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

Department of Health
Annual Report 2014–15

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Department of Health

Annual Report 2014–15

Department of Health

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Statement of compliance

HON DR KIM HAMES 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 2015.

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

16 September 2015

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Overview of agency

Vision statement

Our vision

Healthier, longer and better quality lives for all Western Australians.

Our mission

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 the best use of funds and resources
- supporting our team.

Our 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 can be summarised as:

Executive summary

The 2014–15 financial year was one of progress and reform for Western Australia's public health system, WA Health.

The State's $7 billion health infrastructure program, the largest in WA's history, started bearing fruit with a number of new facilities opening, including the $2 billion Fiona Stanley Hospital and the $120 million Busselton Health Campus.

Health services were reconfigured to support these new developments, with Fremantle Hospital becoming a specialist hospital and closing its Emergency Department, and a number of facilities closing their doors – namely Kaleeya Hospital and Royal Perth Hospital's Shenton Park Campus.

Significant headway was also made in preparation for the upcoming opening of the new Perth Children's Hospital and St John of God Midland Public Hospital, and the construction of more than 100 health infrastructure projects across the State.

Several legislative changes took place this year, including the passing of the *Mental Health Act 2014* and the introduction of the long-awaited *Public Health Bill 2014* – which both included significant input from WA Health.

WA Health also introduced major reforms and changes to governance to help strengthen the system for the future.

The health system's five Governing Councils were dissolved on 30 June 2015 and will be replaced by Health Service Boards on 1 July 2016 with increased governance, accountability and decision-making powers.

The Department of Health will move to a role of 'system manager', ensuring robust policy, planning and resource allocation frameworks are in place, while maintaining a strong focus on the performance of the system, sound governance and standards.

A new information and communications technology strategy was launched to improve the way WA Health uses technology over the next three years to deliver better and safer patient care.

In addition, a comprehensive procurement reform program was instituted throughout the health system, resulting in a significant cultural shift in procurement to deliver transparency, compliance and better value for money.

In 2014–15, WA Health measured its performance against the four pillars within the *WA Health Strategic Intent 2010–2015*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

WA Health's professional, 44,000-strong workforce performed well for the community against these indicators, while also embracing many significant changes throughout the health system.

Delivering a healthy WA

The Department of Health is a key part of the broader health system responsible for health sector planning and providing advice to government. It is staffed by 931 people (full-time equivalent) who work across a range of areas including public health, finance, reform, performance, data, quality, planning and strategic direction. Western Australia's Chief Medical Officer, Chief Nursing and Midwifery Officer, Chief Health Professions Officer, and Chief Psychiatrist are also part of the Department of Health. In 2014–15, WA Health also appointed its first Chief Dentist to the team.

As a whole, Western Australians enjoy an excellent standard of health, reflected in life expectancy among the best in the world and infant mortality rates among the lowest in Australia.

In 2014–15, WA Health's Central Referral Service (CRS) continued to make significant improvements to the management of outpatient referrals in the health system.

WA Health is the first jurisdiction to have successfully implemented a CRS to distribute outpatient activity across the system in a consistent manner, improving patient access to timely care that is not influenced by individual hospital or non-clinical considerations.

Work also continued on the $7 billion infrastructure overhaul that is expanding and transforming hospitals and health facilities across WA. The South Metropolitan Health Service in particular underwent significant reconfiguration to prepare for the opening of Fiona Stanley Hospital.

In addition, the Department of Health launched its new guiding framework, the *WA Health Strategic Intent 2015–2020*, re-focusing the health system on a number of key priorities and enablers over the next five years.

The Strategic Intent commits WA Health to delivering health services that are patient-centred, evidence based and within a culture of continuous improvement.

Caring for individuals and the community

The introduction of the *Public Health Bill 2014* was a major public health initiative and regulatory reform project for Western Australia.

The new Bill repeals much of the outdated *Health Act 1911* and strengthens Western Australia's capacity to deal with public health emergencies, including pandemics and bio-terrorism. It also provides the framework to manage other public health risks, such as preventable diseases.

In 2014–15, WA Health worked with its Australian counterparts to make preparations for the unlikely event that the Ebolavirus disease (EVD), which reached epidemic proportions in West Africa, hit our shores. The Communicable Disease Control Directorate introduced a range of training and education programs throughout the health services, and set-up an SMS-based monitoring program for people returning from EVD-affected countries, requiring them to take their temperature twice a day and report it to health officials.

In March 2015, the Department of Health launched a program to provide whooping cough vaccinations to all pregnant women in WA, resulting in more than 5,000 women being vaccinated to date.

Childhood immunisation coverage rates in WA have risen slowly over the past several years with more than 90 per cent of one-year-old and five-year-old children fully vaccinated. Importantly, rates for WA Aboriginal children now equal or exceed those for non-Aboriginal children at five-years-of-age.

A new set of national strategies for sexually transmitted infections (STIs) and the blood-borne viruses (BBVs) HIV, hepatitis B and hepatitis C have been introduced. These strategies set bold targets for the WA public health response to improve testing, treatment, support and care for target populations most affected by STIs and BBVs.

Focus also continued on reducing health conditions linked to excess body mass, with the launch of a new phase of the LiveLighter campaign, a flagship initiative for WA Health run by the National Heart Foundation WA in partnership with the Cancer Council WA. EatBrighter Live Lighter encouraged all Western Australian to think of colour to get their two serves of fruit and five serves of vegetables.

In 2014-15, The Department of Health developed and implemented two key programs as part of the WA Healthy Workers Initiative. Healthier Workplace WA, delivered by the Heart Foundation WA, helps workplaces develop health and wellbeing programs that focus on smoking, healthy eating, physical activity, alcohol and sedentary behaviour. Also, the WA Health Staff Wellness Initiative supports and encourages workplaces to develop environments, policies and practices that promote employee healthy lifestyle behaviours.

WA Health also continued its delivery of a range of initiatives and resources as part of the Government's commitment to build local government capacity for managing mosquitoes and mosquito-borne disease risks across WA.

Caring for those who need it most

In 2014–15, the *Mental Health Act WA 2014* passed through parliament and WA Health began substantial work to prepare for its commencement on 30 November 2015 – including the release of *A Clinicians' Practice Guide* and an extensive staff and stakeholder education process.

The *WA Mental Health, Alcohol and Other Drug Services Plan 2015–2025*, of which the Department of Health is a co-sponsor, was also launched and will serve as a blueprint for these services over the next decade. Final clarification of the key elements of the Plan is expected in the new financial year.

In addition, the Department is working with the Mental Health Commission and other State Government agencies to implement recommendations from the *2012 Stokes' Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia*. More than 70 per cent of the recommendations for which the Department of Health has responsibility have been completed, with the remainder well underway.

WA Health renewed its commitment to Aboriginal health by making this area one of four main priority areas in its guiding framework for the future – the *WA Health Strategic Intent 2015–2020*.

A comprehensive review of the State's Aboriginal health programs found that more than 90 per cent of the 184 programs evaluated provided good health outcomes and value for money.

WA Health also launched a mandatory Aboriginal Cultural eLearning course for all employees to assist with delivery of culturally secure health services that will lead to improved health outcomes for Aboriginal people in WA.

In addition, Western Australia has become the first jurisdiction in the southern hemisphere to develop a comprehensive plan addressing the healthcare needs of people living with a rare disease, as well as the needs of those who support them, such as carers, families, clinicians and researchers. WA Health's *WA Rare Diseases Strategic Framework 2015–2018* outlines more than 50 initiatives that align with goals such as the delivery of timely and accurate diagnoses, and integrated care for people living with rare diseases.

Making the best use of our funds and resources

In the 2014–15 financial year, WA Health continued its work in Activity Based Funding, a national reform which benchmarks WA Health's performance against other states and affects the amount of funding it receives from the Australian Government. The cost to deliver public hospital services in WA continues to be above the National Efficient Price. Notwithstanding the unique geographical and demographic challenges impacting the cost of health service delivery in WA, WA Health continues to pursue strategies to align with the national average cost of delivering activity based hospital services. To support the sustainability of our health system, WA Health is undertaking a comprehensive reform program with the aim of improving system-wide performance and service delivery while remaining responsive to patient needs.

In 2014–15, WA Health embarked on comprehensive procurement reform throughout the health system to ensure the best outcome for every dollar spent, while also ensuring that the highest standards of professionalism, probity and accountability.

Throughout the year 5,900 procurement enquiries were directed to the newly established Office of the Chief Procurement Officer, and nearly 1,300 participants attended 82 procurement education and training workshops. In addition, four comprehensive internal procurement audit and compliance reviews were completed, with two still ongoing.

As a result of these initiatives, WA Health's Chief Procurement Officer was recently recognised as a global procurement leader for best practice at the International Procurement Leaders Awards 2015.

In 2014–15, WA Health also focused on improvements in information and communications technology (ICT) governance and planning.

A new decision-making framework for ICT, the *WA Health Information and Communications Technology Strategy 2015–2018*, was put in place to help address current system issues.

Unlike previous strategies, this short-term, three-year strategy focuses on stabilising existing systems, bringing infrastructure up to a minimum standard, improving the way we share information and building foundations for the future.

The implementation of the strategy will be guided by a new ICT governance framework, led by the WA Health ICT Executive Board and including an ICT Clinical Reference Group and ICT Consumer Reference Group.

As the strategy is implemented, WA Health will focus on creating a strategic, long-term view that considers how clinical workflows and business practices can best be supported by technology.

As mentioned previously, Western Australia's $7 billion health infrastructure program is starting to take shape, with the following programs completed and opened in 2014–15:

- Fiona Staley Hospital (including the State Rehabilitation Service)
- QEII Medical Centre site – SCGH G block lift upgrade and Mental Health Unit
- Busselton Health Campus
- Kalgoorlie Health Campus upgrade.

An additional 100 infrastructure projects are also underway across the State.

Supporting our team

People are WA Health's greatest asset and attracting and retaining the best people into the workforce is vital to maintaining a quality health system.

The goal is to have the right health staff in the right numbers, in the right places and at the right time to meet the challenging health needs of our State.

In 2014–15, the WA Health workforce faced significant challenges, including the transfer and reconfiguration of people and resources to new hospitals, most significantly due to the opening of Fiona Stanley Hospital.

WA Health has developed a 10-year strategic workforce plan, the *WA Health Clinical Services Framework 2014–2024*, which provides the foundation for the whole health system in planning to meet the high demand for health services given changing service capabilities and evolving models of care.

The Framework addresses the growing demand for services, changing economic environment, and recent adjustments to the configuration of services - including the opening of new facilities.

WA Health is also committed to ensuring that there are excellent leaders at all levels of the health system. Its Institute of Health Leadership continues to deliver a suite of leadership programs and master-classes aimed at improving the quality of leadership in the public health system.

Increasing the number of Aboriginal people working in the health system is essential to bettering the health of Aboriginal people and making sure our health system is culturally secure and respectful.

In 2014–15, WA Health not only met, but surpassed, its target for Aboriginal employment for the first time.

This provides a direct benefit for the staff, as well as for our Aboriginal patients who will have greater access to staff who are culturally aware of their needs.

WA Health enters the new year keen to consolidate and build upon the reforms and achievements of 2014–15.

Professor Bryant Stokes
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH

WA at a glance

23,296
babies were born in a WA public hospital in 2014

WA males are expected to live to **81.6** years of age and females to **85.9** years of age

1,643
deaths in WA are caused by coronary heart disease

11,743
people in WA were diagnosed with cancer in 2013

54.1%
of all potentially preventable hospitalisations in WA were due to chronic conditions

23.6%
of 16–24 year olds in WA consume alcohol at high risk of short-term harm

9,455
children in WA are estimated not to live in a smoke-free home

58.5%
of WA children do not undertake sufficient physical activity

27.8%
of adults living in WA are obese

92.8%
of adults in WA do not eat two serves of fruit and five serves of vegetables daily

26%
of 16–24 year olds in WA experience a mental health condition each year

74.1%
of Year 8 students were fully immunised against Human Papillomavirus during 2014

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 27 Acts and 82 sets of subsidiary legislation.

Administered legislation

Acts administered

- *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*
- *Mental Health Act 1996*
- *Mental Health (Consequential Provisions) Act 1996*
- *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)*
- *Queen Elizabeth II Medical Centre Act 1966*
- *Radiation Safety Act 1975*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *White Phosphorus Matches Prohibition Act 1912*

Acts passed during 2014–15

- *Medicines and Poisons Act 2014* was assented to on 2 July 2014
- *Mental Health Act 2014* passed on 16 October 2014.

Bills in Parliament as at June 2015

- *Public Health Bill 2014*
- *Public Health (Consequential Provisions) Bill 2014*
- *Western Australian Health Promotion Foundation Bill 2015.*

Amalgamation and establishment of Boards

There were no Boards amalgamated or established in 2014–15.

Accountable authority

The Acting Director General of Health, Professor Bryant Stokes, was the accountable authority for the Department of Health in 2014–15.

Responsible Minister

The Department of Health is responsible to the Minister for Health, the Hon. Dr Kim Hames.

WA Health structure

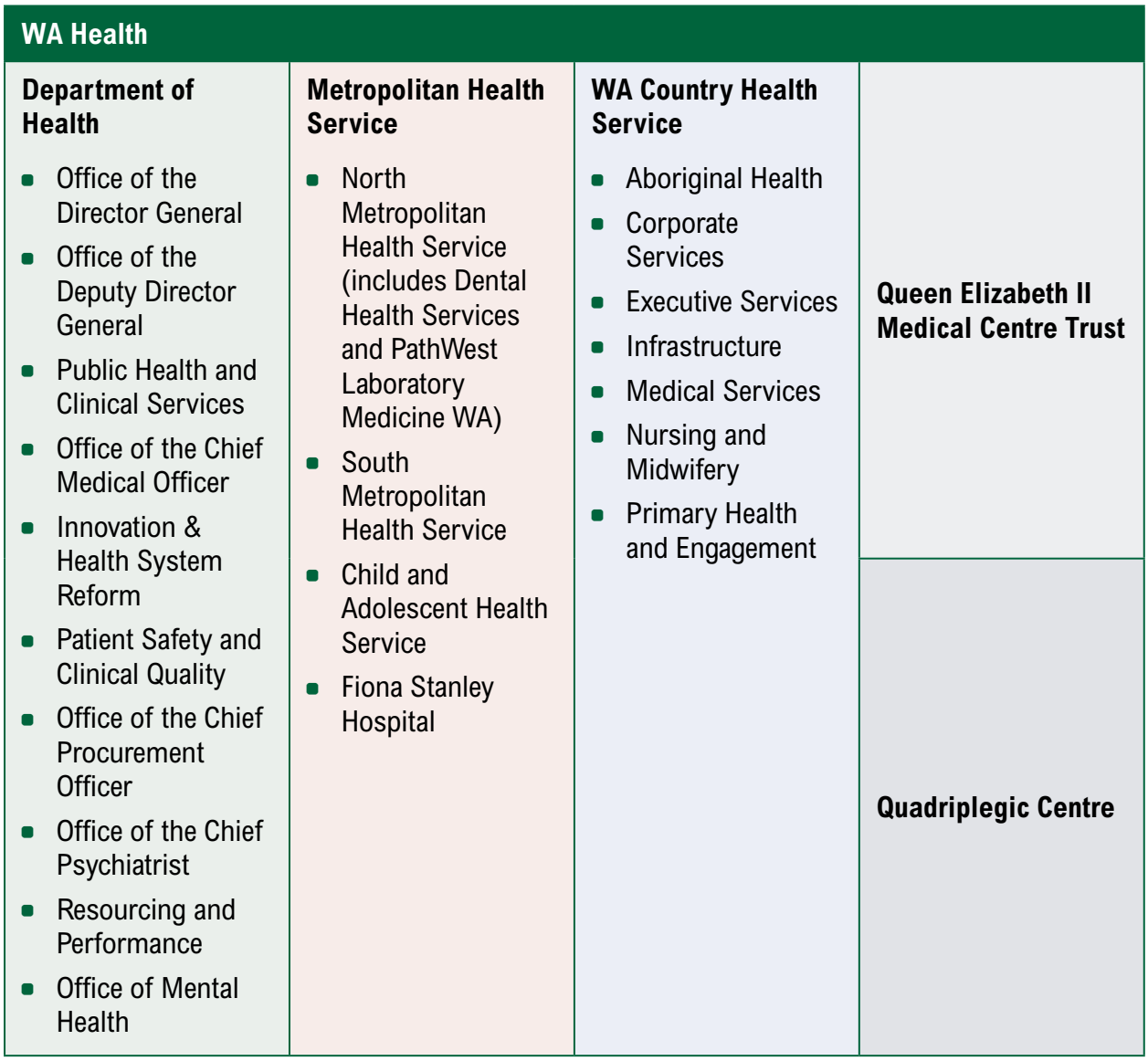
WA Health encompasses five health service areas:

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

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 Department of Health structure displayed in Figure 1 was in place until April 2015. Following this, a restructure occurred at the Department of Health as a result of the WA Health Reform Program.

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, 2014–15.

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

Minister for Health

|

Director General

|

Deputy Director General Department of Health	**Executive Director** Resourcing and Performance	**Group Director Finance** (Chief Finance Officer)
Executive Director Public Health and Clinical Services	**Executive Director** Patient Safety and Clinical Quality	**Chief Medical Officer** (and System Policy and Planning)
Executive Director Office of Mental Health	**Chief Nurse and Midwifery Officer**	**Director** Aboriginal Health
Director Office of 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	**Chief Executive** Fiona Stanley Hospital Commissioning

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	Acting Director General	Prof. Bryant Stokes	Term Contract
Department of Health	Deputy Director General	Rebecca Brown	Term Contract
Innovation & Health System Reform	Operational Director	Gail Milner	Term Contract
Office of the Chief Medical Officer	Chief Medical Officer	Prof. Gary Geelhoed	Term Contract
Office of the Director General	Director	Patsy Turner	Term Contract
Group Director Finance	Chief Financial Officer	Graeme Jones	Term Contract
Patient Safety & Clinical Quality	Acting Executive Director	Olly Campbell	Acting
Office of the Chief Procurement Officer	Chief Procurement Officer	Kylie Towie	Term Contract
Public Health and Clinical Services	Executive Director	Prof. Tarun Weeramanthri	Term Contract
Office of the Chief Psychiatrist	Chief Psychiatrist	Dr Nathan Gibson	Term Contract
Office of Mental Health	Acting Executive Director	Kingsley Burton	Acting
Resourcing and Performance	Acting Executive Director	Angela Kelly	Acting
Aboriginal Health	Acting Director	Wendy Casey	Acting
Public Health and Clinical Services	Chief Nurse & Midwifery Officer	Karen Bradley	Term Contract

The Department of Health's Senior Officer structure displayed above was in place from July 2014 to April 2015. Following this a restructure occurred at the Department of Health as a result of the WA Health Reform Program. 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) to the Department of Health divisions
- providing secretariat support for key coordination meetings and the Health Service Board meetings.

Office of the Deputy Director General

Supports the Director General of Health by:

- supporting key governance changes across WA Health including drafting the new legislation to replace the *Hospitals and Health Services Act 1927* and establishment of interim boards for health services
- providing secretariat support for the WA Health Transition and Reconfiguration Steering Committee and the Health Reform Program Board
- managing the delivery of the Support Services Reform Project, including transitioning Health Information Network, Health Corporate Health Network and Health Supply Network to a combined support services structure.

Office of the Chief Medical Officer

Through the leadership of the Chief Medical Officer:

- supports clinical and health research
- provides support, advice and the development of policy concerning blood, therapeutics and health technology
- provides fertility-related information and resources to the community and oversees the regulation of assisted reproductive technology in WA
- conducts strategic research, planning and projects concerning the medical workforce
- manages recruitment, accreditation, and monitoring of medical pre-vocational training positions.

System Policy and Planning

Sets the strategic direction for the WA Health system towards improvement in health outcomes through:

- coordinating and implementing strategies in the areas of prevention, screening and early detection, equitable access to treatment and efficiency, and effectiveness of cancer control activities
- providing high-level strategic policy and planning advice to drive long-term improvements in Aboriginal health
- providing the primary platform for open communication between community and healthcare providers including through the Clinical Senate.

Office of Mental Health

Leads the strategic planning, coordination, review and reform of public mental health services that includes:

- mental health workforce development
- professional development and leadership programs
- promoting and supporting service growth and service provision
- building resources and knowledge to improve evidence-based care and facilitate innovation
- overseeing development and implementation of mental health information systems for patient management, performance reporting and compliance management
- standardising mental health clinical documentation and policies
- overseeing and managing health service reform recommendations from the *Stokes Review* (2012).

Office of the Chief Psychiatrist

Has responsibility for ensuring patients' rights are protected through the administration of the *Mental Health Act 1996*, and for 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 Western Australia.

Office of Patient Safety and Clinical Quality

Ensures the safety and quality of health services in WA through:

- establishment of safety and quality policy, guidelines and programs
- licensing and regulation of non-government healthcare providers
- 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.

Innovation and Health System Reform

Provides leadership, coordination and expertise to prompt and expedite innovation, change and reform by:

- managing clinical change initiatives and reform projects aimed at improving health service delivery throughout WA
- providing support and direction in the health system to assist with process improvement, service change programs and reform, including policy development and the provision of change facilitation services
- developing and implementing subacute, community and aged care policy and planning
- progressing reform in the areas of community services procurement, aged and community care services, hospital demand management strategies and the interface between hospital, community and residential care
- providing strategic analysis and demographic, epidemiological and utilisation modelling and analysis.

Public Health and Clinical Services

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
- leadership in innovation, advice, information and guidance on system, clinical and workforce issues.

Resourcing and Performance

Responsible for managing the interface of resources and performance with Health Services and the Department of Health divisions by:

- ensuring that the allocation of resources, the purchasing and performance monitoring of publicly-funded health services, and WA Health's infrastructure and workforce 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
- integrating workforce planning with clinical, financial and infrastructure planning.

Office of the Chief Procurement Officer

Oversees professional and strategic procurement planning, policies and procedures across WA Health by:

- delivering training and providing strategic procurement policy advice
- assisting with the standardisation of a wide range of procurement processes, practices and procedures
- conducting reviews of individual procurements and contracts within WA Health divisions and providing detailed reports to the Director General, Deputy Director General and Chief Procurement Officer.

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 2014–15 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 2014–15 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 by:
   - 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**

WA Strategic Outcome
(Whole of Government)

Outcome-based service delivery:

Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians

WA Health strategic intent

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 the best use of funds and resources
- supporting our team.

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

Key effectiveness indicators contributing to Outcome 1

- proportion of people with cancer accessing admitted palliative care services
- response times for patient transport services.

Key effectiveness indicators contributing to Outcome 2

- loss of life from premature death due to identifiable causes of preventable disease or injury
- percentage of fully immunised children
- rate of hospitalisations for selected potentially preventable diseases
- eligible patients on the oral waiting list who have received treatment during the year
- percentage of clients maintaining or improving functional ability while in Transition Care
- rate per 1,000 HACC target population who receive HACC services
- specific HACC contract provider client satisfaction survey.

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 2014–15 was $8 billion. Results for 2014–15 against agreed financial targets (based on Budget statements) are presented in Table 2.

Full details of the Department of Health's financial performance during 2014–15 are provided in the Financial statements.

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

Financial	2014–15 Target $'000	2014–15 Actual $'000	Variation $ +/–
Total cost of service	8,009,452	8,039,055	-29,603
Net cost of service	4,846,427	4,789,204	57,223
Total equity	9,308,623	9,421,256	-112,633
Net increase/decrease in cash held	(174,275)	91,796	-266,071
Approved full time equivalent staff level (salary associated with FTE)	4,622,167	4,594,477	27,690

Note: 2014–15 targets are specified in the 2014–15 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 2014–15 targets is given 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	2014–15 Target	2014–15 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	49.2%	53.1%	3.9%
Response times for patient transport services: Priority 1 calls attended within 15 minutes by St John Ambulance	90%	92.6%	2.6%
Inter-hospital transfers for Priority 1 calls meeting the target contract patient response time by the Royal Flying Doctors Service	80%	81.9%	1.9%
Key efficiency indicators:			
Cost per capita of supporting treatment of patients in public hospitals	$33	$28	-$5
Average cost per home based hospital day of care	$311	$292	-$19
Average cost per home based occasion of service	$124	$117	-$7
Average cost per client receiving contracted palliative care services	$4,734	$5,265	$531
Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Western Australia Service Agreements	$63	$63	$0

Key performance indicators	2014–15 Target	2014–15 Actual	Variation
Outcome 2: Enhanced health and well-being 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	1.5	-0.3
Ischaemic heart disease	2.4	2.5	0.1
Falls	0.2	0.4	0.2
Melanoma	0.5	0.4	-0.1
Percentage of fully immunised children	≥90%	90.1%	0.1
Rate of hospitalisations for selected potentially preventable diseases (per 100,000)	No hospitalisation		N/A
Pertussis		5.50	
Measles		0.46	
Mumps		0.48	
Hepatitis B		0.00	
Rubella		0.00	
Diptheria		0.00	
Poliomyelitis		0.00	
Tetanus		0.00	
Eligible patients on the oral waiting list who have received treatment during the year:			
General practice	1,725	1,718	-7
Oral surgery	1,510	918	-592
Orthodontics	2,310	1,288	-1,022
Paedodontics	780	574	-206
Periodontics	530	286	-244
Other	830	1,131	301
Percentage of clients maintaining or improving functional ability while in transition care	65%	69%	4
Rate per 1,000 Home and Community Care target population who receive Home and Community Care services	343	370	27
Specific Home and Community Care contract provider client satisfaction survey:			
Helps them to be independent	85%	82.9%	-2.1
Improves the quality of life	85%	92.0%	7.0

Key performance indicators	2014–15 Target	2014–15 Actual	Variation
Key efficiency indicators:			
Cost per capita of providing preventive interventions, health promotion and health protection activities	$54	$55	$1
Average cost per dental service provided by the Oral Health Centre of WA	$159	$165	$6
Average cost per person of Home and Community Care services delivered to people with long term disability	$4,111	$3,901	-$210
Average cost per transition care day	$305	$305	$0
Average cost per day of care for non-acute admitted continuing care	$767	$721	-$46
Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	$72	$42	-$30

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 2014–15, WA Health surveyed approximately 8,000 people asking them about their health care experiences during their stay in a general or maternity hospital, or attendance at an emergency department or outpatient clinic.

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

1 Access – getting into hospital
2 Time and care – the time and attention paid 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 a patient places on each of these aspects can vary over time and across patient groups. At the beginning of each Patient Evaluation of Health Services survey, the patient is asked to rank these seven aspects of health care from most important (1) to least important (7). This helps determine the relative importance that the patients placed on each aspect of care. The patient is 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 scores – represent 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 scale scores, weighted by their importance as ranked by patients
- Outcome scale – reflects how patients rate the outcome of their hospital stay (i.e. the impact on physical health and wellbeing).

[1] The mean scale scores do not represent the percentage of people who are satisfied with the service; rather they represent how patients in WA State 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 this year's annual report, results from the following patient groups are presented for all respondents in WA:

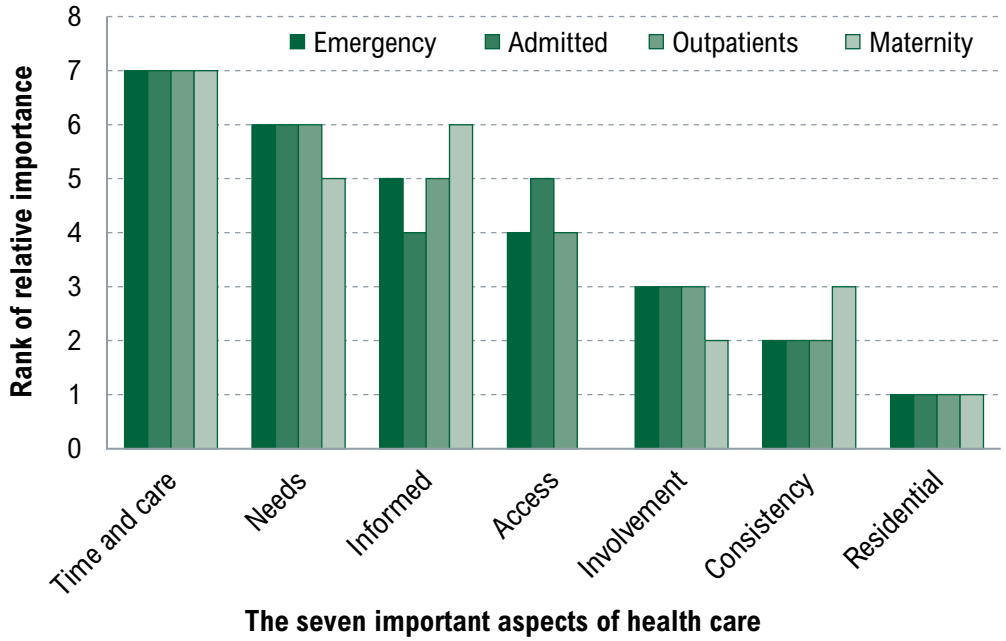
- emergency department patients, aged 16–74 years
- admitted patients, aged 16–74 years who were in hospital from 0–34 nights
- maternity patients
- outpatients aged 16–74 years.

In 2014–15, the survey participation rate was 97 per cent, with 1,490 emergency department patients and 4,387 admitted patients, 1,222 maternity patients and 934 outpatients interviewed.

Order of importance of aspects of health care

In 2014–15, all patient groups ranked time and care as the most important aspect of health care, followed by needs. The exception was maternity patients who ranked being informed as the second most important aspect of care. For the remaining aspects of care both emergency department attendees and outpatients did not vary in their rankings, while admitted patients only differed in that they ranked the importance of access being above informed. The three least important aspects of care for all patient groups were involvement, consistency and residential aspects (see Figure 5).

Figure 5: **The seven aspects of health care ranked by patient groups from most important (7) to least important (1), 2014–15**[2]



[2] The Maternity Survey does not include the access scale

Satisfaction with the aspects of health care

To determine if patient satisfaction with all aspects of health care is increasing, decreasing, or remaining the same over time, comparisons are made with prior year results by patient group.

In 2014–15, mean satisfaction scores rated by emergency department patients were highest for the time and care scale and lowest for the involvement scale (see Table 4). There were no significant differences in satisfaction scale scores for emergency department patients in 2014–15 when compared with prior year scores.

Table 4: **Emergency department patients' mean scale scores, by aspect of health care, 2012–13 to 2014–15**

Emergency department patients (16–74 years)			
Scale	**2012–13**	**2013–14**	**2014–15**
Time and care	87.7	88.6	86.8
Informed	83.0	83.7	82.2
Needs	83.1	83.2	82.2
Consistency	76.9	77.8	76.2
Access	69.9	69.8	69.0
Residential	60.9	61.8	61.3
Involvement	59.9	61.3	60.4

Admitted patients' mean satisfaction scores in 2014–15 were highest for the needs scale and lowest for the residential scale. The 2014–15 access and residential scale scores were significantly higher when compared to 2012–13 and 2013–14, while the time and care scale score was significantly higher when compared to 2012–13 (see Table 5). There were no other significant differences.

Table 5: **Admitted patients' mean scale scores, by aspect of health care, 2012–13 to 2014–15**

Admitted patients (16–74 years)			
Scale	**2012–13**	**2013–14**	**2014–15**
Needs	90.7	90.5	91.3
Time and care	87.7↑	87.9	88.7
Informed	83.6	83.9	84.0
Involvement	74.2	74.5	75.2
Consistency	71.2	72.2	72.0
Access	69.2↑	70.3↑	71.8
Residential	62.7↑	63.4↑	64.8

Notes:

↑ Indicates that the mean scale score for 2014–15 is significantly higher than the comparison score.

In 2014–15, for both maternity patients and outpatients the highest satisfaction score was for the needs scale while the residential scale had the lowest score (see Tables 6 and 7). In 2014–15 the scores for the involvement scale was significantly lower for maternity patients in comparison to 2009. The scores for the time and care scale and the involvement scale were significantly higher for outpatients when compared to 2010–11.

Table 6: **Maternity mean scale scores, by aspect of health care, 2009, 2011–12 and 2014–15**

Maternity patients			
Scale	**2009**	**2011–12**	**2014–15**
Needs	91.4	91.7	91.4
Time and care	87.0	86.2	86.4
Consistency	84.5	83.2	83.5
Informed	81.5	81.8	81.8
Involvement	76.8↓	72.6	74.2
Residential	67.6	67.7	68.6
Access	N/A	N/A	N/A

↓ Indicates that the mean scale score for 2014–15 is significantly lower than comparison score.

Table 7: **Outpatient mean scale scores, by aspect of health care, 2010–11, 2012–13 and 2014–15**

Outpatients (16–74 years)			
Scale	**2010–11**	**2012–13**	**2014–15**
Needs	89.2	90.2	91.2
Time and care	77.7↑	78.9	80.3
Informed	78.8	80.4	79.9
Consistency	75.0	77.1	75.8
Involvement	60.1↑	67.4	68.6
Access	60.2	61.2	61.8
Residential	58.9	59.3	58.8

↑ Indicates that the mean scale score for 2014–15 is significantly higher than the comparison score.

The mean satisfaction scale scores for patients admitted to a hospital in WA in 2014–15 were highest for the needs, and time and care scales. Scores for access and residential scales were significantly lower for patients attending metropolitan hospitals when compared to the State, and for patients attending country hospitals the access and residential scale scores were significantly higher when compared to the State (see Table 8).

Table 8: **Admitted patients' mean scale scores, by location, 2014–15**

Scale	State	Metropolitan	Country
Needs	91.3	90.5	92.0
Time and Care	88.7	88.3	89.1
Informed	84.0	83.3	84.8
Involvement	75.2	74.4	76.2
Consistency	72.0	70.7	73.4
Access	71.8	68.5↓	75.3↑
Residential	64.8	62.9↓	66.7↑

Notes:

↑ Indicates that the location mean scale score for 2014–15 is significantly higher than the State comparison score.
↓ Indicates that the location mean scale score for 2014–15 is significantly lower than the State comparison score.
Mean scale scores by location are only collected for admitted patients.

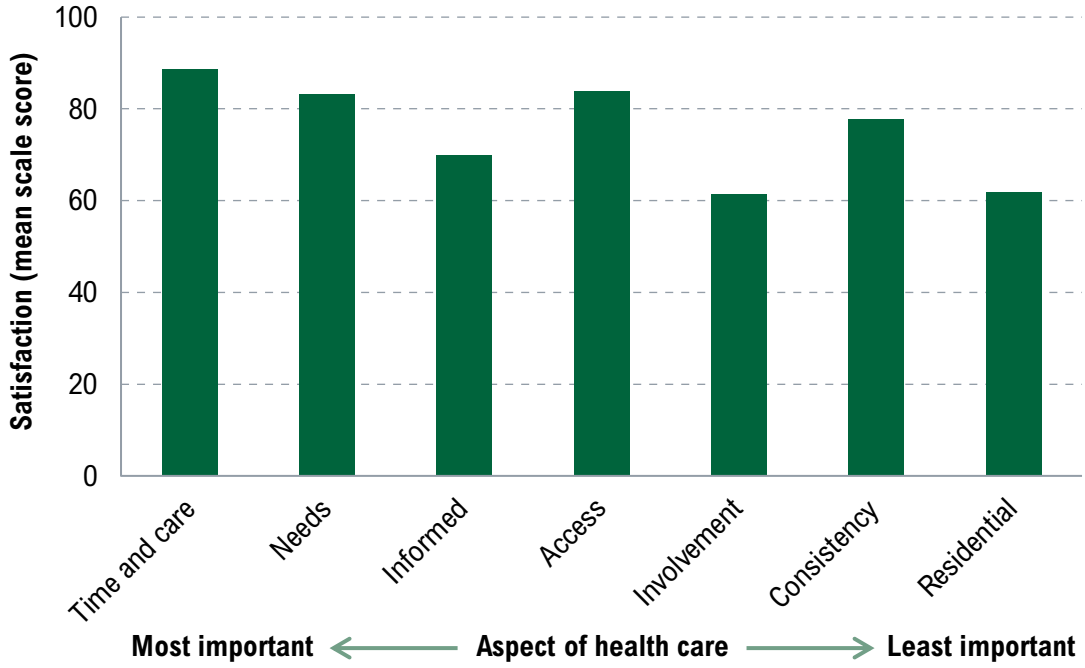
Comparing importance with the satisfaction of aspects of health care

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 2014–15, emergency department patients ranked time and care as the most important aspect of health care, and they were also most satisfied with this aspect.

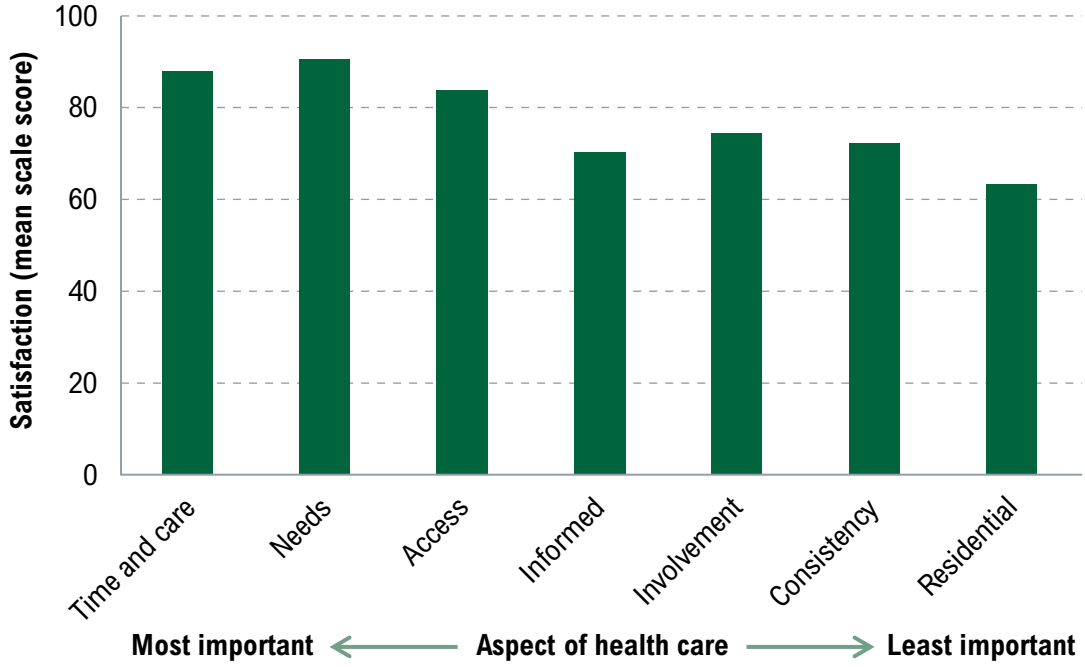
This patient group ranked involvement as the fifth most important aspect of health care; however, involvement was the aspect of emergency department care with which they were least satisfied (see Figure 6).

Figure 6: **Satisfaction with aspects of health care by rank of importance, emergency department patients, 16–74 years, 2014–15**



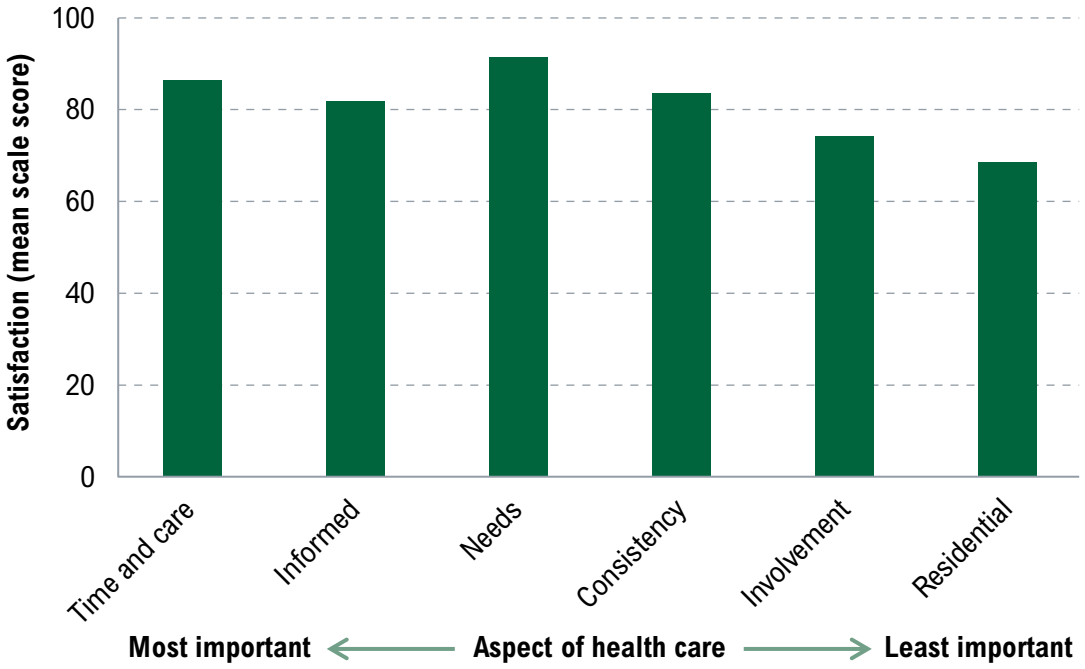
In 2014–15, admitted patients ranked time and care as the most important aspect of health care, however in terms of satisfaction, this aspect was rated second. Admitted patients ranked residential as the least important aspect of health care and it was also rated as the aspect of health care with which they were least satisfied (see Figure 7).

Figure 7: **Satisfaction with aspects of health care by rank of importance, admitted patients, 16–74 years, 2014–15**



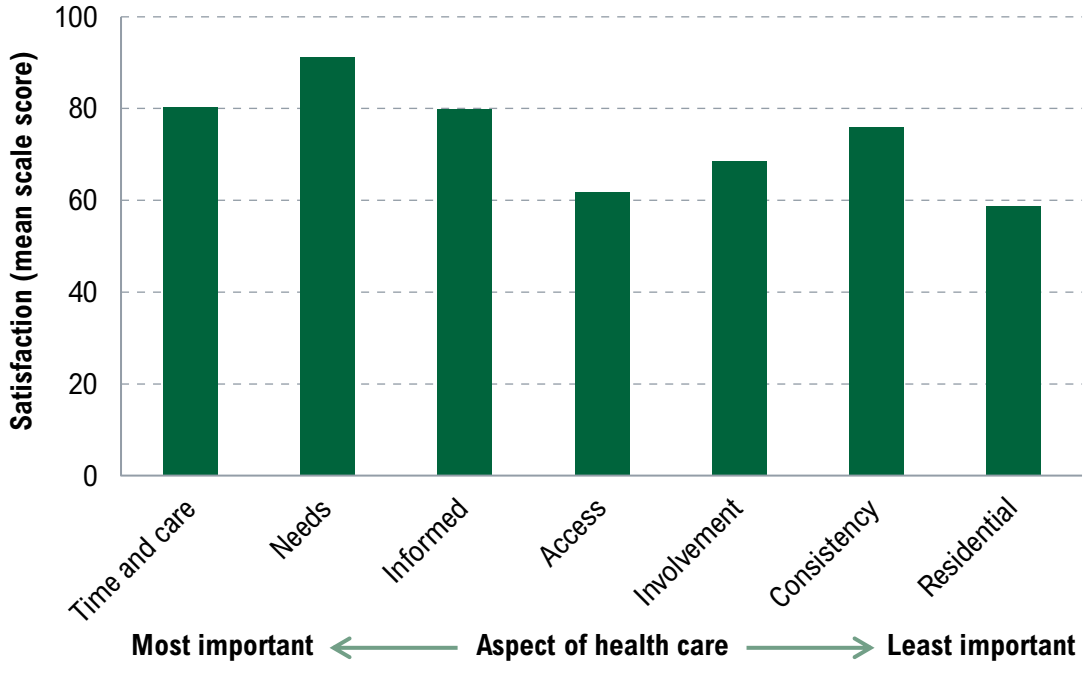
In 2014–15, maternity patients ranked time and care as the most important aspect of health care and residential as the least important aspect of health care. In terms of satisfaction the needs scale was rated first, and the residential scale was rated last (Figure 8).

Figure 8: **Satisfaction with aspects of health care by rank of importance, maternity patients, 2014–15**



In 2014–15, outpatients ranked time and care as the most important aspect of health care and residential as the least important aspect of health care. In terms of satisfaction, the needs scale was rated first, and the residential scale was rated last (Figure 9).

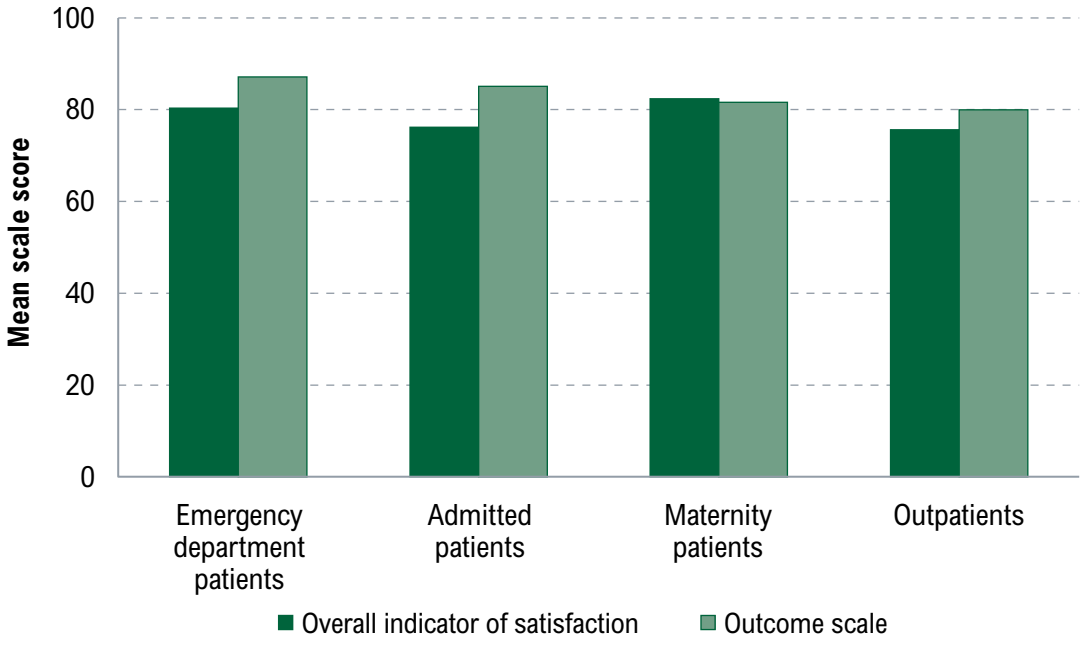
Figure 9: **Satisfaction with aspects of health care by rank of importance, outpatients, 16–74 years, 2014–15**



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 10 shows that emergency department patients, admitted patients and outpatients rated the outcome of their visit higher than their overall indicator of satisfaction. This signifies 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 10: **Patient-rated overall satisfaction with health care compared to their satisfaction of the outcome, emergency department, admitted, maternity, and outpatients, 2014–15**



Significant issues

WA Health continually strives to improve its performance and align its efforts to the four key pillars of the *WA Health Strategic Intent 2010–15*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

In alliance with these pillars, WA Health has continued to deliver health system reform through a broad range of mechanisms in a rapidly changing environment. This has occurred while managing the challenges of current and emerging issues impacting on WA Health's operations.

The *WA Health Strategic Intent 2015–2020* came into effect in December 2014. The Strategic Intent outlines the key direction that the health system will undertake for the next five years and aims to support operational planning that will take into account necessary health service demand management, sustainability and improvement.

WA Health reform

WA Health has commenced a system-wide program of reform to sustain and improve the delivery of quality health care. To oversee the health reform and ensure robust program, project and risk management strategies and practices occur, a Reform Program Office has been established. The Health Reform Program consists of a series of projects including:

- governance reform, which will result in the WA health system transitioning to a more devolved governance model allowing health services to be more autonomous in responding to the changing needs of local communities
- performance reform to create a more integrated and sustainable health system through improvements in leadership and planning which will allow the Department of Health to transition to a 'system manager' role
- support services, governance and operations reform through transparent allocation of resources which will increase ability for clinicians and front-line staff to improve patient outcomes through the delivery of evidence-based, best practice treatment
- procurement and contract management reform supporting standardised and consistent approaches across the system, driving better value and sound decision making.

In 2014–15, key achievements of the WA Health Reform Program include:

- implementation of a new Department of Health Executive structure to enable the set up and transition to a 'system manager' role
- completion of an independent review which resulted in the streamlining of performance reporting and management
- release of the *WA Health ICT Strategy 2015–2018* which will assist in stabilising the existing systems and improve the sharing of information
- introduction of the WA Health Strategic Procurement Program to improve procurement knowledge and awareness of procurement activities and to standardise procurement processes, education, and compliance frameworks
- improvements to the budget and resource allocation process, leading to the development and release of 2015–16 Service Agreements.

Demand and activity

The Department of Health faces a number of challenges in relation to addressing health service demand and activity, including an increasing ageing population combined with an increase in people suffering from chronic health conditions, and lifestyle-related issues. The WA community also has specific expectations around health care that include the need for responsive health services and hospitals that provide safe, high quality services.

A key priority for the Department of Health is to identify and address areas of health service need through clinical service redesign, and strategic and forward planning. The Department developed the *WA Health Clinical Services Framework 2014–2024*, which provides a blueprint to guide the provision of safe, high quality care to the community over the next 10 years.

The Clinical Service Redesign and Improvement Program supports hospital staff to improve clinical efficiencies in patient care processes. The Program assists hospitals to achieve emergency department access and elective surgery performance targets.

Targeted strategies and initiatives directly addressing growth in demand and activity for emergency, inpatient and non-admitted services also continue to be a priority for the Department of Health.

The Demand Management Steering Committee was established to review issues across the continuum of care and to provide high-level advice to senior management. In addition, a new model for ambulance distribution was developed giving service providers enhanced information to ensure patients are redirected to an appropriate emergency department.

In 2014–15, mental health activity within metropolitan and country emergency departments and hospital inpatient settings increased significantly. Mental health reform initiatives to address the current and projected growth in mental health service demand include the implementation of:

- recommendations of the Stokes Review (2012) – concerning mental health service admission, transfer and discharge practices
- *Alcohol and Other Drug Services Plan 2015–2025* – concerning proposed changes to mental health, alcohol and other drug service provision.

In November 2015, mental health services will be required to adopt the new *Mental Health Act 2014* that provides for the treatment, care and support of people who have a mental illness and for the protection of their rights.

The Department of Health also oversees services and policies related to the health care of older Western Australians. With an increase in older people with levels of chronic disease and co-morbidities, ensuring greater availability of non-admitted services to prevent avoidable admissions to hospital is a priority. Strategies to improve the availability of sub-acute care have resulted in an increase in these services to address need.

A key role of the Department of Health is to assess the quality, safety, efficiency and effectiveness of medical devices, medical procedures and pharmaceuticals in order to inform policy, funding and clinical decisions. To support an increase in patient access to cost effective health technologies, the Department of Health is currently working with health services to:

- improve governance and clinical leadership in evaluations of drugs and technologies introduced into public hospitals
- improve the supply and planning of blood and blood products
- develop a statewide medicine formulary to ensure equitable access to treatments across health services and procurement opportunities.

Maintaining adequate levels of funding to support health and medical research in WA is also a focus of the Department of Health, with a total of $14 million provided to support health and medical research in WA in 2014–15.

WA Health acquires goods and services, and community services through procurement and contract management processes. To manage increases in procurement activity and make better use of funds and resources, the Department of Health:

- implemented a Procurement Delegations Schedule and associated Business Rules for WA Health
- developed an Annual Forward Procurement Plan template and guideline to assess and implement a regime of future procurement activity
- introduced a Procurement Data Management System to provide oversight of procurement spend across the WA Health system.

One way the demand for health services can be managed is through the promotion and implementation of public health initiatives to improve the overall health and wellbeing of Western Australians. The Department of Health plays a pivotal role in the development, coordination and delivery of a wide range of statewide public health policies and programs including:

- enabling the community services sector to provide high priority, population-based health promotion programs
- developing effective and strategic State and national policy on preventive health
- intersectional partnerships in chronic disease and injury prevention
- building the evidence base for effective prevention and promotion initiatives
- implementing the *WA Immunisation Strategy 2013–15* to increase vaccination coverage in key areas of WA and for specific subgroups of the population.

Workforce challenges

Workforce challenges for WA Health include ensuring an adequate supply of an appropriately skilled, diverse and flexible workforce within an environment of increasing health service demand, significant funding reforms and major infrastructure development across WA.

The Department of Health has been developing a 10-year strategic workforce plan that will provide a foundation for the whole of health system in planning to meet the high demand for health services. It is expected to be completed by September 2015.

Targeted strategies are also underway to address workforce shortages. Workforce modelling and planning help ensure that the medical workforce in WA's public health system is of the appropriate size and composition to continue to meet the State's healthcare needs. Recent work conducted in this area has resulted in the:

- publication of the *Medical Workforce Report 2013–14*
- development of the Specialist Workforce Capacity Program to identify the short-term and long-term gaps in the medical specialist workforce
- development of the Optimal Consultant Allocation Model to ensure the volume and mix of the consultant medical workforce will meet current and future needs.

Increased demand for hospital, primary and preventative health care has created challenges in providing an adequately skilled nursing and midwifery workforce. To address this issue, the Department of Health has collaborated with key stakeholders to introduce a variety of recruitment, retention and attraction strategies including Refresher Pathways, statewide recruitment, and Transition to Practice Programs. This has resulted in an unprecedented increase in the number of refresher pathways applicants, and graduates applying for positions in graduate transition to practice programs. Due to the success of these programs, availability now exceeds demand and the Department has begun working with public and private providers to promote the number of graduate transition to practice opportunities available.

Department of Health is also engaged in ensuring the availability and development of a highly skilled workforce capable of delivering quality, person-centered mental health services that support client recovery. With the implementation of the *Mental Health Act 2014*, processes and policies are being developed to ensure clinicians working in mental health services are prepared for the changes that will occur.

In addition to addressing workforce volume issues, the Department also provides support to ensure WA Health has a suitably skilled workforce essential for the delivery of services and meeting accountability processes. Recent initiatives have included:

- expanding education and training at major regional hospitals as part of the Rural Clinical Schools Program
- supporting clinical staff transition to more efficient information communication technology and e-health based solutions
- mapping available training for mental health and alcohol staff to a set of core competencies to identify gaps in required training
- assisting in training and providing development opportunities for health professionals and teachers in communicable disease control.

Managing funding reform and cost efficiencies

Health expenditure has grown faster than inflation and the economy as a whole over the past decade, averaging around 10 per cent per annum. In 2014-15, expenditure on Health represented 28 per cent of total general government expenses, compared to 24.7 per cent in 2008–09.

Western Australia, like all other jurisdictions is entering a much tighter fiscal environment. In a growing health system, this requires tight financial management and a focus on driving cost efficiencies to ensure the sustainability of health services, without compromising safety and quality and continuation in the improvement of health outcomes.

In response to the significant decline in general government revenue projections over the forward estimates relative to the 2014–15 budget, the State Government announced a $2 billion cross-government package of revenue and savings measures.

There have also been changes to the Commonwealth financing arrangements with the Commonwealth Government's decision to withdraw from major commitments under the National Health Reform Agreement (NHRA) and the continuation of Activity Based Funding from 2017–18 onwards.

WA Health's budget settings are underpinned by a strategy to converge the cost of providing hospital services in WA to the national average cost. The pricing targets applied in determining the convergence strategy are set with reference to the National Efficient Price (NEP) determined by the Independent Hospital Pricing Authority (IHPA) in its annual Pricing Framework. Inherent in this strategy are efficiencies that WA Health must achieve to control health expenditure growth. This challenge is exacerbated by declining trends in the NEP, a reflection of other states reducing their unit costs faster than WA.

The unit cost of providing hospital services in WA continues to exceed the national average and is increasing at a rate that is higher than the national average. This is partly a consequence of WA having some unique funding issues based around its size, geographical dispersion and level of unavoidable costs that make it challenging to reduce costs in line with other jurisdictions.

WA Health is also undergoing major infrastructure and service reconfiguration resulting from the commissioning of new hospitals. Key elements of this include service reconfiguration in the South Metropolitan Health Service (with the commencement of operations at Fiona Stanley Hospital); the opening of Midland Public Hospital in late 2015 and associated reconfiguration within the North Metropolitan Health Service; the opening of Perth Children's Hospital, scheduled for 2016, transitioning from Princess Margaret Hospital; and increased bed capacity at Joondalup Health Campus.

The financial and reconfiguration challenges present further imperatives for change which require a transformation in WA Health system governance and financing. The corrective measures announced by Government will assist WA Health in achieving price convergence, however, it is essential that WA Health increases the efficiency of resource management and health service delivery to meet the rising care demand while maintaining and improving the quality of care. As previously noted, WA Health has commenced a comprehensive system-wide Reform Program to assist in driving the efficiencies required to shift the current high cost base towards national benchmarks.

Health inequalities

WA Health is actively involved in addressing inequities through targeted interventions to prevent and manage chronic disease and the provision of, and accessibility to, appropriate health services. This is prevalent for people who live in rural and remote areas of WA, live with a disability or mental illness, are Aboriginal or are from culturally and linguistically diverse communities.

Chronic diseases include heart disease, stroke, some types of cancer, type 2 diabetes and respiratory diseases such as chronic obstructive pulmonary disease and asthma. The Department of Health supports chronic disease prevention among priority groups through policy development and purchasing of community services.

The Residential Care Line continues to support staff at residential aged care facilities to better care for older people with complex health care needs. In 2014–15, service availability hours for this outreach service were increased, and the formalised education program continued across the metropolitan area.

The Department of Health is developing multi-disciplinary care pathways including an improved stroke care plan for rural and remote patients, which will assist Aboriginal people who have a much higher stroke disease burden. A framework for improvement in care for patients with cognitive impairments was implemented in public hospitals in 2014–15.

Commonwealth funding was secured for continuation of the Quitline Aboriginal Liaison Team Project. In addition, e-learning and face-to-face seminars on Aboriginal cultural learning and diversity and multicultural health issues support community service providers.

The care and treatment of people living with mental health issues continues to be a priority, with ongoing implementation of major reform initiatives to increase the availability of:

- high quality, efficient hospital-based services in the right location
- community support and treatment services
- community bed-based services such as residential rehabilitation and step up, step down services
- specialised services that cater for young people, Aboriginal people and transcultural groups.

Development of the *Mental Health Agreement 2014* will improve upon the rights and protection of involuntary patients and Aboriginal people to ensure mentally unwell patients receive the best care in a safe environment.

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Disclosure and compliance

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 2015, 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.

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
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.

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 2015 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.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

Report on Controls
I have audited the controls exercised by the Department of Health during the year ended 30 June 2015.

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.

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
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.

Opinion
In my opinion, 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 2015.

Report on the Key Performance Indicators
I have audited the key performance indicators of the Department of Health for the year ended 30 June 2015.

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

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
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.

Opinion
In my opinion, 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 2015.

Independence
In conducting this audit, 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 2015 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
18 September 2015

Certification of financial statements

DEPARTMENT OF HEALTH

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2015

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 2015 and financial position as at 30 June 2015.

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.

Graeme Jones
CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 16 September 2015

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

Date: 16 September 2015

Financial statements

Department of Health

Statement of Comprehensive Income

For the year ended 30 June 2015

	Note	2015 $000	2014 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	6	96,418	86,905
Contracts for services	7	624,410	812,417
Supplies and services	8	53,839	50,926
Grants and subsidies	9	5,940,013	5,142,372
Depreciation expense	10	577	5,301
Finance costs	11	-	793
Loss on disposal of non-current assets	12	7	3
Contribution to Capital Works Fund	13	42,352	17,257
Other expenses	14	24,116	25,181
Total cost of services		**6,781,732**	**6,141,155**
INCOME			
Revenue			
User charges and fees		5,781	5,736
Commonwealth grants and contributions	15	1,951,838	1,831,196
Other grants and contributions	16	9,210	21,765
Finance income	17	2,024	957
Donation revenue	18	1,000	1,000
Other revenue		800	3,258
Total revenue		**1,970,653**	**1,863,912**
Total income other than income from State Government		**1,970,653**	**1,863,912**
NET COST OF SERVICES		**4,811,079**	**4,277,243**
INCOME FROM STATE GOVERNMENT	19		
Service appropriations		4,726,672	4,237,876
Assets transferred		11,243	1,456
Services received free of charge		2,377	2,215
Royalties for Regions Fund		57,438	70,013
Total income from State Government		**4,797,730**	**4,311,560**
(DEFICIT)/SURPLUS FOR THE PERIOD		**(13,349)**	**34,317**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	32	2,579	2,533
Total other comprehensive income		**2,579**	**2,533**
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE PERIOD		**(10,770)**	**36,850**

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 2015

	Note	2015 $000	2014 $000
ASSETS			
Current Assets			
Cash and cash equivalents	33	93,030	26,212
Restricted cash and cash equivalents	20, 33	339,108	376,684
Inventories	21	16,163	12,685
Receivables	22	34,418	39,389
Other current assets	27	813	640
Total Current Assets		483,532	455,610
Non-Current Assets			
Restricted cash and cash equivalents	20, 33	-	57,916
Amounts receivable for services	23	100,417	98,958
Finance lease receivable	24	2,981	957
Property, plant and equipment	25	26,744	24,476
Other non-current assets	27	4,201	4,811
Total Non-Current Assets		134,343	187,118
Total Assets		**617,875**	**642,728**
LIABILITIES			
Current Liabilities			
Payables	29	46,712	63,148
Provisions	30	21,846	18,811
Other current liabilities	31	197	1,100
Total Current Liabilities		68,755	83,059
Non-Current Liabilities			
Provisions	30	3,627	3,406
Total Non-Current Liabilities		3,627	3,406
Total Liabilities		**72,382**	**86,465**
NET ASSETS		**545,493**	**556,263**
EQUITY	32		
Contributed equity		(143,169)	(143,169)
Reserves		305,690	303,111
Accumulated surplus		382,972	396,321
TOTAL EQUITY		**545,493**	**556,263**

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 2015

	Note	2015 $000	2014 $000
CONTRIBUTED EQUITY	32		
Balance at start of period		(143,169)	315,001
Transactions with owners in their capacity as owners:			
Contributions by owners		-	49,728
Distributions to owners		-	(507,898)
Balance at end of period		**(143,169)**	**(143,169)**
RESERVES	32		
Asset Revaluation Reserve			
Balance at start of period		303,111	300,578
Other comprehensive income for the period		2,579	2,533
Balance at end of period		**305,690**	**303,111**
ACCUMULATED SURPLUS	32		
Balance at start of period		396,321	362,004
(Deficit)/Surplus for the period		(13,349)	34,317
Balance at end of period		**382,972**	**396,321**
TOTAL EQUITY			
Balance at start of period		556,263	977,583
Total comprehensive income/(loss) for the year		(10,770)	36,850
Transactions with owners in their capacity as owners		-	(458,170)
Balance at end of period		**545,493**	**556,263**

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 2015

	Note	2015 $000 Inflows (Outflows)	2014 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		4,360,257	4,018,916
Capital appropriations	32	-	49,728
Royalties for Regions Fund	19	57,438	70,013
Assets transferred	19	11,254	-
Net cash provided by State Government		4,428,949	4,138,657
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(92,459)	(85,890)
Supplies and services		(708,026)	(867,428)
Grants and subsidies		(5,575,055)	(4,937,336)
Finance costs		-	(793)
Contribution to Capital Works Fund		(42,352)	(17,257)
GST payments on purchases		(374,202)	(384,505)
Receipts			
User charges and fees		5,779	5,578
Commonwealth grants and contributions		1,940,814	1,816,734
GST receipts on sales		22,074	19,970
GST refunds from taxation authority		355,174	362,372
Other receipts		10,915	28,224
Net cash used in operating activities	33	(4,457,338)	(4,060,331)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(285)	(77,051)
Proceeds from the sale of non-current physical assets		-	1
Net cash used in investing activities		(285)	(77,050)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		-	(1,719)
Net cash used in financing activities		-	(1,719)
Net decrease in cash and cash equivalents		(28,674)	(443)
Cash and cash equivalents at the beginning of the period		460,812	502,123
Cash and cash equivalents transferred to other agencies		-	(40,868)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	33	432,138	460,812

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 2015

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	20,980	26,967	1,290	1,286	2,479	1,710	-	-
Contracts for services	38,215	197,620	21,927	24,897	24,612	23,823	278	45,126
Supplies and services	1,732	3,095	232	233	465	372	-	-
Grants and subsidies	3,808,640	3,259,765	5,115	4,471	8,629	7,517	664,644	575,712
Depreciation expense	74	1,477	6	129	12	151	-	-
Finance costs	-	632	-	-	-	1	-	145
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Contribution to Capital Works Fund	3,780	5,082	1,013	447	1,867	518	-	-
Other expenses	12,803	8,787	196	444	517	577	-	9
Total cost of services	3,886,224	3,503,425	29,779	31,907	38,581	34,669	664,922	620,992
Income								
User charges and fees	333	339	30	22	55	26	-	-
Commonwealth grants and contributions	1,137,086	1,067,007	4,909	5,399	2,174	4,917	154,720	144,813
Other grants and contributions	-	758	-	67	-	77	-	-
Finance income	178	282	48	25	88	29	-	-
Donation revenue	1,000	1,000	-	-	-	-	-	-
Other revenue	141	1,481	7	76	12	88	-	-
Total income other than income from State Government	1,138,738	1,070,867	4,994	5,589	2,329	5,137	154,720	144,813
NET COST OF SERVICES	2,747,486	2,432,558	24,785	26,318	36,252	29,532	510,202	476,179
Income from State Government								
Service appropriations	2,698,690	2,414,939	24,378	29,888	35,669	35,567	501,115	463,600
Assets transferred	-	(15)	-	-	-	-	-	-
Services received free of charge	209	651	56	57	103	66	-	-
Royalties for Regions Fund	9,147	7,796	-	-	3,332	2,985	7,765	7,617
Total income from State Government	2,708,046	2,423,371	24,434	29,945	39,104	38,618	508,880	471,217
(DEFICIT)/SURPLUS FOR THE PERIOD	(39,440)	(9,187)	(351)	3,627	2,852	9,086	(1,322)	(4,962)

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 2015

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	-	-	8,549	5,311	38,046	33,597	715	476
Contracts for services	-	3,519	122,253	114,487	55,475	50,857	10,624	13,093
Supplies and services	-	-	1,964	1,343	41,832	42,582	2,996	120
Grants and subsidies	804,556	697,644	86,026	39,366	386,519	354,305	67,397	84,633
Depreciation expense	-	-	47	746	311	960	4	67
Finance costs	-	15	-	-	-	-	-	-
Loss on disposal of non-current assets	-	-	-	-	7	3	-	-
Contribution to Capital Works Fund	-	-	8,570	2,578	7,312	2,333	717	231
Other expenses	-	-	1,692	2,575	4,844	6,451	138	229
Total cost of services	804,556	701,178	229,101	166,406	534,346	491,088	82,591	98,849
Income								
User charges and fees	-	-	255	127	4,500	4,604	21	11
Commonwealth grants and contributions	224,180	206,447	3,545	11,795	168,390	152,252	21,964	626
Other grants and contributions	-	-	-	384	9,062	7,973	-	34
Finance income	-	-	404	143	345	129	34	13
Donation revenue	-	-	-	-	-	-	-	-
Other revenue	-	-	430	546	75	-	5	39
Total income other than income from State Government	224,180	206,447	4,634	12,995	182,372	164,958	22,024	723
NET COST OF SERVICES	580,376	494,731	224,467	153,411	351,974	326,130	60,567	98,126
Income from State Government								
Service appropriations	570,041	493,395	220,759	113,463	345,954	322,988	59,513	100,164
Assets transferred	-	-	-	-	11,243	1,471	-	-
Services received free of charge	-	-	475	331	405	299	40	30
Royalties for Regions Fund	1,596	1,493	28,407	42,601	4,689	4,330	220	206
Total income from State Government	571,637	494,888	249,641	156,395	362,291	329,088	59,773	100,400
(DEFICIT)/SURPLUS FOR THE PERIOD	(8,739)	157	25,174	2,984	10,317	2,958	(794)	2,274

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 2015

	Continuing Care		Mental Health (a)		TOTAL	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES						
Expenses						
Employee benefits expense	24,359	17,558	-	-	96,418	86,905
Contracts for services	350,686	327,168	340	11,827	624,410	812,417
Supplies and services	4,618	3,181	-	-	53,839	50,926
Grants and subsidies	108,487	118,959	-	-	5,940,013	5,142,372
Depreciation expense	123	1,771	-	-	577	5,301
Finance costs	-	-	-	-	-	793
Loss on disposal of non-current assets	-	-	-	-	7	3
Contribution to Capital Works Fund	19,093	6,068	-	-	42,352	17,257
Other expenses	3,926	6,109		-	24,116	25,181
Total cost of services	511,292	480,814	340	11,827	6,781,732	6,141,155
Income						
User charges and fees	587	607	-	-	5,781	5,736
Commonwealth grants and contributions	234,870	237,940	-	-	1,951,838	1,831,196
Other grants and contributions	-	904	148	11,568	9,210	21,765
Finance income	927	336	-	-	2,024	957
Donation revenue	-	-	-	-	1,000	1,000
Other revenue	130	1,028	-	-	800	3,258
Total income other than income from State Government	236,514	240,815	148	11,568	1,970,653	1,863,912
NET COST OF SERVICES	274,778	239,999	192	259	4,811,079	4,277,243
Income from State Government						
Service appropriations	270,553	263,872	-	-	4,726,672	4,237,876
Assets transferred	-	-	-	-	11,243	1,456
Services received free of charge	1,089	780	-	-	2,377	2,215
Royalties for Regions Fund	2,282	2,985	-	-	57,438	70,013
Total income from State Government	273,924	267,637	-	-	4,797,730	4,311,560
(DEFICIT)/SURPLUS FOR THE PERIOD	(854)	27,638	(192)	(259)	(13,349)	34,317

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

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

Department of Health

Schedule of Assets and Liabilities by Service
As at 30 June 2015

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
Assets								
Current assets	120,251	108,769	5,420	4,575	9,792	26,431	159,414	198,590
Non-current assets	23,838	75,526	2,213	2,885	8,078	7,539	-	4,854
Total Assets	144,089	184,295	7,633	7,460	17,870	33,970	159,414	203,444
Liabilities								
Current liabilities	10,179	25,254	1,310	1,742	3,293	2,437	46	453
Non-current liabilities	895	1,085	34	43	79	71	-	-
Total Liabilities	11,074	26,339	1,344	1,785	3,372	2,508	46	453
NET ASSETS	133,015	157,956	6,289	5,675	14,498	31,462	159,368	202,991

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 2015

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
Assets								
Current assets	11,086	309	21,774	9,657	70,749	56,164	8,982	1,148
Non-current assets	-	8,090	17,407	12,687	35,307	36,419	1,456	1,156
-	11,086	8,399	39,181	22,344	106,056	92,583	10,438	2,304
Liabilities								
Current liabilities	-	16	9,401	9,693	19,905	19,069	1,543	1,751
Non-current liabilities	-	-	280	170	1,512	1,406	23	15
-	-	16	9,681	9,863	21,417	20,475	1,566	1,766
NET ASSETS	11,086	8,383	29,500	12,481	84,639	72,108	8,872	538

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 2015

	Continuing Care		Mental Health		TOTAL	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
Assets						
Current assets	76,064	49,784	-	183	483,532	455,610
Non-current assets	46,044	37,423	-	539	134,343	187,118
-	122,108	87,207	-	722	617,875	642,728
Liabilities						
Current liabilities	23,078	22,557	-	87	68,755	83,059
Non-current liabilities	804	616	-	-	3,627	3,406
-	23,882	23,173	-	87	72,382	86,465
NET ASSETS	98,226	64,034	-	635	545,493	556,263

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

Department of Health

Summary of Consolidated Account Appropriations and Income Estimates

For the year ended 30 June 2015

	2015 Estimate $000	2015 Actual $000	Variance $000	2015 Actual $000	2014 Actual $000	Variance $000
Delivery of Services						
Item 13 Net amount appropriated to deliver services	4,577,949	4,597,359	19,410	4,597,359	4,068,016	529,343
Section 25 transfer of service appropriation	-	7,133	7,133	7,133	49,197	(42,064)
Amount Authorised by Other Statutes						
- Salaries and Allowances Act 1975	680	680	-	680	663	17
- Lotteries Commission Act 1990	122,227	121,500	(727)	121,500	120,000	1,500
Total appropriations provided to deliver services	4,700,856	4,726,672	25,816	4,726,672	4,237,876	488,796
Capital						
Item 118 Capital appropriations	269,414	245,284	(24,130)	245,284	329,441	(84,157)
GRAND TOTAL	4,970,270	4,971,956	1,686	4,971,956	4,567,317	404,639
Details of Expenses by Service						
Public Hospital Admitted Patients	4,267,258	4,332,761	65,503	4,332,761	3,988,145	344,616
Home-Based Hospital Programs	44,929	39,936	(4,993)	39,936	41,795	(1,859)
Palliative Care	31,859	36,910	5,051	36,910	30,553	6,357
Emergency Department	721,693	722,379	686	722,379	643,988	78,391
Public Hospital Non-Admitted Patients	919,517	965,384	45,867	965,384	802,139	163,245
Patient Transport	209,916	207,033	(2,883)	207,033	195,504	11,530
Prevention, Promotion & Protection	603,506	544,923	(58,583)	544,923	510,606	34,317
Dental Health	124,300	99,175	(25,125)	99,175	93,427	5,748
Continuing Care	500,503	459,711	(40,792)	459,711	487,787	(28,076)
Mental Health	585,971	663,642	77,671	663,642	630,472	33,170
Total Cost of Services	8,009,452	8,071,854	62,402	8,071,854	7,424,416	647,439
Less Total income	(3,163,025)	(3,249,851)	(86,826)	(3,249,851)	(2,974,705)	(275,146)
Net Cost of Services	4,846,427	4,822,003	(24,424)	4,822,003	4,449,711	372,293
Adjustments (a)	(145,571)	(95,331)	50,240	(95,331)	(211,835)	116,504
Total appropriations provided to deliver services	4,700,856	4,726,672	25,816	4,726,672	4,237,876	488,797
Capital Expenditure						
Purchase of non-current physical assets	993,592	587,991	(405,601)	587,991	905,066	(317,075)
Repayment of borrowings	77,581	59,185	(18,396)	59,185	20,586	38,599
Adjustments for other funding sources (b)	(801,759)	(401,892)	399,867	(401,892)	(596,211)	194,319
Capital appropriations	269,414	245,284	(24,130)	245,284	329,441	(84,157)

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

(a) Adjustments comprise movements in cash balances, movements in accrual items such as receivables and payables, $57.438 million Royalties for Regions Fund and $2.377 million resources received free of charge from other state government agencies.

(b) Adjustments for the ($401.892 million) comprise $256.414 million funding for New Children's Hospital, $26.779 million funding for Royalties for Regions, $125.028 million CWP Treasury Administered funding and include movements in cash balances and other accrual items such as receivables and payables.

Note 38 'Explanatory statement' provides details of any significant variations between estimates and actual results for 2015 and between actual results for 2015 and 2014.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

Note 1 Australian Accounting Standards

General

The Department's financial statements for the year ended 30 June 2015 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*'.

The Under Treasurer has approved the partial exemption from the prohibition on early adoption of Australian Accounting Standards. The exemption allows WA Not-for-Profit public sector agencies to adopt AASB 2015-7 Amendments to Australian Accounting Standards-Fair Value Disclosures of Not-for-Profit Public Sector Entities. The Department has early adopted AASB 2015-7 during the annual reporting period ended 30 June 2015.

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 and buildings 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 45 '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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

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 46 'Administered assets and liabilities' and note 47 '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), 'Rehabilitation in the Home' (RITH) 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. These services are provided by WA Health Services and contracted non-government providers.

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.

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 include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people and specialist and general dental and oral healthcare provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

Continuing Care

Aged and continuing care services include the HACC Program, Transition Care programs, residential care in rural areas, chronic illness support and non-government continuing care programs. The Healthcare activities provided under this service includes domestic assistance, respite, food and meal services, services for frail or younger persons with a disability unable to access Commonwealth aged care, nursing home care and chronic disease support services.

Mental Health
Contracted mental health services includes specialist inpatient mental health care delivered in designated ward and community-based mental health services, provided by Health Services under an agreement with the Mental Health Commission.

(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 32 'Equity'.

While Metropolitan Health Service (MHS) has previously had full responsibility for managing the Joondalup Health Campus, Peel Health Campus and Midland Health Campus contracts, they have previously been reported within the annual statutory accounts of the Department of Health rather than MHS. This was a technical reporting requirement because of the previous inability under the Hospitals and Health Services Act 1927 which precluded hospital boards from applying money to fund services provided by private hospitals non government providers. The recent amendment of section 21 of the Hospitals and Health Services Act 1927 included the National Health Funding Pool Bill 2012 which clarified the power of the public hospital boards to apply money allocated to them to fund the provision of services by private hospitals and non government providers in their own right rather than have the Department of Health make these payments in the name of the State. The Minister for Health and the Department of Treasury have formally designated the transfer of the WA Health assets and liabilities under these contracts as a contribution by owner which will form part of the contributed equity of the Metropolitan Health Service. Accordingly the relevant assets and liabilities under these contracts as at 31 December 2013 were transferred from the Department of Health to MHS from 1 January 2014. Refer to note 25 'Property, plant and equipment', note 27 'Other assets', note 29 'Payables', and note 32 'Equity'.

(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 19 'Income from State Government' for further information.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

Note 2 Summary of significant accounting policies (continued)

(e) Income (continued)

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 2014-2015 Budget Statements, the Department retained $394m in 2015 ($416m in 2014) from the following:

. proceeds from fees and charges;
· sale of goods;
· Commonwealth specific purpose grants and contributions;
· one-off gains with a value of less than $10,000 derived from the sale of property other than real property; 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

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

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 and buildings is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings 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 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.

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 25 'Property, plant and equipment' and note 26 'Fair value measurements' for further information on revaluations.

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

Derecognition

Upon disposal or derecognition of an item of property, plant and equipment, 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 25 '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
* 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.

Depreciation (continued)

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

Buildings	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

(g) Impairment of assets

Property, plant and equipment 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.

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 28 'Impairment of Assets' for the outcome of impairment reviews and testing.

Refer also to note 2(o) 'Receivables' and note 22 '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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

Note 2 Summary of significant accounting policies (continued)

(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; and
- Amounts receivable for services
- Finance Lease Receivables

Financial Liabilities
- Payables; and
- Borrowings (finance lease liabilities)

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 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 29 '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 20 '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.

Note 2 Summary of significant accounting policies (continued)

(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 23 'Amounts receivable for services' and note 19 '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 21 '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, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, 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 22 '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 29 'Payables'.

(q) Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

(r) 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

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 of 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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

Note 2 Summary of significant accounting policies (continued)

(r) Provisions (continued)

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.

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(s) '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 14 'Other expenses'

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

Note 2 Summary of significant accounting policies (continued)

(s) Superannuation expense

Superannuation expense in the Statement of Comprehensive Income comprises of employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBS or other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the Consolidated Account by the GESB.

(t) 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.

(u) 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.

(v) 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 7.2%. 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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

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 2014 that impacted on the Department.

Title	
AASB 10	*Consolidated Financial Statements* This Standard, issued in August 2011, supersedes AASB 127 *Consolidated and Separate Financial Statements* and Int 112 *Consolidation – Special Purpose Entities*, introducing a number of changes to accounting treatments. The Department has received an exemption from the application of paragraph 4(iv) of Treasurer's Instruction 1105 Consolidated Financial Statements and paragraph 7(ix) of Treasurer's Instructions 1101 Application of Australian Accounting Standards and Other Pronouncements. These exemptions apply to the 2014/15 and 2015/16 reporting periods.
AASB 1031	*Materiality* This Standard supersedes AASB 1031 (February 2010), removing Australian guidance on materiality not available in IFRSs and refers to guidance on materiality in other Australian pronouncements. There is no financial impact.
AASB 1055	*Budgetary Reporting* This Standard requires specific budgetary disclosures in the general purpose financial statements of not-for-profit entities within the General Government Sector. The Department will be required to disclose additional budgetary information and explanations of major variances between actual and budgeted amounts, though there is no financial impact.
AASB 2013-3	*Amendments to AASB 136 – Recoverable Amount Disclosures for Non-Financial Assets* This Standard introduces editorial and disclosure changes. There is no financial impact.
AASB 2013-8	*Amendments to Australian Accounting Standards Australian Implementation Guidance for Not-for-Profit Entities - Control and Structured Entities [AASB 10, 12 & 1049].* The amendments, issued in October 2013, provide significant guidance in determining whether a not-for-profit entity controls another entity when financial returns are not a key attribute of the investor's relationship. The Standard has no financial impact in its own right, rather the impact results from the adoption of the amended AASB 10.
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part B of this omnibus Standard makes amendments to other Standards arising from the deletion of references to AASB 1031 in other Standards for periods beginning on or after 1 January 2014. It has no financial impact.
AASB 2014-1	*Amendments to Australian Accounting Standards* Part A of this Standard consists primarily of clarifications to Accounting Standards and has no financial impact for the Department. Part B of this Standard has no financial impact as the Department contributes to schemes that are either defined contribution plans, or deemed to be defined contribution plans. Part C of this Standard has no financial impact as it removes references to AASB 1031 Materiality from a number of Accounting Standards.
AASB 2015-7	*Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities*

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

Future impact of Australian Accounting Standards not yet operative

The Standard relieves not-for-profit public sector entities from the reporting burden associated with various disclosures required by AASB 13 for assets within the scope of AASB 116 that are held primarily for their current service potential rather than to generate future net cash inflows. It has no financial impact.

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 Standards - 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 2017
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
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments* Part C of this omnibus 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.	1 Jul 2015
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 2015
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

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

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

Future impact of Australian Accounting Standards not yet operative (continued)

Title		Operative for reporting periods beginning on/after
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 2017
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 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 the Standard.	1 Jan 2015
AASB 2015-1	*Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting 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 not yet determined the application or the potential impact of the Standard.	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 2015-3	*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.	1 Jul 2015
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

		2015 $000	2014 $000
Note 6	**Employee benefits expense**		
	Salaries and wages (a)	88,438	79,727
	Superannuation - defined contribution plans (b)	7,980	7,178
		96,418	86,905

(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.

Redundancy payments of $0.928 million were made in 2014/15 ($2.713 million in 2013/14).

Employment on-costs (workers' compensation insurance) are included at note 14 'Other expenses'.

Note 7	**Contracts for services**		
	Public patients services (a)	719	185,624
	Home and community care	268,716	248,623
	Patient transport service	119,512	112,474
	Other aged care services	107,954	118,715
	Mental health	340	11,827
	Blood and organs	31,085	32,889
	Aboriginal health	10,194	7,664
	Palliative care	4,699	7,941
	Oral health	10,231	12,619
	Other contracts	70,960	74,041
		624,410	812,417

(a) Private hospitals and non-government organisations are contracted to provide various services to public patients and the community. The reduction in expenditure is mainly due to the transfer of Joondalup and Peel Health Campuses to Metropolitan Health Service on 1 January 2014.

Note 8	**Supplies and services**		
	Medical supplies	42,581	39,658
	Other consumables	1,798	1,704
	Operating lease rentals	9,460	9,564
		53,839	50,926

Note 9	**Grants and subsidies**		
	Recurrent		
	Funding for the Delivery of Health Services by Autonomous Statutory Authorities (a):		
	Metropolitan Health Service	4,540,200	3,849,524
	WA Country Health Service	1,358,568	1,258,702
	Quadriplegic Centre Board	11,304	9,656
	Queen Elizabeth II Medical Centre Trust	258	285
	Research and development grants	20,017	18,011
	Spectacle subsidy scheme	2,533	2,237
	Other	7,133	3,957
		5,940,013	5,142,372

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

Note 10	**Depreciation expense**		
	Buildings	425	4,440
	Computer equipment	26	25
	Furniture and fittings	3	20
	Other plant and equipment	123	816
		577	5,301

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

		2015 $000	2014 $000
Note 11	**Finance costs**		
	Finance lease charges	-	793
Note 12	**Loss on disposal of non-current assets**		
	Carrying amount of non-current assets disposed:		
	Property, plant and equipment	7	4
	Proceeds from disposal of non-current assets		
	Property, plant and equipment	-	(1)
	Net loss	7	3

Refer to note 25 'Property, plant and equipment'.

Note 13	**Contribution to Capital Works Fund**	42,352	17,257

$42.352 million was paid to the Capital Works Fund during the 2014-15 financial year, an administered trust account of the Department, to fund the capital works program for the Health Services.

Note 14	**Other expenses**		
	Advertising	1,410	959
	Act of Grace payment (d)	8,380	-
	Communication	933	1,042
	Computer related expenses	1,761	850
	Doubtful debts expense	-	10
	Insurance	179	187
	Legal expenses	1,549	1,139
	Other employee related expenses	2,530	2,479
	Promotional expenses	1	9
	Repairs and maintenance	735	924
	Scholarships	2,149	1,867
	Travel related expenses	568	769
	Workers' compensation insurance (a)	992	497
	Freight and cartage	771	655
	Special functions	438	848
	Payment to Consolidated Fund (b)	-	6,990
	Repayment of Commonwealth grant (c)	-	4,459
	Other	1,720	1,497
		24,116	25,181

(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) Repayment of unspent Royalties for Regions Funding received in a previous financial year for Southern Inland Health Initiative projects. Refer to note 45 'Special Purpose Accounts'.

(c) Repayment of Commonwealth funding received in a previous financial year.

(d) Act of Grace payments for patient services delivered to Metropolitan Health Service ($5.904 million) and WA Country Health Service ($2.476 million).

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

		2015 $000	2014 $000
Note 15	**Commonwealth grants and contributions**		
	Cash Grants - Recurrent		
	National Health Reform Agreement (NHRA) (a):		
	Local Hospital Networks	1,539,891	1,328,840
	Public Health	37,154	35,297
	Specific Purpose Grants:		
	Home and Community Care	174,802	163,200
	Department of Veterans' Affairs	72,451	118,184
	Aged Care Programs	28,952	30,171
	Subacute Care	-	57,932
	Multi-Purpose Services Sites	27,434	25,804
	Public Health Outcome Funding Agreement - Vaccines	22,886	-
	Other Public Health Programs	3,438	4,731
	High Cost Drugs	-	652
	Treating More Public Dental Patients	21,964	-
	Other programs	11,841	5,208
	Other Grants		
	Additional one off funding to offset the reduction in NHRA funding received in 2013/14 compared to Commonwealth budget (b)	-	17,814
	Cash Grants - Capital		
	Midland Health Campus	-	28,900
	Non-Cash Contributions		
	Vaccine inventories received free of charge	11,025	14,463
		1,951,838	1,831,196

(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. In previous financial years, the equivalent Commonwealth funding was received in the form of Service Appropriations from the State Treasurer. 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 45 'Special Purpose Accounts'). Under the National Health Reform Agreement, the Commonwealth Government also provides public health funding to the Department of Health.

(b) The 2013-14 National Health Reform (NHRA) Funding for WA was revised downwards in the Commonwealth's 2013-14 Mid-Year Economic and Fiscal Outlook (MYEFO) and the 2014-15 Budget due to parameter updates under the National Health Reform Specific Purpose Payment indexation formula. The Commonwealth provided additional funding to WA in 2013-14 to offset the reduced payments made in 2013-14 for NHRA funding. The reduced payments were relative to the Commonwealth's original 2013-14 Budget estimates for NHRA funding for WA.

Note 16	**Other grants and contributions**		
	Mental Health Commission - service delivery agreement	-	11,392
	Mental Health Commission - Mandatory Program	148	176
	Mental Health Commission - Improving Public Hospitals Service program	-	2,572
	Department of Education - Health services for students at public schools	7,062	6,790
	Main Roads WA - Neurotrauma Research Program	2,000	835
		9,210	21,765

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

Note 17	**Finance income**		
	Finance lease income	2,024	957
Note 18	**Donation revenue**		
	General public contributions	1,000	1,000

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

		2015 $000	2014 $000
Note 19	**Income from State Government**		
	Service appropriations (a)		
	Appropriations received to deliver services	4,604,492	4,117,213
	Amount authorised by other statutes:		
	Salaries and Allowances Act 1975	680	663
	Lotteries Commission Act 1990	121,500	120,000
		4,726,672	4,237,876
	Assets transferred (b)		
	The following assets have been transferred from/(to) other state government agencies during the period:		
	Assets transferred in		
	Radiation health building from Metropolitan Health Service	-	1,471
	Transfer of discretionary cash from Metropolitan Health Service	11,254	-
	Assets transferred out		
	Medical equipment to Metropolitan Health Services and WA Country Health Service	-	(15)
	Other plant & equipment to Metropolitan Health Service	(11)	
		11,243	1,456
	Services received free of charge (c)		
	Determined on the basis of the following estimates provided by agencies:		
	Department of Education - accommodation	887	869
	Landgate - valuation services and land information	272	302
	State Solicitor's Office - legal service	1,218	1,044
		2,377	2,215
	Royalties for Regions Fund (d)		
	Regional Community Services Account (d):		
	Regional Workers Incentives	13,550	20,326
	Royal Flying Doctor Service	4,000	12,125
	Pilbara Health Partnership	9,242	2,500
	St John Ambulance	7,790	6,891
	Rural Generalist Pathways	2,400	1,800
	Fitzroy Kids Health	200	-
	Improving Ear, Eye & Oral Health Child Aboriginal	1,500	-
	Rural Palliative Care Program	1,000	-
	Rural In-Reach Program-Women (Women's Support Health Care)	250	364
	Patient Assisted Travel Scheme	10,080	19,104
	Pilbara Cardiovascular Screen Program	123	91
	Renal Dialysis Service Expansion program	496	340
	Busselton ICT	2,807	6,472
		53,438	70,013
	Regional Infrastructure and Headworks Fund (d):		
	SIHI Residential Aged & Dementia Care	4,000	-
		57,438	70,013

(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.

		2015 $000	2014 $000
Note 20	**Restricted cash and cash equivalents**		
	Current		
	Commonwealth Specific Purpose Grants (a)	104,170	188,575
	Royalties for Regions Fund (b)	146,976	184,073
	Telethon - Perth Children's Hospital Research Fund (c)	4,792	4,036
	Accrued Salaries Suspense Account (d)	83,170	-
		339,108	376,684
	Non-Current		
	Accrued Salaries Suspense Account (d)	-	57,916
		339,108	434,600

(a) Funds held for the specific purposes stipulated by Commonwealth Government for 'Public Health Outcome Funding Agreement (PHOFA)' and Vaccines ($5.5 million), Subacute Care ($28.9 million), Emergency Department ($18.1 million), Aged Care programs ($22.1 million) and other initiatives and programs ($29.4 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 45 'Special Purpose Accounts'.

(d) Funds held in the suspense account at the Department of Treasury will be used only for the purpose of meeting the 27th pay in a financial year that occurs every 11 years (the next one occurring during the 2015/16 financial year). The 2015 amount includes $79.188 million (2014: $53.933 million) held for the Statutory Authorities within WA Health.

Note 21	**Inventories**		
	Current		
	Drug supplies (at cost)	6,828	7,319
	State Distribution Centre - supply stores (at cost)	9,335	5,366
		16,163	12,685

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 22	**Receivables**		
	Current		
	Receivables	1,099	2,708
	Allowance for impairment of receivables	(20)	(22)
	Accrued revenue	3,188	2,388
		4,267	5,074
	GST receivable	30,151	34,315
		34,418	39,389
	Reconciliation of changes in the allowance for impairment of receivables:		
	Balance at start of period	22	181
	Doubtful debts expense	-	9
	Amounts written off during the period	(2)	(168)
	Balance at end of period	20	22

The Department does not hold any collateral or other credit enhancements as security for

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, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, 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 48 'Financial instruments'.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

		2015 $000	2014 $000
Note 23	**Amounts receivable for services (Holding Account)**		
	Current	-	-
	Non-current	100,417	98,958
		100,417	98,958

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.

Note 24	**Finance lease receivable**		
	Non-current	2,981	957

Refer to note 2(i) 'Leases' .

Note 25	**Property, plant and equipment**		
	Land		
	At fair value (a)	11,609	9,404
	Buildings		
	At fair value (a)	14,129	14,181
	Accumulated depreciation	-	-
		14,129	14,181
	Computer equipment		
	At cost	192	203
	Accumulated depreciation	(151)	(149)
		41	54
	Furniture and fittings		
	At cost	48	36
	Accumulated depreciation	(15)	(20)
		34	16
	Other plant and equipment		
	At cost	2,850	2,676
	Accumulated depreciation	(2,004)	(1,940)
		846	736
	Artworks		
	At cost	85	85
	Total property, plant and equipment	26,744	24,476

(a) Land and buildings were revalued as at 1 July 2014 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2015 and recognised at 30 June 2015. In undertaking the revaluation, fair value was determined by reference to market values for land: $3,857,000 (2014: $3,693,000). 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) Information on fair value measurements is provided in Note 26.

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	9,404	54,259
Transfers to Metropolitan Health Service (a)	-	(46,900)
Revaluation increments / (decrements)	2,205	2,045
Carrying amount at the end of year	11,609	9,404

Note 25 Property, plant and equipment (continued)	2015 $000	2014 $000
Buildings		
Carrying amount at the start of year	14,181	280,398
Transfers from/(to) other reporting entities	-	1,471
Transfers to Metropolitan Health Service (a)	-	(263,737)
Revaluation increments/(decrements)	373	488
Depreciation	(425)	(4,440)
Carrying amount at the end of year	14,129	14,181
Computer Equipment		
Carrying amount at the start of year	54	54
Additions	13	25
Depreciation	(26)	(25)
Carrying amount at the end of year	41	54
Furniture & fittings		
Carrying amount at the start of year	16	379
Additions	27	-
Other Disposals	-	-
Transfers to Metropolitan Health Service (a)	(6)	(342)
Depreciation	(3)	(20)
Carrying amount at the end of year	34	16
Other Plant & equipment		
Carrying amount at the start of year	736	9,730
Additions	245	177
Transfers from/(to) other reporting entities	-	(15)
Transfers to Metropolitan Health Service (a)	(5)	(8,342)
Other disposals	(7)	-
Depreciation	(123)	(816)
Carrying amount at the end of year	846	736
Works in progress		
Carrying amount at the start of year	-	123,824
Additions	-	80,620
Transfers to Metropolitan Health Service (a)	-	(204,444)
Carrying amount at the end of year	-	-
Artworks		
Carrying amount at the start of year	85	85
Additions	-	-
Carrying amount at the end of year	85	85
Total property, plant and equipment		
Carrying amount at the start of year	24,476	468,729
Additions	285	80,823
Transfers from/(to) other reporting entities	-	1,456
Transfers to Metropolitan Health Service (a)	(11)	(523,764)
Other disposals	(7)	-
Revaluation increments/(decrements)	2,578	2,533
Depreciation	(577)	(5,301)
Carrying amount at the end of year	26,744	24,476

(a) Property, plant and equipment relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred to the Metropolitan Health Service on 1 January 2014. Refer to note 32 'Equity' for further information.

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Note 26 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); and
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 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	-	-	14,129	14,129
	-	3,857	21,881	25,738

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 2014.

Assets measured at fair value:	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Vacant land	-	3,693	1	3,694
Specialised	-	-	5,710	5,710
Buildings				
Specialised	-	-	14,181	14,181
	-	3,693	19,892	23,585

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 26 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 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, 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 is 50 years. The effective age of a building is initially calculated from the commissioning date, and is reviewed after the building has 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 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 2015:

2015	**Land $000**	**Buildings $000**
Fair value at start of period	5,711	14,181
Additions	-	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	2,040	373
Transfers to Metropolitan Health Service (a)	-	-
Depreciation Expense	-	(425)
Fair value at end of period	7,751	14,129

The following table represents the changes in level 3 items for the period ended 30 June 2014:

2014	**Land $000**	**Buildings $000**
Fair value at start of period	35,962	280,398
Additions	-	1,471
Revaluation increments/(decrements) recognised in Other Comprehensive Income	1,750	488
Transfers to Metropolitan Health Service (a)	(32,001)	(263,737)
Depreciation Expense	-	(4,440)
Fair value at end of period	5,711	14,181

(d) Valuation processes

The Financial Services Branch at the Health Corporate Network (HCN) manages the valuation processes for the Department. These include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports. Discussions of valuation processes and results are held between the HCN and the chief finance officer at least once every year.

Landgate Valuation Services determines the fair values of the Department's land and buildings. A quantity surveyor is engaged by the Department of Health to provide an update of the current replacement costs for specialised buildings. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor and calculates the depreciated replacement costs.

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		2015 $000	2014 $000
Note 27	**Other assets**		
	Current		
	Prepayments	813	640
	Non-current		
	Prepayments (a)	4,201	4,811
		5,014	5,451

(a) During the 2011-12 financial year, $6.555 million was prepaid for palliative care services to be received in the next ten financial years.

Note 28 Impairment of Assets

There were no indications of impairment to property, plant and equipment at 30 June 2015.

The Department held no goodwill during the reporting period.

Note 29 Payables

	2015 $000	2014 $000
Current		
Trade payables	18,889	22,282
Accrued salaries	3,625	2,922
Accrued expenses	24,198	37,944
Total current	46,712	63,148

Refer to note 2(p) 'Payables' and note 48 'Financial Instruments'.

Note 30 Provisions

	2015 $000	2014 $000
Current		
Employee benefits provision		
Annual leave (a)	9,097	7,952
Long service leave (b)	12,522	10,718
Deferred salary scheme (c)	227	141
	21,846	18,811
Non-current		
Employee benefits provision		
Long service leave (b)	3,627	3,406
	25,473	22,217

(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	6,388	5,648
More than 12 months after the end of the reporting period	2,709	2,304
	9,097	7,952

(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	2,615	2,175
More than 12 months after the end of the reporting period	13,534	11,949
	16,149	14,124

(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	227	141
	227	141

		2015 $000	2014 $000
Note 31	**Other current liabilities**		
	Unearned Income	197	1,100

Note 32 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)	315,001
Contributions by owners		
Capital appropriation (a)	-	49,728
Distributions to owner		
Transfer of assets and liabilities to Metropolitan Health Service (c)	-	(507,898)
Balance at the end of period	(143,169)	(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 and liabilities relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred to Metropolitan Health Service on 1 January 2014. This transfer of assets and liabilities 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	303,111	300,578
Net revaluation increments/(decrements):		
Land	2,205	2,045
Buildings	374	488
	2,579	2,533
Balance at the end of period	305,690	303,111
Accumulated surplus		
Balance at the start of period	396,321	362,004
Result for the period	(13,349)	34,317
Balance at the end of period	382,972	396,321

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		2015 $000	2014 $000
Note 33	**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	93,030	26,212
	Restricted cash and cash equivalents (refer to note 20)	339,108	434,600
		432,138	460,812
	Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities		
	Net cost of services	(4,811,079)	(4,277,243)
	Non-cash items:		
	Depreciation expense	577	5,301
	Doubtful debts expense	-	10
	Services received free of charge	2,377	2,215
	Loss on disposal of non current assets	7	3
	Transfer of non-cash funding to Health entities	364,958	205,036
	(Increase)/decrease in assets:		
	Inventories	(3,478)	(8,292)
	Receivables	4,970	974
	Other assets	437	648
	Finance lease receivable	(2,024)	(957)
	Increase/(decrease) in liabilities:		
	Payables	(16,435)	(30,327)
	Provisions	3,255	715
	Other liabilities	(903)	1,034
	Transfer of cash to other agency for payments relating to operating activities.	-	40,552
	Net cash provided by/(used in) operating activities	(4,457,338)	(4,060,331)
	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.		
	Non-cash item for investing activities		
	Payment for construction of QEII Multi Deck Car Park (note 2(i))	-	(104,142)
	Non-cash item for financing activities		
	Receipt of rental prepayment for QEII Multi Deck Car Park (note 2(i))	-	104,142
Note 34	**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	1,687	918
	Department of Corrective Services	116	113
	Department of Education	4	114
	Department of Planning & Infrastructure	139	119
	Town of Port Headland	18	175
	Water Corporation	171	191
	Department of Fire & Emergency Services	37	-
	Department of Housing & Works	49	-
	Department of Water	54	-
	Others	130	269
		2,405	1,899

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

		2015 $000	2014 $000
Note 35	**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	9,429	9,430
Later than 1 year and not later than 5 years	517	9,308
	9,946	18,738

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.

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	578,282	581,920
Later than 1 year and not later than 5 years	904,816	839,051
Later than 5 years and not later than 10 years	54,640	151,845
	1,537,738	1,572,816

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	3,021	2,446
Later than 1 year and not later than 5 years	480	622
	3,501	3,068

Note 36 Contingent liabilities and contingent assets

Contingent liabilities

The following contingent liabilities are additional to the liabilities included in the financial statements:

Litigation in progress

Pending litigation that may affect the financial position of the Department	-	2,100
Number of claims	-	1

Contingent assets

At the reporting date, the Department is not aware of any contingent assets.

Note 37 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.

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Note 38 Explanatory statement

Significant variations between estimates and actual results, and between the actual results for 2015 and 2014, 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%.

Significant variances between estimates and actual for 2015 - Total appropriations to deliver services:

	2015 Estimate $000	2015 Actual $000	Variance $000
(a) Total cost of services			
Home-Based Hospital	44,929	39,936	(4,993)

The variance is due to the continuous refinement of home based care costing models to align to the National Activity Based Funding Framework.

Palliative Care	31,859	36,910	5,051

The variance is due to the increase of Government Sustainability Funding (Component 2) initiative to organisations. This has increased the number of patients treated within these facilities.

Dental Health	124,300	99,175	(25,125)

The variance is due to the NPA funding allocated within the 2014-15 budget process, but when calculating 2014/15 actual expense this funding is excluded due to it not being used for operational purposes.

Mental Health	585,971	663,642	77,671

The budgeted costs were based on the service agreement with the Mental Health Commission. Actual costs include additional expenditure above the contracted value due in part to the provision of additional mental health services outside the agreed scope of service agreement with the Mental Health Commission together with overall increased activity and operating expenditure for mental health inpatients and community services within WA Country Health Service and Metropolitan Health Service.

(b) Adjustments	(145,571)	(95,331)	50,240

The variance is predominantly due to the $50.2 million variation in cash balances, payables and receivables over 2014/15.

Significant variances between estimates and actual for 2015 - Capital expenditure:

(a) Purchase of non-current physical assets	993,592	587,991	(405,601)

The variance is due to delay regarding the implementation of projects within the capital works program including Perth Children's Hospital $155 million; Perth Children's Hospital ICT $57 million; Equipment Replacement Program $29 million; National Partnership Agreement projects $19 million; Southern Inland Health Initiative - Small Hospitals & Nursing Posts $39 million; Southern Inland Health Initiative - Integrated District Health Campuses (Stream 2) $13 million; Esperance Health Campus Redevelopment $12 million and Stabilising ICT Platform $17 million.

(b) Repayment of borrowings	77,581	59,185	(18,396)

The variance is due to the update and realignment of principal repayments for the Fiona Stanley finance leases to reflect updated values for asset acquisitions and the partial drawdown of the lease in 2013/14.

(c) Adjustments for other funding sources	(801,759)	(401,892)	399,867

The variance is due to project delays and changes in project timelines as a result of $485 million less draw-down than originally estimated, including $135 million Perth Children's Hospital; $85 million Royalties for Regions; and $292 million accounts payable, accounts receivable & cash balances which are offset by $62 million receipts of Commonwealth grants.

Note 38 Explanatory statement (continued)

Significant variances between actual for 2015 and 2014 - Total appropriation to deliver services

	2015 Actual $000	2014 Actual $000	Variance $000
(a) Appropriations			
Net amount appropriated to deliver services	4,597,359	4,068,016	529,343

The increase in net amount appropriated to deliver services is mainly due to $216.9 million service appropriation increase for the delivery of hospital services; $69.4 million additional funding for the contract negotiation of the Fiona Stanley Hospital Facilities Management contract with Serco Pty Ltd resulting from the phased opening of the new hospital; $43.9 million for the commissioning of the Fiona Stanley Hospital, the Perth Children's Hospital and the South Metropolitan Health Service reconfiguration; $40.3 million for additional leave liability cap expenditure; $37.7 million of funding for the payments under the 2014-15 Targeted Separation Scheme; $12.3 million additional funding for the nurses award increase; and $11.7 million for payment of a litigation claim in 2014-15.

Section 25 transfer of service appropriation	7,133	49,197	(42,064)

In 2014/15 a $7.133 million S25 Transfer (Component II Delivering Community Services in Partnership Funding Section) took place, from the Department of Treasury. In 2013/14, three S25 Transfers occurred, totalling $48.778 million, consisting of $6.431 million (Component II Delivering Community Services in Partnership Funding Section), $10.929 million (Voluntary Severances), $31.418 million (Closing the Gap), all from the Department of Treasury and $0.419 million regarding Closing the Gap from the Mental Health Commission.

(b) Total Cost of Services			
Palliative Care	36,910	30,553	6,357

The variance is due to the increase of Government Sustainability Funding (Component 2) initiative to the not-for-profit service organisations. This has increased the number of patients treated within these facilities.

Emergency Department	722,379	643,988	78,391

The variance is due to the opening of Fiona Stanley Hospital, the reconfiguration of Emergency Department services to accommodate the opening of Fiona Stanley Hospital and higher than expected attendance rate at Fiona Stanley Hospital's Emergency Department. The introduction of a new costing system in WA Country Health Service has refined expenditure allocation across services, resulting in an increase of expenditure being recorded for Emergency Department services in 2014-15.

Public Hospital Non-Admitted Patients	965,384	802,139	163,245

The variance is due to the opening of Fiona Stanley Hospital and the reconfiguration of Non-Admitted services to accommodate the opening of Fiona Stanley Hospital. The introduction of a new costing system in WACHS has refined expenditure allocation across services, resulting in an increase of expenditure being recorded for Non-Admitted services in 2014-15.

(c) Adjustments	(95,331)	(211,835)	116,504

The variance is predominantly due to the $116.5 million variation in cash balances, payables and receivables over 2014/15.

Significant variances between actual for 2015 and 2014 - Capital appropriations:

(a) Capital appropriations	245,284	329,441	(84,157)

The variance is largely attributable to reductions in the capital appropriation for various asset investment projects, including $64.7 million for the Information and Communication Technology (ICT); $61.8 million for the Midland Health Campus; $28.3 million for the Joondalup Health Campus; and $25.3 for the Busselton Health Campus. These decreases in capital appropriations are partially offset by increases in expenditure for the following projects: $33 million for the Fiona Stanley Hospital finance lease arrangements; $30 million for the Fiona Stanley Hospital ICT Commissioning; $19.2 million for the Equipment Replacement program; and $16.4 million for Stabilising Existing ICT Platform.

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Note 38 Explanatory statement (continued)

	2015 Actual $000	2014 Actual $000	Variance $000
Significant variances between actual for 2015 and 2014 - Capital expenditure:			
(a) Purchase of non-current physical assets	587,991	905,066	(317,075)

The variance is due to long lead times for the procurement of equipment and services on various projects (including Perth Children's Hospital) caused timeline changes resulting in reduced fixed assets purchases during 2014/15.

(b) Repayment of borrowings	59,185	20,586	38,599

Finance lease repayments relating to the Fiona Stanley Hospital occurred on a monthly basis for all of 2014/15 whereas payments occurred only over the last 3 months of 2013/14. A second finance lease arrangement commenced repayments in the later part of 2014/15.

(c) Adjustments for other funding sources	(401,892)	(596,211)	194,319

The variance is due to numerous projects requiring less funding during 2014/15 when compared with 2013/14, including Fiona Stanley Hospital (completed in 2014/15) and Perth Children's Hospital. There was also reduced activities funded through the Royalties for Regions Program during 2014/15, offset by an increase in Treasury Administered funding source during the year.

Note 39 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:

	2015	2014
$60,001 - $70,000		1
$70,001 - $80,000		1
$120,001 - $130,000	1	2
$130,001 - $140,000		1
$150,001 - $160,000		1
$160,001 - $170,000		-
$180,001 - $190,000	2	1
$200,001 - $210,000		1
$210,001 - $220,000	1	
$220,001 - $230,000	2	-
$230,001 - $240,000		
$250,001 - $260,000		-
$260,001 - $270,000		
$280,001 - $290,000	1	
$300,001 - $310,000		1
$350,001 - $360,000		1
$390,001 - $400,000	1	
$410,001 - $420,000		1
$450,001 - $460,000	1	1
$480,001 - $490,000		1
$490,001 - $500,000	1	
$520,001 - $530,000	1	
$650,001 - $660,000	1	1
	12	14

	$000	$000
Base remuneration and superannuation	3,638	3,669
Annual leave and long service leave accruals	249	(9)
Other benefits	69	78
Total remuneration of senior officers	3,956	3,738

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

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		2015 $000	2014 $000
Note 40	**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	341	340
	This expense is included at Note 14 'Other expenses'		

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	20,044	18,032
Public health	7,104	3,925
	27,148	21,957

Note 43 Other statement of receipts and payments

Commonwealth Grant - Christmas and Cocos Island

Balance at the start of period	-	-
Receipts		
Commonwealth grant	2,273	1,609
Payments		
Purchase of WA Health Services	(2,273)	(1,609)
	(2,273)	(1,609)
Balance at the end of period	-	-

Note 44 Private Trust Account

Peel Health Campus Service Agreement Trust Fund

These funds are private in nature and are not incorporated into the controlled and administered transactions of the Department's financial statements.

The purpose of the trust fund is to hold in trust, moneys received from the Private Operator for the purpose of the Peel Health Campus Service Agreement to provide security for claims made in relation to any amount which has become payable by the Private Operator to the State under the Agreement.

Balance at the start of period	-	21
Receipts	-	-
Payments	-	(21)
Balance at the end of period	-	-

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NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2015

		2015 $000	2014 $000
Note 45	**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	1,324,186	1,137,668
	Commonwealth block funding for local hospital networks	215,705	191,172
	Commonwealth public health funding for Department of Health	37,154	35,297
	State activity based funding from Department of Health	1,725,211	2,014,950
	Payments:		
	Commonwealth activity based funding to local hospital networks	(1,324,186)	(1,137,668)
	Commonwealth block funding to State Managed Fund (Health) Account	(215,705)	(191,172)
	Commonwealth public health funding to Department of Health	(37,154)	(35,297)
	State activity based funding to local hospital networks	(1,725,211)	(2,014,950)
		-	-
	Administered by Department of Health		
	Receipts:		
	Commonwealth activity based funding for Mental Health Commission (MHC)	101,288	89,227
	Commonwealth block funding for Mental Health Commission	72,024	65,036
	State activity based funding from Mental Health Commission	160,452	155,102
	Payments:		
	MHC Commonwealth activity based funding to local hospital networks	(101,288)	(89,227)
	Commonwealth block funding to Mental Health Commission	(72,024)	(65,036)
	MHC State activity based funding to local hospital networks	(160,452)	(155,102)
		-	-
	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	215,705	191,172
	State block funding from Department of Health	261,250	486,036
	Payments:		
	Commonwealth block funding to local hospital networks	(215,705)	(191,172)
	State block funding to local hospital networks	(261,250)	(486,036)
		-	-
	Administered by Department of Health		
	Receipts:		
	Mental Health Commission - Commonwealth block funding	70,387	65,036
	Mental Health Commission - State block funding	167,341	112,747
	Payments:		
	Mental Health Commission - Commonwealth block funding to local hospital networks	(70,387)	(65,036)
	Mental Health Commission - State block funding to local hospital networks	(167,341)	(112,747)
		-	-
	Balance at the end of period	-	-

		2015 $000	2014 $000
Note 45	**Special Purpose Accounts (continued)**		
	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	178,367	211,027
	Receipts		
	Aged & Dementia Program	4,000	-
	Payments to WA Country Health Service		
	District Medical Workforce Investment	(26,499)	(20,516)
	District Hospital Investment Program	(5,431)	(3,144)
	Telehealth Investment Program	(3,734)	(2,010)
	Aged & Dementia Program	(153)	-
	Payments to Consolidated Fund		
	Reallocation to the Renal Dialysis Service Expansion Project	-	(6,990)
		146,550	178,367
	Capital		
	Balance at the start of period	94,918	-
	Receipts		
	District Hospital Investment Program - Stream 2	-	30,000
	Primary Health Centres Demonstration Program - Stream 3	-	6,000
	Small Hospital and Nursing Post Refurbishment Program - Stream 4	-	70,000
	Payments to WA Country Health Service		
	District Hospital Investment Program - Stream 2	(4,734)	(4,526)
	Primary Health Centres Demonstration Program - Stream 3	(775)	(775)
	Small Hospital and Nursing Post Refurbishment Program - Stream 4	(17,174)	(5,781)
		72,235	94,918
	Balance at the end of period	**218,785**	**273,285**
	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	4,036	2,000
	Receipts	3,114	3,101
	Payments	(2,358)	(1,065)
	Balance at the end of period	4,792	4,036

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2015

Note 46 Administered assets and liabilities

	2015 $000	2014 $000
Current Assets		
Cash and cash equivalents	334,907	258,873
Receivables	1,949	-
Total administered current assets	336,856	258,873
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 46 "Administered assets and liabilities' and note 47 '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 2015

Note 47 Disclosure of administered income and expenses by service

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Metropolitan Health Service	340,902	485,849	1,381	1,479	1,540	1,867	60,398	95,665
WA Country Health Service	68,201	55,871	-	-	103	82	18,074	17,803
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	409,103	541,720	1,381	1,479	1,643	1,949	78,472	113,468
Income								
Administered for Capital Works Fund:								
Capital appropriations	455,328	512,485	1,240	1,663	1,383	2,635	70,259	117,460
Royalties for Regions Fund	10,071	84,480	-	-	36	412	6,527	14,203
Commonwealth grants and contributions	-	1,034	-	-	-	-	-	658
Contribution from Department of Health	29,486	11,562	-	-	-	-	4,231	2,416
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	494,885	609,561	1,240	1,663	1,419	3,047	81,017	134,737

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2015

Note 47 Disclosure of administered income and expenses by service (continued)

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Metropolitan Health Service	43,784	64,498	7,556	7,854	9,351	15,582	671	683
WA Country Health Service	16,461	17,945	292	1,037	1,799	1,503	-	-
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	60,245	82,443	7,848	8,891	11,150	17,085	671	683
Income								
Administered for Capital Works Fund:								
Capital appropriations	51,513	76,327	6,249	12,441	7,232	17,742	597	882
Royalties for Regions Fund	7,956	12,831	401	6,431	1,055	9,803	-	-
Commonwealth grants and contributions	-	-	-	-	-	-	-	-
Contribution from Department of Health	-	1,725	-	173	-	345	-	-
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	59,468	90,883	6,650	19,045	8,287	27,890	597	882

Note 47 Disclosure of administered income and expenses by service (continued)

	Continuing Care		Mental Health		TOTAL	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES						
Expenses						
Funding for Capital Works Fund transferred to:						
Metropolitan Health Service	23,178	28,804	16,500	15,785	505,261	718,066
WA Country Health Service	7,235	4,069	448	1,810	112,613	100,120
State Pool Account and State Managed Fund Account administered for Mental Health Commission						
Transfer of activity based funding to local hospital networks	-	-	261,740	244,329	261,740	244,329
Transfer of block funding to local hospital networks	-	-	237,728	177,783	237,728	177,783
Transfer of Commonwealth block funding to Mental Health Commission			1,637	-	1,637	-
Total administered expenses	30,413	32,873	518,053	439,707	1,118,979	1,240,298
Income						
Administered for Capital Works Fund:						
Capital appropriations	17,688	44,131	15,237	19,441	626,726	805,207
Royalties for Regions Fund	693	10,780	40	3,046	26,779	141,986
Commonwealth grants and contributions	-	166	-	-	-	1,858
Contribution from Department of Health	8,635	690	-	345	42,352	17,256
State Pool Account and State Managed Fund Account administered for Mental Health Commission						
Commonwealth activity based funding for MHC	-	-	101,288	89,227	101,288	89,227
Commonwealth block funding for MHC	-	-	72,024	65,036	72,024	65,036
State activity based funding from MHC	-	-	160,452	155,102	160,452	155,102
State block funding from MHC	-	-	167,341	112,747	167,341	112,747
Total administered income	27,016	55,767	516,382	444,944	1,196,962	1,388,419

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2015

Note 48 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 48(c) 'Financial Instruments Disclosures' and Note 22 '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 48(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:

	2015 $000	2014 $000
Financial Assets		
Cash and cash equivalents	93,030	26,212
Restricted cash and cash equivalents	339,108	434,600
Loans and receivables (a)	107,665	104,989
Financial Liabilities		
Financial liabilities measured at amortised cost	46,712	63,148

(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
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	-
2014							
Cash and cash equivalents	26,212	26,212	-	-	-	-	-
Restricted cash and cash equivalents	434,600	434,600	-	-	-	-	-
Receivables (a)	5,074	3,537	6	1,490	41	-	-
Finance lease receivable	957	957	-	-	-	-	-
Amounts receivable for services	98,958	98,958	-	-	-	-	-
	565,801	564,264	6	1,490	41	-	-

(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
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	-	-	103,398
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).

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
2014										
Financial Assets										
Cash and cash equivalents		26,212	-	-	26,212	26,212	26,212	-	-	-
Restricted cash and cash equivalents		434,600	-	-	434,600	434,600	434,600	-	-	-
Receivables (a)		5,074	-	-	5,074	5,074	5,074	-	-	-
Finance lease receivable		957			957	957	-		-	957
Amounts receivable for services		98,958	-	-	98,958	98,958	-	-	-	98,958
		565,801	-	-	565,801	565,801	465,886	-	-	99,915
Financial Liabilities										
Payables		63,148	-	-	63,148	63,148	63,148	-	-	-
		63,148	-	-	63,148	63,148	63,148	-	-	-

(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 key performance indicators

DEPARTMENT OF HEALTH

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2015

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 2015.

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

16 September 2015

Key performance indicators

Outcome 1

Proportion of people with cancer accessing admitted palliative care services	102
Response times for patient transport services	103
Cost per capita of supporting treatment of patients in public hospitals	105
Average cost per home-based hospital day of care and occasion of service	106
Average cost per client receiving contracted palliative care services	108
Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – WA Ambulance Service Agreements	109

Outcome 2

Loss of life from premature death due to identifiable causes of preventable disease or injury	111
Percentage of fully immunised children	113
Rate of hospitalisations for selected potentially preventable diseases	115
Eligible patients on the oral waiting list who have received treatment during the year	117
Percentage of clients maintaining or improving functional ability while in transition care	119
Rate per 1,000 HACC target population who receive HACC services	120
Specific HACC contract provider client satisfaction survey	121
Cost per capita of providing preventive interventions, health promotion and health protection activities	123
Average cost per dental service provided by the Oral Health Centre of WA	124
Average cost per person of HACC services delivered to people with long term disability	125
Average cost per transition care day	127
Average cost per day of care for non-acute admitted continuing care	128
Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	129

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.

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.

Cancer is a leading cause of death in Australia and accounts for about three in 10 deaths. Therefore, it is critical that effective palliative care services are available to these terminally ill cancer patients and their families.

Monitoring this indicator's changes over time can facilitate the identification of the demand for palliative care services by terminally ill cancer patients in the hospital, which 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 2013 target is 49.2 per cent.

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

Results

In 2013 the percentage of patients with cancer accessing palliative care services was 53.1 per cent, slightly above the target of 49.2 per cent (see Table 9).

Table 9: **Percentage of patients with cancer accessing palliative care services, 2009–2013**

	2009	2010	2011	2012	2013	Target
Percentage of patients (%)	47.5	44.8	48.8	52.7	53.1	49.2

Notes:

1. This KPI measure is based on the number of patients who accessed public or private palliative care services and cancer mortality rates. The number of cancer related deaths is a nationally accepted proxy for potentially needed palliative care services.
2. Cancer is defined as a principal diagnosis of an invasive malignant neoplasm.

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 (priority 1) of urgent medical treatment. 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:

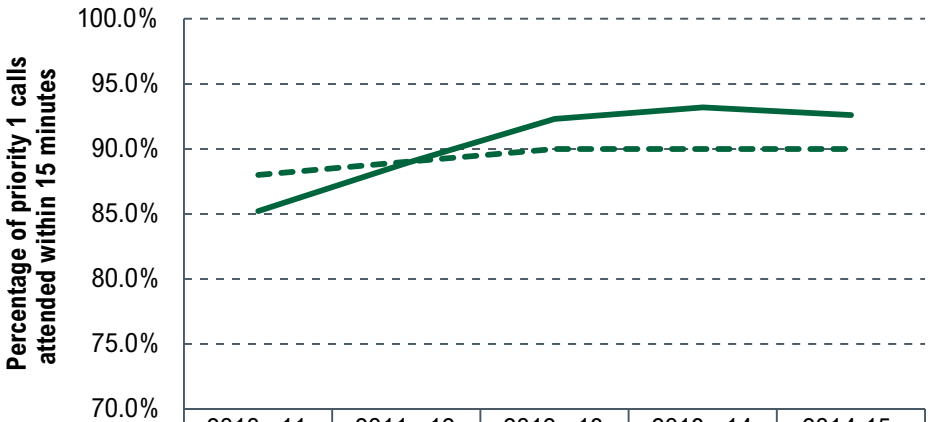
- 80 per cent of inter-hospital transfers for priority 1 calls (excluding regional resource centres) meeting the Target Contract Patient Response Time.

Results

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

In 2014-15, 92.6 per cent of priority 1 calls in the metropolitan area were attended within 15 minutes and above the target (see Figure 11).

Figure 11: **Percentage of priority 1 calls attended within 15 minutes in the metropolitan area by St John Ambulance Australia – Western Australia Ambulance Service, 2010–11 to 2014–15**



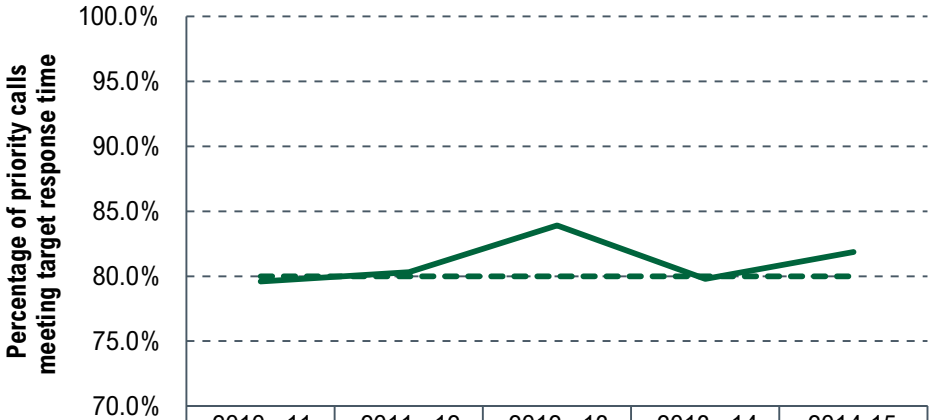
	2010 –11	2011 –12	2012 –13	2013 –14	2014-15
Results	85.2%	88.9%	92.3%	93.2%	92.6%
Target	88.0%	89.0%	90.0%	90.0%	90.0%

Data source: Department of Health unpublished data.

b) Royal Flying Doctors Service:

The Royal Flying Doctor Service achieved 81.9 per cent of inter-hospital transfers for priority 1 calls in 2014–15. This result was above the Target Contract Patient Response Time of 80 per cent (see Figure 12).

Figure 12: **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, 2010–11 to 2014–15**



	2010 –11	2011 –12	2012 –13	2013 –14	2014-15
Results	79.6%	80.3%	83.9%	79.8%	81.9%
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.

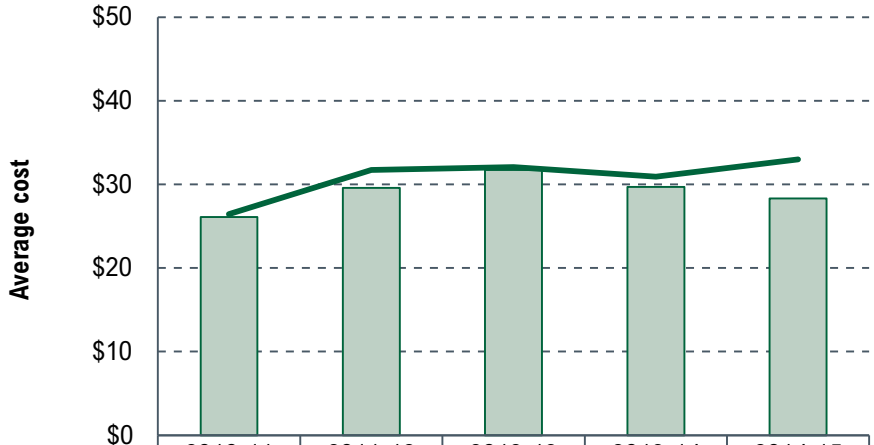
Target

The 2014–15 target unit cost is $33 per capita of supporting the treatment of patients in public hospitals. A result below the target is desirable.

Results

In 2014–15, the average cost of providing care to patients in public hospitals was $28, below the target of $33 (see Figure 13). The lower expenditure to target is attributable to a reduction in statewide corporate overhead costs allocated to the Department of Health.

Figure 13: **Cost per capita of supporting treatment of patients in public hospitals, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$26.09	$29.59	$31.71	$29.68	$28
Target	$26.43	$31.72	$32.06	$30.92	$33

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013, 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:

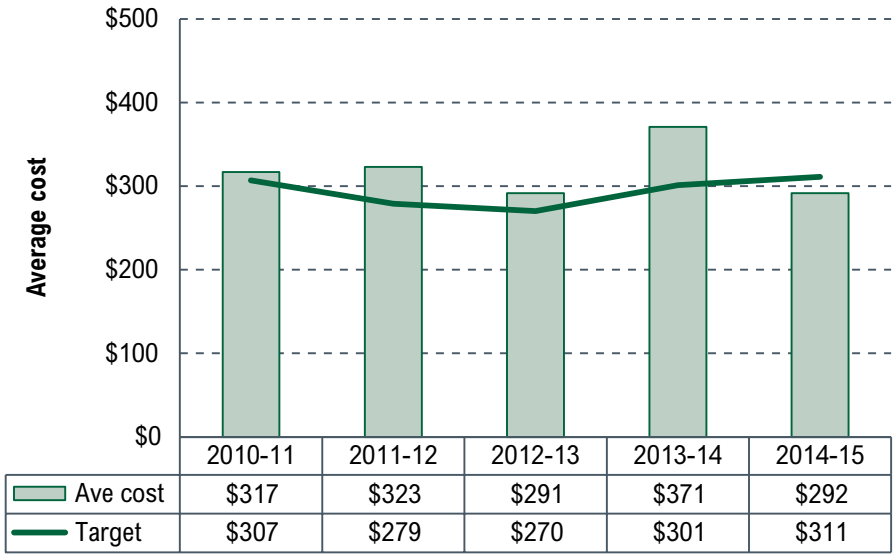
a) home based hospital day of care is $311
b) home-based hospital occasion of service is $124.

Results

a) Home based hospital day of care

In 2014–15, the average cost of home based hospital day of care was $292, slightly below the target (see Figure 14).

Figure 14: **Average cost per home based hospital day of care, 2010–11 to 2014–15**

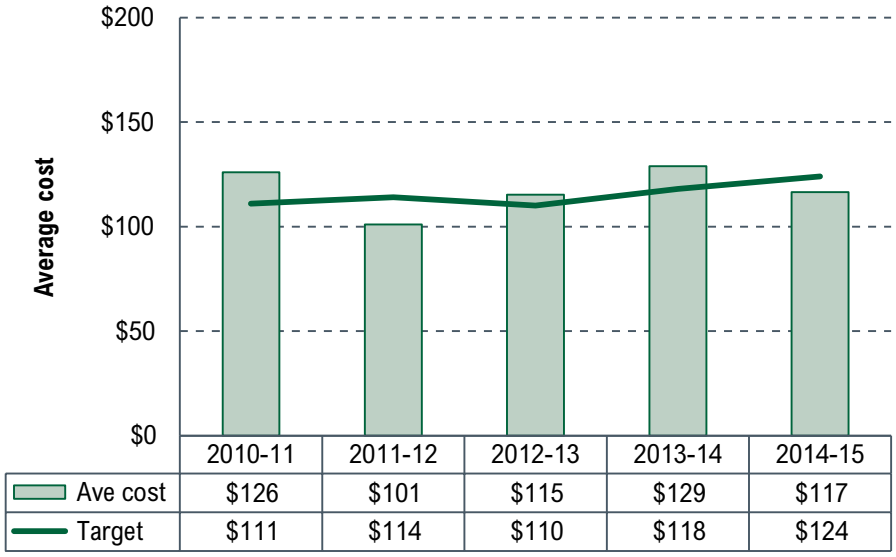


	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$317	$323	$291	$371	$292
Target	$307	$279	$270	$301	$311

b) Home-based hospital occasion of service

In 2014–15, the average cost of home based hospital occasion of service was $117, slightly below the target (see Figure 15).

Figure 15: **Average cost per home based hospital occasion of service, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$126	$101	$115	$129	$117
Target	$111	$114	$110	$118	$124

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.

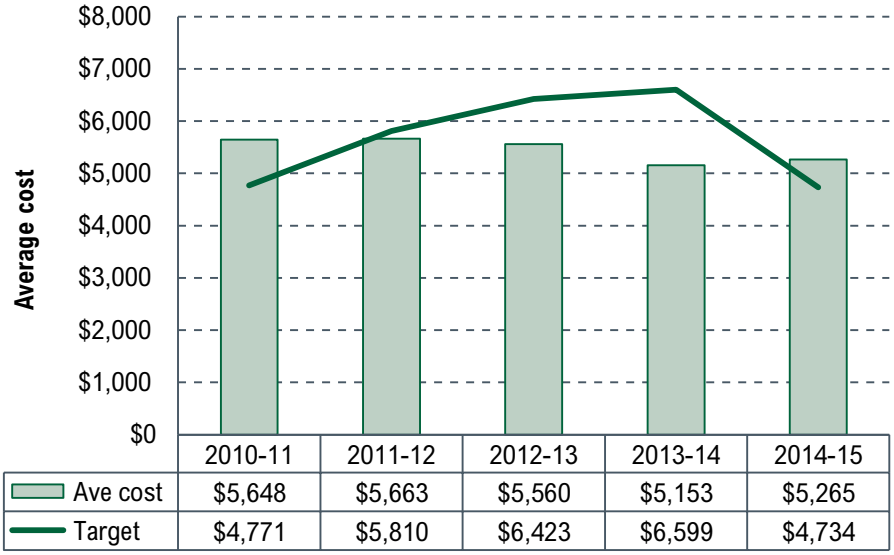
Target

The 2014–15 target unit cost is $4,734 per client receiving contracted palliative care services. A result below the target is desirable.

Results

In 2014–15, the average cost for a client receiving contracted palliative care services was $5,265 and above the target (see Figure 16). The variance to target is due to the increase of Government Sustainability Funding (Component 2) initiative to Not-For-Profit service organisations. This has enabled a greater number of patients to be supported by palliative care services.

Figure 16: **Average cost per client receiving contracted palliative care services, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$5,648	$5,663	$5,560	$5,153	$5,265
Target	$4,771	$5,810	$6,423	$6,599	$4,734

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

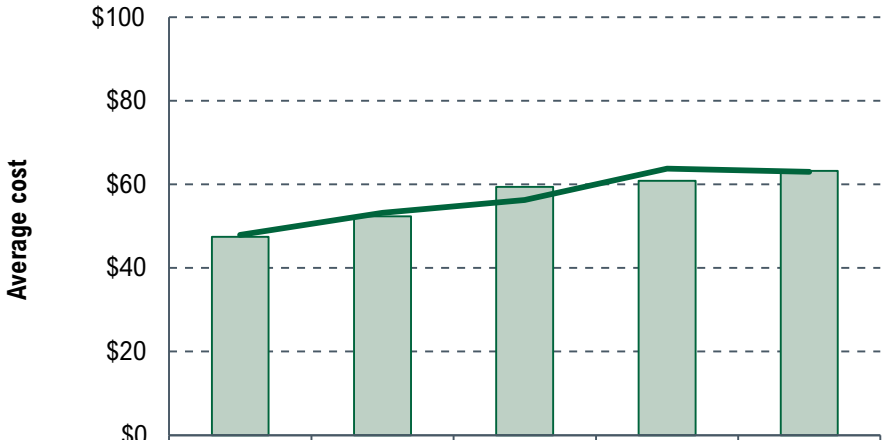
The target unit cost for 2014–15 is $63 per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements

A result below the target was desirable.

Results

The average cost to provide the Western Australian St John Ambulance service and the Royal Flying Doctor Service in 2014–15 was $63 (see Figure 17).

Figure 17: **Cost per capita of Royal Flying Doctors Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$47.47	$52.32	$59.38	$65.25	$63
Target	$47.94	$53.16	$56.23	$63.75	$63

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013, 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 2013 target per preventable disease is based on the 2012 National Person Years of Life Lost per 1,000 population:

Preventable disease	Target (in years)
Lung cancer	1.8
Ischaemic heart disease	2.4
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 and melanomas among Western Australians decreased in 2013 and were below the target of 1.8 and 0.5 respectively. The years of life lost from premature death due to ischaemic heart disease and falls were slightly above target.

Since 2004, ischaemic heart disease, lung cancer and melanoma have all shown decreases in the potential years of life lost (see Table 10).

Table 10: **Person years of life lost due to premature death associated with preventable conditions, 2004–2013**

Condition	Calendar years										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Target
Lung cancer	1.9	1.9	2.0	2.1	1.7	2.1	1.7	1.8	1.8	**1.5**	**1.8**
Ischaemic heart disease	3.4	3.3	3.3	3.7	3.3	3.3	2.9	3.1	2.5	**2.5**	**2.4**
Falls	0.3	0.5	0.4	0.4	0.5	0.5	0.3	0.4	0.2	**0.4**	**0.2**
Melanoma	0.8	0.8	0.7	0.7	0.5	0.7	0.5	0.6	0.6	**0.4**	**0.5**

Notes:

1. Age-standardised PYLLs per 1,000 population.
2. 2004–2011 deaths are final, 2012 deaths are revised and 2013 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.

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

In 2014, non-Aboriginal children in WA at 12 months of age exceeded the target of 90 per cent. However, Aboriginal children continue to have lower rates of immunisation coverage than non-Aboriginal children at 12 months, with the largest difference observed in the metropolitan area at 76.6 per cent. This is associated with a delay in the administration of vaccinations (see Table 11).

The percentage of children immunised at 2 years was below target across metropolitan and country areas. The exception was non-Aboriginal children living in the country. The decline in immunisation rates in the 2-year age group is associated with a change in the definition for 'fully immunised' observed in all Australian jurisdictions.

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 increased since 2010 and is currently within the target range.

Timely immunisation among Aboriginal children is currently a key focus of the Department of Health with the aim to ensure Aboriginal children receive early childhood immunisations without delay in order to protect from vaccine-preventable disease.

Table 11: **Percentage of children fully immunised, by selected age cohort, by Aboriginality, 2010–2014**

Children immunised		2010	2011	2012	2013	2014
12 months (%)						
State	Aboriginal	81.3	81.1	79.1	82.5	**84.0**
	Non-Aboriginal	90.8	90.6	91.3	90.3	**91.5**
Metropolitan	Aboriginal	75.1	82.4	73.3	75.7	**76.6**
	Non-Aboriginal	90.8	90.3	91.0	90.2	**91.3**
Country	Aboriginal	85.4	86.1	82.8	87.0	**88.8**
	Non-Aboriginal	90.7	91.4	92.4	91.1	**92.4**
2 years (%)						
State	Aboriginal	84.0	91.2	92.7	90.4	**85.7**
	Non-Aboriginal	90.2	90.7	90.3	90.7	**89.0**
Metropolitan	Aboriginal	74.6	74.1	89.1	85.7	**80.7**
	Non-Aboriginal	90.1	90.3	89.7	90.2	**88.6**
Country	Aboriginal	84.8	93.4	94.8	93.6	**89.2**
	Non-Aboriginal	90.7	92.2	92.4	92.9	**90.8**
5 years (%)						
State	Aboriginal	81.4	81.6	90.5	90.3	**92.3**
	Non-Aboriginal	86.0	87.5	89.2	89.6	**90.4**
Metropolitan	Aboriginal	74.6	74.1	86.6	84.6	**87.7**
	Non-Aboriginal	85.4	87.0	88.7	89.0	**90.1**
Country	Aboriginal	85.9	87.2	93.0	94.1	**95.2**
	Non-Aboriginal	87.9	89.5	91.2	91.6	**91.8**

Note: Data based on children aged 12 ≤ 15 months, 24 ≤ 27 months and 60 ≤ 63 months between 1 January 2014 – 31 December 2014.

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.

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 *Western Australian Immunisation Strategy 2013–15*, 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 2014 is no reported hospitalisation in any category.

Results

In 2014, the rate of WA hospitalisations for Aboriginals and non–Aboriginals aged 0–12 years for pertussis were 36.9 per 100,000 and 4.3 per 100,000, respectively. Pertussis remains an endemic disease and despite high childhood vaccination coverage periodic epidemics occur, as pertussis vaccines are not as effective as other childhood vaccines in preventing infection. Also, increased rates of pertussis experienced in Australia since 2010 are thought to be associated with increased and improved testing, and waning immunity of individuals.

The rate of hospitalisation for measles and mumps was nil, with the exception of 0.5 rates of hospitalisation for both conditions in non-Aboriginals aged 0–17 residing in the metropolitan area. No hospitalisations for hepatitis B were reported (see Table 12).

In the past five years no hospitalisations for rubella, diphtheria, poliomyelitis and tetanus have been reported.

Table 12: **Rate of hospitalisation for potentially preventable diseases (per 100,000), 2010–2014**

Preventable disease		2010	2011	2012	2013	2014
Whooping Cough (Pertussis): 0–12 year olds						
State	Aboriginal	17.95	86.16	59.63	23.0	**36.9**
	Non-Aboriginal	10.00	19.33	14.76	9.3	**4.3**
Metropolitan	Aboriginal	35.73	145.12	63.00	24.8	**33.5**
	Non-Aboriginal	6.94	17.28	15.49	8.6	**3.4**
Country	Aboriginal	0.07	50.79	57.71	21.9	**39.5**
	Non-Aboriginal	0.20	26.47	12.15	12.1	**10.4**
Measles: 0–17 year olds						
State	Aboriginal	3.25	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.00	0.18	0.00	0.0	**0.0**
Metropolitan	Aboriginal	0.00	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.00	0.00	0.00	0.0	**0.5**
Country	Aboriginal	0.05	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.00	0.76	0.00	0.0	**0.0**
Mumps: 0–17 year olds						
State	Aboriginal	0.00	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.86	0.00	0.19	0.2	**0.0**
Metropolitan	Aboriginal	0.00	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.26	0.00	0.24	0.0	**0.5**
Country	Aboriginal	0.00	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.00	0.00	0.00	0.9	**0.0**
Hepatitis B: 0–12 year olds						
State	Aboriginal	0.00	0.00	0.00	4.6	**0.0**
	Non-Aboriginal	0.00	0.00	0.00	0.3	**0.0**
Metropolitan	Aboriginal	0.00	0.00	0.00	0.0	**0.0**
	Non-Aboriginal	0.00	0.00	0.00	0.0	**0.0**
Country	Aboriginal	0.00	0.00	0.00	7.3	**0.0**
	Non-Aboriginal	0.00	0.00	0.00	1.2	**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 2013, 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.

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 health care for all Western Australians, specialised 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 dental health services emphasises the need for a focus on prevention and health promotion.

This indicator measures the access and timeliness to specialised oral treatment services by monitoring the number of all eligible patients on the oral waiting list who have received treatment during the year. Through monitoring specialised 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 2014–15 target by dental speciality:

Dental speciality	Number
General practice	1,725
Oral Surgery	1,510
Orthodontics	2,310
Paedodontics	780
Periodontics	530
Other	830

Results

In 2014–15, the number of eligible patients receiving treatment through the Oral Health Centre of Western Australia were below the set targets for all specialities with the exception of 'other' (see Table 13). The decline in patients receiving treatment in 2014–15 is due to fewer specialists being available than in 2012–13 and 2013–14. In 2015–16, it is expected that Oral Health Centre of Western Australia will achieve its target activity with the recruitment of five new dental/specialist positions.

Table 13: **Number of eligible patients on the Oral Health Centre of Western Australia dental waiting list who received treatment in the financial year, 2010–11 to 2014–15**

Dental speciality	Year					
	2010–11	2011–12	2012–13	2013–14	2014–15	Target
General practice	2,859	1,598	2,659	1,264	**1,718**	**1,725**
Oral Surgery	1,582	2,646	1,343	2,544	**918**	**1,510**
Orthodontics	3,133	2,759	2,801	2,076	**1,288**	**2,310**
Paedodontics	790	643	930	781	**574**	**780**
Periodontics	872	302	968	534	**286**	**530**
Other	1,058	1,656	1,293	1,200	**1,131**	**830**
Total	10,294	9,604	9,994	8,399	**5,915**	**7,685**

Notes:

1. 'Other' includes the specialities of Endodontics, Oral Pathology, Restorative Care and Temporomandibular Joint.
2. 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.

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 Australian and 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, and ensuring the provision of the most appropriate care to those in need. This enhances the health and wellbeing of elderly Western Australians.

Target

The 2014–15 target for the percentage of clients maintaining or improving functional ability is 65 per cent.

Results

In 2014–15, the percentage of clients maintaining or improving functional ability was 69 per cent (see Table 14).

Table 14: **Percentage of clients maintaining or improving functional ability while in transition care, 2010–11 to 2014–15**

Indicator	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)
Clients maintaining or improving functional ability	65	67	69	68	**69**
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 2014–15, the target is 343 per 1,000 home and community care target population.

Results

In 2014–15, the rate per 1,000 target population receiving home and community care services was 370, slightly above the target of 343 (see Table 15).

Table 15: **Rate per 1,000 home and community care target population receiving HACC services, 2010–11 to 2014–15**

Indicator	2010–11	2011–12	2012–13	2013–14	2014–15
HACC target population (per 1,000)	352	371	368	362	**370**
Target (per 1,000)	-	-	-	347	**343**

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 the:
   a. 2012 population indexed to approximate population growth
   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 2014–15 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 2014–15, 1,055 Home and Community Care clients were involved in the *Home and Community Care Program, Quality of Life Client Survey*, a participation rate of 77.5 per cent. Of all survey respondents 82.9 per cent believed the Home and Community Care Program helped them to be independent, while 92.0 per cent stated it improved their quality of life (see Table 16).

Table 16: **Home and Community Care Program, Quality of Life Client Survey results, 2010–11 to 2014–15**

	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	Target (%)
Percentage of clients that believe the Home and Community Care program helps them to become independent	95.3	92.8	88.0	89.0	**82.9**	**85.0**
Percentage of clients that believe the Home and Community Care program improves their quality of life	96.4	94.8	92.5	93.9	**92.0**	**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) [79.9 , 85.9] and (b) [89.0 , 95.0].

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

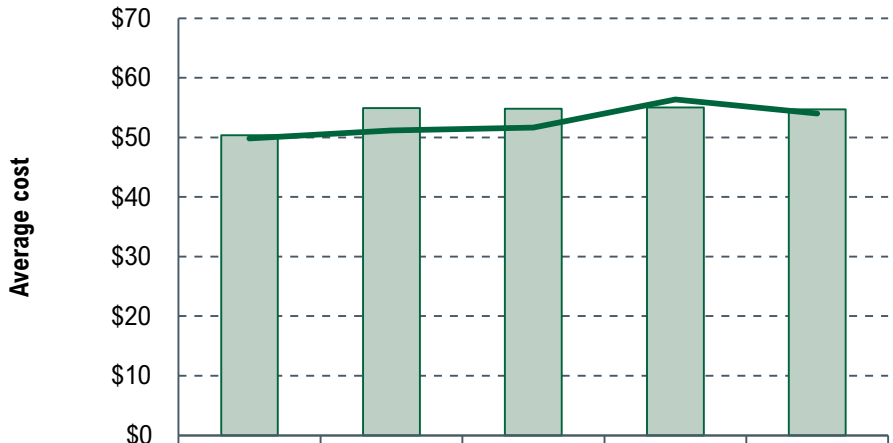
The target unit cost for 2014–15 is $54 per capita to provide preventative interventions, health promotion and health protection activities.

A result below the target is desirable.

Results

In 2014–15, the average cost to provide public health activities was $55 (see Figure 18).

Figure 18: **Cost per capita of providing preventive interventions, health promotion and health protection activities, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$50.34	$54.94	$54.81	$55.01	$55
Target	$49.84	$51.16	$51.63	$56.37	$54

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013, 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 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.

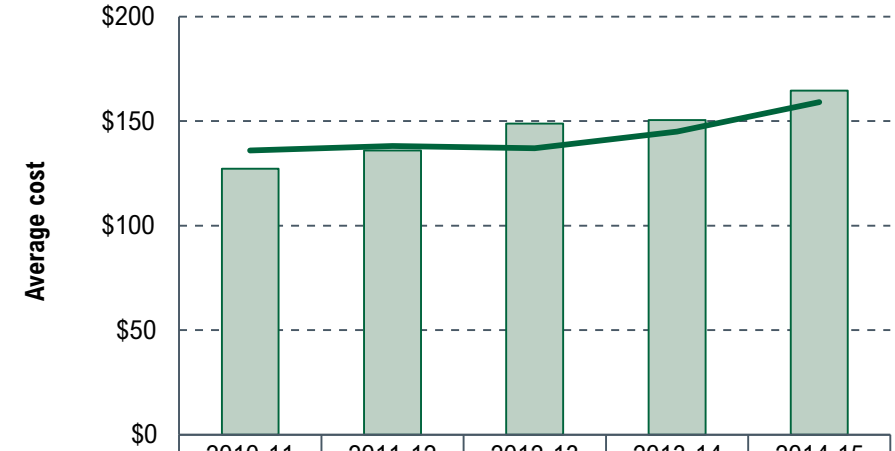
Target

The 2014–15 target unit cost is $159 per dental service provided by the Oral Health Centre of Western Australia. A result below the target is desirable.

Results

The average cost per dental service provided by the Oral Health Centre of Western Australia in 2014–15 was $165, slightly above the target of $159 (see Figure 19).

Figure 19: **Average cost per dental service provided by the Oral Health Centre of Western Australia, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$127	$136	$149	$150	$165
Target	$136	$138	$137	$145	$159

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 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.

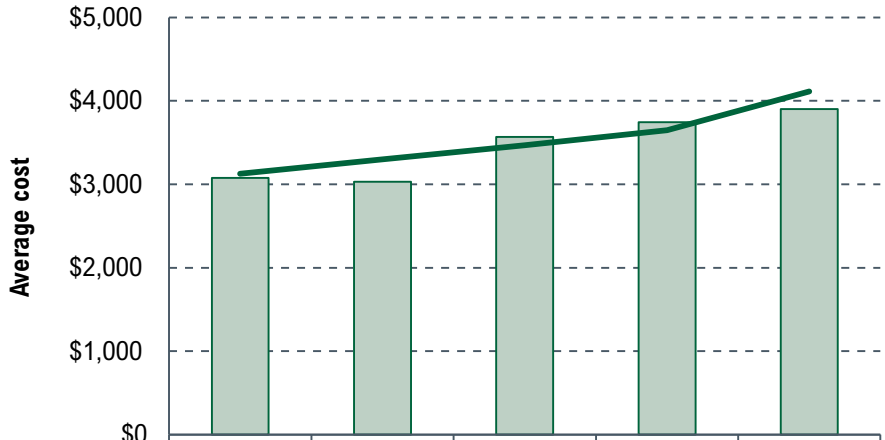
Target

The 2014–15 target unit cost is $4,111 per person of Home and Community Care services to people with a long term disability. A result below the target is desirable.

Results

In 2014–15, the average cost per person to provide Home and Community Care services to people with a long term disability was $3,901, below the target of $4,111 (see Figure 20).

Figure 20: **Average cost per person of Home and Community Care services delivered to people with long term disability, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014 –15
Ave cost	$3,075	$3,030	$3,569	$3,745	$3,901
Target	$3,125	$3,299	$3,468	$3,649	$4,111

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.

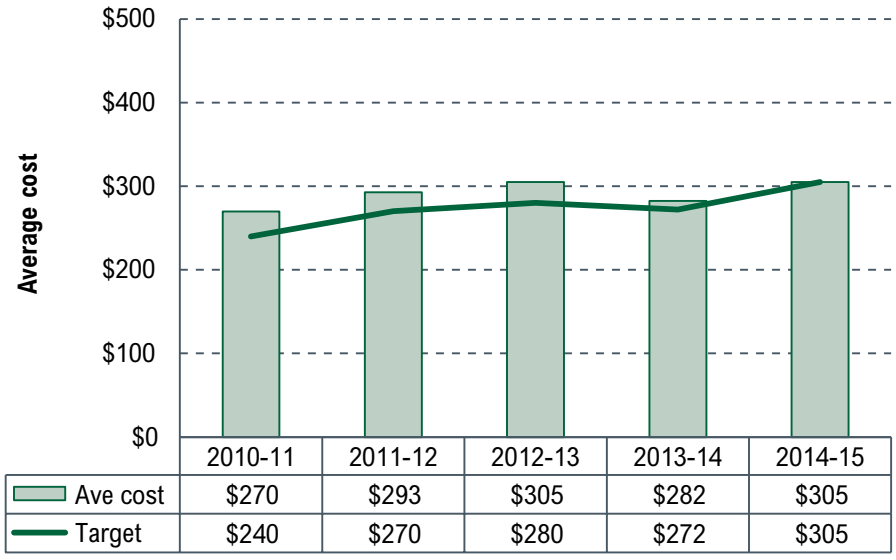
Target

The 2014–15 target unit cost is $305 per transition care day. A result below the target is desirable.

Results

The average cost per transition care day in 2014–15 was $305 (see Figure 21).

Figure 21: **Average cost per transition care day, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$270	$293	$305	$282	$305
Target	$240	$270	$280	$272	$305

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 or vital modifications to be made to their homes or when their carer needs a break.

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.

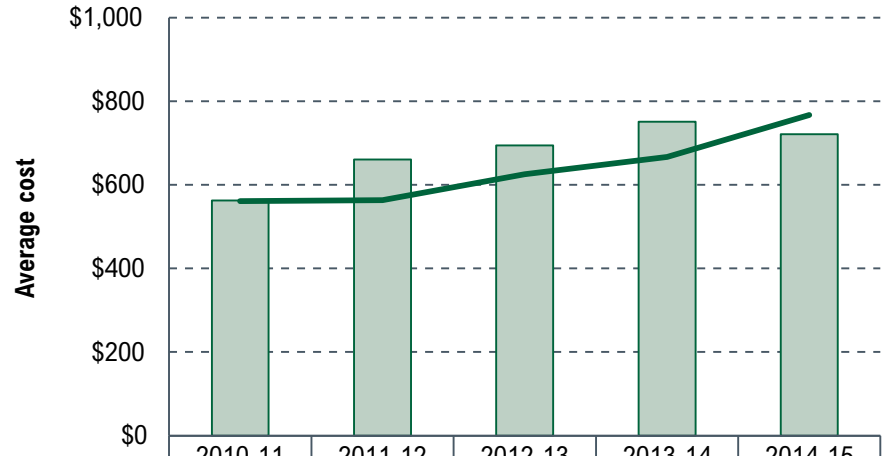
Target

The 2014–15 target unit cost is $767 per day of care for non-acute admitted continuing care. A result below the target is desirable.

Results

In 2014–15, the average cost per day to provide non-acute admitted continuing care was $721, below the target of $767 (see Figure 22).

Figure 22: **Average cost per day of care for non-acute admitted continuing care, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$562	$661	$694	$751	$721
Target	$561	$563	$625	$667	$767

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

For 2014–15 the target has been changed to reflect the unit cost within the 2015–16 budget papers.

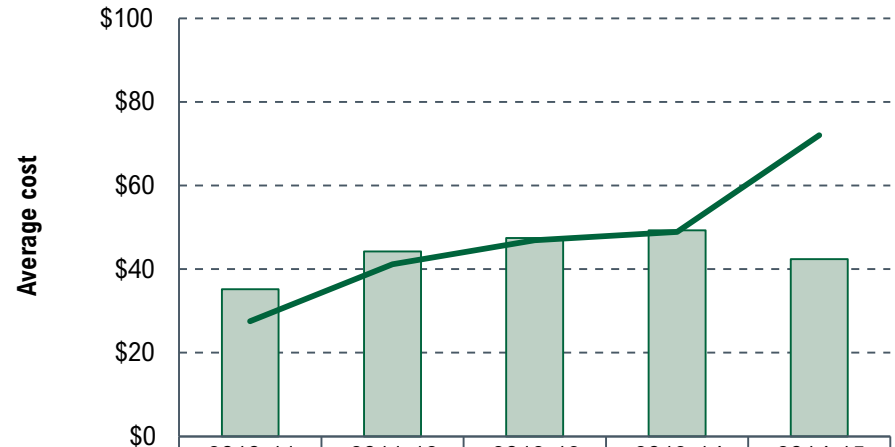
The 2014–15 target unit cost is $72 to support patients who suffer specific chronic illness and other clients who require continuing care. A result below the target is desirable.

Results

For 2014–15, the average cost to support patients who suffer specific chronic illness and clients who require continuing care was $42 and below target (see Figure 23).

The expenditure variance to target is attributable to the target including an overestimation of increased expenditure for contracted services.

Figure 23: **Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$35.19	$44.19	$47.45	$49.28	$42
Target	$27.54	$41.16	$46.88	$48.93	$72

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 17). For details of individual board or committee members please refer to Appendix 1.

Table 17: **Summary of State Government boards and committees within the Department of Health, 2014–15**

Board/Committee name	Total remuneration
Animal Resources Authority Board	$1,360
Cardiovascular Health Network Executive Advisory Group	$0
Department of Health WA Human Research Ethics Committee	$49,460
Diabetes and Endocrine Health Network Executive Advisory Group	$180
Falls Prevention Health Network Executive Advisory Group	$0
Fluoridation of Public Water Supplies Advisory Committee	$150
Local Health Authorities Analytical Committee	$632
Musculoskeletal Health Network Executive Advisory Group	$180
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia	$27,066
Pharmacy Registration Board of Western Australia	$22,430
Radiological Council	$0
Renal Health Network Executive Advisory Group	$1,028
Respiratory Health Network Executive Advisory Group	$1,026
Stimulant Assessment Panel	$2,304
Western Australian Aged Care Advisory Council	$575
Western Australian Board of the Medical Board of Australia	$32,249

Board/Committee name	Total remuneration
Western Australian Board of the Nursing and Midwifery Board of Australia	$29,232
Western Australian Child and Youth Health Network Executive Advisory Group	$60
WA Health Transition and Reconfiguration Steering Committee	$0
WA Reproductive Technology Council	$32,944
WA Reproductive Technology Counselling Committee	$994
WA Reproductive Technology Counselling Embryo Storage Committee	$0
WA Reproductive Technology Counselling Licensing and Administration Advisory Committee	$0
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee	$710
WA Reproductive Technology Counselling Scientific Advisory Committee	$639
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.

Fees and charges also apply as follows:

- 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 is the holder of 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 in receipt of 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 remodelling 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.

Table 18: **Major Asset Investment Program works completed in 2014–15**

Initiative	Estimated total cost in 2014–15 $`000
Metropolitan Health Service	
Capital Works (including major redevelopments and equipment)	
Fremantle Hospital – B Block Roof Replacement	4,469
FSH ICT – Intensive Care Clinical Information Systems (ICCIS)	4,200
Graylands Hospital – Redevelopment Planning	600
Kalamunda Maternity Service	482
King Edward Memorial Hospital – Holding	1,397
King Edward Memorial Hospital Maternal Fetal Assessment	5,500
Mandurah Community Health Centre – Development Stage 2	3,418
Murray District Health Centre	4,970
Peel Health Campus – Emergency Department Expansion	3,000
Peel Health Campus – Theatres Cooling System	480
Princess Margaret Hospital – Emergency Power Generation System	2,546
QEIIMC – Hydraulics Infrastructure Upgrade	5,814

Initiative	Estimated total cost in 2014–15 $`000
QEIIMC Electrical Switchgear Upgrade	2,291
QEIIMC Pneumatic tube upgrade	1,161
QEIIMC – State Mortuary Extension	2,301
Rockingham Kwinana Hospital – Redevelopment Stage 1	113,280
SCGH Rethermalisation System Replacement	900
Swan District Hospital ED Upgrade	310
Subtotal	**157,119**
WA Country Health Service	
Capital Works (including major redevelopments and equipment)	
Albany Regional Resource Centre – Redevelopment Stage 1	168,341
Broome Mental Health – 14-bed unit	9,177
Broome Paediatrics Facility	7,862
Broome Regional Resource Centre – Redevelopment Stage 1	42,000
Carnarvon CT Scanner	1,700
Carnarvon Integrated Health Service – Redevelopment Stage 1	2,908
Country Staff Accommodation – Holding	1,111
Denmark Multi-Purpose Centre – Replacement	18,077
Derby Community Mental Health Refurbishment	1,177
East Kimberley Development Package	41,129
Esperance CT Scanner	1,426
Hedland Regional Resource Centre – Stage 2	136,371
Kimberley – Various Health Project Developments	45,300
Kimberley Renal Support Service (KRSS)	400
Kununurra Integrated District Health Service – Development (incl New Dental Clinic)	5,900
Nickol Bay Hospital Roof Replacement	2,500
Regional Health Administrative Accommodation	2,174
South West Health Campus – Critical Care Unit	14,688
South West Health Campus – Upgrade of Engineering Infrastructure Works	1,693
WACHS – Holding	1,104
WACHS PACS – Regional Resource Centre	6,300
Wyndham Multi-Purpose Centre – Development	4,100
Subtotal	**515,438**

Initiative	Estimated total cost in 2014–15 $`000
Statewide	
Chemotherapy and Radiotherapy Election Commitment	2,080
Clinical Training Fund	3,301
COAG Four Hour Rule Solutions – ABM/Decision Support System	4,539
Community Health Facilities Expansion Statewide	6,202
Community Mental Health Initiatives	5,822
Hospital Nurses Support Fund	2,282
Information and Communication Technology	237,863
Junior Doctors – Simulated Learning Environments	1,004
Neonatal Medical Equipment	875
PABX Upgrade	3,812
Subtotal	**267,780**

Table 19: **Major capital works in progress during 2014–15**

Initiative	Estimated Total Cost in 2014–15 ($'000)[a) i]	Reported in 2013–14 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Metropolitan Health Service				
Armadale Kelmscott Hospital – Development	15,970	15,970	0	Jan 17
Fiona Stanley Hospital – Development[7]	1,607,281	1,600,526	6,755	Complete
Fremantle Hospital – Holding[1]	1,550	1,550	0	Complete
FSH ICT – Pharmacy Automation[1]	9,600	0	9,600	Apr 16
Joondalup Health Campus – Development Stage 11	218,152	223,952	-5,800	Jul 15
Joondalup Health Campus Telethon Paediatric Ward[1]	15,018	0	15,018	Apr 16
Kalamunda Hospital – Redevelopment Stage 2	9,761	9,761	0	TBA
Kalamunda Hospital Surgical Theatres Redevelopment	2,864	2,864	0	Complete
Midland Health Campus – Development Stage 1	360,200	360,200	0	Jun 15

Initiative	Estimated Total Cost in 2014–15 ($'000)[a) i]	Reported in 2013–14 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Osborne Park Hospital additional parking facility	3,500	3,500	0	TBA
Peel Health Campus – Development Stage 1	2,464	2,464	0	Dec 16
Perth Children's Hospital – Development [1,7]	1,162,668	1,168,734	-6,066	Nov 15
Perth Children's Hospital Information Communication Technology[1]	187,980	0	187,980*	Various
Princess Margaret Hospital – Holding[1]	6,462	6,962	-500	Various
QEIIMC – Multi Deck Carpark Planning Phase 2[7]	3,487	5,125	-1,638	Complete
QEIIMC – New Central Plant Facility[7]	221,562	221,762	-200	Complete
Royal Perth Hospital – Plastics Clinics Relocation[7]	4,596	4,636	-40	Complete
Royal Perth Hospital Medical Oncology Redevelopment	2,450	0	2,450	Complete
Royal Perth Hospital Redevelopment Stage 1[1]	8,000	180,000	-172,000*	Various
SCGH – G Block Lift Upgrade[7]	6,092	6,101	-9	Complete
SCGH – Mental Health Unit[7]	28,926	28,932	-6	Complete
SCGH – Redevelopment Stage 1[1,7]	51,730	52,736	-1,006	Various
South Metropolitan Health Service Reconfiguration (Fiona Stanley Hospital link)[2]	1,111	0	1,111	Various
State Rehabilitation Service – Development[7]	225,689	230,802	-5,113	Complete
WA Country Health Service				
Busselton Health Campus[7]	120,227	120,271	-44	Complete
Carnavon Health Campus Redevelopment[7]	26,191	26,497	-306	Sep 15
Country – Staff Accommodation-Stage 4	8,889	8,889	0	Complete
Country – Transport Initiatives	3,326	3,326	0	Various
Country Staff Accommodation – Stage 3[7]	27,161	27,666	-505	Dec 15

Initiative	Estimated Total Cost in 2014–15 ($'000)[a) i]	Reported in 2013–14 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Eastern Wheatbelt District (including Merredin) – Stage 1	9,000	9,000	0	Aug 16
Enhancing Health Services for the Pilbara in Partnership With Industry[7]	8,483	8,286	197	Various
Esperance Health Campus Redevelopment[7]	32,743	32,747	-4	Nov 16
Exmouth Multipurpose Service Redevelopment[7]	7,684	7,820	-136	Oct 15
Harvey Health Campus Redevelopment[7]	13,879	13,900	-21	Feb 19
Kalgoorlie Regional Resource Centre – Redevelopment Stage 1[7]	58,345	58,900	-555	Apr 15
Karratha Health Campus – Development[7]	207,142	207,130	12	Apr 18
Remote Indigenous Health[7]	21,156	22,000	-844	Various
Southern Inland Health Initiative – Integrated District Health Campuses[2]	145,436	147,100	-1,664	Dec 18
Southern Inland Health Initiative – Primary Health Centres[7]	43,314	43,360	-46	Various
Southern Inland Health Initiative – Small Hospitals & Nursing Posts[7]	108,718	108,604	114	Dec 17
Southern Inland Health Initiative – Telehealth	5,496	5,496	0	Dec 16
St John's Ambulance (Regional WA)[7]	1,838	1,889	-51	Aug 15
Strengthening Cancer Services – Regional Cancer Patient Accommodation	4,507	4,507	0	Jun 18
Strengthening Cancer Services in Regional WA - Geraldton Cancer Centre	4,100	4,100	0	Jun 16
Upper Great Southern District (including Narrogin) – Stage 1	9,000	9,000	0	Aug 18
WACHS Staff Accommodation Transition Project[7]	942	943	-1	Complete
Wheatbelt Renal Dialysis[2]	2,000	0	2,000	Aug 18

Initiative	Estimated Total Cost in 2014–15 ($'000)[a) i]	Reported in 2013–14 ($'000)[a) ii]	Variance ($'000)	Expected Completion Date
Statewide				
BreastScreen WA – Digital Mammography Technology[7]	12,998	13,322	-324	May 16
Clinical Incident Management System (CIMS)[7]	4,405	4,557	-152	Complete
Corporate and Shared Services Reform – HCN[7]	9,824	10,697	-873	Jun 15
Equipment Replacement Program[1,7]	441,040	495,584	-54,544	Ongoing
Land Acquisition	5,750	5,750	0	N/A
Minor Buildings Works[7]	145,423	141,367	4,056	Ongoing
NPA – Improving Public Hospital Services[7]	89,397	91,515	-2,118	Dec 16

Notes:

a) The above information is based on:
   i. 2014–15 published budget papers.
   ii. 2013–14 published budget papers.

b) Completion timeframes are based upon a combination of known dates at the time of reporting.

c) Projects listed above as 'complete' may still be in the defects period.

d) Project variations were due to the following:
   1 transfer of funding between projects
   2 *Royalties for Regions* Funding changes
   3 additional state funding
   4 additional Commonwealth funding
   5 transfer of funding from recurrent
   6 impact of Whole of Government Capital Audit
   7 2014–15 budget excludes amounts that will not be capitalised, therefore the estimated total cost appears lower than reported in the 2013–14 Budget.

* denotes reallocation of funds from Royal Perth Hospital to the Perth Children's Hospital ICT, leaving funds to undertake planning for RPH's future needs.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, in comparison with the preceding financial year. Table 20 shows the number of Department of Health full-time equivalent employees for 2013–14 and 2014–15 as at June 2015.

Table 20: **Department of Health total full-time employees by category**

Category	Definition	2013–14	2014–15
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	759	813
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.	26	32
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	14
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	3	3
Medical support	Includes all allied health and scientific/technical related occupations.	35	37
Nursing	Includes all nursing occupations. Does not include agency nurses.	26	31
Site services	Includes engineering, garden and security-based occupations.	0	0
Other categories	Includes Aboriginal and ethnic health worker related occupations.	1	1
	Total	**864**	**931**

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 this as 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', opportunities
- the in-house training program that provides legislative and public sector compliance, safety and quality and leadership and management skills training
- 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 2014–15 included the completion of new industrial agreements for health professionals, administrative, clerical, technical and supervisory staff and the oral health workforce. Progress was also made in negotiations for a new industrial agreement for hospital support workers.

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 & Rehabilitation 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 2014–15 a total of 4 workers' compensation claims were made (see Table 21).

Table 21: **Number of Department of Health workers' compensation claims in 2014–15**

Employee category	Number
Nursing Services/Dental Care Assistants	0
Administration and Clerical	4
Medical Support	0
Hotel Services	0
Maintenance	0
Medical (salaried)	0
Total	**4**

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, dietitions 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.

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 2014–15, no Department of Health senior officer declared a pecuniary interest.

Other legal disclosures

Advertising

In 2014–15, in accordance with section 175Z of the *Electoral Act 1907*, the Department of Health incurred a total advertising expenditure of $2,289,297 (see Table 22). The majority (93%) of all expenditure was afforded to media advertising organisations and advertising agencies.

Table 22: **Summary of Department of Health advertising in 2014–15**

Summary of advertising	Amount ($)
Advertising agencies	181,001
Market research organisations	988,594
Polling organisations	0
Direct mail organisations	30,603
Media advertising organisations	1,089,099
Total advertising expenditure	**2,289,297**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 23.

Table 23: **Department of Health advertising, by class of expenditure, 2014–15**

Recipient /organisations	Amount ($)
Advertising agencies	
The Brand Agency	173,917
303 Lowe	7,084
Total	**181,001**
Market research organisations	
Painted dog	18,920
Metrix	36,053
Ipsos	37,840
Edith Cowan University	895,781
Total	**988,594**
Polling organisations	
	0
Total	**0**
Direct mail organisations	
Quickmail	30,603
Total	**30,603**
Media advertising organisations	
OMD	274,440
Carat	594,953
Adcorp	18,816
Facebook	4,316
International recruitment	196,574
Total	**1,089,099**
Total advertising expenditure	**2,289,297**

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.

Amendments to the *Disability Services Act 1993* resulted in a key change for public authorities in WA in June 2014. Public authorities are now required 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*.

The following information details the current initiatives and programs being implemented by the Department of Health in line with the *WA Health Disability Access and Inclusion Plan 2010–15*.

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.

In the organisation of internal or external events, consideration and planning is undertaken to select appropriate venues which 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 can be provided for people with disability if required and all communication materials can be provided in alternate formats.

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 including the canteen, gym and education and training facilities are on ground floor level. These areas include motion-activated and timed access doors.

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*.

Website content is accessible and supportive of the requirements for people with disabilities that are using assistive technologies. Publications can be provided in larger fonts, audio and/or PDF with accessibility features that improve readability for people with visual impairment.

Quality of service by staff

Delivering information and services is undertaken in accordance with the *State Government Access Policy* and *the Disability Access and Inclusion Policy 2010–15*.

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. In September 2014 a recommendation was endorsed to align the internal reporting and management requirements for disability access and inclusion planning and reporting. This will facilitate more specific and targeted attention to this area within the Department of Health.

Opportunity to provide feedback

The Department of Health's Complaint Management Policy outlines the processes for consumers, patients and carers to make a complaint about the care they receive in a State public hospital. People with disability are provided with the same access to a complaints management process, with complaints able to 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 as appropriate to ensure that barriers to inclusion or participation are addressed.

The Department of Health initiatives and programs are assessed for potential impact for people with disability within the staffing population or broader public impact. Facilitated focus groups are generally used as a consultation approach in this regard.

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 employees of WA Health are responsible for ensuring that their behaviour reflects the standards of conduct embodied in the *WA Health Code of Conduct*. 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. Since 2010, a total of 42,155 WA Health employees have undertaken the Accountable and Ethical Decision Making training.

The Department of Health is also required to review and investigate all complaints alleging non-compliance with the *Code of Ethics or Code of Conduct*. In 2014–15, a total of 61 applications were lodged and investigated internally.

Compliance in relation 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 2014–15, two Breach of Standard claims were lodged concerning the recruitment, selection, and appointment process, and the process of the management of an employee's performance. One claim is currently with the Public Sector Commission for review, the other remains pending.

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.

Members of the public can access varying types of Department of Health information from the WA Health internet website WA Health (http://ww2.health.wa.gov.au). This includes health related reports and publications, information concerning health service performance, research and health data/statistics.

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
Corporate 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 2398
Email foi@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, in the event of an adverse access decision.

For the year ending 30 June 2015, the Department of Health dealt with 84 applications for information, of which 40 applications were granted full or partial access and 23 were refused (see Table 24).

Table 24: **Freedom of Information applications to the Department of Health in 2014–15**

Summary of number of applications	Number
Applications carried over from 2013–14	4
Applications received in 2014–15	80
Total number of applications active in 2014–15	84
Applications granted – full access	20
Applications granted – partial or edited access	20
Applications withdrawn by applicant	3
Applications refused	23
Applications in progress	1
Other applications	17
Total number of applications dealt with in 2014–15	**84**

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.

In 2014–15, the Department of Health continued 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 the recordkeeping system(s), disposal arrangements, policies, practices and processes. Staff compliance within the Department of Health was monitored through an audit in 2014–15.

Recordkeeping training is provided for staff via a range of educational initiatives that include:

- intranet websites and newsletters
- online recordkeeping awareness training
- online induction programs in recordkeeping
- inclusion of a recordkeeping module in Accountability and Ethical Decision Making training.

The primary means for raising awareness of recordkeeping is the Online Recordkeeping Awareness training. In total 43,076 staff have been enrolled in the training course, with 8,364 staff enrolled during 2014–15 and 6,963 staff completing the training during 2014–15.

The efficiency and effectiveness of the recordkeeping training program is reviewed on a regular basis via feedback and assessments of training by attendees. These training programs have proved popular, with 83 per cent of staff describing the course as either informative, essential or stimulating, and 88 per cent of staff agreeing that their knowledge has improved as a consequence of the training.

Significant documents created in 2014–15 include a revised Patient Information Retention and Disposal Schedule and the Digitisation and Disposal of Patient Records Policy.

Within the Department of Health, more than 270,000 records were captured into the Electronic Documents and Records Management Systems during 2014-15. Health Corporate Network also captured more than 2.5 million records.

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 addressing the diverse needs and sensitivities of the communities in which it operates.

Each entity within WA Health has developed policies and implemented initiatives distinctive to its unique environment, and appropriate and sensitive to cultural needs, patient focussed, innovative, accessible and safe.

In 2014–15 the Department of Health developed and continued to implement a number of initiatives to ensure substantive equality continues across all areas of service. Some of these initiatives include:

- Aboriginal Health launching the *WA Aboriginal Health and Wellbeing Framework 2015–2030*
- Public Health facilitating a number of forums and seminars that consulted on effective strategies and approaches to engaging with people from culturally linguistic and diverse backgrounds
- continued delivery of the Aboriginal Health Worker Up-skilling Project, providing professional training opportunities to further the current knowledge, skills and abilities of Aboriginal Health Workers.

Occupational safety, health and injury

WA Health is committed to continuously improving the 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 and health injury management

The Department of Health adopts a continuous improvement approach to occupational safety and health and injury management through the Occupational Safety and Health Committee, which is accountable to the Director, Office of the Director General, Department of Health.

Duties of the Occupational Safety and Health Committee include, but are not limited to:

- advising senior management on policies and statutory obligations regarding occupational safety and health
- evaluating, reporting and developing recommendations to improve the effectiveness of the standards for occupational safety and health
- advising on methods of identification, reduction and control of risks to the safety and health of all Department of Health employees, contractors, visitors and volunteers
- assisting in securing a safe and hygienic working environment through the provision of relevant education, training and resource information.

Compliance with occupational safety and health injury management

The Department of Health is committed to complying with all occupational safety and health legal requirements and continues to develop and implement safe systems and work practices that reflect its commitment to safety and health. This is achieved through ensuring the safety management process is compliant with the requirements of the *Occupational Safety and Health Act 1984* and the coordination of injury management activities is compliant with the *Workers Compensation and Injury Management Act 1981*. Written policies and procedures are in place to support all safety and injury management processes.

Employee consultation

The Department of Health Occupational Safety and Health Committee meets once every six weeks and includes employee representatives from within the Department of Health. The committee meets to facilitate consultation and cooperation in the identification and proactive management of risks within the workplace, including the review of all reported incidents or accidents. The committee also provides advice and feedback to senior managers on policy development.

Committee membership and contact details are communicated to all employees at induction, and via the intranet and noticeboards.

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, including the negotiation of appropriate hours, work duties and reasonable adjustment to any other circumstances.

Occupational safety and health assessment and performance indicators

An external audit of the Department of Health Occupational Safety and Health Management System and its compliance to *The Code of Practice: Occupational Safety and Health in the Western Australian Public Sector* pursuant to the *Occupational Safety and Health Act 1984* was undertaken in February 2015.

Audit results found that the Department of Health was compliant with the code of practice. Recommendations, where identified, have been logged for action and follow up through the Department of Health Corporate Governance audit review process.

The annual performance reported for the Department of Health in relation to occupational safety, health and injury for 2014–15 is summarised in Table 25.

Table 25: **Occupational safety, health and injury performance for 2014–15**

	2014–15
Fatalities	0
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	0.77
Lost time injury severity rate (rate per 100)	46.67
Percentage of injured workers returned to work within 26 weeks	71.4%
Percentage of managers trained in occupational safety, health and injury management responsibilities	34.6%

Special purpose accounts

Government of **Western Australia**
Department of **Treasury**

Your ref : FAA27944
Our ref : 00184523
Enquiries : Lily Mirco
Telephone : 6551 2576

Professor Bryant Stokes
Acting Director General
Department of Health
PO Box 8172
PERTH BUSINESS CENTRE WA 6849

Dear Professor Stokes

MENTAL HEALTH COMMISSION FUND (FIONA STANLEY HOSPITAL) SPECIAL PURPOSE ACCOUNT

Further to your letter of 27 June 2014, I am pleased to advise that acting under the delegated authority from the Treasurer, I have approved:

- pursuant to section 16(1)(d) of the *Financial Management Act 2006* (the Act) the establishment of the Mental Health Commission Fund (Fiona Stanley Hospital) agency special purpose account to be administered by the Department of Health; and
- under section 17(3) and (4) of the Act, the associated special purpose statement.

The original statement is enclosed for your records. A copy of the approved special purpose statement is required to be sent to the Auditor General pursuant to section 17(4) of the Act.

Please note that under Treasurer's Instruction (TI) 950 'Publication of special purpose statements and trust statements', you are required to publish the approved statement in your 2014-15 annual report.

Further, under TI 1103(15)(ii) 'Statements of Financial Position', you are required to separately disclose the special purpose account in the notes to your annual financial statements.

Yours sincerely

Michael Barnes
ACTING UNDER TREASURER
2 JUL 2014

Enc.

Gordon Stephenson House, 140 William Street, Perth, Western Australia 6000
Locked Bag 11, Cloisters Square, Western Australia 6850
Telephone (08) 6551 2777 Facsimile (08) 6551 2500
www.treasury.wa.gov.au

Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(FIONA STANLEY HOSPITAL) ACCOUNT

Version 1.03 (06/14)

Title and Responsibility	A special purpose account, entitled the Mental Health Commission Fund (Fiona Stanley Hospital) Account (the "Account") is to be established and maintained by the Department of Health, pursuant to s16(1)(d) of the *Financial Management Act 2006*.
Purpose	To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the Fiona Stanley Hospital, in accordance with the annual Service Agreement and subsequent agreements.
Commencement Date	1 July 2014
Receipts	There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.
Payments	Moneys standing to the credit of the Account are to be expended for the purposes detailed: ▪ in the Service Agreement between the Mental Health Commission and the Department of Health ▪ in subsequent agreements between the Mental Health Commission and Fiona Stanley Hospital, or the Department of Health and the Mental Health Commission on behalf of Fiona Stanley Hospital.
Administration, Accounting and Reporting	Money in the Account is to be administered, accounted for and reported on by the Director General of the Department of Health in accordance with the *Financial Management Act 2006*, the *Financial Management Regulations 2007*, the *Treasurer's Instructions*, and any other legal requirements.
Completion Date	Not Applicable
Disposal of Funds on Cessation	Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(FIONA STANLEY HOSPITAL) ACCOUNT

Version 1.03 (06/14)

I have examined and agree to the provisions of this Special Purpose Statement.

Professor Bryant Stokes

A/Director General

Department of Health

Date: 27.6.14

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes

A/Under Treasurer

Department of Treasury

Date: 2/7/14

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(NORTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

Title and Responsibility	A special purpose account, entitled the Mental Health Commission Fund (North Metropolitan Health Service) Account (the "Account") is to be established and maintained by the Department of Health, pursuant to s16(1)(d) of the *Financial Management Act 2006*.
Purpose	To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the North Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.
Commencement Date	1 July 2014
Receipts	There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.
Payments	Moneys standing to the credit of the Account are to be expended for the purposes detailed: ▪ in the Service Agreement between the Mental Health Commission and the Department of Health ▪ in subsequent agreements between the Mental Health Commission and the North Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the North Metropolitan Health Service.
Administration, Accounting and Reporting	Money in the Account is to be administered, accounted for and reported on by the Director General of the Department of Health in accordance with the *Financial Management Act 2006*, the *Financial Management Regulations 2007*, the *Treasurer's Instructions*, and any other legal requirements.
Completion Date	Not Applicable
Disposal of Funds on Cessation	Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(NORTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

I have examined and agree to the provisions of this Special Purpose Statement.

Professor Bryant Stokes
A/Director General
Department of Health
Date: 12.6.14

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
A/Under Treasurer
Department of Treasury
Date: 26/6/14

Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(SOUTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

Title and Responsibility	A special purpose account, entitled the Mental Health Commission Fund (South Metropolitan Health Service) Account (the "Account") is to be established and maintained by the Department of Health, pursuant to s16(1)(d) of the *Financial Management Act 2006*.
Purpose	To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the South Metropolitan Health Service, in accordance with the annual Service Agreement and subsequent agreements.
Commencement Date	1 July 2014
Receipts	There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.
Payments	Moneys standing to the credit of the Account are to be expended for the purposes detailed: • in the Service Agreement between the Mental Health Commission and the Department of Health • in subsequent agreements between the Mental Health Commission and the South Metropolitan Health Service, or the Department of Health and the Mental Health Commission on behalf of the South Metropolitan Health Service.
Administration, Accounting and Reporting	Money in the Account is to be administered, accounted for and reported on by the Director General of the Department of Health in accordance with the *Financial Management Act 2006*, the *Financial Management Regulations 2007*, the *Treasurer's Instructions*, and any other legal requirements.
Completion Date	Not Applicable
Disposal of Funds on Cessation	Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(SOUTH METROPOLITAN HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

I have examined and agree to the provisions of this Special Purpose Statement.

Professor Bryant Stokes
A/Director General
Department of Health
Date: 12.6.14

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
A/Under Treasurer
Department of Treasury
Date: 26/6/14

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(CHILD AND ADOLESCENT HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

Title and Responsibility	A special purpose account, entitled the Mental Health Commission Fund (Child and Adolescent Health Service) Account (the "Account") is to be established and maintained by the Department of Health, pursuant to s16(1)(d) of the *Financial Management Act 2006*.
Purpose	To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the Child and Adolescent Health Service, in accordance with the annual Service Agreement and subsequent agreements.
Commencement Date	1 July 2014
Receipts	There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.
Payments	Moneys standing to the credit of the Account are to be expended for the purposes detailed: ▪ in the Service Agreement between the Mental Health Commission and the Department of Health ▪ in subsequent agreements between the Mental Health Commission and the Child and Adolescent Health Service, or the Department of Health and the Mental Health Commission on behalf of the Child and Adolescent Health Service.
Administration, Accounting and Reporting	Money in the Account is to be administered, accounted for and reported on by the Director General of the Department of Health in accordance with the *Financial Management Act 2006*, the *Financial Management Regulations 2007*, the *Treasurer's Instructions*, and any other legal requirements.
Completion Date	Not Applicable
Disposal of Funds on Cessation	Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(CHILD AND ADOLESCENT HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

I have examined and agree to the provisions of this Special Purpose Statement.

Professor Bryant Stokes

A/Director General

Department of Health

Date: 12.6.14

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes

A/Under Treasurer

Department of Treasury

Date: 26/6/14

Department of Health
GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(WA COUNTRY HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

Title and Responsibility	A special purpose account, entitled the Mental Health Commission Fund (WA Country Health Service) Account (the "Account") is to be established and maintained by the Department of Health, pursuant to s16(1)(d) of the *Financial Management Act 2006*.
Purpose	To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the WA Country Health Service, in accordance with the annual Service Agreement and subsequent agreements.
Commencement Date	1 July 2014
Receipts	There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.
Payments	Moneys standing to the credit of the Account are to be expended for the purposes detailed: ▪ in the Service Agreement between the Mental Health Commission and the Department of Health ▪ in subsequent agreements between the Mental Health Commission and the WA Country Health Service, or the Department of Health and the Mental Health Commission on behalf of the WA Country Health Service.
Administration, Accounting and Reporting	Money in the Account is to be administered, accounted for and reported on by the Director General of the Department of Health in accordance with the *Financial Management Act 2006*, the *Financial Management Regulations 2007*, the *Treasurer's Instructions*, and any other legal requirements.
Completion Date	Not Applicable
Disposal of Funds on Cessation	Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement
for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND
(WA COUNTRY HEALTH SERVICE) ACCOUNT

Version 1.03 (06/14)

I have examined and agree to the provisions of this Special Purpose Statement.

Professor Bryant Stokes

A/Director General

Department of Health

Date: 12.6.14

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes

A/Under Treasurer

Department of Treasury

Date: 26/6/14

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Appendices

Appendix 1: Board and committee remuneration

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Animal Resources Authority Board				
Chair	Anthony Tate	Per meeting	12 months	$460
Deputy Chair and Member	Dr Campbell Thomson	Per meeting	12 months	$0
Member	Leslie Chalmers	Per meeting	12 months	$300
Member	Michael Robins	Per meeting	12 months	$0
Member	Prof. Jennet Harvey	Per meeting	12 months	$300
Member	Prof. Elizabeth Rakoczy	Per meeting	12 months	$300
Member	Prof. David Morrison	Per meeting	12 months	$0
Member	Charles Thorn	Per meeting	12 months	$0
			Total:	**$1,360**
Cardiovascular Health Network Executive Advisory Group				
Chair	Dr Jacquie Garton-Smith	Not eligible	Not applicable	$0
Member	Michelle Ammerer	Not eligible	Not applicable	$0
Member	Stephen Bloomer	Not eligible	Not applicable	$0
Member	Tom Briffa	Not eligible	Not applicable	$0
Member	Jille 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	Shirley Fitzthum	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	Tony Mylius	Not eligible	Not applicable	$0
Member	Lesley Nelson	Not eligible	Not applicable	$0
Member	Paul Norman	Not eligible	Not applicable	$0
Member	John Powdrill	Per meeting	12 months	$0
Member	James Rankin	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Member	Julie Smith	Not eligible	Not applicable	$0
Member	Shelley McRae	Not eligible	Not applicable	$0
			Total:	**$0**
Department of Health WA Human Research Ethics Committee				
Chair	Asst. Prof. Judith Allen	Annual	12 months	$19,100
Deputy Chair	Dr Katrina Spilsbury	Per meeting	12 months	$2,970
Member	Jennifer Wall	Per meeting	12 months	$3,300
Member	Patricia Fowler	Per meeting	12 months	$3,630
Member	Dr Alison Garton	Per meeting	12 months	$3,960
Member	Reverend Jenifer Goring	Per meeting	12 months	$3,960
Member	Gary Langham	Per meeting	12 months	$3,300
Member	Ross Monger	Per meeting	12 months	$3,300
Member	Mary Archibald	Per meeting	12 months	$2,640
Member	Mary Miller	Not eligible	Not applicable	$0
Member	Dr Janine Alan	Not eligible	Not applicable	$0
Member	Stephen Woods	Not eligible	Not applicable	$0
Member	Meike Dixon	Per meeting	12 months	$330
Member	Timothy Smith	Not eligible	Not applicable	$0
Member	Prof. Tom Briffa	Per meeting	12 months	$330
Member	Dr Geoffrey Hammond	Not eligible	Not applicable	$0
Member	Assoc. Prof. Angela Ives	Per meeting	12 months	$660
Member	Reverend Brian Carey	Per meeting	12 months	$0
Member	Shane Gallagher	Per meeting	12 months	$660
Member	Dr Phillip Jacobsen	Per meeting	12 months	$660
Member	Kathryn Kirk	Per meeting	12 months	$330
Member	Yvonne Rate	Per meeting	12 months	$330
			Total:	**$49,460**
Diabetes and Endocrine Health Network Executive Advisory Group				
Co-Chair	Dr Scott Westover	Not eligible	Not applicable	$0
Co-Chair	Prof. Tim Davis	Not eligible	Not applicable	$0
Member	Alan Wright	Not eligible	Not applicable	$0
Member	Andrew Wagstaff	Not eligible	Not applicable	$0
Member	Belinda Whitworth	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Member	Bruce Campbell	Per meeting	12 months	$120
Member	Cara Westphal	Not eligible	Not applicable	$0
Member	Dr Chhaya Mehrotra	Not eligible	Not applicable	$0
Member	David Mulligan	Not eligible	Not applicable	$0
Member	Debra Royle	Not eligible	Not applicable	$0
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 Mitchel	Not eligible	Not applicable	$0
Member	Mel Robinson	Not eligible	Not applicable	$0
Member	Merinda March	Not eligible	Not applicable	$0
Member	Rachele Humbert	Not eligible	Not applicable	$0
Member	Dr Rhonda Clifford	Not eligible	Not applicable	$0
Member	Dr 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	Teresa di Franco	Not eligible	Not applicable	$0
Member	Tim Benson	Per meeting	12 months	$60
Member	Prof. Tim Jones	Not eligible	Not applicable	$0
			Total:	**$180**
Falls Prevention Health Network Executive Advisory Group				
Chair	Dr Nicholas Waldron	Not eligible	Not applicable	$0
Member	Emily Anderson	Not eligible	Not applicable	$0
Member	Jenna Athans	Not eligible	Not applicable	$0
Member	Dr Erica Davison	Not eligible	Not applicable	$0
Member	Mononita Ghosh	Not eligible	Not applicable	$0
Member	Ailsa Dinnes	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
Member	Dr Katherine Ingram	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Member	Dr Aru Moodley	Not eligible	Not applicable	$0
Member	Tony Petta	Not eligible	Not applicable	$0
Member	Marisa Skrzypek	Not eligible	Not applicable	$0
Member	Anthea McGuigan	Not eligible	Not applicable	$0
Member	Kim Watkins	Not eligible	Not applicable	$0
Member	Kathryn Devereux	Not eligible	Not applicable	$0
			Total:	**$0**
Fluoridation of Public Water Supplies Advisory Committee*				
Chair	Dr Richard Lugg	Not eligible	Not applicable	$0
Secretary	Richard Theobald	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		Per meeting	12 months	$150
*Approval to withhold the names of the committee members was obtained from the Minister for Health			**Total:**	**$150**
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	$0
Member	David Wilson	Not eligible	Not applicable	$0
Member	Colin Dent	Not eligible	Not applicable	$0
Member	Councillor Belinda Rowland	Per meeting	12 months	$632
			Total:	**$632**
Musculoskeletal Health Network Executive Advisory Group				
Co-Chair	Jennifer Persaud	Not eligible	Not applicable	$0
Co-Chair	Dr Dan Xu	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Member	Kerryn Barton	Not eligible	Not applicable	$0
Member	Assoc. Prof. Kathy Briffa	Not eligible	Not applicable	$0
Member	Eng Soon Chew	Not eligible	Not applicable	$0
Member	Kathryn Devereux	Not eligible	Not applicable	$0
Member	Ric Forlano	Not eligible	Not applicable	$0
Member	Dr Jeff Herbert	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	12 months	$180
Member	Jean Mangharam	Not eligible	Not applicable	$0
Member	Helen Marsden	Not eligible	Not applicable	$0
Member	Yvonne Page	Not eligible	Not applicable	$0
Member	Prof. Stephan Schug	Not eligible	Not applicable	$0
Member	Robyn Timms	Not eligible	Not applicable	$0
Member	Dr James Williamson	Not eligible	Not applicable	$0
			Total:	**$180**
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia				
Chair	Dr Jennifer Thornton	Per meeting	12 months	$8,280
Member	Assoc. Prof. David Leach	Per meeting	12 months	$5,757
Member	Neil McLean	Per meeting	12 months	$6,666
Member	Theodore Sharp	Per meeting	12 months	$6,363
			Total:	**$27,066**
Pharmacy Registration Board of Western Australia				
Chair	John Harvey	Per meeting	12 months	$8,400
Deputy Chair	Zoe Mullen	Per meeting	12 months	$5,060
Member	Prof. Michael Garlepp	Per meeting	12 months	$4,370
Member	Margaret Ford	Per meeting	12 months	$4,600
			Total:	**$22,430**
Radiological Council				
Chair	Dr Andrew Robertson	Not eligible	Not applicable	$0
Deputy Chair	Dr Geoffrey Groom	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Member	Dr Padmini Hewavitharana	Not eligible	Not applicable	$0
Member	Dr Richard Fox	Not eligible	Not applicable	$0
Member	Maxwell Ross	Not eligible	Not applicable	$0
Member	Assoc. Prof. Janice McKay	Not eligible	Not applicable	$0
Member	Gary Fee	Not eligible	Not applicable	$0
Member	Gregory Scott	Not eligible	Not applicable	$0
Deputy Member	Dr Deepthi Dissanayake	Not eligible	Not applicable	$0
Deputy Member	Dr Elizabeth Thomas	Not eligible	Not applicable	$0
Deputy Member	Dr Roger Price	Not eligible	Not applicable	$0
Deputy Member	John O'Donnell	Not eligible	Not applicable	$0
Deputy Member	Assoc. Prof. Zhoghua Sun	Not eligible	Not applicable	$0
Deputy Member	Christopher Whennan	Not eligible	Not applicable	$0
			Total:	**$0**
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	$968
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	Dr Rupthi Hermes	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	$60
Member	Mel Robinson	Not eligible	Not applicable	$0
Member	Prof. Johan Rosman	Not eligible	Not applicable	$0
Member	Emma Griffiths	Not eligible	Not applicable	$0
Member	Dr Stephen Wright	Not eligible	Not applicable	$0
			Total:	**1,028**

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Respiratory Health Network Executive Advisory Group				
Co-Chair	Assoc. Prof. Peter Kendall	Not eligible	Not applicable	$0
Co-Chair	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	Maree Creighton	Not eligible	Not applicable	$0
Member	Dr Jacquie Garton-Smith	Per meeting	12 months	$484
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
Member	Frank Smith	Per meeting	12 months	$60
Member	Kim Watkins	Per meeting	12 months	$242
			Total:	**$1,026**
Stimulant Assessment Panel				
Chair	Neil Keen	Per meeting	12 months	$0
Member	Alpa Dodhia	Per meeting	12 months	$0
Member	Dr Nathan Gibson	Per meeting	12 months	$0
Member	Dr Richard O'Regan	Per meeting	12 months	$0
Member	Dr Peter Rowe	Per meeting	12 months	$0
Member	Dr Johana Stefan	Per meeting	12 months	$0
Member	Dr Oleh Kay	Per meeting	12 months	$2,304
Member	Dr Nikki Panotidis	Per meeting	12 months	$0
Member	Prof. Charles Watson	Per meeting	12 months	$0
			Total:	**$2,304**

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Western Australian Aged Care Advisory Council				
Chair	Dr Penny Flett	Per meeting	12 months	$213
Member	Gail Milner	Not eligible	Not applicable	$0
Member	Rob Willday	Not eligible	Not applicable	$0
Member	Dr Nick Bretland	Per meeting	12 months	$220
Member	Beth Cameron	Not eligible	Not applicable	$0
Member	Dr Ron Chalmers	Not eligible	Not applicable	$0
Member	Paul Coates	Not eligible	Not applicable	$0
Member	Prof. Leon Flicker	Not eligible	Not applicable	$0
Member	Dr Helen McGowan	Not eligible	Not applicable	$0
Member	Rhonda Parker	Not eligible	Not applicable	$0
Member	Paul Purdy	Not eligible	Not applicable	$0
Member	Ann Banks	Per meeting	12 months	$142
Member	Linda Jackson	Not eligible	Not applicable	$0
Member	Jennifer Collard	Not eligible	Not applicable	$0
Member	Trevor Lovelle	Not eligible	Not applicable	$0
			Total:	**$575**
Western Australia Board of the Medical Board of Australia				
Chair	Prof. Constantine Michael	Per meeting	12 months	$4,070
Member	Prof. Bryant Stokes	Not eligible	Not applicable	$0
Member	Assoc. Prof. Peter Wallace	Per meeting	12 months	$3,333
Member	Dr Steven Patchett	Per meeting	12 months	$1,818
Member	Dr Ken McKenna	Per meeting	12 months	$2,727
Member	Dr Michael McComish	Per meeting	12 months	$2,727
Member	Dr Frank Kubicek	Per meeting	12 months	$3,030
Member	Dr Michael Levitt	Per meeting	8 months	$1,818
Member	Maria Ciffolilli	Per meeting	12 months	$3,636
Member	Prudence Ford	Per meeting	12 months	$2,727
Member	Virginia Rivalland	Per meeting	12 months	$3,636
Member	Prof. Stephan Millett	Per meeting	12 months	$2,727
			Total:	**$32,249**

Position	Name	Type of remuneration	2014–15 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	$4,070
Member	Assoc. Prof. Karen Clark-Burg	Per meeting	3 months	$909
Member	Karen Gullick	Per meeting	12 months	$3,030
Member	Jennifer Wood	Per meeting	12 months	$3,636
Member	Anthony Dolan	Per meeting	9 months	$2,428
Member	Michael Piu	Per meeting	12 months	$3,636
Member	Lynn Hudson	Per meeting	9 months	$2,732
Member	Virginia Seymour	Per meeting	12 months	$3,333
Member	Pamela Lewis	Per meeting	12 months	$2,727
Member	Dr Margaret Crowley	Per meeting	3 months	$606
Member	Marie Baxter	Not eligible	Not applicable	$0
Member	Prof. Selma Ailex	Per meeting	9 months	$2,125
			Total:	**$29,232**
Western Australian Child and Youth Health Network Executive Advisory Group				
Co-Chair	Dr Helen Wright	Not eligible	Not applicable	$0
Co-Chair	Dr Alide Smith	Not eligible	Not applicable	$0
Member	Elaine Bennett	Not eligible	Not applicable	$0
Member	Sue Bradshaw	Not eligible	Not applicable	$0
Member	Phillippa Farrell	Not eligible	Not applicable	$0
Member	Denese Griffin	Not eligible	Not applicable	$0
Member	Tanyana Jackiewicz	Not eligible	Not applicable	$0
Member	Caron Molster	Not eligible	Not applicable	$0
Member	Sue Peter	Not eligible	Not applicable	$0
Member	Mel Robinson	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**

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
WA Health Transition and Reconfiguration Steering Committee				
Chair	Prof. Bryant Stokes	Not eligible	Not applicable	$0
Member	Peter Conran	Not eligible	Not applicable	$0
Member	Tim Marney	Not eligible	Not applicable	$0
Member	Michael Barnes	Not eligible	Not applicable	$0
			Total:	**$0**
WA Reproductive Technology Council				
Chair	Prof. Michael Con	Per meeting	12 Months	$2556
Deputy Chair	Prof. Roger Hart	Per meeting	12 Months	$1704
Member	Brenda McGivern	Per meeting	12 Months	$1704
Member	Antonia Clissa	Per meeting	12 Months	$1704
Member	Justine Garbelline	Per meeting	12 Months	$1704
Member	Anne Marie Loney	Per meeting	12 Months	$1704
Member	James Cummins	Per meeting	12 Months	$1704
Member	Joseph Parkinson	Per meeting	12 Months	$1704
Member	Katherine Sanders	Per meeting	12 Months	$1704
Member	Maureen Harris	Per meeting	12 Months	$0
Deputy	Lucy Williams	Per meeting	12 Months	$1704
Deputy	Angela Cooney	Per meeting	12 Months	$1704
Deputy	Andrew Harman	Per meeting	12 Months	$1704
Deputy	Rachel Oakley	Per meeting	12 Months	$1704
Deputy	Iolanda Rodino	Per meeting	12 Months	$1704
Deputy	Peter Burton	Per meeting	12 Months	$1704
Deputy	Peter Roberts	Per meeting	12 Months	$1704
Deputy	Brian Carey	Per meeting	12 Months	$1704
Deputy	Diane Scarle	Per meeting	12 Months	$1420
Deputy	Michele Hansen	Per meeting	12 Months	$1704
			Total:	**$32,944**
WA Reproductive Technology Counselling Committee				
Chair	Iolanda Rodino	Sessional	12 months	$426
Member	Justine Garbellini	Sessional	12 months	$142
Member	Anne-Marie Loney	Sessional	12 months	$0
Member	Dr Elizabeth Webb	Sessional	12 months	$426
			Total:	**$ 994**

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
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	12 months	$0
Member	Prof. Roger Hart	Sessional	12 months	$0
Member	Reverend Dr Joseph Parkinson	Sessional	12 months	$0
			Total:	**$0**
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee				
Chair	Assoc. Prof. Kathy Sanders	Sessional	12 months	$426
Member	Dr Peter Burton	Sessional	12 months	$284
Member	Dr Ashleigh Murch	Sessional	9 months	$0
Member	Dr Sharron Townshend	Sessional	12 months	$0
			Total:	**$710**
WA Reproductive Technology Counselling Scientific Advisory Committee				
Chair	Assoc. Prof. James Cummins	Sessional	12 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	$142
Member	Reverend Dr Joseph Parkinson	Sessional	12 months	$142
Member	Assoc. Prof. Kathy Sanders	Sessional	12 months	$0
			Total:	**$639**

Position	Name	Type of remuneration	2014–15 period of membership	Gross/actual remuneration
Womens and Newborns Health Network Executive Advisory Group				
Co-Chair	Assoc. Prof. Graeme Boardley	Not eligible	Not applicable	$0
Co-Chair	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	Debbie Chiffings	Not eligible	Not applicable	$0
Member	Assimina Di Lollo	Not eligible	Not applicable	$0
Member	Dr Alison Evans	Not eligible	Not applicable	$0
Member	Rachael Giaccari	Not eligible	Not applicable	$0
Member	Dr Mostyn Harndorf	Not eligible	Not applicable	$0
Member	Dr Peter Kell	Not eligible	Not applicable	$0
Member	Dr Helen Leonard	Not eligible	Not applicable	$0
Member	Karla Lister	Not eligible	Not applicable	$0
Member	Tracy Martin	Not eligible	Not applicable	$0
Member	Jenny O'Callaghan	Not eligible	Not applicable	$0
Member	Kate Reynolds	Not eligible	Not applicable	$0
Member	Melanie Robinson	Not eligible	Not applicable	$0
Member	Jan Ryan	Not eligible	Not applicable	$0
Member	Bev Sinclair	Per meeting	12 months	$180
Member	Linda Sinclair	Not eligible	Not applicable	$0
Member	Sue Somerville	Not eligible	Not applicable	$0
Member	Pippa Vines	Not eligible	Not applicable	$0
Member	Jennifer White	Not eligible	Not applicable	$0
Member	Liza Fowler	Not eligible	Not applicable	$0
			Total:	**$180**

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 2014–15 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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Produced by the Purchasing and System Performance Division

PSP-012856 DOH SEP'15