Human Resource Services. Accountability rests with the Office of the Director General.

Compliance with occupational safety, health and injury management

The Department of Health is committed to complying with all occupational safety, health legal requirements and continues to develop and implement safe systems and work practices that reflect its commitment to safety and health.

The Department of Health Occupational Safety and Health Committee provides advice and feedback to senior management on policy development, identification and proactive management of identified risks, and reviews all incidents or accidents reported. The Committee members consist of nominated employees and management representatives from the Department of Health. Committee membership and contact details are communicated to all employees at induction and via noticeboards and the intranet. The Department of Health intranet page is currently being updated.

Employee consultation

The provision of training for all Department of Health managers in occupational safety, health is ongoing and participation is mandatory. In line with the commitment to continuous improvement, the training model was reviewed and updated in 2016. A program of Manual Handling in an Office Environment also commenced in February 2016. Health and safety representatives attend required training with accredited external providers.

Employee rehabilitation

In the event of a work-related injury or illness, the Department of Health is committed to assisting injured workers to return to work as soon as medically appropriate through their Return to Work Program. Senior Human Resource Coordinators are trained in the fundamentals of injury management and work with all concerned to facilitate an early return to the workplace. This includes the negotiation of appropriate hours, work duties and reasonable adjustment to any other circumstances.

Occupational safety, health assessment and performance indicators

The annual performance reported for the Department of Health in relation to occupational safety, health and injury for 2015–16 is summarised in Table 24.

Table 24: **Occupational safety, health and injury performance, 2013–14 to 2015–16**

Measure	Actual Results		Results against Target	
	2013–14	2015–16	Target	Comments
Fatalities (number of deaths)	0	**0**	0	**Target achieved**
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	0.74	**0.55**	0 or 10% reduction	26% reduction **Target achieved**
Lost time injury severity rate (rate per 100)	74.43	**63.64**	0 or 10% reduction	14% reduction **Target achieved**
Percentage of injured workers returned to work within 13 weeks	N/A	**40.0%**	N/A	N/A
Percentage of injured workers returned to work within 26 weeks	47.1%	**50.0%**	Greater than or equal to 80%	**Target not achieved**
Percentage of managers trained in occupational safety, health and injury management responsibilities	36.0%	**56.5%**	Greater than or equal to 80%	**Target not achieved**

Note: Performance is based on a three-year trend and so the comparison base year is two years prior to the current reporting year.

Annual estimates

The WA Health annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the *Financial Management Act 2006*, and Treasurer's Instruction 953.

The annual estimates for 2016–17 as approved by the Minister for Health are provided in Table 25.

Table 25: **2016–17 budget estimates for WA Health**

Statement of comprehensive income	2016–2017 Estimate $'000s
Cost of services	
Expenses	
Employee benefits expense	126,619
Contracts for services	709,325
Supplies and services	56,236
Grants and subsidies	6,184,278
Depreciation expense	768
Other expenses	160,180
Total cost of services	**7,237,406**
Income	
Revenue	
User charges and fees	3,112
Commonwealth grants and contributions	2,104,816
Other grants and contributions	17,355

Statement of comprehensive income	2016–2017 Estimate $'000s
Donation revenue	1,023
Other revenue	884
Total revenue	**2,127,190**
Total income other than income from State Government	**2,127,190**
Net cost of services	**5,110,216**
Income from State Government	
Service appropriation	5,087,230
Services received free of charge	1,291
Total income from State Government	**5,088,521**
Deficit for the period	**(21,695)**
Total comprehensive loss for the period	**(21,695)**

Statement of financial position	2016–2017 Estimate $'000s
Assets	
Current Assets	
Cash and cash equivalents	8,085
Restricted cash and cash equivalents	182,741
Inventories	15,723
Receivables	41,033
Other current assets	3,301
Total Current Assets	**250,883**
Non-Current Assets	
Amounts receivable for services	36,858
Finance lease receivable	4,942
Property, plant and equipment	26,458
Other non-current assets	9,838
Total Non-Current Assets	**78,096**
Total Assets	**328,979**
Liabilities	
Current Liabilities	
Payables	57,875
Provisions	21,267
Other current liabilities	778

Statement of financial position	2016–2017 Estimate $'000s
Total Current Liabilities	**79,920**
Non-Current Liabilities	
Provisions	5,235
Total Non-Current Liabilities	**5,235**
Total Liabilities	**85,155**
Net assets	**243,824**
Equity	
Contributed equity	(213,342)
Reserves	306,647
Accumulated surplus	150,519
Total equity	**243,824**

Statement of cash flows	2016–2017 Estimate $'000s
Cash flows from State Government	
Service appropriation	4,655,854
Net cash provided by State Government	**4,655,854**
Cash flows from operating activities	
Payments	
Employee benefits	(125,357)
Supplies and services	(924,449)
Grants and subsidies	(5,752,335)
GST payments on purchases	(282,117)
Receipts	
User charges and fees	3,112
Commonwealth grants and contributions	2,104,805
Other grants and contributions	17,355
Donations received	1,023
GST receipts on sales	19,435
GST refunds from taxation authorities	262,682
Other receipts	45
Net cash used in operating activities	**(4,675,801)**
Net decrease in cash and cash equivalents	**(19,947)**
Cash and cash equivalent at the beginning of the period	210,773
Cash and cash equivalents at the end of the period	**190,826**

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Appendix

Appendix 1: Board and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Animal Resources Authority Board				
Chair	Anthony Tate	Per meeting	12 months	$2,300
Deputy Chair and Member	Dr Campbell Thomson	Not eligible	Not applicable	$0
Member	Leslie Chalmers	Per meeting	12 months	$1,500
Member	Michael Robins	Not eligible	Not applicable	$0
Member	Prof. Jennet Harvey	Per meeting	12 months	$1,200
Member	Prof. Elizabeth Rakoczy	Per meeting	12 months	$900
Member	Prof. David Morrison	Not eligible	Not applicable	$0
Member	Charles Thorn	Not eligible	Not applicable	$0
			Total:	**$5,900**
Cardiovascular Health Network Executive Advisory Group				
Clinical Co-lead	Dr Jacquie Garton-Smith	Not eligible	Not applicable	$0
Co-lead	Dr Tony Mylius	Not eligible	Not applicable	$0
Member	Stephen Bloomer	Not eligible	Not applicable	$0
Member	Tom Briffa	Not eligible	Not applicable	$0
Member	Julie Burns	Not eligible	Not applicable	$0
Member	Craig Cheetham	Not eligible	Not applicable	$0
Member	Trevor Cherry	Not eligible	Not applicable	$0
Member	Geraldine Ennis	Not eligible	Not applicable	$0
Member	Julie Smith	Not eligible	Not applicable	$0
Member	Lesley Gregory	Not eligible	Not applicable	$0
Member	Lorraine Linacre	Not eligible	Not applicable	$0
Member	Andrew Maiorana	Not eligible	Not applicable	$0
Member	Lesley Nelson	Not eligible	Not applicable	$0
Member	Prof. Paul Norman	Not eligible	Not applicable	$0
Member	John Powdrill	Per meeting	12 months	$60
Member	Dr Jamie Rankin	Not eligible	Not applicable	$0
Member	Shelley McRae	Not eligible	Not applicable	$0
			Total:	**$60**
Department of Health WA Human Research Ethics Committee				
Chair	Honoray Fellow Judith Allen	Annual	12 months	$19,100
Deputy Chair	Dr Katrina Spilsbury	Per meeting	12 months	$2,640
Deputy Chair	Dr Alison Garton	Per meeting	12 months	$3,960
Member	Assoc. Prof. Angela Ives	Per meeting	12 months	$2,425
Member	Patricia Fowler	Per meeting	12 months	$3,630
Member	Jennifer Wall	Per meeting	12 months	$4,735
Member	Reverend Jenifer Goring	Per meeting	12 months	$3,960
Member	Gary Langham	Per meeting	12 months	$3,630
Member	Ross Monger	Per meeting	12 months	$3,300

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Joyce Archibald	Per meeting	12 months	$2,970
Member	Mary Miller	Not eligible	Not applicable	$0
Deputy	Dr Janine Alan	Not eligible	Not applicable	$0
Deputy	Stephen Woods	Not eligible	Not applicable	$0
Deputy	Nadia Saba	Per meeting	11 months	$660
Deputy	Timothy Smith	Not eligible	Not applicable	$0
Deputy	Prof. Tom Briffa	Per meeting	12 months	$0
Deputy	Dr Geoffrey Hammond	Not eligible	Not applicable	$0
Deputy	Reverend Brian Carey	Per meeting	12 months	$0
Deputy	Shane Gallagher	Per meeting	12 months	$330
Deputy	Dr Phillip Jacobsen	Per meeting	12 months	$330
Deputy	Kathryn Kirk	Per meeting	12 months	$990
Deputy	Yvonne Rate	Per meeting	12 months	$660
			Total:	**$53,320**
Diabetes and Endocrine Health Network Executive Advisory Group				
Co-lead	Mark Shah	Not eligible	Not applicable	$0
Co-lead	Prof. Tim Davis	Not eligible	Not applicable	$0
Member	Dr Alan Wright	Per Meeting	12 months	$660
Member	Andrew Wagstaff	Not eligible	Not applicable	$0
Member	Belinda Whitworth	Not eligible	Not applicable	$0
Member	Bruce Campbell	Per meeting	12 months	$180
Member	Cara Westphal	Not eligible	Not applicable	$0
Member	Nila Cecconi	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Deborah Schofield	Not eligible	Not applicable	$0
Member	Denise Smith	Not eligible	Not applicable	$0
Member	Genevieve Stone	Not eligible	Not applicable	$0
Member	Dr Gerry Fegan	Not eligible	Not applicable	$0
Member	Helen Mitchell	Not eligible	Not applicable	$0
Member	Merinda March	Not eligible	Not applicable	$0
Member	Dr Rhonda Clifford	Not eligible	Not applicable	$0
Member	Prof Richard Prince	Not eligible	Not applicable	$0
Member	Dr Sean George	Not eligible	Not applicable	$0
Member	Dr Seng Khee Gan	Not eligible	Not applicable	$0
Member	Sophie McGough	Not eligible	Not applicable	$0
Member	Tim Benson	Per meeting	12 months	$180
Member	Prof. Tim Jones	Not eligible	Not applicable	$0
			Total:	**$1,020**
Falls Prevention Health Network Executive Advisory Group				
Clinical lead	Dr Nicholas Waldron	Not eligible	Not applicable	$0
Member	Emily Anderson	Not eligible	Not applicable	$0
Member	Denise Kluck	Not eligible	Not applicable	$0
Member	Dr Erica Davison	Not eligible	Not applicable	$0
Member	Anthea McGuigan	Not eligible	Not applicable	$0
Member	Jenna Athans	Not eligible	Not applicable	$0
Member	Luke Hays	Not eligible	Not applicable	$0
Member	Dr Anne-Marie Hill	Not eligible	Not applicable	$0
Member	Su Kitchen	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Katherine Ingram	Not eligible	Not applicable	$0
Member	Dr Aru Moodley	Not eligible	Not applicable	$0
Member	Tony Petta	Not eligible	Not applicable	$0
Member	Kim Watkins	Not eligible	Not applicable	$0
Member	Bronwyn Middleton	Not eligible	Not applicable	$0
			Total:	**$0**
Fluoridation of Public Water Supplies Advisory Committee*				
Chair	Dr Richard Lugg	Not eligible	Not applicable	$0
Member 1		Not eligible	Not applicable	$0
Member 2		Not eligible	Not applicable	$0
Member 3		Not eligible	Not applicable	$0
Member 4		Not eligible	Not applicable	$0
Member 5		Not eligible	Not applicable	$0
*Approval to withhold the names of the committee members was obtained from the Minister for Health			**Total:**	**$0**
Local Health Authorities Analytical Committee				
Member	Eugene Lee	Not eligible	Not applicable	$0
Member	Joseph Zappavigna	Not eligible	Not applicable	$0
Member	Jason Jenke	Not eligible	Not applicable	$0
Member	Graeme Blakey	Not eligible	Not applicable	$0
Member	Greg Ducas	Not eligible	Not applicable	$0
Member	Phillip Oorjitham	Not eligible	Not applicable	$0
Member	Robert Boardman	Not eligible	Not applicable	$694
Member	David Wilson	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Colin Dent	Not eligible	Not applicable	$0
Member	Councillor Belinda Rowland	Not eligible	Not applicable	$693
			Total:	**$1,387**
Musculoskeletal Health Network Executive Advisory Group				
Co-Lead	Jennifer Persaud	Not eligible	Not applicable	$0
Co-Lead	Dr Dan Xu	Not eligible	Not applicable	$0
Member	Eng Soon Chew	Not eligible	Not applicable	$0
Member	Ric Forlano	Not eligible	Not applicable	$0
Member	Ben Horgan	Not eligible	Not applicable	$0
Member	Dr Helen Keen	Not eligible	Not applicable	$0
Member	Kerry Mace	Per meeting	Per meeting	$180
Member	Jean Mangharam	Not eligible	Not applicable	$0
Member	Prof. Stephan Schug	Not eligible	Not applicable	$0
Member	Robyn Timms	Not eligible	Not applicable	$0
Member	Johannes Nossent	Not eligible	Not applicable	$0
			Total:	**$180**
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia				
Chair	Assoc. Prof. Jennifer Thornton	Per meeting	12 months	$8,615
Member	Prof. Emeritus David Leach	Per meeting	12 months	$7,372
Member	Neil McLean	Per meeting	12 months	$6,359
Member	Theodore Sharp	Per meeting	12 months	$6,457
			Total:	**$28,803**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Pharmacy Registration Board of Western Australia				
Presiding Member	John Harvey	Per meeting	12 months	$7,000
Deputy Presiding Member	Lynette Mullen	Per meeting	12 months	$2,888
Member	Prof. Michael Garlepp	Per meeting	12 months	$3,244
Member	Margaret Ford	Per meeting	12 months	$3,426
			Total:	**$16,558**
Radiological Council				
Chair	Dr Andrew Robertson	Not eligible	Not applicable	$0
Deputy Chair	Dr Geoffrey Groom	Per meeting	12 months	$800
Member	Dr Chandra Padmini Hewavitharana	Not eligible	Not applicable	$0
Member	Dr Richard Fox	Per meeting	12 months	$1,440
Member	Maxwell Ross	Per meeting	12 months	$1,280
Member	Associate Prof Janice McKay	Per meeting	12 months	$960
Member	Christopher Whennan	Not eligible	Not applicable	$0
Member	Gregory Scott	Per meeting	11 months	$0
Member	Barry Cobb	Per meeting	12 months	$1,440
Member	Nick Tsurikov	Per meeting	12 months	$1,280
Member	Garry Fee	Per meeting	10 months	$320
Deputy	Dr Deepthi Kumari Dissanayake	Not eligible	Not applicable	$0
Deputy	Dr Elizabeth Thomas	Not eligible	Not applicable	$0
Deputy	Dr Roger Price	Not eligible	Not applicable	$0
Deputy	John O'Donnell	Not eligible	Not applicable	$0
Deputy	Associate Prof Zhonghua Sun	Per meeting	12 months	$0
Deputy	Dr Robin Hart	Not eligible	Not applicable	$0
			Total:	**$7,520**
Renal Health Network Executive Advisory Group				
Co-Chair	Dr Hemant Kulkarni	Not eligible	Not applicable	$0
Co-Chair	Dr Harry Moody	Not eligible	Not applicable	$0
Member	Dr Neil Boudville	Not eligible	Not applicable	$0
Member	Dr Aron Chakera	Not eligible	Not applicable	$0
Member	Dr Mike Civil	Per meeting	12 months	$660
Member	Evelyn Coral	Not eligible	Not applicable	$0
Member	Jenny Cutter	Not eligible	Not applicable	$0
Member	Lois Dear	Not eligible	Not applicable	$0
Member	Debbie Fortnum	Not eligible	Not applicable	$0
Member	Sandra Porter	Not eligible	Not applicable	$0
Member	Steve Marshall	Not eligible	Not applicable	$0
Member	Simone McMahon	Per meeting	12 months	$180
Member	Emma Griffiths	Not eligible	Not applicable	$0
Member	Dr Greg Perry	Not eligible	Not applicable	$0
			Total:	**$840**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Respiratory Health Network Executive Advisory Group				
Executive Advisory Group Lead	Assoc. Prof. Peter Kendall	Not eligible	Not applicable	$0
Executive Advisory Group Lead	Prof. Mark Everard	Not eligible	Not applicable	$0
Member	Nigel Barker	Not eligible	Not applicable	$0
Member	Helen Bell	Not eligible	Not applicable	$0
Member	Nola Cecins	Not eligible	Not applicable	$0
Member	Rohonda Clifford	Not eligible	Not applicable	$0
Member	Dr Maree Creighton	Per meeting	6 months	$440
Member	Dr Jacquie Garton-Smith	Per meeting	12 months	$880
Member	David Hillman	Not eligible	Not applicable	$0
Member	Jenni Ibrahim	Per meeting	12 months	$240
Member	David Johnson	Not eligible	Not applicable	$0
Member	Lou Landau	Not eligible	Not applicable	$0
Member	Holly Landers	Not eligible	Not applicable	$0
Member	Siobhain Mulrennan	Not eligible	Not applicable	$0
Member	Kathryn Pekin	Not eligible	Not applicable	$0
			Total:	**$1,560**
Stimulant Assessment Panel				
Chair	Neil Keen	Not eligible	12 months	$0
Member	Alpa Dodhia	Not eligible	12 months	$0
Member	Dr Nathan Gibson	Not eligible	12 months	$0
Member	Dr Richard O'Regan	Not eligible	12 months	$0
Member	Dr Peter Rowe	Not eligible	12 months	$0
Member	Dr Johana Stefan	Per meeting	3 months	$0
Member	Dr Oleh Kay	Per meeting	12 months	$1,143
Member	Dr Nikki Panotidis	Not eligible	3 months	$0
Member	Prof. Charles Watson	Not eligible	12 months	$0
Member	Prof. Wai Chen	Not eligible	10 months	$0
Member	Dr Elizabeth Green	Per meeting	10 months	$228
			Total:	**$1,372**
Western Australian Aged Care Advisory Council				
Chair	Dr Penny Flett	Per meeting	12 months	$639
Deputy Chair	Gail Milner	Not eligible	12 months	$0
Member	Rob Willday	Not eligible	12 months	$0
Member	Ann Banks	Per meeting	12 months	$284
Member	Dr Nick Bretland	Per meeting	12 months	$440
Member	Beth Cameron	Not eligible	12 months	$0
Member	Dr Ron Chalmers	Not eligible	12 months	$0
Member	Paul Coates	Not eligible	12 months	$0
Member	Prof. Leon Flicker	Not eligible	12 months	$0
Member	Trevor Lovelle	Not eligible	12 months	$0
Member	Dr Helen McGowan	Not eligible	12 months	$0
Member	Rhonda Parke	Not eligible	12 months	$0
Resigned – April 2016	Anthea McGuigan	Not eligible	9 months	$0
Resigned – January 2016	Linda Jackson	Not eligible	6 months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Resigned – December 2015	Paul Purdy	Not eligible	5 months	$0
Member	Helen Grinbergs	Not eligible	12 months	$0
Proxy	Kathy Stack	Not eligible	3 months	$0
			Total	**$1,363**
Western Australia Board of the Medical Board of Australia				
Chair	Prof. Constantine Michael	Per meeting	12 months	$6,370
Member	Prof. Bryant Stokes	Per meeting	12 months	$4,366
Member	Assoc. Prof. Peter Wallace	Per meeting	12 months	$4,601
Member	Dr Steven Patchett	Per meeting	11 months	$3,680
Member	Dr Mark McKenna	Per meeting	12 months	$5,287
Member	Dr Michael McComish	Per meeting	12 months	$4,605
Member	Dr Frank Kubicek	Per meeting	3 months	$917
Member	Dr Michael Levitt	Per meeting	8 months	$3,071
Member	Nicoletta Ciffolilli	Per meeting	12 months	$3,987
Member	Prudence Ford	Per meeting	12 months	$4,900
Member	Virginia Rivalland	Per meeting	12 months	$5,522
Member	Prof. Stephan Millett	Per meeting	12 months	$3,377
Member	Dr Daniel Heredia	Per meeting	9 months	$2,456
Member	John Pintabona	Per meeting	6 months	$2,736
Member	Dr Mark Edwards	Per meeting	12 months	$307
			Total:	**$56,182**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Western Australian Board of the Nursing and Midwifery Board of Australia				
Chair	Marie-Louise McDonald	Per meeting	12 months	$4,870
Member	Assoc. Prof. Karen Clark-Burg	Per meeting	12 months	$3,193
Member	Assoc. Prof. Karen Gullick	Per meeting	12 months	$3,680
Member	Jennifer Wood	Per meeting	9 months	$2,145
Member	Mary Miller	Per meeting	2 months	$0
Member	Michael Piu	Per meeting	12 months	$2,759
Member	Virginia Seymour	Per meeting	7 months	$1,224
Member	Pamela Lewis	Per meeting	12 months	$2,145
Member	Dr Margaret Crowley	Per meeting	3 months	$3,987
Member	Marie Baxter	Not eligible	Not applicable	$0
			Total:	**$24,003**
Western Australian Child and Youth Health Network Executive Advisory Group				
Clinical Co-lead	Dr Helen Wright	Not eligible	Not applicable	$0
Clinical Co-lead	Dr Alide Smith	Not eligible	Not applicable	$0
Member	Elaine Bennett	Not eligible	Not applicable	$0
Member	Sharon Bushby	Not eligible	Not applicable	$0
Member	Phillippa Farrell	Not eligible	Not applicable	$0
Member	Linda Hop	Not eligible	Not applicable	$0
Member	Andrew Jones	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Caron Molster	Not eligible	Not applicable	$0
Member	Sue Peter	Not eligible	Not applicable	$0
Member	Gitana Matthews	Not eligible	Not applicable	$0
Member	Janine Spencer	Not eligible	Not applicable	$0
Member	Carolyn Franklin	Not eligible	Not applicable	$0
Member	Helen Pepper	Per meeting	12 months	$60
Member	Emma Davidson	Not eligible	Not applicable	$0
Member	Trulie Pinnegar	Not eligible	Not applicable	$0
			Total:	**$60**
WA Health Transition Steering Committee				
Chair	Dr David Russell-Weisz	Not eligible	Not applicable	$0
Member	Peter Conran	Not eligible	Not applicable	$0
Member	Michael Barnes	Not eligible	Not applicable	$0
Member	Prof. Bryant Stokes	Not eligible	Not applicable	$0
			Total:	**$0**
WA Reproductive Technology Council				
Chair	Prof. Constantine Michael	Per meeting	10 months	$1,491
Chair	Dr Brenda McGovern	Per meeting	12 months	$1,420
Member	Dr Simon Clark	Per meeting	12 months	$1,420
Member	Antonia Clissa	Per meeting	12 months	$1,278
Member	Dr Angela Cooney	Per meeting	12 months	$426
Member	Prof. James Cummins	Per meeting	6 months	$284
Member	Justine Garbellini	Per meeting	12 months	$1,278
Member	Prof. Roger Hart	Per meeting	12 months	$923
Member	Anne Marie Loney	Not eligible	Not applicable	$0
Member	Rev. Dr Joseph Parkinson	Per meeting	12 months	$845
Member	Professor Stephan Millett	Per meeting	2 months	$0
Member	Dr Peter Roberts	Per meeting	12 months	$852
Member	Dr Katherine Sanders	Per meeting	6 months	$781
Deputy Member	Dr John Beilby	Not eligible	Not applicable	$0
Deputy Member	Dr Peter Burton	Sessional	12 months	$0
Deputy Member	Rev Brian Carey	Sessional	12 months	$1,349
Deputy Member	Dr Louise Farrell	Sessional	12 months	$0
Deputy Member	Dr Michele Hansen	Sessional	12 months	$355
Deputy Member	Dr Andrew Harman	Sessional	12 months	$284
Deputy Member	Iolanda Rodino	Sessional	12 months	$639
Deputy Member	Rachel Oakeley	Sessional	12 months	$284
Deputy Member	Diane Scarle	Sessional	12 months	$0
Deputy Member	Dr Lucy Williams	Sessional	12 months	$284
			Total:	**$14,193**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
WA Reproductive Technology Counselling Committee				
Chair	Iolanda Rodino	Sessional	12 months	$1,065
Member	Justine Garbellini	Sessional	12 months	$426
Member	Anne-Marie Loney	Not eligible	Not applicable	$0
Member	Dr Elizabeth Webb	Sessional	12 months	$568
			Total:	**$2,059**
WA Reproductive Technology Counselling Embryo Storage Committee				
Chair	Reverend Brian Carey	Sessional	12 months	$0
Member	Dr Michelle Hansen	Sessional	12 months	$0
Member	Dr Andrew Harman	Sessional	12 months	$0
Member	Antonia Clissa	Sessional	12 months	$0
			Total:	**$0**
WA Reproductive Technology Counselling Licensing and Administration Advisory Committee				
Chair	Prof. Constantine Michael	Sessional	10 months	$213
Member	Prof. Roger Hart	Sessional	12 months	$0
Member	Reverend Dr Joseph Parkinson	Sessional	12 months	$156
Member	Dr Angela Cooney	Sessional	4 months	$0
			Total:	**$369**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee				
Chair	Dr Katherine Sanders	Sessional	12 months	$213
Member	Dr Peter Burton	Not eligible	Not applicable	$142
Member	Dr John Beilby	Sessional	12 months	$0
Member	Dr Sharron Townshend	Sessional	12 months	$0
			Total:	**$355**
WA Reproductive Technology Counselling Scientific Advisory Committee				
Chair	Assoc. Prof. James Cummins	Sessional	6 months	$213
Member	Dr Peter Burton	Sessional	12 months	$0
Member	Dr Michelle Hansen	Sessional	12 months	$142
Member	Dr Andrew Harman	Sessional	12 months	$0
Member	Prof. Roger Hart	Sessional	12 months	$0
Member	Reverend Dr Joseph Parkinson	Sessional	12 months	$0
Member	Assoc. Prof. Peter Roberts	Sessional	5 months	$0
Member	Dr Katherine Sanders	Sessional	12 months	$142
Member	Dr Lucy Williams	Sessional	2 months	$0
			Total:	**$497**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Womens and Newborns Health Network Executive Advisory Group				
Clinical Co-lead	Assoc. Prof. Graeme Boardley	Not eligible	Not applicable	$0
Clinical Co-lead	Dr Janet Hornbuckle	Not eligible	Not applicable	$0
Member	Dr Sara Armitage	Not eligible	Not applicable	$0
Member	Susan Bradshaw	Not eligible	Not applicable	$0
Member	Janice Butt	Not eligible	Not applicable	$0
Member	Etwell Mari	Not eligible	Not applicable	$0
Member	Hayley Sherratt	Not eligible	Not applicable	$0
Member	Leanda Verrier	Not eligible	Not applicable	$0
Member	Richard King	Not eligible	Not applicable	$0
Member	Selena Knowles	Not eligible	Not applicable	$0
Member	Dr Peter Kell	Not eligible	Not applicable	$0
Member	Megan Burley	Not eligible	Not applicable	$0
Member	Karla Lister	Not eligible	Not applicable	$0
Member	Melissa Trivic	Not eligible	Not applicable	$0
Member	Jenny O'Callaghan	Not eligible	Not applicable	$0
Member	Kate Reynolds	Not eligible	Not applicable	$0
Member	Jan Ryan	Not eligible	Not applicable	$0
Member	Bev Sinclair	Per meeting	12 months	$180
Member	Jennifer Watchorn	Not eligible	Not applicable	$0
Member	Sue Somerville	Not eligible	Not applicable	$0
Member	Pippa Vines	Not eligible	Not applicable	$0
			Total:	**$180**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Interim North Metropolitan Health Service Board				
Chair	Prof. Bryant Stokes	Annual	7 months	$35,482
Deputy Chair	Prof. Rosanna Capolingua	Annual	2 months	$5,677
Member	Dr Margaret Crowley	Annual	2 months	$5,677
Member	Dr Felicity Jefferies	Annual	2 months	$5,677
Member	Michele Kosky	Annual	2 months	$5,677
Member	Graham McHarrie	Annual	2 months	$5,677
Member	Maria Saraceni	Annual	2 months	$5,677
Member	Dr Simon Towler	Annual	2 months	$0
Member	Prof. Grant Waterer	Annual	2 months	$0
			Total:	**$69,544**
Interim South Metropolitan Health Service Board				
Chair	Robert McDonald	Annual	7 months	$35,482
Deputy Chair	Adjunct Associate Prof. Robyn Collins	Annual	2 months	$5,677
Member	Adjunct Associate Prof. Kim Gibson	Annual	2 months	$5,677
Member	Prof. Julie Quinlivan	Annual	2 months	$5,677
Member	Fiona Stanton	Annual	2 months	$5,677
Member	David Rowe	Annual	2 months	$5,677
Member	Michelle Manook	Annual	2 months	$5,677
Member	Yvonne Parnell	Annual	2 months	$5,677
Member	Julian Henderson	Annual	2 months	$5,677
Member	Clinical Professor Mark Khangure	Annual	2 months	$5,677
			Total:	**$86,575**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Interim East Metropolitan Health Service Board				
Chair	Ian Smith	Annual	7 months	$35,482
Deputy Chair	Suzie May	Annual	2 months	$5,677
Member	Peter Forbes	Annual	2 months	$5,677
Member	Ross Keesing	Annual	2 months	$5,677
Member	Richard Guit	Annual	2 months	$5,677
Member	Debra Zanella	Annual	2 months	$5,677
Member	Prof. Kingsley Faulkner	Annual	2 months	$5,677
Member	Dr Hannah Seymour	Annual	2 months	$0
Member	Dr Stephanie Trust	Annual	2 months	$5,677
			Total:	**$75,221**
Interim Child and Adolescent Health Service Board				
Chair	Ms Deborah Karasinski	Annual	7 months	$35,482
Deputy Chair	Prof. Geoffrey Dobb	Annual	2 months	$5,677
Member	Dr Daniel McAullay	Annual	2 months	$5,677
Member	Brendan Ashdown	Annual	2 months	$5,677
Member	Kathleen Bozanic	Annual	2 months	$5,677
Member	Anne Donaldson	Annual	2 months	$5,677
Member	Peter Mott	Annual	2 months	$5,677
Member	Andrew Thompson	Annual	2 months	$5,677
Member	Dr Alexius Julian	Annual	2 months	$5,677
			Total:	**$80,898**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Interim WA Country Health Service Board				
Chair	Dr Neale Fong	Annual	7 months	$35,482
Deputy Chair	Wendy Newman	Annual	2 months	$0
Member	Michael Hardy	Annual	2 months	$5,677
Member	Dr Daniel Heredia	Annual	2 months	$5,677
Member	Dr Kim Isaacs	Annual	2 months	$5,677
Member	Joshua Nisbet	Annual	2 months	$5,677
Member	Mary Anne Stephens	Annual	2 months	$5,677
			Total:	**$63,867**

Notes:

1. The above list of Boards is as per the State Government Boards and Committees Register.
2. Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2015–16 financial year. If a member was ineligible to receive remuneration, their period of membership is immaterial to the remuneration amount and has been defined as 'Not applicable'.

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