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

Department of Health
Annual Report 2016–2017

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Department of Health
Annual Report 2016–2017

Department of Health

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Statement of compliance

HON MR ROGER COOK 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 2017.

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

Ms Rebecca Brown
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

27 September 2017

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Overview of agency

Department of Health

Vision

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

Mission

To lead and steward the WA health system.

Values

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

Our values are:

- Respect
- Excellence
- Integrity
- Teamwork
- Leadership

Executive summary

In the 2016–17 financial year, the WA health system made significant progress in embedding substantial reform that has transformed the way the system is governed.

On 1 July 2016, the system's centralised governance structure was abolished and a new, devolved structure consisting of Health Service Providers (HSPs), including a new East Metropolitan Health Service, was introduced.

The HSPs were created to operate as separate statutory authorities, governed by Boards, legally responsible and accountable for the oversight of hospital and health service delivery.

Under this new structure, which is underpinned by the *Health Services Act 2016*, the Department of Health assumes the role of 'System Manager', responsible for the overall management, performance and strategic direction of the health system.

This reform is already yielding significant benefits, with the increased clarity of roles, responsibilities and accountabilities leading to a more efficient and effective balance between statewide governance and policy, local service delivery and decision-making, and strong financial performance in line with expectations.

In the past financial year, the Department of Health worked hard to transition functions to Health Service Providers, and establish robust mechanisms to set clear expectations of performance and hold the Boards to account.

In turn, the Health Service Boards have driven transparency around clinical and financial performance, and have been innovative in improving financial sustainability.

This model of devolved accountability is leading to a positive cultural change and constructive competition between Health Service Providers in regards to performance.

As the Department continues to distinguish the detail around roles under the new legislation, the priority is to ensure that the WA health system's strong and proud record of safety and quality remains.

Between February and May 2017, I commissioned a review of safety and quality in the WA health system in recognition of the need for continuous improvement and assurance in a time of system change.

The Review, led by international expert Professor Hugo Mascie-Taylor, made 28 recommendations regarding strategic priorities for safety and quality, and on areas for continuous improvement and future development.

The Department of Health and Health Service Providers will work together to address all recommendations over the coming year-and-a-half.

Another significant change occurred in March 2017 when Western Australia experienced a change in government.

The Department of Health has a responsibility to the new Government's priorities – which mirror its own in terms of focus on areas such as clinical performance, financial sustainability, safety and quality, and patient experience.

The Department worked hard to support the Government's launch of the *Sustainable Health Review* in June 2017, which will inform future decisions about the way that health is managed and delivered.

This is an excellent opportunity to ensure that Western Australians are receiving quality health care that can be sustained for future generations by focusing on value and innovation to improve health outcomes, improve patient experience and drive our clinical and financial performance.

As always, however, the most notable achievement of 2016–17 was the way in which the Department of Health's staff assisted the WA health system's 44,000-strong workforce to deliver world-class health care to the people of Western Australia.

In 2016–17 the WA health system:

- managed more than one million ED attendances
- performed 86,000 elective surgeries
- delivered 25,000 babies
- conducted more than three million outpatient occasions of service, up by more than 130,000 (or 4.6%) from the previous financial year
- performed 930,000 community mental health service contacts.

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

Prevention and Community Care Services

The *Public Health Act 2016* received Royal assent on 25 July 2016, repealing the outdated *Health Act 1911* and strengthening Western Australia's capacity to deal with contemporary public health issues.

The new Act provides a modern, flexible and proactive framework to facilitate the comprehensive reform of public health regulation in WA.

Over the next three years, the Department will assist with developing supporting regulations for the new Act.

In January, the Department of Health launched an Australian-first meningococcal ACWY vaccination program targeted at 15 to 19 year olds. The three-year, State-funded program was launched in response to a rise in cases of the meningococcal W strain. By the end of School Term 2, approximately 10,000 vaccinations had been given to Year 10–12 students in approximately 81 schools in WA. The vaccine is also offered at university health care centres, Aboriginal Medical Services and immunisation clinics.

Immunisation coverage of one-year-old children in Western Australia is at an all-time high, with data from the Australian Immunisation Register showing approximately 93 per cent are fully vaccinated. This is the highest coverage figure since recording first began in 2004. The most recent data for maternal pertussis vaccinations indicate nearly 80 per cent of pregnant women are being immunised; this is a 10 per cent increase from the previous year, and one of the highest rates of coverage reported worldwide.

The Department of Health is also a leading partner in AusVaxSafety – the national program for identifying and following up adverse events following immunisation in the Australian community.

Additionally, in 2016–17, the Department of Health:

- responded to more than 40,000 infectious disease notifications, an increase of 11 per cent on the previous year
- ran social marketing campaigns to promote awareness of sexually transmitted infections and blood-borne viruses
- conducted 2,562 inspections of tobacco-related premises
- ran the mosquito control campaign 'Fight the Bite', developed a mosquito data collecting app, and initiated national research initiatives into novel technologies and advanced chemical control methods for mosquitoes
- increased fines to deter dumping of asbestos
- updated the blood-lead notification legislation
- became the first in Australia to establish health-based guidelines for WA for PFAS (Per- and poly-fluoroalkyl) chemicals found in firefighting foams and products such as non-stick cookware and stain-resistant carpets.

Work also progressed on the development of the *Youth Mental Health Inpatient Stream Implementation Plan* in collaboration with Health Service Providers and the implementation of the *Mental Health, Alcohol and Other Drug Services Plan 2015–2025*.

In December 2016, the inaugural *State Oral Health Plan 2016–2020* was launched, providing a framework for collaborative action in oral health in Western Australia over the next five years.

The Department of Health's Environmental Health Directorate also worked closely with stakeholders to ensure the safety and health of patrons using the new Perth Stadium, which is set to open to the public at the end of 2017.

The WA health system

In its role as System Manager, the Department of Health is responsible for the strategic direction, oversight and management of the WA health system.

In 2016–2017, the Department completed the first phase of a systemwide reform program, which included the implementation of a transition plan and devolution of functions to Health Services Providers to enable greater decision-making and authority closer to service delivery and patient care.

The Department provided strong secretariat advice and governance to help embed the Health Service Boards into the health system and conducted two highly successful Board development days, coordinating a reappointment process for Board members, and developing a Board Assurance Framework.

The Department of Health also works to support health services in the delivery of safe and high quality care. In 2016–17, the following patient safety and clinical quality strategies and initiatives were implemented:

- High Value Health Care program to improve the efficacy and efficiency of healthcare provision without compromising on patient outcomes
- Closing the Loop program to assist clinicians to improve health care delivery and patient outcomes through the evaluation of serious clinical incidents
- National Safety and Quality Health Service Standard (second edition) User Guide for Aboriginal and Torres Strait Islander Health.

A review of safety and quality across the health system was undertaken between February and May 2017. This review, conducted by international expert Professor Hugo Mascie-Taylor, produced 28 recommendations regarding areas for continuous improvement and future development. These recommendations will be addressed across the system over the next 12 to 18 months.

The Department of Health's Institute for Health Leadership continued to deliver leadership development programs and initiatives for clinical and non-clinical staff. Achievements up to 2017 included:

- more than 100 Resident Medical Officers completing the Medical Service Improvement Program
- 230 Medical Consultants completing the Consultant Development Program
- 180 Graduate Officers completing the Graduate Development Program.

In 2016–17, the Department's Nursing and Midwifery Office awarded 319 undergraduate and 262 post-graduate scholarships for nursing and midwifery education, and attracted 670 applications for the GREaT Work Experience program, which encourages high school students to experience nursing as a profession.

Other strategies resulted in 80 additional graduate nurses transitioning to practise in areas of clinical specialty including operating theatres, mental health services, child and school health and via NurseWest. In addition, 32 graduates completed the Statewide Mental Health Nurse Graduate Program 2016.

Other workforce achievements in 2016–17 included:

- coordinating the annual centralised Intern and Resident Medical Officers recruitment process which placed approximately 2,000 junior doctors across the WA health system.
- implementing the inaugural Registrar Research Fellowship Program to complement the Clinician Research Fellowship program and support clinician researchers.
- establishing of the Surgical Service Registrar Employment Advisory Committee to promote the practice of surgery in Western Australia
- managing the Clinical Training Reform Program 2015–2020.

The Department also launched the Research Governance Service IT system in November 2016 to support the governance of all human research conducted within the WA health system. To date, more than 1,500 users and 400 research projects have registered with the system.

In 2016–17, the WA Health Translation Network, of which the Department of Health is a founding partner, successfully obtained National Health and Medical Research Council accreditation as an Advanced Health Research and Translation Centre, making it among the world's top centres performing translational research to directly improve patient care.

In addition to these achievements, the Department is working on setting systemwide policy direction via Optimal Care Pathways to improve efficiency, and reduce duplication and variance in practice. These pathways will enable Health Service Providers to prioritise how resources are allocated and ensure the best patient care.

Strategic development has begun on the *WA Cancer Plan 2018–2023*, as well as on the *WA End-of-life and Specialist Palliative Care Strategy 2017–2027*.

Other new developments included:

- the first statewide data collection for acute stroke care in WA which will improve care quality and cost efficiency
- an improved process for health services to manage the discharge and data collection for patients awaiting aged care services
- improved processes for Transition Care Program providers to reduce the administrative burden and improve cost efficiency
- Tele-stroke resources, in partnership with WACHS, to deliver more efficient care to regional stroke patients.

Planning has begun for two key ICT strategies that will ensure sound ICT investment into the future: the 10 Year Digital Strategy and the development of the Applications Roadmap for core statewide applications.

These projects will ensure that the Department continues improvements in ICT systems that support patient care into the future.

The Department is also working to develop a workforce reform and industrial relations strategy for the next three years which will set the strategic direction to build a sustainable and innovative health workforce.

In 2016–17 the Department of Health took part in the Government's third tranche of the Agency Expenditure Review. This required a review of non-hospital services and the identification of programs no longer delivering benefits to the WA community. Through the examination of these programs, the WA health system has realised a number of savings.

The Department also issued a number of binding policy frameworks to HSPs, setting standards they must comply with in the performance of their functions.

Chronic Disease Services

In 2016–17 the Department of Health maintained its commitment to positioning the prevention of chronic disease and injury as a priority of the WA health system.

Chronic disease costs WA hospitals more than $715 million each year, but almost one-third of the disease burden in Australia could be prevented by reducing people's exposure to modifiable risk factors.

This financial year, the Department launched the *WA Health Promotion Strategic Framework 2017–2021*, the third in a series first launched in 2007.

This high-level strategic plan aims to reduce the toll of preventable chronic disease and injury in the community by targeting common risk factors: being overweight or obese, having a poor diet, not getting sufficient physical activity, smoking, and consuming alcohol at harmful levels.

The Framework is a key strategy for the WA health system, and is also increasingly used by other Government departments and agencies, as well as the non-government health sector.

LiveLighter, the Department's innovative obesity prevention campaign, has now been licensed for use in Victoria, New South Wales, Queensland, Tasmania, the Northern Territory and the ACT, and has an international profile in Tonga and the City of New York.

The Department's cutting-edge, evidence-based tobacco mass media program *Make Smoking History* continues to deliver high-impact campaigns across the State, with 60 per cent of smokers who saw last year's campaigns considering quitting, and attempting to quit or cut down on their smoking.

Injuries cost the WA community an estimated $9.6 billion annually; therefore, injury prevention remains an important part of the Department of Health's work. In 2016–17, the Department published *Incidence and costs of injury in Western Australia 2012*, a vital resource to inform future policy and funding priorities in injury prevention, and the first analysis of its kind in Australia.

Another initiative to combat injury included the WA Consumer Product Advocacy Network, developed in partnership with Kidsafe WA, which responds rapidly to potential child injury risks as they are identified. In 2016–17, this Network prompted the removal of unsafe toys from sale, and generated media attention to inform the public about potentially risky products. It was also shortlisted for an Institute of Public Administration Australia (WA) achievement award for 'best practice in collaboration between government and non-government organisations'.

Aboriginal Health Services

The Department of Health is committed to addressing the health inequalities faced by Aboriginal people.

The *WA Aboriginal Health and Wellbeing Framework 2015–2030* builds on this commitment, identifying a set of strategic directions and priority areas to improve Aboriginal health and wellbeing over the next 15 years.

In 2016–17, the Department developed a comprehensive Implementation Guide to inform the application and use of the Framework across the WA health system.

The *Implementation Guide for the WA Aboriginal Health and Wellbeing Framework 2015–2030* seeks to build the capacity and responsiveness of the health system so it can better meet both the clinical and cultural needs of Aboriginal people.

The Department has also developed the *WA Aboriginal Health and Wellbeing Framework 2015–2030 Monitoring and Reporting Plan*, a companion document to the Implementation Guide, which will be used to monitor eight headline measures within the Implementation Guide. The headline measures are aligned to both the vision and six strategic directions of the Framework.

A new key performance indicator has been developed to monitor 'Discharge Against Medical Advice' in hospitals in order to drive and increase accountability for Health Service Providers to achieve a more equitable outcome for Aboriginal patients.

This new indicator, which will be reported in the Health Service Performance Report from 2017–2018, measures the high proportion of Aboriginal patients who leave hospitals without being formally discharged by a physician.

The Department of Health has also continued its commitment to increasing the Aboriginal workforce and progressing towards the Public Sector Commission's Aboriginal employment target of 3.2 per cent. I am pleased to say that in 2016–17, the health system surpassed the set target of 100 by employing 110 Aboriginal people.

The Department aims to further increase its Aboriginal workforce by using Section 51 of the *Equal Opportunity Act 1984* as a targeted recruitment strategy that supports growing diversity of the workforce. The application of Section 51 will be piloted in advertising and recruitment throughout the health system over the next 12 months.

The Department of Health also continues to work towards building organisational cultural competency and the system's capacity to embed culturally secure structures, policies and processes. As of June 2017, 78 per cent of the WA public health system had completed the mandatory Aboriginal Cultural eLearning – *A Healthier Future*.

In addition, the Environmental Health Directorate collaborated with outside agencies to build upon recent legislative changes and upskill environmental health workers to fix basic emergency plumbing issues in remote Aboriginal communities.

Due to the isolation of some Aboriginal communities in Western Australia, it is often difficult to have issues fixed by a licensed tradesperson.

Environmental Health Workers can now complete a 10-week Certificate II training program enabling them to complete basic plumbing repair jobs.

The WA health system enters the new financial year well placed to consolidate and build upon the reforms and achievements of 2016–17.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

Department of Health highlights

The ***Public Health Act 2016–2020*** enacted.

Nearly **80% of pregnant women vaccinated** against **Whooping Cough** – one of the highest rates of coverage in the world.

Australia's **first meningococcal ACWY vaccination program** targeting 15 to 19 year olds launched.

2,562 inspections of tobacco-related premises conducted.

The ***State Oral Health Plan 2016–2020*** released to improve oral health outcomes.

The ***Health Services Act 2016*** began 1 July – with the DoH assuming the role of **'System Manager'**.

Leadership development programs and initiatives provided to:

- more than 100 Resident Medical Officers
- 230 Medical Consultants
- 180 Graduate Officers.

319 undergraduate and **262 post-graduate scholarships** awarded for nursing and midwifery education.

$14 million provided to support WA health and medical **researchers**, innovative research projects, and indirect research costs.

An additional **$8 million** provided through the **FutureHealth WA** program to boost the quality and capacity of the WA health and medical research sector.

A ***Sustainable Health Review*** launched to position the WA health system for the future.

A **Review of Safety and Quality** in the WA health system conducted, proposing 28 recommendations for improvement.

WA Health Promotion Strategic Framework 2017–2021 launched to reduce preventable chronic disease and injury in WA.

WA's Patient Blood Management Program saved $18.5 million in red cell, platelet and fresh frozen plasma costs over six years and was associated with a **28% reduction in hospital mortality**.

Launch of a targeted recruitment strategy using Section 51 of the ***Equal Opportunity Act 1984*** in advertising and recruitment throughout the health system to **grow diversity of the workforce**.

24 graduate positions for Aboriginal nurses and midwives offered across the WA health system, nearly double the number offered the previous year.

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 26 Acts and 60 sets of subsidiary legislation.

Administered legislation

Acts administered as at 30 June 2017

- *Anatomy Act 1930*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cremation Act 1929*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Quality Improvement) Act 1994*
- *Health Services Act 2016*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medicines and Poisons Act 2014*
- *National Health Funding Pool Act 2012*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Pharmacy Act 2010*
- *Private Hospitals and Health Services Act 1927*
- *Prostitution Act 2000* (except s.62 & Part 5, which are administered by the Department of the Attorney General)
- *Public Health Act 2016*
- *Radiation Safety Act 1975*
- *Royal Perth Hospital Protection Act 2016*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School, Teaching Hospitals Act 1955*
- *Western Australian Health Promotion Foundation Act 2016.*

Acts passed during 2016–17

- *Royal Perth Hospital Protection Act 2016.*

Bills in Parliament as at June 2017

Nil

Amalgamation and establishment of Boards

- North Metropolitan Health Service Board
- South Metropolitan Health Service Board
- East Metropolitan Health Service Board
- Child and Adolescent Health Service Board
- WA Country Health Service Board
- Western Australian Health Promotion Foundation Board.

Accountable authority

The Director General of Health, Dr David Russell-Weisz, was the accountable authority for the Department of Health in 2016–17.

Responsible Minister

The Department of Health is responsible to the Deputy Premier, Minister for Health and Mental Health, the Hon Roger Cook MLA .

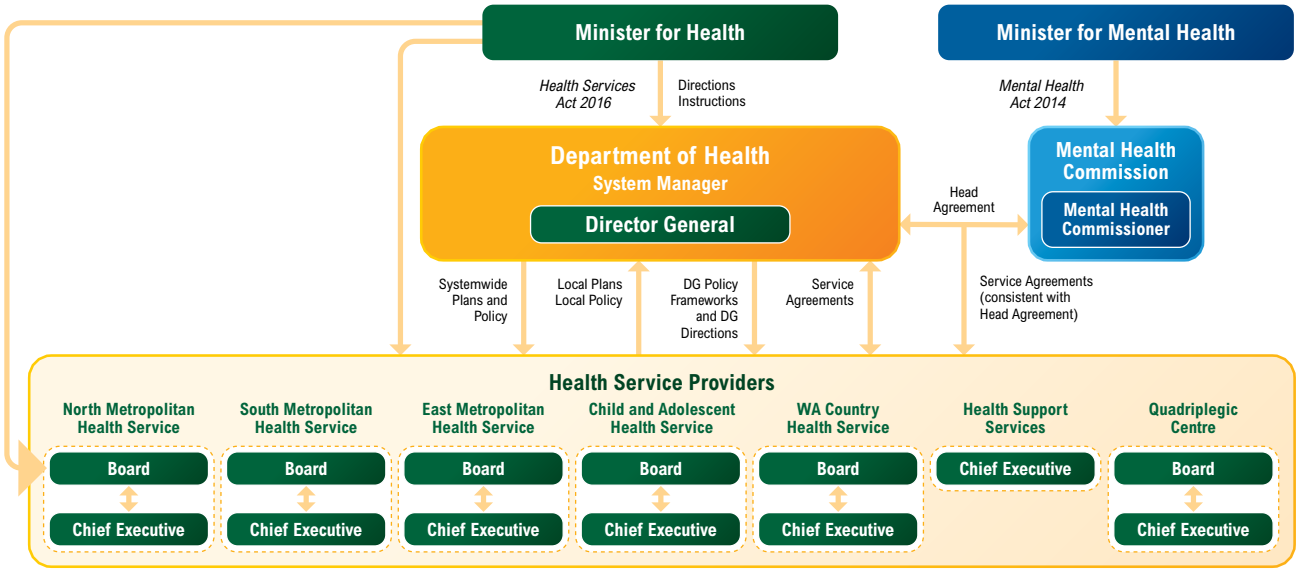
WA health system structure

The WA health system is comprised of the Department of Health, Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, Health Support Services and Quadriplegic Centre) and to the extent that contracted health entities provide health services to the State, the contracted health entities. This structure is depicted in Figure 1.

The Department of Health, led by the Director General, provides leadership and management of the WA health system as a whole, ensuring the delivery of high quality, safe and timely health services.

Six of our Health Service Providers are governed by boards whose appointed members bring extensive experience in the fields of health care, finance, law, and community and consumer engagement. Each Health Service Provider is responsible and accountable for the delivery of safe, high quality, efficient and economical health services to their local areas and communities. Health Support Services is governed by a Chief Executive and provides systemwide support that includes technology, supply, workforce and financial services.

Figure 1: **WA health system structure, 2016–17**

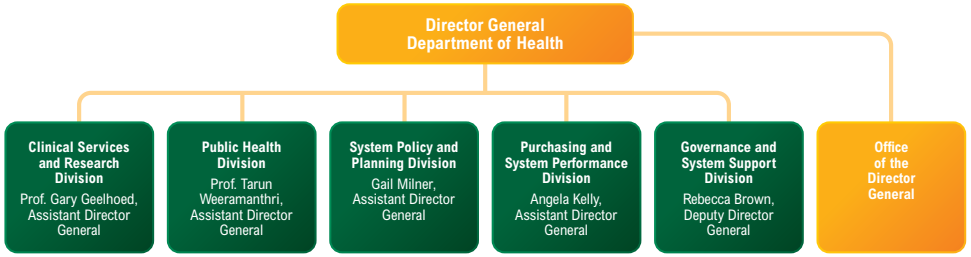


Department of Health organisational structure

The Department of Health is led by Director General, Dr David Russell-Weisz, and is supported by a Deputy Director General, the Office of the Director General and five Assistant Directors General (see Figure 2), working in key areas of health, including:

- public health
- clinical services and research
- purchasing and system performance
- system policy and planning
- governance and system support.

Figure 2: **Department of Health organisational and senior management structure, 2016–17**



Notes:

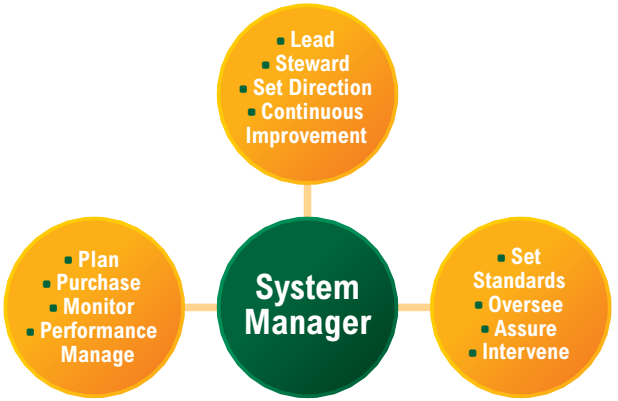
1. The senior officer structure for the Department of Health from July 2016 to June 2017 includes all officers who were members of the Department of Health Executive for a period greater than three months.
2. Senior officers are appointed on term contracts.

Roles and responsibilities

On 1 July 2016, the *Health Services Act 2016* commenced operation and introduced a contemporary devolved governance model for the WA health system. The *Health Services Act 2016* clarifies roles and responsibilities at each level of the system, establishing the Director General of the Department of Health as the System Manager responsible for the overall management of the WA health system and the seven Health Service Providers as separate statutory authorities.

The Department of Health plays an important role in supporting the Director General to fulfil legislative responsibilities and functions as both a Department of State under the *Public Sector Management Act 1994* and as a System Manager under the *Health Services Act 2016*. The Director General is therefore established as both the Chief Executive Officer and the System Manager for the WA health system. As the System Manager, the Director General is responsible for the strategic direction (aligned to government objectives), oversight and management of the WA health system. Figure 3 represents the interconnectedness of each of the key functions critical to encouraging effective System Manager functions and capability, and demonstrates that leadership and stewardship are at the pinnacle of the System Manager role.

Figure 3: **The System Manager role**



In 2016–17, the functions of the Department of Health were delivered through the Office of the Director General and the Department's five divisions – the Clinical Services and Research Division, Public Health Division, System Policy and Planning Division, Purchasing and System Performance Division and Governance and System Support Division.

1. Leading and stewarding

The Department of Health provides strategic leadership and stewardship for the WA health system, in accordance with the *Health Services Act 2016* and the *Public Sector Management Act 1994*. This involves setting the vision and direction for the WA health system, as well as providing executive oversight of strategic decision making, identifying the WA health system priorities, and guiding, overseeing and protecting the entire system. The Department of Health is responsible for articulating health system standards, maintaining and encouraging integrity, ensuring commitment to service delivery and embedding ethics and integrity into the organisation's values and operations.

2. Strategy and policy

The Department of Health is responsible for identifying the strategic direction for the WA health system and providing policy advice to the Minister, as required under both the *Health Services Act 2016* and the *Public Sector Management Act 1994*. The Department of Health provides strategic leadership and direction for the provision of public health services in the State. This involves the development of an overarching systemwide strategy encapsulating the long-term vision for the WA health system, as well as setting organisational objectives and applying resources and capabilities to facilitate the achievement of these objectives. Developing, advising and facilitating the implementation of systemwide policy is also fundamental to the Department of Health's role and is critical in encouraging both the achievement and delivery of government priorities, and responding to emerging and current needs of the Western Australian community.

3. Services planning

The Department of Health is responsible for advising and assisting the Minister for Health in the development and implementation of WA health systemwide planning. System level service planning is a component of this and involves both long-term and short-term planning to ensure health care provision across the system is safe and of high quality; is coordinated and accessible; and represents best value for money. The Department of Health, through planning and the Clinical Networks, also has a role in supporting and promoting evidence-based service innovation across the WA health system collaboratively with Health Service Providers.

4. Purchasing

Resourcing is a key function of the Department of Health and aligns with its legislative functions under the *Health Services Act 2016* and the *Financial Management Act 2006*. Under the *Health Services Act 2016*, the Department of Health purchases health services from Health Service Providers through service agreements, and may arrange for the provision of health services by contracted health entities. The purchasing function of the Department of Health extends to include responsibility for recommending to the Minister for Health the amounts that may be allocated via the annual government budget allocation process by advocating for the needs and priorities of the WA health system.

5. Building capability/education and training

The Department of Health engages in strategic workforce planning and modelling, and invests in education and training to enhance the skills, capability, flexibility and satisfaction of the workforce. This contributes to achieving the required standards of performance, continuing to improve outcomes for patients, and encouraging advances in innovation and research capabilities for the State.

6. Setting standards

Through service agreements and policy frameworks, the Department of Health sets the standards and parameters within which health services will be delivered. These mechanisms enable the System Manager to achieve a consistent and cohesive health system.

7. Performance monitoring and evaluation

The Department of Health monitors and evaluates performance and oversees the quality of health services provided by the Health Service Providers. As such, the *Health Services Act 2016* recognises that the System Manager needs to receive and validate performance data and other data in order to monitor and evaluate performance. The legislated functions of the System Manager are complemented by service agreements and policy frameworks as accountability mechanisms which establish standards and facilitate evaluation and assessment of Health Service Provider performance.

8. Assurance and audit

A key function of the Department of Health is to oversee, monitor and promote performance and improvements in the safety and quality of health services provided by the Health Service Providers. This function is an important assurance role that ensures a safe and high quality service delivery to the Western Australian community. Additionally, through audit the Department of Health provides assurance that the WA health system is meeting statutory and other obligations (including meeting the standards set in policy frameworks), operating effectively and efficiently and delivering consistent, high quality and safe care.

9. Intervention

The Department of Health is responsible for monitoring the performance of Health Service Providers and taking remedial action when performance does not meet the expected standard. There are five intervention levels to remediate performance concerns:

Level 1: Under Review

Performance issue identified.

Level 2: Performance Concern

The System Manager determines a formal recovery plan is required. The Health Service Provider Board must endorse the plan prior to submission to the Director General for approval.

Level 3: Sustained Performance Concern

The System Manager may:

1. Assign appropriate personnel from the Department to provide additional support if the recovery plan is not achieving improved performance.
2. Assign an expert advisor appointed by the System Manager to review the root cause(s) of the sustained performance concern and provide a series of recommendations for implementation by the Health Service Provider.
3. Require the Health Service Provider Board Chair or a delegate to attend performance review meetings.
4. Advise the Minister of the sustained performance concern.
5. Other intervention as deemed appropriate.

Additionally, a representative to assist the Health Service Provider Board may be appointed by the Minister to oversee the necessary performance improvements. This could include the Minister appointed representative attending Health Service Provider Board meetings.

Level 4: Performance Failure

The Director General may:

1. Commission an investigation, inspection, audit or inquiry into a Health Service Providers governance and operations in accordance with parts 13 and 14 of the *Health Services Act 2016*.
2. In monitoring the performance of Health Service Providers and taking remedial action when performance does not meet the expected standard, may do anything necessary or convenient for the performance of that function in accordance with section 21 of the *Health Services Act 2016*.

The Minister may:

1. Issue a direction requiring the Health Service Provider to show cause.
2. Require the Health Service Provider to demonstrate that the Board and/or Chief Executive are able to achieve performance and capability improvement within a reasonable timeframe.

Level 5: Sustained Performance Failure

The Minister may:

1. Remove the Chair, Deputy Chair or members of the Health Service Provider Board in accordance with sections 77(4) or 102 of the *Health Services Act 2016*, the latter of which requires the Minister to lay before each House of Parliament notice of the action.
2. Appoint an Administrator in accordance with section 99 of the *Health Services Act 2016*.

Performance management framework

The WA health system operates under the Outcome Based Management performance management framework to comply with its legislative obligation as a WA government agency. 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.

The WA health system's outcomes and key performance indicators for 2016–17 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 4). The Outcome Based Management Framework for 2016–17 was updated to reflect the implementation of the *Health Services Act 2016* and the legal entities that now comprise the WA health system. In order to comply with this change a new Outcome, new Services and key performance indicators were introduced to align the WA health system to the State Government Goal. The alignment of the WA health system key performance indicators to Services, Outcomes and the State Government Goal are demonstrated in Figures 4 and 5.

The WA Health outcomes for achievement in 2016–17 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

Outcome 3 Strategic leadership, planning and support services that enable a safe, high-quality and sustainable WA health system.

The health service activities that are aligned to Outcome 1, 2 and 3 are cited below (Figure 5).

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)
   - monitor 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.

Activities related to **Outcome 3** aim to:

1. Provide strategic leadership, policy, planning services, system performance management, and purchasing linked to statewide planning, budgeting and regulation processes
2. Provide purchased health support services to WA Health entities.

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

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 Home and Community Care target population who receive Home and Community Care services
- Specific Home and Community Care contract provider client satisfaction survey.

Figure 5: **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

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

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.

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 2

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

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.

Outcome 3

Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system

Services delivered to achieve Outcome 3

11. Health System Management – Policy and Corporate Services
12. Health Support Services.

Key efficiency indicators for services within Outcome 3

- Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers.

Shared Responsibilities with Other Agencies

The Department of Health collaborates with the Health Service Providers within the WA health system, as well as a number of other government agencies and non-government organisations to contribute to the WA health system desired outcomes. These collaborations ensure that high quality health services are delivered to the Western Australian public in an efficient and effective manner.

Agency performance

Summary of financial performance

Table 1 provides the financial and performance information of the Department of Health during 2016–17.

Full details of the Department of Health's financial performance during 2016–17 are provided in the Financial statements section of this report.

Table 1: **Actual results versus budget targets for the Department of Health**

Financial	2016–17 Target ($'000)[1]	2016–17 Actual ($'000)	Variation (+/–) ($'000)[2]
Total cost of services	7,237,406	7,487,090	249,684
Net cost of services	5,110,216	5,142,109	31,893
Total Equity	243,824	1,545,734	1,301,910
Net increase/decrease in cash held	(19,947)	59,396	79,343
Approved Salary expense level	126,619	116,942	(9,677)
Agreed borrowing limit	-	-	-

Notes:

1. As specified in the Budget Statements.
2. Explanations can be found in the notes to the financial statements.

Agencies are required to operate within an agreed working cash limit, defined as five per cent of budgeted cash payments. In 2016–17 the cash limit target and actual for the Department of Health was nil (see Table 2).

Table 2: **Actual results versus working cash limit targets for the Department of Health**

Financial	2016–17 Agreed limit ($'000)	2016–17 Target Actual ($'000)	Variation (+/–) ($'000)
Agreed Working Cash Limit (at Budget)	Nil	Nil	-
Agreed Working Cash limit (at actuals)	Nil	Nil	-

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 2016–17 targets is provided in Table 3.

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

Table 3: **Actual results versus key performance indicator targets**

Key performance indicators	2016–17 Target	2016–17 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	37.9%	33.2%	-4.7%
Response times for patient transport services: (a) Per cent of priority 1 calls attended within 15 minutes by St John Ambulance	90%	93%	3%
(b) Per cent of inter-hospital transfers for Priority 1 calls meeting the Contract Target patient Response Time by the Royal Flying Doctor Service	80%	81%	1%
Key efficiency indicators:			
Cost per capita of supporting treatment of patients in public hospitals	$28	$26	-$2
Average cost per home based hospital day of care	$293	$316	$23
Average cost per home based occasion of service	$125	$121	-$4
Average cost per client receiving contracted palliative care services	$4,240	$3,061	-$1,179
Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Western Australia Service Agreements	$63	$67	$4

Key performance indicators	2016–17 Target	2016–17 Actual	Variation
Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Key effectiveness indicators:			
Loss of life from premature death due to identifiable causes of preventable disease or injury (in years):			
▪ Lung Cancer	1.8	1.7	-0.1
▪ Breast Cancer (females only)	2.2	2.0	-0.2
▪ Ischaemic heart disease	2.5	2.2	-0.3
▪ Falls	0.2	0.3	0.1
▪ Melanoma	0.5	0.4	-0.1
Percentage of fully immunised children at:			
▪ 12 months	≥90.0	93.0	3.0
▪ 2 years of age	≥90.0	90.0	0.0
▪ 5 years of age	≥90.0	91.0	1.0
Rate of hospitalisations for selected potentially preventable diseases (per 100,000):			
▪ Pertussis (0-12 year olds)	No hospitalisation per 100,000	2.5	2.5
▪ Measles (0-17 year olds)		0.0	0.0
▪ Mumps (0-17 year olds)		1.5	1.5
▪ Hepatitis B (0-12 year olds)		0.0	0.0
▪ Rubella (0-17 year olds)		0.1	0.1
▪ Diptheria (0-12 year olds)		0.0	0.0
▪ Poliomyelitis (0-12 year olds)		0.0	0.0
▪ Tetanus (0-12 year olds)		0.0	0.0

Key performance indicators	2016–17 Target	2016–17 Actual	Variation
Eligible patients on the oral waiting list who have received treatment during the year:			
▪ General practice	1,580	1,465	-115
▪ Oral surgery	910	913	3
▪ Orthodontics	2,100	1,141	-959
▪ Paedodontics	790	450	-340
▪ Periodontics	480	613	133
▪ Other	780	2,355	1,575
▪ Total	6,640	6,937	297
Percentage of clients maintaining or improving functional ability while in transition care	65%	73%	8%
Rate per 1,000 Home and Community Care target population who receive Home and Community Care services	350	353	3
Specific Home and Community Care contract provider client satisfaction survey:			
(a) Assist independence	85%	82%	-3%
(b) improve quality of life	85%	94%	9%
Key efficiency indicators:			
Cost per capita of providing preventive interventions, health promotion and health protection activities	$51	$42	-$9
Average cost per dental service provided by the Oral Health Centre of WA	$169	$140	-$29

Key performance indicators	2016–17 Target	2016–17 Actual	Variation
Average cost per person of Home and Community Care services delivered to people with long-term disability	$4,009	$4,015	$6
Average cost per transition care day	$308	$308	$0
Average cost per day of care for non-acute admitted continuing care	$780	$714	-$66
Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	$42	$36	-$6
Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system			
Key efficiency indicator:			
Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers	N/A	$7,698	

Patient Evaluation of Health Services

Background

The Patient Evaluation of Health Services survey is conducted annually to assess patient satisfaction levels with the WA health system. In 2016–17, the Department of Health surveyed approximately 8,000 people asking them about their health care experiences during their stay in hospital or attendance at an outpatient clinic.

Patient satisfaction is influenced by the 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 (7) to least important (1). This helps determine the relative importance that the patients place 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 aspect scores, weighted by their importance as ranked by patients
- outcome score – reflects how patients rate the outcome of their hospital stay (i.e. the impact on physical health and wellbeing).

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

Results

Annual report results are presented for respondents in WA from the following patient groups:

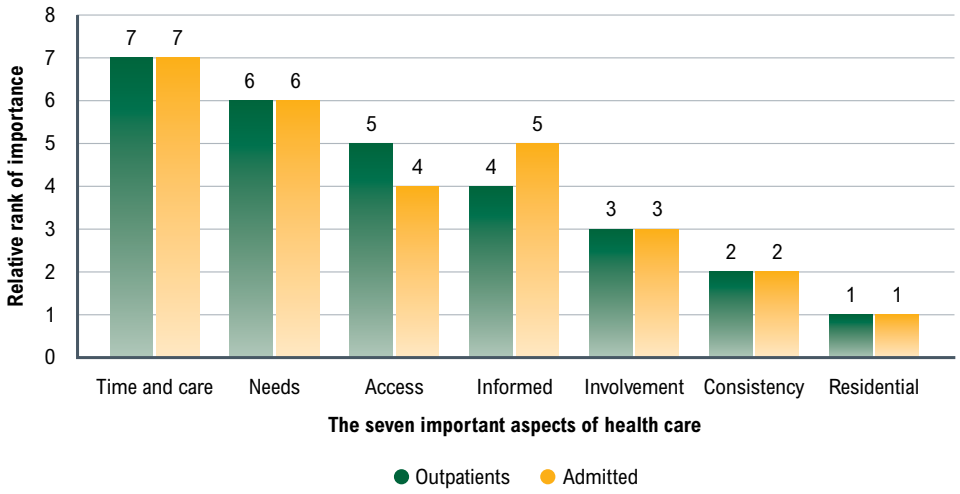
- outpatients, aged 16–74 years
- admitted patients, aged 16–74 years who were in hospital from 0–34 nights.

In 2016–17, the survey participation rate was 95 per cent, with 1,017 adult outpatients and 4,448 adult admitted patients interviewed.

Ranked importance of the aspects of health care

In 2016–17, both patient groups ranked time and care as the most important aspect of health care, followed by needs. Outpatients ranked access as the third most important, followed by informed, where admitted patients ranked the importance of informed above access. The least important aspect of care for both patient groups was residential (see Figure 6).

Figure 6: **The seven aspects of health care ranked by patient groups from most important (7) to least important (1), 2016–17**



Satisfaction with the aspects of health care

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

In 2016–17, mean satisfaction scores rated by outpatients were highest for the needs aspect and lowest for the access aspect (see Table 4). Patient rated satisfaction with the residential aspect was significantly higher in 2016–17 compared with previous years.

Table 4: **Outpatients' mean scores, by aspect of health care, 2012–13 to 2016–17**

Outpatients (16–74 years)			
Aspect	**2012–13**	**2014–15**	**2016–17**
Needs	90.2	91.2	91.2
Informed	80.4	79.9	80.9
Time and care	78.9	80.3	80.5
Consistency	77.1	75.8	77.4
Involvement	67.4	68.6	69.2
Residential	59.3↑	58.8↑	63.7
Access	61.2	61.8	62.8

Note:

↑ Indicates that the mean score for 2016–17 is significantly higher than the comparison score.

Admitted patients' mean satisfaction scores in 2016–17 were highest for the needs aspect and lowest for the residential aspect. The 2016–17 residential score was significantly higher when compared to 2014–15 and 2015–16, while the access score was significantly higher compared with 2014–15. There were no other significant differences (Table 5).

Table 5: **Admitted patients' mean scores, by aspect of health care, 2014–15 to 2016–17**

Admitted patients (16–74 years)			
Aspect	**2014–15**	**2015–16**	**2016–17**
Needs	91.3	91.9	91.9
Time and care	88.7	88.6	89.1
Informed	84.0	84.3	84.9
Involvement	75.2	75.6	75.6
Access	71.8↑	72.7	73.6
Consistency	72.0	71.9	73.2
Residential	64.8↑	65.1↑	66.4

Note:

↑ Indicates that the mean score for 2016–17 is significantly higher than the comparison score.

The mean satisfaction scores for patients admitted to a metropolitan or country hospital in WA in 2016–17 were highest for the needs and time and care aspects. The scores for access and residential were significantly lower for patients attending metropolitan hospitals compared with the State and significantly higher for patients attending country hospitals compared with the State (see Table 6).

Table 6: **Admitted patients' mean scores, by location, 2016–17**

Aspect	State	Metropolitan	Country
Needs	91.9	91.4	92.5
Time and Care	89.1	88.6	89.7
Informed	84.9	84.4	85.5
Involvement	75.6	74.8	76.4
Access	73.6	70.6↓	76.6↑
Consistency	73.2	71.9	74.4
Residential	66.4	64.9↓	67.8↑

Notes:

1. ↑ Indicates that the location mean score for 2016–17 is significantly higher than the State comparison score.
2. ↓ Indicates that the location mean score for 2016–17 is significantly lower than the State comparison score.
3. Mean scores by location are only available for admitted patients.

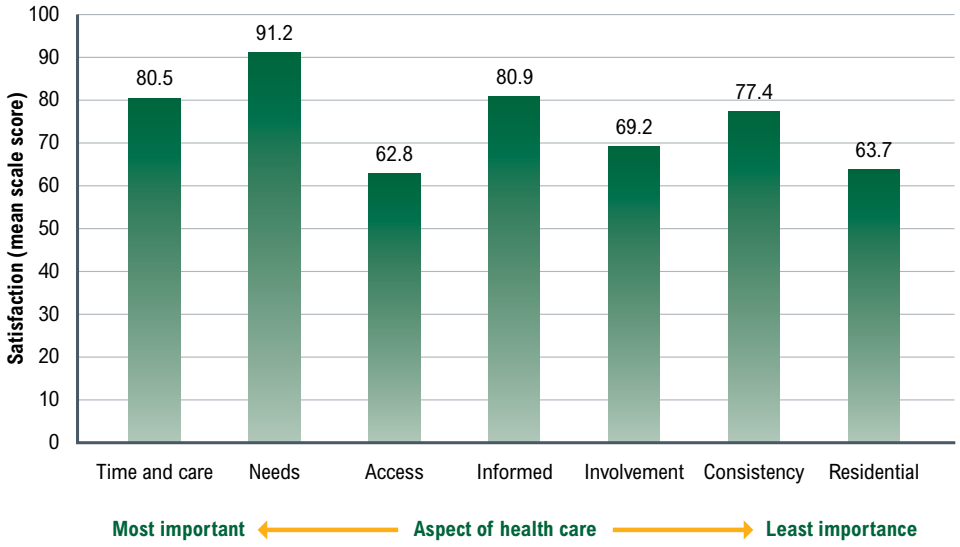
Comparing importance with the satisfaction of aspects of health care

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 2016–17, outpatients ranked time and care as the most important aspect of health care. However in terms of satisfaction this aspect rated third. The needs aspect was rated the second most important aspect of health care, and achieved the highest satisfaction score.

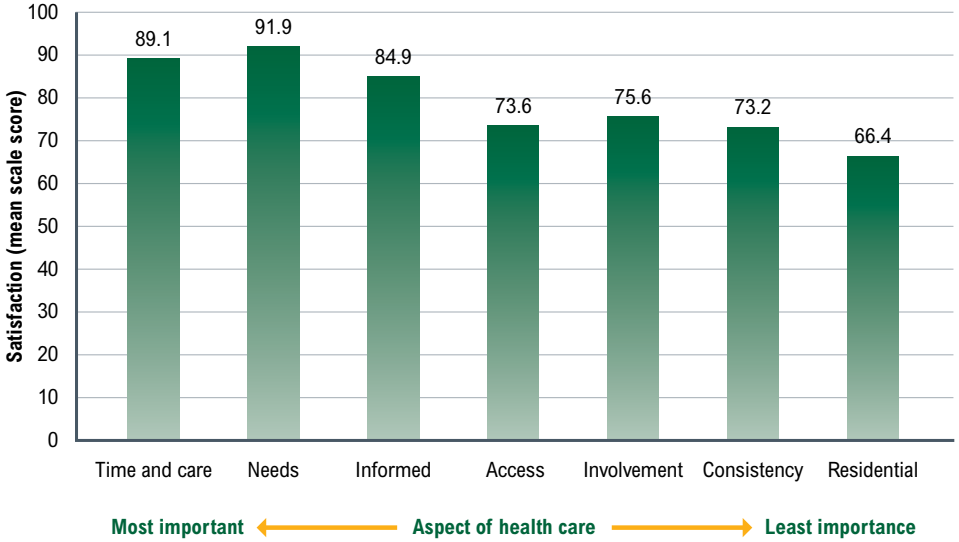
This patient group ranked access as the third most important aspect of health care. However access was rated last in terms of satisfaction. Finally, residential was ranked as the least important aspect of health care amongst outpatients, and had the second lowest satisfaction score (see Figure 7).

Figure 7: **Satisfaction with the aspects of health care by rank of importance, outpatients, 16–74 years, 2016–17**



In 2016–17, 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 8).

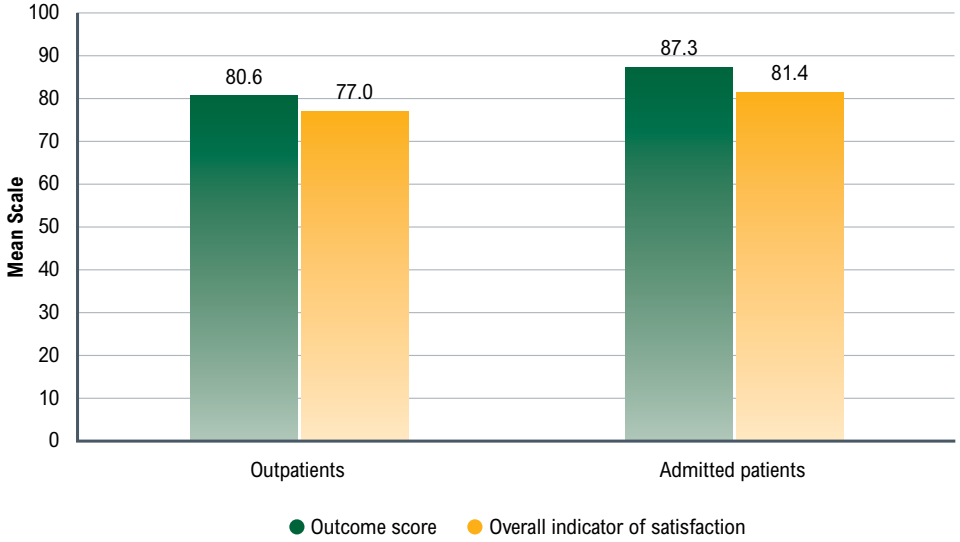
Figure 8: **Satisfaction with the aspects of health care by rank of importance, admitted patients, 16–74 years, 2016–17**



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 9 shows that outpatients and admitted patients rated the outcome of their visit higher than their overall indicator of satisfaction. This suggests that although patients were satisfied with their experience in WA hospitals, they were more satisfied with the outcome of their hospital visit and the improvement in their condition.

Figure 9: **Patient-rated satisfaction of the outcome of their hospital visit compared to their overall satisfaction with outpatient and admitted patient health care, 2016–17**



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Significant issues

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

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

To enable the WA health system to be more responsive and innovative in meeting the health needs of local communities and of a growing and ageing population, significant system reform was required.

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

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

A major initiative of the reform program in 2016–17 was the implementation of the *Health Services Act 2016*. The Act commenced on 1 July 2016 providing a legal framework for clear roles, responsibilities and accountabilities at all levels of the health system. The Act establishes a devolved model of governance to enable decision-making and accountability closer to service delivery and patient care.

The Department of Health, led by the Director General, as the System Manager, is responsible for the overall management, performance and strategic direction of the WA health system to ensure the delivery of high-quality, safe and timely health services.

Establishing an effective System Manager

Since July 2016, the Department of Health has worked towards establishing itself as an effective System Manager and Department of State. This has involved the transitioning of functions and the development of new relationships with Health Service Providers. Under the new governance arrangements, the Functional Review and Readiness Assessment project evaluated 120 non-clinical functions with a view to devolving certain functions from the Department of Health to the Health Service Providers. Detailed preparation for the transition of these functions was undertaken including the implementation of a Systemwide Transition Plan setting out the functions for devolution and timeframes, with the majority of changes taking effect between January and June 2017. The devolution of some functions from the Department to the Health Service Providers has enabled greater decision-making and authority closer to service delivery and patient care.

As System Manager, the Director General is responsible for issuing binding policy frameworks that must be implemented as part of ongoing operations by Health Service Providers. In 2016–17, 18 policy frameworks were released. The policy frameworks ensure service coordination and integration, and efficiency and effectiveness in the provision of health services across the WA health system.

Defining and developing a fit for purpose workforce and organisation has also been a key focus of the Department of Health to support the new roles and responsibilities of the System Manager.

Key initiatives implemented in 2016–17 included:

- developing the Department of Health's *People and Organisational Development Strategy 2017–18*
- conducting a whole of Department of Health Employee Survey to identify and assess staff culture and engagement.

To further establish the key foundations for an effective System Manager the Department of Health is currently:

- consolidating and transforming workforce, employment and industrial relation functions
- assisting the State Government in conducting a Sustainable Health Review to prioritise delivery of patient-centred, high quality and financially sustainable healthcare across the State
- aligning its strategic policy, planning, modelling, purchasing and performance functions
- developing and supporting safety and quality improvement, and an innovation culture across the system.

Ensuring statewide health service needs are met

The Department of Health supports Health Service Providers in addressing the challenges of health service inpatient, emergency and outpatient demand and activity associated with an increase in the proportion of people who are ageing, combined with increased levels of chronic disease and co-morbidities, and declines in functional independence. In 2016–17 this included:

- supporting strategies to improve patient flow to reduce emergency and surgical wait times
- implementing the *Youth Mental Health Inpatient Stream Implementation Plan* in collaboration with Health Service Providers
- implementing an integrated care program involving patients and their General Practitioners that aims to reduce preventable admissions to hospital, the length of hospital stay, and use of health resources
- implementing *The Interim Hospital Package* program that enables public hospitals to purchase short-term community services and support for patients who may otherwise remain in hospital, or be admitted to hospital due to lack of availability or suitability of mainstream community support services
- developing the *WA Cancer Plan 2018–2023* and the *WA End-of-life and Specialist Palliative Care Strategy 2017–2027*
- completing the implementation of the *Theatre Efficiency Reform Program* to improve operating theatre efficiencies.

The Department of Health also supports Health Service Providers in the delivery of safe and high quality care. In 2016–17 the following patient safety and clinical quality strategies and initiatives were either supported for implementation or implemented:

- High Value Health Care program to improve the efficacy and efficiency of healthcare provision without compromising on patient outcomes
- Closing the Loop program to assist clinicians to improve healthcare delivery and patient outcomes through the evaluation of serious clinical incidents
- *National Safety and Quality Health Service Standard (second edition) User Guide for Aboriginal and Torres Strait Islander Health*.

The demand for health services can be managed through the prevention, promotion and implementation of public health initiatives. In July 2016, the *Public Health Act 2016* received assent with the purpose to protect, promote and improve health and wellbeing and reduce the incidence of preventable illness. Also, in December 2016, the inaugural *State Oral Health Plan 2016–2020* was published, setting the State direction and providing a framework for collaborative action in oral health.

Health research and innovation is essential to ensure that health services are based on best practice and lead to improved consumer and patient health outcomes and/or health system performance. In 2016–17, the Department of Health partnered with the WA Health Translation Network. The Network is a statewide consortium of major hospitals, medical research institutes and five universities, formed to capitalise on existing resources and expertise to translate research into better health for Western Australians.

Developing our workforce and managing industrial relations

Systemwide strategic planning and management of the medical, dental, nursing and allied health professions workforce is crucial to ensure that the healthcare needs of Western Australians are appropriately met. WA is experiencing a shortage of suitably trained and experienced doctors at resident and registrar level and a small but critical workforce shortage in health sciences and medical specialities. To manage these workforce shortages and plan future workforce needs the Department of Health in 2016–17:

- continued the Clinician and Registrar Research Fellowship program to increase the research capacity and capability of clinicians in the WA health system
- continued the Specialist Training Program, with placement of 25 medical specialists in rural areas
- completed a review of the General Practice workforce and training in WA
- provided key findings on the WA specialist workforce to inform systemwide medical workforce strategic planning
- provided policy direction and systemwide support for the international sourcing of in-demand and specialist health workforce
- completed 'critical professions' workforce plans, highlighting industrial relations issues that may compromise development of these workforces.

The Department of Health aims to provide a sustainable nursing and midwifery workforce with the expertise, knowledge and skills to provide safe, compassionate care to patients and the community. In 2016–17:

- a NurseWest Assistant in Nursing Pool was established, providing student nurses an opportunity to work as an Assistant in Nursing during their studies
- 80 additional graduate nurses transitioned to practice in non-traditional areas of clinical specialty including operating theatres, mental health services, and child and school health
- 32 graduates completed the Statewide Mental Health Graduate Program 2016.

In accordance with the *Health Services Act 2016*, the System Manager is responsible for the management of systemwide industrial relations on behalf of the State, including negotiation of industrial agreements and applications to make or vary awards. In 2016–17, the development of a workforce reform and industrial relations strategy commenced. It will set the strategic direction to build a sustainable and innovative health workforce to meet the health needs of Western Australians. The strategy will emphasise the identification of workforce efficiencies including:

- rostering practices
- occupational rationalisation and review
- streamlining fixed-term contract and casual conversion to permanency
- reviewing and assessing contracts for services.

Managing our budget and resources efficiently

The Director General of the Department of Health, as System Manager, is responsible for the overall management and financial stewardship of the WA health system. In order to acquit its responsibilities under the *Financial Management Act 2006*, the Department of Health has established the *Financial Management Policy Framework* (2016), which seeks to ensure:

- accountability and transparency in financial management
- long-term financial sustainability
- effective and efficient control over, and use of, financial resources
- accuracy, timeliness and completeness of financial information
- effective management of financial risks
- compliance with legislative and government policy requirements.

In 2016–17, the WA health system took part in the State Government's third tranche of the Agency Expenditure Review program. The review resulted in savings measures being endorsed by health senior executives and the independent Agency Expenditure Review Project Board, including:

- ways to deliver services more efficiently
- reducing the scope of services that no longer met the needs of the community
- cessation of contracts where there were alternative mechanisms to service delivery
- Voluntary Severance Scheme.

Managing financial and service delivery performance

The Department of Health, as the System Manager, is responsible for the management of health resources and maintaining a focus on cost efficiencies to ensure the delivery of a safe, high quality, sustainable health system for all Western Australians. This includes:

- purchasing health services via service agreements between the Department of Health and Health Service Providers
- developing policy frameworks that outline standards and parameters for the delivery of health services
- monitoring the performance of Health Service Providers and taking remedial action when performance does not meet expected standards
- establishing oversight to ensure WA health system is meeting expected standards and compliance.

In July 2016, the *Performance Management Policy* (2016) within the *Performance Policy Framework* was implemented to support the introduction of the *Health Services Act 2016* and ensure the System Manager is able to undertake effective Health Service Provider performance management.

Managing health information and communications technology

Information, Communications and Technology (ICT) is a key enabler for efficient, effective and safe patient care. It provides the foundation for ensuring patient information is accessible and can be shared when needed for treatment purposes. ICT also provides the basis for enabling patients to receive care closer to home or 'at home'. Tight fiscal challenges limit the investments made in ICT. Conversely, there is also a high patient expectation, particularly in today's fast-paced technology environment and the availability of off-the-shelf health devices. Other key challenges are the privacy and security of patient information and embracing digital disruption in healthcare whilst ensuring appropriate governance and policy and legislative frameworks are met.

Collaborative relationships with the Health Service Providers and the Office of the Government Chief Information Officer have been fostered to ensure appropriate ICT policies, processes and governance are in place that support the use of technology in healthcare

The *WA Health ICT Strategy 2015–2018* is a short-term strategy specifically designed to help stabilise existing systems, bring infrastructure up to a minimum standard, improve the way we share information and build a strong foundation for the future. Building this strong foundation has been a critical step in the journey. The 2017–18 financial year is the final year of this three-year Strategy and work will commence on the development of a future Digital Strategy over the coming months.

Key achievements in 2016–17 include:

- The *WA Health Information Management Strategy 2017–2021* was released in November 2016. The Strategy has been designed to help set the future direction for ICT across the WA health system and presents a vision for health information management that is transparent and efficient, and protects patient privacy and confidentiality, while meeting information needs across the continuum of care.
- A patient administration system (PAS) replacement program commenced in 2010. The previous PAS systems were deemed unsuitable for the current ICT environment and current clinical practice. To date, a new PAS has been implemented at metropolitan and country sites, with the remaining six sites to be completed by September 2018.
- A Software Asset Management Plan has been developed to improve the deployment and management of the WA health system's $120 million software asset base. The implementation of the Plan will provide an opportunity to mitigate existing risks and reduce costs through greater visibility of software deployments and the ability to optimise and rationalise software assets.

Initiatives that commenced in 2016–17 include:

- The WA health system, through Health Support Services continued to work closely with the National Digital Health Agency in the roll-out of My Health Record. With the Commonwealth recently announcing the move to an 'opt out' model for My Health Record, the WA health system will work closely with the Agency in ensuring readiness throughout the WA health system.
- Roll-out of core clinical applications across WA Country Health Service. The availability of core clinical applications across country areas will improve patient care, reduce clinical risk and make patient data more available at the point of care and between sites for transient patients.
- A Community Health Information System will be implemented across country areas in 2017–18. This system will provide an electronic clinical record for patients attending country community and primary health centres.
- A new Laboratory Information System will replace the current ageing systems and databases used by PathWest. This system will integrate all areas of diagnostic testing, enable more accurate specimen tracking, quicker turnaround of diagnostic results, and provide a seamless pathology data connection across the State.
- The Medical Imaging Replacement Project has been initiated to transition from the existing Picture Archiving Communication System and Radiology Information System to a system with new medical imaging capabilities.
- An Applications Roadmap is under development and will set the direction for ICT investment by determining the current state of applications, describing a broad vision for the future state of applications, defining the core statewide applications to be used across the system, and making recommendations for bringing all sites up to a consistent standard.
- Work is also underway on the development of an enterprise architecture framework by Health Support Services. The WA Health Enterprise Architecture will provide interoperability and integration between systems to enhance business processes and information access; reduce technical risks and costs; and improve agility and security.

Disclosure and compliance

Audit opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

DEPARTMENT OF HEALTH

Report on the Financial Statements

Opinion
I have audited the financial statements of the Department of Health which comprise the Statement of Financial Position as at 30 June 2017, 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.

In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Department of Health for the year ended 30 June 2017 and the financial position at the end of that period. They are in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions.

Basis for Opinion
I conducted my audit in accordance with the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Department in accordance with the *Auditor General Act 2006* and the relevant ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial statements. I have also fulfilled my other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibility of the Director General 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, the *Financial Management Act 2006* 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.

In preparing the financial statements, the Director General is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Department.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

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As part of an audit in accordance with Australian Auditing Standards, I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Director General.
- Conclude on the appropriateness of the Director General's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Director General regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report on Controls

Opinion
I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Department of Health. The controls exercised by the Department 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 (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

In my opinion, in all material respects, the controls exercised by the Department of Health are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2017.

The Director General's Responsibilities
The Director General is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's Responsibilities
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and the controls, necessary to achieve the overall control objectives, were implemented as designed.

An assurance engagement to report on the design and implementation of controls involves performing procedures to obtain evidence about the suitability of the design of controls to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including the assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

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

Limitations of Controls
Because of the inherent limitations of any internal control structure it is possible that, even if the controls are suitably designed and implemented as designed, once the controls are in operation, the overall control objectives may not be achieved so that fraud, error, or noncompliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the Key Performance Indicators

Opinion
I have undertaken a reasonable assurance engagement on the key performance indicators of the Department of Health for the year ended 30 June 2017. The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators of the Department of Health are relevant and appropriate to assist users to assess the Department's performance and fairly represent indicated performance for the year ended 30 June 2017.

The 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 internal control as the Director General determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Director General is responsible for identifying key performance indicators that are relevant and appropriate having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's Responsibility
As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the agency's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion.

I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

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

My Independence and Quality Control Relating to the Reports on Controls and Key Performance Indicators
I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory 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 2017 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
28 September 2017

Certification of financial statements

DEPARTMENT OF HEALTH

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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 from the financial year ending 30 June 2017 and financial position as at 30 June 2017.

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.

Mr Peter May
A/CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

27 September 2017

Ms Rebecca Brown
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

27 September 2017

Financial statements

Department of Health

Statement of Comprehensive Income
For the year ended 30 June 2017

	Note	2017 $000	2016 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	6	116,942	111,542
Contracts for services	8	676,938	648,525
Supplies and services	9	74,230	53,487
Grants and subsidies	10	6,510,165	6,381,354
Depreciation expense	11	591	574
Loss on disposal of non-current assets	12	29	10
Contribution to Capital Works Fund	13	27,372	2,414
Other expenses	14	80,823	22,754
Total cost of services		**7,487,090**	**7,220,660**
INCOME			
Revenue			
User charges and fees		6,077	14,708
Commonwealth grants and contributions	16	2,295,735	2,070,404
Other grants and contributions	17	7,508	7,415
Finance income	18	1,749	1,961
Other revenue	19	33,912	3,136
Total revenue		**2,344,981**	**2,097,624**
Total income other than income from State Government		**2,344,981**	**2,097,624**
NET COST OF SERVICES		**5,142,109**	**5,123,036**
INCOME FROM STATE GOVERNMENT	20		
Service appropriations		5,139,298	4,853,583
Assets (transferred)/assumed		(15,867)	1,055
Services received free of charge		2,249	1,947
Royalties for Regions Fund		44,084	51,921
Total income from State Government		**5,169,764**	**4,908,506**
SURPLUS/(DEFICIT) FOR THE PERIOD		**27,655**	**(214,530)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	35	1,136	957
Total other comprehensive income		**1,136**	**957**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**28,791**	**(213,573)**

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 2017

	Note	2017 $000	2016 $000
ASSETS			
Current Assets			
Cash and cash equivalents	36	127,968	8,706
Restricted cash and cash equivalents	21, 36	129,463	202,067
Inventories	22	16,549	15,723
Receivables	23	64,211	41,032
Other current assets	29	3,870	3,902
Non-current assets classified as held for sale	30	12,489	-
Total Current Assets		354,550	271,429
Non-Current Assets			
Restricted cash and cash equivalents	21	485	-
Amounts receivable for services	24	55,046	36,858
Finance lease receivable	25	6,692	4,942
Property, plant and equipment	26	1,131,353	27,226
Intangible assets	28	105,822	-
Other non-current assets	29	2,910	9,237
Total Non-Current Assets		1,302,308	78,263
Total Assets		**1,656,858**	**349,692**
LIABILITIES			
Current Liabilities			
Payables	32	81,020	61,645
Provisions	33	18,935	20,287
Other current liabilities	34	6,147	778
Total Current Liabilities		106,102	82,710
Non-Current Liabilities			
Provisions	33	5,022	5,235
Total Non-Current Liabilities		5,022	5,235
Total Liabilities		**111,124**	**87,945**
NET ASSETS		**1,545,734**	**261,747**
EQUITY	35		
Contributed equity		1,041,854	(213,341)
Reserves		307,783	306,647
Accumulated surplus		196,097	168,442
TOTAL EQUITY		**1,545,734**	**261,748**

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 Cash Flows

For the year ended 30 June 2017

	Note	2017 $000 Inflows (Outflows)	2016 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		4,743,697	4,475,422
Capital appropriations	35	121,456	-
Royalties for Regions Fund	20	44,084	51,921
Assets transferred	20	-	1,132
Net cash provided by State Government		4,909,236	4,528,475
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(119,698)	(112,176)
Supplies and services		(773,250)	(689,523)
Grants and subsidies		(6,132,752)	(6,009,806)
Contribution to Capital Works Fund		(27,372)	(2,414)
GST payments on purchases		(404,911)	(382,154)
Receipts			
User charges and fees		6,085	14,694
Commonwealth grants and contributions		2,264,526	2,045,404
GST receipts on sales		26,387	23,707
GST refunds from taxation authority		375,366	357,940
Other receipts		27,639	4,580
Net cash used in operating activities	36	(4,757,980)	(4,749,748)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(91,860)	(92)
Net cash used in investing activities		(91,860)	(92)
Net decrease in cash and cash equivalents		59,396	(221,365)
Cash and cash equivalents at the beginning of the period		210,773	432,138
Cash and cash equivalents held by Children and Adolescent Health Service on behalf of the Health Ministerial Body		(12,253)	-
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	36	257,916	210,773

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

Department of Health

Statement of Changes in Equity

For the year ended 30 June 2017

	Note	2017 $000	2016 $000
CONTRIBUTED EQUITY	35		
Balance at start of period		(213,341)	(143,169)
Transactions with owners in their capacity as owners:			
Contributions by owners		1,259,165	-
Distributions to owners		(3,970)	(70,172)
Balance at end of period		**1,041,854**	**(213,341)**
RESERVES	35		
Asset Revaluation Reserve			
Balance at start of period		306,647	305,690
Other comprehensive income for the period		1,136	957
Balance at end of period		**307,783**	**306,647**
ACCUMULATED SURPLUS	35		
Balance at start of period		168,442	382,972
Surplus/(Deficit) for the period		27,655	(214,530)
Balance at end of period		**196,097**	**168,442**
TOTAL EQUITY			
Balance at start of period		261,748	545,493
Total comprehensive income/(loss) for the year		28,791	(213,573)
Transactions with owners in their capacity as owners		1,255,195	(70,172)
Balance at end of period		**1,545,734**	**261,748**

The Statement of Changes in Equity 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 2017

	2017 Estimate $000	2017 Actual $000	Variance $000	2017 Actual $000	2016 Actual $000	Variance $000
Delivery of Services						
Item 35 Net amount appropriated to deliver services	4,919,644	5,018,081	98,437	5,018,081	4,723,889	294,192
Section 25 transfer of service appropriation	-	501	501	501	(754)	1,255
Amount Authorised by Other Statutes						
- Salaries and Allowances Act 1975	716	716	-	716	697	19
- Lotteries Commission Act 1990	135,718	120,000	(15,718)	120,000	129,750	(9,750)
Total appropriations provided to deliver services	5,056,078	5,139,298	83,220	5,139,298	4,853,582	285,716
Capital						
Item 132 Capital appropriations	188,049	157,810	(30,239)	157,810	146,494	11,316
GRAND TOTAL	5,244,127	5,297,108	52,981	5,297,108	5,000,076	297,032
Details of Expenses by Service						
Public Hospital Admitted Patients	4,731,074	4,449,045	(282,029)	4,449,045	4,562,408	(113,363)
Home-Based Hospital Programs	35,225	39,061	3,836	39,061	36,735	2,326
Palliative Care	33,626	38,924	5,298	38,924	33,199	5,725
Emergency Department	766,911	762,914	(3,997)	762,914	807,760	(44,846)
Public Hospital Non-Admitted Patients	951,780	1,045,052	93,272	1,045,052	961,045	84,007
Patient Transport	215,858	267,645	51,787	267,645	218,084	49,561
Prevention, Promotion & Protection	603,704	491,679	(112,025)	491,679	547,230	(55,551)
Dental Health	106,569	111,552	4,983	111,552	103,623	7,929
Continuing Care	477,969	419,725	(58,244)	419,725	472,650	(52,925)
Mental Health	645,357	693,356	47,999	693,356	721,415	(28,059)
Health System Management - Policy and Corporate Services (c)	-	266,774	266,774	266,774	-	266,774
Health Support Services (c)	-	245,533	245,533	245,533	-	245,533
Total Cost of Services	8,568,073	8,831,260	263,187	8,831,260	8,464,149	367,111
Less Total income	(3,427,554)	(3,827,734)	(400,180)	(3,827,734)	(3,487,651)	(340,083)
Net Cost of Services	5,140,519	5,003,526	(136,993)	5,003,526	4,976,498	27,028
Adjustments (a)	(84,441)	135,772	220,213	135,772	(122,916)	258,688
Total appropriations provided to deliver services	5,056,078	5,139,298	83,220	5,139,298	4,853,582	285,716
Capital Expenditure						
Purchase of non-current physical assets	526,289	321,563	(204,726)	321,563	399,404	(77,841)
Repayment of borrowings	77,631	78,569	938	78,569	68,815	9,754
Adjustments for other funding sources (b)	(415,871)	(242,322)	173,549	(242,322)	(321,725)	79,403
Capital appropriations	188,049	157,810	(30,239)	157,810	146,494	11,316

The Summary of Consolidated Account Appropriations and Income Estimates comprises the Department and Health Service Providers within WA Health which are North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service, Childrens and Adolescent Health Service, Health Support Services and WA Country Health Service.

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

(b) Adjustments for the ($242.322 million) comprise $82.411 million funding for New Children's Hospital, $41.045 million funding for Royalties for Regions, $11.279 million CWP Treasury Administered funding and include movements in cash balances and other accrual items such as receivables and payables.

(c) WA Health Outcome Based Management Framework was revised during 2016/17 resulting in 2 new services: Health System Management - Policy and Corporate Services and Health Support Services.

Department of Health

Schedule of Income and Expenses by Service

For the year ended 30 June 2017

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	232	22,668	297	2,268	-	3,057	-	-
Contracts for services	33,383	34,491	30,161	30,128	22,565	23,582	-	-
Supplies and services	-	1,901	-	610	-	1,098	-	-
Grants and subsidies	3,960,437	4,125,129	2,099	1,774	2,887	1,837	722,085	769,962
Depreciation expense	-	71	-	9	-	10	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Contribution to Capital Works Fund	-	248	-	111	-	115	-	-
Other expenses	19,551	12,586	0	234	-	320	-	-
Total cost of services	4,013,603	4,197,094	32,557	35,134	25,452	30,019	722,085	769,962
Income								
User charges and fees	-	8,538	-	86	-	89	-	-
Commonwealth grants and contributions	1,397,393	1,224,039	45	1,270	-	2,202	228,842	191,685
Other grants and contributions	-	-	-	-	-	-	-	-
Finance income (a)	-	1,377	-	2	-	-	-	218
Other revenue	2,164	2,079	-	37	-	41	-	-
Total income other than income from State Government	1,399,557	1,236,033	45	1,395	-	2,332	228,842	191,903
NET COST OF SERVICES	2,614,046	2,961,061	32,512	33,739	25,452	27,687	493,243	578,059
Income from State Government								
Service appropriations	2,619,627	2,802,217	32,512	32,167	22,930	26,451	467,504	546,942
Assets (transferred)/assumed	-	52	-	42	-	38	-	-
Services received free of charge	-	162	-	72	-	75	-	-
Royalties for Regions Fund	3,803	4,734	-	-	648	678	16,471	17,790
Total income from State Government	2,623,430	2,807,165	32,512	32,281	23,578	27,242	483,975	564,732
SURPLUS/(DEFICIT) FOR THE PERIOD	9,384	(153,896)	(0)	(1,458)	(1,874)	(445)	(9,268)	(13,327)

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 2017

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
COST OF SERVICES								
Expenses								
Employee benefits expense		-	252	11,121	5,812	42,177	-	911
Contracts for services	-	-	135,991	133,360	43,414	46,012	13,950	14,529
Supplies and services		-		1,946	48,996	43,389	-	159
Grants and subsidies	855,413	805,114	90,620	107,135	377,426	399,594	80,638	74,245
Depreciation expense		-		49	19	315	-	4
Loss on disposal of non-current assets	-	-		-	-	-	-	-
Contribution to Capital Works Fund	-	-		614	-	464	-	50
Other expenses	-	-	43	1,287	1,916	5,271	-	105
Total cost of services	855,413	805,114	226,906	255,512	477,583	537,222	94,588	90,003
Income								
User charges and fees		-		477	1,324	4,408	-	39
Commonwealth grants and contributions	337,044	248,649	1,583	3,593	104,897	153,452	6,514	12,041
Other grants and contributions	-	-	-	-	7,508	7,415	-	-
Finance income (a)	-	269	-	-		83	-	-
Other revenue	-	-	-	203	30	307	-	16
Total income other than income from State Government	337,044	248,918	1,583	4,273	113,759	165,665	6,514	12,096
NET COST OF SERVICES	518,369	556,196	225,323	251,239	363,824	371,557	88,074	77,907
Income from State Government								
Service appropriations	523,198	526,257	205,327	239,082	380,836	352,584	88,087	73,825
Assets (transferred)/assumed	-	-	-	235	(585)	176	-	19
Services received free of charge	-	-	-	402	-	303	-	33
Royalties for Regions Fund	1,966	3,321	9,547	20,372	3,562	4,247	-	-
Total income from State Government	525,164	529,578	214,874	260,091	383,813	357,310	88,087	73,877
SURPLUS/(DEFICIT) FOR THE PERIOD	6,795	(26,618)	(10,449)	8,852	19,989	(14,247)	13	(4,030)

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 2017

	Continuing Care		Mental Health (b)		Health System Management Policy and Corporate Services		Health Support Services		TOTAL	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 1000	2016 1000	2017 1000	2016 1000	2017 $000	2016 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	25	29,340	-	-	110,324	-	-	-	116,942	111,542
Contracts for services	352,546	366,101	292	322	44,636	-	-	-	676,938	648,525
Supplies and services	-	4,384	-	-	25,234	-	-	-	74,230	53,487
Grants and subsidies	147,695	96,564	14,142	-	1,889	-	254,834	-	6,510,165	6,381,354
Depreciation expense	-	116	-	-	572	-	-	-	591	574
Loss on disposal of non-current assets	-	10	-	-	29	-	-	-	29	10
Contribution to Capital Works Fund	-	812	-	-	27,372	-	-	-	27,372	2,414
Other expenses	186	2,951	-	-	59,127	-	-	-	80,823	22,754
Total cost of services	500,452	500,278	14,434	322	269,183	-	254,834	-	7,487,090	7,220,660
Income										
User charges and fees	-	1,071	-	-	4,753	-	-	-	6,077	14,708
Commonwealth grants and contributions	219,417	233,473	-	-	-	-	-	-	2,295,735	2,070,404
Other grants and contributions	-	-	-	-	-	-	-	-	7,508	7,415
Finance income (a)	-	-	-	12	1,749	-	-	-	1,749	1,961
Other revenue	-	453	-	-	31,718	-	-	-	33,912	3,136
Total income other than income from State Government	219,417	234,997	-	12	38,220	-	-	-	2,344,981	2,097,624
NET COST OF SERVICES	281,035	265,281	14,434	310	230,963	-	254,834	-	5,142,109	5,123,036
Income from State Government										
Service appropriations	264,524	254,058	13,867	-	266,007	-	254,879		5,139,298	4,853,583
Assets (transferred)/assumed	-	493	-	-	(15,282)	-	-	-	(15,867)	1,055
Services received free of charge	-	900	-	-	2,249	-	-	-	2,249	1,947
Royalties for Regions Fund	7,797	779	290	-	-	-	-	-	44,084	51,921
Total income from State Government	272,321	256,230	14,157	-	252,974	-	254,879	-	5,169,764	4,908,506
SURPLUS/(DEFICIT) FOR THE PERIOD	(8,714)	(9,051)	(277)	(310)	22,011	-	45	-	27,655	(214,530)

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 2017

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
Assets								
Current assets	41,881	48,648	3,323	4,570	2,566	2,711	33,067	113,417
Non-current assets (a)	1,117	28,174	-	766	1,531	4,342	-	549
Total Assets	42,998	76,822	3,323	5,336	4,097	7,053	33,067	113,966
Liabilities								
Current liabilities	151	12,567	259	2,104	-	2,260	-	-
Non-current liabilities	36	1,005	2	113	-	123	-	-
Total Liabilities	187	13,572	261	2,217	-	2,383	-	-
NET ASSETS	42,811	63,250	3,062	3,119	4,097	4,670	33,067	113,966

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

WA Health Outcome Based Management Framework was revised during 2016/17 resulting in 2 new services: Health System Management - Policy and Corporate Services, and Health Support Services. Also refer to Note 2 (c) Services.

Department of Health

Schedule of Assets and Liabilities by Service (continued)

As at 30 June 2017

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
Assets								
Current assets	2,449	-	7,946	11,325	26,909	39,737	10,400	13,412
Non-current assets (a)	-	677	-	3,178	-	27,239	-	260
Total Assets	2,449	677	7,946	14,503	26,909	66,976	10,400	13,672
Liabilities								
Current liabilities	-	-	3,780	14,045	2,809	19,109	1,975	4,548
Non-current liabilities	-	-	-	518	310	2,103	-	42
Total Liabilities	-	-	3,780	14,563	3,119	21,212	1,975	4,590
NET ASSETS	2,449	677	4,166	(60)	23,790	45,764	8,425	9,082

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

WA Health Outcome Based Management Framework was revised during 2016/17 resulting in 2 new services: Health System Management - Policy and Corporate Services, and Health Support Services. Also refer to Note 2 (c) Services.

Department of Health

Schedule of Assets and Liabilities by Service (continued)

As at 30 June 2017

	Continuing Care		Mental Health		Health System Management Policy and Corporate Services		Health Support Services		TOTAL	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
Assets										
Current assets	18,423	37,609	237	-	207,001	-	348		354,550	271,429
Non-current assets (a)	-	13,048	-	30	1,299,399		261		1,302,308	78,263
Total Assets	18,423	50,657	237	30	1,506,400	-	609	-	1,656,858	349,692
Liabilities										
Current liabilities	812	28,077	-	-	96,316	-	-		106,102	82,710
Non-current liabilities	-	1,331	-	-	4,674	-	-		5,022	5,235
Total Liabilities	812	29,408	-	-	100,990	-	-	-	111,124	87,945
NET ASSETS	17,611	21,249	237	30	1,405,410	-	609	-	1,545,734	261,747

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

WA Health Outcome Based Management Framework was revised during 2016/17 resulting in 2 new services: Health System Management - Policy and Corporate Services, and Health Support Services. Also refer to Note 2 (c) Services.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 1 Australian Accounting Standards

General

The Department's financial statements for the year ended 30 June 2017 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

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

Early adoption of standards

The Department cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Partial exemption permitting early adoption of AASB 2015-7 'Amendments to Australian Accounting Standards - Fair Value Disclosures of Non-for-Profit Public Sector Entities' has been granted. Aside from AASB 2015-7, there has been no early adoption of any other Australian Accounting Standards that have been issued or amended (but not operative) by the Department for the annual reporting period ended 30 June 2017.

Exemption

ON 13 September 2017, approval was obtained which exempts the Department from the reporting requirements of Treasurer's Instructions 1101 (7)(ix) and 1105 (4)(iv) in relation to the Application of Australian Accounting Standards and Other Pronouncements, and preparing Consolidated Financial Statements. The exemption relates to the financial years from 2016/17 to 2018/19.

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 Department has adopted AASB 124 Related Party Disclosures for the first time in 2016-17 annual financial reports. This complies with the requirements fo Treasurer's Instruction 924.

The Department of Health was established by the Governor under Section 35 of the Public Sector Management Act 1994 (PSM). The Director General of Health is the appointed chief executive officer (CEO) and is responsible for fulfilling the functions of a CEO as set out in the PSM Act.

On 1 July 2016, the Health Services Act 2016 (the Act) commenced operation introducing a contemporary devolved governance model for the WA health system. The Director General is established as the System Manager and is responsible for the strategic direction, oversight and management of the WA health system.

The Act provides the establishment of the Health Ministerial Body, a body corporate through which the Minister can perform any of the Minister's functions under the Act. Any act done through the Ministerial Body is regarded as services under the control of the Department of Health for the purposes of the Financial Management Act.

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

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

(b) Basis of preparation

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

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

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

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

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

(c) Reporting entity

The reporting entity comprises the Department, the Ministerial Body and is based on the control exercised by the Department over the funding provided to the Health Service Providers (HSP's). The HSP's include North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service, Childrens and Adolescent Health Service, Health Support Services and WA Country Health Service.

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 46 '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.

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 47 'Administered assets and liabilities' and note 48 'Disclosure of administered income and expenses by service'.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(c) Reporting entity (continued)

Mission

The mission of the Department is to lead and steward the WA health system. 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 of Health and Statutory Authorities within WA Health which are Child and Adolescent Health Service, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, WA Country Health Service, Health Support Services, Queen Elizabeth II Medical Centre Trust and Quadriplegic Centre Board.

Subsequent to approval in the 2016/17 Published Budget Paper, on 18 January 2017, WA health system's approved Outcome Based Management Framework for 2016/17 includes a new Outcome 3 relating to Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system. Two new services were approved being Health System Management - Policy and Corporate Services, and Health Support Services. The additional outcome and services are reflective of the changes to WA health system's governance structure resulting from the Health Services Act 2016.

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 the Department of 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

Home-Based Hospital Programs

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

Palliative Care

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

Emergency Department

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

Public Hospital Non-admitted Patients

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

Patient Transport

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

Prevention, Promotion and Protection

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

Dental Health

Dental Health Services (DHS) include the school dental servcie, 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 health care 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 practionioners participating in the metropolitan, country and orthodontidc patient dental subsidy schemes.

Continuing Care

Aged and continuing care services include:

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

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

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

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

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

Note 2 Summary of significant accounting policies (continued)

(c) Reporting entity (continued)

Contracted Mental Health

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

Health System Management - Policy and Corporate Services

Provide strategic leadership, policy, planning services, system performance management, and purchasing linked to state-wide planning budgeting and regulation processes.

Health Support Services

Provide purchased health support services to WA Health entities.

(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 35 'Equity'.

The Act provides that the Director General is responsible for 'commissioning and delivering capital works and maintenance works for public health service facilities', which are approved by the Minister for Works. The Perth Children's Hospital (PCH) Commission and Transition Taskforce oversees the delivery of clinical commissioning of PCH and associated impacts across the WA health system. That effective control of the commissioning and delivery of Perth Children's Hospital (PCH) is retained by the Director General and is supported by the PCH Governance Transition Document. For the financial year ending 30 June 2017, the Department of Health financial accounts include the PCH financial records.

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

Net appropriation determination
The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the Department. In accordance with the determination specified in the 2016-2017 Budget Statements, the Department retained $435million in 2017 ($401 million in 2016) from the following:

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

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

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

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

Gains

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

(f) Property, plant and equipment and site infrastructure

Site infrastructure

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

Capitalisation/expensing of assets

Items of property, plant and equipment and site infrastructure 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 and site infrastructure are initially recognised at cost.

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

Subsequent measurement

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

Department of Health

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(f) Property, plant and equipment (continued)

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

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

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

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

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 26 'Property, plant and equipment' and note 27 'Fair value measurements' for further information on revaluations.

Derecognition

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

Asset revaluation reserve

The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets as described in note 26 '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 - straight line
* Site Infrastructure - straight line
* Plant and equipment - straight line

The depreciation method for buildings and site infrastructure was changed to straight line on 1 July 2016. Up to 30 June 2016, building and site infrastructure were depreciated using the diminishing value with a straight line switch method.

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

Buildings	50 years
Site Infrastructure	50 years
Computer equipment	4 to 5 years
Furniture and fittings	5 to 20 years
Other plant and equipment	2 to 15 years

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

(g) Intangible assets

Capitalisation/Expensing of Assets
Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

All acquired and internally developed intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

The cost model is applied for subsequent measurement requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life which is reviewed annually) on the straight line basis. All intangible assets controlled by the Department have a finite useful life and zero residual value.

The expected useful live for below class of intangible asset is:

Computer software	5 years

Computer Software

Software that is an integral part of the related hardware is treated as property, plant and equipment. Software that is not an integral part of the related hardware is treated as an intangible asset. Sofeware costing less than $5,000 is expensed in the year of acquisition.

(h) Impairment of assets

Property, plant and equipment, site infrastructure and intangible assets 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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(h) Impairment of assets (continued)

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

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

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

Refer also to note 2(p) 'Receivables' and note 23 'Receivables' for impairment of receivables.

(i) 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.

(j) 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.

(k) Financial Instruments

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

Financial instruments have been disaggregated into the following classes:

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

Financial Liabilities
- Payables

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

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

(l) Cash and cash equivalents

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

(m) Accrued salaries

Accrued salaries (refer note 32 '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 21 'Restricted cash and cash equivalents') consists of amounts paid annually, from Department appropriations for salaries expense, 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.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(n) 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 24 'Amounts receivable for services' and note 20 'Income from State Government'.

(o) 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 22 'Inventories'.

(p) 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 entities in the GST group include the Department of Health, North Metropolitan Health Service, East Metropolitan Health Service, South Metropolitan Health Service, Childrens and Adolescent Health Service, Health Support Services and WA Country Health Service, Mental Health Commission, 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(k) 'Financial instruments' and note 23 'Receivables'.

(q) 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(k) 'Financial instruments' and note 32 'Payables'.

Note 2 Summary of significant accounting policies (continued)

(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 benefits

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

Annual leave

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

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

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

Long service leave

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

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

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

Sick Leave

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

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

Deferred Salary Scheme

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

Superannuation

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

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

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

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 2 Summary of significant accounting policies (continued)

(r) Provisions (continued)

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

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

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

Refer to note 2(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'

(s) Superannuation expense

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

(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 reporting period.

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 reporting period.

Buildings

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

Employee benefits provision

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

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

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

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, or adopted, for annual reporting periods beginning on or after 1 July 2016 that impacted on the Department.

Title	
AASB 1057	*Application of Australian Accounting Standards* This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.
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.
AASB 2015-1	*Amendments to Australian Accounting Standards – Annual Improvements to Australian Accounting Standards 2012–2014 Cycle [AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140]* These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012–2014 Cycle in September 2014, and editorial corrections. The Department has determined that the application of the Standard has no financial impact.
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.
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.

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supercedes AASB 139 *Financial Instruments: Recognition and Measurement* , introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards* . The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Department shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from a contract with a customer. The Department has not yet determined the application or the potential impact of the	1 Jan 2019
AASB 16	*Leases* This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Department has not yet determined the application or the potential impact of the Standard. Whilst the impact of AASB 16 has not yet been quantified, the entity currently has operating lease commitments for $19.01 million. The Department anticipates most of this amount will be brought onto the statement of financial position, excepting amounts pertinent to short-term or low-value leases. Interest and amortisation expense will increase and rental expense will decrease.	1 Jan 2019
AASB 1058	*Income of Not-for-Profit Entities* This Standard clarifies and simplifies the income recognition requirements that apply to not-for-profit(NFP) entities, more closely reflecting the economic reality of NFP entity transactions that are not contracts with customers. Timing of income recognition is dependent on whether such a transaction gives rise to a liability, a performance obligation (a promise to transfer a good or service), or, an obligation to acquire an asset. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

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

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Department to determine the application or potential impact of the Standard.	1 Jan 2018
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Department has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-10	*Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & 128]* This Standard amends AASB 10 and AASB 128 to address an inconsistency between the requirements in AASB 10 and those in AASB 128 (August 2011), in dealing with the sale or contribution of assets between an investor and its associate or join venture. The mandatory effective date (application date) for the Standard has been deferred to 1 Jan 2018 by AASB 2015-10. The Department has determined that the Standard has no financial impact.	1 Jan 2018
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. The Department has not yet determined the application or the potential impact of AASB 15.	1 Jan 2019

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

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 2016-2	*Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107* This Standard amends AASB 107 Statement of Cash Flows (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Department has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Department has not yet determined the application or the potential impact.	1 Jan 2017
AASB 2016-7	*Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities* This Standard amends the mandatory effective date (application date) of AASB 15 and defers the consequential amendments that were originally set out in AASB 2014-5 *Amendments to Australian Accounting Standards arising from AASB 15* for not-for-profit entities to annual reporting periods beginning on or after 1 January 2019, instead of 1 January 2018. There is no financial impact.	1 Jan 2017
AASB 2016-8	*Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities* This Standard inserts Australian requirements and authoritative implementation guidance for not-for-profit entities into AASB 9 and AASB 15. This guidance assists not-for-profit entities in applying those Standards to particular transactions and other events. There is no financial impact.	1 Jan 2019
AASB 2017-2	*Amendments to Australian Accounting Standards – Further Annual Improvements 2014-2016 Cycle* This Standard clarifies the scope of AASB 12 by specifying that the disclosure requirements apply to an entity's interests in other entities that are classified as held for sale, held for distribution to owners in their capacity as owners or discontinued operations in accordance with AASB 5. There is no financial impact.	1 Jan 2017

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 6 Employee benefits expense

	2017 $000	2016 $000
Salaries and wages (a)	107,485	102,569
Superannuation - defined contribution plans (b)	9,457	8,973
	116,942	111,542

(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) Includes defined contribution plans to West State, Gold State and GESB Super of $8.138 million ($8.069 million in 2015/16). These transactions are considered to be a significant related party transactions.

Redundancy expenses of $5.907 million were incurred in 2016/17 ($6.274 million in 2015/16).

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

Note 7 Compensation of Key Management Personnel

The Department has determined that key management personnel includes Ministers and senior officers of the Department. However, the Department is not obligated to compensate Ministers and therefore disclosures in relation to Ministers' compensation many be found in the Annual Report on State Finances.

Total compensation for senior officers of the Department for the reporting period are presented within the following bands:

Compensation Band ($)	2017	2016
$660,001 - $670,000	1	-
$590,001 - $600,000	1	-
$580,001 - $590,000	-	1
$550,001 - $560,000	-	1
$520,001 - $530,000	-	1
$460,001 - $470,000	1	-
$370,001 - $380,000	1	2
$350,001 - $360,000	1	-
$340,001 - $350,000	1	1
$280,001 - $290,000	-	1
	6	7

	$000	$000
Short-term employee benefits	2,436	2,686
Post-employment benefits	269	288
Other long-term benefits	95	19
Termination benefits	-	-
Total compensation of key management personnel	2,800	2,993

Note 8 Contracts for services

Home and community care	274,811	276,809
Patient transport service	136,037	129,607
Other aged care services	102,316	105,879
Mental health	292	322
Blood and organs	32,419	24,326
Aboriginal health	9,431	8,484
Palliative care	22,565	22,639
Oral health	13,950	14,127
Other contracts	85,117	66,332
	676,938	648,525

Note 9 Supplies and services

Medical supplies	59,106	42,602
Other consumables	5,385	1,420
Operating lease rentals	9,739	9,465
	74,230	53,487

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 10	**Grants and subsidies**		
	Recurrent		
	Funding for the Delivery of Health Services by Autonomous Statutory Authorities (a):		
	North Metropolitan Health Service (b)	1,777,858	-
	East Metropolitan Health Service (b)	1,073,935	-
	South Metropolitan Health Service (b)	1,415,222	-
	Children and Adolescent Health Service (b)	433,304	-
	Health Support Services (b)	254,879	-
	Metropolitan Health Service	-	4,943,622
	WA Country Health Service (b)	1,399,221	1,405,873
	Quadriplegic Centre Board	9,951	9,980
	Queen Elizabeth II Medical Centre Trust	674	231
	Commonwealth Specific Grants (d)	113,365	-
	Research and development grants	20,547	17,861
	Spectacle subsidy scheme	72	68
	Other (c)	11,137	3,719
		6,510,165	6,381,354

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

(b) The Health Services Act 2016 came into effect from 1 July 2016. Changes under this Act included the establishment of Health Services (Child and Adolescent, East Metropolitan, North Metropolitan, South Metropolitan and WA Country Health Services) and Health Support Services (HSS) as separate legal entities. These transactions are considered to be a significant related party transactions.

(c) Includes $6.58 million grant to PlusLife.

(d) Distributed as State Appropriations in prior financial years.

Note 11	**Depreciation and amortisation expense**		
	Depreciation		
	Buildings	269	349
	Site infrastructure	55	75
	Computer equipment	70	22
	Furniture and fittings	9	9
	Other plant and equipment	146	119
	Total depreciation	549	574
	Amortisation		
	Computer Software	43	-
	Total amotisation	43	
	Total depreciation and amortisation	591	574
Note 12	**Loss on disposal of non-current assets**		
	Carrying amount of non-current assets disposed:		
	Property, plant and equipment	29	10
	Net loss	29	10
	Refer to note 26 'Property, plant and equipment'.		
Note 13	**Contribution to Capital Works Fund**	27,372	2,414
	$27.372 million was paid to the Capital Works Fund during the 2016/17 financial year, an administered trust account of the Department, to fund the capital works program for the Health Services.		
Note 14	**Other expenses**		
	Advertising	1,167	1,217
	Ex-gratia payments (b)	19,185	8,865
	Communication	994	987
	Computer related expenses	2,541	1,777
	Doubtful debts expense	7	-
	Insurance	332	200
	Legal expenses	1,240	1,051
	Other employee related expenses	2,032	2,273
	Promotional expenses	23	358
	Repairs and maintenance (d)	37,918	900
	Scholarships	1,754	1,772
	Services Provided Free of Charge by Health Support Services and North Metropollitan Health	-	-
	Travel related expenses	646	493
	Workers' compensation insurance (a)	285	228
	Freight and cartage	809	683
	Special functions	367	538
	Other (c)	11,523	1,412
		80,823	22,754

(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) Under the Private Patient Scheme approved by the State Government, the Department commenced the ex-gratia payments towards patient fee debts in July 2015. The total amounts of ex-gratia payments is $19.185 million for 2016/17 ($0.117 million Child and Adolescent, $2.492 million for East Metropolitan Health Service, $1.676 million for North Metropolitan Health Service, $12.637 million for South Metropolitan Health Service, and $2.263 million for WA Country Health Service).

(c) Includes $8.174 million compensation payment to Capella Parking Pty Limited.

(d) Includes $31.197 million Telethon Kids Institute project expenses.

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000

Note 15 Related Party Transactions

The Department is a wholly owned and controlled entity of the State of Western Australia. In conducting its activities, the Department is required to pay various taxes and levies based on the standard terms and conditions that apply to all tax and levy payers to the State and entities related to State.

Related parties of the department include:

- all Ministers and their close family members, and their controlled or jointly controlled entities;

- all senior officers and their close family members, and their controlled or jointly controlled entities;

- other departments and public sector entities, including related bodies included in the whole of government consolidated financial statements;

- associates and joint ventures, that are included in the whole of government consolidated financial statements; and

- the Government Employees Superannuation Board (GESB)

Significant transactions with government related entities

Significant transactions with government related entities include:

- service appropriations from the Department of Treasury (note 20)

- services received free of charge from Department of Education, Landgate , and State Solicitor's Office (note 20)

- Royalties for Regions Fund (note 20)

- assets transferred to other government agencies (note 20)

- grants from the Department of Education (note 17)

- Grants and subsidies to Health Service Providers (note 10)

- superannuation payments to GESB (note 6)

Material transactions with related parties

Remuneration applicable to Key Management Personnel is disclosed under Note 7 Compensation of Key Management Personnel.

The Department had no material related party transactions with Ministers/Senior Officers or their close family members or their controlled (or jointly controlled) entities for disclosure.

Note 16	**Commonwealth grants and contributions**		
	Cash Grants - Recurrent		
	National Health Reform Agreement (NHRA) (a):		
	Health Service Providers	1,886,931	1,638,623
	Public Health	39,306	38,528
	Specific Purpose Grants:		
	Home and Community Care	182,224	178,285
	Department of Veterans' Affairs	60,000	73,403
	Public Health Programs	1,774	6,948
	Aged Care Programs	33,217	41,273
	Multi-Purpose Services Sites	31,655	27,823
	Public Health Outcome Funding Agreement - Vaccines	13,573	17,894
	Other Public Health Programs		-
	Treating More Public Dental Patients	6,514	12,041
	Other programs	9,331	10,587
	Non-Cash Contributions		
	Vaccine inventories received free of charge	31,210	24,999
		2,295,735	2,070,404

(a) As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement (NHRA) for services, health teaching, training and research provided by local hospital networks or other organisations, and any other matter that under that Agreement is to be funded through the National Health Funding Pool, the State Managed Fund (Health) Account and the State Managed Fund (Mental Health) Account. The new funding arrangement established under the Agreement requires the Commonwealth to make funding payments to the State Pool Account from which distributions to the local hospital networks are made by the Department of Health and Mental Health Commission. All moneys in the State Pool Account and in the State Managed Fund (Health) Account are fully allocated to local hospital networks in each financial year (refer note 46 'Special Purpose Accounts'). Under the National Health Reform Agreement, the Commonwealth Government also provides public health funding to the Department of Health.

Note 17	**Other grants and contributions**		
	Department of Education - Health services for students at public schools	7,508	7,415
		7,508	7,415

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 18	**Finance income**		
	Finance lease income	1,749	1,961
Note 19	**Other revenue**		
	General public contributions and donations	2,065	2,107
	Transfer of Telethon Kids Institute revenue to Ministerial Body	31,210	-
	Other revenue	637	1,029
		33,912	3,136
Note 20	**Income from State Government**		
	Service appropriations (a)		
	Appropriations received to deliver services	5,018,582	4,723,136
	Amount authorised by other statutes:		
	Salaries and Allowances Act 1975	716	697
	Lotteries Commission Act 1990	120,000	129,750
		5,139,298	4,853,583
	Assets (transferred)/assumed (b)		
	The following assets have been transferred from/(to) other state government agencies during the period:		
	Assets transferred in:		
	Cash from Metropolitan Health Services in relation to surplus interest and facility charges held in the specific purpose accounts for private practice income of medical practitioners	-	1,132
	Assets transferred out:		
	Case Management Unit land and buildings to Child and Adolescent Health Service	(835)	(42)
	Forrestfield Adult Day Care Centre and WA School of Nursing to East Metropolitan Health Service	(15,032)	(35)
		(15,867)	1,055
	Services received free of charge from other State government agencies during the period (c)		
	Determined on the basis of the following estimates provided by agencies:		
	Department of Education - accommodation	926	898
	Landgate - valuation services and land information	318	174
	State Solicitor's Office - legal service	1,005	874
		2,249	1,947
	Royalties for Regions Fund (d)		
	- Regional Infrastructure and Headworks Account		-
	Regional Community Services Account (d):		
	Regional Workers Incentives	7,974	8,941
	Royal Flying Doctor Service	7,898	16,476
	Pilbara Health Partnership	3,299	1,472
	St John Ambulance	-	8,000
	Rural Generalist Pathways	-	82
	Fitzroy Kids Health	50	150
	Improving Ear, Eye & Oral Health Child Aboriginal	981	1,500
	Rural Palliative Care Program	-	1,250
	Rural In-Reach Program-Women (Women's Support Health Care)	-	1
	Patient Assisted Travel Scheme	10,742	10,480
	Regional Palliative Care	1,250	-
	Renal Dialysis Service	511	-
	Regional (Kalgoorlie Esperance) Telehealth	169	3,569
		32,874	51,921
	Regional Infrastructure and Headworks Fund (d):		
	SIHI Residential Aged & Dementia Care	11,210	-
		44,084	51,921

(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.

(e) The above transactions are considered to be a significant related party transactions.

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 21	**Restricted cash and cash equivalents**		
	Current		
	Commonwealth Specific Purpose Grants (a)	85,871	90,624
	Royalties for Regions Fund (b)	36,042	105,044
	Telethon - Perth Children's Hospital Research Fund (c)	7,550	6,399
		129,463	202,067
	Non-Current		
	Accrued Salaries Suspense Account (d)	485	-
		129,948	202,067

(a) Funds held for the specific purposes stipulated by Commonwealth Government for Public Health Outcome Funding Agreement (PHOFA) and Vaccines ($6.4 million), Subacute Care ($22.3 million), Emergency Department ($18.2 million), Aged Care programs ($9.4 million), NPA Adult Public Dental Services ($10.4 million) and other initiatives and programs ($19.1 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 46 'Special Purpose Accounts'.

(d) Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year.

		2017 $000	2016 $000
Note 22	**Inventories**		
	Current		
	Drug supplies (at cost)	9,742	8,909
	State Distribution Centre - supply stores (at cost)	6,807	6,814
		16,549	15,723

Since the opening of the State Distribution Centre at Jandakot during the 2013/14 financial year, the financial responsibility for the supply inventory stores has been with the Department of Health.

Refer to note 2(o) 'Inventories'.

		2017 $000	2016 $000
Note 23	**Receivables**		
	Current		
	Receivables	16,739	6,605
	Allowance for impairment of receivables	(13)	(6)
	Accrued revenue	13,221	4,139
		29,947	10,738
	GST receivable	34,264	30,294
		64,211	41,032
	Reconciliation of changes in the allowance for impairment of receivables:		
	Balance at start of period	6	20
	Doubtful debts expense	7	-
	Amounts written off during the period	-	(14)
	Balance at end of period	13	6

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

Refer to note 2(p) 'Receivables' and note 50 'Financial instruments'.

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 24	**Amounts receivable for services (Holding Account)**		
	Non-current	55,046	36,858
		55,046	36,858
	Represents the non-cash component of service appropriations (refer to note 2(n) '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 25	**Finance lease receivable**		
	Non-current	6,692	4,942
	Refer to note 2(j) 'Leases' .		
Note 26	**Property, plant and equipment**		
	Land		
	At fair value (a)	3,621	12,577
	Buildings		
	At fair value (a) (d)	6,811	11,341
		6,811	11,341
	Site infrastructure		
	At fair value (b) (d)	941	2,352
		941	2,352
	Computer equipment		
	At cost	234	157
	Accumulated depreciation	(143)	(138)
		91	19
	Furniture and fittings		
	At cost	84	84
	Accumulated depreciation	(33)	(24)
		51	60
	Other plant and equipment		
	At cost	2,643	2,757
	Accumulated depreciation	(1,977)	(1,965)
		666	792
	Works in progress		
	Buildings under construction (at cost) (c)	1,006,012	-
	Other Work in Progress (at cost) (c)	113,085	-
		1,119,097	-
	Artworks		
	At cost	75	85
	Total property, plant and equipment	1,131,353	27,226

(a) Land and buildings were revalued as at 1 July 2016 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2017 and recognised at 30 June 2017. In undertaking the revaluation, fair value was determined by reference to market values for land: $3,619,650 (2016: $3,825,700). 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,

(b) Site infrastructure was revalued as at 1 July 2015 by Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor).The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016. A revaluation of site infrastructure has not been undertaken in the 2016/17, as no external events have occurred since the last date of valuation, such as changes in market conditions, that would indicate that the fair value of site infrastructure recorded have materially changed. The fair value is determined on the basis of depreciated replacement cost. See note 2 (f) 'Property, plant and equipment'.

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

Information on fair value measurements is provided in Note 27.

(c) Includes the transfer of Perth Children's Hospital related work in progress to the Ministerial Body. Refer to note 2(d) 'Contributed equity'.

(d) During 2016/17 financial year, the Department reviewed the depreciation method of buildings and site infrastruture and changed method from diminishing value with a straight line switch method to straight-line, to bring it in line with other asset classes. It is also the method applied by Landgate Valuation Services to derive their depreciated replacement cost valuation for building assets. The impact of this change is increase in depreciation expense by $120,844 in 2016-17 and expected increase in depreciation expense by $149,438 each year from 2017-18 and

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 26	**Property, plant and equipment (continued)**		
	Reconciliations		
	Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below.		
	Land		
	Carrying amount at the start of year	12,576	11,609
	Transfer to Department of Lands		(2)
	Transfer to Health Service	(8,749)	
	Revaluation increments / (decrements)	(206)	969
	Carrying amount at the end of year	3,621	12,576
	Buildings		
	Carrying amount at the start of year	11,341	12,684
	Transfers between asset classes		(1,055)
	Transfers to Health Service Provider	(5,760)	-
	Revaluation increments/(decrements)	1,499	61
	Depreciation	(269)	(349)
	Carrying amount at the end of year	6,811	11,341
	Site Infrastructure		
	Carrying amount at the start	2,352	1,445
	Transfers between asset classes		1,055
	Transfers to Health Service Provider	(1,356)	
	Revaluation increments/(decrements)		(73)
	Depreciation	(55)	(75)
	Carrying amount at the end of year	941	2,352
	Computer Equipment		
	Carrying amount at the start of year	19	41
	Additions	142	-
	Depreciation	(70)	(22)
	Carrying amount at the end of year	91	19
	Furniture & fittings		
	Carrying amount at the start of year	60	34
	Additions		36
	Depreciation	(9)	(9)
	Carrying amount at the end of year	51	60
	Other Plant & equipment		
	Carrying amount at the start of year	792	846
	Additions	47	152
	Transfers to Health Service Provider	(7)	(77)
	Other disposals	(20)	(10)
	Depreciation	(146)	(119)
	Write-off	-	-
	Carrying amount at the end of year	666	792
	Works in progress		
	Carrying amount at the start of year	-	-
	Additions	40	-
	Transfers from/(to) other reporting entities	1,119,057	-
	Carrying amount at the end of year	1,119,097	0
	Artworks		
	Carrying amount at the start of year	85	85
	Other disposals	(10)	-
	Carrying amount at the end of year	75	85
	Total property, plant and equipment		
	Carrying amount at the start of year	27,226	26,744
	Additions	229	188
	Transfer to the Department of Lands	-	(2)
	Transfer to asset held for resale	-	-
	Transfers to Health Service Provider	(15,872)	(77)
	Other disposals	(30)	(10)
	Revaluation increments/(decrements)	1,293	957
	Depreciation	(549)	(574)
	Transfers from/(to) other reporting entities	1,119,057	
	Carrying amount at the end of year	1,131,354	27,226

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For the year ended 30 June 2017

Note 27 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 2017.

Assets measured at fair value:	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Non-current assets classified as held for sale (note 30)	-	12,489	-	12,489
Land (note 26)				
Vacant land	-	3,620	1	3,621
Specialised	-	-	-	-
Buildings (note 26)				
Specialised	-	-	6,811	6,811
Site Infrastructure (note 26)	-	-	941	941
	-	16,109	7,753	23,862

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 2016.

Assets measured at fair value:	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Non-current assets classified as held for sale (note 30)	-	-	-	-
Land (note 26)				
Vacant land	-	3,826	-	3,826
Specialised	-	-	8,751	8,751
Buildings (note				
Specialised	-	-	11,341	11,341
Site Infrastructure (note 26)	-	-	2,352	2,352
	-	3,826	22,444	26,270

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, and independent valuations of site infrastructure from external quantity surveyors. There were no changes in valuation techniques during the period. 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.

Non-current assets held for sale have been written down to fair value less costs to sell. Fair value has been determined by reference to market evidence of sales prices of comparable assets.

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.

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Note 27 Fair value measurements (continued)

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

Current use type assets - level 3 valuations

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

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

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

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

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

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

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

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

(c) Fair value measurements using significant unobservable inputs

The following table represents the changes in level 3 items for the period ended 30 June 2017:

2017	Site Infrastructure $000	Land $000	Buildings $000
Fair value at start of period	2,352	8,751	11,341
Revaluation increments/(decrements)	-	-	1,499
Transfers from/(to) other reporting entities	(1,356)	(8,750)	(5,760)
Depreciation Expense	(55)	-	(269)
Fair value at end of period	941	1	6,811

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

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

(d) Valuation processes

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

Landgate Valuation Service determines the fair values of the Department's land and buildings, and prior to 1 July 2014, also determined the fair values of site infrastructure. After 1 July 2014, external quantity surveyors determine the fair values of site infrastructure.

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 28	**Intangible Assets**		
	Computer software		
	At cost	640	-
	Accumulated amortisation	(43)	-
		597	-
	Works in progress (a)	105,224	-
	Total intangible assets	105,821	-
	Reconciliations		
	Computer software		
	Carrying amount at the start of period	-	-
	Additions	640	-
	Amortisation expense	(43)	-
	Carrying amount at the end of period	597	-
	Works in progress		
	Carrying amount at the start of period	-	-
	Additions	833	-
	Transfer from other reporting entities	104,391	-
	Carrying amount at the end of period	105,224	-
	Total intangiable assets		
	Carrying amount at the start of period	-	-
	Additions	1,473	-
	Amortisation expense	(43)	-
	Transfer from other reporting entities	104,391	-
	Carrying amount at the end of period	105,821	-

(a) Includes the transfer of Perth Children's Hospital related work in progress to the Ministerial Body.

Note 29	**Other assets**		
	Current		
	Prepayments (a)	3,870	3,902
		3,870	3,902
	Non-current		
	Prepayments (a)	2,910	9,237
		6,779	13,139

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

Note 30	**Non-current assets classified as held for sale**		
	Current		
	Opening balance	-	-
	Add: Non-current assets held for sale (a)	12,645	-
	Less: write-down from cost to fair value less selling costs	(156)	-
	Closing balance	12,489	-

(a) In 2016-17, the following listed land and buildings, surplus to South Methorpolitan Health Service's requirments, and with a fair value of $12. 489 million were transferred back to the ministerial body which have the ownership on these assets to sale:

Woodside hospital $8.489 million
Calista Avenue $0.25 million
Alma Street Fremantle $3.75 million

Note 31 Impairment of Assets

There were no indications of impairment to property, plant and equipment, site infrastructure or intangible assets at 30 June 2017.

The Department held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Note 32	**Payables**		
	Current		
	Trade payables	18,365	24,206
	Accrued salaries	1,751	2,941
	Accrued expenses (a)	60,904	34,498
	Total current	81,020	61,645

Includes $17.6 million accrued expenditure relating to Perth Children's Hospital project, transferred to the Ministerial Body.

Refer to note 2(q) 'Payables' and note 50 'Financial Instruments'.

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 33	**Provisions**		
	Current		
	Employee benefits provision		
	Annual leave (a)	9,212	9,661
	Long service leave (b)	9,604	10,358
	Deferred salary scheme (c)	119	268
		18,935	20,287
	Non-current		
	Employee benefits provision		
	Long service leave (b)	5,022	5,235
		23,957	25,522

(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	6,228	6,841
More than 12 months after the end of the reporting period	2,984	2,820
	9,212	9,661

(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	1,857	2,072
More than 12 months after the end of the reporting period	12,770	13,522
	14,627	15,594

(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	119	268
	119	268

Note 34	**Other current liabilities**		
	Unearned Income	6,147	778
Note 35	**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	(213,341)	(143,169)
Contributions by owners		
Capital appropriation (a)	121,456	-
Transfer Perth Childrens Hospital to Ministerial Body	1,125,239	-
Transfer of assets from other agencies (a)	12,471	-
Distributions to owner		
Transfer of assets to other agencies (a)	(2,770)	(2)
Other (c)	(1,200)	(70,170)
Balance at the end of period	1,041,854	(213,341)

(a) Treasurer's Instruction 955 '*Contributions by Owners Made to Wholly Owned Public Sector Entities*' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*'.

(b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

Under Treasurer's Instruction 955 non-discretionary and non-reciprocal transfers of net assets between state government agencies have been designated as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(c) In accordance with the Minister's direction, the assets (Amounts Receivable for Services) relating to Joondalup Health Campus, Peel Health Campus and Midland Health Campus were transferred to Metropolitan Health Service on 1 June 2016. This transfer of assets has been formally designated as a contributions by owner for the Metropolitan Health Service and a distribution to owners for the Department.

(d) Includes the transfer of Perth Children's Hospital related work in progress to the Ministerial Body. Refer to note 2(d) 'Contributed equity'.

Reserves		
Asset revaluation reserve		
Balance at the start of period	306,647	305,690
Net revaluation increments/(decrements):		
Land	(303)	969
Buildings	1,439	61
Site infrastructure	-	(73)
	1,136	957
Balance at the end of period	307,783	306,647
Accumulated surplus		
Balance at the start of period	168,442	382,972
Result for the period	27,655	(214,530)
Balance at the end of period	196,097	168,442

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NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 36	**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	127,968	8,706
	Restricted cash and cash equivalents (refer to note 21)	129,948	202,067
		257,916	210,773
	Reconciliation of net cost of services to net cash flows provided by/(used in) operating activities		
	Net cost of services	(5,142,109)	(5,123,036)
	Non-cash items:		
	Depreciation expense	591	574
	Doubtful debts expense	7	-
	Services received free of charge	2,249	1,947
	Loss on disposal of non current assets	30	11
	Transfer of non-cash funding to Health entities	377,413	371,549
	Donation of non-current assets	(65)	(94)
	Adjustments for other non-cash items	126	(4)
	(Increase)/decrease in assets:		
	Inventories	(827)	440
	Receivables	(23,187)	(6,614)
	Finance lease receivable	(1,749)	(1,961)
	Other assets	6,360	(8,125)
	Increase/(decrease) in liabilities:		
	Payables	19,375	14,934
	Provisions	(1,565)	50
	Other liabilities	5,371	581
	Net cash provided by/(used in) operating activities	(4,757,980)	(4,749,748)
	At the end of the reporting period, the Department had fully drawn on all financing facilities, details of which are disclosed in the financial statements.		
Note 37	**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	819	1,453
	Department of Corrective Services	-	119
	Department of Education	237	-
	Department of Planning & Infrastructure	155	143
	Water Corporation	190	181
	Department of Fire & Emergency Services	-	38
	Department of Housing & Works	-	50
	Department of Water	-	31
	Others	-	146
		1,401	2,161
Note 38	**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	9,438	9,470
	Later than 1 year and not later than 5 years	9,571	19,077
	Later than 5 years	-	-
		19,009	28,547
	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	612,335	597,453
	Later than 1 year and not later than 5 years	378,162	571,736
	Later than 5 years and not later than 10 years	-	15,532
		990,497	1,184,720
	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	17,718	7,612
	Later than 1 year and not later than 5 years	2,068	320
	Later than 5 years	-	-
		19,786	7,932

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 39	**Contingent liabilities and contingent assets**		
	Contingent liabilities		
	The following contingent liabilities are additional to the liabilities included in the financial statements:		
	Interstate charging for patients transferred to hospitals outside of Western Australia	8,122	1,568
	Contingent assets		
	Interstate charging for patients transferred to hospitals inside of Western Australia	5,818	-
Note 40	**Events occurring after the end of the reporting period**		
	On 11 August 2017, the State Government accepted the recommendation of the Chief Health Officer regarding concern over water issues at the Perth Children's Hospital. The Department of Health, the Department of Finance and the Building Commission will develop a plan to implement the recommendation.		
	The Perth Children's Hospital facility is currently under a two year defects liability period with the Managing Contractor.		
	The Perth Children's Hospital project site has transitioned to the Health Ministerial Body with care and control of the asset now under the Director General, Department of Health. The Director General holds overarching governance responsibility for the clinical commissioning of Perth Children's Hospital up to the Final Move Day, at which time responsibility completely transfers to the Child and Adolescent Health Service Board.		
Note 41	**Remuneration of auditor**		
	Remuneration paid or payable to the Auditor General in respect of the audit for the current reporting period is as follows:		
	Auditing the accounts, financial statements, controls, and key performance indicators	350	345
Note 42	**Supplementary financial information**		
	Write-offs		
	During the reporting period, the Department has written off debts and inventory under the authority of:		
	The Accountable Authority	51	49
		51	49
Note 43	**Related bodies**		
	A related body is a body that 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 for the reporting period.		
Note 44	**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	21,749	20,342
	Public health	9,766	1,199
		31,515	21,541
Note 45	**Other statement of receipts and payments**		
	Commonwealth Grant - Christmas and Cocos Island		
	Balance at the start of period	(34)	-
	Receipts		
	Commonwealth grant	2,798	2,906
	Payments		
	Purchase of WA Health Services (a)	(2,763)	(2,940)
		(2,763)	(2,940)
	Balance at the end of period	1	(34)
	(a) Costs incurred in the 2015/16		
Note 46	**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 Health Service Providers	1,688,524	1,410,406
	Commonwealth activity based funding for Department of Health	-	36,719
	Commonwealth block funding for Health Service Providers	198,407	191,498
	Commonwealth public health funding for Department of Health	39,306	38,528
	State activity based funding from Department of Health	2,058,042	2,498,987
	Payments:		
	Commonwealth activity based funding to Health Service Providers	(1,688,524)	(1,410,406)
	Commonwealth activity based funding to Department of Health	-	(36,719)
	Commonwealth block funding to State Managed Fund (Health) Account	(198,407)	(191,498)
	Commonwealth public health funding to Department of Health	(39,306)	(38,528)
	State activity based funding to Health Service Providers	(2,058,042)	(2,498,987)
		-	-

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 46	**Special Purpose Accounts (continued)**		
	State Pool Account (continued)		
	Administered by Department of Health		
	Receipts:		
	Commonwealth activity based funding for Mental Health Commission (MHC)	89,121	92,040
	Commonwealth block funding for Mental Health Commission	73,699	73,580
	State activity based funding from Mental Health Commission	161,977	157,463
	Payments:		
	MHC Commonwealth activity based funding to Health Service Providers	(87,735)	(90,617)
	MHC Commonwealth activity based funding to non-government organisation (NGO)	(1,386)	(1,423)
	Commonwealth block funding to Mental Health Commission	(73,699)	(73,580)
	MHC State activity based funding to Health Service Providers	(161,977)	(157,463)
		-	-
	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	198,407	191,498
	State block funding from Department of Health	253,203	349,227
	Payments:		
	Commonwealth block funding to Health Service Providers	(198,407)	(191,498)
	State block funding to Health Service Providers	(253,203)	(349,227)
		-	-
	Administered by Department of Health		
	Receipts:		
	Mental Health Commission - Commonwealth block funding	72,638	72,539
	Mental Health Commission - State block funding	175,974	176,434
	Payments:		
	Mental Health Commission - Commonwealth block funding to Health Service Providers	(72,638)	(72,539)
	Mental Health Commission - State block funding to Health Service Providers	(175,974)	(176,434)
		-	-
	Balance at the end of period	-	-
	Southern Inland Health Initiative Special Purpose Account		
	The purpose of the special purpose account is to hold capital and recurrent funds for expenditure on approved Southern Inland Health Initiative projects as authorised by the Treasurer and the Minister, pursuant to section 9(1) of the *Royalties for Regions Act 2009* to be charged to the Royalties for Regions Fund and credited to the Account.		
	Recurrent		
	Balance at the start of period	103,052	146,550
	Receipts		
	Aged & Dementia Program	11,210	-
	Payments to WA Country Health Service		
	District Medical Workforce Investment	(30,421)	(32,626)
	District Hospital Investment Program	(5,392)	(5,310)
	Telehealth Investment Program	(4,846)	(3,960)
	Aged & Dementia Program	(14,146)	(839)
	Payments to Metropolitan Health Service		
	Southern Inland Health Initiatives - Stream 5	-	(200)
	Payments to Department of Health		
	Sliver Chain	-	(215)
	Diabetic Assocation of WA	-	(350)
	District Hospital Investment Program - Stream 2	(26,000)	-
		33,457	103,052

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

		2017 $000	2016 $000
Note 46	**Special Purpose Accounts (continued)**		
	Southern Inland Health Initiative Special Purpose Account (continued)		
	Capital		
	Balance at the start of period	52,735	72,235
	Receipts		
	District Hospital Investment Program - Stream 2	26,000	-
	Telehealth Investment Program	-	2,707
	Payments		
	District Hospital Investment Program - Stream 2	(36,740)	(10,000)
	Primary Health Centres Demonstration Program - Stream 3	(3,950)	(500)
	Small Hospital and Nursing Post Refurbishment Program - Stream 4	(15,000)	(9,000)
	Telehealth Investment Program	-	(2,707)
		23,045	52,735
	Balance at the end of period	**56,502**	**155,787**
	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	6,400	4,792
	Receipts	4,164	4,119
	Payments	(3,013)	(2,511)
	Balance at the end of period	7,550	6,400
Note 47	**Administered assets and liabilities**		
	Current Assets		
	Cash and cash equivalents	185,609	226,132
	Receivables	-	-
	Total administered current assets	185,609	226,132
	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 47 "Administered assets and liabilities' and note 48 'Disclosure of administered income and expenses by service' using the same basis as the financial statements.		

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2017

Note 48 Disclosure of administered income and expenses by service

	Public Hospital Admitted Patients		Home-Based Hospital Programs		Palliative Care		Emergency Department	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Health Service Providers	162,541	306,126	140	1,019	122	1,251	26,110	52,812
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to Health Service Providers	-	-	-	-	-	-	-	-
Transfer of block funding to Health Service Providers	-	-	-	-	-	-	-	-
Transfer of Commonwealth block funding to Mental Health Com	-	-	-	-	-	-	-	-
Total administered expenses	162,541	306,126	140	1,019	122	1,251	26,110	52,812
Income								
Administered for Capital Works Fund:								
Capital appropriations	102,783	211,846	92	788	79	921	12,652	30,079
Royalties for Regions Fund	31,930	22,602	-	-	-	45	5,034	4,981
Commonwealth grants and contributions	-	-	-	-	-	-	-	-
Contribution from Department of Health	-	1,865	-	1	-	12	-	35
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	134,713	236,313	92	789	79	978	17,686	35,095

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2017

Note 48 Disclosure of administered income and expenses by service (continued)

	Public Hospital Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
COST OF SERVICES								
Expenses								
Funding for Capital Works Fund transferred to:								
Health Service Providers	26,657	43,906	3,308	6,547	11,522	9,136	2,746	506
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to Health Service Provider	-	-	-	-	-	-	-	-
Transfer of block funding to Health Service Providers	-	-	-	-	-	-	-	-
Transfer of Commonwealth block funding to Mental Health C	-	-	-	-	-	-	-	-
Total administered expenses	26,657	43,906	3,308	6,547	11,522	9,136	2,746	506
Income								
Administered for Capital Works Fund:								
Capital appropriations	13,619	20,273	2,161	3,646	7,251	3,418	1,794	401
Royalties for Regions Fund	4,081	11,122	-	508	-	1,339	-	-
Commonwealth grants and contributions	-	-	-	-	-	1,602	-	-
Contribution from Department of Health	-	4	-	-	-	114	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	-	-
Commonwealth block funding for MHC	-	-	-	-	-	-	-	-
State activity based funding from MHC	-	-	-	-	-	-	-	-
State block funding from MHC	-	-	-	-	-	-	-	-
Total administered income	17,700	31,399	2,161	4,154	7,251	6,473	1,794	401

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Notes to the Financial Statements

For the year ended 30 June 2017

Note 48 Disclosure of administered income and expenses by service (continued)

	Continuing Care		Mental Health		Health System Management Policy and Corporate		Health Support Services		TOTAL	
	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000	2017 $000	2016 $000
COST OF SERVICES										
Expenses										
Funding for Capital Works Fund transferred to:										
Health Service Providers	2,312	18,366	1,193	3,760	121,734	-	3,772	-	362,157	443,429
									-	
State Pool Account and State Managed Fund Account administered for Mental Health Commission										
Transfer of activity based funding to Health Service Providers	-	-	251,098	249,503	-	-	-	-	251,098	249,503
Transfer of block funding to Health Service Providers	-	-	249,673	248,973	-	-	-	-	249,673	248,973
Transfer of Commonwealth block funding to Mental Health Commission	-	-	-	1,041	-	-	-	-	-	1,041
Total administered expenses	2,312	18,367	501,964	503,276	121,734	-	3,772	-	862,928	942,946
Income										
Administered for Capital Works Fund:										
Capital appropriations	1,924	15,550	715	268	105,684	-	4,464	-	253,218	287,190
Royalties for Regions Fund	-	880	-	51	-	-	-	-	41,045	41,528
Contribution from Department of Health	-	-	-	-	27,370	-	-	-	27,370	1,602
Contribution from Department of Health	-	380	-	3	-	-	-	-	-	2,414
State Pool Account and State Managed Fund Account administered for Mental Health Commission										
Commonwealth activity based funding for MHC	-	-	89,121	92,040	-	-	-	-	89,121	92,040
Commonwealth block funding for MHC	-	-	73,699	73,580	-	-	-	-	73,699	73,580
State activity based funding from MHC	-	-	161,977	157,463	-	-	-	-	161,977	157,463
State block funding from MHC	-	-	175,974	176,434	-	-	-	-	175,974	176,434
Total administered income	1,924	16,810	501,486	499,839	133,054	-	4,464	-	822,404	832,251

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 49 Explanatory statement

All variances between estimates (original budget) and actual results for 2017, and between the actual results for 2017 and 2016 are shown below. Narratives are provided for selected major variances, which are generally greater than:

5% and $25.0 million for the Statements of Comprehensive Income and Cash Flows; and 5% and $6.58 million for the Statements of Financial Position.

Statement of Comprehensive Income (Controlled Operations)	Variance Note	Estimate 2017 $000	Actual 2017 $000	Actual 2016 $000	Variance between estimate and actual $000	Variance between actual results for 2017 and 2016 $000
COST OF SERVICES						
Expenses						
Employee benefits expense		126,619	116,942	111,542	(9,677)	5,400
Contracts for services		709,325	676,938	648,525	(32,387)	28,413
Supplies and services		56,236	74,230	53,487	17,994	20,743
Grants and subsidies	1	6,184,278	6,510,165	6,381,354	325,887	128,811
Depreciation expense		768	591	574	(177)	17
Loss on disposal of non-current assets		0	29	10	29	19
Contribution to Capital Works Fund	2	0	27,372	2,414	27,372	24,958
Other expenses	3,A	160,180	80,823	22,754	(79,357)	58,069
Total cost of services		**7,237,406**	**7,487,090**	**7,220,660**	**249,684**	**266,430**
INCOME						
Revenue						
User charges and fees		3,112	6,077	14,708	2,965	(8,631)
Commonwealth grants and contributions	4,B	2,104,816	2,295,735	2,070,404	190,919	225,331
Other grants and contributions		17,355	7,508	7,415	(9,847)	93
Finance income		0	1,749	1,961	1,749	(212)
Donation revenue		1,023	-	-	(1,023)	-
Other revenue	5,C	884	33,912	3,136	33,028	30,776
Total revenue		**2,127,190**	**2,344,981**	**2,097,624**	**217,791**	**247,357**
Total income other than income from State Government		**2,127,190**	**2,344,981**	**2,097,624**	**217,791**	**247,357**
NET COST OF SERVICES		**5,110,216**	**5,142,109**	**5,123,036**	**31,893**	**19,073**
INCOME FROM STATE GOVERNMENT						
Service appropriations	D	5,087,230	5,139,298	4,853,583	52,068	285,715
Assets (transferred)/assumed		0	(15,867)	1,055	(15,867)	(16,922)
Services received free of charge		1,291	2,249	1,947	958	302
Royalties for Regions Fund	6	0	44,084	51,921	44,084	(7,837)
Total income from State Government		**5,088,521**	**5,169,764**	**4,908,506**	**81,243**	**261,258**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(21,695)**	**27,655**	**(214,530)**	**49,350**	**242,185**
OTHER COMPREHENSIVE INCOME						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		0	1,136	957	1,136	179
Total other comprehensive income		**0**	**1,136**	**957**	**1,136**	**179**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(21,695)**	**28,791**	**(213,573)**	**50,486**	**242,364**

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 49 Explanatory statement (continued)

	Variance Note	Estimate 2017	Actual 2017	Actual 2016	Variance between estimate and actual	Variance between actual results for 2017 and 2016
		$000	$000	$000	$000	$000
ASSETS						
Current Assets						
Cash and cash equivalents		8,085	127,968	8,706	119,883	119,262
Restricted cash and cash equivalents		182,741	129,463	202,067	(53,278)	(72,604)
Inventories		15,723	16,549	15,723	826	826
Receivables		41,033	64,211	41,032	23,178	23,179
Other current assets		3,301	3,870	3,902	569	(32)
Non-current assets held for sale	7,E	-	12,489	-	12,489	12,489
Total Current Assets		**250,883**	**354,550**	**271,430**	**103,667**	**83,120**
Non-Current Assets						
Restricted cash and cash equivalents		-	485	-	485	485
Amounts receivable for services	8,F	36,858	55,046	36,858	18,188	18,188
Finance lease receivable		4,942	6,692	4,942	1,750	1,750
Property, plant and equipment	9,G	26,458	1,131,353	27,226	1,104,895	1,104,127
Intangible assets	10,H	-	105,822	-	105,822	105,822
Other non-current assets	11	9,838	2,910	9,237	(6,928)	(6,327)
Total Non-Current Assets		**78,096**	**1,302,308**	**78,263**	**1,224,212**	**1,224,045**
Total Assets		**328,979**	**1,656,858**	**349,693**	**1,327,879**	**1,307,166**
LIABILITIES						
Current Liabilities						
Payables		57,875	81,020	61,645	23,145	19,375
Provisions		21,267	18,935	20,287	(2,332)	(1,352)
Other current liabilities		778	6,147	778	5,369	5,369
Total Current Liabilities		**79,920**	**106,102**	**82,710**	**26,182**	**23,392**
Non-Current Liabilities						
Provisions		5,235	5,022	5,235	(213)	(213)
Total Non-Current Liabilities		**5,235**	**5,022**	**5,235**	**(213)**	**(213)**
Total Liabilities		**85,155**	**111,124**	**87,945**	**25,969**	**23,179**
NET ASSETS		**243,824**	**1,545,734**	**261,748**	**1,301,910**	**1,283,987**
EQUITY						
Contributed equity		(213,342)	1,041,854	(213,341)	1,255,196	1,255,195
Reserves		306,647	307,783	306,647	1,136	1,136
Accumulated surplus		150,519	196,097	168,442	45,578	27,655
TOTAL EQUITY		**243,824**	**1,545,734**	**261,748**	**1,301,910**	**1,283,986**

Department of Health

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Note 49 Explanatory statement (continued)

	Variance Note	Estimate 2017 $000	Actual 2017 $000	Actual 2016 $000	Variance between estimate and actual $000	Variance between actual results for 2017 and 2016 $000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriations		4,655,854	4,743,697	4,475,422	87,843	268,275
Capital appropriations	12,I	0	121,456	-	121,456	121,456
Royalties for Regions Fund		0	44,084	51,921	44,084	(7,837)
Assets transferred		0	-	1,132	(0)	(1,132)
Net cash provided by State Government		**4,655,854**	**4,909,236**	**4,528,475**	**253,382**	**380,761**
Utilised as follows:						
CASH FLOWS FROM OPERATING ACTIVITIES						
Payments						
Employee benefits		(125,357)	(119,698)	(112,176)	5,659	(7,522)
Supplies and services	13,J	(924,449)	(773,250)	(689,523)	151,199	(83,727)
Grants and subsidies		(5,752,335)	(6,132,752)	(6,009,806)	(380,417)	(122,946)
Contribution to Capital Works Fund		0	(27,372)	(2,414)	(27,372)	(24,958)
GST payments on purchases	14	(282,117)	(404,911)	(382,154)	(122,794)	(22,757)
Receipts					-	-
User charges and fees		3,112	6,085	14,694	2,973	(8,609)
Commonwealth grants and contributions		2,104,805	2,264,526	2,045,404	159,721	219,121
GST receipts on sales		19,435	26,387	23,707	6,952	2,680
GST refunds from taxation authority	15	262,682	375,366	357,940	112,684	17,426
Other receipts		18,423	27,639	4,580	9,216	23,059
Net cash used in operating activities		**(4,675,801)**	**(4,757,980)**	**(4,749,748)**	**(82,179)**	**(8,232)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payment for purchase of non-current physical assets	16,K	0	(91,860)	(92)	(91,860)	(91,769)
Net cash used in investing activities		**0**	**(91,860)**	**(92)**	**(91,860)**	**(91,769)**
Net decrease in cash and cash equivalents		(19,947)	59,396	(221,365)	79,343	280,761
Cash and cash equivalents at the beginning of the period		210,773	210,773	432,138	0	(221,365)
Cash and cash equivalents held by Children and Adolescent Health Service on behalf of the Health Ministerial Body		-	(12,253)	-	(12,253)	(12,253)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**190,826**	**257,916**	**210,773**	**67,090**	**47,143**

Department of Health
Notes to the Financial Statements
For the year ended 30 June 2017

Note	49 Explanatory statement	2017 Estimate $000	2017 Actual $000	Variance $000
	Major Estimate and Actual (2017) Variance Narratives for Controlled Operations			
	Grants and subsidies	6,184,278	6,510,165	325,887
1	The variance is attributed to an increase in funding to the Health Service Providers as a result of budget changes during the financial year. Specifically increases in Government Appropriation of $59 million , National Health Reform Agreement funding of $179 million and Royalties for Regions of $86 million.			
	Contribution to Capital Works Fund	0	27,372	27,372
2	The movement is mainly due to the conversion of $26 million Southern Inland Health Initiative cash, which was received as recurrent funding, to capital bank account in 2016/17. Approval to transfer this $26 million from recurrent to capital funding within the SIHI SPA was originally provided by Government in 2013-14.			
	Other expenses	160,180	80,823	(79,357)
3	The variance is mainly attributable to lower than anticipated expenditure levels, due to financial restraint exercised over discretionary spending.			
	Commonwealth grants and contributions	2,104,816	2,295,735	190,919
4	The variance is mainly due to $143.1 million increase in National Health Reform Agreement revenue, and $47.2m increase in Commonwealth revenue, when compared to initial estimate.			
	Other revenue	884	33,912	33,028
5	The variance is mainly due to revenue from the Telethon Kids Institute (TKI) for cost recovery of the TKI Fitout Project at the Perth Children's Hospital.			
	Royalties for Regions Fund	0	44,084	44,084
6	The variance is largely due to unbudgeted funding received from the Department for Regional Development.			
	Non-current assets held for sale	-	12,489	12,489
7	The movement is due to the transfer of $12.49 million land and buildings from South Metropolitan Health Services to the Ministerial Body for sale, relating to the future disposal of properties in Alma St Fremantle, Calista Avenue Kwinana, and Woodside Hospital Fremantle.			
	Amounts receivable for services	36,858	55,046	18,188
8	The movement is mainly due to $16.14 million accrual appropriation greater than budget following the transfer of Perth Children's Hospital project to the Department of Health.			
	Property, plant and equipment	26,458	1,131,353	1,104,895
9	The increase is mainly due to the transfer of work in progress balances following the transfer of Perth Children's Hospital project to the Department of Health.			
	Intangible assets	-	105,822	105,822
10	The increase is mainly due to the transfer of work in progress balances following the transfer of Perth Children's Hospital project to the Department of Health.			
	Other non-current assets	9,838	2,910	(6,928)
11	The variance is due to the offsetting of a $5.7 million surplus of WA Health monies held by the Natonal Blood Authority against current year payments.			
	Capital appropriations	0	121,456	121,456
12	At the time of budget submission, it was estimated that there will not be any Capital appropriations.			
	Supplies and services	(924,449)	(773,250)	151,199
13	The variance is mainly attributable to lower than anticipated expenditure levels, resulting from financial restraint exercised over discretionary spending; delays in research and other programs; and budget transfers to Health Service Providers.			
	GST payments on purchases	(282,117)	(404,911)	(122,794)
14	The variance is mainly due to actual costs exceeding estimates, resulting in higher amounts of GST claimed.			
	GST refunds from taxation authority	262,682	375,366	112,684
15	The variance is due to actual GST payments on purchases exceeding estimates, resulting in higher GST refunds from the taxation authority.			
	Payment for purchase of non-current physical assets	0	(91,860)	(91,860)
16	At the time of budget submission, it was estimated that there will not be any payment to purchase non-current physical assets.			

Department of Health
Notes to the Financial Statements
For the year ended 30 June 2017

Note	49 Explanatory statement (continued)	2017 Actual $000	2016 Actual $000	Variance $000
	Major Actual (2017) and Comparative (2016) Variance Narratives for Controlled Operations (continued)			
	Other expenses	80,823	22,754	58,069
A	The increase is mainly due to $31.2 million repairs and maintenance balances following the transfer of Perth Children's Hospital project to the Department of Health, an $8.17 million compensation payment to Capella Parking Pty Limited, and a $10.3 million increase in ex-gratia payments during the 2016/17 financial year.			
	Commonwealth grants and contributions	2,295,735	2,070,404	225,331
B	The variance is mainly attributable to increases in Commonwealth National Health Reform Agreement revenue in the current financial year of $249 million, off-set by a reduction in Commonwealth grants revenue of $24 million.			
	Other revenue	33,912	3,136	30,777
C	The variance is mainly due to revenue from the Telethon Kids Institute (TKI) for cost recovery of the TKI Fitout Project at the Perth Children's Hospital.			
	Service appropriations	5,139,298	4,853,583	285,715
D	The variance predominately relates to additional Appropriation provided to WA Health during the year when compared to the previous year, specifically increases in service appropriation of $268 million and accrual appropriation of $17 million.			
	Non-current assets held for sale	12,489	-	12,489
E	The movement is due to the transfer of $12.49 million land and buildings from South Metropolitan Health Services to the Ministerial Body for sale, relating to the future disposal of properties in Alma St Fremantle, Calista Avenue Kwinana, and Woodside Hospital Fremantle.			
	Amounts receivable for services	55,046	36,858	18,188
F	The movement is mainly due to $16.14 million accrual appropriation greater than prior year following the transfer of Perth Children's Hospital project to the Department of Health.			
	Property, plant and equipment	1,131,353	27,226	1,104,127
G	The increase is mainly due to the transfer of work in progress balances following the transfer of Perth Children's Hospital project to the Department of Health.			
	Intangible assets	105,822	-	105,822
H	The increase is mainly due to the transfer of work in progress balances following the transfer of Perth Children's Hospital project to the Department of Health.			
	Capital appropriations	121,456	-	121,456
I	$122 million is received in 2016/17 while no funding has been received in prior year.			
	Supplies and services	(773,250)	(689,523)	(83,727)
J	The increase is mainly due to repairs and maintenance balances following the transfer of Perth Children's Hospital project to the Department of Health, an compensation payment to Capella Parking Pty Limited, and an increase in ex-gratia payments during the 2016/17 financial year.			
	Payment for purchase of non-current physical assets	(91,860)	(92)	(91,769)
K	The increase predominantly relates to the payment for the purchase on non-current assets relating to the Perth Children's Hospital project, transferred to the Department of Health.			

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2017

Note 50 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 50(c) 'Financial Instruments Disclosures' and Note 23 '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 50 (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:

	2017 $000	2016 $000
Financial Assets		
Cash and cash equivalents	127,968	8,706
Restricted cash and cash equivalents	129,948	202,067
Loans and receivables (a)	91,685	52,538
Financial Liabilities		
Financial liabilities measured at amortised cost	81,020	61,645

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

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2017

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
2017							
Cash and cash equivalents	127,968	127,968	-	-	-	-	-
Restricted cash and cash equivalents	129,948	129,948	-	-	-	-	-
Receivables (a)	29,947	29,893	98	86	(131)	-	-
Finance lease receivable	6,692	6,692	-	-	-	-	-
Amounts receivable for services	55,046	55,046	-	-	-	-	-
	349,601	349,547	98	86	(131)	-	-
2016							
Cash and cash equivalents	8,706	8,706	-	-	-	-	-
Restricted cash and cash equivalents	202,067	202,067	-	-	-	-	-
Receivables (a)	10,738	10,384	36	253	64	-	-
Finance lease receivable	4,942	4,942	-	-	-	-	-
Amounts receivable for services	36,858	36,858	-	-	-	-	-
	263,312	262,958	36	253	64	-	-

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

Department of Health

Notes to the Financial Statements
For the year ended 30 June 2017

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
2017										
Financial Assets										
Cash and cash equivalents		127,968	-	-	127,968	127,968	127,968	-	-	-
Restricted cash and cash equivalents		129,948	-	-	129,948	129,948	129,948	-	-	-
Receivables (a)		29,947	-	-	29,947	29,947	29,947	-	-	-
Finance lease receivable		6,692	-	-	6,692	6,692	-		-	6,692
Amounts receivable for services		55,046	-	-	55,046	55,046	-	-	-	55,046
		349,601	-	-	349,601	349,601	287,863	-	-	61,738
Financial Liabilities										
Payables		81,020	-	-	81,020	81,020	81,020	-	-	-
		81,020	-	-	81,020	81,020	81,020	-	-	-

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

Department of Health

Notes to the Financial Statements
For the year ended 30 June 2017

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
2016										
Financial Assets										
Cash and cash equivalents		8,706	-	-	8,706	8,706	8,706	-	-	-
Restricted cash and cash equivalents		202,067	-	-	202,067	202,067	202,067	-	-	-
Receivables (a)		10,738	-	-	10,738	10,738	10,738	-	-	-
Finance lease receivable		4,942			4,942	4,942	-		-	4,942
Amounts receivable for services		36,858	-	-	36,858	36,858	-	-	-	36,858
		263,312	-	-	263,312	263,312	221,511	-	-	41,801
Financial Liabilities										
Payables		61,645	-	-	61,645	61,645	61,645	-	-	-
		61,645	-	-	61,645	61,645	61,645	-	-	-

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

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.
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.

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Certification of key performance indicators

DEPARTMENT OF HEALTH

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2017

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 2017.

Ms Rebecca Brown
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

27 September 2017

Key performance indicators

Outcome 1

Proportion of people with cancer accessing admitted palliative care services 74

Response times for patient transport services 75

Cost per capita of supporting treatment of patients in public hospitals 76

Average cost per home based hospital day of care and occasion of service 77

Average cost per client receiving contracted palliative care services 78

Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – WA Ambulance Service Agreements 79

Outcome 2

Loss of life from premature death due to identifiable causes of preventable disease or injury 80

Percentage of fully immunised children 81

Rate of hospitalisations for selected potentially preventable diseases 82

Eligible patients on the oral waiting list who have received treatment during the year 83

Percentage of clients maintaining or improving functional ability while in transition care 85

Rate per 1,000 Home and Community Care target population who receive Home and Community Care services 85

Specific Home and Community Care contract provider client satisfaction survey 86

Cost per capita of providing preventive interventions, health promotion and health protection activities 87

Average cost per dental service provided by the Oral Health Centre of WA 88

Average cost per person of Home and Community Care services delivered to people with long term disability 88

Average cost per transition care day 89

Average cost per day of care for non-acute admitted continuing care 90

Average cost to support patients who suffer specific chronic illness and other clients who require continuing care 91

Outcome 3

Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers 92

Proportion of people with cancer accessing admitted palliative care services

Outcome 1
Effectiveness KPI

Rationale

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

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

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

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

Target

The 2015 target is 37.9 per cent.

Target value is based on the average of the previous five years.

Results

In 2015, the percentage of people with cancer accessing palliative care services as a public patient in a public hospital or a private hospital was 33.2 per cent. This result was below the target of 37.9 per cent (see Table 7).

Table 7: **Percentage of patients with cancer accessing palliative care services in a WA public hospital, or a WA private hospital contracted by the Department of Health, 2012–2015**

	2012	2013	2014	2015	Target
Percentage of people with cancer accessing palliative care services	35.9%	35.1%	42.6%	**33.2%**	**37.9%**

Notes:

1. This KPI measure is based on:
   a. the number of people who received palliative care services as a patient in a WA public hospital, or a public patient in a WA private hospital
   b. cancer mortality rates.
2. Cancer is defined as a principal diagnosis of an invasive malignant neoplasm.
3. The number of cancer related deaths is a nationally accepted proxy for potentially needed palliative care services.
4. A lag period of 12 months is due to delays related to Coroner's cases.

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.

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 effectiveness of road-based patient transport services delivered to the WA public. It is understood that adverse effects on patients and the community are reduced if response times are decreased.

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 Doctor 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 2016–17, 93 per cent of Priority 1 calls in the metropolitan area were attended within 15 minutes, above the target of 90 per cent (see Table 8)

Table 8: **Percentage of Priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17	Target
Percentage of Priority 1 calls attended within 15 minutes	92.3%	93.2%	92.6%	93.0%	**93.0%**	**90.0%**

Data source: Department of Health unpublished data

b) Royal Flying Doctor Service

The Royal Flying Doctor Service achieved 81 per cent of inter-hospital transfers for Priority 1 calls in 2016–17. This result was above the Target Contract patient Response Time of 80 per cent (see Table 9).

Table 9: **Percentage of Royal Flying Doctor Service inter-hospital transfers meeting the Contract Target Response Time for Priority 1 calls, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17	Target
Percentage of priority calls meeting Target Contract patient Response Time	83.9%	79.8%	81.9%	83.3%	**80.8%**	**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 2016–17 target unit cost is $28 per capita of supporting the treatment of patients in public hospitals. A result below the target is desirable.

Results

In 2016–17, the average cost of providing care to patients in public hospitals was $26, below the target of $28 (see Table 10).

Table 10: **Cost per capita of supporting treatment of patients in public hospitals, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$31.71	$29.68	$28	$26	**$26**
Target	$32.06	$30.92	$33	$32	**$28**

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2015, as defined by the Australian Statistical Geography Standard.
2. In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

Data source: Department of Health unpublished data, Australian Bureau of Statistics.

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 $293
b) home based hospital occasion of service is $125.

Results

a) Home based hospital day of care

In 2016–17, the average cost of home based hospital occasion of service was $316, above the target of $293 (see Table 11).

Table 11: **Average cost per home based hospital day of care, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$291	$371	$292	$312	**$316**
Target	$270	$301	$311	$353	**$293**

b) Home based hospital occasion of service

In 2016–17, the average cost of home based hospital occasion of service was $121. This was below the target of $125 (see Table 12). The variance to target is attributable to increased activity levels.

Table 12: **Average cost per home based hospital occasion of service, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$115	$129	$117	$129	**$121**
Target	$110	$118	$124	$125	**$125**

Note: In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

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 2016–17 target unit cost is $4,240 per client receiving contracted palliative care services. A result below the target is desirable.

Results

In 2016–17 the average cost for a client receiving contracted palliative care services was $3,061 below the target of $4,240 (see Table 13). The lower expenditure to target is attributable to a methodological change in the reporting of activity by a Department of Health contract Service Provider.

Table 13: **Average cost per client receiving contracted palliative care services, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$5,560	$5,153	$5,265	$4,941	**$3,061**
Target	$6,423	$6,599	$4,734	$4,919	**$4,240**

Note: In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

Data source: Department of Health unpublished data.

Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australia 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 2016–17 is $63 per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australia Ambulance Service Agreements.

A result below the target is desirable.

Results

The average unit cost for 2016–17 is $67 per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – Western Australia Ambulance Service Agreements. This is above the target of $63 (see Table 14).

Table 14: **Cost per capita of Royal Flying Doctors Service Western Operations and St John Ambulance Australia – Western Australian Ambulance Service Agreements, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$59.38	$65.25	$63	$65	**$67**
Target	$56.23	$63.75	$63	$65	**$63**

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2015, as defined by the Australian Statistical Geography Standard.
2. In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

Data source: Department of Health unpublished data, Australian Bureau of Statistics.

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, lung cancer and breast 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.

Target

The 2015 target per preventable condition is based on the 2013 National Person Years of Life Lost per 1,000 population:

Preventable condition	Target (in years)
Lung cancer	1.8
Ischaemic heart disease	2.5
Falls	0.2
Melanoma	0.5
Breast cancer	2.2

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

Results

The result for potential years of life lost due to lung cancer was 1.7, ischaemic heart disease 2.2, melanoma 0.4 and breast cancer 2.0, all below set targets. The years of life lost from premature death due to falls was 0.3, slightly above the target of 0.2 (see Table 15). Since 2006, the potential years of life lost for the conditions lung cancer, breast cancer, melanoma and ischaemic heart disease have decreased.

Table 15: **Person years of life lost due to premature death associated with preventable conditions, 2006–2015**

Condition	Calendar years										
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Target
Lung cancer	1.93	1.94	1.76	2.04	1.62	1.76	1.71	1.52	1.68	**1.70**	**1.8**
Breast Cancer	2.77	2.37	2.70	2.38	2.15	2.14	2.13	2.28	1.90	**1.96**	**2.2**
Ischaemic heart disease	3.31	3.47	3.17	3.21	2.82	2.88	2.39	2.48	2.43	**2.16**	**2.5**
Falls	0.24	0.34	0.31	0.46	0.24	0.25	0.18	0.35	0.17	**0.29**	**0.2**
Melanoma	0.60	0.52	0.49	0.61	0.54	0.58	0.59	0.41	0.44	**0.44**	**0.5**

Notes:

1. Age-standardised Person Years of Life Lost per 1,000 population.
2. 2006–2013 deaths are final, 2014 deaths are revised and 2015 deaths are preliminary.
3. 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
   - Breast cancer (C50.0 – C50.9) (females only).
4. Minor methodological improvements and updates to death data mean that figures are not directly comparable with previous reports.

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

Percentage of fully immunised children

Outcome 2
Effectiveness KPI

Rationale

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

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

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

Target

The target endorsed by the National Partnership Agreement on Essential Vaccines is ≥90 per cent of children fully immunised at 12 months, two years and five years of age.

Results

In 2016, non-Aboriginal children in Western Australia at 12 months of age exceeded the target of 90 per cent. The rates of immunisation of Aboriginal children at this age are below that of non-Aboriginal children. However, in 2016 immunisation coverage for both non-Aboriginal and Aboriginal children at 12 months was the highest since 2012.

The percentage of non-Aboriginal children at two years of age exceeded the target for both metropolitan and country areas. The percentage of Aboriginal children immunised did not meet the target in either metropolitan or country areas.

Current strategies continue to focus on improving timeliness of vaccination in Aboriginal children at 12 months and two years.

The immunisation rates for WA Aboriginal and non-Aboriginal five-year-old children, continues to exceed the target of 90 per cent for the third year. In 2016, the immunisation rate of Aboriginal children in the metropolitan area, exceeded the target for the first time (see Table 16).

Table 16: **Percentage of children fully immunised, by selected age cohort, by Aboriginality, 2012–2016**

Children fully immunised		2012	2013	2014	2015	2016	Target
12 months (%)							
State	Aboriginal	79.1	82.5	84.0	83.4	88.0	≥90%
	Non-Aboriginal	91.3	90.3	91.5	92.6	93.2	
Metropolitan	Aboriginal	73.3	75.7	76.6	77.6	83.7	
	Non-Aboriginal	91.0	90.2	91.3	92.4	93.1	
Country	Aboriginal	82.8	87.0	88.8	87.4	91.1	
	Non-Aboriginal	92.4	91.1	92.4	93.6	93.7	
2 years (%)							
State	Aboriginal	92.7	90.4	85.7	83.2	83.8	≥90%
	Non-Aboriginal	90.3	90.7	89.0	88.4	90.5	
Metropolitan	Aboriginal	89.1	85.7	80.7	77.8	80.7	
	Non-Aboriginal	89.7	90.2	88.6	88.0	90.1	
Country	Aboriginal	94.8	93.6	89.2	87.0	86.0	
	Non-Aboriginal	92.4	92.9	90.8	90.1	92.2	
5 years (%)							
State	Aboriginal	90.5	90.3	92.3	92.0	94.1	≥90%
	Non-Aboriginal	89.2	89.6	90.4	91.0	91.3	
Metropolitan	Aboriginal	86.6	84.6	87.7	88.2	91.3	
	Non-Aboriginal	88.7	89.0	90.1	90.7	90.8	
Country	Aboriginal	93.0	94.1	95.2	94.6	95.9	
	Non-Aboriginal	91.2	91.6	91.8	92.5	93.7	

Notes:

1. Data based on children aged 12 ≤ 15 months, 24 ≤ 27 months and 60 ≤ 63 months between 1 January 2016 – 31 December 2016.
2. The definition of fully immunised for measuring coverage rates was expanded to include the 18 month DTPa dose for children 24 ≤ 27 months.
3. National data for immunisation coverage for 2016 of cohort aged 12 ≤ 15 months can be accessed at www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/acir-ann-hist-data-ATSI-child.htm.

Data source: Australian Childhood Immunisation Register.

Rate of hospitalisations for selected potentially preventable diseases

Outcome 2
Effectiveness KPI

Rationale

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

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

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

The surveillance of hospitalisations for vaccine preventable conditions amongst children can support the further development and delivery of targeted health promotion initiatives and prevention strategies, such as the *WA Immunisation Strategy 2016–2020* that aims to reduce the impact of these conditions on individuals and the community. This ensures enhanced health and wellbeing of Western Australians, while supporting the sustainability of the public health system.

Target

The target for 2016 is zero reported hospitalisation in any category.

Results

WA hospitalisation rates for hepatitis B, diphtheria, tetanus, poliomyelitis, and measles in 2016 was nil per 100,000 for both Aboriginal and non-Aboriginal children, meeting the target of no reportable hospitalisations (see Table 17).

In 2016, the rate of hospitalisation for pertussis for 0–12 year old non-Aboriginal children was 2.4 per 100,000. The rate for Aboriginal children was 6.3 per 100,000.

The result of hospitalisation for mumps was 27.5 and 0.5 per 100,000 for WA Aboriginal and non-Aboriginal children aged 0–17 years of age respectively. The increase in hospitalisations was due to an unprecedented outbreak of mumps spanning over two years. Measures were implemented to provide prophylactic immunisation to assist in containing the spread of disease at the commencement of the outbreak in 2015–16.

Table 17: **Rate of hospitalisation for potentially preventable diseases (per 100,000), 2012–2016**

Annual Reporting Period		2012	2013	2014	2015	2016
Whooping Cough (Pertussis); 0–12 year olds						
State	Aboriginal	59.63	23.0	36.9	0.0	6.3
	Non-Aboriginal	14.76	9.3	4.3	3.9	2.4
Metropolitan	Aboriginal	63.00	24.8	33.5	0.0	0.0
	Non-Aboriginal	15.49	8.6	3.4	3.6	2.4
Country	Aboriginal	57.71	21.9	39.5	0.0	6.3
	Non-Aboriginal	12.15	12.1	10.4	5.9	3.7
Measles; 0–17 year olds						
State	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.0	0.0	0.0
Metropolitan	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.5	0.0	0.0
Country	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.0	0.0	0.0

Annual Reporting Period		2012	2013	2014	2015	2016
Mumps; 0–17 year olds						
State	Aboriginal	0.00	0.0	0.0	19.6	27.5
	Non-Aboriginal	0.19	0.2	0.0	0.8	0.5
Metropolitan	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.24	0.0	0.5	0.4	0.2
Country	Aboriginal	0.00	0.0	0.0	19.6	27.5
	Non-Aboriginal	0.00	0.9	0.0	10.2	1.8
Hepatitis B; 0–12 year olds						
State	Aboriginal	0.00	4.6	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.3	0.0	0.0	0.0
Metropolitan	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.0	0.0	0.0
Country	Aboriginal	0.00	7.3	0.0	0.0	0.0
	Non-Aboriginal	0.00	1.2	0.0	0.0	0.0
Rubella; 0–17 year olds						
State	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.0	0.0	0.2
Metropolitan	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.5	0.0	0.2
Country	Aboriginal	0.00	0.0	0.0	0.0	0.0
	Non-Aboriginal	0.00	0.0	0.0	0.0	0.0

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2015, as defined by the Australian Statistical Geography Standard.
2. Care should be taken in the interpretation of the results due to the small number of hospitalisations of children aged 0–17 for all preventable diseases, and the overall number of Aboriginal children living within the Metropolitan and WA Country area.
3. Hospitalisations are based on patient records whereby a preventable disease is recorded as the principal diagnosis.

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

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

Outcome 2
Effectiveness KPI

Rationale

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

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

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

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

Target

The 2016–17 target by dental speciality:

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

Results

In 2016–17, the number of eligible patients receiving treatment through the Oral Health Centre of Western Australia was 6,937.

The number of eligible patients receiving treatment was above the set targets for the specialties Oral Surgery, Periodontics and Other (see Table 18). In 2016–17, there was an increase in implant associated procedures performed under the specialities Periodontics and Other. Services for General Dental have increased in 2016–17 due to the introduction of two new waitlists.

Table 18: **Number of eligible patients on the Oral Health Centre of Western Australia dental waiting list who received treatment in the financial year, 2013–14 to 2016–17**

Dental speciality	Year				
	2013–14	2014–15	2015–16	2016–17	Target
General practice	1,106	1,179	639	**1,465**	**1,580**
Oral surgery	1,418	762	1,206	**913**	**910**
Orthodontics	1,372	1,034	1,248	**1,141**	**2,100**
Paedodontics	498	385	349	**450**	**790**
Periodontics	604	334	575	**613**	**480**
Other[1]	1,092	2,169	3,637	**2,355**	**780**
Total	6,090	5,863	7,654	**6,937**	**6,640**

Notes:

1. 'Other' includes the specialities of Endodontics, Oral Pathology, Restorative Care (including general restorative care treatment) 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.
3. Aspiration targets agreed with 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 Federal, 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. Transition Care Program services take place in either a residential or a community setting, including in a client's home. A number of care options are available, designed to be flexible in helping meet each person's needs. 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 older Western Australians.

Target

The 2016–17 target for the percentage of clients maintaining or improving functional ability is 65 per cent.

Results

In 2016–17, the percentage of clients maintaining or improving functional ability was 73 per cent (see Table 19).

Table 19: **Percentage of clients maintaining or improving functional ability while in transition care, 2012–13 to 2016–17**

Indicator	2012–13	2013–14	2014–15	2015–16	2016–17
Clients maintaining or improving functional ability	69%	68%	69%	70%	**73%**
Target	65%	65%	65%	65%	**65%**

Note: In 2016–17, the process for the collection and collation of client information was enhanced to enable more comprehensive and accurate reporting of client functional ability improvements.

Data sources: Subacute, Community and Aged 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 wellbeing and quality of life for Western Australians in need.

Target

For 2016–17, the target is 350 per 1,000 Home and Community Care target population.

Results

In 2016–17, the rate per 1,000 target population receiving Home and Community Care services was 353, slightly above the target of 350 (see Table 20).

Table 20: **Rate per 1,000 Home and Community Care target population receiving Home and Community Care services, 2012–13 to 2016–17**

Indicator	2012–13	2013–14	2014–15	2015–16	2016–17
HACC target population (per 1,000)	368	362	370	349	**353**
Target (per 1,000)	-	347	343	350	**350**

Note: The calculation of this KPI is based on:

a. estimates derived from ABS population projections applied to the ABS Survey of Disability, Ageing and Carers (SDAC) rates.

b. estimated proportion of people living in the community who have a profound, severe or moderate disability.

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

Specific Home and Community Care contract provider client satisfaction survey

Outcome 2
Effectiveness KPI

Rationale

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

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

Through measuring client satisfaction in 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 wellbeing and quality of life for Western Australians in need.

Target

The target for 2016–17 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 2016–17, 1,044 Home and Community Care clients were involved in the Home and Community Care Program, Quality of Life Client Survey. This equates to a participation rate of 82.9 per cent. The overall satisfaction rate of clients receiving HACC support was 92.2 per cent. Of all survey respondents 81.8 per cent believed the Home and Community Care Program helped them to be independent, while 93.5 per cent stated it improved their quality of life (see Table 21).

Table 21: **Home and Community Care Program, Quality of Life Client Survey results, 2012–13 to 2016–17**

Indicator	2012–13	2013–14	2014–15	2015–16	2016–17	Target
Percentage of clients that believe the Home and Community Care Program helps them to be independent	88.0%	89.0%	82.9%	80.8%	82%	**85%**
Percentage of clients that believe the Home and Community Care Program improves their quality of life	92.5%	93.9%	92.0%	86.1%	94%	**85%**

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 Key Performance Indicator (a) [79.46, 84.14] and (b) [92.00, 95.00].

Data sources: 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 and protection

Rationale

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 or injury within the community, fostering the ongoing health and wellbeing of Western Australians.

Target

The target unit cost for 2016–17 is $51 per capita to provide preventative interventions, health promotion and health protection activities.

A result below the target is desirable.

Results

In 2016–17, the average cost to provide public health interventions and programs was $42. This was below the target of $51 (see Table 22). The lower expenditure to target is attributable to cost centre realignment associated with the Department of Health assuming the role of 'System Manager'.

Table 22: **Cost per capita of providing preventive interventions, health promotion and health protection activities, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$54.81	$55.01	$55	$49	**$42**
Target	$51.63	$56.37	$54	$55	**$51**

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2015, as defined by the Australian Statistical Geography Standard.
2. In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

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

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

Outcome 2
Efficiency KPI
Service 8: Dental health

Rationale

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

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

Target

The 2016–17 target unit cost is $169 per subsidised public specialist dental service provided by the Oral Health Centre of Western Australia. A result below the target is desirable.

Results

The average cost per subsidised public specialist dental service provided by the Oral Health Centre of Western Australia in 2016–17 was $140, below the target of $169 (see Table 23).

The expenditure variation to target is attributable to Department of Health contract variations below that estimated at the time of budget allocation.

Table 23: **Average cost per specialist dental service provided by the Oral Health Centre of Western Australia, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$149	$150	$165	$144	**$140**
Target	$137	$145	$159	$162	**$169**

Note: In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.
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 Western Australian Home and Community Care Program is a joint funding initiative of the Commonwealth and WA State Governments that provides basic support services for eligible people of all ages with a disability, and their carers, to assist them to continue living independently at home. The program is designed to assist people with the greatest need and aims to maximise their independence.

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 wellbeing and quality of life for Western Australians in need.

Target

The 2016–17 target unit cost is $4,009 per person of Home and Community Care services to people with a long term disability. A result below the target is desirable.

Results

The cost per person of Home and Community Care services to people with a long term disability is $4,015 for 2016–17. This is slightly above the target of $4,009 (see Table 24).

Table 24: **Average cost per person of Home and Community Care services delivered to people with long term disability, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$3,569	$3,745	$3,901	$3,991	**$4,015**
Target	$3,468	$3,649	$4,111	$4,082	**$4,009**

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.
3. In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

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 2016–17 target unit cost is $308 per transition care day. A result below the target is desirable.

Results

In 2016–17, the average cost per transition care day was $308 (see Table 25).

Table 25: **Average cost per transition care day, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$305	$282	$305	$316	**$308**
Target	$280	$272	$305	$300	**$308**

Note: In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

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, having vital modifications made to their homes, or when requiring respite care.

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

Target

The 2016–17 target unit cost is $780 per day of care for non-acute admitted continuing care. A result below the target is desirable.

Results

The average cost per day to provide non-acute admitted continuing care was $714, below the target of $780 (see Table 26). The variance to target was a result of cost centre realignment due to the introduction of the Department of Health as a System Manager.

Table 26: **Average cost per day of care for non-acute admitted continuing care, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$694	$751	$721	$764	**$714**
Target	$625	$667	$767	$769	**$780**

Note:

In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

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

Target

The 2016–17 target unit cost is $42 to support patients who suffer specific chronic illness and other clients who require continuing care. A result below the target is desirable.

Results

In 2016–17, the average cost to support patients who suffer specific chronic illness and clients who require continuing care was $36, below the target of $42 (see Table 27). The lower expenditure to target is attributable to cost centre realignment associated with the Department of Health assuming the role of 'System Manager'.

Table 27: **Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2012–13 to 2016–17**

	2012–13	2013–14	2014–15	2015–16	2016–17
Average cost	$47.45	$49.28	$42	$40	**$36**
Target	$46.88	$48.93	$72	$51	**$42**

Note:

In 2016–17, with the advent of the Department of Health assuming the role of 'System Manager' a methodological change was required to how Department of Health corporate expenditure was allocated to key performance indicators. As a result caution should be taken in the interpretation of 2016–17 findings with prior year results.

Data sources: Department of Health unpublished data, Australian Bureau of Statistics 2015 Survey of Disability, Ageing and Carers (Cat. No. 4430.02), Oracle Financial Systems.

Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers

Outcome 3
Efficiency KPI
Service 11: Health System Management – Policy and Corporate Services

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 systemwide health and corporate policy and programs enables the Department of Health to perform the role as a change agent, leading development and implementation of policy to meet the State's health needs. This measure aligns to the strategic policy and planning services provided by the Department of Health to the whole of the WA health system. It measures how efficient the Department is in its provision of System Manager services to Health Service Providers.

Target

No target available.

This KPI was developed after publication of the 2016–17 Government Budget Papers, and hence a target has not been set. A target of $5,394 has been set for 2017–18.

Results

The average cost per full time equivalent worker to undertake the System Manger role of providing strategic leadership, planing and support services to Health Service Providers was $7,698 (see Table 28).

Table 28: **Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers**

	Actual	Target
Average cost	$7,698	N/A

Notes:

1. Health Service Providers include North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, Health Support Services, and Department of Health staff that provide a Public Health Regulatory function.
2. Expenditure includes Perth Children's Hospital commission costs.
3. Full Time Equivalent figures (FTE) used in the calculation of this KPI are based on Actual (Paid) month to date FTE.

Data sources: Oracle 11i Financial System, DOH HR Data Warehouse.

Ministerial directives

Treasurer's Instructions 903 (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.

The WA health system 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 29). For details of individual board or committee members please refer to Appendix 1.

Table 29: **Summary of State Government boards and committees within the Department of Health, 2016–17**

Boards/Committee name	Total remuneration
Animal Resources Authority Board	$5,000
Cannabis-Based Products Assessment Panel	$0
Cardiovascular Health Network Executive Advisory Group	$60
Department of Health WA Human Research Ethics Committee	$40,725
Diabetes and Endocrine Health Network Executive Advisory Group	$1,020
Falls Prevention Health Network Executive Advisory Group	$0
Fluoridation of Public Water Supplies Advisory Committee	$1,660
Local Health Authorities Analytical Committee	$2,943
Musculoskeletal Health Network Executive Advisory Group	$180
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia	$27,245
Perinatal and Infant Mortality Committee	$69,772
Pharmacy Registration Board of Western Australia	$21,960
Radiological Council	$6,260
Renal Health Network Executive Advisory Group	$840
Respiratory Health Network Executive Advisory Group	$1,560
Stimulant Assessment Panel	$2,058
Western Australian Aged Care Advisory Council	$1,363
Western Australian Board of the Medical Board of Australia	$43,989
Western Australian Board of the Nursing and Midwifery Board of Australia	$25,674
Western Australian Child and Youth Health Network Executive Advisory Group	$60
WA Health Transition and Reconfiguration Steering Committee	$0
WA Reproductive Technology Council	$14,495
WA Reproductive Technology Counselling Committee	$1,207
WA Reproductive Technology Counselling Embryo Storage Committee	$497
WA Reproductive Technology Counselling Licensing and Administration Advisory Committee	$1,065
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee	$568
WA Reproductive Technology Counselling Scientific Advisory Committee	$284
Women's and Newborn's Health Network Executive Advisory Group	$180
Total:	**$270,665**

Other financial disclosures

Pricing policy

The *National Health Reform Agreement 2011* 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 *National Health Reform Agreement 2011*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Health Services (Fees and Charges) Order 2016* that is reviewed annually. The following informs WA public hospital patient fees and charges for:

- **Nursing Home Type Patients**

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

- **Compensable or ineligible patients**

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

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

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

- **Veterans**

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

The following fees and charges also apply:

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

Capital works

The WA health system has a substantial Asset Investment Program comprised of new builds, and the upgrade and refurbishment of facilities for 100 projects across the State.

Tables 30 and 31 list the initiatives that are delivered through one or more health service providers and/or are under the management of the Department of Health or the WA Health Ministerial Body.

Please refer to respective Health Service Provider annual reports for entity-specific Asset Investment Programs.

Table 30: **Major Asset Investment Program works completed in 2016–17**

Initiative	Estimated total cost in 2016–17 $'000
Clinical Incident Management System	2,679
Community Mental Health Initiatives	5,788
PMH – Interim Holding Works at Existing PMH Hospital Site	995
Princess Margaret Hospital (PMH) – Holding	6,245
Subtotal	**15,707**

Table 31: **Major Asset Investment Program works in progress during 2016–17**

Initiative	Estimated Total Cost in 2016–17 ($'000)	Reported in 2015–16 ($'000)	Variance ($'000)	Expected Completion Date	2015–16 and 2016–17 variation to cost explanation (>=10%)
Equipment Replacement Program [2,3]	433,960	433,864	96	Ongoing	
Health Services Development Fund [1,2,3]	1,374	3,992	-2,618	Various	See footnotes
ICT iPharmacy	1,364	-	-	April 2017	New project
King's Park Link Bridge	6,700	-	-	TBA	New project
Minor Buildings Works [2,3]	160,642	157,198	3,444	Ongoing	
NPA – Improving Public Hospital Services [3]	88,227	89,126	-899	December 2017	
Perth Children's Hospital – Development [3]	1,160,168	1,162,668	-2,500	Completed	
Perth Children's Hospital Information Communication Technology [3]	162,373	179,152	-16,779	Various	
Replacement of the Monitoring of Drugs and Dependence System	992	-	-	TBA	New project
Telethon Kids Institute Fit-out – Perth Children's Hospital	40,037	-	-	TBA	New project
Osborne Park Hospital – Reconfiguration Stage 1 [4]	-	26,301	- 26,301	-	See footnote
Fremantle Hospital – Reconfiguration Stage 1 [4]	-	10,163	-10,163	-	See footnote

a) The above information is based upon the:
   i. 2016–17 published budget papers
   ii. 2015–16 published budget papers.

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

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

d) The footnotes that apply to individual projects are:
   1. transfer of funding between projects
   2. impacted as part of Whole of Government Capital Audit
   3. 2016–17 Budget excludes amounts that will not be capitalised, therefore the Estimated Total Cost may vary from that reported in the 2015–16 Budget
   4. remaining budget is outside the forward estimate period; but was within the 2015–16 forward estimate period.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 32 shows the number of Department of Health full-time equivalent employees for 2015–16 and 2016–17 as at June 2017.

Table 32: **Department of Health total full-time employees by category**

Category	Definition	2015–16	2016–17
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff	707	618
Agency	Includes FTE associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional	32	27
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners	12	13
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis	2	3
Medical support	Includes all allied health and scientific/ technical related occupations	37	33
Nursing	Includes all nursing occupations. Does not include agency nurses	22	11
Other categories	Includes Aboriginal and ethnic health worker related occupations	3	3
	Total	**815**	**708**

Notes:

1. The total 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. Excludes Department of Health (DOH) staff employed under the Health Services Union award.

Data Source: WA Health 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 include:

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

Industrial relations

The Department of Health as System Manager is responsible for the management of industrial relations across the WA health system, including negotiation of industrial agreements and applications to make or vary awards.

In 2016–17, the development of a workforce reform and industrial relations strategy commenced to build a sustainable and innovative health workforce to meet the health needs of Western Australians. The strategy will focus on establishing workforce efficiencies including:

- improved rostering practices
- occupational rationalisation and review
- streamlining fixed-term contract and casual conversion to permanency
- reviewing and assessing contracts for service.

In 2016, in line with the then *Public Sector Wages Policy Statement 2016* the Department of Health achieved an industrial agreement wage increase of 1.5 per cent per annum for doctors, nurses, salaried health officers, engineering and building trade employees. Negotiations for replacement agreements for dental officers and support workers have commenced.

Workers' compensation

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

The Department of Health is committed to providing staff with a safe and healthy work environment in order to deliver effective and efficient health care services. In 2016–17 a total of six workers' compensation claims were made (see Table 33).

Table 33: **Number of Department of Health workers' compensation claims in 2016–17**

Employee category	Number
Administration and Clerical	6
Agency	0
Medical salaried	0
Medical sessional	0
Medical support	0
Nursing	0
Other categories	0
Total	**6**

Note: For the purposes of the Annual Report employee categories are defined as:

- Administration and clerical – includes administration staff and executives, ward clerks, receptionists and clerical staff.
- Medical support – includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.

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

Unauthorised use of credit card

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

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

Despite being made aware of obligations pertaining to the use of credit cards, one Department of Health cardholder used their card for personal purposes. The full amount ($32.59) was refunded before the end of the reporting period (see Table 34).

Table 34: **Personal use expenditure by Department of Health cardholders, 2016–17**

Credit card personal use expenditure	2016–17
Aggregate amount of personal use expenditure for the reporting period	$32.59
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$0
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$32.59
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0

Other legal disclosures

Advertising

In 2016–17, in accordance with section 175ZE of the *Electoral Act 1907*, the Department of Health incurred a total advertising expenditure of $2,121,644 (see Table 35), of which, 86 per cent was through the procurement of media advertising and market research.

Table 35: **Summary of Department of Health advertising in 2016–17**

Summary of advertising	Amount ($)
Advertising agencies	236,596
Market research organisations	913,962
Polling organisations	0
Direct mail organisations	56,783
Media advertising organisations	914,303
Total advertising expenditure	**2,121,644**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 36.

Table 36: **Department of Health advertising, by class of expenditure, 2016–17**

Recipient/organisations	Amount ($)
Advertising agencies	
Brand Agency	117,290
Chop Shop Media	70,727
Alan Gregory Charles Little	4,021
Boogie Monster	4,890
Chanelle Hawkins	3,300
Cordell Jigsaw Zapruder	13,605
Damian Foley	1,144
In Shot Productions	9,702
Josie Kate Dickinson	4,909
Simone Alice Detourbet	3,438
Longtail Communications	3,570
Total	**236,596**
Market research organisations	
Edith Cowan University	913,962
Total	**913,962**
Polling organisations	
	0
Total	**0**
Direct mail organisations	
Quickmail	56,460
Zipform	323
Total	**56,783**
Media advertising organisations	
OMD	526,959
Carat	209,052
Adcorp	744
Facebook	1,179
Gerard Daniels Pty Ltd (recruitment)	1,719
Department of Premier and Cabinet (Gazette)	35,967
International recruitment	138,683
Total	**914,303**
Total advertising expenditure	**2,121,644**

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.

The Department of Health ensures compliance with this and all other principles through the implementation of the Department of Health *Disability Access and Inclusion Plan 2016–2020*. The Plan outlines proactive strategies to enhance policies, practices, services and facilities to improve access for people with disability. Current initiatives and programs being implemented in accordance with the Plan are outlined below.

Access to service

The Department of Health is committed to the development and implementation of a systemwide 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 events and/or services. This includes consideration of invitations and promotional material. It also includes choosing appropriate venues which are compliant with recommended 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. The Department of Health funds the Technology Assisting Disability WA initiative, which provides services to assist people with disability. Outpatient Direct is another initiative which supports people with disability and their carers in managing appointments, transport and provision of information.

Agents and contractors providing goods and services on behalf of the Department of Health are aware of and required to conduct their business in accordance with the Department of Health *Disability Access and Inclusion Plan 2016–2020*. Disability access requirements are included in tender documentation when procuring and contracting services.

Access to buildings

All Department of Health buildings and facilities are accessible to people with disability. Public areas of the Department of Health are accessible to wheelchairs and modified vehicles, with access ramps and lifts available to all levels of the building. Concierge services and dedicated ACROD parking bays are available to people with disability. General access areas are on the ground floor level and these areas include motion-activated and timed access doors.

Workplace assessments conducted at the Department of Health consider people with disability, including people who have intellectual, cognitive or psychiatric disabilities, for access to and within the building. The needs of people with disability are considered and embedded into the purchase of equipment and planning for any new or redevelopment works. Training is being developed to ensure administration staff are aware of facilities available, and fire wardens are trained in evacuation procedures for people with disability.

Access to information

The Department of Health is committed to ensuring people with disability are able to access information, and provides direction to health professionals and other WA health system staff to enable clear communication with consumers and carers. Assistance is provided for managing health, legal and other risks that may arise in the delivery of health services to people with no or limited English proficiency, including people who are deaf or who have a hearing impairment.

Internet and intranet websites meet the internationally recognised *Web Content Accessibility Guidelines* developed by the World Wide Web Consortium (W3C) and are continually reviewed and updated to meet accessibility requirements. All Department of Health publications can be provided in alternative formats on request and this availability is promoted and advertised. Podcasts and radio use have increased to ensure greater reach for those with vision or reading difficulties, as well as the use of videos to assist people with low literacy to access information. All television advertisements and YouTube videos are closed captioned.

All staff, agents and contractors who provide services to the Department of Health are informed of their responsibilities to ensure information is accessible to people with disability.

Quality of service by staff

Information and services are delivered consistently to all staff and members of the public in accordance with the *State Government Access Guidelines for Information, Services and Facilities* and the Department of Health *Disability Access and Inclusion Plan 2016–2020*. The Department of Health funds the Training Centre in Subacute WA, an initiative that supports enhanced opportunities in training and skill development for staff working in the areas of rehabilitation, geriatric evaluation and management, and psychogeriatric care. In addition, a project to provide Disability Liaison Officers in Health Services is currently in place.

All staff, agents and contractors who provide services on behalf of the Department of Health are required to comply with the *State Government Access Guidelines for Information, Services and Facilities*.

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. Complaints can be lodged via written correspondence, telephone or in person. All complaints are fully investigated and the outcome provided to the complainant in a relevant and accessible format.

Participation in public consultation

Public consultation with consumer groups is undertaken to ensure that barriers to inclusion or participation are addressed. This is inclusive of individuals and groups representing specific disability areas, their families and carers. To ensure a range of stakeholders representing patients/consumers is included in public consultations, media advertising is used. Facilitated focus groups are generally used to learn about opinions and to guide future action.

Initiatives and programs provided by the Department of Health are assessed for any potential impact on people with disability.

Contractors of the Department of Health who conduct public consultation are made aware of their access and inclusion responsibilities.

Opportunities to obtain and maintain employment

The Department of Health complies with the *WA Health Recruitment, Selection and Appointment Policy* which applies equal opportunity and diversity principles, and ensures recruitment and selection is undertaken in a consistent, inclusive, open and transparent manner. Training is available to those participating in selection processes to ensure a full understanding of the relevant public sector standards, legislation and regulations, including those that relate to disability discrimination.

Department of Health employees with disability are supported via regular reviews of workplace accessibility and adjustments to the work environment as required. Co-workers are required to adapt their work practices including tailoring their methods of delegation and giving instruction to staff members with learning disabilities. Training for co-workers is offered to provide staff with the necessary skills and confidence to help employees with disabilities. Recently, Department of Health staff completed training on Mentoring Co-Workers with Disabilities, which provided education and insight into assisting and supporting colleagues with disabilities.

Compliance with public sector standards

The *WA Health Code of Conduct* has been developed to comply with the principles of appropriate behaviour outlined in the WA Public Sector Commission's Code of Ethics. All employees of the WA health system are responsible for ensuring their behaviour reflects the standards of conduct embodied in this Code.

The Code of Conduct builds upon the relevant provision of the *Public Sector Management Act* and the Code of Ethics. Collectively, they provide a broad framework to guide ethical and accountable behaviour and specify employment governance requirements that all Health Service Providers, and the Department of Health, must comply with to ensure an effective and consistent approach to:

- industrial relations
- human resource management
- ethics and integrity.

To assist staff in understanding and complying with the principles of workplace behaviour and conduct, the Department of Health inducts, informs and educates its employees through various online communications, e-learning and face-to-face program training. The mandatory Accountable and Ethical Decision Making Program is integral to training employees in this area and is designed to communicate expectations of workplace conduct through internal discussions on real ethical dilemmas. In 2016–17, 85 per cent of Department of Health staff had completed the course.

Employee compliance with the Code of Conduct is assessed on Accountable and Ethical Decision Making course completion rates, and qualitative and quantitative reviews of matters reported through the Case Management System. The WA health system is required to review and investigate all complaints alleging non-compliance with the Code of Ethics or Code of Conduct. The Department of Health reported a total of six misconduct matters during 2016–17. This is considered an overall high level of compliance with the ethical codes.

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
- implementation of the Grievance Resolution Policy and Guidelines
- management of redeployment.

In 2016–17, the Department of Health received three Breach of Standard claims against the Employment Standard. One claim was withdrawn and the other two were referred to the Public Sector Commission and dismissed.

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 for Health 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 some of the above information from the Department of Health website (ww2.health.wa.gov.au). Links to other health-related websites are also available. Members of the public who do not have internet access can obtain hard copy documents for free or at nominal cost. Access to information can also be made through a Freedom of Information application that involves the lodgment of a written request. The written request must provide sufficient detail to enable the application to be processed, including contact details and an Australian address for correspondence. In the case of an application for amendment or annotation of personal information it is required that the request include:

- detail of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out-of-date or misleading
- the applicant's reasons for holding that belief
- detail of the amendment that the applicant wishes to have made.

Applications should be addressed to the Freedom of Information Office, and may be lodged by:

Person Department of Health
Legal and Legislative Services
189 Royal Street
East Perth WA 6004

Mail Freedom of Information
Department of Health, Western Australia
PO Box 8172
Perth Business Centre WA 6849

Email FOI.DOH@health.wa.gov.au

All requests for information can be granted, partially granted or may be refused in accordance with the Western Australian *Freedom of Information Act 1992*. The applicant can appeal if dissatisfied with the process or the reasons provided and in the event of an adverse access decision.

For the year ended 30 June 2017, the Department of Health dealt with 58 applications for information, of which 23 applications were granted full or partial access and 14 were refused (see Table 37).

Table 37: **Freedom of Information applications to the Department of Health in 2016–17**

Summary of number of applications	Number
Applications carried over from 2015–16	3
Applications received in 2016–17	55
Total number of applications active in 2016–17	**58**
Applications granted – full access	18
Applications granted – partial or edited access	5
Applications withdrawn by applicant	2
Applications refused	14
Applications in progress	4
Other applications	12
Total number of applications dealt with in 2016–17	**58**

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 all State Government agencies. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

The Department of Health Recordkeeping Plan includes information on the recordkeeping system(s), record disposal arrangements, policies, practices and processes that comply with the *State Records Act 2000*.

In 2016–17, a review of the Department of Health Recordkeeping Plan commenced. This is in accordance with section 28 of the *State Records Act 2000* that states no more than five years is to elapse between the review of standards, practices and policies. The following components of the recordkeeping system are also under review:

- Business Classification System
- Retention and Disposal Schedule for Administrative and Functional (Non Patient) Records
- Digitisation of Administrative and Functional (Non Patient) Records.

Strategies to ensure employees are aware and comply with the Department of Health Recordkeeping Plan include online recordkeeping and awareness and systems training. In 2016–17, 92 employees completed the online Recordkeeping Awareness training course. The efficiency and effectiveness of the training program is reviewed on a regular basis via trainee feedback and assessments. In 2016–17, feedback from participants indicated that 85 per cent found the course informative, essential or stimulating, and 86 per cent agreed that it improved their understanding of the topic.

Within the Department of Health, 242,837 records were created in the Electronic Documents and Records Management Systems during 2016–17.

Substantive equality

The WA health system continues to contribute towards substantive equality for all Western Australians through the implementation of the *Policy Framework for Substantive Equality*. The Framework provides a clear direction for all persons employed in the WA health system by addressing the diverse needs and sensitivities of the communities in which it operates.

The *WA Aboriginal Health and Wellbeing Framework 2015–2030* identifies a set of guiding principles, strategic directions and priority areas to improve the health and wellbeing of Aboriginal people in Western Australia. In 2016–17, the *Implementation Guide* to the Framework was completed. The Framework aims to build the overall capacity and responsiveness of the WA health system to better meet both the clinical and cultural needs of Aboriginal people, families and communities.

In 2016–17, the *WA Health System Language Services Policy 2017* was introduced to guide Health Service Provider staff about systemwide and professional standards to enable effective communication with consumers and carers who may need language assistance. The *WA Health System Multicultural Health Services Directory 2017* was also commenced. The Directory provides advice and support to Health Service Provider staff when caring for Western Australians from culturally and linguistically diverse backgrounds.

To support the development of a culturally respectful and non-discriminatory health system 82 per cent of WA health system employees completed the Aboriginal Cultural eLearning component of the Aboriginal Cultural Learning package.

Occupational safety, health and injury management

The Department of Health is committed to occupational safety, health and injury management systems in line with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*.

Commitment to occupational safety and health injury management

The Department of Health adopts a continuous improvement approach to occupational safety, health and injury management. In 2017–18, the Department of Health will implement a comprehensive and integrated Occupational Health and Safety Management System. The proposed Occupational Health and Safety Management System will comply with the *Occupational Health and Safety Act 1984* and *Occupational Health and Safety Regulations 1996* as per elements outlined in the WorkSafe Plan. The WorkSafe Plan has five elements, each with a supporting standard and a number of indicators that can be used to measure performance. The WorkSafe Plan provides a systematic way of measuring how well safety and health is being managed.

Compliance with occupational safety and health injury management

The Occupational Safety and Health Committee and employee representatives form the key mechanism for consultation 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.

Employee consultation

The Department of Health provides occupational safety, health and injury management training to all employees. Training offered during 2016–17 included:

- Manual Handling
- Mental Health First Aid
- Occupational Safety and Health for Managers
- Fire Warden Training.

In addition, workplace assessments were conducted in accordance with occupational safety and health requirements. Actions to address issues identified during the assessment are being progressively implemented according to risk.

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 the Return to Work Program. Senior Human Resource Coordinators work with accredited external rehabilitation providers to facilitate the Program.

Injury Management and Return to Work Plans are developed for all injured or sick employees. These plans are continually revised and adjusted to accommodate the needs of the employee and facilitate an early return to the workplace. This includes the negotiation of appropriate hours, work duties and reasonable adjustment to any other circumstances.

Occupational safety and health assessment and performance indicators

The annual performance reported for the Department of Health in relation to occupational safety, health and injury for 2016–17 is summarised in Table 38.

Table 38: **Occupational safety, health and injury performance, 2014–15 to 2016–17**

Measure	Actual Results		Results against Target	
	2014–15	2016–17	Target	Comments
Fatalities (number of deaths)	0	0	0	Achieved
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	0.77	0.33	0 or 10% improvement on the previous three (3) years	Achieved
Lost time injury severity rate (rate per 100)	46.67	33.33	0 or 10% improvement on the previous three (3) years	Achieved
Percentage of injured workers returned to work: (i) within 13 weeks	N/A	60%	N/A	
(ii) within 26 weeks	71.4%	60%	Greater than or equal to 80%	Not achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	34.6%	42.3%	Greater than or equal to 80%	Not achieved

Notes:

1. Performance is based on a three-year trend and so the comparison base year is two years prior to the current reporting year. Care should be taken in the interpretation of the comparative results due to Department of Health organisational change that occurred in 2016–17.
2. The reporting of 'Percentage of injured workers returned to work within 13 weeks' commenced in 2015–16.
3. There is no performance target for the 'Percentage of injured workers returned to work within 13 weeks'.

Annual estimates

The WA Health annual operational budget estimates for the following financial year are reported to the Minister for Health under Section 40 of the *Financial Management Act 2006*, and Treasurer's Instruction 953.

The annual estimates for 2017–18 as approved by the Minister for Health are provided in Table 39, comprising the statement of comprehensive income, statement of financial position and statement of cash flows.

Table 39: **Department of Health Section 40 Estimates for 2017–18**[1]

Statement of comprehensive income	2017–18 Estimate $'000s
Cost of services	
Expenses	
Employee benefits expense	107,874
Contracts for services	708,458
Supplies and services	40,454
Grants and subsidies[2]	6,540,458
Depreciation expense	894
Other expenses	51,728
Total cost of services	**7,449,866**
Income	
Revenue	
User charges and fees	9,056
Commonwealth grants and contributions[3]	2,284,279
Other revenue	26,625
Total revenue	2,319,960
Total income other than income from State Government	**2,319,960**
Net cost of services	**5,129,906**
Income from State Government	
Service appropriation	5,041,025
Royalties for Regions Fund	89,886
Total income from State Government	5,130,911
Surplus for the period	**1,005**
Total comprehensive income for the period	**1,005**

Statement of financial position	2017–18 Estimate $'000s
Assets	
Current Assets	
Cash and cash equivalents	128,973
Restricted cash and cash equivalents	129,948
Inventories	16,880
Receivables	43,132
Other current assets	3,870
	12,489
Total Current Assets	**335,292**
Non-Current Assets	
Amounts receivable for services	55,939
Finance lease receivable	6,692
Property, plant and equipment	1,392,253
Other non-current assets	2,910
Total Non-Current Assets	**1,457,794**
Total Assets	**1,793,086**

Statement of financial position	2017–18 Estimate $'000s
Liabilities	
Current Liabilities	
Payables	62,080
Provisions	18,935
Other current liabilities	908
Total current liabilities	**81,923**
Non-Current Liabilities	
Provisions	5,022
Total Non-Current Liabilities	5,022
Total Liabilities	**86,945**
Net assets	**1,706,141**

Statement of financial position	2017–18 Estimate $'000s
Equity	
Contributed equity	1,141,867
Reserves	307,534
Accumulated surplus	256,740
Total equity	**1,706,141**

Statement of cash flows	2017–18 Estimate $'000s
Cash flows from State Government	
Service appropriation	4,662,439
Royalties for Regions Fund	89,886
Net cash provided by State Government	**4,752,325**
Cash flows from operating activities	
Payments	
Employee benefits	(107,418)
Supplies and services	(40,454)
Grants and subsidies	(6,898,921)
GST payments on purchases	(282,117)
Other payments	(24,487)
Receipts	
User charges and fees	9,056
Commonwealth grants and contributions	2,284,279
GST receipts on sales	19,435
GST refunds from taxation authorities	262,682
Other receipts	26,625
Net cash used in operating activities	**(4,751,320)**
Net decrease in cash and cash equivalents	**(1,005)**
Cash and cash equivalent at the beginning of the period	257,916
Cash and cash equivalents at the end of the period	**258,921**

Notes:

1. The WA State Government has yet to finalise the financial year 2017–18 budget process and the final budget figures may be subject to change.
2. Grants and subsidies include funding to Statutory Authorities for delivery of health services.
3. Commonwealth grants and contributions include funding received from the Commonwealth Government under the National Health Reform Agreement.
4. The new Perth Children's Hospital project has been included in this Section 40 Estimates and also incorporated in the annual financial report for financial year 2016–17.

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Appendix

Appendix 1: Board and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Animal Resources Authority Board				
Chair	Anthony Tate	Per meeting	12 months	$2,300
Deputy Chair	Dr Campbell Thomson	Per meeting	12 months	$0
Member	Leslie Chalmers	Per meeting	12 months	$900
Member	Prof. Jennet Harvey	Per meeting	12 months	$1,200
Member	Prof. David Laing Morrison	Per meeting	12 months	$0
Member	Prof. Elizabeth Piroska Rakoczy	Per meeting	12 months	$600
Member	Michael James Robins	Per meeting	12 months	$0
Member	Charles William Thorn	Per meeting	12 months	$0
			Total:	**$5,000**
Cannabis Based Product Assessment Panel*				
Chair	*	Not eligible	Not applicable	$0
Member 1	*	Not eligible	Not applicable	$0
Member 2	*	Not eligible	Not applicable	$0
Member 3	*	Not eligible	Not applicable	$0
Member 4	*	Not eligible	Not applicable	$0
Member 5	*	Not eligible	Not applicable	$0
Member 6	*	Not eligible	Not applicable	$0
Member 7	*	Not eligible	Not applicable	$0
Member 8	*	Not eligible	Not applicable	$0
Member 9	*	Not eligible	Not applicable	$0
Member 10	*	Not eligible	Not applicable	$0
Member 11	*	Not eligible	Not applicable	$0
*Approval to withhold the names of the committee members was obtained from the Minister for Health			**Total:**	**$0**
Cardiovascular Health Network Executive Advisory Group				
Clinical co-lead	Dr Jacquie Garton-Smith	Sessional	3 meetings per year	$0
Clinical co-lead	Dr Tony Mylius	Sessional	3 meetings per year	$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

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Trevor Cherry	Not eligible	Not applicable	$0
Member	Geraldine Ennis	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	Shelley McRae	Not eligible	Not applicable	$0
Member	Lesley Nelson	Not eligible	Not applicable	$0
Member	Prof. Paul Norman	Not eligible	Not applicable	$0
Member	John Powdrill	Per meeting	3 meetings per year	$60
Member	Dr Jamie Rankin	Not eligible	Not applicable	$0
Member	Julie Smith	Not eligible	Not applicable	$0
			Total:	**$60**
Department of Health WA Human Research Ethics Committee				
Chair	Dr Peter Bentley	Annual	6 months	$7,958
Lay person	Joyce Archibald	Per meeting	12 months	$3,300
Professional Care	Patricia Fowler	Per meeting	12 months	$3,300
Researcher	Dr Alison Garton	Per meeting	12 months	$3,630
Pastoral Care	Rev Jenifer Goring	Per meeting	12 months	$2,970
Researcher	Dr Angela Ives	Per meeting	12 months	$3,300
Information security	Gary Langham	Per meeting	12 months	$3,300
Lawyer	Jennifer Wall	Per meeting	12 months	$3,300
Lay person	Harley White	Not eligible	Not applicable	$0
Lay person	Mary Miller	Not eligible	Not applicable	$0
Former Chair	Dr Judy Allen	Annual	6 months	$6,367
Former Lay person	Ross Monger	Per meeting	6 months	$1,650
Deputy Member Researcher	Associate Prof. Tom Briffa	Per meeting	12 months	$0
Deputy Member Pastoral	Rev Brian Carey	Per meeting	12 months	$0
Deputy Member Information security	Shane Gallagher	Not eligible	Not applicable	$0
Former Deputy Member Researcher	Dr Geoffrey Hammond	Per meeting	6 months	$0
Deputy Member Lay person	Dr Phillip Jacobsen	Per meeting	12 months	$660
Deputy Member Lay person	Kathryn Kirk	Per meeting	12 months	$330

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Deputy Member Lawyer	Nadia Saba	Per meeting	12 months	$330
Former Deputy Member Professional Care	Tim Smith	Not eligible	Not applicable	$0
Deputy Member Researcher	Dr Katrina Spilsbury	Per meeting	12 months	$330
Deputy Member Lay person	Yvonne Rate	Per meeting	12 months	$0
Deputy Member Professional Care	Ann McDonald	Per meeting	6 months	$0
Deputy Member Researcher	Alison Reid	Per meeting	6 months	$0
			Total:	**$40,725**
Diabetes and Endocrine Health Network Executive Advisory Group				
Member	Dr Alan Wright	Per meeting	3 meetings per year	$660
Member	Bruce Campbell	Per meeting	3 meetings per year	$180
Member	Tim Benson	Per meeting	3 meetings per year	$180
Member	Andrew Wagstaff	Not eligible	Not applicable	$0
Member	Belinda Whitworth	Not eligible	Not applicable	$0
Member	Cara Westphal	Not eligible	Not applicable	$0
Member	Nila Cecconi	Not eligible	Not applicable	$0
Member	Deborah Schofield	Not eligible	Not applicable	$0
Member	Denise Smith	Not eligible	Not applicable	$0
Member	Dr Gerry Fegan	Not eligible	Not applicable	$0
Member	Helen Mitchell	Not eligible	Not applicable	$0
Diabetes & Endocrine Health Network Co-Lead	Mark Shah	Not eligible	Not applicable	$0
Member	Merinda March	Not eligible	Not applicable	$0
Member	Dr Rhonda Clifford	Not eligible	Not applicable	$0
Member	Prof. Richard Prince	Not eligible	Not applicable	$0
Member	Dr Sean George	Not eligible	Not applicable	$0
Member	Dr Seng Khee Gan	Not eligible	Not applicable	$0
Member	Sophie McGough	Not eligible	Not applicable	$0
Diabetes & Endocrine Health Network Co-Lead	Prof. Tim Davis	Not eligible	Not applicable	$0
Member	Prof. Tim Jones	Not eligible	Not applicable	$0
			Total:	**$1,020**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Falls Prevention Health Network Executive Advisory Group				
Clinical lead	Dr Nicholas Waldron	Sessional	3 meetings per year	$0
Member	Anne-Marie Hill	Not eligible	Not applicable	$0
Member	Dr Aru Moodley	Per meeting	3 meetings per year	$0
Member	Emily Anderson	Not eligible	Not applicable	$0
Member	Erica Davison	Not eligible	Not applicable	$0
Member	Katherine Ingram	Not eligible	Not applicable	$0
Member	Kim Watkins	Not eligible	Not applicable	$0
Member	Luke Hays	Not eligible	Not applicable	$0
Member	Su Kitchen	Not eligible	Not applicable	$0
Member	Tony Petta	Not eligible	Not applicable	$0
Member	Anthea McGuigan	Not eligible	Not applicable	$0
Member	Bronwyn Middleton	Not eligible	Not applicable	$0
Member	Jenna Athans	Not eligible	Not applicable	$0
			Total:	**$0**
Fluoridation of Public Water Supplies Advisory Committee*				
Chair	Dr Richard Lugg	Per meeting	12 months	$1,510
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:**	**$1,660**
Local Health Authorities Analytical Committee				
Member	Eugene Teik Hock Lee	Not eligible	Not applicable	$0
Member	Joseph Zappavigna	Not eligible	Not applicable	$0
Member	Jason Marc Gerhardt Jenke	Not eligible	Not applicable	$0
Member	Graeme Blakey	Not eligible	Not applicable	$0
Member	Greg Ducas	Not eligible	Not applicable	$0
Member	Phillip Gerar Oorjitham	Not eligible	Not applicable	$0
Member	Robert Eric Boardman	Per meeting	12 months	$1,849
Member	David Wilson	Not eligible	Not applicable	$0
Member	Colin Richard Dent	Not eligible	Not applicable	$0
Member	Cr Belinda Ann Rowland	Per meeting	12 months	$1,094
			Total:	**$2,943**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Musculoskeletal Health Network Executive Advisory Group				
Co-Lead	Jennifer Persaud	Sessional	Not applicable	$0
Member	Ben Horgan	Not eligible	Not applicable	$0
Member	Eng Soon Chew	Not eligible	Not applicable	$0
Member	Helen Keen	Not eligible	Not applicable	$0
Member	Jean Mangharam	Not eligible	Not applicable	$0
Member	Johannes Nossent	Not eligible	Not applicable	$0
Consumer	Kerry Mace	Per meeting	3 meetings per year	$180
Member	Ric Forlano	Not eligible	Not applicable	$0
Member	Robyn Timms	Not eligible	Not applicable	$0
Member	Stephan Schug	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	$8,783
Member	David Leach	Per meeting	6 months	$4,064
Member	Neil McLean	Per meeting	12 months	$6,572
Member	Theodore Sharp	Per meeting	12 months	$7,826
			Total:	**$27,245**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Perinatal and Infant Mortality Committee				
Investigator	Dr Keren Witcombe	Annual	12 month	$13,478
Investigator	Dr Christine Marsack	Annual	12 month	$11,517
Investigator	Dr Paddy Pemberton	Annual	12 month	$28,792
Investigator	Dr Ronnie Hagan	Annual	12 month	$15,985
Chair / Member	Professor John Newnham	Not eligible	Not eligible	$0
Deputy Chair / Member	Dr Noel French	Not eligible	Not eligible	$0
Member	Dr Corrado Minutillo	Not eligible	Not eligible	$0
Member	Dr Michael Gannon	Not eligible	Not eligible	$0
Member	Dr Ian Taylor	Not eligible	Not eligible	$0
Member	Dr Andrew Warren Thyer	Not eligible	Not eligible	$0
Member	Dr Keith Meadows	Not eligible	Not eligible	$0
Member	Dr Disna Abeysuriya	Not eligible	Not eligible	$0
Member	Ms Louise Keyes	Not eligible	Not eligible	$0
Member	Mrs Sonja Criddle	Not eligible	Not eligible	$0
			Total:	**$69,772**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Pharmacy Registration Board of Western Australia				
Presiding Member	John Lionel Harvey	Per meeting	12 months	$7,350
Member	Margaret Nona Ford	Per meeting	12 months	$4,830
Member	Prof. Michael John Garlepp	Per meeting	12 months	$4,600
Member	Zoe Lenette Mullen	Per meeting	12 months	$5,180
			Total:	**$21,960**
Radiological Council				
Chair	Dr Andrew Geoffrey Robertson	Not eligible	Not applicable	$0
Deputy Chair	Dr Geoffrey Norman Groom	Per meeting	12 months	$980
Member	Dr Chandra Padmini Hewavitharana	Not eligible	Not applicable	$0
Member	Dr Richard Alan Fox	Per meeting	12 months	$1,120
Member	Associate Prof. Janice Christine McKay	Per meeting	12 months	$1,120
Member	Maxwell John Ross	Per meeting	12 months	$800
Deputy Member	Dr Roger Ian Price	Not eligible	Not applicable	$0
Deputy Member	Associate Prof. Zhonghua Sun	Not eligible	Not applicable	$0
Member	Christopher John Whennan	Not eligible	Not applicable	$0
Deputy Member	Dr Elizabeth Thomas	Not eligible	Not applicable	$0
Member (Non-voting)	Barry Cobb	Per meeting	12 months	$1,280
Member (Non-voting)	Nick Tsurikov	Per meeting	12 months	$960
Member	Dr Deepthi Dissanayake	Not eligible	Not applicable	$0
Member	Dr Robin Hart	Not eligible	Not applicable	$0
Member	John O'Donnell	Not eligible	Not applicable	$0
			Total:	**$6,260**
Renal Health Network Executive Advisory Group				
Renal Health Network Co-Lead	Dr Hemant Kulkarni	Not eligible	Not applicable	$0
Renal Health Network Co-Lead	Dr Harry Moody	Not eligible	Not applicable	$0
Member	Dr Mike Civil	Per meeting	3 per year	$660
Member	Simone McMahon	Per meeting	3 per year	$180
Member	Dr Neil Boudville	Not eligible	Not applicable	$0
Member	Dr Aron Chakera	Not eligible	Not applicable	$0
Member	Evelyn Coral	Not eligible	Not applicable	$0
Member	Jenny Cutter	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Lois Dear	Not eligible	Not applicable	$0
Member	Debbie Fortnum	Not eligible	Not applicable	$0
Member	Steve Marshall	Not eligible	Not applicable	$0
Member	Dr Greg Perry	Not eligible	Not applicable	$0
Member	Sandra Porter	Not eligible	Not applicable	$0
Member	Emma Griffiths	Not eligible	Not applicable	$0
			Total:	**$840**
Respiratory Health Network Executive Advisory Group				
Lead	Mark Everard	Not eligible	Not applicable	$0
General Practitioner	Dr Jacquie Garton-Smith	Per meeting	12 months	$880
General Practitioner	Dr Mareer Creighton	Per meeting	6 months	$440
Consumer	Jenni Ibrahim	Per meeting	12 months	$240
Member	Nigel Barker	Not eligible	Not applicable	$0
Member	Nola Cecins	Not eligible	Not applicable	$0
Member	Rhonda Clifford	Not eligible	Not applicable	$0
Member	David Hillman	Not eligible	Not applicable	$0
Member	David Johnson	Not eligible	Not applicable	$0
Member	Lou Landau	Not eligible	Not applicable	$0
Member	Holly Landers	Not eligible	Not applicable	$0
Member	Siobhain Mulrennan	Not eligible	Not applicable	$0
Member	Kathryn Pekin	Not eligible	Not applicable	$0
			Total:	**$1,560**
Stimulant Assessment Panel				
Chair	*	Not eligible	Not applicable	$0
Member 1	*	Not eligible	Not applicable	$0
Member 2	*	Not eligible	Not applicable	$0
Member 3	*	Not eligible	Not applicable	$0
Member 4	*	Not eligible	Not applicable	$0
Member 5	*	Not eligible	Not applicable	$0
Member 6	*	Per meeting	12 months	$2,058
Member 7	*	Not eligible	Not applicable	$0
Member 8	*	Not eligible	Not applicable	$0
*Approval to withhold the names of the committee members was obtained from the Minister for Health			**Total:**	**$2,058**
Western Australian Aged Care Advisory Council				
Chair	Dr Penny Flett	Per meeting	12 months	$639
Deputy Chair	Gail Milner	Not eligible	Not applicable	$0
Member	Rob Willday	Not eligible	Not applicable	$0
Member	Ann Banks Resigned Dec 2016	Per meeting	12 months	$284

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Nick Bretland	Per meeting	12 months	$440
Member	Beth Cameron Resigned Aug 2016	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	Trevor Lovelle	Not eligible	Not applicable	$0
Member	Dr Helen McGowan	Not eligible	Not applicable	$0
Member	Rhonda Parker	Not eligible	Not applicable	$0
Member	Helen Grinbergs Resigned Nov 2016	Not eligible	Not applicable	$0
Proxy	Kathy Stack	Not eligible	Not applicable	$0
			Total	**$1,363**
Western Australia Board of the Medical Board of Australia				
Chair	Prof. Con Michael	Per meeting	12 months	$4,971
Member	Prof. Bryant Stokes	Per meeting	12 months	$3,209
Member	Dr Michael Levitt	Per meeting	12 months	$3,133
Member	Adjunct Prof. Peter Foord Wallace	Per meeting	12 months	$4,075
Member	Dr Mark Edwards	Per meeting	12 months	$3,761
Member	Dr Ken Mark McKenna	Per meeting	12 months	$3,830
Member	Dr Michael McComish	Per meeting	12 months	$3,133
Member	Dr Daniel Heredia	Per meeting	12 months	$3,454
Member	Nicoletta Ciffolilli	Per meeting	12 months	$3,761
Member	Stephan John Millett	Per meeting	12 months	$2,512
Member	Virginia Rivalland	Per meeting	12 months	$3,761
Member	Giovanni (John) Pintabona	Per meeting	12 months	$4,389
			Total:	**$43,989**
Western Australia Board of the Nursing and Midwifery Board of Australia				
Chair	Marie Louise MacDonald	Per meeting	12 months	$4,588
Member	Karen Gullick	Per meeting	12 months	$3,830
Member	Pamela Lewis	Per meeting	12 months	$3,140
Member	Associate Prof. Karen Clark-Burg	Per meeting	12 months	$4,075
Member	Marie Baxter	Per meeting	12 months	$0
Member	Mary Miller	Per meeting	12 months	$0
Member	Dr Margaret Crowley	Per meeting	12 months	$3,761
Member	Michael Piu	Per meeting	12 months	$3,140
Member	John Kimberley Laurence	Per meeting	12 months	$3,140
			Total:	**$25,674**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Western Australian Child and Youth Health Network Executive Advisory Group				
Consumer	Helen Pepper	Per meeting	2 meetings	$60
Member	Elaine Bennett	Not eligible	Not applicable	$0
Member	Sharon Bushby	Not eligible	Not applicable	$0
Member	Emma Davidson	Not eligible	Not applicable	$0
Member	Phillippa Farrell	Not eligible	Not applicable	$0
Member	Carolyn Franklin	Not eligible	Not applicable	$0
Member	Linda Hop	Not eligible	Not applicable	$0
Member	Caron Molster	Not eligible	Not applicable	$0
Member	Helen Pepper	Not eligible	Not applicable	$0
Member	Sue Pepper	Not eligible	Not applicable	$0
Member	Trulie Pinnegar	Not eligible	Not applicable	$0
Member	Alide Smit	Not eligible	Not applicable	$0
Member	Janine Spencer	Not eligible	Not applicable	$0
Member	Helen Wright	Not eligible	Not applicable	$0
			Total:	**$60**
WA Health Transition and Reconfiguration Steering Committee				
Chair	Dr David Russell-Weisz	Not eligible	Not applicable	$0
Member	Michael Barnes	Not eligible	Not applicable	$0
Member	David Smith	Not eligible	Not applicable	$0
Member	Peter Conran	Not eligible	Not applicable	$0
			Total:	**$0**
WA Reproductive Technology Council				
Chair	Dr Brenda McGivern	Per meeting	12 months	$2,059
Member	Dr Simon Clark	Per meeting	12 months	$994
Member	Antonia Clissa	Per meeting	12 months	$1,278
Member	Dr Angela Cooney	Per meeting	12 months	$1,562
Member	Anne Marie Loney	Not eligible	Not applicable	$0
Member	Justine Garbellini	Per meeting	12 months	$1,420
Member	Prof. Roger Hart	Per meeting	12 months	$639
Member	Prof. Stephan Millet	Per meeting	12 months	$852
Member	Dr Joseph Parkinson	Per meeting	12 months	$1,360
Member	Derek Paton	Not eligible	Not applicable	$0
Member	Prof. Peter Roberts	Per meeting	12 months	$1,704
Deputy Member	Dr John Beilby	Not eligible	Not applicable	$0
Deputy Member	Dr Peter Burton	Sessional	12 months	$0
Deputy Member	Rev Brian Carey	Sessional	12 months	$497

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Deputy Member	Dr Louise Farrell	Sessional	12 months	$142
Deputy Member	Dr Michele Hansen	Sessional	12 months	$426
Deputy Member	Dr Andrew Harman	Sessional	12 months	$142
Deputy Member	Iolanda Rodino	Sessional	12 months	$710
Deputy Member	Rachel Oakeley	Sessional	12 months	$284
Deputy Member	Diane Scarle	Not eligible	Not applicable	$0
Deputy Member	Dr Lucy Williams	Sessional	12 months	$426
			Total:	**$14,495**
WA Reproductive Technology Counselling Committee				
Chair	Iolanda Rodino	Sessional	12 months	$639
Member	Justine Garbellini	Sessional	12 months	$142
Member	Anne-Marie Loney	Not eligible	Not applicable	$0
Member	Dr Elizabeth Webb	Sessional	12 months	$426
Member	Derek Paton	Not eligible	Not applicable	$0
			Total:	**$1,207**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
WA Reproductive Technology Counselling Embryo Storage Committee				
Chair	Rev Brian Carey	Sessional	12 months	$213
Member	Antonia Clissa	Sessional	12 months	$0
Member	Dr Michelle Hanson	Sessional	12 months	$142
Member	Dr Andrew Harman	Sessional	12 months	$142
			Total:	**$497**
WA Reproductive Technology Counselling Licensing and Administration Advisory Committee				
Chair	Dr Joseph Parkinson	Sessional	12 months	$639
Member	Dr Angela Cooney	Sessional	12 months	$142
Member	Prof. Roger Hart	Sessional	12 months	$0
Member	Prof. Peter Roberts	Sessional	11 months	$142
Member	Iolanda Rodino	Sessional	11 months	$142
			Total:	**$1,065**
WA Reproductive Technology Counselling Preimplantation Genetic Diagnosis Technical Advisory Committee				
Chair	Dr John Beilby	Not eligible	Not applicable	$0
Member	Dr Kathy Sanders	Sessional	12 months	$426
Member	Dr Peter Burton	Sessional	12 months	$142
Member	Dr Sharon Townshend	Not eligible	Not applicable	$0
			Total:	**$568**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
WA Reproductive Technology Counselling Scientific Advisory Committee				
Chair	Prof. Roger Hart	Sessional	12 months	$0
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	Dr Joseph Parkinson	Sessional	12 months	$0
Member	Prof. Peter Roberts	Sessional	12 months	$0
Member	Dr Lucy Williams	Sessional	12 months	$142
			Total:	**$284**
Women and Newborns Health Network Executive Advisory Group				
Consumer	Bev Sinclair	per meeting	12 months	$180
Member	Etwell Mari	Not eligible	Not applicable	$0
Member	Graeme Boardley	Not eligible	Not applicable	$0
Member	Hayley Sherratt	Not eligible	Not applicable	$0
Member	Jan Ryan	Not eligible	Not applicable	$0
Member	Janet Hornbuckle	Not eligible	Not applicable	$0
Member	Janice Butt	Not eligible	Not applicable	$0
Member	Jenny O'Callaghan	Not eligible	Not applicable	$0
Member	Karla Lister	Not eligible	Not applicable	$0
Member	Leanda Verrier	Not eligible	Not applicable	$0
Member	Peter Kell	Not eligible	Not applicable	$0
Member	Pippa Vines	Not eligible	Not applicable	$0
Member	Richard King	Not eligible	Not applicable	$0
Member	Selena Knowles	Not eligible	Not applicable	$0
Member	Sue Somerville	Not eligible	Not applicable	$0
Member	Susan Bradshaw	Not eligible	Not applicable	$0
Member	Kate Reynolds	Not eligible	Not applicable	$0
Member	Sara Armitage	Not eligible	Not applicable	$0
			Total:	**$180**

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