2007-2008

Department of Health
Annual Report

ANNUAL REPORT

Department of Health

Annual Report 2007-08

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Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Department of Health for the financial year ended 30 June 2008.

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

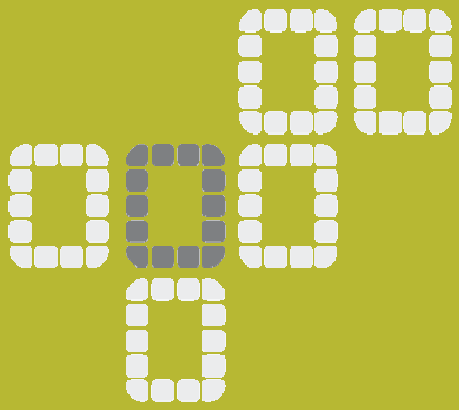
Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH
Accountable Authority

26th September 2008

Contents

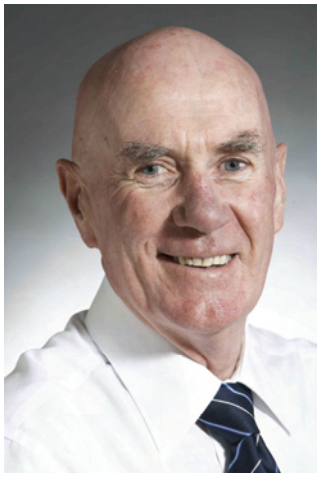
Illustrations

This Report is available in alternative formats upon request from a person with a disability



Overview of Agency

Executive Summary



The Department of Health is committed to ensuring healthier, longer and better lives for all Western Australians and protecting the health of our community. We aim to do this by providing a safe, high quality, accountable and sustainable health care system. In 2007-08 the Department has continued to implement a broad-based reform agenda, underpinned by our *Strategic Directions 2005 – 2010* framework. Below is just a small sample of the progress we have made in our six priority areas: healthy workforce; healthy hospitals, health services and Infrastructure; healthy partnerships; healthy communities; healthy resources and healthy leadership.

Healthy workforce

A record 586 new registered nursing graduates commenced with WA Health in 2008 – an increase of 110 on the 2007 recruitment year. In 2007-08, new initiatives were introduced to boost the skills and sustainability of our workforce. These included programs to attract experienced nurses back into the profession, introduction of training for the Assistant in Nursing role and the successful piloting of a program of community residencies for junior doctors. Workforce improvements were also delivered through the completion of the Aged Care Assessment Team quality framework and the delivery of an improved suite of disaster training courses. In these ways and more the Department delivered on its commitment to develop and maintain a skilled, healthy and sustainable workforce to protect and promote the health of the WA community.

Healthy hospitals, health services and infrastructure

In 2007-08 the Department continued to improve and enhance the quality of our hospitals, infrastructure and health services, with a focus on accessibility, efficiency and responsiveness to community needs. Significant improvements have been made in terms of waiting times for elective surgery at Perth public hospitals and for clinic appointments at metropolitan outpatient clinics. Substantial progress has been made on the improvement and expansion of our hospital infrastructure. The past year saw the completion of the new $8 million State Major Trauma Unit at Royal Perth Hospital, while the $115 million expansion of Rockingham-Kwinana Hospital is more than two thirds complete. The upgrade of the Emergency Department at Peel Health Campus has been completed, while emergency department upgrades are underway at Royal Perth Hospital and Armadale-Kelmscott Memorial Hospital. The Department has also made strong progress in our ongoing $600 million regional infrastructure program. New facilities completed in 2007-08 include the Fitzroy Crossing Hospital and Morawa Health Centre, while upgrades or redevelopments have been completed at Carnarvon Hospital, Derby Hospital and Dental Clinic and Bunbury's Acute Psychiatric Unit.

The past year saw the endorsement of a new model of care for palliative care and ongoing work by the WA Health Aged Care Network on the formulation of service models that specifically include a model of care for dementia. In addition, aged care services in country areas have been enhanced and Transition Care programs introduced in the South West, Mid West and Great Southern regions. Construction of supported, community-based mental health accommodation was completed at Albany, Bunbury, Busselton, Geraldton and Kelmscott. In 2007-08 more than 241,000 schoolchildren across WA continued to access free oral health treatment through the school dental program.

Healthy partnerships

The Department of Health has continued to develop innovative partnerships with non-government organisations, private sector providers, community groups and other government agencies aimed at improving service delivery, boosting research and development and maximising capital investment. Our partnership with the Telethon Institute of Child Health Research has gained international recognition, linking WA's genomics sector with the global genomics industry. There have been significant developments in the Department's collaborative

Aboriginal health partnerships, while the 2007 Mental Health Good Outcomes Awards recognised innovation and excellence across the WA mental health sector.

Healthy communities

In 2007-08 the Department has continued to work towards improving lifestyles, preventing ill-health and implementing long term, integrated health promotion programs. There has been strong action to combat childhood obesity through the implementation of healthy eating, healthy weight and physical activity programs to be delivered in school and community settings. A number of new initiatives have been established to combat perinatal and postnatal depression and the Australian Better Health Initiative has been progressively implemented at several locations across the state. Falls prevention activities have continued and we have commenced demonstration projects to simplify client access to Home and Community Care services. The Public Health Division has been drafting the new Public Health Bill and has undertaken a number of sexual health initiatives. Licensing infrastructure for tobacco retailers and wholesalers has been established and a statewide compliance program implemented. The Department has improved the health of our workplaces and facilities through implementation of non-smoking and positive food and nutrition policies at WA Health facilities.

Healthy resources

The Department has continued to deliver robust resource administration, planning and management practices to oversee our health service programs and support the area health services. Disaster preparedness and management arrangements have been enhanced, including through significant upgrades to emergency communication facilities at rural hospitals. Video-conferencing equipment to allow the expansion of tele-psychiatry services has been installed in an additional 58 centres across the state. Health information improvements have included significant progress towards the new WA Cancer Registry information system and preparation for the ongoing monitoring of road safety indicators.

Healthy leadership

The Department recognises that identifying, nurturing and promoting strong leadership at all levels is vital for the effectiveness of the health system now and into the future. The Institute for Healthy Leadership was established in July 2007. The Institute has already commissioned a number of programs to develop WA Health's future leaders. The Institute's Service Improvement Workshops provide training in the principles and methods of health service improvement. The Emerging Leaders Development Program and the Delivering the Future Leadership Development Program target senior managers and potential future directors and executive directors and provide high-level leadership training. As part of our commitment to fostering leadership at all levels, nine graduate officers were recruited and commenced with the Department in February 2008.

Conclusion

The report that follows provides more detail on how the Department of Health has worked towards its goal of delivering a healthy WA. None of the achievements detailed below would have been possible without the hard work and dedication of all our staff. I would like to thank each member of our WA Health workforce for their contribution over the past year and reaffirm our commitment to providing a world-class health service to the people of Western Australia.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Figure 1: 2007 WA Health facts at a glance

2007 WA Health Facts at a Glance	
Population we care for	2,082,982
Number of public hospital discharges	387,931
Public discharges in private facilities	79,067
All private hospital discharges not funded or administered by the Department of Health	267,486
All hospital Emergency Department visits	756,704
Numbers of babies born	30,051
Number of same day surgery separations	85,082
Number of overnight surgery separations	120,771
Number of clients receiving Home and Community Care Services	70,694
Inpatient overnight separations for mental health disorders in all public hospitals	13,537
Number of people provided with individual consultations for community public mental health services	37,787
Number of contacts for community public mental health services	541,597

Our Purpose

Our purpose is to ensure healthier, longer and better lives for all West Australians.

Our Vision

Our vision is to improve and protect the health of West Australians by providing a safe, high quality, accountable and sustainable health care system. We recognise that this care is achieved through an integrated approach to all the components of our health system. These components include workforce, hospitals and infrastructure, partnerships, communities, resources and leadership. We also recognise that the Department of Health must work with a vast number of groups if it is to achieve the vision of a world-class health system.

Address and Location

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Service Framework

Better Planning: Better Futures

In September 2006, the State Government of Western Australia released Better Planning: Better Futures – *A Framework for the Strategic Management of the Western Australian Public Sector.*

The framework states that the Western Australian public sector seeks to provide the best opportunities for current and future generations to live better, longer and healthier lives. Its vision is to promote a creative, sustainable and economically successful state that embraces the diversity of its people and values its rich natural resources.

The framework outlines five strategic goals. Broad, high-level government goals are supported at agency level by more specific desired outcomes. The whole of health delivers services to achieve these desired outcomes, which ultimately contribute to meeting the high-level government goals.

Goal 1:
Better services

Enhancing the quality of life and wellbeing of all people throughout Western Australia by providing high quality, accessible services.

Goal 2:
Jobs and economic development

Creating conditions that foster a strong economy, delivering more jobs, opportunities and greater wealth for all West Australians.

Goal 3:
Lifestyle and environment

Protecting and enhancing the unique Western Australian lifestyle and ensuring sustainable management of the environment.

Goal 4:
Regional development

Ensuring that regional Western Australia is strong and vibrant.

Goal 5:
Governance and public sector improvement

Developing and maintaining a skilled, diverse and ethical public sector, serving the Government with consideration of the public interest.

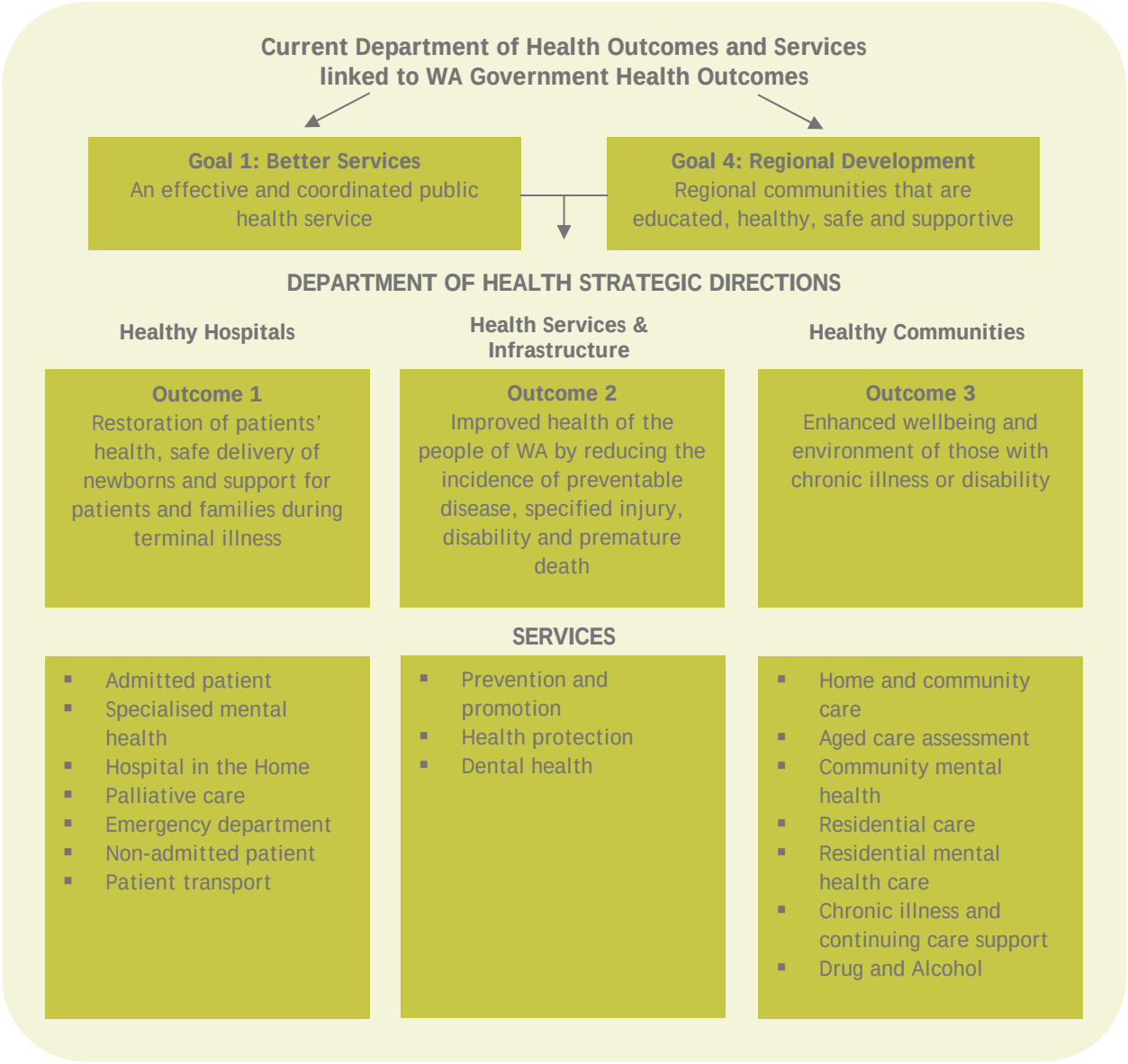
WA health outcomes and strategic directions

WA Health principally contributes to Better Planning: Better Futures - Goals 1 and 4.

Figure 2 shows the relationship between the Government's and WA Health's desired outcomes.

The strategic directions or priority areas of healthy 'hospitals, health services and infrastructure', 'communities' along with 'workforce', 'partnerships', 'resources' and 'leadership' were identified by the Department of Health's senior leadership team in December, 2004 and provide the WA Health framework for improving the efficiency and effectiveness of health care provided to West Australians for the period 2005-2010.

Figure 2: Department of Health strategic directions



Compliance Reports

The Department of Health is 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 40 Acts and 101 sets of subsidiary legislation.

Acts administered

- *Alcohol and Drug Authority Act 1974*
- *Anatomy Act 1930*
- *Animal Resources Authority Act 1981*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cannabis Control Act 2003*
- *Chiropractors Act 2005*
- *Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951*
- *Cremation Act 1929*
- *Dental Act 1939*
- *Dental Prosthetists Act 1985*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Conciliation and Review) Act 1995*
- *Health Services (Quality Improvement) Act 1994*
- *Hospital Fund Act 1930*
- *Hospitals and Health Services Act 1927*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medical Act 1894*
- *Medical Practitioners Act 2008*
- *Medical Radiation Technologists Act 2006*
- *Mental Health Act 1996*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Nurses and Midwives Act 2006*
- *Occupational Therapists Act 2005*
- *Optometrists Act 2005*
- *Osteopaths Act 2005*
- *Pharmacy Act 1964*
- *Physiotherapists Act 2005*
- *Podiatrists Act 2005*
- *Poisons Act 1964*
- *Psychologists Act 2005*
- *Queen Elizabeth II Medical Centre Act 1966*
- *Radiation Safety Act 1975*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *White Phosphorous Matches Prohibition Act 1912*

Acts passed during 2007-08

- *Food Act 2008*
- *Medical Practitioners Act 2008*

Bills in Parliament as at 30 June 2008

- *Alcohol and Drug Authority Repeal Bill 2005*
- *Dental Bill 2005*
- *Pharmacists Bill 2005*
- *Surrogacy Bill 2006*

Amalgamation and establishment of Boards

There were no Boards amalgamated or established during 2007-08.

Statement of Compliance with Public Sector Standards

In the administration of the Department of Health, I have complied with the Public Sector Standards in Human Resource Management, the Western Australian Public Sector Code of Ethics and the Department of Health Code of Conduct.

I have put in place procedures designed to ensure such compliance and have undertaken appropriate internal processes to satisfy myself that the statement made above is correct.

To ensure consistency with the requirements of the Public Sector Standards and to encourage best practice, regular reviews are undertaken of relevant policies and procedures. The Department's human resources consultants continually monitor compliance on a transaction by transaction basis and occasionally external consultants are requested to undertake breach reviews to gain an independent view of our processes.

The Department of Health provides employees with opportunities to attend selection panel training and endeavours to ensure that selection panels contain at least one person who has received the appropriate training. The Department also participates in compliance audits undertaken by the Internal Audit Branch, conducts employee surveys and exit interviews to gather information regarding public sector standards for human resource management and the application of the Code of Ethics.

During 2007-08 the Department of Health (including Health Corporate Network) received 10 breach claims in relation to recruitment and selection and four for grievance resolution. Seven were resolved internally or withdrawn while seven were referred to the Office of the Public Sector Standards Commissioner (OPSSC) for review and action where appropriate.

Code of Ethics and Code of Conduct

The Public Sector Code of the Ethics and the Department of Health Code of Conduct are available to employees on the intranet site and are provided to all new employees at orientation and induction at which time they are required to acknowledge the Codes. Ethics and conduct awareness raising seminars and workshops are conducted for all employees.

Compliance with the codes is monitored through analysis of employee grievances, complaints and the identification of relevant subject matter. During 2007-08 the Department of Health including the Health Corporate Network received no complaints alleging non-compliance with either the Code of Ethics or the Department of Health Code of Conduct where the complaint required further investigation and/or action following internal review.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Accountable Authority

The Acting Director General of Health, Peter Flett, in his capacity as Chief Executive Officer, is the accountable authority for the Department of Health.

Pecuniary Interests

Senior officers of the Department of Health have declared no pecuniary interests in 2007-08.

Senior Officers

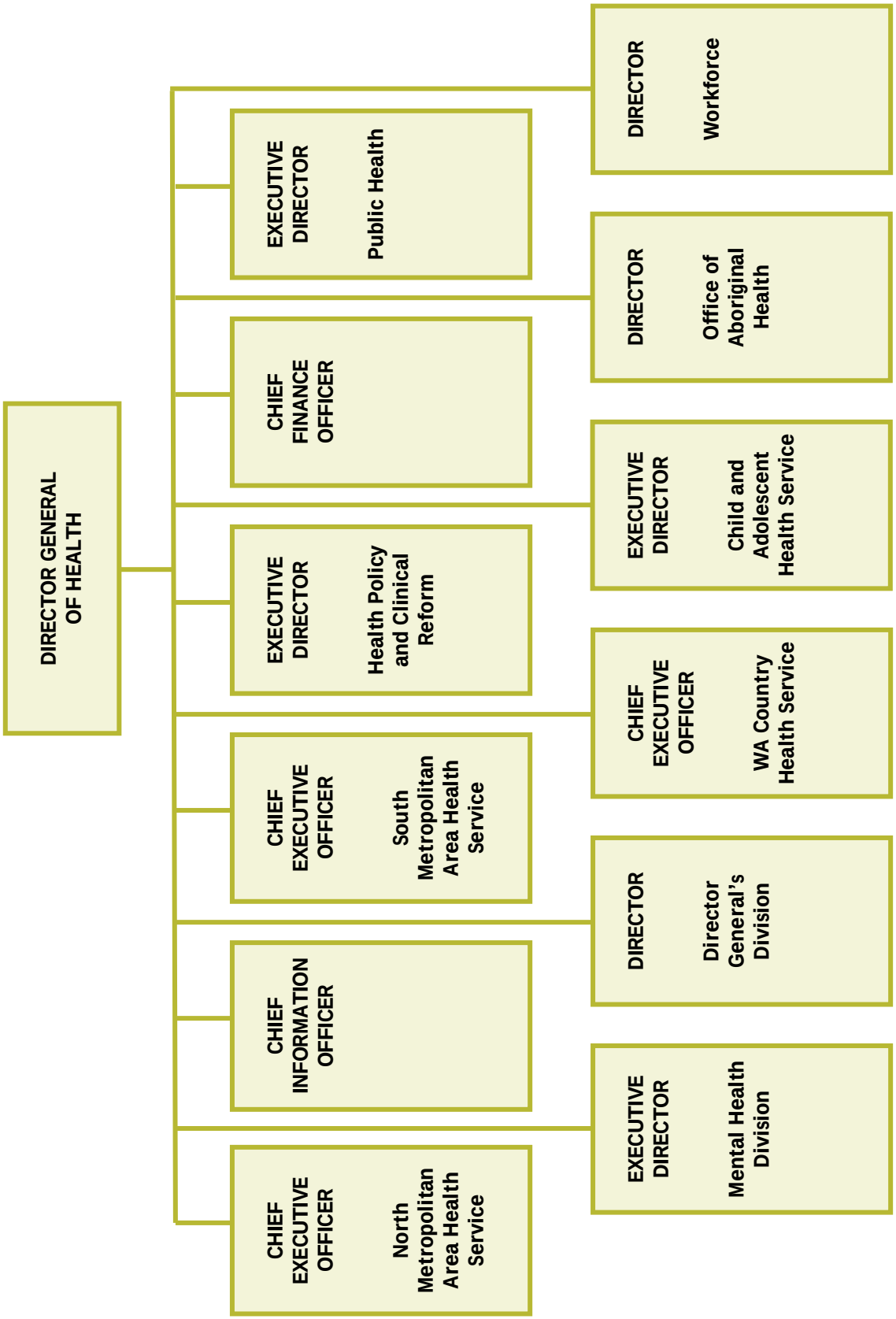
The senior officers for the Department of Health and their areas of responsibility are listed below:

Table 1: Senior officers – Department of Health as at 30 June 2008

Area of responsibility	Title	Name
Department of Health	**A/Director General of Health**	**Peter Flett**
Director General's Division	A/Director	Wayne Salvage
Health Information Division	A/Chief Information Officer	Colin Xanthis
Health Finance	Chief Finance Officer	John Leaf
Health Policy and Clinical Reform	Executive Director	Simon Towler
Mental Health Division	Executive Director	Steve Patchett
Public Health	Executive Director	Tarun Weeramanthri
Workforce	A/Director	Elizabeth Rohwedder
Health Corporate Network	General Manager	Bill Bleakley

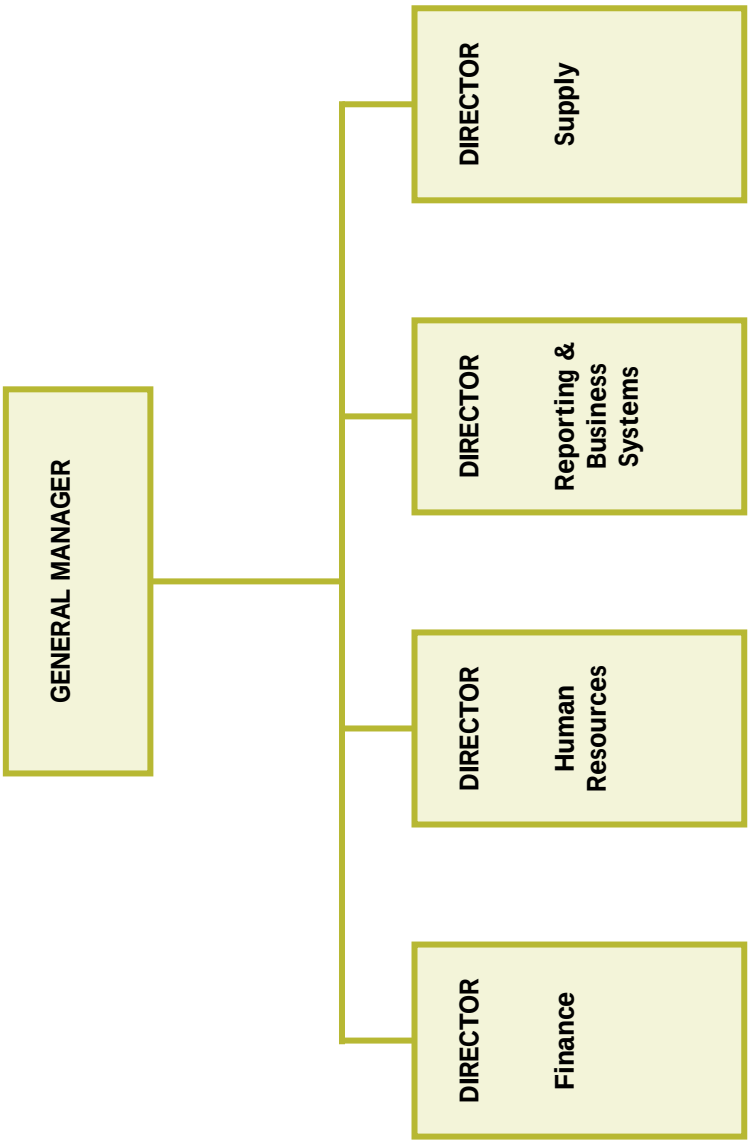
Management Structure

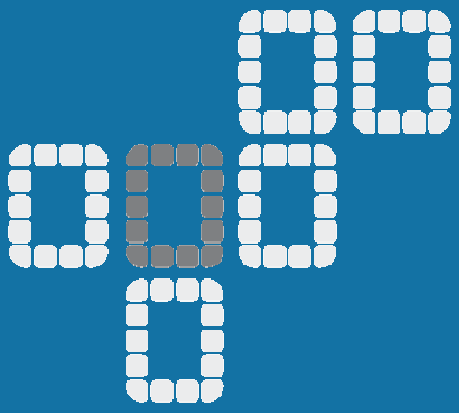
Department of Health State Health Executive Forum (June 2008)



Management Structure (continued)

Health Corporate Network (June 2008)





Key Performance Indicators

Certification Statement

DEPARTMENT OF HEALTH
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Department of Health and fairly represent the performance of the Department for the financial year ended 30 June 2008.

Dr Peter Flett
ACCOUNTABLE OFFICER
Acting Director General of Health

17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

DEPARTMENT OF HEALTH
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

I have audited the accounts, financial statements, controls and key performance indicators of the Department of Health.

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, a summary of significant accounting policies and other explanatory Notes.

The key performance indicators consist of key indicators of effectiveness and efficiency.

Director General's Responsibility for the Financial Statements and Key Performance Indicators
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 (including the Australian Accounting Interpretations) and the Treasurer's Instructions, and the key performance indicators. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements and key performance indicators that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; making accounting estimates that are reasonable in the circumstances; and complying with the Financial Management Act 2006 and other relevant written law.

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and key performance indicators is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements and key performance indicators.

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel 08 9222 7500 Fax 08 9322 5664

Audit Opinion (continued)

Department of Health
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion

In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the Department of Health at 30 June 2008 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

(ii) the controls exercised by the Department 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, and

(iii) the key performance indicators of the Department are relevant and appropriate to help users assess the Department's performance and fairly represent the indicated performance for the year ended 30 June 2008.

GLEN CLARKE
ACTING AUDITOR GENERAL
22 September 2008

Page 2 of 2

Introduction

The Department of Health (DOH) is required under the Financial Management Act 2006 (s61) (FMA) and the supporting Treasurer's Instruction TI 904, to present annual indicators of effectiveness and efficiency to Parliament. The effectiveness indicators report how well the Department achieves its outcomes while efficiency indicators show accountability for funds spent in delivery of the services.

The key performance indicators in this report provide the Parliament and public of Western Australia with information on the performance in the delivery of services, the management or funding of which is provided directly by the DOH. This includes programs managed by branches of the DOH and non-government organisation contracts, for example the Royal Flying Doctor Service contract and privately managed public patient contracts.

Services provided by the area health services are reported separately in 2 different reports.

These reports are listed below:

- Metropolitan Health Service
- WA Country Health Service

The key performance indicators reported in the DOH annual report, together with the two health services annual reports listed above form an important part of the Department of Health's accountability framework and demonstrate the ongoing commitment of the Department to improving the health of the people of Western Australia.

Commencing for 2007-08 reporting period the Key Performance Indicators (KPIs) for the Peel Health Service will be included with the Metropolitan Health Service KPIs.

A key aim in presenting this information and that reported by the separate legal reporting entities, is to assist the public to understand the complex and diverse nature of the services and activities of the health system and how these contribute to its performance.

The key performance indicators reported in the following pages address the extent to which the strategies and activities of the DOH and those contracted to provide services have contributed to the DOH's required health outcomes. The three outcomes are:

- **Outcome 1:** Restoration of patients' health, safe delivery of newborns and support for patients and families during terminal illness
- **Outcome 2:** Improved health of the people of WA by reducing the incidence of preventable disease, specified injury, disability and premature death
- **Outcome 3:** Enhanced wellbeing and environment of those with chronic disease or disability

The outcomes above are achieved by the delivery of 17 service types shown in the table on the next page.

Refer to next page for Table 2

Introduction (continued)

Table 2: Service activities in relation to the components of the outcome

Outcome 1		Outcome 2		Outcome 3	
Service 1	Admitted patient	**Service 8**	Prevention and promotion	**Service 11**	Home and Community Care
Service 2	Specialised mental health	**Service 9**	Health protection	**Service 12**	Aged care Assessment
Service 3	Hospital in the Home (HITH)	**Service 10**	Dental health	**Service 13**	Community mental health
Service 4	Palliative care			**Service 14**	Residential care
Service 5	Emergency department			**Service 15**	Residential mental health-care
Service 6	Non-admitted patient			**Service 16**	Chronic illness and continuing care support
Service 7	Patient transport			**Service 17**	Drug and Alcohol

Consumer Price Index (CPI) Deflator Series

The consumer price index (CPI) figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarters and uses 2003-04 as the base year in the annual reports. The average of the December and March quarter is used because the full year index series is not available in time for the annual reporting cycle.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2003-04 dollars:

Cost_n x (100/Index_n) where n is the financial year or calendar year where appropriate.

Table 3: Consumer price index figures for the financial years

Financial year	2003-04	2004-05	2005-06	2006-07	2007-08
Index (Base 2003-04)	100.00	102.48	105.44	108.44	112.34

Outcome 1: Restoration of patients' health, safe delivery of newborns and support for patients and families during terminal illness

The achievement of this component of the health objective involves activities which:

- Ensure that people have appropriate and timely access to acute care services when they are in need of them so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness does do not progress or the effects of injury do not progress, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery).
- Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
- Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
- Provide appropriate care and support for patients and their families during terminal illness.

The activities required to meet this outcome are mostly provided in hospitals wholly managed by the DOH. The Health Services report separately on the services they provide. The DOH mainly provides a policy, planning and support role to health services. The DOH contracts with the private sector to provide services for public patients. This section of the annual report contains indicators reporting on those services.

The DOH is also responsible for the statewide services contracts, for example patient transport service provided by St John Ambulance, the Royal Flying Doctor Service and the provision of blood products.

While the Health Services play the major role in the restoration of people to health the following table lists the indicators, which show the performance of the DOH in relation to Outcome 1 restoration of patients' health, safe delivery of newborns and support for patients and families during terminal illness.

Table 4: Key Performance Indicators for Outcome 1 by reporting entity

Outcome 1	Department of Health	Metropolitan Health Service	WA Country Health Service
Restoration of patients' health	R1-50 R1-51	1-00 1-02 1-03	1-00 1-02 1-03 1-20
Timely access to admitted hospital care		1-01	1-01
Provide safe services	R1-53	1-05	1-05
Safe delivery of newborns		1-06	1-06
Timely emergency care		1-07 1-08	1-07
Provide palliative care services	R1-54		

R1-50: Proportion of privately managed public patients discharged to home

This indicator reports the proportion of privately managed public patients discharged to home.

Rationale

A direct measure of the extent to which people have been restored to health after an acute illness is that they are well enough to be discharged home after an acute illness that required hospitalisation. The percentage of people discharged home over time provides an indication of how effective the public system is in restoring people to health.

The performance indicator shows the percentage of all separations for patients admitted to hospitals (excluding inter-hospital transfers) directly funded under a contractual arrangement from Department of Health appropriation that are discharged home. The contracts which are in the scope for this performance indicator are those relating to treating public patients at private hospitals. These hospitals are Joondalup Health Campus and Peel Health Campus.

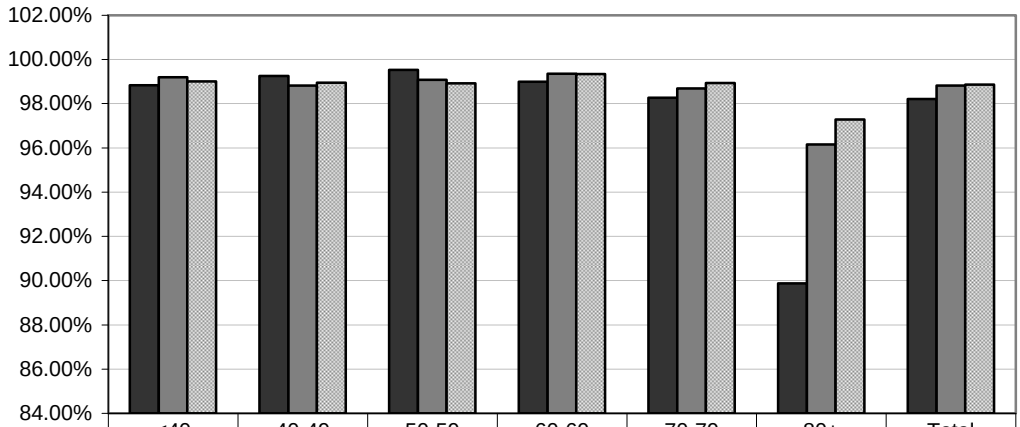
An important indicator of how well patients have been restored to health (as well as survival rate) is that they are not readmitted to hospital for treatment of the same condition within a short time of discharge. This indicator should be linked with R1-51 when results are considered.

Results

In 2007, the overall percentage of privately managed public patients discharged home was 98.86% and is within target. The data contributes to the body of evidence that the probability of being restored to health, as demonstrated by being able to be discharged home after hospitalisation, is more likely for patients in the younger age groups. In 2007, the proportion under 40 years of age was 99.00%, while 97.29% of those over the age of 80 years were discharged to home.

Figure 3: Proportion of privately managed public patients discharged to home

Overall (total) target
≥98%



	<40	40-49	50-59	60-69	70-79	80+	Total
2005	98.84%	99.25%	99.53%	99.00%	98.27%	89.87%	98.21%
2006	99.20%	98.82%	99.08%	99.35%	98.68%	96.16%	98.82%
2007	99.00%	98.95%	98.92%	99.34%	98.93%	97.29%	98.86%

Data Source
Hospital Morbidity Data System

R1-51: Unplanned readmission rate for the same or related condition for privately managed public patients

This indicator reports the rate of unplanned readmission for the same or related condition to the same hospital within 28 days for privately managed public patients.

Rationale

Good medical and/or surgical care intervention with good discharge planning will decrease the likelihood of unplanned hospital readmissions. The extent to which a patient is restored to health after illness can be gauged by the rate of patients who are readmitted to hospital for the same condition or for a complication caused by treatment or care given during a recent admission. Readmission within a short time may indicate that the patient has not been restored to health.

This indicator measures the rate of readmissions to the same hospital within 28 days and results should be read in conjunction with R1-50 in annual reports.

A low planned readmission rate suggests that good clinical practice as well as good discharge planning has occurred.

Results

The unplanned readmission rate for privately managed public patients is 0.6%.

The target of an unplanned readmission in WA is less than 2.8% and the results are therefore within target.

Table 5: Unplanned readmission rate for the same or related condition for privately managed public patients

	2004	2005	2006	2007	Target
Unplanned readmission rate	0.6%	0.5%	0.9%	0.6%	<2.8%

Data Source
Department of Health, unpublished.

R1-53: Survival rates for sentinel conditions of privately managed public patients

This indicator reports the survival rates for sentinel conditions of privately managed public patients.

Rationale

The survival rate of patients in hospital can be affected by many factors which include the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital.

Three sentinel conditions: stroke, heart attack and hip fractures are reported, as there is evidence that a good recovery rate is more likely if there is early intervention and appropriate care.

The comparison of 'whole of hospital' survival rates is not appropriate due to differences in mortality associated with different diagnoses.

Results

In 2007 stroke was 85.9%, heart attack 94.6% and hip fractures 98.0%.

The survival rates for stroke and hip fractures in 2007 were above the target range. Heart attack was slightly below target.

The rates of survival for hip fractures and stroke are comparable with the Metropolitan Teaching Hospitals survival rates for these conditions.

Table 6: Survival rates for sentinel conditions of privately managed public patients

Condition	2003	2004	2005	2006	2007	Target
Stroke	83.8%	83.3%	82.9%	80.3%	85.9%	≥83%
Heart attack	92.7%	92.5%	92.9%	91.6%	94.6%	≥95%
Hip fractures	97.5%	85.5%	93.3%	98.2%	98.0%	≥93%

Data Source
Hospital Morbidity Data System.

R1-54: Proportion of people with cancer accessing admitted palliative care services

This indicator reports the rate of patients with cancer who accessed an admitted palliative care program in Western Australia.

Rationale

Palliative care provides for the well being of a patient with terminal illness, working to ensure dignity, peace and comfort for the person over the duration of the illness. During the illness care may be provided in hospital or at home.

Palliative care is concerned with the family and carers of the person with the illness, supporting them in their role in caring for the ill person and also dealing with their grief during the illness and after the bereavement. The service deals directly with quality of life issues.

This indicator reports the rate per 1000 of patients with cancer who access the admitted palliative care program.

Results

The proportion of people with cancer who accessed admitted palliative care services in 2006 is 64.5% and slightly higher than the target.

Table 7: Proportion of people with cancer accessing admitted palliative care services

	2003	2004	2005	2006	2007	Target
Individuals with a palliation episode(s)	2024	2122	2208	2302	2685	
Number of cancer deaths	3318	3341	3432	3570	Not available	
Proportion of patients using palliative care services	61.0%	63.5%	64.3%	64.5%	Not available	64%

Data Sources
WA Cancer Registry – Health Data Collections.
Hospital Morbidity Data System.

Notes
The number of cancer related deaths is a nationally accepted proxy for the need for palliative care.
Around 90% of patients referred to palliative care services have cancer.
Admitted palliative care includes admission for symptom management, respite care and terminal care.

RS1-50: Average cost of public admitted patient treatment episodes in private hospitals

This indicator measures the average cost of public admitted patient treatment episodes in private hospitals.

Rationale

The Western Australian Government has a responsibility to ensure that public patients have access to effective, timely and appropriate treatment. As such, the Government has entered into collaborative arrangements with private sector health service providers in the State to deliver hospital services to the community. These services are provided under private management through arrangements that are similar to those available to patients in public hospitals. Similar to public hospitals, a significant part of the arrangements cover services to admitted patients.

This indicator measures the average cost of public patient treatment episodes in private hospitals.

Results

In 2007-08, the average cost of public admitted patient treatment episodes in private hospitals was $2,485. This exceeds the target due to the additional costs incurred especially in relation to clinically-based services.

Table 8: Average cost of public patient treatment episodes in private hospitals – admitted patients

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$2,563	$2,253	$2,416	$2,120	$2,485	$2,036
CPI adjusted	$2,563	$2,198	$2,291	$1,955	$2,292	

Data Sources
Department of Health, Unpublished.
Hospital Morbidity Data System.

Note 1
The information is reported in this way to preserve the confidentiality of private contracts.

Note 2
The target was set as part of the Government Budget Statements process.

RS1-51: Cost per capita of supporting treatment of patients in public hospitals

This indicator reports the cost per capita of supporting treatment in public hospitals and provides a measure of the Department's efficiency in providing this support.

Rationale

The Western Australian health system provides public hospital services to eligible persons, recognising that the system operates in an environment where eligible persons have the right to choose private health care in public (and private) hospitals supported by private health insurance.

This indicator measures the average cost to support patients in public hospitals. It accounts for the associated costs of infrastructure, resource management, policy, governance, workforce, and information systems provision. It provides a measure of the Department of Health's financial accountability. Comparisons over time showing a lower result may indicate greater technical efficiency in governance and provision of treatment in public hospitals.

Results

The cost per capita of supporting treatment of patients in public hospitals was $72.12 and was over the target of $64.

Actual costs are lower than the previous year, but still over target due to more services being provided than estimated.

Table 9: Cost per capita of supporting treatment of patients in public hospitals

	2006-07	2007-08	Target
Actual cost	$73.36	$72.12	$64.00

Data sources
Oracle Financial System.
ABS population statistics.

Note
The target was set as part of the Government Budget Statements process.

RS3-00: Average cost per Hospital in the Home patient day

This indicator reports the average cost per Hospital in the Home patient day.

Rationale

Hospital in the Home (HITH) and Hospital at the Home (HATH) is a recognised method of providing acute medical care for some patients in their home environment. The medical governance for the patient care remains with the hospital physician and may be a full episode of care or part of an episode of care.

Results

The average cost per Hospital in the Home patient day was $309 and was over the target of $200.

Actual costs were under-estimated as this is indicator has not previously been reported.

Table 10: Average cost per Hospital in the Home patient day

	2007-08	Target
Actual cost	$309	$200

Data sources
Oracle Financial System.
Dept of Health unpublished.

Note
The target was set as part of the Government Budget Statements process.

RS4-50: Average cost per client receiving palliative care services (contracts only)

This indicator measures the average cost per client for admitted palliative care services provided to public patients attending privately contracted admitting facilities. It also includes those receiving community palliative care services under contractual arrangements managed by the Department of Health.

Rationale

Palliative care provides for the wellbeing of a person with terminal illness, working to ensure dignity, peace and comfort for the person over the duration of his/her illness. Palliative care is also concerned with the family and carers of the person with terminal illness, supporting them in the role in caring for the ill person and also dealing with their grief during the illness and after the bereavement.

Palliative care services include home care services, inpatient respite care services, designated inpatient palliative care facilities, community care and support and bereavement care.

This indicator measures the average cost per client for both admitted and community based palliative care services.

Results

In 2007-08 the cost per client receiving palliative care services was $4,946 and is below target.

Table 11: Average cost per client receiving palliative care services (contracts only)

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$3,255	$3,708	$4,275	$4,279	$4,946	$4,700
CPI adjusted	$3,255	$3,618	$4,054	$3,946	$4,402	

Data Sources
Department of Health, Unpublished.
Hospital Morbidity Data System.

Note
The target was set as part of the Government Budget Statements process.

RS6-50: Average cost of public non-admitted patient treatment episodes in private hospitals

This indicator measures the average cost of public non-admitted patient treatment episodes in private hospitals.

Rationale

The Western Australian Government has a responsibility to ensure that public patients have access to effective, timely and appropriate treatment. As such, the Government has entered into collaborative arrangements with private sector health service providers in the State to deliver hospital services to the community. These services are provided under private management through arrangements that are similar to those available to patients in public hospitals. Similar to public hospitals, a significant part of the arrangements cover services to non-admitted patients.

This indicator measures the average cost of public patient non-admitted patient treatment episodes in private hospitals.

Results

In 2007-08, the average cost of public non-admitted patient treatment episodes in private hospitals was $253 and is over target. This indicator includes emergency and other non-admitted patient services.

Table 12: Average cost of public non-admitted patient treatment episodes in private hospitals

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$242	$258	$323	$354	$253	$248
CPI adjusted	$242	$252	$306	$326	$225	

Data Sources
Department of Health, Unpublished.
Hospital Morbidity Data System.

Note 1
The information is reported in this way, to preserve the confidentiality of private contracts.

Note 2
The target was set as part of the Government Budget Statements process.

RS7-50: Response times for St John Ambulance Priority 1 calls

This indicator reports the response times for Priority 1 calls.

Priority 1 calls are those where the ambulance aims to be in attendance within an average of 10 minutes of the call being made.

Rationale

Timely access to appropriate health services can be critical to the outcome of the treatment of acute illness and injury.

To facilitate timely response and transport of patients to the appropriate facilities, the DOH contracts with St John Ambulance Australia – WA Ambulance Service. The St John Ambulance contract requires rapid response to emergencies in the metropolitan area and major regional centres. This ensures the best possible outcome for the patient when there is an acute illness or injury requiring urgent medical treatment.

The most urgent response is required for Priority 1 calls and the ambulance aims to be in attendance within an average of ten minutes of the call being made.

Results

In 2007-08 the average response time was 10 minutes and has met the target.

Table 13: Response times for Priority 1 calls

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Average waiting time (minutes)	9.8	9.9	9.8	9.6	10.0	10.0

Data Source
Department of Health, Unpublished.

RS7-51: Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – WA Ambulance Service agreements

This indicator reports the cost per capita of Department of Health outlays on the Royal Flying Doctor Service Western Operations (RFDSWO) and St John Ambulance Australia (StJAA) – WA Ambulance Service agreements.

Rationale

Rapid and accurate identification of patients who require medical support and the subsequent patient care during inter-hospital transfer or transport to hospital can be critical to the outcome of an illness or accident. The Department of Health has contracts with St John's Ambulance (SJAA) and the Royal Flying Doctor Service Western Operations (RFDSWO) to ensure inter-hospital transfer and emergency retrieval services are available throughout much of the state.

This indicator measures the average cost for transfer by St John's Ambulance or Royal Flying Doctor Service.

Results

The cost per capita of $26.41 is slightly over target.

Table 14: Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia - WA Ambulance Service agreements

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$13.89	$17.35	$18.85	$24.41	$26.41	$26.00
CPI adjusted	$13.89	$16.93	$17.88	$22.51	$23.51	

Data Source
Department of Health, Unpublished.

Note 1
Due to methodology changes in 2006-07, data for previous years cannot be compared.

Note 2
The target was set as part of the Government Budget Statements process.

Outcome 2: Improved health of the people of Western Australia by reducing the incidence of preventable disease, specified injury, disability and premature death

The services or outputs of all parts of the DOH contribute to the above outcome. The achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death.

Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. Dental health services are also reported in this outcome.

Indicators developed to measure performance of the DOH in Outcome 2 link to the areas indicated in the framework table below. While the whole of the DOH activities are directed to the achievements of the outcomes listed in the above outcome statement, these health outcomes are influenced also by socioeconomic, lifestyle and personal choice factors.

Table 15: Key Performance Indicators for Outcome 2 by reporting entity

Outcome 2	Department of Health	Metropolitan Health Service	WA Country Health Service
Prevention of illness and the promotion of good health	R2-50	2-00 2-01 2-02	2-01 2-02
Protection against diseases	R2-51 R2-52		R2-51 R2-52
Dental health services	R2-53	2-03 2-04 2-05 2-06	

R2-50: Loss of life from premature death due to identifiable causes of preventable diseases or injury

This indicator reports the loss of life from premature death due to identifiable causes of preventable diseases or injury.

Rationale

Cancer, heart disease, mental health and injury represent five of the seven National Health Priority areas. As premature death from these causes contributes significantly to the total years of life lost from all deaths that occurred prior to the age of 74, it is evident that these conditions should be targeted. This indicator covers Health Promotion Programs that address suicide, falls, heart disease, melanoma, and lung cancer.

Person Years of Life Lost (PYLL) are used to reflect the impact of premature deaths. Deaths occurring in WA and Australia over the period 1997 to 2006 from any of the five major categories are used to indicate the impact of the preventative programs. PYLL should be lower if the programs are successfully meeting needs.

Results

Lung cancer, heart disease and suicide have decreased over the ten year period. Falls and melanoma have stayed constant over the same period.

Table 16: Person years of life lost from selected preventable diseases and injury WA 1997-2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Target
Lung cancer	3.2	3.4	3.5	3.3	3.2	3.3	3.3	2.9	2.9	2.8	**3.1**
Ischaemic Heart Disease	7.0	6.9	6.4	5.7	6.1	5.6	4.6	4.8	4.7	4.3	**5.4**
Suicide	5.4	6.2	5.1	5.5	5.4	5.1	4.3	3.5	4.0	3.3	**3.8**
Falls	0.3	0.3	0.4	0.3	0.4	0.3	0.2	0.3	0.3	0.3	**0.3**
Melanoma	0.8	0.7	0.7	0.6	0.7	0.7	0.8	1.0	1.0	0.8	**0.8**

Notes

a. Age- standardised PYLLs up to 74 years of age per 1,000 population.

b. The following ICD-10 and 9-CM codes were used to select deaths for conditions known to be largely preventable.

ICD-9CM	ICD 10	
Lung cancer	162.0 to 162.9	C33.0 to C34.9
Ischaemic Heart Disease	410.0 to 414.9	I20.0 to I25.9
Suicide	Ecode 950.0 to 959.9	X60.0 to X84.9
Melanoma	172.0 to 172.9	C43.0 to C43.9

c. Although not all cases of these conditions will be avoidable, it is very difficult to assess what proportion was avoidable without extensive meta-analysis of the literature. The conditions identified above are those for which the Department of Health has screening or health promotion programs; premature deaths from these should be largely preventable. Although the Department of Health has programs specifically targeted at reducing the impact of these diseases and injuries, not all of the reduction in PYLL can be attributed to these programs, as other influences outside of the Department's jurisdiction may be responsible for part of it.

b. Additional deaths registered in years following the year of occurrence may result in slight changes in some data shown in this report compared with previous years. Due to some cases still being before the Coroner's office, some deaths occurring in 2006 were not registered by the Australian Bureau of Statistics until 2006 and were not included in this analysis. The preliminary nature of the 2006 death data is likely to affect the calculation of PYLLs for conditions, which contribute to the greatest proportion of deaths. Non-WA residents who died in WA were included. PYLL calculations were based on three year moving averages.

e. Person Years of Life Lost have been recalculated for all years as the method of calculation has been improved. The new method has resulted in higher PYLL values, but the relative trends over time have remained the same as found by the previous method.

Data Source

Mortality Database, Epidemiology Branch, Department of Health, Western Australia.

R2-51: Percentage of fully immunised children

This indicator reports the percentage of fully immunised children.

Rationale

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential. One of the key components of this is to attempt to ensure that every child experiences the full benefit provided by appropriate and timely immunisation against disease. This is provided by adopting internationally recognised vaccination practices.

Without access to immunisation the consequences for children of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

This indicator measures the rate of complete immunisation against particular diseases, by age group, of the resident child population in the catchment area for the Health Service within the reporting entity by postcode.

Targets

The agreed targets in the National Childhood Immunisation Program are as follows:

At least 90% of children fully immunised at 12 months of age.

At least 90% of children fully immunised at 2 years of age.

At least 90% of children fully immunised at 5 years of age.

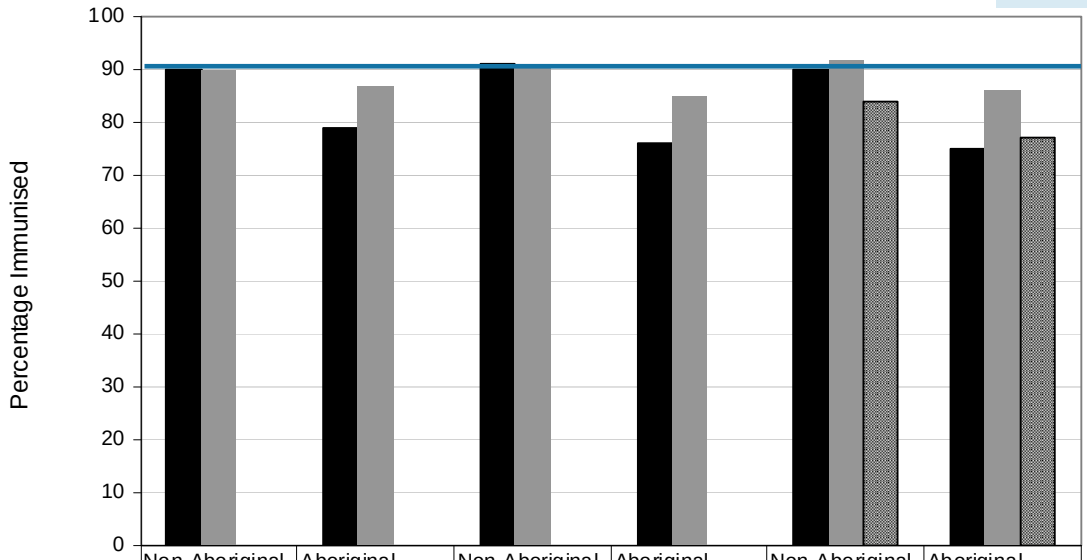
Results

The target was reached for the non-Aboriginal population at 12 months and 2 years but was under for the 5 year age group.

The coverage of all age groups for the Aboriginal population was lower than for the non-Aboriginal population.

Figure 4: Percentage of fully immunised children at 12 and 24 months

Target
90%



	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal
	2005 (Dec Quarter)		2006 (Dec Quarter)		2007 (Dec Quarter)	
12-15 months	90	79	91	76	90	75
24-27 months	90	87	91	85	92	86
60-63 months					84	77

Data Sources
Australian Childhood Immunisation Register
Australian Bureau of Statistics population figures.
Note
60-63 months is a new age group as per the National Childhood Immunisation Program.

R2-52: Rate of hospitalisations with an infectious disease for which there is an immunisation program

This indicator reports the rate of hospitalisations with an infectious disease for which there is an immunisation program.

Rationale

To provide additional information about the effect of the immunisation program, the rates of hospitalisation for treatment of the infectious diseases measles, mumps, diphtheria, pertussis, poliomyelitis, rubella, hepatitis B and tetanus are reported.

Targets

There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results

In 2007, there were 4 hospitalisations for whooping cough. Two of these admissions were non-Aboriginal children and two Aboriginal.

There was one admission of a non-Aboriginal child with hepatitis B and one admission of an Aboriginal child with mumps.

The low or absent numbers of these vaccine-preventable diseases indicates that the vaccination and immunisation schedules are effective.

Table 17: Rate of hospitalisations per 100,000 with an infectious disease for which there is an immunisation program – 0-12 years

	2006		2007	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.30	0.00
Whooping cough	3.12	4.56	0.61	9.31
Poliomyelitis	0.00	0.00	0.00	0.00
Tetanus	0.00	0.00	0.00	0.00

Table 18: Rate of hospitalisations per 100,000 with an infectious disease for which there is an immunisation program – 0-17 years

	2006		2007	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Measles	0.44	0.00	0.00	0.00
Mumps	0.00	0.00	0.00	3.30
Rubella	0.00	0.00	0.00	0.00

Data Sources
Hospital Morbidity Data System.
Australian Bureau of Statistics population figures.

R2-53: Eligible patients on the oral waiting list who have received treatment during the year

This indicator reports the number of eligible patients on the oral waiting list who have been offered treatment during the year.

Rationale

Within a contract agreement with the DOH, the Oral Health Centre of Western Australia (OHCWA) provides specialist oral health care to those eligible for state government subsidised dental care (Health Care Card holders) and general dental care to eligible patients within their local catchment area. Waiting times to access these services and the proportion of those who are removed from waiting lists during the year are an indication of service access.

Dental services provided by Dental Health Services and School Dental Services are reported in the Metropolitan Health Services Annual Report.

Results

The number of patients on the oral waiting list as at the end of June 2008 was 1726. The numbers on the dental waiting list decreased from the previous year. In 2007 the specialist initiative was extended for orthodontics screening program to other specialist disciplines. During 2007-08 there was a slight increase in the number of students in the UWA dental school. Overall, the number of eligible patients receiving treatment was 8997, 701 more than 2006-07.

The target for treatment was met or exceeded in the specialities of Paedodonics, Periodontics, General Practice and 'other' areas and was slightly under for Oral Surgery and Orthodontics.

Table 19: Number of eligible patients from the OHCWA waiting list who were offered treatment during 2007-08.

Dental speciality	Number of patients on waiting list as 30th June					Eligible patients offered treatment					
	2004	2005	2006	2007	2008	2003-04	2004-05	2005-06	2006-07	2007-08	Target
General practice	233	581	163	30	248	1772	716	960	1,010	865	716
Oral surgery	1,041	892	843	854	407	2,618	2,707	2,405	2,400	2395	2,405
Orthodontics	2,899	3,503	1,314	906	735	497	1959	5,216**	3,287	2877	3,200
Paedodontics	208	194	174	177	61	661	1168	755	543	846	755
Periodontics	748	648	328	407	63	350	797	941	469	874	797
Other*	413	804	729	581	212	537	767	423	855	1140	423
Total	5,542	6,622	3,551	2,955	1726	6,435	8,114	10,700	8,564	8997	8,296

* Other includes specialities of Endodontics, Oral Pathology, Restorative Care and Temporomandibular Joint.
** Significant reduction in waitlist and increase in patients treated as a result of Orthodontic waitlist initiative.

Data Source
Oral Health Centre of WA database.

RS8-50: Cost per capita of providing preventive interventions and health promotion activities

This indicator measures the cost per capita of providing preventive interventions and health promotion activities.

Rationale

Preventive interventions within the Department of Health focus on groups rather than individuals. The interventions aim to eliminate or reduce modifiable risk factors associated with biomedical, genetic, or environmental health determinants to prevent disease before it develops. Such services and activities include, but are not limited to, the screening of targeted populations predisposed to certain conditions, and health education programs.

Health promotion is the process of enabling individuals to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases. Such measures encourage lifestyle and behavioural choices, attitudes and beliefs that protect and promote health and reduce disease and premature death. Services and activities include health priority programs for indigenous people, programs to increase awareness of good nutrition and physical exercise and injury prevention programs.

This indicator measures the cost of preventive measures and health promotion activities that reduce the incidence of disease, disability or injury. Over time a lower figure may indicate well-structured public health interventions which operate with technical efficiency.

Results

The cost per capita of providing preventive interventions and health promotion activities for 2007-08 was $23.81 per West Australian. This was over the target due to greater resource availability to fund programs.

Table 20: Cost per capita of providing preventive interventions and health promotion activities

	2006-07	2007-08	Target
Actual cost	$19.79	$23.81	$21.00

Data Sources
Department of Health, Unpublished.
Australian Bureau of Statistics population figures.

Note
The target was set as part of the Government Budget Statements process.

RS9-50: Cost per capita of health protection services

This indicator reports the cost per capita of providing health protection services.

Rationale

The role Health Protection Group within the Department of Health is to protect the health of the WA community through promoting health, preparing against external threats, and preventing harm and reducing risks to health from hazards such as infectious agents and chemicals.

It is also responsible for coordination and delivery of a wide range of statewide public health policy and programs such as food safety, vector control, waste water management, immunisation, infectious disease surveillance, infectious disease outbreak investigation, sexual health and disaster management.

This indicator reports the cost per capita of providing all the programs that deliver health protection services in Western Australia.

Results

Cost per capita of health protection services are over target due to the increased cervical cancer vaccination program for age groups 14 to 26 years.

Table 21: Cost per capita of providing health protection services

	2006-07	2007-08	Target
Actual cost	$31.29	$48.56	$27.00

Data Sources
Australian Bureau of Statistics population figures.
Department of Health, Unpublished.

Note
The target was set as part of the Government Budget Statements process.

RS10-50: Average cost per dental service provided by OHCWA and CRROH

This indicator measures the average cost per dental service provided by the Oral Health Centre Western Australia (OHCWA) and the Centre for Rural and Remote Oral Health (CRROH). (Both are strategic partnerships between The University of Western Australia and the State Government).

Rationale

Dental treatment is provided to those eligible for care by the Oral Health Centre Western Australia (OHCWA). OHCWA forms a strategic partnership between The University of Western Australia and the State Government.

OHCWA's main responsibilities are to train dentists to a standard that meets community expectations, and to provide general and specialist dental services to eligible members of the Western Australian community.

CRROH aims to facilitate the development and effective delivery of oral health in rural and remote Aboriginal communities. It provides a network of support for remote oral health workers, promotes oral health, supports remote oral health workers, facilitates ongoing oral health research into issues of importance to rural and remote communities and provides support for the ongoing development of best practice principles for the provision of remote oral health care.

Results

Average cost per dental treatment is $119.34 and slightly above target. Average cost per dental service is $91.67 and over target due to the Esperance Clinic figures not included this year. Esperance Clinic is now being funded through the Esperance Hospital.

Table 22: Average cost per dental treatment item – OHCWA

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$83.17	$96.93	$93.80	$106.29	$119.34	$110.00
CPI adjusted	$83.17	$94.58	$88.96	$98.01	$106.23	

Data Sources
Department of Health, Unpublished.
OHCWA Database.

Table 23: Average cost per dental service provided by CRROH

	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$54.03	$65.24	$66.42	$91.67	$66.00
CPI adjusted	$52.72	$61.87	$61.25	$81.60	

Data Source
Department of Health, Unpublished.

Outcome 3: Enhanced wellbeing and environment of those with chronic illness or disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness or disability.

To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided in clients' homes to enable normal patterns of living that are valued in the general community.

Sometimes services are provided in residential facilities when the care needs of the clients exceed what can be provided in a normal home environment.

Indicators developed to measure performance of the DOH in Outcome 3 link to the areas indicated in the framework table below.

Table 24: Key Performance Indicators for Outcome 3 by reporting entity

Outcome 3	Department of Health	Metropolitan Health Service	WA Country Health Service
Home and community care services	R3-50 R3-51		
Community mental health services	R3-52	3-00	3-00
Residential care			3-20

R3-50: Rate per 1,000 HACC target population who receive HACC services

This indicator measures the rate per Home and Community Care (HACC) target population who received HACC services.

Rationale

The Home and Community Care (HACC) program is a key provider of community care services to frail aged and younger people with disabilities and their carers.

The HACC program is a joint Commonwealth State and Territory initiative under the auspices of the Home and Community Care Act 1985. It provides services to support people who live at home whose capacity for independent living is at risk.

The services provided through the HACC Program are described in the HACC Minimum Data Set V1.6 and include domestic assistance, social support, nursing and allied health professional care, personal care, prepared meals, linen services, transport and respite care.

The support services provided by HACC prevent inappropriate or premature admission to long-term residential care. It is generally accepted that most people value independence and prefer to live in their own homes for as long as they are able to manage the tasks of daily living.

Without support services the quality of life of those who are frail or disabled may not be sustained and carers may feel the only option left is permanent care in a residential aged care facility.

The program's aims are to:

- Provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with disability and their carers.
- Support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long-term residential care.
- Provide flexible, timely services that respond to the needs of consumers.

Results

The 2007-08 estimated rate (per 1000 HACC target population) of 347 was less than the target rate of 376 and similar to the rate in previous years. This indicates that although client numbers have increased, they have only increased at the same rate as the overall target population increase.

Table 25: Rate per 1,000 HACC target population who receive HACC services

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Rate per 1,000 HACC target population	332	349	355	349	347	376

Data Sources
HACC Minimum Data Set Database.
Target Population by Age and Sex in Survey of Disability, Ageing and Carers Australia 2003 (Cat No 4430).

Note
Benchmark information has been provided in previous years comparing average hours of HACC services in WA with the whole of Australia. This information, sourced from HACC Minimum Data Set Annual Bulletins produced by the Australian Government Department of Health and Ageing, is not yet available for the relevant year.

R3-51: Specific HACC program client satisfaction survey

This indicator reports on a survey conducted by the largest non-government provider of the full range of HACC services in Western Australia.

Rationale

The Home and Community Care (HACC) Program is a key provider of community care services to frail aged and younger people with disabilities and their carers. HACC provides services that provide support people who live at home whose capacity for independent living is at risk.

The support services prevent inappropriate or premature admission to long-term residential care. It is generally accepted that most people value independence and prefer to live in their own homes for as long as they are able to manage the tasks of daily living. Without support services the quality of life of those who are frail or disabled may not be sustained and carers may feel the only option left is permanent care in a residential aged care facility.

It is important to ensure that people receiving the services are satisfied with the care provided and they feel the quality of their life has been improved by the care they receive.

Client Survey

The survey was designed to provide feedback to Silver Chain and the Department of Health as to how satisfied clients are with the HACC services they receive.

Response rate	49.0%
Population size	9,042 clients
Sample size	1,510 clients
Selection of sample	Silver Chain identified a random sample of clients through their Client Management System.

Sampling error rate ± 1.95% for the 95% confidence level.

Results

Surveys were completed and returned by 740 clients. The responses indicated that:

- 93.8% of clients agreed that the service helped them to be independent. While this percentage is slightly under the target of 95% it remains a significant and positive result.
- 95.4% of clients agreed the service improves their quality of life. This exceeded the target.

This service has allowed the clients who were surveyed to remain in their own home or their carer's home and improved their quality of life through increased functional independence.

Table 26: HACC program survey results

Survey question	Agree	Target
The program helps you to be more independent	93.8%	95.0%
The program improves your quality of life	95.4%	90.0%

Data Source
Silver Chain Nursing Association – November 2007 survey.

R3-52: Proportion of people with a severe and persistent psychiatric illness receiving non-clinical community support from non-government organisations

This indicator measures the proportion of people with a mental illness receiving non-clinical community-based support from non-government organisations.

Rationale

The aim of community based non-clinical support programs, delivered by non-government organisations, is to support people with mental illness to develop/maintain skills required for daily living, social interaction and to increase their participation in community life and activities; assist in improving personal coping skills to allow people with mental illness to remain independent and enhance their quality of life; and, aim to decrease the burden of care for carers.

These services are provided primarily in the consumer's home or in the local community. The range of services provided is dependent on the needs and goals of the individual.

The target group for non clinical, non government, community support programs is primarily adults living in the State who have been diagnosed with a mental illness and discharged from a public hospital during the last five years.

Results

The proportion of people with a mental illness receiving non-clinical community-based support from non-government organisations was 45.8% in 2007-08. This result is much lower than the set target as the target group has been expanded to be more inclusive.

As well as non-clinical community-based support provided by non-government organisations, people with a mental illness also have access to clinical support services provided by public mental health services, general practitioners, private psychiatrists and psychologists.

Table 27: Proportion of people with a severe and persistent psychiatric illness receiving non-clinical community support from non-government organisations

	2005-06	2006-07	2007-08	Target
Proportion of people with a severe and persistent psychiatric illness receiving non-clinical community support from non-government organisations	58.9%	65.4%	45.8%	65%

Data Sources
Non Government Mental Health service activity reports.
Mental Health Information System, Information Collection and Management, Department of Health.

RS11-50: Average cost per person of HACC services delivered to people with long-term disability

This indicator reports the average cost of HACC services per person with long-term disability.

Rationale

Home and Community Care (HACC) provides funding for services that support people who live at home and whose capacity for independent living is at risk of premature or inappropriate admission to long-term residential care. The HACC Program is a key provider of community care services to frail aged people and younger people with disabilities and their carers.

The service types provided through the HACC Program are described in the HACC Minimum Data Set V1.6 and include domestic assistance, social support, nursing and allied health professional care, personal care, prepared meals, linen services, transport and respite care.

The performance indicator provides an indication of the average cost per person with long-term disability living in the community who receives services under the HACC Program.

Results

The cost per HACC client of $2,354 was higher than the target.

The observed increased in average cost per person is likely to reflect several factors. One possibility is that the general desire of elderly people to stay at home longer together with government policies that support this option, are resulting in higher client dependency levels in community care programs such as HACC.

Table 28: Average cost of HACC services per person with long term disability

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$1,967	$1,900	$2,000	$2,176	$2,354	$2,171
CPI adjusted	$1,967	$1,854	$1,897	$2,007	$2,095	

Data Sources
HACC Minimum Data Set Database.
HACC Program Plan Documents.

Note 1
Clients of the HACC program have the right to 'opt out' of being included in the Minimum Data Set collection. The figures used here therefore relate only to those clients who agree to be part of the reporting process.

The financial figures include the total allocation of HACC funding. This consists of funding to both community based, non-government and local government organisations and funding allocated to the Department of Health, WA Country Health Service.

Note 2
The target was set as part of the Government Budget Statements process.

RS12-01: Average cost per care awaiting placement (CAP) day

This indicator reports the average cost per CAP day.

Rationale

Some people with chronic illness or disability, who are not able to be cared for at home, even with regular respite care and HACC service, may need long term residential care to ensure that their quality of life is maintained. In some instances there may be a period of waiting before long-term residential care becomes available.

A number of transition care options for the elderly are available in WA. These include:

- Residential Care Awaiting Placement (CAP)
- Home Care Packages (HCP) (formerly Home Care Packages and Elderly Post Acute Services)
- Transitional Care Program (TPC)

The CAP program aims to facilitate the timely transfer of older patients who are approved for permanent residential care from the public acute care sector to an environment that is more appropriate for the provision of aged care services. HCP provides older patients therapy or non-therapy based services and post acute treatment services usually brokered through the health service to assist their transition from hospital to home. The TCP services provide time limited low-level post acute rehabilitation options to older people.

This indicator measures the cost per care-day of TCP places for Department of Health only. Please refer to the Metropolitan Health Service annual report for the other services.

Results

In 2007-08 the average cost per TPC day was $192 and under target. Actual costs were under-estimated as TCP funding was included in KPI RS14-50 in previous years.

Table 29: Average cost per TPC day

	2007-08	Target
Actual cost	$192	$254
CPI adjusted	$171	

Data Source
Health Service Activity Systems.
Area Health Service Financial Systems.

RS13-50: Average cost per hour for community support provided by non-government organisations to people with a severe and persistent psychiatric disability

This indicator reports the average cost per hour for community support provided by non-government organisations to people with a severe and persistent psychiatric disability.

Rationale

The aim of community based non-clinical support programs is to support consumers to develop skills and abilities to maximise their capacity to live in the community. These programs support clients to develop/maintain skills required for daily living (budgeting, using public transport, personal care, cooking, cleaning and shopping) improve personal and social interaction, and increase participation in community life and activities. They also aim to decrease the burden of care for carers.

These services primarily are provided in the consumer's home or in the local community. The range of services provided is dependent on the needs and goals of the individual. The target group for community support programs is primarily adults who have a mental disability.

Results

The average cost per hour to provide community support to an individual with a mental illness was $57.92 per person. This result is lower than the set target as more hours of service were provided than was estimated.

Table 30: Average cost per hour for community support provided by non-government organisations to people with a severe and persistent psychiatric disability

	2005-06	2006-07	2007-08	Target
Actual cost	$57.72	$62.47	$57.92	$62.00
CPI adjusted	$54.74	$57.61	$51.56	

Data Source
Mental Health Division, Department of Health.

Note
The target was set as part of the Government Budget Statements process.

RS14-50: Average cost per day of care for non-acute admitted continuing care

This indicator reports the average cost per day of care for non-acute admitted continuing care.

Rationale

Continuing care is defined as the range of care services provided by those facilities that are required to assist a person to maintain, where possible, their functional ability and independence and enhance their quality of life.

Non-acute care facilities in the non-government sector 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. These services are considered to form a part of the range of continuing care services for the frail aged and younger disabled.

In some facilities, specialist rehabilitation and restorative care services are provided to increase the level of functional ability associated with the tasks of daily living and enhance the quality of life for the person.

Results

The average cost per day of care for non-acute admitted continuing care in 2007-08 was $91.31 and above target due to the transitional care program being allocated to RS12-01.

Table 31: Average cost per day of care for non-acute admitted continuing care

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$39.61	$33.09	$34.61	$37.29	$91.31	$41.00
CPI adjusted	$39.61	$32.29	$32.82	$34.39	$81.28	

Data Source
Department of Health, Unpublished.

Note
The target was set as part of the Government Budget Statements process.

RS15-50: Average Department of Health subsidy per bedday provided to support people with psychiatric illness living in community residential accommodation provided by non-government organisations

This indicator reports the cost per bedday to support people with psychiatric illness living in community residential accommodation.

Rationale

Non-government services provide accommodation in staffed residential units that have been established in community settings for people affected by mental illness.

The target group for this type of accommodation is primarily adults who have a mental illness.

Results

In 2007-08 the bedday cost was $148. This result is higher than the target set due to actual costs being higher than the estimated costs.

Table 32: Average Department of Health subsidy per bedday provided to support people with psychiatric illness living in community residential accommodation provided by non-government organisations

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$109	$115	$121	$99	$148	$94
CPI adjusted	$109	$112	$114	$91	$132	

Data Source
Mental Health Division, Department of Health.

Note
The target was set as part of the Government Budget Statements process.

RS15-51: Average Department of Health subsidy per bedday to support residents in metropolitan licensed private psychiatric hostels

This indicator reports the average Department of Health subsidy per bedday to support residents in metropolitan licensed private psychiatric hostels

Rationale

Licensed psychiatric hostels provide personal care support services to residential clients with mental health problems to assist them to develop and maintain their current skills, autonomy and self-management in the area of personal care in order to improve their overall quality of life.

Without subsidised care in licensed psychiatric hostels many people with chronic mental illness would not be able to live relatively independent lives in a supported environment and the quality of life for these people would be diminished.

Results

The actual cost per subsidised bedday for eligible residents in metropolitan licensed private psychiatric hostels for 2007-08 was $18.90. This result is higher than the set target.

Additional funding was provided in 2004-05 from the Mental Health Strategy 2004-2007 to metropolitan private licensed psychiatric hostels to improve the quality of personal care services provided to residents with a mental illness. This additional funding continued in 2007-08.

Table 33: Average Department of Health subsidy per bedday to support residents in metropolitan licensed private psychiatric hostels

	2003-04	2004-05*	2005-06*	2006-07*	2007-08*	Target
Actual cost	$10.04	$14.41	$15.04	$16.52	$18.90	$17.00
CPI adjusted	$10.04	$14.06	$14.27	$15.24	$16.82	

* Includes additional funding provided through the Mental Health Strategy 2004-2007.

Data Sources
Mental Health Division, Department of Health.
Mental Health Information System, Information Collection and Management, Department of Health.

Note
The target was set as part of the Government Budget Statements process.

RS15-52: Average Department of Health subsidy per bedday provided to aged care nursing homes to manage people who have a psychiatric illness and significant behavioural problems

This indicator reports the average Department of Health subsidy per bedday provided to aged care nursing homes to manage people who have a psychiatric illness and significant behavioural problems.

Rationale

Some aged care nursing homes provide accommodation to people who have a psychiatric illness and significant behavioural problems. The average subsidy per bed day provides a basis on which to monitor the overall funding process.

The target group for this type of accommodation is primarily older persons who have a mental illness with complex mental health and other health needs including significant behavioural problems, who cannot live independently or be cared for and managed in the community or other aged care facilities without a subsidy.

Results

The cost per bedday to support people living in aged care nursing homes in 2007-08 was $126. This result is much lower than the set target due to costs being more adequately allocated across service types.

Table 34: Average Department of Health subsidy per bedday provided to aged care nursing homes to manage people who have a psychiatric illness and significant behavioural problems

	2003-04	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$147	$154	$175	$191	$126	$209
CPI adjusted	$147	$150	$166	$176	$112	

Data Source
Mental Health Division, Department of Health.

Note
The target was set as part of the Government Budget Statements process.

RS16-50: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care

This indicator reports the average cost to support patients who suffer specific chronic illness and other clients who require continuing care.

Rationale

Chronic diseases contribute significantly to the burden of disease in Western Australia. Chronic conditions which have been identified by the Government as requiring special health services include motor neurone disease, multiple sclerosis, cystic fibrosis, Huntington's disease, stroke, arthritis, cancer, chronic renal failure, asthma and diabetes. Special assistance is given to clients with these illnesses as chronic illness can affect their general well-being and quality of life.

In addition to those with chronic illness there are those who have a permanent disability or may require mental health services. The care and support services provided include some residential care, community care, respite care and assessment services and are provided by non-government organisations that are contracted to provide the services.

This indicator considers the means by which care of the chronically ill are directed and controlled, accounting for the cost of infrastructure, resource management, policy, governance, workforce and information systems provision. A lower result indicates greater technical efficiency in governing and sustaining activities to ensure those with chronic illness or long term disability are appropriately supported. This indicator accounts for the cost of client care from under a variety of different providers. The services reported in this indicator are not as easily defined as other indicators in Output 3.

Results

In 2007-08, the average cost to support patients who suffer specific chronic illness and other clients who require continuing care was $44.56 per patient. This exceeds the target due to the additional costs incurred especially in relation to clinically-based services.

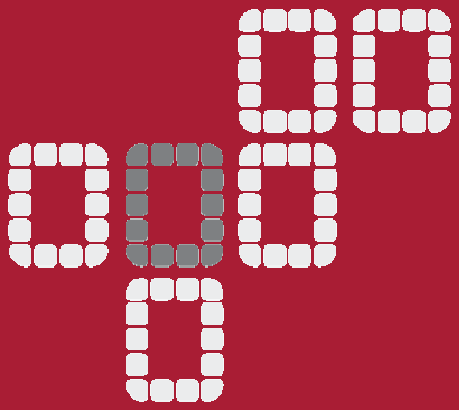
Table 35: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care

	2004-05	2004-05	2005-06	2006-07	2007-08	Target
Actual cost	$19.92	$18.58	$36.60	$39.54	$44.58	$37.00
CPI adjusted	$19.92	$18.13	$34.73	$36.46	$39.68	

Data Sources
Oracle Financial System, Department of Health WA.
Australian Bureau of Statistics 2003 Survey of Disability, Ageing and Carers (Cat. No. 4430.0)
Australian Bureau of Statistics population figures.

Note
Statewide overhead costs have been apportioned to this key performance indicator from 2005-06.

The target was set as part of the Government Budget Statements process.



Significant Issues and Trends

Overview

Progress on the health reform plan and policies for the WA health system implemented by the Government of Western Australia has continued during 2007-08. This reform work continues to be a balancing act against the challenge of providing for the increasing demands on hospitals and other health services.

New federal partnership

The newly elected Federal Government has identified health reform as a key priority area and has committed to a number of health reform initiatives from its 2007 election platform. A key aim for Western Australia is to ensure maximum integration between State and National health reform agendas. Particular areas of interest for Western Australia include improved cooperative arrangements in the areas of emergency demand management, ambulatory care, elective surgery and improving the interface between public hospitals and aged care. This commitment to improving health outcomes for all Australians and health service delivery is reflected in the architecture of the national reform agenda emphasizing the collaborative approach through the Council of Australian Governments (COAG) and the establishment of the National Health and Hospitals Reform Commission (NHHRC) which has been tasked with developing a long-term health reform plan for Australia by mid-2009.

The current Australian Health Care Agreement (AHCA) for the funding of public hospitals expires on 30 June 2008 and a new health care agreement is to be signed in December 2008, with a commencement date of 1 July 2009. The existing AHCA will continue until the new agreement is in place. However the Commonwealth Government has committed an immediate one-off injection of $500 million nationally for expenditure in 2008-09 with WA's share being approximately $45 million.

The Commonwealth Government has also announced a number of other health related election commitments which have benefited WA Health:

- an elective surgery 'blitz' targeting patients who are waiting longer than the clinically recommended guidelines with WA receiving an allocation of $15.4 million to deliver an additional 2,720 elective surgery cases in 2008;
- the establishment of General Practitioner (GP) Super Clinics as a key element in building a stronger primary care system, including a greater focus on health promotion and illness prevention with better coordination between GP services, community health and services provided by the State Government. Two GP Super Clinics have been announced in Western Australia at Midland and Wanneroo, with a funding commitment from the Commonwealth Government;
- a Commonwealth Dental Health Program to assist State and Territory Governments to reduce waiting lists for public dental services;
- incentives to increase the nursing and midwifery workforce by encouraging nurses and midwives who have not been employed for at least 12 months to return to the workforce;
- funding for additional transitional care places for older Australians waiting in hospital for a residential aged care bed;
- a program to provide zero interest loans to aged care service providers to enable up to an additional 2,500 permanent places to be created; and
- establishment of a Preventative Health Care Taskforce.

Aboriginal health

The new Federal Government has also emphasised the priority it is giving to resolving the disparity in health status between Aboriginal and non-Aboriginal populations and has instigated high level strategic health care planning and service delivery with the states to progress the improvement in the health status of indigenous people. During 2007-08 the Office of Aboriginal Health has continued its work to develop close partnerships with area health services, other government agencies and non-government organisations to progress this health outcome.

Major Achievements 2007-08

Healthy workforce

The Department of Health is committed to providing and promoting a healthy working environment, providing opportunities for personal and professional development, ensuring a high standard of knowledge and skill and implementing workforce planning tools to address workforce requirements to meet the needs of a diverse population.

Workforce

The Community Residency Program commenced in 2007 as a pilot program to extend Post Graduate Year 1 (PGY1) and Post Graduate Year 2 (PGY2) rotations into community settings. The program is managed by WA General Practice Education and Training and funded by WA Health. Following a successful evaluation, the program has been fully implemented in 2008. Planning has commenced for the implementation phase at 10 community residency sites across the State providing approximately 50 PGY2 rotations for 2009.

The Expanded Specialist Training Program is a Council of Australian Governments initiative to allow medical specialist trainees to undertake a rotation beyond the traditional teaching hospital setting. Twenty-three positions have been created to date, 16 of which have been funded for 2008.

WA Health has been promoted as a workplace of choice via a marketing and promotional presence within the United Kingdom. In 2007-08 approximately 200 FTE have been attracted by this campaign.

Aboriginal health

The Office of Aboriginal Health and Workforce Education and Training published the WA Health Aboriginal and Torres Strait Islander (ATSI) Employment Framework and Business Plan. The document provides objectives for attraction and retention, workforce skill development, workforce culture and environment, workforce design and workforce planning and evaluation. The Reconciliation Action Plan (RAP) was also finalised. Initiatives in the RAP are directly linked to the Employment Framework and Business Plan with a focus on three major areas (relationships, respect and opportunities).

Other workforce achievements include the development of pathways into the health workforce for ATSI people:

- an ATSI Primary Health Care vocational education and training (VET) in Schools Program;
- a PathWest Laboratory Technician traineeship for Aboriginal job seekers;
- a Diploma of Nursing program (in conjunction with Marr Mooditj);
- a Cultural Maintenance component of the Department of Health orientation training package;
- a national Scope of Practice model for Aboriginal Health Workers; and
- the incorporation of the national Aboriginal Health Worker Association.

Mental health

Twenty-nine mental health nurses have been appointed as a result of the nursing recruitment drive held in April 2008.

Obstetrics

Medical and nursing directors for the state-wide Obstetric Support Unit have been recruited.

Aged care

The Aged Care Assessment Team (ACAT) quality framework, which identifies and promotes good practice, has been completed and provided to the aged care assessment teams.

In 2007-08 the ACAT Quality and Training Reference Group was formed to implement Western Australian training and quality frameworks. The group met on a quarterly basis to develop and plan the implementation of training. Nine training sessions covering the key clinical, operational and policy requirements of aged care assessment have been completed.

The ACAT Managers Group was developed and met twice in 2007-08 to provide a forum for the development, promotion and implementation of operational management initiatives, particularly in relation to timeliness, quality and consistency of assessments.

Healthy workforce (continued)

Health protection

The Disaster Preparedness and Management Unit (DPMU) have amalgamated the various disaster education courses into a single suite with standardised training aims, objectives and delivery methods.

In 2007-08 the DPMU coordinated the delivery of 34 disaster training courses, as well as providing workshops for general practitioners and health support staff, in organisations such as HealthDirect and Silver Chain.

The DPMU also developed and presented a legislative training program to Western Australian Police and to Drug and Alcohol Coordination officers.

Chief Psychiatrist

The Chief Psychiatrist and staff of the Office of the Chief Psychiatrist (OCP) provided education and training sessions for mental health clinicians, students and other government and non-government agencies. These sessions related to activities of the OCP and the *Mental Health Act 1996*. By conducting education sessions the OCP ensures that clinicians and others are informed and educated about lawful procedures and best practice. Over this period there were 53 education sessions on the Act to more than 800 people.

Two Authorised Mental Health Practitioner three-day training courses were conducted which enable these practitioners to be registered to undertake particular duties under the Act.

In the first half of the year there were 12 education sessions to mental health services in relation to the Chief Psychiatrist's Clinical Governance Review Program. This includes three 2-day training sessions for Clinical Governance Reviewers, seconded from the health services and Consumer and Carer groups.

Towards the end of 2007 the self-assessment pilot project in relation to the monitoring of the Service Standards for Non Government Providers of Community Mental Health Services commenced. Thirteen education sessions were provided in relation to the Chief Psychiatrist's new Non Government standards monitoring program.

Safety and quality

The Office of Safety and Quality in Healthcare provided education and training to health care workers to support the provision of safe, high-quality health care to the WA community. In 2007-08 the following has been achieved:

- provided training programs for the health workforce in patient safety, clinical investigation and root cause analysis techniques;
- held the 4th Annual Incident Management and Reporting Seminar in May 2008;
- supported the WA Medication Safety Symposium to raise awareness of the need for medication safety and for clinicians to share successful strategies for reducing medication error;
- trained Area Health Service staff in change management and quality improvement methodologies to support the implementation of eight Clinical Practice Improvements under the SQuIRE program; and
- implementation and evaluation of a Policy for Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners.

Corporate governance

The Corporate Governance Directorate has been implementing a range of professional standards strategies. This approach includes:

- ongoing development of a misconduct resistance framework;
- improved integrated risk management strategies;
- a centralised misconduct complaints process; and
- provision of ongoing education to all staff relating to accountability requirements within the public sector.

Corporate Governance Directorate is also responsible for Freedom of Information for the Department of Health, together with undertaking all criminal records screening for new employees.

Chief Nurse

The Office of the Chief Nurse has implemented a number of initiatives to attract, retain and recruit nurses including:

- Since 2003, WA Health has recruited graduate nurses using a centralised application system called 'Graduate Nurse Connect'. In 2007 for the 2008 recruitment year WA Health recruited 586 graduate registered nurses into graduate transition programs across the WA public health sector. This is an increase of 110 graduates on the previous year;

- Increased the number of undergraduate's places from 350 in 1999 to 775 for the 2008 intake;
- The Department of Health provides funding support to health services to conduct a number of re-entry, refresher and up-skill programs for registered and enrolled nurses and midwives to re-enter the nursing workforce. In 2007, 137 nurses were supported to undertake these programs;
- The Department of Health has for many years offered nursing scholarships for undergraduate nursing and postgraduate nursing and midwifery studies. For the 2008 academic year 459 scholarships have been awarded totalling $1,105,141;
- Nurse Practitioner Role: The Nurse Practitioner was established in 2003 and today we have 96 areas of practice for a nurse practitioner being designated across the state, 150 nurses are enrolled in Nurse Practitioner Programs and 22.5 FTE Nurse Practitioners in full scope of practice across the Public Health System;
- International Recruitment – the Department of Health has participated in centralised overseas recruitment initiatives since late 2005 in the United Kingdom, Germany, Asia and the Netherlands to promote opportunities available to registered nurses across the WA Public Health Sector. In 2007-08 WA Health provided temporary visa sponsorship nomination to an additional 311 nurses and midwives and 134 permanent sponsorship visa nominations across a range of nursing specialty areas;
- The Department of Health maintains a competitive national position in both wages and conditions which is reflected in the industrial awards and agreements covering enrolled nurses, nursing assistants and registered nurses. The 2007 Industrial Agreement includes a rebasing of all pay classifications with further wage increases of 4.5% in July 2007, 4% in July 2008 and 4% in July 2009. Other benefits will include an ongoing qualification allowance, significant increases in shift penalties and increases in parental leave;
- The management of nursing workloads assists in the retention of nursing staff for the public health system. The 'Nursing Hours per Patient Day' model developed for WA Health in 2002 is now a feature of both the registered and enrolled nurses industrial agreements and promotes and monitors reasonable workloads for all nurses and midwives working in inpatient areas. The Western Australian model has since been adopted by other states;
- Work Life Balance - The Department of Health has taken an innovative approach in introducing work life balance for its 35,000 employees. Nurses working in WA Health can look forward to a workplace that offers them a satisfying job while achieving optimum family, community and leisure time; and
- Assistant in Nursing Pilot**:** This initiative is aimed at job redesign /reconfiguration of the workforce to allow assistants in nursing to work alongside registered nurses and provide support. This will allow registered nurses to focus on planning, coordinating and assessing outcomes of care provided to patients. It will also provide career pathways into nursing for unregulated workers. Commencement of the first cohort of Assistants in Nursing Training commenced in February 2008 at Fremantle Hospital.

Enrolled Nurse (EN) Post Registration Courses have been established and the programs that have commenced are:

- Principles of Emergency Care Enrolled Nursing - 46 ENs have completed the course;
- Neonatal Certificate Course for Enrolled Nurses - 7 ENs have completed the course;
- Operating Room for Enrolled Nurses has commenced; and
- Mental Health course for Enrolled Nurses has commenced.

Healthy hospitals, health services and infrastructure

The Department of Health is committed to ensuring the services that it provides directly or via contracted services to the people of Western Australia are accessible, innovative and responsive to community needs, are efficient, and are of the highest quality.

Aboriginal health

The Office of Aboriginal Health, in partnership with the WA Country Health Service and the Department of Defense, replaced the clinic at the Kalumburu community. This improved facility enhanced the clinic's service provision with capabilities for renal dialysis and dental services, as well as providing overnight accommodation for visiting health professionals.

A strategic approach was developed for an Aboriginal Men's Health Program in WA, including a series of practical and responsive solutions at a low cost. The strategic approach identifies ways to reduce the levels of mortality and morbidity among Aboriginal men, including social and emotional wellbeing.

Recognising the importance of providing an effective engagement of Aboriginal and non Aboriginal men in the process of planning, designing, delivering health programs and services in order to progress Aboriginal men's health and well being, a representative group of Aboriginal men were called together in April 2008 for a two-day Aboriginal Men's Health Forum.

In setting the platform for change for the betterment of Aboriginal men's health and well being in Western Australia the following has been undertaken:

- establishment of a targeted Aboriginal men's health program – portfolio area;
- establishment of an Aboriginal Men's Health Reference Group;
- development of a Pit Stop Training initiative targeting Aboriginal Health Workers in partnership with WACHS;
- progression of an Aboriginal Men's Health Policy Framework / Action Plan; and
- establishment of a Departmental Working Group for the National Men's Health Policy Consultation Process.

Aged care

The Care Awaiting Placement program provides time limited transition care options for aged care patients who are waiting in a public hospital bed for alternative aged care services to become available. The program has expanded from 114 beds in February 2007 to 223 beds in February 2008.

Transitional care programs were implemented in the South West region in September 2007, MidWest region in February 2008 and Great Southern region in March 2008. This collaborative State and Commonwealth Government funded program provides time-limited, goal-oriented therapeutic care in a non-hospital environment while assisting the patient to make long-term care arrangements.

Aged care services in country areas have been enhanced by the appointment of Aged Care Managers in each region and the implementation of risk screening of all older patients accessing emergency departments.

Genomics

During 2007-08 the Office of Population Health Genomics developed a clinical care pathway for the identification and management of individuals with, or at risk of, familial hypercholesterolaemia. The pathway was developed in consultation with peak national and international bodies including Heart UK and the Australian Arthrosclerosis Society and has received broad support from the National Heart Foundation.

The Genomics Health Network has been active in addressing issues raised by the National Health & Medical Research Council, the Australian Law Reform Commission and the Australian Health Ministers Advisory Committee in relation to genetic privacy, genetic testing, gene patents, newborn and prenatal screening and a range of technical and social issues arising from genomics technology in healthcare.

The Office of Population Health Genomics is conducting a major project to map the health burden of genetic disease in WA, including the total cost of diagnosis, management and associated treatment of genetic disease. The current focus is on evaluation of the burden associated with single gene and chromosome disorders. The project will provide evidence to guide strategic planning in this health service area that has previously proved too complex to be comprehensively evaluated.

The Office of Population Health Genomics uses a systematic, evidence-based framework to determine the health benefits derived from

testing for specific genetic disorders. This year, a number of tests for a genetic heart condition (long QT syndrome), congenital adrenal hyperplasia in newborns and a number of familial cancer tests have been systematically evaluated. This work will ensure that the technical advances in the area are translated into health benefits in the most clinically effective and cost-beneficial manner.

Cancer and palliative care

An integrated model of care for palliative care was presented to the Health Networks Leads Forum in March 2008 and endorsed by the State Health Executive Forum in April 2008.

A palliative care rural audit was conducted with 100% input form stakeholders. This will inform the development of a Rural Palliative Care Model.

Attention to Australian Palliative Care Standards has progressed with the development of a standard palliative care admission form. The use of forms will be audited.

The Cancer Network has developed a trial to deliver oncology education and clinical services to regional centres via Telehealth. This will facilitate more accessible professional development for clinical staff and GPs, improved access to services for patients in regional locations and enable 'virtual' visiting for social and emotional support of patients and their families during periods of hospitalisation in Perth.

Smokefree WA

On 1 January 2008, WA Health implemented a no smoking policy. This policy applied to all WA Health buildings and grounds including leased premises. The SmokeFree Western Australia Working Party provided guidelines and support services to ensure a smooth implementation of the policy

Patient transport

The St John Ambulance Association has introduced five day-ambulances and an additional four career paramedics in the greater metropolitan area to enable timely responses to emergency calls.

Mental health

Construction of Community Supported Residential Units in Albany, Busselton and Geraldton was completed between November 2007 and February 2008 and residents have commenced moving in.

Construction of the Community Options group homes in Kelmscott was completed in April 2008 and the homes officially opened in June 2008.

Construction of the Bunbury Community Supported Residential Unit was completed in May 2008.

Tenders were awarded in April and May 2008 for the construction of transition accommodation in East Perth for homeless adults with a mental illness and Fremantle for homeless young people with a mental illness.

A call for tenders was announced in April 2008 for the construction of the mental health inpatient facility at Rockingham (30 beds).

The new discharge lounge at Graylands Hospital became operational in June 2008 and is staffed by peer support workers.

The construction of the mental health inpatient facility at Joondalup Health Campus (15 public beds) is underway, with the tender awarded in October 2007.

The eating disorders program at Princess Margaret Hospital is being expanded to provide more places in the intensive day treatment program and in-home therapy programs.

The Bentley rehabilitation unit opened in April 2008. This unit will assist in the overall bed management for mental health services at Bentley Hospital and across the metropolitan area. The unit is operating with eight beds, which will increase to 18 beds following staff recruitment.

Early intervention and mental health promotion programs provided by non-government organisations have been expanded. These programs include support services for children of parents with a mental illness, parenting programs and school mental health promotion programs.

Chief Psychiatrist

The Office of the Chief Psychiatrist (OCP) receives and acts on information provided about standards and issues regarding psychiatric care. During 2007-08 OCP received and managed 539 complaints. The issues raised fell into four main categories access; communication; quality of clinical care; and rights, respect and dignity. The majority of issues were raised by patients themselves (38%) and relatives (29%). Advocacy agencies on behalf of patients and carers were

Healthy hospitals, health services and infrastructure (continued)

Chief Psychiatrist (continued)

6% and the rest made up of health professionals and concerned others. Action taken on complaints lodged with the OCP enables services to improve the patient's health care experience.

The Chief Psychiatrist maintains, under the *Mental Health Act 1996,* a register of Authorised Hospitals which are hospitals where patients can be detained to receive mental health assessment and treatment. The *Chief Psychiatrist Standards for the Authorisation of Hospitals under the Mental Health Act 1996 w*as published to guide health services in establishing a safe environment.

The Chief Psychiatrist is informed, as a matter of first priority, of any death of a patient receiving mental health care and any serious incidents in mental health services (Operational Circular 2061/06). The Chief Psychiatrist also collects reported information on patients whose events or death may have a relationship to mental health issues but have had no contact with mental health services**.** Serious Incidents may include, but are not confined to, serious assaults on or by staff, other patients or visitors, absconding of any forensic patient, detained involuntary patients or serious medication error in regard to a mental health patient.

The information the OCP receives about deaths and serious incidents is used to act, where appropriate, in early intervention, to prepare data and report, in order to gain an overview of events in WA that may relate to standards of mental health care. The data and reports are used in a number of ways:

- to examine specific incidents or deaths individually as they are reported and where necessary take immediate action;
- to inform the Clinical Governance monitoring processes which will result in recommendations to the service; and
- to inform the Director of General of Health and the Minister for Health;
- to assist with the responses to Parliamentary Questions; and
- to analyse the data gathered over longer periods to enable trend identification and where appropriate, take action.

Health protection

EmergoTrain is a simulation system which enables health services to test their capacity to function effectively during a major incident (such as a natural or manmade disaster).

The Disaster Preparedness and Management Unit (DPMU) conducted an EmergoTrain simulation exercise, 'Exercise Pegasus', in December 2007. The exercise simulated 500 casualties, the largest number of casualties of any such simulation conducted in Western Australia. 'Exercise Pegasus' was successful in achieving its aim of evaluating WA Health's capacity to handle such a large number of patients in a mass casualty incident. The exercise also identified training needs within the hospital Emergency Control Centres and the improvements required in radio communications.

The DPMU has also developed mini EmergoTrain kits to allow health services to conduct small local exercises for small hospitals or even individual hospital departments.

Biomedical engineering

During 2007-08 Biomedical Engineering contributed to a wide range of tender submissions, providing technical specifications and support and has been on the tender evaluation panels of the following projects:

- Perth Chest Clinic, where it has maintained the X-ray equipment for more than 30 years. Current equipment will be replaced with a totally digital system, removing the need for film processing and improving work flows.
- Biomedical Engineering has provided technical support for the acquisition of up to 4 new Computed Tomography (CT) scanners. The new machines will replace existing equipment at Kalgoorlie and Geraldton and enable new installations at Nickol Bay (Karratha) and Narrogin subject to funding and clinical need.
- Biomedical Engineering has been involved in establishing a panel contract for Common Use Radiology equipment. This has helped in the tendering for radiology equipment. This new project will provide a wide range of imaging equipment on a pick-and-buy arrangement, which will significantly reduce the time and resources used to purchase in this area. This arrangement is new to radiology and has been successful in purchasing general electromedical equipment for a number of years.

HealthDirect

High volume specialties at all tertiary facilities are now using WA Health's call centre, 'Outpatient Direct', for cancellation and rescheduling of appointments.

Safety and quality

The Office of Safety and Quality in HealthCare (OSQ) continues to develop and implement statewide policies, standards and procedures across the four pillars of the WA Clinical Governance Framework. It has:

- coordinated a Statewide response to the Office of the Auditor General's report 'First Do No Harm: Reducing Adverse Events in Public Hospitals' by establishing the Managing Adverse Events project with a governance structure and work plan identifying key milestones and timeframes. Accountable Department of Health divisions and Area Health Services will facilitate the work under the Project Control, Clinical Advisory and Data Advisory Groups;
- continued implementation of the Safety and Quality Investment in Reform program;
- supported Area Health Service teams to implement eight mandated Clinical Practice Improvement programs: Acute Myocardial Infarction, Venous Thromboembolism, Pressure Ulcers, Falls Prevention, Medication Reconciliation, Central Line Associated Blood Stream Infections, Surgical Site Infections and Hand Hygiene;
- continued support of the Healthcare Associated Infection Council of WA to oversee a statewide response to healthcare associated infection, including surveillance, monitoring and policy/procedure development;
- completed the WA Open Disclosure Pilot Project in the South Metropolitan Area Health Service;
- published the third annual Sentinel Event Report for July 2006 to June 2007;
- published Paving the Way: Promoting Safer Health Care in WA 2002-2007, a history of safety and quality reforms in WA; and
- revised the 'WA Review of Mortality Policy' to integrate the identification of preventable deaths into the sentinel event management process.

Epidemiology

The Patient Evaluation of Health Services (PEHS) is in its twelfth year of data collection. This year along with admitted patients, emergency department patients were surveyed. The information from the PEHS surveys are used to support and evaluate initiatives undertaken by hospitals to improve service provision.

Healthy partnerships

The Department of Health recognises the importance of, and is committed to, developing strong partnerships and co-operative arrangements with government agencies, non-government organisations, community groups and private sector providers. These relationships support improvements in service delivery, facilitate research and development, and maximise the benefits of capital investment.

Genomics

A partnership between the Western Australian General Practice Network and the Australasian Society for HIV Medicine has been developed to roll out human immunodeficiency virus training for General Practitioners and allied health professionals.

A familial hypercholesterolaemia (FH) (high blood cholesterol) program has been established with the appointment of nurses, a project coordinator and a dietician. More than 60 index cases and more than 50 relatives (cascade screening) have been reviewed by the Familial Hypercholesterolaemia Clinic. Partnerships have been formed with divisions of general practice and the Familial Hypercholesterolaemia Sub-Committee of the Australian Atherosclerosis Society. This project has been funded by the Australian Better Health Initiative (2007-2009).

In collaboration with the Department of Internal Medicine, Royal Perth Hospital and the University of Western Australia School of Medicine and Pharmacology, the Office of Population Health Genomics is leading a pilot program of cascade screening of FH. The program involves the identification of people and families with FH using genetic and clinical criteria so that appropriate treatment can be tailored to reduce the risk of stroke and cardiovascular disease. More than 80 index cases have been assessed and treated. The program provides support to patients and their families as well as to general practitioners. This project has been identified by the Commonwealth Department of Health and Aging, Australian Better Health Initiative funding program, as a flagship project and a model for future health care strategies.

The Genome-based Research and Public Health International Network has recognised a partnership between the Office of Population Health Genomics and the Telethon Institute of Child Health Research as a regional centre. This links WA Health's capacity to translate genetic knowledge into health benefits with international public health genomics enterprise.

In collaboration with Genetic Services WA, the Curriculum Council and the Department of Education and Training, the Office of Population Health Genomics provided professional development to 200 Western Australian teachers on genetics. This was part of the development of the new course of study in Human Biological Sciences that will be implemented in WA schools in 2009.

Mental health

A total of $1.5 million over four years has been approved to continue the State's partnership with '*beyondblue*' to support the national depression initiative.

Refugee health

The refugee health service has been expanded and a pilot integrated service team has been implemented in two primary schools in partnership with the Department for Communities and the Office of Multicultural Interests.

Health promotion

Implementation of health promotion and prevention programs for childhood obesity has commenced. Five contracts have been awarded to the Cancer Council of Western Australia in partnership with Diabetes Western Australia, Foodbank Western Australia, the Australian Red Cross Western Australia and the National Heart Foundation of Western Australia for the period 2006-07 to 2008-09. This will deliver childhood healthy eating, physical activity and healthy weight programs over the next three years. The program will be delivered in school and community settings and will include healthy weight education strategies for parents.

Childhood obesity is also being addressed through the Western Australian funded component of the Australia Better Health Initiative. Under the Healthy Canteens Project, healthy school canteen guidelines are being implemented by the Department of Education and Training within Western Australian public schools. The Healthy

Schools project has been established and Healthy School coordinators are being recruited and established. These posts will support targeted schools across Western Australia with implementation of school nutrition and physical activity initiatives.

WA Health targeted the advertising of unhealthy foods and drinks to children through participation in the Health Ministers' Food and Drink Advertising and Marketing Practices State and Territory Jurisdictional Working Party. Departmental and joint working group submissions were made to the review of the Australian Communications and Media Authority Children's Television Standards and to the Australian Association of National Advertisers review of the Code for Advertising to Children (December 2007).

Health protection

Falls prevention network activities have continued with the development of an information resources network across the health sector. Service agreements have been put into place with the Injury Control Council of Western Australia and the Council on the Ageing Western Australia and 'Stay on Your Feet' Western Australia. These agreements promote awareness and communication of the 'Stay on Your Feet' program, volunteer management of programs in falls prevention with older people, and professional development in injury prevention to increase the falls prevention workforce.

A consortium of Divisions of General Practice has been awarded the contract to develop the Metropolitan Healthy Lifestyles Project, a coordinated patient-centred lifestyle and risk modification approach to early stage Type 2 diabetes, microalbuminuria and coronary heart disease.

Over the past three years, $21.5 million has been provided to non-government agencies for promotion programs and campaigns in line with the Western Australian Health Promotion Strategic Framework 2007-2011. From 2005-06 to 2008-09 a total of $25.3 million has been allocated for the following programs:

- smoking and related harm prevention;
- healthy diet;
- physical activity;
- healthy weight for adults and children; and
- injury prevention.

Redevelopment of the 'Go for 2 and 5' fruit and vegetable campaign by the Cancer Council of Western Australia, began in late 2007 and is due for completion by late 2008 as part of the Cancer Council's health promotion service agreement.

Aboriginal health

Partnership frameworks have been established with the Aboriginal Health Council of WA, Health Network Leads Forum, the Commonwealth Department of Health and Ageing, the Office for Aboriginal and Torres Strait Islander Health and the Aboriginal Health Worker Association to collectively work towards improving the health of Indigenous Australians.

The Western Australian Aboriginal Health Partnership has expanded to include general practitioners. The Clinical Senate meeting in March 2008 focused on strategic directions to close the gap between life expectancy of Indigenous and non-Indigenous West Australians and to improve health outcomes for Indigenous people in Western Australia.

Participation in the Department of Indigenous Affairs Bilateral Senior Officer Groups has commenced. Membership on the Director General's Indigenous Affairs Working Groups and involvement with COAG reforms for Indigenous Affairs has also commenced.

Aged care

WA Health has participated in national funding programs to provide additional transitional care places for older West Australians waiting in hospital for a residential care bed and to support aged care service providers to create additional capacity with zero interest loans.

In partnership with the Health Consumers' Council Western Australia, a consumer-focused brochure on transitional care options for the elderly has been developed and published.

Chief Psychiatrist

The Chief Psychiatrist represents Western Australia on a number safety and quality initiatives in mental health. These includes the Steering Group of the Review of National Standards for Mental Health Services; the Safety and Quality in Mental Health Partnership Subcommittee involved in the National Safety Priorities in Mental Health; National Plan for Reducing Harm; Reduction of Restraint and Seclusion; and the Reducing Adverse Medication Events in Mental Health Working Party.

Healthy partnerships (continued)

Chief Psychiatrist (continued)

The Office of the Chief Psychiatrist (OCP) continues to undertake a clinical governance review program of public and private mental health services as well as working with the licensed psychiatric hostels to improve the standard of care provided to residents. In 2008 this program has included the North Metropolitan Area Mental Health Service Graylands Hospital, Sir Charles Gairdner Hospital Mental Health Unit, the Frankland Unit of the State Forensic Service and Hawthorn House.

Recommendations from the clinical governance reviews have had 42 per cent of recommendations achieved, with another 51 per cent being actively addressed by mental health services. The Chief Psychiatrist will continue to engage with the mental health services through a series of progress visits until all recommendations have been achieved. The aim of the visits is to work collaboratively with the service to identify and address any challenges that the service may encounter in relation to the recommendations.

Safety and quality

The Office of Safety and Quality I HealthCare have been strengthening partnerships with Area Health Services to improve the planning, implementation, monitoring and review of clinical governance policy and programs in WA public health services by:

- the Coronial Liaison Team continuing to coordinate communication between the Department of Health, Area Health Services and Office of the State Coroner with respect to action on Coronial Inquest recommendations;
- continued support for the WA Audit of Surgical Mortality (WAASM) in partnership with the Royal Australasian College of Surgeons; and
- continued support for the safe, quality and cost-effective use of medicines through the WA Therapeutics Advisory Group and its associated subcommittees, the WA Drug Evaluation Panel, WA Psychotropic Drugs Committee and the WA Medication Safety Group.

The Office of Safety and Quality in HealthCare worked with the WA Council for Safety and Quality in Health Care to commence the development of the five-year WA Strategic Plan for Safety and Quality in Health Care for 2008-13.

Healthy communities

The Department of Health provides and supports numerous health promotion and protection programs that focus on both individuals and communities, and provides information to the public about prevention of illness and injury, about healthy lifestyles and the self management of chronic disease. The initiatives implemented by the Department follow extensive collaboration with Area Health Services, other government and non-government agencies, general practitioners and community groups.

Information management and reporting

The detailed design specifications for the new Western Australian Cancer Registry information system have been completed and development of the new system is being progressed.

The Western Australian Data Linkage Advisory Board has been established and held its first meeting in November 2007. Its membership comprises nominees from the University of Western Australia, Curtin University of Technology, Telethon Institute for Child Health Research, WA Health and the Health Consumers' Council of WA.

In preparation for ongoing monitoring of road safety indicators, a report on the severity of road injury has been produced using hospital diagnoses and death records. A memorandum of understanding has been signed with the Insurance Commission of Western Australia. Data linkage commenced in April 2008. Data from Main Roads WA and WA Health has been linked for the years 2001 to 2006.

A memorandum of understanding with the Department of Corrective Services was signed in September 2007 and demographic data for the Developmental Pathways in Children program has been received for data linkage. This was completed in June 2008.

Monitoring of the health and wellbeing of the Western Australian population continues with the release of reports on time series analysis of the prevalence of chronic diseases and major health risk factors and the health impact of alcohol on the Western Australian population. Health services are also evaluating and reporting on satisfaction levels of admitted patients, including long stay and maternity patients.

Home and Community Care

The review agreement for the operation of the Western Australian Home and Community Care (HACC) program was signed by the Minister for Health and the Commonwealth Minister for Health and Ageing. The agreement sets out the strategic directions, priorities and allocation of funds for the HACC program over the next three years.

The first Western Australian HACC Triennial Plan was provided to the Commonwealth Government in March 2008. The Triennial Plan is part of the review agreement for the operation of the Western Australian HACC program.

Access Networks demonstration projects have commenced in Esperance and are due to commence in the Kimberley and the City of Swan in 2008. Access Networks meet Council of Australian Government requirements to simplify client access to HACC services.

Cancer and palliative Care

The Australian Better Health Initiative has supported the placement of 18 cancer nurse coordinators, in both metropolitan and country areas, to work with service providers in order to improve coordination of care for cancer patients.

Community health

In 2007-08, a number of initiatives were undertaken to promote breastfeeding including; staff trained in the Breastfeeding Matters Program, a lactation consultant network was established, breastfeeding was promoted through community media and WA Health policy on breastfeeding was promoted to staff.

Ambulatory care

The Ambulatory Care Service Directory, a searchable online database, is in the final stages of testing and is nearing completion. Details of Ambulatory Care Services across the state, including public, non-government and private providers are listed in the database.

Genomics

The family history awareness program has been developed for the community, allied health professionals and GPs to identify individuals who are at increased risk of developing common chronic diseases in Western Australia. The project has been funded by the Australian Better Health Initiative (2007-2009) and a project officer has been appointed to progress the work.

Healthy communities (continued)

Genomics (continued)

The Office of Population Health Genomics has undertaken extensive community consultation in the areas of birth defects reporting, folate fortification of food and attitudes toward new genomic technologies.

Tobacco control

Licensing infrastructure has been established and approximately 3,800 licences issued to tobacco retailers and wholesalers. Information regarding the new legislation and display restrictions has been provided to all tobacco retailers across the State.

A Statewide compliance program was implemented, including a legislation education campaign, inspections at retailer and wholesaler premises, investigations of complaints, and joint investigations with the Australian Federal Police and Australian Customs to address illegal tobacco sales activity, particularly pertaining to illegally imported tobacco products.

Following endorsement by the Minister for Health, the WA Tobacco Action Plan 2007-2011 was disseminated to key stakeholders throughout WA in December 2007. The Plan provides a framework for tobacco control activities for five years, outlining public health policy on tobacco control and facilitating the implementation of key recommendations of the National Tobacco Strategy 2004-2009. The Plan is aligned with the WA Health Promotion Strategic Framework 2007-2011.

The legislative training program was developed and presented to the Western Australia Police and Drug and Alcohol Coordination officers.

The Tobacco Control Branch provided advice and assistance to the Respiratory Health Network's Smoke Free WA Health System Working Party in relation to development and implementation of the Smoke Free WA Health System Policy.

Health promotion

The Human Papilloma Vaccine program for the prevention of cervical cancer commenced for school-based students in Years 10, 11, and 12 and with GPs for 18 to 26 year olds.

The rotavirus vaccine program for newborns commenced in July 2007.

The new Western Australian Sentinel Practitioner Network surveillance was implemented and the weekly Virus Watch publication commenced.

The Paediatric Influenza Vaccine Program for children aged six months to four years in the Perth metropolitan area has commenced.

The revised WA Health Management Plan for Pandemic Influenza has been completed and was reviewed by the Western Australian Influenza Pandemic Advisory Committee in mid-April before general release.

Operational plans for the Communications Plan and the Fluborderplan (International Border Surveillance) have been completed.

The Food and Nutrition Policy for WA Health Services and Facilities was endorsed by the Minister for Health; implementation began in January 2008. The policy aims to increase the availability of healthy foods and drinks and to restrict unhealthy items to less than 10 per cent of overall items for sale. It determines the supply of food and drinks in all health services, hospitals, facilities and other establishments.

Continence management

The Continence Management and Advice Service was established across Western Australia to provide community-based management and advice on the basis of clinically-assessed need to people with ongoing continence conditions who are financially disadvantaged and unable to access existing assistance schemes. The overall project is managed in association with the Disability Services Commission, which administers the product subsidy component of the scheme. A single non-government organisation provides both the clinical and the product subsidy components of the scheme.

Residential aged care

A number of initiatives have been implemented to enhance residential aged care:

- stronger links have been made with Royal Perth Hospital emergency department's Care Coordinating Team. This multi-disciplinary team identifies high-risk residential aged care patients over the age of 65 (or 45 for Aboriginal and Torres Strait Islander patients) who might require follow up when discharged back to a residential aged care facility;
- stronger partnerships and links have been established with Divisions of General Practice and Silver Chain; and
- Residential Care Line data collection has been streamlined to ensure all services are reporting information.

The Residential Care Line continues to demonstrate rapid growth since implementation in 2004. Of all referrals in 2007, 56 per cent demonstrated emergency department prevention, which is 20 per cent above target. This service expanded to a seven-days-per-week service.

Health networks

The Networks have developed evidence based models of care within their speciality area. These models have been developed with wide consultation of all stakeholder groups ensuring that they meet the needs and aspirations of the broader community. At this stage over 20 models of care have been developed across the variety of Networks that outline a patient centred approach to the continuum of care for a variety of health conditions or for a population based health care framework. These include;

- The WA Health Aged Care Network is continuing to work towards the formulation of the service models that specifically include a model of care for dementia. The Western Australian Model of Care for Dementia will provide a framework to incorporate and report on the objectives of the National Action Plan for Dementia;
- The Diabetes Model of Care has been completed by the Endocrine Health Network and endorsed by the State Health Executive Forum. Key stakeholders across health sectors attended a workshop in February 2008 to contribute to service planning for the NMAHS diabetes service;
- A Respiratory Health Network working group has developed a draft model of care for chronic obstructive pulmonary disease. This model builds on the Western Australian Chronic Respiratory Disease Clinical Service Improvement Framework; and
- Falls prevention network activities have continued with the development of an Information Resources Network across the health sector. Service agreements have been put into place with the Injury Control Council of Western Australia, the Council of Ageing and Stay on Your Feet Western Australia. These agreements are to promote awareness and communication of the Stay on Your Feet program, volunteer management, and programs in falls prevention with older people and professional development in injury prevention to increase the falls prevention workforce.

Preventive health care

In partnership with the Commonwealth and the other States, WA Health has participated in the establishment of a Preventative Health Care Taskforce to develop a plan for the future of preventative health in Australia that will inform initiatives and programs to increase the health of the population and to improve workforce participation and productivity.

Health protection

In 2007-08 Health Protection Group undertook a Health Impact Assessment of climate change. The assessment was released to raise awareness about climate change and health and to seek feedback.

The Health Protection Group drafted the new *Public Health Bill* and invited public comment during February-April 2008.

The Health Protection Group continued to deliver sexual health and blood borne virus workforce training in 2007-08. Almost 200 health professionals undertook Hepatitis C training, while social marketing campaigns included a continuation of 'Chlamydia, Most people haven't got a clue', 'Safe Sex, No Regrets' and increased investment in 'Travelsafe'.

Following a desktop review that revealed a lack of sexual health information or dedicated services for culturally and linguistically diverse groups in Western Australia, the Department of Health funded a Murdoch University project to provide peer-based sexual health and HIV education to members of the West African community. An evaluation report was completed and submitted to the Department in May 2008.

The Needle Syringe Distribution Program review was completed. The final report was endorsed by the project reference group and will be submitted for approval for wider distribution.

Disaster preparedness and management arrangements have been enhanced, including a warehouse for the storage and maintenance of equipment and stores, the ongoing procurement of medical consumables, the continuing development of the Disaster Medical Assistance Team model, provision of satellite phones to 74 WACHS facilities and provision of standardised disaster response kits to 29 WACHS facilities.

Mental health

To help address postnatal depression, the Mental Health Division implemented a number of initiatives. The 'Beyond the Boundaries Perinatal Mental Health Symposium' was held in August 2007 to promote perinatal mental health to the broader WA health sector. A culturally appropriate perinatal mental health training module for Indigenous Health Workers was developed and delivered at the Marr Mooditj Aboriginal Health Training College.

Healthy communities (continued)

Mental health (continued)

The Mental Health Division developed new service model frameworks and service agreements to improve postnatal depression services for Iraqi, Sudanese and Ethiopian communities in WA, as well as developing a six-month pilot project to provide perinatal 'hospital at home' services. The aim of this program was to decrease the pressure on the utilisation of beds in the new King Edward Memorial Hospital Mother Baby Unit.

The inaugural Mental Health Community Network Forum was held in April 2008. Almost 50 participants attended with more than 60 discussion topics addressed throughout the day. A second Mental Health Community Network Forum was held in June 2008 in Broome. It is expected that further forums will facilitate community input into WA mental health planning and public policy development.

In collaboration with local mental health services, the Mental Health Division held the National Outcomes and Casemix Collection forum in November 2007 with over 100 attendees. The forum is held annually to highlight issues relating to the collection, recording and reporting of the mandatory consumer outcome measures in mental health.

Commonwealth funding of $650,000 provided under the 'Quality through Outcomes in Mental Health Care 2006-2008' initiative was utilised to conduct three projects in mental health services. The aim of the projects was to better integrate consumer outcome measurement in clinical practice and to further improve consumer participation in outcome measurement. Clinicians and consumers have indicated that there is increased awareness of consumer outcome measures used in mental health services.

Aboriginal health

The Australian Better Health Initiative program has been progressively implemented in Halls Creek, Jigalong, Norseman and Kwinana. Program coordinators have been appointed and a program management forum for the teams to share best practice methodologies, develop a project management and evaluation framework to assist with the need to focus on the unique elements for each site has been developed. Community engagement is a priority for all teams and coordinators.

The program has been expanded to include Mandurah to address the identified health needs that focus initially on the early years and ultimately the chronic care needs of adults.

Biomedical engineering

The Royal Society for the Protection of Cruelty to Animals established a new shelter in Malaga and required some basic imaging equipment. Biomedical Engineering was able to assist with the donation of obsolete and surplus equipment including a mobile x-ray machine, film processor, fixed x-ray table, diagnostic ultrasound and other minor items.

Safety and quality

The Office of Safety and Quality in Health Care continued to fund the Health Consumers' Council to undertake recruitment, training and support for consumer representatives in metropolitan and rural health services.

The Office of Safety and Quality in Health Care supported the continued implementation of 'Patient First' program (use of identified strategies and resources developed) in WA hospitals and commenced extensions and customisation to the priority populations.

Healthy resources

The provision of health care services in a sustainable, equitable, efficient and accountable manner, in a safe working environment (that will deliver the best health outcome possible) is a priority for all WA Health services.

Genomics

WA has a long history in the area of developing research and clinical biobanks to better understand disease and develop new medical treatments. The established biobanks, and the associated data that attend these collections, are a result of successful collaborations between WA Health and academia. Biobank stakeholders have met to develop security measures for these valuable resources and ensure appropriate governance practices are implemented. The Office of Population Health Genomics conducted an inventory of the biobanks and biobanking activity across the public and tertiary sectors in WA and has used the information to the governance and storage of these resources.

Health protection

Disaster preparedness and management arrangements have been enhanced, including;

- a warehouse for the storage and maintenance of equipment and stores;
- the ongoing procurement of medical consumables;
- the continuing development of the Disaster Medical Assistance Team model;
- provision of satellite phones to 74 WACHS facilities; and
- provision of standardised disaster response kits to 29 WACHS facilities.

Emergency Communications development, including extension of internal and external radio networks and provision of satellite phones to the rural hospitals that can deploy medical teams to the site of a disaster, has been undertaken.

The medical equipment stock pile has been enhanced with the purchase of cardiac monitors for the treatment of critically injured casualties.

Chemical, biological and radiological (CBR) incident response enhancements have included commencement of hospital perimeter security upgrades at Princess Margaret Hospital and Fremantle Hospital. Responsibility for the provision of personal protective equipment for medical teams to wear in the event of a CBR event has been allocated.

Information management and reporting

The *WA Health Performance Quarterly Web Report* was first published in June 2007. During 2007/08 the scope of the report has increased to include 26 quantitative indicators. This report can be accessed on the Department of Health's Internet website and provides the public with information on trends in health service activity.

BedState is a new web-based system that was implemented in March 2008 to enable daily capture and reporting of bed information, including specific details on mental health beds.

The Department of Health established the Human Research Ethics Committee (HREC) to replace the Confidentiality of Health Information Committee. The HREC has been registered with the National Health Medical and Research Council (NHMRC) and held its inaugural meeting in April 2008. The committee will provide advice about the ethics of research and on requests for release of identified information from WA Health data collections.

Mental health

Video-conferencing equipment has been installed in an additional 58 centres across the state to expand telepsychiatry services. These services include specialist mental health services to clients and professional development opportunities for staff within country mental health services. A two-month project in three sites trialled the provision of specialist mental health services to clients in their own homes utilising video-conferencing.

Home and Community Care

Western Australian Home and Community Care (HACC) program funding has increased by $13 million from 2006-07 to 2007-08. This increase has supported people who live at home and whose capacity for independent living is at risk of premature or inappropriate admission to long term residential care.

Healthy resources (continued)

Epidemiology

The Health and Wellbeing Surveillance System (HWSS), an ongoing data collection system is in its seventh year of continuous collection. For the first time, a report on the trends of significant indicators of health and wellbeing was produced. This report has been used throughout the Department to support and underpin health promotion activities and to inform the Operational Plan.

Information from the Patient Evaluation of Health Services surveys are used to support and evaluate initiatives undertaken by hospitals to improve service provision and results are being used to support the Clinical Redesign Project.

The Epidemiology Branch published a report describing the impact of alcohol consumption on the WA population by quantifying alcohol-related deaths and hospitalisations. The analysis used local information to improve estimates previously based on national data. A series of regional reports utilising local information were released in conjunction with the State report. The data in the reports supported the launch of the 'Rethink Drink' campaign, assessment of alcohol-related issues in local areas and the planning of interventions in regional areas.

A standard health profile was developed and prepared for each health district in collaboration with WACHS for inclusion in the regional clinical service plans.

The following reports published during 2007/2008 can be accessed on the Epidemiology Branch intranet site:

- Health and Wellbeing Surveillance System Questionnaire 2008 (Jan 2008);
- Health and Wellbeing of Children in Western Australia, July 2006 to June 2007, Overview of Results (Dec 2007);
- Chronic Disease and Quality of Life (Nov 2007);
- Health and Wellbeing of Adults in Western Australia 2006, Overview of results (Oct 2007);
- Health and Wellbeing of Adults in Western Australia 2006, Trends over Time for Selected Chronic Conditions and Risk Factors (Oct 2007);
- Impact of Alcohol on the Population of Western Australia (Feb 2008);
- Impact of Alcohol on the Population of Western Australia: Regional Profiles (Feb 2008); and
- Population Health Profiles for each district in the Western Australia Country Health Service (March 2008).

Legal and Legislative Services

The Minister for Health is responsible for the Health portfolio's extensive legislative reform program. The Department of Health supports the Minister in the administration of 40 Acts and 101 sets of subsidiary legislation. The Legal and Legislative Services Directorate at the Department of Health provides and co-ordinates the necessary support for this program. As at 30 June, staff was involved in over 18 separate legislative review and development initiatives.

Healthy leadership

Establishing and maintaining an environment that develops and provides strong leadership at all levels is a priority for WA Health. The Department of Health focuses on recognising, developing and supporting its leaders in delivering superior health care service, with quality management and ensuring all strategic directions are progressed.

Public health

The Public Health Division is conducting a review of both medical and non-medical public health training, which commenced in May 2008. The review will outline future public health training, including integration with and support for the broader Healthy Leadership programs.

The Institute for Healthy Leadership

The Institute for Healthy Leadership was established in July 2007 to recognise, develop and support emerging leaders to deliver a superior health care service in Western Australia.

Over the past year, the Institute has worked with area health services to ensure there is organisation-wide support for staff participation in leadership programs. The Institute has adopted the United Kingdom National Health Service's Leadership Qualities Framework for all development and assessment activities.

In December 2007 the Institute commissioned the following leadership programs:

- *Service Improvement Workshops*

  Places in these workshops are offered to alumni of leadership programs run previously by WA Health. The workshops provide basic training in health service improvement principles and methods. The Institute for Healthy Leadership also provides further support to participants to implement service improvement activities in their workplaces.
- *Emerging Leaders Development Program*

  This program, designed for 100 senior managers within WA Health, is run jointly by Curtin University of Technology and Edith Cowan University.
- *Delivering the Future Leadership Development Program*

  This program for 22 senior staff identified as potential successor directors and executive directors within WA Health is delivered by University of Western Australia Business School in partnership with a commercial management training organisation.

In addition to six two-day workshops over 18 months, participants have undertaken a leadership assessment to assist them in forming a personal development plan. Participants also are required to undertake an alternative action-oriented learning experience. Each participant receives support and mentoring from the Director General and a State Health Executive Forum leader throughout the program.

The Institute of Healthy Leadership is also responsible for the following programs:

- *Graduate Development Program*

  The Institute assumed responsibility for the Graduate Development Program from the Workforce Division in February 2008. Nine graduate officers commenced in February 2008. A full program of management training sessions based on action learning will be undertaken by these graduates. Up to 10 graduate officers will be recruited from health and social science, business and finance and IT disciplines to commence within WA Health in February 2009.
- *Executive Development*

  The Director of the Institute for Healthy Leadership has met with more than 70 executive directors throughout WA Health to assist with their leadership development needs and to obtain feedback for future development programs.
- *Masterclasses*

  The Institute has commenced a series of Leadership Masterclasses, which are presentations to various leadership groups within WA Health such as participants in the Health Network Leads and Graduate Development programs.

In addition to the focus on personal development, the Institute for Healthy Leadership is assisting a number of groups within WA Health with improving team and organisational effectiveness.

Priorities for 2008-09

WA Health's Strategic Directions 2005-10 provided by the Health Reform process to deliver a 'Healthy WA' will continue to drive health care in 2008-09. Priorities for 2008-09 for each of these strategic directions are detailed below.

Healthy workforce

Department of Health Divisions and area health services continue to face pressures in the recruitment and retention of their workforces to meet the changing population demographics, accelerating retirement rate, workforce sustainability and to position as an employer of choice. The Healthy Workforce Strategic Framework 2006-16 continues to inform future health workforce planning and strategic deployment.

Workforce strategies for 2008-09 continue to focus on:

- delivering a family friendly work environment through the Department's 'Work-Life Balance' and the 'Creating Family Friendly Workplace' initiatives including implementing the Department's Child Care Strategy;
- workforce planning to improve attraction and retention strategies, promote workforce innovation, improve the employment of Indigenous health professionals and develop workforce strategies to meet future needs; and
- assessing workforce satisfaction with work-life balance strategies, leadership and management, workplace values and culture, and the provision of a safe work environment.
- A Marketing Campaign entitled "Never Just Another Day" was developed in 2006 to attract high school students into nursing. The aim of the campaign was to market the profession as a positive career choice, which offers flexibility, diversity and opportunities to travel and work across a range of industries and specialty areas. A further marketing campaign is planned for September 2008.

Healthy hospitals, health services and infrastructure

The increasing demand for health services remains the critical challenge for WA Health.

During 2008-09 WA Health will continue to work to achieve optimum performance in the delivery of elective surgery category targets especially for Category 1 and to provide timely care in emergency departments and services. Other initiatives will include increasing activity levels at GP after-hours clinics and in the Ambulatory Surgery and Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) programs.

WA Health's strong focus on safety and quality will continue through implementation of the Safety and Quality Investment for Reform (SQuIRe) and Patient First programs.

Implementation of WA Health's approved capital works program will be further progressed during 2008-09, especially the Fiona Stanley Hospital and hospital developments in Busselton, Broome, Port Hedland, Rockingham-Kwinana, Joondalup, stage two of the State Cancer Centre and the PathWest development at the QE II Medical Centre.

Drafting, enactment and implementation of a new Mental Health Act is planned for 2008-09 and the Office of the Chief Psychiatrist will continue to play a vital role in this process especially when the Act comes into force. The implementation of the Act will include a major education programme throughout WA for clinicians, patients, carers and the general community.

Healthy partnerships

The Department of Health works to create stronger partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, and health professionals all of whom have an interest and stake in the future of the WA health system.

Key priorities for 2008-09 include:

- progressing the Health Networks, which bring together relevant clinical expertise and

consumer input to plan the future development and delivery of services for major disease conditions. The focus of the Networks in 2008-09 will include both developmental work on new models of care and implementation of recommendations for improving service design and delivery;

- implementing a second round of Research Translation Projects under the Strategic Plan for Health and Medical Research in WA;
- strengthening the framework for the Western Australian Aboriginal Health Partnership promoting collaborative work to improve program service delivery, efficacy of resources allocated to improve Indigenous health outcomes and policy and planning processes;
- establishing formal partnering arrangements inclusive of Indigenous people. These arrangements will be established at all levels of government and within the health sector to address the health priorities of Indigenous people in Western Australia; and
- the Commonwealth Department of Health and Ageing, the Office for Aboriginal and Torres Strait Islander Health and the Office of Aboriginal Health will form a partnership to deliver health services to Indigenous Australians including a shared website detailing programs and services offered by each agency.

Healthy communities

WA Health continues its focus on improving lifestyles, preventing ill-health and the implementing a long-term, integrated health promotion programs in collaboration with Area Health Services, other government and non-government agencies, general practitioners and community groups. Priority remains on the provision of community-based management of chronic and long-term health conditions and improving access to services in the community.

Key priorities for 2008-09 include:

- The Office of Aboriginal Health will continue implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health specifically the provision of counselling services for Indigenous children at risk, and antenatal and postnatal care;
- The recommendations of the Anaphylaxis Expert Working Committee report will be implemented;
- A bereavement package for the family members of recently deceased patients will be developed to be available to all hospital wards;
- The Office of Population Health Genomics will develop and implement professional education for allied health staff and GPs to increase awareness of family health history in chronic disease, develop the engagement between professional and community stakeholders to ensure the appropriate protection and health benefits of deoxyribonucleic acid (DNA) sample collections held in Biobanks and develop the Genetic Burden of Disease program to monitor the impact of hereditary and genetic diseases on the services provided by WA Health;
- The familial hypercholesterolaemia (high blood cholesterol) program will continue to identify index cases and to cascade screen relatives. Patients identified with the conditions are to be treated appropriately to reduce their risk of cardiovascular disease and then returned to their GP for ongoing care;
- A model of care for screening adults and children at risk of familial hypercholesterolaemia will be developed and the project extended to regional areas;
- Implementation of a metropolitan area Indigenous newborn notification process will ensure all families of newborn Indigenous babies are offered available health services. An early years 0-5 health assessment program for Indigenous children will be implemented across the metropolitan area;
- Development of a state-wide Stay on Your Feet Western Australia Resources Information Centre to provide a single access point for information and tools on falls prevention;
- Implementation of the Metropolitan Healthy Lifestyles Project to identify and manage care for a minimum of 2,000 patients newly diagnosed with type 2 diabetes, microalbuminaria or risk factors for coronary heart disease;
- The Human Papilloma Vaccine program for the prevention of cervical cancer will expand to school-based Years 7, 8 and 9;
- Enhance linkages from the Emergency Department surveillance, inpatient data and laboratory notifications to the Western Australian Sentinel Practitioner Network Surveillance;
- The Public Health Division will audit hospital planning to determine readiness in case of a flu outbreak, purchase personal protective equipment for health employees and liaise with the Department of Corrective Services and the Mental Health Division to expedite their pandemic influenza business continuity plans;

Priorities for 2008-09 (continued)

Healthy communities (continued)

- The Health Protection Group will carry out a health impact assessments of resource development around the Swan River. Guidelines for specific mosquito-borne disease will be drafted and the Group will complete a review of the funding for health related Local Government mosquito management programs;
- The Health Protection Group will establish a climate change steering group to identify priorities for action and implement strategies to address climate change;
- Development of a new *Public Health Bill 2008* is near completion and the Health Protection Group will develop the regulations, policies and guidelines to support the implementation of the new Act;
- In September 2008, the Australasian Sexual Health Conference and Australasian Society for HIV Medicine will be held in Perth; and
- Sexual health and blood-borne virus workforce training will continue, including funding for the Hepatitis Council of Western Australia to provide multi-disciplinary seminars on Hepatitis C. The Council will also develop a training program and resources for the pharmacy sector.

The school dental program will continue its focus on providing enrolled school children with an annual oral health check. Approximately 250,000 school children are targeted to be enrolled and under care in the school dental program in 2008-09.

HACC service providers in Western Australia, including those managed by the WA Country Health Service (WACHS), will adopt the Wellness Approach to Community Homecare that promotes an enabling model rather than a maintenance model.

New services will be provided by non-government organisations to provide expanded support services for children of parents with a mental illness and to provide physical health and other health promotion programs for people with chronic mental health conditions.

The work of *Healthright* identified that the physical health care of patients with a mental illness requires particular attention. The Chief Psychiatrist will increase the focus on physical health care in all monitoring activities including the Clinical Governance Review program.

Healthy resources

A key focus for reforming Western Australia's public health system is the need to deliver a sustainable, equitable and accountable health care service to all Western Australians.

Key priorities for 2008-09 include:

- continued implementation of the Information and Communication Technology Strategy;
- progressing the implementation of a population and output-based resource allocation model for WA Health; and
- finalising transition planning for the expansion of the Rockingham-Kwinana District Hospital and develop a transition plan for the Fiona Stanley Hospital.

Data linkage to deliver an enhanced road safety information resource that will be expanded from 2001- 2006 to 2007 data from Main Roads Western Australia to that of WA Health. Additionally, data for the years 1996 to 2000 will be linked to provide an expansive archive. This linked data will be used as a resource by agencies in researching programs to reduce road trauma.

The Disaster Preparedness and Management Unit will develop and implement a process for the rotation and maintenance of stock. The Unit will also procure medical consumables for the Australian Medical Assistance Teams and Urban Search and Rescue team and develop distribution processes for surge events and the Australian Medical Assistance Teams. Further operational data will be added to the generic pandemic plans by each hospital, including human resource, service reduction plans and other responses.

Care provision standards specific to Care Awaiting Placement (CAP) will be developed to implement a consistent framework across Western Australia.

Capital works for Community Supported Residential Units in Bentley, Stirling (Osborne Park) and Middle Swan are scheduled for completion between July 2008 and April 2009 and planning for community supported

residential units in Armadale, Kalamunda and Peel will be progressed.

Capital works for Community Options group homes in Mount Claremont, Bentley and Osborne Park are scheduled for completion during 2008-09.

An implementation strategy for the diabetes model of care will be developed and the chronic obstructive pulmonary disease model of care will be completed.

The Ambulatory Care Service Directory is to be embedded as a fully sustainable information service with regular information updates. Partnerships will be developed with other directory providers such as Diabetes Western Australia, Perth Primary GP Network and the Cancer and Palliative Care Network to optimise links and information sharing to the benefit of consumers and service providers.

The WoundsWest project will continue with the investigation of methods to audit implementation and effectiveness of evidence-based wound management, development and 'go live' of online satellite wound education modules 2-6, the completion of the Indigenous wound management improvement initiative (State Health Research Advisory Council grant in association with Murdoch University), associated report recommendations and the evaluation of a pilot wound imaging and documentation system producing recommendations for Statewide implementation.

Healthy leadership

It is vital in the development of leadership capacity and capability that WA Health provides opportunities to its staff to develop their leadership skills across all levels of service delivery.

Key initiatives in the area of healthy leadership include:

- continuing the delivery of leadership development programs for senior staff;
- implementing the Graduate Development Program for up to 10 graduates from diverse disciplines;
- continuing Service Improvement Workshops to provide basic training in health service improvements with support for implementation in their areas: and
- ensuring governance, transparency and accountability at all levels of management.

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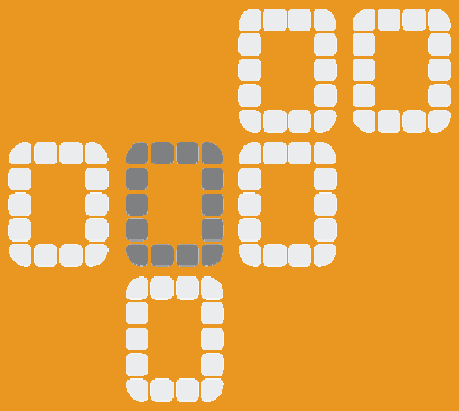


Operations

Advertising

In accordance with section 175ZE of the *Electoral Act 1907*, the Department of Health incurred the following expenditure on advertising agencies, market research, polling, direct mail and media advertising. Total expenditure for 2007-08 was $2,872,443.

Table 36: Total expenditure for Advertising

Summary of Advertising	Amount ($)
Advertising Agencies	257,609
Media Advertising Organisations	1,826,303
Polling	Nil
Market Research Organisations	628,153
Direct Mail Organisations	160,378

Expenditure Category	Recipient / Organisation	Amount	Total
Advertising Agencies			
	303 Group Pty Ltd	60,858	
	The Brand Agency Pty Ltd	24,640	
	Convenience Advertising (Aust) Pty Ltd	25,879	
	EOC Group Pty Ltd	12,007	
	Gatecrasher Advertising Pty Ltd	87,145	
	Parmelia Productions Unit Trust	44,880	
	Van Baren Brown Strategic Communications	2,200	**257,609**
Media Advertising Organisations			
	303 Group Pty Ltd	292,276	
	Albany Weekender	880	
	Appointment Solutions	1,278	
	Australian Government Directory	770	
	Curtin Student Guild	2,000	
	Dardeesings	3,000	
	Department of Premier and Cabinet	13,438	
	Edith Cowan University Student Guild	825	
	Great Southern Health Region	880	
	Guardian News and Media Ltd	6,736	
	Guild of Undergraduates, University of Western Australia	1,100	
	HMA Blaze Pty Ltd	23,719	
	IIA Website	209	

Expenditure Category	Recipient / Organisation	Amount	Total
Media Advertising Organisations (continued)			
	Lasso Media	516	
	Marketforce Express	247,706	
	Media Decisions WA	1,190,955	
	Media Monitors Australia Pty Ltd	994	
	Medical Forum Magazine	1,733	
	Murdoch University Guild of Students	1,650	
	Print Black	3,000	
	Sensis Pty Ltd	1,122	
	State Law Publisher	46	
	Sun City News	498	
	Telethon Institute for Child Health Research	2,416	
	Telstra	745	
	TR Beckett	10,602	
	Travellers Information Radio 88FM	2,880	
	WA Aids Council	11,756	
	West Australian	2,573	**1,826,303**
Market Research Organisations			
	303 Group Pty Ltd	15,663	
	The Brand Agency Pty Ltd	6,557	
	Curtin University of Technology	20,967	
	Edith Cowan University	355,415	
	Hay Group Pty Ltd	21,607	
	Patterson Market Research	22,000	
	University of Western Australia	185,944	**628,153**
Direct Mail Organisations			
	Australia Post	4,508	
	GP Down South	220	
	Packcentre Marketing Services Pty Ltd	42,018	
	Salmat Document Management Solutions Pty Ltd	105,002	
	Specialist Mail Services	7,983	
	Templar International	647	**160,378**

Corruption Prevention

The existence of an effective accountability mechanism is fundamental to good corporate governance. This year WA Health carried out a total of 337 investigations of alleged misconduct.

Strategies introduced across WA Health in 2007-08 assisting in preventing corruption include:

- A Fraud and Corruption Control (FCC) Committee has been established to consider system-wide initiatives, monitor and review fraud and corruption risk assessments and monitor fraud prevention development. The FCC Committee includes representatives from all areas of WA Health;
- A Fraud and Corruption Control Plan has been established; its goals being to set an appropriate strategic framework that defines management and staff responsibilities and ensure the implementation of robust practices for the effective detection, investigation and prevention of fraud and corruption of all types that may arise in WA Health or as a result of its organisation or staff activities;
- An education awareness program is in place for the Department and all health services and is being delivered to all staff in all disciplines and locations. Presentations were developed in consultation with appropriate external oversight agencies, including the Corruption and Crime Commission and the Office of the Public Sector Standards Commissioner;
- Reviews of all WA Health policies and supporting documents pertaining to professional standards, misconduct and the promotion of ethical behaviour have been commenced;
- Misconduct and corruption risk has been included for mandatory assessment by all units in the annual WA Health Significant Risk Assessment and is acknowledged and addressed in the annual Significant Risk Register;
- Mechanisms have been established for ensuring an appropriate knowledge among staff is achieved in relation to awareness of compliance requirements, legislation and lawful instructions, delegation, application of the risk management process, suitable governance arrangements and improvement plans where indicated;
- Misconduct incidents are reportable to the Corporate Governance Directorate, which assesses and investigates where appropriate, provides advice to health services and maintains liaison with relevant external agencies. Its monitoring activities inform the WA Health Executive, external authorities, the WA Health Strategic Risk Management programs, the risk management programs of the Department of Health, all health services and Internal Audit; and
- Risk Management education, advice and support for misconduct risk management is provided by Risk Management Coordinators within the Department of Health and health services and the Corporate Governance Directorate.

Disability Access and Inclusion Plan

The Disability Services Act 1993 was introduced to ensure that people with disabilities have the same opportunities as other West Australians. A 2004 amendment to the Act required the Department of Health to fully develop and implement a Disability Access and Inclusion Plan (DAIP). During 2007-08, the Department of Health provided a range of programs and initiatives to meet disability access outcomes.

In line with the Act, WA Health has submitted DAIPs to the Disability Service Commission from the following health entities:

- Sir Charles Gairdner Hospital;
- Royal Perth Hospital;
- Fremantle Hospital;
- King Edward Memorial Hospital;
- Princess Margaret Hospital; and
- Department of Health (a collective DAIP incorporating all health areas other than teaching hospitals).

An extensive statewide consultation process was conducted to inform WA Health DAIPs. The process included:

- analysis of previous Disability Service Plans, DAIPs, subsequent review reports and other relevant DOH documents and strategies;
- investigation of contemporary trends and good practice in access and inclusion;
- consultation with the Disability Services Commission; and
- consultation with the community and staff.

The DOH has a well-established practice of community consultation in all of its programs. During 2007-08, the Department of Health provided a range of programs and initiatives to meet Disability Access and Inclusion Plan key outcomes, as detailed below.

Outcome 1:

People with disabilities have the same opportunities as other people to access the services of, and events organised by, the relevant public authority:

- The Department of Health is committed to equity of access for people with disabilities to attend all public events in appropriate venues.

Outcome 2:

People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority:

- Disabled access is available at the Department of Health at Royal Street, East Perth and at Grace Vaughan House in Shenton Park, including disabled parking spaces. There are also flat access ramps at the entrances, lifts and disabled toilets;
- Local corridor access is reviewed as part of Occupational Safety and Health biannual reviews;
- Verbal announcements of floor levels operate in the elevators at the Department of Health at Royal Street, East Perth. Control panels in elevators are in line with current regulations; and
- The Royal Street offices have a ramp from the forecourt carpark to the front of the building.

Outcome 3:

People with disabilities receive information from the relevant public authority in a format that will enable them to access the information as readily as other people are able to access it:

- All contracts for non-government organisation health promotion programs must comply with the Department of Health Disability Services Plan (e.g. television advertisements to be closed captions);
- The WA Health Communication Style Guide has been reviewed by the Organisational Development Directorate and the Disability Services Commission and the implementation of recommended changes is ongoing;
- Access to Information Guidelines have been produced;
- Publications are produced using the standards provided in the Department's Communications Style Guide; and
- Web sites are continuously reviewed or updated in accordance with standards. The Department of Health provides web-based material in formats which enable people with sight impairment to change presentation styles in such areas as font size and colour.

Disability Access and Inclusion Plan (continued)

Outcome 4:

People with disabilities receive the same level and quality of service from the staff of the relevant public authority:

- Policy units of the Department of Health address disability access and inclusion when developing policy;
- The Case Management Program (CMP) has clients with disabilities and acts as an advocate to ensure that they have access to all appropriate facilities and services;
- The WA HIV/AIDS Action Plan 2006-2008 and the WA Sexually Transmitted Infections Action Plan 2006-2008 recognise that people with a disability have particular education, prevention, treatment and care needs and that disability workers, carers, and families require appropriate training and support;
- The Sexual Health and Blood borne Virus Program (SHBBVP) funds 'secca' (Sexuality Education Counselling and Consultancy Agency) to provide education and training programs to health care professionals, staff, carers, and families of people with disabilities in the areas of human relationships and sexuality. Subjects include HIV/STIs and BBVs and related support/counselling and referral services, planning and implementing health promotion programs to enhance the health and wellbeing of people with disabilities and educate the wider community, and providing a consultancy service to agencies, health and human service professionals, and carers, families and work colleagues;
- As part of the SHBBVP contract management process, all non-government agencies are required to provide information related to access for people with disabilities as part of the due diligence checklist; and
- It is a condition of employment that DOH employees have knowledge of disability services. All staff members are given opportunities to attend seminars and information sessions on providing services to people with disabilities.

Outcome 5:

People with disabilities have the same opportunities as other people to make complaints to the relevant public authority:

- The Department of Health has in place complaints procedures suitable for disabled clients who are unable to make written complaints and grievance mechanisms to allow people with disabilities to participate without impediment. For example, the Quit WA program accommodates complaints lodged in writing, by telephone, in person or via a "contact us" facility provided on the Quit WA website;
- The Department of Health is committed to equity of access for people with disabilities and conduct all public events in appropriate venues; and
- Where members of the public attend seminars in the theatrette at the Department of Health at Royal Street, East Perth an audio loop has been installed to assist people with hearing difficulties if such assistance is required.

Outcome 6:

People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority:

- WA Health Disability Access Committees include community representatives who have a disability, and who can provide input on their behalf;
- The DOH consults extensively with the community and staff to gain information and feedback about its services and access issues via media and electronic distributions inviting submissions on issues affecting service delivery to people with a disability;

Employee Profile

The table below shows the number of full-time equivalent (FTE) staff employed by the Department of Health year-to-date June 2008 by category.

Table 37: Total Department of Health FTE by category

Category	Definition	2006-07 FTE	2007-08 FTE
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1,214	1,341
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.	16	64
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	0	0
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	n/a	22
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	79	62
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	9	9
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	0	0
Medical support	Includes all Allied Health and scientific/technical related occupations.	26	28
Nursing	Includes all nursing occupations. Does not include agency nurses.	30	31
Site services	Includes engineering, garden and security-based occupations.	0	0
Other categories	Captures Aboriginal and ethnic health worker related occupations.	0	0
Total		**1,374**	**1,557**

Note: The Department of Health includes Health Finance, Health Policy & Clinical Reform, Information Management and Reporting, the Director General's Division & Health Corporate Network.

2006-07 reported data has been realigned to reflect 2007-08 FTE definitions.

Freedom of Information

For the year ending 30 June 2008, the Department of Health received 72 formal applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 38: Freedom of information applications 2007-08

Applications	Number
Carried over from 2006-07	6
Received in 2007-08	66
Total applications received in 2007-08	**72**
Granted: full access	16
Granted: partial or edited access	16
Withdrawn	6
Refused	20
In progress	7
Transferred and other	7

The types of documents held by the Department of Health include:

- reports on health programs and projects;
- health circulars, policies, standards, guidelines;
- health articles and discussion papers;
- departmental magazines, bulletins and pamphlets;
- health research reports (epidemiologic, health surveys, statistical analyses);
- publications relating to health planning and management;
- committee meeting minutes;
- general administrative correspondence;
- financial and budget reports; and
- staff personnel records.

Industrial Relations

The Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations and significant workforce management issues for metropolitan and country health services.

Key activities for 2007-08 included the settlement of new enterprise bargaining agreements for salaried medical practitioners, nursing and ancillary direct care workers and ancillary support workers. At the end of the reporting period negotiations for health professional, administrative, technical and clerical staff were ongoing.

Internal Audit Controls

The Corporate Governance Directorate has the role of accountability adviser and independent appraiser, reporting directly to the Director General. The Directorate provides internal audit, accountability and risk services to the Director General, Senior Management and WA Health, in support of the common objective of achieving and maintaining sound managerial control over all aspects of operations.

The Director General has assigned to the Director, Corporate Governance responsibility for developing and maintaining an effective internal audit function and requires that management and staff within WA Health cooperate with authorised Directorate staff as necessary in the conduct of this assigned work.

Audits undertaken were generally planned audits; however, on occasion, management-initiated or special audits were also carried out. Audits were of a compliance, performance or information systems nature. External consultants were utilised to complete four out of a total of thirty-three audits completed during 2007-08.

WA Health has an overarching Audit Committee that considers matters of strategic importance and system-wide issues. This Committee is advised by and receives information from a number of sub-committees, which consider operational issues as they relate to specific areas. Sub-committees exist for the North Metropolitan Area Health Service, the Child and Adolescent Health Service, the South Metropolitan Area Health Service, the WA Country Health Service, the Department of Health and Health Corporate Network. Each sub-committee has an external chairperson, who is responsible for reporting any matters of operational importance to the WA Health Audit Committee. To ensure appropriate and timely advice is provided to the Director General, the Audit Committee also has oversight of WA Health's Strategic Audit Plan and other associated governance issues and governance-related programs.

Refer to next page for Table 39

Internal Audit Controls (continued)

Table 39: Completed Audits

Audit	Area audited
Accounts Payable, Supply & Finance	Health Corporate Network
Accounts Receivable	Health Corporate Network
Asset Accounting	Health Corporate Network
Audit Log Integrity	WA Health
Budgeting	Health Finance, WA Country Health Service
Clinical Credentialing	Child and Adolescent Health Service, Health Workforce, North Metropolitan Area Health Service, South Metropolitan Area Health Service
Corporate HR Data Warehouse	Health Corporate Network
Email Management, Archiving and Security (Health Information)	Health Information
Financial and Governance Audits Royal Perth Hospital (RPH) Staff Amenities Fund (SMAHS)	South Metropolitan Area Health Service
Financial Returns (Volunteer organisations within Metropolitan Health Services)	Volunteer Organisations with in Metropolitan Health Services
FMA Compliance	South Metropolitan Area Health Service
Governance Review Wirraka Maya Health Service	Drug and Alcohol Office, WA Country Health Service
Health Accounting Manual	Health Corporate Network
Information Protection	Health Information
Major Capital Works Project Management	South Metropolitan Area Health Service
Non-government organisation contract management	Health Finance
Payroll processing and follow-up	Health Corporate Network
Privately referred non-inpatient initiative	Child and Adolescent Health Service, North Metropolitan Area Health Service, South Metropolitan Area Health Service
Records management	WA Country Health Service
Review of Health Reform Implementation Taskforce Projects	Health Reform Implementation Taskforce
Salary packaging and fringe benefits tax reporting	Health Workforce
System control review of pharmacy stocks, Royal Perth Hospital	South Metropolitan Area Health Service
Theatre Management, Royal Perth Hospital	South Metropolitan Area Health Service

Major Capital Works

The following tables show major capital works in progress and works completed during 2007-08.

Table 40: Major capital works in progress

Project	Expected completion date	Approved cost 2007-08 budget ($000)	Estimated total cost ($000)
Albany Regional Resource Centre - Redevelopment Stage 1	September 2011	1,800	26,800
Armadale Kelmscott Hospital - Development	December 2009	2,600	15,970
Broome Regional Resource Centre - Redevelopment Stage 1	August 2009	22,261	42,000
Busselton Integrated District Health Service - Replacement	April 2011	3,720	65,000
Carnarvon Sobering Up Centre	June 2009	500	500
Carryover - Various	N/A	164	1,857
Central Tertiary Hospital - Development Stage 1	December 2013	1,495	53,0672
Corporate & Shared Services Reform - Health Corporate Network	May 2011	4,000	12,813
Country Staff Accommodation- Stage 3	June 2011	6,000	24,068
Country Transport Initiatives	September 2011	47	3,326
Denmark Multi Purpose Centre - Replacement	September 2008	12610	18000
Equipment Replacement Program	June 2015	37,500	241,400
Fremantle Hospital - Holding	June 2012	3,720	15,000
Graylands Hospital - Redevelopment Planning	June 2009	500	600
Harvey Hospital - Redevelopment	December 2012	33	6,200
Hedland Regional Resource Centre – Replacement Stage 2	May 2010	10,253	114,000
Information and Communication Technology	June 2017	26,000	335,000
Infrastructure Planning	N/A	1,088	11,700
Joondalup Health Campus – Development Stage 1	December 2012	15,740	122,672
Joondalup Health Campus – Inpatient Mental Health Unit Expansion	March 2009	5,500	8,650
Kalamunda – Redevelopment Stage 2	March 2012	500	15,439
Kimberley – Various Health Project Developments	August 2008	13,247	45,300
King Edward Memorial Hospital – Holding	June 2014	3,500	20,000
Land Acquisition	June 2009	900	5,750
Mandurah Community Health Centre Stage 2	February 2010	792	3,200
Mental Health Initiatives	June 2009	400	11,900
Minor Buildings Works	June 2015	34,500	253,430
Murray Districts Health Centre	October 2008	3,810	5,470
North Perth Dental Clinic Extension	December 2008	279	300
Osborne Park Hospital – Reconfiguration Stage 1	November 2014	1,000	79,039

Major Capital Works (continued)

Table 40: Major capital works in progress (continued)

Project	Expected completion date	Approved cost 2007-08 budget ($000)	Estimated total cost ($000)
Picture Archive and Communication System - Stage 1	December 2008	1,300	6,500
Princess Margaret Hospital - Holding	December 2010	5,600	15,000
Rockingham-Kwinana Hospital - Redevelopment Stage 1	June 2009	45,000	92,136
Royal Perth Hospital - Holding	June 2011	3,255	10,000
Shenton Park - Holding	September 2011	1,860	5,000
South West Health Campus - Intensive Care Unit	June 2009	300	300
South West Health Campus - New Radiotherapy Facility	December 2009	660	8,500
Southern Tertiary Hospital - New Stage 1 (Fiona Stanley Hospital)	December 2013	15,150	1,092,421
Swan Health Campus	March 2013	200	181,200
WACHS Picture Archiving and Communication System	June 2009	3,000	6,500
Wyndham Multi Purpose Centre - Development	July 2009	1,464	4,500

Table 41: Major capitals works completed

Project	Project commencement date	Project completion date	Approved cost 2007-08 budget ($000)	Final cost ($000)
Bunbury – Replacement Dental Clinic	January 2005	November 2007	2,206	3,186
Carnarvon Integrated District Health Service – Redevelopment Stage 1	August 2004	April 2008	1,950	2,300
Kununurra Integrated District Health Service – Development	January 2005	July 2007	1,157	6,800
Morawa & Perenjori – Multi Purpose Centre – Replacement	October 2004	May 2008	6,700	9,130
Pathways Home Program	January 2005	June 2008	11,000	23,000
Peel Health Campus – Emergency Department expansion	October 2005	March 2008	2,046	300
Sir Charles Gairdner Hospital – Neurosciences Centre – Radiological Services	January 2005	November 2007	3,956	7,604
South West Health Campus – Inpatient Mental Health Unit Expansion	January 2005	November 2007	1,706	3,754
South West Health Campus – New Mental Health Clinic	January 2006	December 2007	1,505	5,505

Notes

- The above information is based upon the 2007-08 published budget papers.
- Minor projects forming part of internal funds and balances have not been included.
- Commencement year for the completed projects is the year when planning and documentation commenced.
- The estimated total cost for the projects in progress, is based upon the current figures as per 2007-08 budget papers.
- Some project descriptions have been altered over time to ensure consistency.
- New works commencing with funding cashflow in outyears have not been included.
- Completion timeframes are based upon a combination of known dates and financial closure.
- Projects completed in prior year that do not have a cashflow in 2007-08 are not included.

Pricing Policy

The Australian Health Care Agreement (AHCA) sets the macro pricing framework for the charging of public hospital fees and charges.

Under the AHCA, where a Medicare eligible patient elects to be receive medical treatment as a public patient in a public hospital, they will be treated 'free of charge'.

The only exception to this pricing policy for eligible patients is where Nursing Home Type Patients (after 35-days convalescence), may be charged a patient contribution, as determined by the Commonwealth Minister for Health and Ageing.

Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State of Western Australia.

The one exception to the charging of health services to these chargeable classes of patients is that pharmaceutical services to admitted private patients will be provided 'free of charge' and cannot be claimed under the Pharmaceutical Benefits Scheme.

The pricing policy for the setting of public hospital accommodation charges to private patients is dictated by our ability to pass on these costs to the private health insurers.

Current arrangements with the Commonwealth allow for the Department of Health to charge both compensable and ineligible patients on the basis of full cost recovery.

Under the AHCA, eligible patients who have entered into 'third party' arrangements with compensable insurers are known as compensable patients. This includes the Australian Defence Forces, the Insurance Commission of Western Australia covering motor vehicle accident patients and WorkCover for workers' compensation patients.

The one exception with compensable patients is the charging of eligible war service veterans, who are covered under a separate Commonwealth-State agreement with the Department of Veterans' Affairs. Under this agreement the Department of Health does not charge medical treatment costs to eligible war service veteran patients, instead medical costs are fully recouped from the Department of Veterans' Affairs.

The majority of fees and charges for public hospitals are set out in the *Hospitals (Services Charges) Regulations 1984 and the Hospitals (Services Charges for Compensable Patients) Determination 2005*. The public hospital fees and charges are reviewed annually and increased in accordance with Ministerial and other approval processes. The exceptions are fees for pharmaceuticals and nursing home type patients, which are increased on advice from the Department of Health and Ageing.

Dental Health Services charges eligible patients subsidised dental care based on the Commonwealth Department of Veterans' Affairs Local Dental Officers fee schedule, with eligible patients charged either of the following co-payment rates:

- 50% of the treatment fee if the patient is the holder of a Health Care Card or Pensioner Concession Card; and
- 25% of the treatment fee if the patient is the holder of one of the above cards and in receipt of a near full pension or benefit from Centrelink or the Australian Government Department of Veterans' Affairs.

Recordkeeping

The Department of Health Recordkeeping Plan was cleared in 2004; both the Retention and Disposal Schedule for Administrative/Functional Records and the Recordkeeping Plan were approved by the State Records Commission on 8 March 2007.

The Department of Health continues to progress the Recordkeeping Plan. During 2007-08 the Business Classification System and the Retention and Disposal Schedule for Administrative/Functional Records were implemented throughout the Royal Street Divisions.

Performance indicators for recordkeeping have been developed around the broad areas of quality, quantity, responsiveness and participation and it is planned that an evaluation of the efficiency and effectiveness of the recordkeeping systems will be conducted during 2008-09.

Examples of measures include:

- Number of staff who have successfully completed Recordkeeping Awareness Training;
- Number of documents electronically saved into TRIM;
- Number of files created within 24 hours of receiving request; and
- Number of staff using the Electronic Document and Records Management System (EDRMS).

An EDRMS training and development officer provides training to Royal Street Divisions staff regarding the use of the EDRMS and Records Management. It is planned to develop an online recordkeeping awareness package to further educate and inform staff of their recordkeeping responsibilities.

All new employees are reminded of their obligations in regard to recordkeeping through the induction program. The Electronic Documents and Records Management System (EDRMS) support officer provides additional training as required.

The document management software SharePoint has been further implemented to reduce duplication of electronic and hard copy documents used by teams. SharePoint provides document tracking, revision history and an audit parth of document development. It is used as a tool to reduce document storage requirements.

Recruitment

WA Health is using alternative methods to recruit clinical coders, a skilled group that is in short supply nationally. The Workforce Division of WA Health has participated in international recruitment initiatives in New Zealand and the United Kingdom where direct recruitment of clinical coders is being pursued, as well as seeking interest from clinical coders who might be undertaking working holidays in Australia.

Staff Development

The Department of Health has a strategic goal to promote and fully utilise the skills, knowledge and attributes of all staff. Training and development is the single most important mechanism for developing individual effectiveness consistent with the aims of the department.

Through continuous learning and development, Department of Health staff are able to:

- understand the department's core business goals;
- understand their contribution to the work of the department, as well as the contributions of their colleagues;
- undertake current duties with maximum effectiveness;
- deal positively and productively with change;
- develop skills and expertise in order to progress their own career development; and
- develop new areas of expertise which allow the most recent work practices and technology to be easily assimilated into the work of the department.

Staff development programs focus on developing skills for effective government business. These programs include:

- Performance development training;
- Training of managers in flexible work practices;
- WA Health Graduate Development Program: This program, conducted in 2008 by the Institute of Healthy Leadership after being conducted by Workforce Development for the past three years, provides opportunities for the best and brightest graduates of Australia's universities to work in the Department's corporate business arm. Nine graduates are participating in 2008;
- Prevention of bullying in the workplace: This program provides employees and managers with information on how to manage or resolve incidents of bullying behaviour and reinforces the department's policy of non-tolerance; and
- Ministerial writing and policy writing.

The Institute of Healthy Leadership was established in July 2007 and has developed a range of new leadership development programs as part of WA Health's strategy to build leadership capacity and capability as integral and important components of the health system reforms.

Three important programs have been designed to assist in building a greater pool of future senior leaders. 100 managers are participating in the Emerging leaders program, 22 on the Delivering the Future program and two in the Top Leaders Program. These programs will continue throughout 2008-09 and further development opportunities offered to others. Throughout the Institute's programs there is a strong focus on service improvement.

During 2007-08 all past participants in the Vital Leadership and Leading 100 programs have been invited to further workshops on delivering service improvement.

In addition to the focus on personal development the Institute for Healthy Leadership is assisting a number of groups within WA Health with improving team and organisational effectiveness.

Mental health

Staff in the Mental Health Division have undertaken various development courses over 2007-08, including the following:

- Recruitment and selection;
- Managing performance;
- Performance development;
- Interview techniques;
- Writing ministerial briefings;
- Media training;
- Consultation and stakeholders management;
- Project management;
- Conflict management;
- Career management;
- Practical editing;
- Contract management;
- Introduction to PowerPoint; and
- Excel courses.

Substantive Equality

The Department of Health is committed to providing services in a fair and non-discriminatory manner, with improved access to services to meet the different needs of its client groups.

In December 2004 the Western Australian Government released the Policy Framework for Substantive Equality. The Policy Framework recognises the principles of the WA Charter of Multiculturalism and is underpinned by the objectives of the Equal Opportunity Act 1984.

The Policy Framework for Substantive Equality encompasses five stages:

1. Commitment to implementing the Policy Framework for Substantive Equality
2. Identifying clients and their needs
3. Setting objectives/ targets and developing strategies to address needs
4. Monitoring strategies
5. Review and evaluation.

The following provides an update on the progress of the Department of Health in implementing the Policy Framework.

The BreastScreen Initial Needs and Impact Assessment Report highlights a number of positive findings relating to how BreastScreen WA's service delivery aims to meet the needs of Indigenous and ethnic minority women. Key results are:

- positive practices in community consultation and engagement;
- the use of a range of methodologies to encourage women from different Indigenous and ethnic minority backgrounds to attend screening services; and
- specific strategies developed for Indigenous women in rural and remote regions including block bookings, transport assistance, interpreting services and partnerships with Indigenous community health workers.

As the BreastScreen participation rate of Indigenous women in the WA metropolitan area is low (as it is across Australia), the main recommendations of the report relate to adopting the same methods of engagement for Indigenous women in the metropolitan area that are were already successful in rural and remote WA, as well as researching and determining key barriers for participation for Indigenous women in metro areas.

The Department of Health has also achieved the following outcomes from Level 1:

- the use of a range of methodologies to A corporate and executive policy on the Policy Framework; and
- an organisational structure for supporting the implementation of the Policy Framework – the Substantive Equality Implementation Committee.

The following outcomes will be progressed through the Implementation Committee:

- resources and clear lines of responsibility for implementing the Policy Framework;
- negotiating the scope of implementation for 2008/2009 with the Commissioner for Equal Opportunity; and
- a clear communication strategy for informing and educating designated staff about the Policy Framework.

Sustainability

The Department of Health's Sustainability Action Plan was developed following consultation with officers throughout WA Health and endorsed by the Acting Director General of Health in December 2004. The plan outlined an approach to addressing sustainability in the WA health system over the subsequent three years. The principles of economic, social and environmental sustainability ensure that WA has a health system that is economically sustainable while continuing to provide high-quality health services.

Since the release of the Sustainability Action Plan (SAP), further work has been undertaken across the system to support the actions, commitments and targets identified in the plan. The range of initiatives undertaken by WA Health in relation to each of the commitments is outlined below.

Strategic planning

WA Health has incorporated sustainability, principles and actions into setting goals and determining strategic plans, consistent with *Better Planning: Better Services – A Strategic Planning Framework for the Western Australian Public Sector*.

Sustainability assessments

Sustainability assessments have been incorporated into business case pro forma documents and project plans where appropriate.

Legislation

The draft Public Health Bill was released for public comment in February 2008. The aims of the Bill are to protect and promote the health of the public of Western Australia and to reduce the incidence of preventable illness. The new Act will provide modern, flexible public health laws and the tools by which traditional and emerging public health concerns can be addressed.

Importantly, the Bill establishes the following principles:

- sustainability principles;
- the precautionary principle;
- the principle of proportionality;
- the principle of intergenerational equity; and
- the principle relating to local government.

Public comments received have informed the draft Bill.

Consulting citizens

Across WA Health, there has been significant consultation in policy development and decision-making with stakeholders and the public on a continuous basis. For example, when developing the *Healthy Options WA: Food and Nutrition Policy for WA Health Services and Facilities* (released in December 2007), key health stakeholders were consulted through an Advisory Group and consultation processes. The WA Country Health Service participates in seven Regional Aboriginal Health Planning Forums providing a key avenue for planning, problem solving and joint management for the development and delivery of health services to Aboriginal people.

Procurement

The Department of Treasury and Finance issued a Procurement Practice Guide in January 2008 to assist agencies in purchasing products and services. The issue of sustainability is specifically covered in the guide, which states that a 'Public Authority should consider procurement that will deliver the best value-for-money outcome through reduced greenhouse emissions, improved energy efficiency and support the use of recycled and recyclable goods'. The guide provides advice on considering environmental impacts and opportunities throughout the procurement process.

Service delivery

The key area in which sustainability principles have been endorsed and implemented is the provision of health services across the state. For example, the introduction of Emergency Department Mental Health Liaison services at Armadale-Kelmscott, Fremantle, Rockingham Kwinana and Royal Perth hospitals has enhanced service delivery to community members with mental health conditions.

Sustainability (continued)

Environmental performance

In 2007-08, the Environmental Health Directorate (EHD) developed a workshop with the following aims:

- to determine how WA Health could respond to the challenge/requirement to reduce its environmental footprint;
- to acknowledge the activities that were already occurring across WA Health;
- to understand the scope of what is involved; and
- to agree on the first steps to take, and how these could be coordinated across WA Health.

The first such workshop will be delivered in July 2008. A report on the workshop outcomes including key recommendations will be developed for senior executives.

Vehicles and travel

All area health services have complied with the WA Health fleet policy requirements, including a carbon neutral fleet, use of four-cylinder vehicles where appropriate, and use of LPG on six-cylinder vehicles where possible.

The QEII Medical Centre Trust and Sir Charles Gairdner Hospital are committed to managing travel through implementation of the new QEIIMC Travel Plan. QEIIMC is the first public hospital site in WA to take such proactive steps towards managing travel. This plan was highly commended in the Sustainable Transport Awards 2007.

Government buildings, built assets and land

WA Health has incorporated sustainability into the design and management of buildings and other assets, e.g. the QEII and Midland Health Campus redevelopments.

Volunteering for community development

Staff from across the health system have participated in a diverse range of community based voluntary initiatives. A number of staff members have volunteered through various agencies and initiatives significant to community, emergency/disaster and relief teams.

Sustainability through diversity

The Office of Aboriginal Health developed the WA Aboriginal Health Cultural Respect Framework to ensure that WA Health better developed and delivered health services to Indigenous people.

The cultural respect implementation framework has four key parts:

- an Aboriginal impact statement for policy and program development;
- services reform through cultural partnerships, education, review and practice development;
- Aboriginal workforce development; and
- monitoring and evaluation.

Occupational health and safety

WA Health has policies and procedures in place to effectively manage workplace safety as advocated in occupational health and safety legislation.

State sustainability strategy actions

As required by the Sustainability Code of Practice, the following describes how WA Health has progressed health-related actions:

- A Health Impact Assessment (HIA) Discussion Paper was released for 4 month public comment in June 2007. This paper sought feedback on the means by which HIA could be incorporated into existing assessment procedures for sectors other than health. The outcomes of the discussion process are being used for the development of policy positions related to HIA implementation. A number of health sectors have started investigating the use of HIA as a tool for assessment of DOH activities. EHD has worked collaboratively with the School of Public Health at Curtin University of Technology to develop a Graduate Diploma in Health Impact Assessment, with first enrolments in Term 1 2008;
- WA Health contracts a number of NGOs to deliver an extensive range of programs and campaigns that promote healthy lifestyles, with the aim of preventing chronic disease and injury. These include the continuation of the *Find thirty*® physical activity program and the *Go for 2&5*® fruit and vegetable nutrition program, as well as the long-running *Make Smoking History* program;
- In October 2007, the EHD published and released *Health Impacts of Climate Change:*

Adaptations for Western Australia for public comment. The document was released to inform Government and the public about the potential health impacts of climate change in WA, obtain further information on components that were not identified during the study, and identify stakeholder individuals and groups interested in future involvement in actions to address the proposed adaptations. The EHD is currently working with a number of sectors external to the Department of Health that have responsibility for addressing the adaptation outcomes;

- In November 2007 the Director General of Health approved the formation of the Health and Climate Change Steering Group with leadership provided from the Public Health Division. The purpose of the Steering Group is to present a forum for whole of sector collaboration on activities associated with its responses to climate change and to coordinate Department of Health responses arising from these activities; and
- Twenty four District Health Advisory Councils continue to build their capacity in the WA Country Health Service.
  These facilitate community participation and involvement in improving country health services in four functional areas:
  - effective two-way communication as well as individual and system advocacy;
  - contributing to improved service safety and quality (e.g. Patient First & health service audits);
  - participating in health service planning; and
  - assisting to build healthy and safe communities.

Workers' Compensation and Rehabilitation

The Department of Health is committed to the prevention of occupational injuries and diseases, and to ensuring that effective rehabilitation services are available to employees.

Table 42: Workers' compensation and rehabilitation claims 2007-08

Employee category	Number of claims in 2007-08
Nursing Services/Dental Care Assistants	Nil
Administration and Clerical	10
Medical Support	Nil
Hotel Services	Nil
Maintenance/ Supply (HCN)	Nil
Medical (salaried)	Nil
Total	**10**

Occupational injury and illness prevention

Programs provided in 2007-08:

- Induction of new staff, including ergonomic principles and hazard reporting;
- Six-monthly audit inspections;
- OSH training for managers and supervisors;
- Ergonomic assessments of employees by the Consultant Occupational Safety and Health; and
- Website information including policy guidelines on ergonomics and self-directed programs in relation to workstation ergonomics.

Employee rehabilitation

Programs provided in 2007-08:

- Injury management programs provided in-house through the Consultant Occupational Safety and Health and external approved rehabilitation providers. Theses included return to work programs and working guidelines for individual employees on workers compensation or extended sick leave;
- Compulsory injury management training for all managers and supervisors;
- Ongoing liaison with treating medical practitioners and treatment providers for injured or sick employees; and
- Provision of alternative or restricted duties and alternative positions for sick and injured employees.

Occupational Safety & Health and Injury Management Performance

The Department of Health aims to establish a single strategic approach to occupational safety and health, workers' compensation and injury management across WA Health. The intention of the injury management system is to achieve compliance with regulatory requirements and Australian Council of Healthcare Standards accreditation, as well as establishing a best practice model for managing safety, health and workers' compensation. The Department of Health acknowledges that effective injury management ranks along side the traditional areas of productivity and quality as an essential component in the overall efficiency of the organisation.

The Department also acknowledges and actively promotes the philosophy of consultation and co-operation between employer and employee, recognising that the fostering and the development of this alliance will lead to the Department of Health achieving best practice in injury management.

Consultation between management and employees allows decisions on managing workplace Safety and Health to be based on information gained from a holistic approach. A consequence of this co-operative approach is a greater commitment to the decisions that are made resulting from all concerned participating and having ownership of the process.

The Department of Health carries out all its injury management obligations within the guidelines set out under the *Workers Compensation and Injury Management Act 1981* and the WorkCover *Workers' Compensation Code of Practice (Injury Management) 2005*. While adherence to the Act and code of practice is a minimum standard requirement, it is the view and vision of the Department of Health that a best practise Injury Management System should be maintained. This will achieve a self-regulated, pro-active and innovative approach to injury management, which will enable the Department of Health to strive towards leadership in injury management within the health sector.

The Department of Health provided the following occupational injury and illness prevention and employee rehabilitation programs in 2008:

- principles and hazard reporting;
- occupational safety and health induction for all new staff, including ergonomic advice;
- on-site workstations ergonomic advice on request;
- a website with interactive program on office-based ergonomics;
- Occupational Safety & Health staff induction training;
- risk assessments and site inspections for various worksites as requested;
- an active injury management policy and program to facilitate early return to work;
- an injury management coordinator facilitating injury management, contact with the injured worker and their medical practitioner, provision of alternative duties and amended duties as required;
- collaboration with medical practitioners, the injured worker, the rehabilitation provider and insurer RiskCover; and
- liaison with vocational rehabilitation providers to assist in the graduated return to work of injured workers.

Table 43: Occupational safety and health incidence and severity

Fatalities	Lost time injury/disease incidence rate	Lost time injury/disease severity rate
0	0.26	25

Patient Evaluation of Health Services 2007-08

Background: Patient satisfaction ratings of the service and outcome of the health care provided give an indication of the perceived quality of service provided. Research has shown that satisfaction is related to better health outcomes.[1]

Every year since 1997, the Patient Evaluation of Health Services (PEHS) has surveyed thousands of patients and asked about their experiences in the health system. Since 2004-05, surveys have been completed as a telephone survey with the exception of some special patient groups. This has attracted excellent response rates of more than 85 per cent with participation rates of more than 90 per cent. These high response rates lend more weight to the results and can be assumed to be representative, reliable and valid. All patient groups are surveyed within a three-year cycle.

As part of the 2007-08 PEHS, 5,086 admitted patients and 1,657 emergency patients were interviewed about their experience. Admitted patient groups included adults and children (children's carers answered on behalf of the children) who stayed for 0-1 night; adults and children (children's carers answered on behalf of the children) who stayed for 2-34 nights; adults who stayed 35 nights or more and persons aged 75 years or more. The surveys were conducted between February and June 2008.

What aspects of health care are important to patients

A review of the literature and a series of focus groups determined that there were seven stable aspects of health care that are related to patient satisfaction. However, the relative importance that patients attribute to each aspect of health care might change in response to circumstances. Each year, respondents are asked to rank the seven aspects from most important to least important in order to determine the relative importance of the aspects of care.

For all admitted patient groups and emergency patients surveyed this year, the most important aspect of health care is time and attention given to care and the least important aspect of health care relates to the residential aspects of the health facility.

The 2007-08 admitted patient survey: scale scores, overall indicator of satisfaction and outcome score

Scale scores represent the level of satisfaction (out of 100) for each aspect of health care. A score of 80 is considered average, while a score of 90 or above is considered a best practice. The seven scales correspond with the seven important aspects of health care. An overall indicator of satisfaction is calculated from the seven scale scores, weighted by the degree of importance as ranked by the respondents. Also presented is the outcome score (out of 100); this is a measure of how satisfied people are with the outcome of their visit to the hospital. All tables present the results as scores out of 100.

The 2007-08 results for admitted patients

Table 44 shows the comparison of the Scales Scores, Overall Indicator of Satisfaction and Outcome Scores of patients admitted for 0 to 1 night, 2 to 34 nights and 35 or more nights.

[1] Ostir, Simonsick et al. 2002; Staiger 2005

Table 44: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score for admitted patients by length of stay, PEHS 2007-08

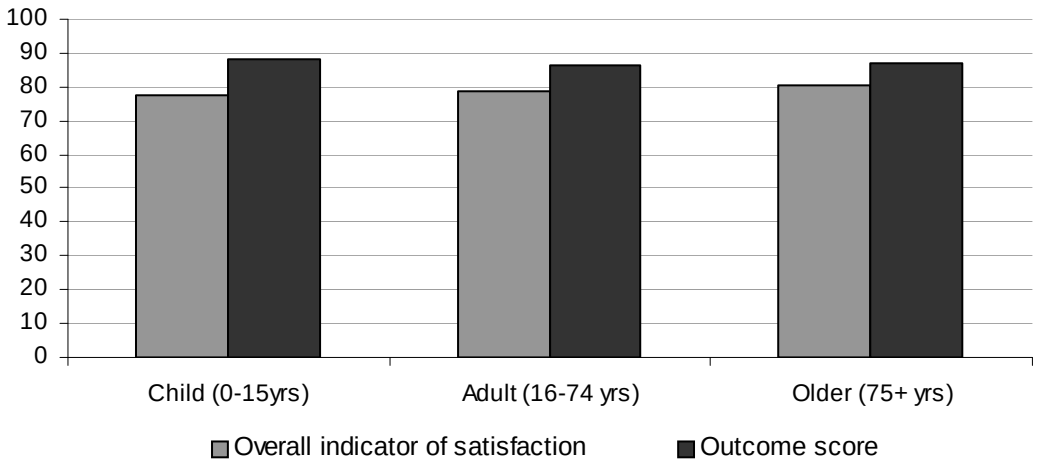
Scales, Overall Indicator of Satisfaction and Outcome Score	0-1 Night	2-34 Night	35+ Nights
Getting into hospital	67.3	65.0 ↓	73.0
Time and attention paid to patients' care	85.1	88.7 ↑	83.7
Information and Communication	80.3	83.8 ↑	75.2
Meeting personal as well as clinical needs	88.8	92.1 ↑	79.7 ↓
Continuity of Care	72.2	71.8	68.8
Involved in decisions about your care and treatment	73.5	74.0	70.2
Food and Residential aspects	59.5	63.3 ↑	53.3 ↓
Overall indicator of satisfaction	**77.2**	**79.2**	**74.2**
Outcome score	**85.1**	**87.7**	**72.4 ↓**

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the comparison score

Four scales are significantly higher for patients who stayed for between two and 34 nights when compared with the other two groups. *Time and attention paid to patients' care* is significantly higher and is also the most important aspect of health care for this patient group.

Patients who stayed in hospital for 35 nights or more had scale scores significantly lower for *Food and residential aspects, Meeting personal as well as clinical needs* and *the outcome score* when compared with the other two groups.

Figure 5: Overall Indicator of Satisfaction and Outcome Score for admitted patients, by age group, PEHS 2007-08



* Indicates the mean score is significantly higher than the other groups

Figure 5 presents the overall indicator of satisfaction and outcome scores for admitted patient age groups.

The older patient group has a significantly higher overall indicator of satisfaction than the younger age groups.

Comparison across hospital peer groups

Hospitals are given information each year about how their hospital performed compared to others within their peer group. Results for the State are presented in Table 45.

Table 45: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score for admitted patients, 0-34 night, by hospital peer groups, PEHS 2007-08

Scales, Overall Indicator of Satisfaction and Outcome Score	All admitted 0-34 night	Tertiary	Non-Tertiary Metro	Regional Resource Centre	Integrated District Health Service	Other Service Location
Getting into hospital	66.0	62.9	66.8	64.7	70.1	71.5
Time and attention paid to patients' care	87.2	86.0	88.5	86.5	87.3	89.1
Information and communication	82.4	82.2	82.8	81.3	81.4	84.5
Meeting personal as well as clinical needs	90.7	89.0↓	92.0	90.9	91.3	92.6
Continuity of care	72.0	70.8	72.6	70.4	70.0	79.1↑
Involved in decisions about care and treatment	73.8	73.3	72.8	74.3	75.0	75.2
Food and residential aspects	61.7	57.7↓	63.6	61.2	64.9	68.2
Overall indicator of satisfaction	**78.3**	**76.9**	**79.1**	**77.7**	**79.1**	**81.5**
Outcome score	**86.6**	**85.6**	**87.2**	**86.4**	**87.2**	**88.6**

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the comparison score.

Tertiary hospitals have scale scores significantly lower for *Meeting personal as well as clinical needs* and *Food and residential aspects* than all other peer groups.

Other service locations have scales scores significantly higher for *Continuity of care* than all other peer groups.

As has been found in previous years, hospital size is inversely related to satisfaction across many scales, indicating that patients tend to be more satisfied in the smaller hospitals.

The Outcome score is not significantly different for all hospital peer groups and is higher than the overall indicator of satisfaction for all groups indicating that although patients are satisfied with their experience while in hospital they are more satisfied with the outcome of their hospital visit irrelevant of the hospital visited.

Comparison of 2007-08 with previous years

Results of this year's survey have been calculated and compared with the results from 2006-07 and Table 46 presents the results.

Table 46: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2007-08 compared with 2006-07 for patients admitted 0 to 1 night

Scales, Overall Indicator of Satisfaction and Outcome Score	2006-07	2007-08
Getting into hospital	66.3	65.0
Time and attention paid to patients' care	89.0	88.7
Information and Communication	83.9	83.8
Meeting personal as well as clinical needs	91.9	92.1
Continuity of Care	72.7	71.8
Involved in decisions about your care and treatment	73.9	74.0
Food and Residential aspects	64.8	63.3↓
Overall indicator of satisfaction	**79.5**	**79.2**
Outcome score	**88.6**	**87.7**

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the comparison score.

The food and residential aspects is significantly lower in 2007-08 when compared with 2006-07. All other scales, the overall indicator of satisfaction and the outcome score are not different.

Results of this year's survey have been calculated and compared with the results from 2006-07 and 2005-06 and Table 47 presents the results.

Table 47: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2007-08 compared with 2006-07 and 2005-06 for patients admitted 2 to 34 nights

Scales, Overall Indicator of Satisfaction and Outcome Score	2005-06	2006-07	2007-08
Getting into hospital	69.8	69.6	67.3↓
Time and attention paid to patients' care	86.2	86.4	85.1
Information and Communication	81.8	81.5	80.3
Meeting personal as well as clinical needs	89.6	89.9	88.8
Continuity of Care	68.7	68.8	72.2
Involved in decisions about your care and treatment	73.2	74.2	73.5
Food and Residential aspects	62.0	61.7	59.5↓
Overall indicator of satisfaction	**78.0**	**77.9**	**77.2**
Outcome score	**85.7**	**86.0**	**85.1**

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the comparison score

Getting into hospital and *Food and residential aspects* are both significantly lower when compared with the two previous years.

The 2007-08 results for emergency patients

Emergency patients in metropolitan and WACHS regional resource centres were surveyed about their experience. Figure 6 presents the scale scores for the state.

Figure 6: Mean Scale Scores for State Emergency patients, PEHS 2007-08

The three highest satisfaction scale scores align with the three most important aspects of health care as ranked by patients; *Time and Attention Given to Care*, ranked most important, has an average scale score of 84.4; *Meeting Personal as well as Clinical* Needs, ranked second most important, has an average state score of 82.1; and *Information and Communication*, ranked third most important, has an average state score of 87.0. The *Food and Residential Aspects* Scale show the lowest levels of satisfaction which is also the least important to these patients.

Table 48 presents the overall indicator of satisfaction and patient rated outcome of hospital stay for emergency patients by health service area.

Table 48: Overall Indicator of Satisfaction and Outcome Score for Emergency patients, by health service area, PEHS 2007-08

Scales, Overall Indicator of Satisfaction and Outcome Score	State	Metropolitan	WACHS
Overall indicator of satisfaction	75.7	76.2	74.9
Outcome score	85.7	86.5	84.3

There were no significant differences in the emergency patients when comparing health service area.

Comparison of 2007-08 with 2004-05

Results of this year's survey have been calculated and compared with the results from 2004-05 Table 49 presents the results.

Table 49: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2007-08 compared with 2004-05 for emergency patients

Scales, Overall Indicator of Satisfaction and Outcome Score	2004-05	2007-08
Getting into hospital	69.0	67.3↓
Time and attention paid to patients' care	86.1	87.5
Information and Communication	83.6	84.8
Meeting personal as well as clinical needs	82.8	82.6
Continuity of Care	75.5	77.2
Involved in decisions about your care and treatment	57.4	56.8
Food and Residential aspects	62.4	57.8↓
Overall indicator of satisfaction	76.1	76.0
Outcome score	84.2	86.2↑

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the comparison score

Getting into hospital and *Food and residential aspect* scales are significantly lower for 2007-08 when compared with 2004-05. The outcome score is significantly higher for 2007-08 when compared with 2004-05.

Conclusions

Satisfaction exceeds the average level of 80 for three of the seven scales when patients are admitted between 0 to 34 nights. This indicates high levels of satisfaction with these areas of health care. These best performing scales are also among the most important as indicated by patients. This suggests that hospital personnel are putting their efforts into the most important areas as defined by patients. Improvements can be made but patients agree that the most important aspects of service are done well.

For admitted patients, the outcome score is stable and consistent across all groups except length of stay where patients who stayed for 35 nights or more had a significantly lower score.

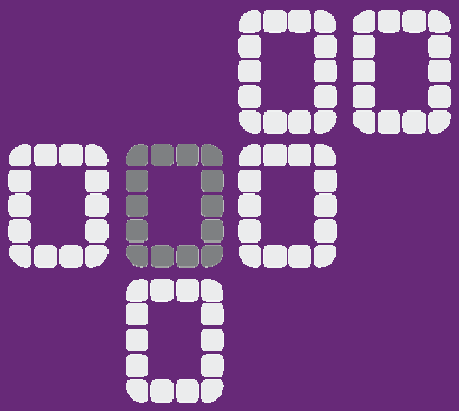
Emergency patients are most satisfied with the three aspects of health care that are most important to them and this has remained stable from 2004-05 to 2007-08. The outcome score this year is significantly higher when compared with 2004-05. Higher outcome scores show that patients can distinguish between the process of being cared for in a hospital setting and the outcome of the hospital visit.

References

Ostir, G. V., E. Simonsick, et al. (2002). "Satisfaction with support given and its association with subsequent health status." Journal of Aging and Health **14**(3): 355-369.

Staiger, T. O., Jarvik, J.G. Deyo, R.A. et al (2005). "Brief Report: Patient-physician agreement as a predictor of outcomes in patients with back pain." Journal of General Internal Medicine **20**: 935-937.

Data Source: WA Consumer Evaluation of Health Services survey. This year 6743 people were interviewed by telephone and answered questions about their hospital stay.



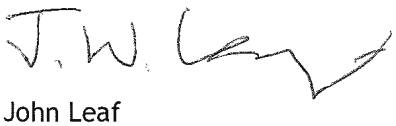
Financial Statements

Certification Statement

DEPARTMENT OF HEALTH
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2008

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 present fairly the financial transactions for the financial year ending 30 June 2008 and the financial position as at 30 June 2008.

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.



John Leaf
Chief Finance Officer
Department of Health

Date: 17 September 2008

Dr Peter Flett
Accountable Authority
Department of Health

Date: 17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

DEPARTMENT OF HEALTH
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

I have audited the accounts, financial statements, controls and key performance indicators of the Department of Health.

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, a summary of significant accounting policies and other explanatory Notes.

The key performance indicators consist of key indicators of effectiveness and efficiency.

Director General's Responsibility for the Financial Statements and Key Performance Indicators
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 (including the Australian Accounting Interpretations) and the Treasurer's Instructions, and the key performance indicators. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements and key performance indicators that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; making accounting estimates that are reasonable in the circumstances; and complying with the Financial Management Act 2006 and other relevant written law.

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and key performance indicators is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements and key performance indicators.

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel 08 9222 7500 Fax 08 9322 5664

Audit Opinion (continued)

Department of Health
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the Department of Health at 30 June 2008 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

(ii) the controls exercised by the Department 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, and

(iii) the key performance indicators of the Department are relevant and appropriate to help users assess the Department's performance and fairly represent the indicated performance for the year ended 30 June 2008

GLEN CLARKE
ACTING AUDITOR GENERAL
22 September 2008

Financial Statements

Department of Health

Income Statement

For the year ended 30 June 2008

	Note	2008 $000	2007 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	8	71,444	63,771
Contracts for services	9	597,788	527,660
Supplies and services	10	74,682	47,288
Grants and subsidies	11	18,963	14,822
Depreciation expense	12	3,861	3,501
Finance costs	13	7,640	8,023
Capital user charge	14	-	8,070
Loss on disposal of non-current assets	15	145	738
Other expenses	16	17,240	13,846
Contribution to Hospital Fund	17	103,930	66,845
Total cost of services		**895,693**	**754,564**
INCOME			
Revenue			
User charges and fees		7,525	7,089
Commonwealth grants and contributions	18	165,220	130,824
Other revenue		4,692	8,023
Total revenue		**177,437**	**145,936**
Total income other than income from State Government		**177,437**	**145,936**
NET COST OF SERVICES		**718,256**	**608,628**
INCOME FROM STATE GOVERNMENT			
Service appropriation	19(a)	666,404	607,284
Liabilities assumed by the Treasurer	19(b)	132	574
Assets assumed/(transferred)	19(c)	2	(19)
Resources received free of charge	19(d)	1,938	3,500
Total income from State Government		**668,476**	**611,339**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(49,780)**	**2,711**

The Income Statement should be read in conjunction with the notes to the financial statements.

Department of Health

Balance Sheet

As at 30 June 2008

	Note	2008 $000	2007 $000
ASSETS			
Current Assets			
Cash and cash equivalents	20	5	28,820
Restricted cash and cash equivalents	21	12,544	7,489
Inventories	22	7,202	6,300
Receivables	23	2,706	2,721
Other current assets	25	154	162
Total Current Assets		22,611	45,492
Non-Current Assets			
Restricted cash and cash equivalents	21	670	430
Amounts receivable for services	24	41,391	35,505
Land and buildings	26	171,828	154,693
Plant and equipment	27	7,770	1,142
Total Non-Current Assets		221,659	191,770
Total Assets		**244,270**	**237,262**
LIABILITIES			
Current Liabilities			
Payables	29	48,496	19,607
Provisions	30	13,312	12,531
Borrowings	31	42,296	4,328
Total Current Liabilities		104,104	36,466
Non-Current Liabilities			
Provisions	30	3,412	3,244
Borrowings	31	34,292	76,588
Total Non-Current Liabilities		37,704	79,832
Total Liabilities		**141,808**	**116,298**
NET ASSETS		**102,462**	**120,964**
EQUITY			
Contributed equity	32	27,491	16,743
Reserves	32	239,583	219,053
Accumulated surplus/(deficiency)	32	(164,612)	(114,832)
TOTAL EQUITY		**102,462**	**120,964**
TOTAL LIABILITIES AND EQUITY		**244,270**	**237,262**

The Balance Sheet should be read in conjunction with the notes to the financial statements.

Department of Health

Statement of Changes in Equity
For the year ended 30 June 2008

	Note	2008 $000	2007 $000
Balance of equity at start of period		120,964	90,216
CONTRIBUTED EQUITY	32		
Balance at start of period		16,743	12,301
Capital contribution		10,748	4,442
Other contributions by owners		-	-
Distributions to owners		-	-
Balance at end of period		**27,491**	**16,743**
RESERVES	32		
Asset Revaluation Reserve			
Balance at start of period		219,053	194,321
Gains/(losses) from asset revaluation		20,530	24,732
Balance at end of period		**239,583**	**219,053**
ACCUMULATED SURPLUS	32		
Balance at start of period		(114,832)	(116,406)
Change in accounting policy		-	(1,137)
Restated balance at start of period		(114,832)	(117,543)
Surplus/(deficit) for the period		(49,780)	2,711
Balance at end of period		**(164,612)**	**(114,832)**
Balance of equity at end of period		**102,462**	**120,964**
Total income and expense for the period (a)		(29,250)	27,443

(a) The aggregate net amount attributable to each category of equity is: Deficit $49,780,000 plus gains from asset revaluation $20,530,000 (2007: surplus $2,711,000 plus gain from asset revaluation $24,732 ,000).

The Statement of Changes in Equity should be read in conjunction with the notes to the financial statements.

Department of Health

Cash Flow Statement

For the year ended 30 June 2008

	Note	2008 $000 Inflows (Outflows)	2007 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		660,518	600,932
Capital contributions	32	10,748	3,941
Net cash provided by State Government		671,266	604,873
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(70,363)	(60,138)
Supplies and services		(659,662)	(582,793)
Grants and subsidies		(18,963)	(14,822)
Finance costs		(7,641)	(8,026)
Capital user charge		-	(8,070)
Contribution to Hospital Fund		(103,930)	(66,845)
Other payments		(4)	5
Receipts			
User charges and fees		7,526	7,492
Commonwealth grants and contributions	18	165,220	127,624
Other receipts		4,705	7,352
Net cash (used in) / provided by operating activities	33(b)	(683,112)	(598,221)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(7,347)	-
Proceeds from the sale of non-current physical assets		-	-
Net cash (used in) / provided by investing activities		(7,347)	-
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(4,327)	(3,941)
Net cash (used in) / provided by financing activities		(4,327)	(3,941)
Net increase / (decrease) in cash and cash equivalents		(23,520)	2,710
Cash and cash equivalents at the beginning of period		36,738	34,028
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	33(a)	13,219	36,738

Department of Health

Schedule of Income and Expenses by Service

For the year ended 30 June 2008

	Admitted Patient Services		Specialised Mental Health		Hospital in the Home		Palliative Care		Emergency Department		Non-Admitted Patient		Patient Transport		Preventation & Promotion		Health Protection	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES																		
Expenses																		
Employee benefits expense	37,975	35,689	-	-	-	5	1,010	148	-	-	-	30	-	35	11,330	7,069	16,281	14,889
Contracts for services	212,862	184,837			5,851	5,424	18,470	10,056			40,128	40,769	54,994	50,123	31,162	25,591	20,047	14,404
Supplies and services	14,550	8,711	-	-	-	9	53	72	-	-	-	73	-	87	1,408	6,193	56,958	31,089
Grants and subsidies	15,648	13,742	-	-	-	-	5	-	-	-	-	-	-	-	1,473	587	1,102	406
Depreciation expense	2,949	2,704	-	-	-	-	-	-	-	-	-	-	-	-	242	301	420	343
Finance costs	5,948	6,091	-	-	-	-	74	-	-	-	1,618	1,932	-	-	-	-	-	-
Capital user charge	-	4,842	-	-	-	-	-	-	-	-	-	-	-	-	-	807	-	807
Loss on disposal of non-current assets	21	660	-	-	-	-	-	-	-	-	-	-	-	-	103	65	18	13
Other expenses	11,642	9,197	-	-	-	1	64	13	-	-	1	2	-	2	1,894	1,107	2,548	2,650
Contribution to Hospital Fund	62,279	31,780	6,228	-	1,038	669	-	1,222	4,152	-	17,645	5,269	-	6,213	5,191	3,832	-	3,507
Total cost of services	363,874	298,253	6,228	-	6,889	6,108	19,676	11,511	4,152	-	59,392	48,075	54,994	56,460	52,803	45,552	97,374	68,108
INCOME																		
Revenue																		
User charges and fees	1,690	1,677	-	-	-	29	2	-	-	-	-	-	-	-	576	179	1,668	4,726
Commonwealth grants and contributions	1,153	270	-	-	-	-	576	408	87	-	296	192	-	-	9,674	10,424	55,247	30,112
Other revenue	4,292	6,528	-	-		-		-	-	-		-		-	79	128	44	1,295
Total income other than income from State Government	7,135	8,475	-	-	-	29	578	408	87	-	296	192	-	-	10,329	10,731	56,959	36,133
NET COST OF SERVICES	356,739	289,778	6,228	-	6,889	6,079	19,098	11,103	4,065	-	59,096	47,883	54,994	56,460	42,474	34,821	40,415	31,975
INCOME FROM STATE GOVERNMENT																		
Service appropriation	313,211	288,712	6,664	-	6,664	6,078	19,992	11,100	6,664	-	59,977	47,870	53,312	56,444	39,984	34,814	39,984	31,864
Liabilities assumed by the Treasurer	132	180	-	-	-	4	-	7	-	-	-	30	-	35	-	22	-	20
Assets assumed/(transferred)	(7)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	(18)	9	(1)
Resources received free of charge	757	1,102	-	-	19	23	39	42	-	-	97	182	136	215	116	133	233	121
Total income from State Government	314,093	289,994	6,664	-	6,683	6,105	20,031	11,149	6,664	-	60,074	48,082	53,448	56,694	40,100	34,951	40,226	32,004
SURPLUS/(DEFICIT) FOR THE PERIOD	(42,646)	216	436	-	(206)	26	933	46	2,599	-	978	199	(1,546)	234	(2,374)	130	(189)	29

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

Department of Health

Schedule of Income and Expenses by Service

For the year ended 30 June 2008

	Dental Health		Home & Community Care		Aged Care Assessment		Community Mental Health		Residential Care		Residential Mental Health		Chronic Illness & Continuing Care		TOTAL	
	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
COST OF SERVICES																
Expenses																
Employee benefits expense	-	201	264	815	402	-	-	5	-	9	-	5	4,182	4,871	71,444	63,771
Contracts for services	9,529	9,787	155,483	144,040	3,735		7,842	8,111	10,013	12,661	8,312	6,514	19,360	15,343	597,788	527,660
Supplies and services	-	496	2	101	7	-	-	13	-	52	-	11	1,704	381	74,682	47,288
Grants and subsidies	-	-	-	-	-	-	-	-	-	-	-	-	735	87	18,963	14,822
Depreciation expense	-	-	-	1	-	-	-	-	-	-	-	-	250	152	3,861	3,501
Finance costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7,640	8,023
Capital user charge	-	-	-	-	-	-	-	-	-	-	-	-	-	1,614	-	8,070
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-	-	-	-	-	3	-	145	738
Other expenses	-	12	3	24	30	-	-	-	-	1	-	-	1,058	837	17,240	13,846
Contribution to Hospital Fund	2,076	1,125	-	7,083	1,038	-	4,152	951	-	1,573	-	807	131	2,814	103,930	66,845
Total cost of services	11,605	11,621	155,752	152,064	5,212	-	11,994	9,080	10,013	14,296	8,312	7,337	27,423	26,099	895,693	754,564
INCOME																
Revenue																
User charges and fees	-	-	-	-	-	-	3,248	-	-	-	-	-	341	478	7,525	7,089
Commonwealth grants and contributions	-	-	95,204	88,978	2,383	-	600	440		-	-	-	-	-	165,220	130,824
Other revenue		-		21	-	-		-		-		-	277	51	4,692	8,023
Total income other than income from State Government	-	-	95,204	88,999	2,383	-	3,848	440	-	-	-	-	618	529	177,437	145,936
NET COST OF SERVICES	11,605	11,621	60,548	63,065	2,829	-	8,146	8,640	10,013	14,296	8,312	7,337	26,805	25,570	718,256	608,628
INCOME FROM STATE GOVERNMENT																
Service appropriation	13,328	10,217	59,976	64,353	-	-	6,664	8,638	6,664	14,291	6,664	7,336	26,656	25,567	666,404	607,284
Liabilities assumed by the Treasurer	-	201	-	40	-	-	-	5	-	9	-	5	-	16	132	574
Assets assumed/(transferred)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	(19)
Resources received free of charge	19	1,225	388	245	19	-	19	33	19	54	19	28	58	97	1,938	3,500
Total income from State Government	13,347	11,643	60,364	64,638	19	-	6,683	8,676	6,683	14,354	6,683	7,369	26,714	25,680	668,476	611,339
SURPLUS/(DEFICIT) FOR THE PERIOD	1,742	22	(184)	1,573	(2,810)	-	(1,463)	36	(3,330)	58	(1,629)	32	(91)	110	(49,780)	2,711

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

Department of Health

Summary of Consolidated Account Appropriations and Income Estimates

For the year ended 30 June 2008

	2008 Estimate $000	2008 Actual $000	Variance $000	2008 Actual $000	2007 Actual $000	Variance $000
DELIVERY OF SERVICES						
Item 70 Net amount appropriated to deliver services	680,366	703,948	23,582	703,948	641,027	62,921
Section 25 transfer of service appropriation	-	356	356	356	(1,566)	1,922
Item 71 Contribution to Hospital Fund	2,661,970	2,804,682	142,712	2,804,682	2,680,288	124,394
Amount Authorised by Other Statutes						
- Salaries and Allowances Act 1975	531	613	82	613	503	110
- Lotteries Commission Act 1990	88,900	95,228	6,328	95,228	89,687	5,541
Total appropriations provided to deliver services	3,431,767	3,604,827	173,060	3,604,827	3,409,939	194,888
CAPITAL						
Item 156 Capital Contribution	168,698	157,730	(10,968)	157,730	77,165	80,565
GRAND TOTAL	3,600,465	3,762,557	162,092	3,762,557	3,487,104	275,453
Details of Expenses by Service						
Admitted Patient	2,218,791	2,385,770	166,979	2,385,770	2,255,781	129,989
Specialised Mental Health	179,369	177,016	(2,353)	177,016	153,868	23,148
Hospital in the Home	16,206	26,221	10,015	26,221	12,598	13,623
Palliative Care	17,341	18,962	1,621	18,962	16,405	2,557
Emergency Department	128,112	144,111	15,999	144,111	129,454	14,657
Non-Admitted Patient	570,322	610,838	40,516	610,838	576,072	34,766
Patient Transport	69,309	71,497	2,188	71,497	66,011	5,486
Preventation & Promotion	196,837	223,735	26,898	223,735	194,545	29,190
Health Protection	57,415	100,893	43,478	100,893	63,947	36,946
Dental Health	60,816	63,999	3,183	63,999	63,031	968
Home & Community Care	166,248	166,022	(226)	166,022	153,055	12,967
Aged Care Assessment	21,264	36,791	15,527	36,791	25,423	11,368
Commununity Mental Health	149,045	160,902	11,857	160,902	165,565	(4,663)
Residential Care	96,168	82,690	(13,478)	82,690	82,660	30
Residential Mental Health	6,728	8,301	1,573	8,301	6,481	1,820
Chronic Illness & Continuing Care	34,838	44,239	9,401	44,239	39,730	4,509
Drug & Alcohol	45,746	47,887	2,141	47,887	43,423	4,464
Total Cost of Services	4,034,555	4,369,874	335,319	4,369,874	4,048,049	321,825
Less total income	(594,225)	(726,667)	(132,442)	(726,667)	(629,410)	(97,257)
Net Cost of Services	3,440,330	3,643,207	202,877	3,643,207	3,418,639	224,568
Adjustments (a)	(8,563)	(38,608)	(30,045)	(38,608)	(8,699)	(29,909)
Total appropriations provided to deliver services	3,431,767	3,604,599	172,832	3,604,599	3,409,940	194,659
Capital Expenditure						
Purchase of non-current physical assets	313,544	232,145	(81,399)	232,145	164,736	67,409
Repayment of borrowings	13,619	13,619	-	13,619	12,935	684
Adjustments for other funding sources (b)	(158,465)	(88,034)	70,431	(88,034)	(100,506)	12,472
Capital Contribution (appropriation)	168,698	157,730	(10,968)	157,730	77,165	80,565
DETAILS OF INCOME ESTIMATES						
Income disclosed as Administered Income	915,412	920,868	5,456	920,868	868,895	51,973

(a) Adjustments reflects Net Cost of Service is greater than appropriation to deliver health services including movement in cash balances, accrual items such as receivables, payables and notional revenue from Government.
(b) Adjustments comprise fundng for Capital Works Administered by DTF including movements in cash balances and other accrual items such as receivables and payables.

Note 39 'Explanatory statement' provides details of any significant variations between estimates and actual results for 2008 and between actual results for 2007 and 2008.

Department of Health
NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2008

Note 1 Departmental mission and funding

The mission of the Department is to ensure the best achievable health status for all of the Western Australian community. In particular, the system will deliver:

* strong public health and preventive measures to protect the community and promote health;
* high quality acute and chronic health care to those in need;
* appropriate health, rehabilitation and domiciliary care for all stages of life; and
* a continuing and co-operative emphasis on improving the health status for our Indigenous, rural and remote and disadvantaged populations.

The Department is predominantly funded by Parliamentary appropriations. The financial statements encompass all funds through which the Department controls resources to carry on its functions.

Note 2 Australian equivalents to International Financial Reporting Standards

General

The Department's financial statements for the year ended 30 June 2008 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the Department has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the AASB and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The Department cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the Department for the annual reporting period ended 30 June 2008.

Note 3 Summary of significant accounting policies

(a) General statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with the Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording.

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

Where modification is required and has 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 in accordance with Accounting Standard AAS 29 'Financial Reporting by Government Departments' on the accrual basis of accounting using the historical cost convention, modified by the revaluation of land and buildings which have been measured at fair value.

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

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

The judgements that have been made in the process of applying the Department's accounting policies that have the most significant effect on the amounts recognised in the financial statements are disclosed at note 4 'Judgements made by management in applying accounting policies'.

The key assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 5 'Key sources of estimation uncertainty'.

(c) Reporting entity

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

Note 3 Summary of significant accounting policies (continued)

(d) Contributed equity

UIG interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities' requires transfers in the nature of equity contributions 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 contributions (appropriations) have been designated as contributions by owners by Treasurer's Instruction (TI) 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed Equity.

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. See note 32 'Equity'.

(e) Income

Revenue recognition
Revenue is 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 control transfer to the purchaser and can be measured reliably.

Rendering of services
Revenue is recognised upon delivery of the service to the client or by reference to the stage of completion of the transaction.

Interest
Revenue is recognised as the interest accrues.

Service appropriations
Service Appropriations are recognised as revenues 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 into the Department's bank account or credited to the holding account held at the Treasury. See note 19 'Income from State Government' for further detail.

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 2007-2008 Budget Statements, the Department retained $177.452 million in 2008 ($142.468 million in 2007) from the following:

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

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

Where contributions recognised as revenues during the reporting period were obtained on the condition that they be expended in a particular manner or used over a particular period, and those conditions were undischarged as at the balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains
Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(f) Property, plant and equipment

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

Initial recognition and measurement
All items of property, plant and equipment are initially recognised at cost.

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

Note 3 Summary of significant accounting policies (continued)

Subsequent measurement
After recognition as an asset, the Department uses the revaluation model for the measurement of land and buildings, and the cost model for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation on buildings and accumulated impairment losses. All other items of property, plant and equipment are carried at historical cost less accumulated depreciation and accumulated impairment losses.

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

Where market-based evidence is not available, the fair value of land and buildings is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost.

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

Independent valuation of land and buildings are provided annually by the Western Australian Land Information Authority (Valuation Services) and recognised with sufficient regularity to ensure that the carrying amount does not differ materially from the asset's fair value at the balance sheet date.

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated useful 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 to note 26 'Land and buildings' for further information on revaluations.

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

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.

Land is not depreciated. Depreciation on buildings is calculated using the reducing balance method. Depreciation on other assets are calculated using the reducing balance with a straight-line switch method under which the cost amounts of the assets are allocated on a reducing balance basis, on average, over the first half of their useful lives and on a straight line basis for the second half of the useful lives.

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

Buildings	50 years
Computer equipment	4 to 5 years
Furniture and fittings	10 to 15 years
Other plant and equipment	10 to 15 years

(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 Income Statement.

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) on the reducing balance basis using rates which are reviewed annually. All intangible assets controlled by the Department have a finite useful life and zero residual value. The expected useful lives for each class of intangible asset are:

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.

Note 3 Summary of significant accounting policies (continued)

(h) Impairment of assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at each balance sheet date. 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 and an impairment loss is recognised. As the Department is a not-for-profit entity, unless an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of 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 each balance sheet date 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 flow 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 each balance sheet date.

See note 28 'Impairment of Assets' for the outcome of impairment reviews and testing.
See note 3(p) 'Receivables' and note 23 'Receivables' for impairment of receivables.

(i) Non-Current Assets (or Disposal Groups) Classified as Held for Sale

Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

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

(j) Leases

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

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 buildings, 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.

The Department holds operating leases for buildings and office equipments. Lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased properties.

(k) Financial Instruments

In addition to cash and bank overdraft, the Department has two categories of financial instrument:

- Loans and receivables; and
- Financial liabilities measured at amortised cost.

These have been disaggregated into the following classes:

Financial Assets
- Cash and cash equivalents
- Restricted cash and cash equivalents
- Receivables
- Amounts receivable for services

Financial Liabilities
- Payables
- Borrowings
- Finance lease liabilities

Note 3 Summary of significant accounting policies (continued)

(k) Financial Instruments (continued)

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or 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 Cash Flow Statement, cash and cash equivalents includes restricted cash and cash equivalents. These are comprised of cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(m) Accrued salaries

The accrued salaries suspense account (refer note 21 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur in that year instead of the normal 26. No interest is received on this account.

Accrued salaries (refer note 29 'Payables') represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with 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 the net fair value.

(n) Amounts receivable for services (holding account)

The Department receives appropriation funding on an accrual basis that recognises the full annual cash and non-cash cost of services. The appropriations are paid partly in cash and partly as an asset (Holding Account receivable) that is accessible on the emergence of the cash funding requirement to cover items such as leave entitlements and asset replacement.

See also note 24 'Amounts receivable for services' and note 19 '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 valued at net realisable value.

See note 22 'Inventories'.

(p) Receivables

Receivables are recognised and carried 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.

Change to accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST were assigned on the 1st January 2006 to the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals. This change in accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative.

See note 3(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.

See note 3(k) 'Financial Instruments' and note 29 'Payables'.

Note 3 Summary of significant accounting policies (continued)

(r) Borrowings

As a consequence of the closure of several public hospitals in previous years, the Department has taken up Treasury Loans as detailed in note 31 'Borrowings'. The Department is funded for the debt servicing arrangements.

All loans are initially recognised at cost being an amount equal to the fair value of the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method. Borrowing costs expense are recognised on an accrual basis. See note 3(k) 'Financial instruments'.

(s) Borrowing costs

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

(t) Provisions

Provisions are liabilities of uncertain timing and amount. The Department recognises a provision where there is a present legal, equitable 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 each balance sheet date.

See note 30 'Provisions'.

Provisions - Employee Benefits

(i) Annual Leave and Long Service Leave
The liability for annual and long service leave expected to be settled within 12 months after the end of the balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and 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 balance sheet date.

(ii) Superannuation
The Government Employees Superannuation Board (GESB) administers the following superannuation schemes.

Employees may contribute to the Pension Scheme, a defined benefit pension scheme now closed to new members or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme also closed to new members. The Department has no liabilities for superannuation charges under the Pension or the GSS Schemes, as the liability has been assumed by the Treasurer.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes 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). Both of these schemes are accumulation schemes. The Department makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

The GESB makes all benefit payments in respect of the Pension and GSS Schemes, and is recouped by the Treasurer for the employer's share.

See also note 3(u) 'Superannuation Expense'.

(iii) Deferred Salary Scheme
With the written agreement of the Department, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Department is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the balance sheet date and includes related on-costs.

Note 3 Summary of significant accounting policies (continued)

Provisions - Other

Employment on-costs
Employment on-costs are not employee benefits and are recognised as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and the related liability is included in employment on-costs provision.

See note 16 'Other expenses' and note 30 'Provisions'.

(u) Superannuation expense

The following elements are included in calculating the superannuation expense in the Income Statement:

(i) Defined benefit plans - Change in the unfunded employer's liability (i.e. current service cost and actuarial gains and losses) assumed by the Treasurer in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme (GSS); and

(ii) Defined contribution plans - Employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS Scheme transfer benefits are recognised as expenses directly in the Income Statement. As these liabilities are assumed by the Treasurer (refer note 3(t)(ii)), a revenue titled 'Liabilities assumed by the Treasurer' equivalent to the expense is recognised under Income from State Government in the Income Statement.

See note 19 'Income from State Government'.

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided in the current year.

Defined contribution plans - in order to reflect the Department's true cost of services, the Department is funded for the equivalent of employer contributions in respect of the GSS Scheme (excluding transfer benefits). These contributions were paid to the GESB during the year and placed in a trust account administered by the GESB on behalf of the Treasurer. The GESB subsequently paid these employer contributions in respect of the GSS Scheme to the Consolidated Account.

(v) Resources received free of charge or for nominal cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(w) Comparative figures

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

Note 4 Judgements made by management in applying accounting policies

Judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

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 life.

Note 5 Key sources of estimation uncertainty

The Department makes estimates and assumptions concerning the future. The estimates and assumptions that have a significant risk

of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

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 liabilities, employees are assumed to leave the Department each year on account of resignation or retirement at 10.6%. 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.

Note 6 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Department has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2007 that impacted on the Department:

1. AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments and while there is no financial impact, the changes have resulted in increased disclosures, both quantitative and qualitative, of the Department's exposure to risks, including enhanced disclosure regarding components of the Department's financial position and performance, and changes to the way of presenting certain items in the notes to the financial statements.

The following Australian Accounting Standards and Interpretations are not applicable to the Department as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretations	
101	'Presentation of Financial Statements' (relating to the changes made to the Standard issued in October 2006)
2005-10	'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'
2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11 [AASB 2]'
2007-4	'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. The amendments arise as a result of the AASB decision to make available all options that currently exist under IFRSs and that certain additional Australian disclosures should be eliminated. The Treasurer's instructions have been amended to maintain the existing practice when the Standard was first applied and as a consequence there is no financial impact.
2007-5	'Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102]'
2007-7	'Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'
ERR	Erratum 'Proportionate Consolidation [AASB 101, AASB 107, AASB 121, AASB 127, Interpretation 113]'
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'
Interpretation 1003	'Australian Petroleum Resource Rent Tax'

Voluntary changes in accounting policy

Effective from 1 July 2007, the Department has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment. The change in asset capitalisation policy does not apply to land and buildings.

Retrospective application of the change in accounting policy has resulted in assets below the $5,000 threshold amounting to $1,137,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The amounts of adjustments for each of the financial periods prior to 2006-07 have not been disclosed, as it is impracticable to trace back acquisitions, disposals, depreciation and amortisation of these assets.

The comparatives for property, plant and equipment, depreciation and amortisation expense, loss on disposal of non-current assets, and repairs, maintenance and consumable equipment expense have been restated to disclose the effect of the policy change (See note 41 'Changes in accounting policy').

Future impact of Australian Accounting Standards not yet operative

The Department cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the Department has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued and which may impact the Department but not yet effective. Where applicable, the Department plans to apply these Standards and Interpretations from their application date:

Note 6 Disclosure of changes in accounting policy and estimates (continued)

Title	Operative for reporting periods beginning on/after
AASB 101 'Presentation of Financial Statements' (September 2007). This Standard has been revised and will change the structure of the financial statements. These changes will require that owner changes in equity are presented separately from non-owner changes in equity. The Department does not expect any financial impact when the Standard is first applied.	1 January 2009
Review of AAS 27 'Financial Reporting by Local Governments', 29 'Financial Reporting by Government Departments and 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:	
AASB 1004 'Contributions' (December 2007).	1 July 2008
AASB 1050 'Administered Items' (December 2007).	1 July 2008
AASB 1051 'Land Under Roads' (December 2007).	1 July 2008
AASB 1052 'Disaggregated Disclosures' (December 2007).	1 July 2008
AASB 2007-9 'Amendments to Australian Accounting Standards arising from the review of AASs 27, 29 and 31 [AASB 3, AASB 5, AASB 8, AASB 101, AASB 114, AASB 116, AASB 127 & AASB 137] (December 2007).	1 July 2008
Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities (December 2007).	1 July 2008
The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and existing topic-based Standards and Interpretation. These requirements remain substantively unchanged. The new and revised Standards make some modifications to disclosures, otherwise there will be no financial impact.	
AASB 3 'Business Combinations' (March 2008)	1 January 2009
AASB 8 'Operating Segments'	1 January 2009
AASB 123 'Borrowing Costs' (June 2007). This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. Agencies already capitalising borrowing costs directly attributable to buildings under construction will have no financial impact when the Standard is first applied. Agencies presently expensing such borrowing costs will need to report the financial impact.	1 January 2009
AASB 127 'Consolidated and Separate Financial Statements' (March 2008)	1 July 2009
AASB 1049 'Whole of Government and General Government Sector Financial Reporting'	1 July 2008
AASB 2007-2 'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]'	1 January 2008
AASB 2007-3 'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'	1 January 2009
AASB 2007-6 'Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'	1 January 2009
AASB 2007-8 'Amendments to Australian Accounting Standards arising from AASB 101'	1 January 2009
AASB 2008-1 'Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations'	1 January 2009
AASB 2008-2 'Amendments to Australian Accounting Standards – Puttable Financial Instruments and Obligations arising on Liquidation [AASB 7, AASB 101, AASB 132, AASB 139 & Interpretation 2]'	1 January 2009

Note 6 Disclosure of changes in accounting policy and estimates (continued)

AASB 2008-3 'Amendments to Australian Accounting Standards arising from AASB 3 and AASB 127 [AASB 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138, 139 and Interpretations 9 & 107]'	
Interpretation 4 'Determining whether an Arrangement contains a Lease' (February 2007)	1 January 2008
Interpretation 12 'Service Concession Arrangements'	1 January 2008
Interpretation 13 'Customer Loyalty Programmes'	1 July 2008
Interpretation 14 'AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'	1 January 2008
Interpretation 129 'Service Concession Arrangements: Disclosures'	1 January 2008

Note 7 Services of the Department

Information about the Department's services and the expenses and revenues which are reliably attributable to those services is set out in the Schedule of Expenses and Revenues by Service. Information about expenses, revenues, assets and liabilities administered by the Department for Health Services are given in note 45 'Administered expenses and income' and note 46 'Administered assets and liabilities'.

The key services of the Department and Health Services are:

Admitted Patient Services
Admitted patient services are provided for the care of inpatients in public hospitals (excluding specialised mental health wards) and public patients treated in private facilities under contract to WA Health. Care during an admission to hospital can be for periods of one or more days. Care includes medical and surgical treatment, renal dialysis, oncology services, mental health and obstetric care.

Specialised Mental Health Services
Specialised mental health services include authorised mental health units that are hospitals or hospital wards devoted to the specialised treatment and care of patients with psychiatric, mental or behavioural disorders. Specialised mental health care is also provided in designated mental health wards in acute hospitals.

Hospital in the Home Services
Hospital in the Home (HITH) is the delivery of short-term acute services in the patient's home for conditions that traditionally required hospital admission and inpatient treatment. HITH services are based on daily home visits by nurses with medical governance usually by a hospital-based doctor. Patients who may receive HITH services include those who can be safely cared for without constant monitoring, such as those who may require regular intravenous drug treatments or wound dressings.

Palliative Care
Palliative care services provide 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 Services
Emergency department services are provided by some metropolitan hospitals. Emergency services are provided to treat 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. Emergency departments provide a range of services from immediate resuscitation to urgent medical advice. An emergency department presentation may result in an admission or treatment without admission.

Non-admitted Patient Services
Medical officers, nurses and allied health staff provide non-admitted services. Services include outpatient health and medical care as well as similar emergency services as described for Metropolitan emergency department but provided in smaller country hospitals.

Patient Transport Services
Patient transport services are those services provided by St John Ambulance Australia, the Royal Flying Doctor Service (Western Operations) (RFDS) 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 and Promotion Services
Prevention and promotion services include genomics, the management and development of health information, Aboriginal health, breast screening services, child and community health and health promotion.

Health Protection Services
Health protection services include communicable disease control, environmental health, disaster planning and management, statutory medical notifications and services provided by the Office of the Chief Medical Advisor.

Note 7 Services of the Department (continued)

Dental Health Services
Dental health services include the school dental service, providing dental health assessment and treatment for school children; the adult dental service, for financially and/or geographically disadvantaged people; and the provision of specialist and general dental and oral health care 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 through private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes

Home and Community Care Services
Home and Community Care (HACC) provides services that support people who live at home and whose capacity for independent living is at risk of premature admission to long-term residential care. Services include domestic assistance, social support, nursing care, respite care, food services and home maintenance.

Aged Care Assessment Services
Aged care assessment services determine eligibility for, and the level of care required by frail aged people. They include assessments for those who require permanent care in an appropriate residential aged care facility including the Care Awaiting Placement program, and eligibility for community-based aged care services.

Community Mental Health Services
Community mental health care provides a range of community-based services for people with mental health disorders, which may include emergency assessment and treatment; case management, psycho-geriatric assessment and day programs provided in either a clinic or home environment. Service providers include both government and non-government service agencies. Contracted non-government non-clinical services also provide support to long-term mental health patients living in the community.

Residential Care
Residential care services are provided for people assessed as no longer being able to live at home. Services include non-acute admitted continuing care, nursing home care provided by the State, nursing home type care provided in public hospitals and hostel care.

Residential Mental Health Care
Non-government agencies contracted to provide 'home type' or nursing home or hostel residential care to people with a long-term mental health condition.

Chronic Illness and Continuing Care Support
Chronic illness and continuing care support services are provided to people with a chronic condition, enabling them to remain healthy at home. The services offered include the chronic disease management program. These services reduce unplanned and avoidable admissions and presentations to emergency departments as well as reducing length of stay for patients requiring inpatient care.

Drug and Alcohol Services
The Drug and Alcohol Office is responsible for drug and alcohol strategies and services in Western Australia. The agency provides or contracts a State-wide network of treatment services, a range of prevention programs, professional education and training and research activities. It coordinates whole-of-government policies and strategies in conjunction with State and Commonwealth Government agencies.

		2008 $000	2007 $000
Note 8	**Employee benefits expense**		
	Salaries and wages [(a)]	58,834	49,873
	Superannuation - defined contribution plans [(b)]	5,488	5,021
	Superannuation - defined benefit plans [(c)(d)]	132	574
	Annual leave [(e)]	5,421	5,520
	Long service leave [(e)]	1,569	2,783
		71,444	63,771

(a) Fringe benefit to the employee plus the fringe benefits tax component are included in Other Expenses.
(b) Defined contribution plans include West State, Gold State and GESB Super Scheme (contributions paid).
(c) Defined benefit plans include Pension scheme and Gold State (pre-transfer benefit).
(d) An equivalent notional income is also recognised (see note 19 'Income from State Government').
(e) Includes a superannuation contribution component.

Employment on-costs are included at note 16 'Other expenses'. The employment on-costs liability is included in at note 30 'Provisions'.

Note 9	**Contracts for services**		
	Public patients in private services	171,203	145,254
	Home and community care	155,099	143,321
	Patient transport service	53,965	50,530
	Other aged care services	42,968	35,662
	Mental health	40,367	35,854
	Blood and organs	26,131	22,934
	Aboriginal health	19,030	18,665
	Other contracts	89,025	75,440
		597,788	527,660
Note 10	**Supplies and services**		
	Medical supplies	64,575	38,774
	Other consumables	4,427	2,860
	Operating lease rentals	5,674	5,652
	Other	6	2
		74,682	47,288
Note 11	**Grants and subsidies**		
	Recurrent		
	Research and development grants	9,587	8,854
	Spectacle subsidy scheme	2,472	2,532
	Other	6,904	3,436
		18,963	14,822
Note 12	**Depreciation expense**		
	Buildings	798	696
	Leased buildings	2,455	2,359
	Computer equipment	247	272
	Plant and equipment	358	170
	Furniture and fittings	3	4
		3,861	3,501
Note 13	**Finance costs**		
	Finance lease finance charges	7,354	7,726
	Interest on Treasury loans	286	297
		7,640	8,023
Note 14	**Capital user charge**		
	Capital user charge	-	8,070

The charge was a levy applied by Government for the use of its capital. The final charge was levied in 2006-07.

Note 15 Net gain / (loss) on disposal of non-current assets	2008 $000	2007 $000
Costs of disposal of non-current assets		
Plant and equipment	(145)	(738)
Proceeds from disposal of non-current assets		
Plant and equipment	-	-
Net gain / (loss)	(145)	(738)

See also note 3(i) 'Non-current assets classified as held for sale' and Note 27 'Plant and equipment'.

Note 16 Other expenses

Promotional expenses	1,037	719
Advertising	825	691
Communication	1,503	1,706
Computer related expenses	1,289	902
Travel related expenses	1,617	1,437
Legal expenses	900	487
Employment on-costs [(a)]	4,093	3,269
Scholarships	1,264	1,699
Insurance	167	225
Doubtful debts expense	12	(215)
Repairs and Maintenance	1,137	948
Other	3,396	1,978
	17,240	13,846

(a) Includes workers' compensation insurance, fringe benefit tax, staff development and other employment on-costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 30 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 17 Contribution to Hospital Fund

$103.9m ($66.8m in 2007) of the Department's cash at bank was paid as a contribution to Hospital Fund, an administered trust account of the Department, to fund expenditure in the Health Services.

Note 18 Commonwealth grants and contributions

Cash grants	165,220	127,624
Vaccine inventories received free of charge	-	3,200
	165,220	130,824

Note 19 Income from State Government

(a) Service appropriations [(a)]

Amount appropriated to deliver services	665,791	606,781
Amount authorised by other statutes		
- Salaries and Allowances Act 1975	613	503
	666,404	607,284

(b) Liabilities assumed by the Treasurer

The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation [(b)]	132	574

(c) Assets assumed/(transferred)

The following assets have been assumed from/(transferred to) other state government agencies during the financial year: [(c)]		
- Plant and equipment	2	(19)

		2008 $000	2007 $000
Note 19	**Income from State Government (continued)**		
	(d) Resources received free of charge [(d)]		
	Determined on the basis of the following estimates provided by agencies:		
	Department of Education & Training - accommodation	1,456	1,398
	Landgate (valuation services) - valuation, aerial photography and maps	36	2,102
	State Solicitor's Office - legal service	446	-
		1,938	3,500

(a) Service appropriations are accrual amounts reflecting the full cost of services delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

(b) The assumption of the superannuation liability by the Treasurer is a notional income to match the notional superannuation expense reported in respect of current employees who are members of the Pension Scheme and current employees who have a transfer benefit entitlement under the Gold State Superannuation scheme. (The notional superannuation expense is disclosed at note 8 'Employee benefits expense').

(c) Where the Treasurer or other entity has assumed a liability, the Department recognises revenues equivalent to the amount of the liability assumed and an expense relating to the nature of the event or events that initially gave rise to the liability. From 1 July 2002 non-discretionary non-reciprocal transfers of net assets (i.e. restructuring of administrative arrangements) have been classified as Contributions by Owners under Treasurer's Instruction 955 and are taken directly to equity. Discretionary non-reciprocal transfer of assets between State Government agencies are reported as Assets assumed/ (transferred).

(d)

Where assets or services have been received free of charge or for nominal cost, the Department recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable. The exception occurs where the contribution of assets or services are in the nature of contributions by owners, in which case the Department makes the adjustment direct to equity.

Note 20	**Cash and cash equivalents**		
	Operating bank account	-	28,816
	Cash on hand	5	4
		5	28,820
Note 21	**Restricted cash and cash equivalents**		
	Current		
	Commonwealth Trust Accounts [(a)(b)]	12,544	7,489
	Non-Current		
	Accrued Salaries Suspense Account [(c)]	670	430
		13,214	7,919

(a) Cash held in the account is to be used only for the specific purposes stipulated by Commonwealth Government for PHOFA and vaccines, public health programs, mental health programs, home and community care, postgraduate medical council, clinical preceptor program, HealthConnect, civilian disaster medical assistance, strengthening cancer care, CanNet and clinical handover program.

(b) $1,591,000 has been used on a temporary basis to fund health services operations.

(c) Amount held in suspense account at the Department of Treasury and Finance is only to be used for the purpose of meeting the 27th pay in a financial year that occurs every 11 years.

Note 22	**Inventories**		
	Current		
	Engineering supplies (at cost)	160	437
	Drug supplies (at cost)	7,042	5,863
		7,202	6,300

See also note 3(o) 'Inventories'.

		2008 $000	2007 $000
Note 23	**Receivables**		
	Current		
	Receivables	2,315	1,460
	Less: Allowance for impairment of receivables	(11)	(10)
	Accrued Revenue	402	1,271
		2,706	2,721
	Reconciliation of changes in the allowance for impairment of receivables:		
	Balance at start of year	10	225
	Doubtful debts expense recognised in the income statement	12	(215)
	Amounts written off during the year	(11)	-
	Amount recovered during the year	-	-
	Balance at end of year	11	10
	Credit Risk		
	Ageing of receivables past due but not impaired based on the information provided to senior management, at the balance sheet date:		
	Not more than 3 months	637	575
	More than 3 months but less than 6 months	153	44
	More than 6 months but less than 1 year	27	38
	More than 1 year	36	68
		853	724
	See also note 3(p) 'Receivables' and note 49 'Financial instruments'.		
Note 24	**Amounts receivable for services**		
	Current	-	-
	Non-current	41,391	35,505
		41,391	35,505
	Balance at start of the year	35,505	29,175
	Credit to holding account	5,886	6,352
	Less holding account drawdown	-	(22)
	Balance at end of the year	41,391	35,505
	Represents the non-cash component of service appropriations (see note 3(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	**Current assets**		
	Prepayments	154	162
		154	162
Note 26	**Land and buildings**		
	Land		
	At fair value	58,998	45,542
		58,998	45,542
	Buildings		
	At fair value	28,654	30,927
	Accumulated depreciation	(734)	(4,327)
		27,920	26,600
	Building under construction		
	Construction costs	-	116
		-	116
	Leased buildings		
	At fair value	84,910	82,435
	Accumulated depreciation	-	-
		84,910	82,435
	Total	171,828	154,693

Note 26 Land and buildings (continued)

Land and buildings were revalued as at 1 July 2007 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2008 and recognised at 30 June 2008. In undertaking the revaluation, fair value was determined by reference to market values for land: $488,400. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See note 3(f) 'Property, plant and equipment'.

Valuation Services, the Office of the Auditor General and the Department of Treasury and Finance assessed the valuations globally to ensure that the valuations provided (as at 1 July 2007) were compliant with fair value at 30 June 2008.

Reconciliations

Reconciliations of the carrying amounts of land and buildings at the beginning and end of the reporting period are set out below.

2008

	Land $000	Buildings $000	Building under construction $000	Leased buildings $000	**2008 Total $000**
Carrying amount at the start of year	45,542	26,600	116	82,435	154,693
Additions	-	49	-	27	76
Other Disposals	-	(102)	-	-	(102)
Write-down of assets	-	-	(116)	-	(116)
Revaluation	13,456	2,171	-	4,903	20,530
Depreciation	-	(798)	-	(2,455)	(3,253)
Carrying amount at the end of year	58,998	27,920	-	84,910	171,828

2007

	Land $000	Buildings $000	Building under construction $000	Leased buildings $000	**2007 Total $000**
Carrying amount at the start of year	30,659	23,886	-	78,950	133,495
Additions	-	21	-	107	128
Transfers between asset classes	-	-	207	-	207
Transfers to Health Services	-	-	(91)	-	(91)
Other Disposals	-	(723)	-	-	(723)
Revaluation	14,883	4,112	-	5,737	24,732
Depreciation	-	(696)	-	(2,359)	(3,055)
Carrying amount at the end of year	45,542	26,600	116	82,435	154,693

Note 27 Plant and equipment

	2008 $000	**2007 $000**
Computer equipment		
At cost	9,377	3,284
Accumulated depreciation	(2,834)	(2,839)
	6,543	445
Furniture and fittings		
At cost	165	69
Accumulated depreciation	(34)	(31)
	131	38
Other plant and equipment		
At cost	2,744	2,166
Accumulated depreciation	(1,648)	(1,506)
	1,096	659
Total	7,770	1,142

Note 27 Plant and equipment (continued)

Reconciliations
Reconciliations of the carrying amounts of plant and equipment at the beginning and end of the reporting period are set out below.

2008

	Computer equipment $000	Furniture & fittings $000	Other plant & equipment $000	**2008 Total $000**
Carrying amount at the start of year	445	38	659	1,142
Additions	6,347	101	824	7,272
Transfers between asset classes	-	(5)	5	-
Transfers from/(to) Health Services	-	-	2	2
Other Disposals	(2)	-	(36)	(38)
Depreciation	(247)	(3)	(358)	(608)
Carrying amount at the end of year[(a)]	6,543	131	1,096	7,770

2007

	Computer equipment $000	Furniture & fittings $000	Other plant & equipment $000	**2007 Total $000**
Carrying amount at the start of year	465	89	909	1,463
Additions	-	-	385	385
Transfers between asset classes	259	(33)	(435)	(209)
Transfers from/(to) Health Services	8	(10)	(24)	(26)
Other Disposals	(15)	(4)	(6)	(25)
Depreciation	(272)	(4)	(170)	(446)
Carrying amount at the end of year	445	38	659	1,142

(a) Computer equipment includes work-in-progress of $6,166,000.

Note 28 Impairment of Assets

There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2008.

The Department held no goodwill or intangible assets with an indefinite useful life during the reporting period and at balance sheet date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2008 have either been classified as assets held for sale or written off.

Note 29 Payables	**2008 $000**	**2007 $000**
Current		
Trade payables	6,459	2,197
Accrued salaries	2,194	378
Accrued expenses	39,821	17,008
Interest payable	22	24
	48,496	19,607

See also note 3(q) 'Payables' and note 49 'Financial Instruments'.

Note 30 Provisions

Current		
Employee benefits provision		
Annual leave[(a)]	6,925	6,507
Long service leave[(b)]	6,292	5,947
Deferred salary scheme	95	77
	13,312	12,531
Non-current		
Employee benefits provision		
Long service leave[(b)]	3,412	3,244
Total	16,724	15,775

(a) Annual leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	4,882	4,733
More than 12 months after balance sheet date	2,043	1,774
	6,925	6,507

		2008 $000	2007 $000
Note 30	**Provisions (continued)**		

(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 balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	1,748	1,792
More than 12 months after balance sheet date	7,956	7,399
	9,704	9,191

(c) The settlement of annual and long service leave liabilities gives rise to the payment of employment on-costs. The provision is the present value of expected future payments. The associated expense is included at Note 16 'Other expenses'.

Note 31 Borrowings

Current		
Treasury loans	277	266
Finance lease liabilities (secured)	42,019	4,062
Total current	42,296	4,328
Non-current		
Treasury loans	4,276	4,554
Finance lease liabilities (secured)	30,016	72,034
Total non-current	34,292	76,588

The finance lease liability for the Peel Health Campus will be repaid in full on 1 July 2008.

Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

The carrying amounts of non current assets pledged as security are:		
Buildings under finance lease (see note 26)	84,910	82,435

Note 32 Equity

Equity represents the residual interest in the net assets of the Department. The Government holds the equity interest in the Department on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

Contributed equity		
Balance at the start of the year	16,743	12,301
Contributions by owners		
Capital contributions [(a)]	10,748	4,442
Balance at end of the year	27,491	16,743

(a) Capital Contributions (appropriations) and non-discretionary (non-reciprocal) transfers of net assets from other State government agencies have been designated as contributions by owners in Treasurer's Instruction TI 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity.

Reserves

Asset revaluation reserve

Balance at the start of the year	219,053	194,321
Net revaluation increments/(decrements)		
- Land	13,456	14,884
- Buildings	7,074	9,848
Balance at the end of the year	239,583	219,053

Accumulated surplus/(deficit)

Balance at the start of the year	(114,832)	(116,406)
Result for the period	(49,780)	2,711
Change in accounting policy	-	(1,137)
Balance at the end of the year	(164,612)	(114,832)

Note 33 Notes to the Cash Flow Statement	2008 $000	2007 $000
(a) Reconciliation of cash		
Cash at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:		
Cash and cash equivalents	5	28,820
Restricted cash and cash equivalents (see note 21)	13,214	7,919
	13,219	36,739
(b) Reconciliation of net cost of services to net cash flows used in operating activities		
Net cost of services (Income Statement)	(718,256)	(608,628)
Non-cash items:		
Depreciation expense	3,861	3,501
Doubtful debts expense	11	(215)
Superannuation liability assumed by Treasurer	132	574
Resources received free of charge	1,938	3,500
Gain/(loss) of disposal of non current assets	145	738
Write-down of assets	116	-
Other	(8)	120
(Increase)/decrease in assets:		
Inventories	(902)	(821)
Receivables	3	(22)
Other assets	8	5
Increase/(decrease) in liabilities:		
Payables	28,890	(1)
Provisions	949	3,060
Other liabilities	-	(32)
Net cash used in operating activities	(683,112)	(598,221)

At the balance sheet date, the Department had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 34 Voluntary changes in accounting policy

Effective from 1 July 2007, the Department has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets (See note 6 'Voluntary changes in accounting policy'). The adjustments relating to the 2006-07 financial year are as follows:

Reconciliation of equity at the end of the last reporting period under previous asset capitalisation policy : 30 June 2007

	Before policy change 30 June 2007	Adjustment	After policy change 30 June 2007
	$000	$000	$000
Assets			
Current Assets	45,492	-	45,492
Non-Current Assets [(a)]	192,675	(905)	191,770
Total Assets	238,167	(905)	237,262
Liabilities			
Current Liabilities	36,466	-	36,466
Non-Current Liabilities	79,832	-	79,832
Total Liabilities	116,298	-	116,298
Total Equity [(b)]	121,869	(905)	120,964
Accumulated surplus/(deficiency)			
Opening balance	(116,406)	(1,137)	(117,543)
Surplus/(Deficit) for the period	2,479	232	2,711
Closing Balance	(113,927)	(905)	(114,832)
(a) Plant and equipment	*2,047*	*(905)*	*1,142*
(b) Accumulated surplus/(deficiency)	*(113,927)*	*(905)*	*(114,832)*

Note 34 Voluntary changes in accounting policy (continued)

Reconciliation of income statement for the year ended 30 June 2007

	Before policy change 30 June 2007	Adjustment	After policy change 30 June 2007
	$000	$000	$000
Expenses [(a)]	754,796	(232)	754,564
Total income other than income from State Government	145,936	-	145,936
Net cost of services	608,860	(232)	608,628
Income from State Government	611,339	-	611,339
Surplus/(Deficit) for the period	(2,479)	(232)	(2,711)
(a) Depreciation expense	*3,935*	*(434)*	*3,501*
Loss on disposal of non-current	*750*	*(12)*	*738*
Supplies and Services	*574,734*	*214*	*574,948*
	579,419	*(232)*	*579,187*

Reconciliation of cash flow statement for the year ended 30 June 2007

	Before policy change 30 June 2007	Adjustment	After policy change 30 June 2007
	$000	$000	$000
Cash flows from State	604,873	-	604,873
Utilised as follows:			
Net cash (used in)/ provided by -			
Operating activities [(a)]	(598,114)	(107)	(598,221)
Investing activities [(b)]	(107)	107	-
Financing activities	(3,941)	-	(3,941)
Net increase / (decrease) in cash and cash equivalent	2,711	-	2,711
Cash and cash equivalents at the beginning of period	34,028	-	34,028
Cash and cash equivalents at the end of period	36,739	-	36,739
(a) Payment for supplies and services	*(582,686)*	*(107)*	*(582,793)*
(b) Payment for purchase of non-current physical	*(107)*	*107*	-

Note 35 Resources provided free of charge

	2008	**2007**
	$000	**$000**

During the year the following resources were provided to other agencies free of charge for functions outside the normal operations of the Department:

Department of Environment & Conservation - assist inter-agency response	100	-
Department of Planning & Infrastructure - on site waste water disposal review	115	-
Department of the Attorney General - meat inspection at Karnet Prison, health surveillance of correctional services	171	-
Botanical Gardens & Park Authority - inspection of public building, surveillance of food outlets, etc	62	-
Rottnest Island Authority - inspection and surveillance of food premises, tourist accommodation, etc	35	-
Department of Environment & EPA - specialist toxicology advice	300	-
Others	775	-
	1,558	-

Note 36 Commitments	2008 $000	2007 $000
(a) Finance lease commitments		
Minimum lease payment commitments in relation to finance leases are payable as follows:		
Within 1 year	67,804	11,407
Later than 1 year and not later than 5 years	20,095	45,011
Later than 5 years	22,786	65,674
Minimum finance lease payments	110,686	122,092
Less: Future finance charges	38,650	45,996
Present value of finance lease liabilities	72,035	76,096
Included in the financial statements as:		
Current (Note 31 'Borrowings')	42,019	4,062
Non-current (Note 31 'Borrowings')	30,016	72,034
	72,035	76,096

The Department owns the land on which the leased buildings are located and consequently it has the option to take possession of the leased buildings on expiry of the leases. These leasing arrangements do not have escalation clauses, other than in the event of payment default. There are no restrictions imposed by these leasing arrangements on other financing transactions. The finance leases do not have a contingent rental obligation.

(b) Operating lease commitments		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Within 1 year	7,866	3,498
Later than 1 year and not later than 5 years	8,408	7,115
Later than 5 years	-	-
	16,274	10,613

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.

(c) Private sector contracts for the provision of Health Services		
Expenditure commitments in relation to private sector organisations contracted for at the balance sheet date but not recognised as liabilities, are payable as follows:		
Within 1 year	571,364	484,724
Later than 1 year and not later than 5 years	1,571,246	1,507,361
Later than 5 years and not later than 10 years	1,785,760	1,644,761
Later than 10 years	98,148	274,422
	4,026,518	3,911,268

(d) Capital expenditure commitments		
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:		
Within 1 year	1,316	-

(e) Other expenditure commitments		
Other expenditure commitments contracted for at the balance sheet date but not recognised as liabilities, are payable as follows:		
Within 1 year	3,691	2,139
Later than 1 year and not later than 5 years	3,742	-
	7,433	2,139

		2008 $000	2007 $000
Note 37	**Contingent liabilities and contingent assets**		

Contingent liabilities

In addition to the liabilities included in the financial statements, the Department has the following contingent liabilities:

(a) Litigation in progress

Pending litigation that are not recoverable from Riskcover insurance and may affect the financial position of the Department.	290	573
Number of claims	1	2

(b) Contaminated Sites

Under the Contaminated Sites Act 2003, the Department is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required or possibly contaminated – investigation required*, the Department may have a liability in respect of investigation or remediation expenses.

The Department does not have any suspected contaminated sites.

Contingent assets

The Department does not have any contingent assets.

Note 38 Events occurring after reporting date

The Department is not aware of any events occurring after reporting date that have significant financial effect on the financial statements.

Note 39 Explanatory statement

Significant variations between estimates and actual results for income and expenses as presented in the financial statement titled 'Summary of Consolidated Account Appropriations and Income Estimates' are shown below. Significant variations are considered to be those greater than 10% or $5 million.

Significant variances between estimates and actual for 2008 - Total appropriation to deliver services:

	2008 Estimate $000	2008 Actual $000	Variance $000
(a) Appropriations			
Net amount appropriated to deliver services	680,366	703,948	23,582
The variance is due to approved funding for new awards in 2007/08, Mental Health Strategy and other priority			
Contribution to Hospital Fund	2,661,970	2,804,682	142,712
The variance is due to approved funding for new awards in 2007/08, Mental Health Strategy and other priority			
Lotteries Commission Act 1990	88,900	95,228	6,328
Improved revenue mainly due to more revenue from the Lotteries Commission from improved sales revenue.			
(b) Total Cost of Services			
Admitted Patient	2,218,791	2,385,770	166,979
Actual expenditure reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures.			
Hospital in the Home	16,206	26,221	10,015
2007-08 HITH expenditure includes the transfer of a Department of Health's non-government organisation based HITH program from admitted services as well as additional resource allocation to address the impact of clinical and general cost pressures. In addition the estimate was based on expenditure reported during the initial stages of program development and may not have captured the full cost of the programs.			

Note 39 Explanatory statement (Continued)

Significant variances between estimates and actual for 2008 - Total appropriation to deliver services:

	2008 Estimate $000	2008 Actual $000	Variance $000
Emergency Department	128,112	144,111	15,999
Actual expenditure reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures as well as to provide for an increase over the estimated activity in emergency departments.			
Non-Admitted Patient	570,322	610,838	40,516
Actual expenditure reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures as well as to provide for an increase over the estimated activity for doctor attended outpatient services and non-admitted services especially in country areas.			
Prevention & Promotion	196,837	223,735	26,898
Actual expenditure reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures as well as increased expenditure and improved expenditure identification for the Child and Adolescent Health Service Population Health Unit.			
Health Protection	57,415	100,893	43,478
Actual expenditure reflects additional vaccine funding provided by the Commonwealth not included in the estimates.			
Aged Care Assessment	21,264	36,791	15,527
Expenditure detailed under Aged Care Assessment in 2007-08 includes the transfer of transitional care funding previously reported under Residential Care as well as higher than estimated Care Awaiting Placement expenditure provided by the Metropolitan Health Services.			
Community Mental Health	149,045	160,902	11,857
Actual expenditure reflects additional Mental Health strategy funding allocated during the year for community based mental health services provided by public mental health services.			
Residential Care	96,168	82,690	(13,478)
Actual expenditure under Residential Care excludes the Department of Health's transitional care funding now included in the Aged Care Assessment Service.			
Residential Mental Health Care	6,728	8,301	1,573
Actual expenditure reflects additional Mental Health strategy funding allocated during the year for the community supported residential services.			
Chronic Illness and Continuing Care Support	34,838	44,239	9,401
Includes funding provided to the Quadriplegic Centre which was not included in the Service estimate.			
(c) Total Income	(594,225)	(726,667)	(132,442)
Increased revenue compared to estimate was mainly due to additional Commonwealth funding, patient revenue and recognition of revenue for rebates from RiskCover.			
(d) Adjustments	(8,563)	(38,608)	(30,045)
The actual Net Cost of Service is greater than appropriation to deliver health services and includes movement in cash balances, accrual items such as receivables, payables and notional revenue from Government.			

Significant variances between estimates and actual for 2008 - Capital Contribution:

(a) Capital Contribution	168,698	157,730	(10,968)
The reduction of capital contributions compared with budgeted figures is mainly due to approved revisions of the capital works program.			

Note 39 Explanatory statement (Continued)

Significant variances between estimates and actual for 2008 - Total appropriation to deliver services:

	2008 Estimate $000	2008 Actual $000	Variance $000
Significant variances between estimates and actual for 2008 - Capital Expenditure:			
(a) Purchase of non-current physical assets	313,544	232,145	(81,399)
The reduction reflects the delay of some capital works expenditure to future reporting periods, as approved in the revised capital works program.			
(b) Adjustments for other funding sources	(158,465)	(88,034)	70,431
The change in actual expenditure compared to the original estimate reflects the timing of expenditure for the capital works program, as per the revised capital works program.			

	2008 Actual $000	2007 Actual $000	Variance $000
Significant variances between actuals for 2007 and 2008 - Total appropriation to deliver services:			
(a) Appropriations			
Net amount appropriated to deliver services	703,948	641,027	62,921
Increased health and reform activities, increased funding for new awards in 2007/08 and Mental Health and other priority funding, as well as cost pressures in delivering health reforms and initiatives, have contributed to increased expenditure from the previous financial year.			
Contribution to Hospital Fund	2,804,682	2,680,288	124,394
Variance was attributed to increased funding for new awards in 2007/08, Mental Health Strategy, other priority funding and activities in delivering patient services.			
Lotteries Commission Act 1990	95,228	89,687	5,541
Higher revenue reflects more revenue from the Lotteries Commission from improved sales revenue.			
(b) Total Cost of Services			
Admitted Patient	2,385,770	2,255,781	129,989
Compared to 2006-07, expenditure in 2007-08 reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures.			
Specialised Mental Health	177,016	153,868	23,148
Compared to 2006-07, the 2007-08 expenditure reflects allocations for specialised admitted mental health units previously reported in Admitted Patient Services as well as new services at KEMH and Bentley commencing during the year.			
Hospital in the Home	26,221	12,598	13,623
Compared to 2006-07, expenditure detailed under HITH includes the transfer of a Department of Health's non-government organisation based HITH program from admitted services to HITH not included in the estimate as well as improved data collection and more definitive cost capturing for the HITH and RITH programs in 2007-08.			
Palliative Care	18,962	16,405	2,557
Compared to 2006-07, expenditure in 2007-08 reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures.			
Emergency Department	144,111	129,454	14,657
Actual expenditure for 2007-08 compared to 2006-07 reflects increased emergency department activity and the impact of clinical and general cost pressures in 2007-08.			
Non-admitted Patient	610,838	576,072	34,766
Actual expenditure for 2007-08 compared to 2006-07 reflects the significant increase in the provision of doctor attended outpatient services and non-admitted services especially in country areas as well as the impact of clinical and general cost pressures.			

Note 39 Explanatory statement (Continued)

Significant variances between actuals for 2007 and 2008 - Total appropriation to deliver services:

	2008 Actual $000	2007 Actual $000	Variance $000
Patient Transport	71,497	66,011	5,486
Actual expenditure for 2007-08 compared to 2006-07 reflects cost pressures in the provision of patient transport services.			
Prevention & Promotion	223,735	194,545	29,190
Compared to 2006-07, expenditure in 2007-08 details increased expenditure and improved data capture for the Child and Adolescent Health Population Health Unit.			
Health Protection	100,893	63,947	36,946
Compared to 2006-07, expenditure in 2007-08 includes significant additional vaccine expenditure especially for the cervical cancer program.			
Home and Community Care	166,022	153,055	12,967
Actual expenditure for 2007-08 compared to 2006-07 reflects joint Commonwealth / State agreed expense level.			
Aged Care Assessment	36,791	25,423	11,368
Actual expenditure for 2007-08 compared to 2006-07 reflects significant additional CAP service activity.			
Residential Mental Health	8,301	6,481	1,820
Compared to 2006-07, 2007-08 reflects expenditure for new community supported residential services provided by non-government organisations commencing during the year.			
Chronic Illness & Continuing Care	44,239	39,730	4,509
Compared to 2006-07, expenditure in 2007-08 reflects the expense level approved for 2007-08 to address the impact of clinical and general cost pressures.			
Drug & Alcohol	47,887	43,423	4,464
The increase in 2007-08 expenditure is mainly due to the Amphetamine Programs and WA Strategic Intervention Halls Creek Treatment Facility - Ngnowar Aer			
(c) Total Income	(726,667)	(629,410)	(97,257)
Increased revenue compared to 2007 was mainly due to additional Commonwealth revenue including Gardisil vaccines, patient and pathology revenue as well as recovery revenue from use of facilities.			
(d) Adjustments	(38,608)	(8,699)	(29,909)
Compared to 2006-07, adjustments reflects the Net Cost of Service is greater than appropriation provided to deliver services and cash movement to fund operational activities.			

Significant variances between actuals for 2007 and 2008 - Capital Contribution:

(a) Capital Contribution	157,730	77,165	80,565
The increase in capital contribution in 2007-08 compared to 2006-07 is consistent with approved Health capital works program.			

Significant variances between actuals for 2007 and 2008 - Capital Expenditure:

(a) Purchase of non-current physical assets	232,145	164,736	67,409
The increase in the purchase of non-current physical assets in 2007-08 compared to 2006-07 is consistent with approved revisions to the Health capital works program.			
(b) Adjustments for other funding sources	(88,034)	(100,506)	12,472
The variance reflects the change in capital contribution in 2007-08 compared to 2006-07 along with the capital works expenditure between the two years.			

Note 40 Remuneration of senior officers

Remuneration

The number of senior officers, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

	2008	2007
$30,001 - $40,000	-	1
$60,001 - $70,000	-	-
$80,001 - $90,000	-	1
$90,001 - $100,000	-	1
$120,001 - $130,000	1	-
$170,001 - $180,000	1	1
$210,001 - $220,000	2	-
$220,001 - $230,000	-	1
$270,001 - $280,000	-	-
$290,001 - $300,000	-	1
$360,001 - $370,000	-	1
$370,001 - $380,000	-	1
$390,001 - $400,000	1	-
$490,001 - $500,000	1	1
$500,001 - $510,000	1	-
$630,001 - $640,000	-	1
	7	10

	$000	$000
The total remuneration of senior officers is:	2,126	2,786

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

No senior officers are members of the Pension Scheme.

Note 41 Remuneration of auditor

Remuneration payable to the Auditor General for the financial year is as follows:

Auditing the accounts, financial statements and performance indicators	290	290

This expense is included at Note 16 'Other expenses'.

Note 42 Supplementary financial information

Write-offs

During the financial year the Department has written off debts and inventory under the authority of:

The Accountable Officer	71	-
The Minister for Health	-	-
	71	**-**

Note 43 Affiliated bodies

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	9,145	8,965
Public health	6,516	2,656
Mental health	32	12
	15,693	11,633

Note 44 Other statement of receipts and payments	$000	$000
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of the year	-	-
Receipts		
Commonwealth Grant	1,304	848
Payments		
Retainer Fee	30	30
Purchase of WA Health Services	1,251	818
	1,281	848
Balance at the end of the year	23	-

Note 45 Administered expenses and income		
Expenses		
Appropriations transferred to:		
Metropolitan Health Services	2,633,648	2,413,234
WA Country Health Services	752,460	731,917
WA Alcohol and Drug Authority	45,203	41,555
Quadriplegic Centre	6,850	6,505
QEII Medical Centre Trust	631	1,999
Total administered expenses	3,438,792	3,195,210
Income		
Service Appropriations from Government for transfer	2,938,422	2,802,656
Capital Contributions from Government for transfer	261,099	150,120
Commonwealth grants and contributions	172,226	152,894
Contribution to Hospital Fund from Department of Health	103,930	66,845
Other revenue	6,265	6,091
Total administered revenues	3,481,942	3,178,606

Note 46 Administered assets and liabilities		
Current Assets		
Cash assets	54,458	11,014
Receivables	259	10
Total administered current assets	54,717	11,024
Current Liabilities		
Payables	1,712	19
Other liabilities	0	1,149
Total administered current liabilities	1,712	1,168

Health services are statutory authorities in their own right. Accordingly, the Department only administers funds appropriated to health services.

Note 47 Commonwealth Trust Account

Commonwealth Grants and Advances Account

These funds are incorporated into the controlled and administered transactions of the Department's financial statements.

The purpose of the trust account is to hold funds received from the Commonwealth for the purposes stated in the Register of Commonwealth Programs which is maintained by the Department of Health.

	2008 $000	2007 $000
Balance at the start of the year	15,309	14,492
Opening Balance Adjustment [(1)]	-	(4,501)
Receipts	337,491	280,991
Payments	326,294	275,673
Balance at the end of the year	26,506	15,309

(1) Adjustment for accrued revenue included in the opening balance.

Note 48 Private Trust Account

Peel Health Campus Service Agreement Trust Fund

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

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

	2008 $000	2007 $000
Balance at the start of the year	572	540
Receipts	38	32
Payments	-	-
Balance at the end of the year	610	572

Notes to the Financial Statements
For the year ended 30 June 2008

Note 49 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, Treasury loans and receivables and payables. All of the Department's cash is held in the public bank account (non-interest bearing) apart from restricted cash held in a special purpose account. 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 Department measures credit risk on a fair value basis and monitors risk on a regular basis.

The maximum exposure to credit risk at balance sheet date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment, as shown in the table at Note 46(c).

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. There are no significant concentrations of credit risk.

Provision for impairment of financial assets is calculated based on past experience, and current and expected changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 21 'Receivables'.

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

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
The Department does not trade in foreign currency and is not materially exposed to other price risks. Other than as detailed in the Interest rate sensitivity analysis table at Note 46(c), the Department is not exposed to interest rate risk because all cash and cash equivalents and restricted cash and cash equivalents are non-interest bearing and have borrowings with fixed interest rate only.

b) **Categories of Financial Instruments**

In addition to cash and bank overdraft, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows

	2008	2007
Financial Assets		
Cash and cash equivalents	5	28,820
Restricted cash and cash equivalents	13,214	7,919
Loans and receivables	44,097	38,226
Financial Liabilities		
Financial liabilities measured at amortised cost	125,084	100,523

c) **Financial Instrument disclosures**

Credit Risk, Liquidity Risk and Interest Rate Risk Exposures

The following table details the exposure to liquidity risk and interest rate risk as at the balance sheet date. The Department's maximum exposure to credit risk at the balance sheet date is the carrying amount of the financial assets as shown on the following table. The table is based on information provided to senior management of the Department. The contractual maturity amounts in the table are representative of the undiscounted amounts at the balance sheet date. An adjustment for discounting has been made where material.

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

The Department does not hold any financial assets that had to have their terms renegotiated that would have otherwise resulted in them being past due or impaired.

				Contractual Maturity Dates:						
	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
2008	**%**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Financial Assets										
Cash and cash equivalents			5							5
Restricted cash and cash equivalents			13,214							13,214
Receivables(a)			2,706							2,706
Amounts receivable for services			41,391							41,391
		-	57,316	-	-	-	-	-	-	57,316
Financial Liabilities										
Payables			48,496							48,496
Borrowings										
- W A Treasury loans	6.4%			277	290	304	318	332	3,033	4,554
- Finance lease liabilities	9.6%			42,019	2,514	2,733	2,971	3,230	18,567	72,034
		-	48,496	42,296	2,804	3,037	3,289	3,562	21,600	125,084

Notes to the Financial Statements

For the year ended 30 June 2008

c) **Financial Instrument disclosures (continued)**

				Contractual Maturity Dates:						
	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
2007	**%**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Financial Assets										
Cash and cash equivalents			28,820							28,820
Restricted cash and cash equivalents			7,919							7,919
Receivables(a)			2,721							2,721
Amounts receivable for services			35,505							35,505
		-	74,965	-	-	-	-	-	-	74,965
Financial Liabilities										
Payables			19,607							19,607
Borrowings										
- W A Treasury loans	6.3%			266	279	291	304	318	3,362	4,820
- Finance lease liabilities	9.6%			4,062	4,762	5,211	5,702	6,240	50,119	76,096
		-	19,607	4,328	5,041	5,502	6,006	6,558	53,481	100,523

The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities.

c) **Financial Instrument disclosures (continued)**

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Department's financial assets and liabilities at the balance sheet date on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-1% change		+1% change	
2008	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Liabilities					
Borrowings					
- W A Treasury loans	4,554	46	46	(46)	(46)
- Finance lease liabilities	72,034	720	720	(720)	(720)

		-1% change		+1% change	
2007	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Liabilities					
Borrowings					
- W A Treasury loans	4,820	48	48	(48)	(48)
- Finance lease liabilities	76,096	761	761	(761)	(761)

Fair Values
All financial assets and liabilities recognised in the balance sheet, 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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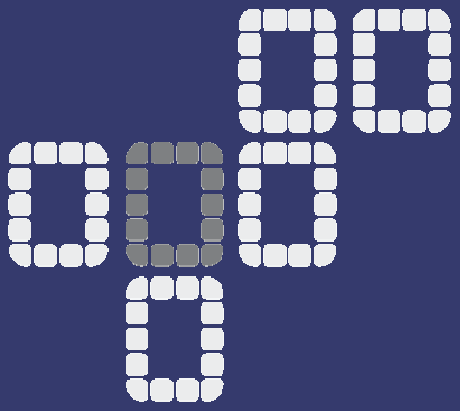

Appendices

Appendix 1: Abbreviations

ABCD	Audit for Best Practice in Chronic Disease
ABHI	Australian Better Health Initiative
ACAT	Aged Care Assessment Team
ACSHM	Australasian Chapter of Sexual Health Medicine
AHPF	Aboriginal Health Planning Forum
AIDS	Acquired Immunodeficiency Syndrome
ASI	Ambulatory Surgical Initiative
BBV	Blood-borne Viruses
CMP	Case Management Program
CPI	Consumer Price Index
CRROH	The Centre for Rural and Remote Oral Health
DAIP	Disability Access and Inclusion Plan
DG	Director General of Health
DOH	Department of Health
DPMU	Disaster Preparedness and Management Unit
ECT	Electroconvulsive Therapy
EDRMS	Electronic Document Record Management System
EEO	Equal Employment Opportunity
EPDS	Edinburgh Postnatal Depression Scale
FMA	Financial Management Act 2006
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HCC	Health Consumers' Council of WA
HCN	Health Corporate Network
HIV	Human Immunodeficiency Virus
HNS	Health Network Support Office
HRIT	Health Reform Implementation Taskforce
ICT	Information Communications Technology
IM & ICT	Information Management and Information Communications Technology
LSRU	Licensing Standards and Review Unit
MIMMS	Major Incident Medical Management and Support
MRSA	Methycillin Resistant Staphylococcus aureus
NHMRC	National Health Medical Research Council
NMAHS	North Metropolitan Area Health Service

OAH	Office of Aboriginal Health
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OCNO	Office of the Chief Nursing Officer
OCP	Office of the Chief Psychiatrist
OHCWA	Oral Health Centre of WA
OPSSC	Office of the Public Sector standards Commissioner
OSH	Occupational Safety and Health
OSQ	Office of Safety and Quality
PARTY	Prevent Alcohol and Risk Related Trauma in Youth
PATS	Patient Assisted Travel Scheme
PEHS	Patient Evaluation of Health Services
PYLL	Person Years of Life Lost
QEIIMC	QEII Medical Centre
RFDSWO	Royal Flying Doctor Service Western Operations
RPH	Royal Perth Hospital
SAP	Sustainability Action Plan
SCGH	Sir Charles Gairdner Hospital
SECCA	Sexuality Education Counselling and Consultancy Agency
SHBBVP	Sexual Health and Blood-borne Virus Program
SQuIRe	Safety and Quality Investment in Reform
STI	Sexually Transmitted Infection
StJAA	St John Ambulance Australia
TI	Treasurer's Instruction
VRE	Vancomycin Resistant Enterococcus
WAASM	WA Audit of Surgical Mortality
WACHAS	WA Committee on HIV/AIDS and Sexually Transmitted Infections
WACHS	WA Country Health Service
WLB	Work Life Balance

Delivering a **Healthy WA**

Produced by the
Information Management and Reporting Directorate
Department of Health

Government of Western Australia
Department of Health