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

Department of Health

Annual Report 2008-09

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Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

HON DR GRAHAM JACOBS MLA
MINISTER FOR MENTAL 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 2009.

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

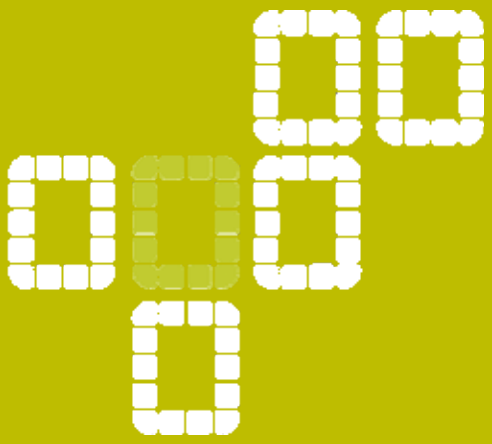
Dr Peter Flett
DIRECTOR GENERAL OF HEALTH
Accountable Authority

17 September 2009

Contents

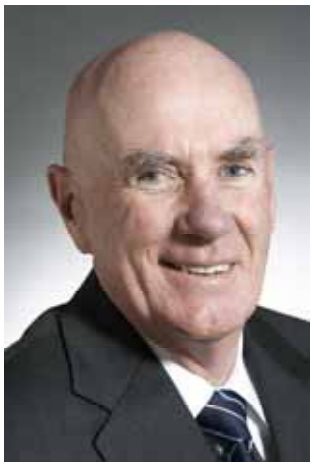
Illustrations

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



Overview of Agency

Executive Summary



WA Health – the Western Australian public health system – works to ensure healthier, and better lives for all Western Australians and to protect the health of our community by providing a safe, high-quality, accountable and sustainable health care system.

Like health services around the world, WA Health faces serious challenges in meeting the health needs of our community today and building a sustainable health care system for the future. Growing demand for health care services, a worldwide shortage of health personnel, burgeoning technology costs, the growth of lifestyle diseases, and a looming workforce crisis are just some of the problems we confront. These challenges cannot be ignored until a later date, and must be met in the context of limited resources, competing calls on public finances and the need to meet current service demands.

To ensure we meet our goal of delivering high-quality, sustainable health care to the people of Western Australia, WA Health is building a system wide culture of innovation and reform. We know that we cannot overcome the problems facing our health system by simply doing the same things in the same way. We are working hard to find new, better and smarter ways of doing things.

The Department of Health is the principal driver of health system reform and innovation, infrastructure development, and strategic management and direction. Over the past year, the Department has taken the lead in driving the delivery of cost efficiencies to meet expenditure constraints resulting from global and local economic conditions. The Department also contributes significantly to service provision of acute admitted and non-acute care, residential care, mental health care and health promotion, prevention and protection programs. I am proud to present the snapshot below, which profiles just some of the Department's activities and achievements over the past year.

Managing Unplanned Care

Since 2004-05, attendances at WA Health Emergency Departments (EDs) have increased by more than 25 per cent, to over 800,000 in 2008-09. We are putting in place innovative reforms to improve emergency care and manage demand on our EDs. During 2008-09 the State Government, the Department and the Area Health Services have developed a demand management strategy around the implementation of the Four Hour Rule Program. This program will revolutionise the way we manage patients requiring emergency or unplanned care and ensure that the majority of patients arriving at EDs are admitted, discharged or transferred within a four-hour timeframe, unless they need to remain in the ED for clinical reasons. The first stage of the Four Hour Rule Program commenced at Fremantle, Princess Margaret, Royal Perth and Sir Charles Gairdner Hospitals early in 2009, with other metropolitan and regional hospitals to follow. Friend in Need – Emergency (FINE) scheme has commenced delivering care and support to people in need enabling them to remain in their home, hostel or nursing home, rather than present to an ED or be admitted to hospital.

Elective Surgery

Elective surgery remains a key priority. As a result of population growth and significant improvements in outpatient processes, additions to surgical wait lists have increased. However, due to our reform efforts WA Health is carrying out more elective surgery procedures than ever before and overall waiting times have trended downwards in 2008-09. A combined total of 84,520 cases of elective surgery (including completed Ambulatory Surgery Initiative cases) were undertaken in 2008-09, an increase of almost 4,000 cases on 2007/08. In 2008, WA exceeded its target for additional elective

surgery cases under the Commonwealth Elective Surgery Blitz Program Stage One by 37 per cent.

Health Workforce

In 2009, the number of medical interns has been increased from 190 to 235, with increased rural and community rotations. Community residency and rural generalist programs have also been introduced to promote interest in rural and general practice — areas experiencing significant workforce gaps. Five new general physician training posts have also been established to take advantage of an interest in generalist internal medicine. This initiative will be important for delivering clinical services in line with ongoing reforms to the role delineation and service responsibilities of our hospitals. WA Health recruited 676 new graduate registered nurses for commencement in 2009 — an increase of 15 per cent on the previous year's intake. More than 600 nurses and midwives received postgraduate specialisation scholarships to support their professional development and contribute to high standards in our nursing and midwifery workforce.

Aboriginal Health

The Department is working to deliver initiatives under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, agreed by the Council of Australian Governments in October 2008. As part of the agreement, the Western Australian Government has committed more than $117million over four years to build on current Aboriginal Health strategies and programs. The agreement targets the five priority areas of preventative health, primary health care, hospital and hospital-related care, patient experience, and sustainability.

Health Promotion and Protection, and Illness Prevention

The human swine influenza pandemic and major incidents at Ashmore Reef, Manjimup and Learmonth have presented considerable public health and emergency management challenges. The health-related state disaster plans (WESTPLANS) were activated and enabled successful management of these incidents.

The Department has continued work to combat childhood obesity through health promotion activities, and to deliver major chronic disease prevention and healthy lifestyle promotion campaigns in partnership with non-government organisations.

Primary care and chronic disease management

Substantial progress has been made in areas including primary health; care and management of chronic disease and long-term conditions; and the application and implementation of health and medical research. Health Networks has finalised a number of new evidence-based models of care to improve the design and delivery of chronic disease management. With technology being one of the most significant drivers of increased healthcare expenditure, the Department also formed an advisory body to consider the adoption of high-cost technology into clinical practice.

Leadership

The Institute for Healthy Leadership provides innovative programs to improve and enhance health system leadership now and into the future. Twenty senior managers and lead clinicians entered our 'Emerging Leaders' program in 2009 with 12 participants in the 'Delivering the Future Leadership' program. Participants of previous leadership programs also have the opportunity to participate in Delivering Service Improvement workshops to build project management and service improvement skills.

In the pages that follow, you will find greater detail about the Department's activities and achievements for 2008-09. What cannot be adequately reflected in this report are the enormous efforts of the Department of Health's staff in delivering ongoing innovation and reform to build a stronger health system for Western Australia.

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH

17 September 2009

Table 1: 2008 WA Health facts at a glance

2008 WA Health Facts at a Glance	
Population we care for	2,139,838
Number of public hospital discharges	391,487
Public discharges in private facilities	99,475
All private hospital discharges not funded or administered by the Department of Health	296,509
All hospital Emergency Department visits	809,533
Numbers of babies born	30,598
Number of same day surgery separations	97,469
Number of overnight surgery separations	129,426
Number of clients receiving Home and Community Care Services	66,416
Inpatient overnight separations for mental health disorders in all public hospitals	14,034
Number of people provided with individual consultations for community public mental health services	38,929
Number of contacts for community public mental health services	588,918

Address and Location

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

Service Framework

The State Government of Western Australia uses an outcome-based management framework to illustrate the contribution by agencies to the achievement of Whole of Government goals. New goals were developed during the 2008-09 financial year.

There are five strategic goals of the Western Australian Government. These broad, high-level government goals are supported at agency level by more specific desired outcomes. These outcomes contribute to the achievement of the high-level government goals.

The current Whole of Government goals are:

- **State Building – Major Projects**. Building strategic infrastructure that will create jobs and underpin Western Australia's long-term economic development;
- **Financial and Economic Responsibility.** Responsibly managing the State's finances through the efficient and effective delivery of services, encouraging economic activity and reducing regulatory burdens on the private sector;
- **Outcomes Based Service Delivery.** Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians;
- **Stronger Focus on the Regions.** Greater focus on service delivery, infrastructure investment and economic development to improve the overall quality of life in remote and regional areas; and
- **Social and Environmental Responsibility**. Ensuring that economic activity is managed in a socially and environmentally responsible manner for the long-term benefit of the State.

The Whole of Government goal to which the Department of Health contributes is "Outcomes Based Service Delivery".

WA Health delivers three 'Outcomes' to meet this goal. They are:

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

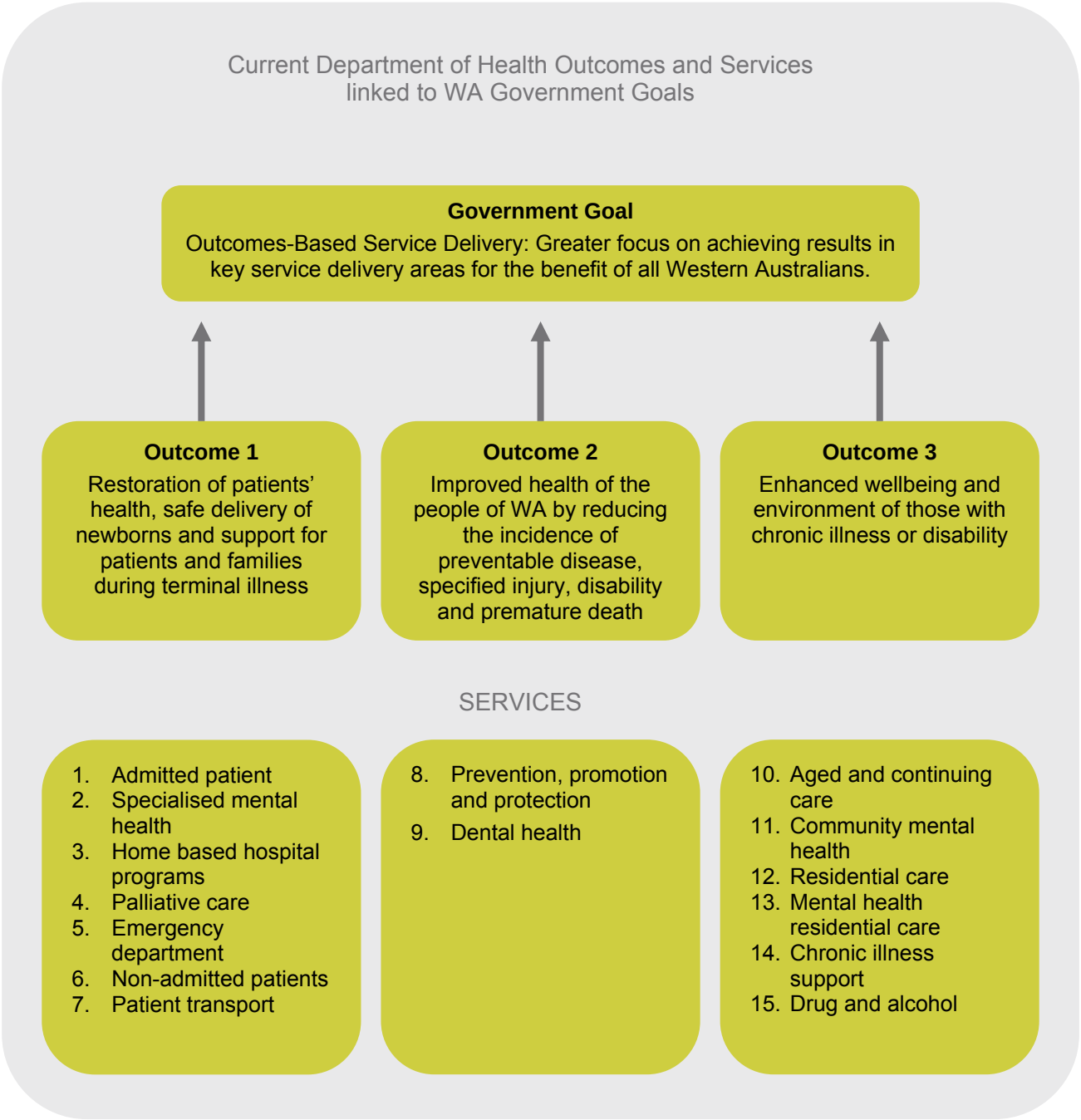
A range of Key Effectiveness Indicators measure progress achieved toward meeting these 'Outcomes'. Reporting of these is found in the Key Performance Indicators section of this annual report.

Fifteen services support the delivery of these three outcomes. A significant number of Key Efficiency Indicators are used to measure the cost effectiveness of delivery of these services over time. The Key Performance Indicators section of this annual report provides current year and prior year results for these indicators.

A diagrammatic representation of the WA Health outcome structure follows in Figure 1 on the next page.

Service Framework (continued)

Figure 1: Department of Health outcome structure



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 Ministers for Health and Mental Health for the efficient and effective management of the organisation. The Department of Health supports the Ministers in the administration of 42 Acts and 105 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*
- *Prostitution Act 2000 (Act other than s.62 and Part 5)*
- *Psychologists Act 2005*
- *Queen Elizabeth II Medical Centre Act 1966*
- *Radiation Safety Act 1975*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *White Phosphorous Matches Prohibition Act 1912*

Acts passed during 2008-09

- *Surrogacy Act 2008*

Bills in Parliament as at 30 June 2009

Royal Perth Hospital Protection Bill 2008

Amalgamation and establishment of Boards

There were no Boards amalgamated or established during 2008-09.

Statement of Compliance with Public Sector Standards

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

Human Resource Management

The Department of Health undertakes analysis of breach of standards claims lodged within our agency and subsequent review and feedback from the Office of the Public Sector Standards Commissioner (OPSSC) is the primary method of monitoring and assessment.

General monitoring of human resource activities within the workplace is managed by the various lead human resource areas across Royal Street Divisions, which includes the Health Corporate Network and the Health Information Network.

The numbers of claims lodged continue to be low for the Department of Health. In 2008-09, the Department of Health received 17 claims alleging breach of Public Sector Standards in Human Resource Management. Included in this total seven claims were related to recruitment, selection and appointment, one to temporary deployment and nine to grievance resolution.

Of the 17 claims made, ten were resolved in the agency, four are still pending and three have been referred to the OPSSC to undertake investigation and appropriate action.

Induction facilities, both online and through face to face sessions for new employees are the most interactive processes for educating staff on the Public Sector Standards. Material is provided at the induction sessions and information is readily available to all staff through the Department of Health intranet.

Code of Ethics

A revised Department of Health Code of Conduct and Values statement was issued in September 2008. A specific communication strategy was implemented across the agency.

The online induction facility has a focus on employees understanding and acknowledging their requirement to comply with the Code of Conduct. The responses are monitored by human resources personnel. Royal Street Division offers Bullying Awareness Training sessions for staff and managers which also attracts participants across the metropolitan health services.

Health Corporate Network have internal policy and guideline documents on outside employment and performance development / management. This area also has in-house and external information sessions for employees and managers on workplace bullying and harassment, misconduct reporting, public interest disclosure and conflict of interest.

The Department of Health has concluded a second “Health Climate Survey” following an initial survey in 2006. At the time of reporting, the results of the survey were not available.

In 2008-09, there were nine complaints alleging non-compliance with the Public Sector Code of Ethics and the WA Health Code of Conduct. Eight were investigated within the agency and the other referred to the OPSSC.

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH

17 September 2009

Pecuniary Interests

Senior officers of the Department of Health have declared no pecuniary interests in 2008-09.

Accountable Authority

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

Senior Officers

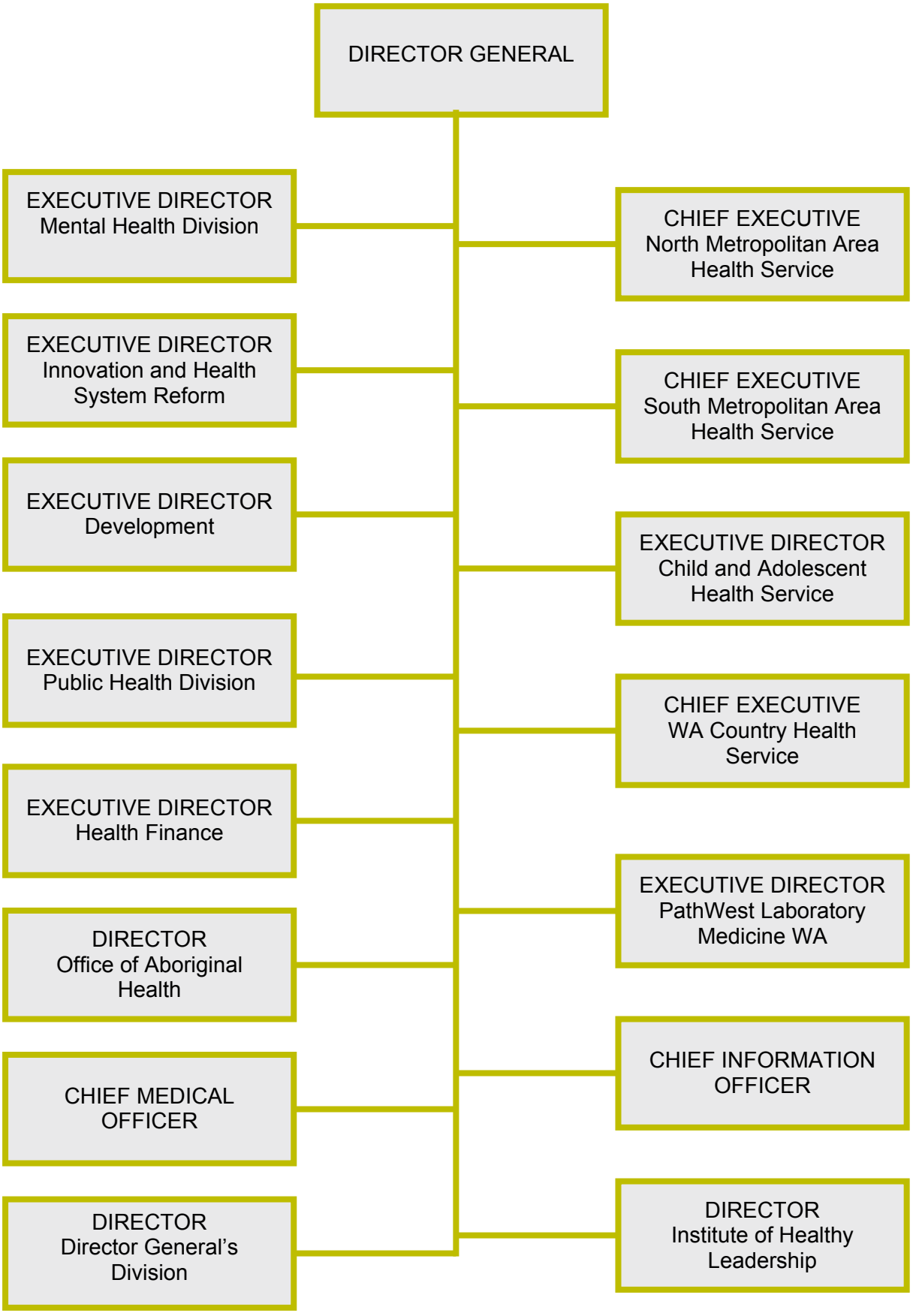
The senior officers as at 30 June 2009 for the Department of Health and their areas of responsibility are listed below.

Table 2: Senior officers – Department of Health as at 30 June 2009

Area of responsibility	Title	Name
Department of Health	**Director General of Health**	**Dr Peter Flett**
Director General's Division	Acting Director	Patsy Turner
Health Information Network	Chief Information Officer	Richard McFadden
Health Finance	Acting Chief Finance Officer	Brett Roach
Office of the Chief Medical Officer and Health Networks	Chief Medical Officer	Dr Simon Towler
Mental Health Division	Executive Director	Dr Steve Patchett
Innovation and System Health Reform	Executive Director	Dr Robyn Lawrence
Public Health	Executive Director	Dr Tarun Weeramanthri
Development Division	Executive Director	Danny Cloghan
Health Corporate Network	General Manager	Bill Bleakley
Office of Aboriginal Health	Director	Ken Wyatt

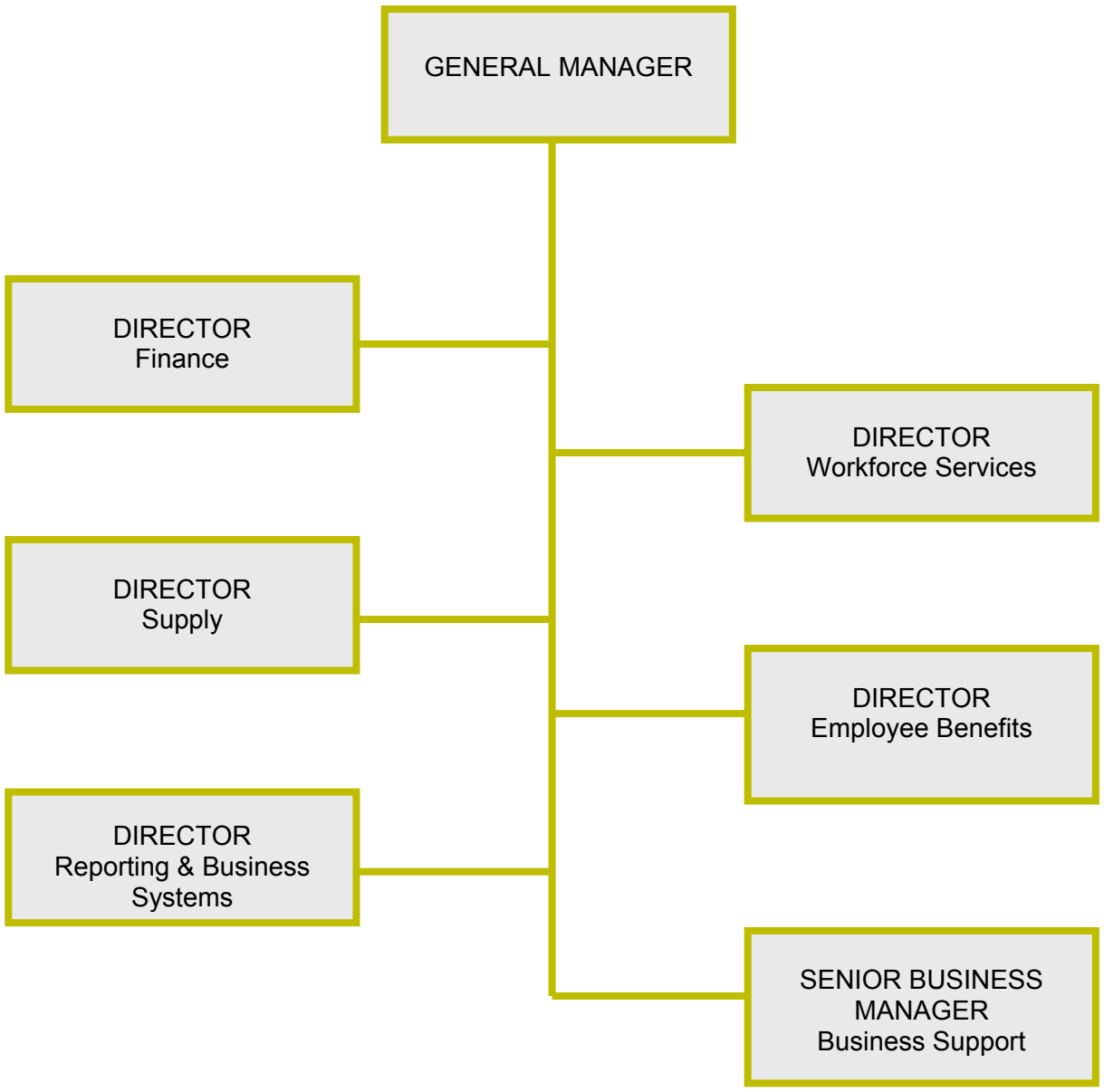
Management Structure

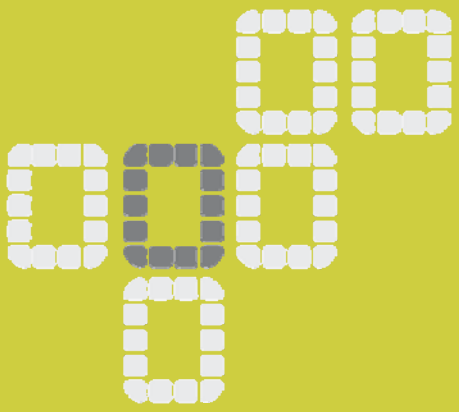
Department of Health State Health Executive Forum (June 2009)



Management Structure (continued)

Health Corporate Network (June 2009)





Key Performance Indicators

Certification Statement

DEPARTMENT OF HEALTH
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2009

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 2009.

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH
ACCOUNTABLE OFFICER

17 September 2009

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 2009

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 2009, and the Income Statement, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, 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 www.audit.wa.gov.au/pubs/AuditPracStatement_Feb09.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.

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Audit Opinion (continued)

Department of Health
Financial Statements and Key Performance Indicators for the year ended 30 June 2009

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 2009 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 2009.

COLIN MURPHY
AUDITOR GENERAL
21 September 2009

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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; and
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.

Since the 2007-08 reporting period the Key Performance Indicators (KPIs) for the Peel Health Service are 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 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 15 service types shown in the table below.

Table 3: Service activities in relation to the components of the outcome

Outcome 1		Outcome 2		Outcome 3	
Service 1	Admitted patient	**Service 8**	Prevention, promotion and protection	**Service 10**	Aged and continuing care
Service 2	Specialised mental health	**Service 9**	Dental health	**Service 11**	Community mental health
Service 3	Home-based hospital programs			**Service 12**	Residential care
Service 4	Palliative care			**Service 13**	Residential mental health care
Service 5	Emergency department			**Service 14**	Chronic illness support
Service 6	Non-admitted patient			**Service 15**	Drug and alcohol
Service 7	Patient transport				

Comparative Results	Performance Targets
Where possible comparative results to prior years are provided.	Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages where available, or from the analysis of previous performance results. Efficiency indicator targets are those contributing to the State-wide targets published in the 2008-09 Government Budget Statements (GBS) for estimated expenditure for 2008-09.

Consumer Price Index (CPI) Deflator Series

The Consumer Price Index Deflator Series is calculated on a five year cycle and 2007-08 completed a five year cycle. The deflator information required to calculate the CPI-adjusted results is therefore not required for 2008-09 as this year will form the base year for the next five year cycle.

Efficiency Indicators

The efficient use of resources can help minimise the overall costs of providing health care. The efficiency indicators included in the Annual Report describe the health service's expenditure against a selected number of activity outputs representative of the health service's provision of health care.

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; and
- 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. 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.

This section of the annual report contains indicators reporting on those services.

R1-50: 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.

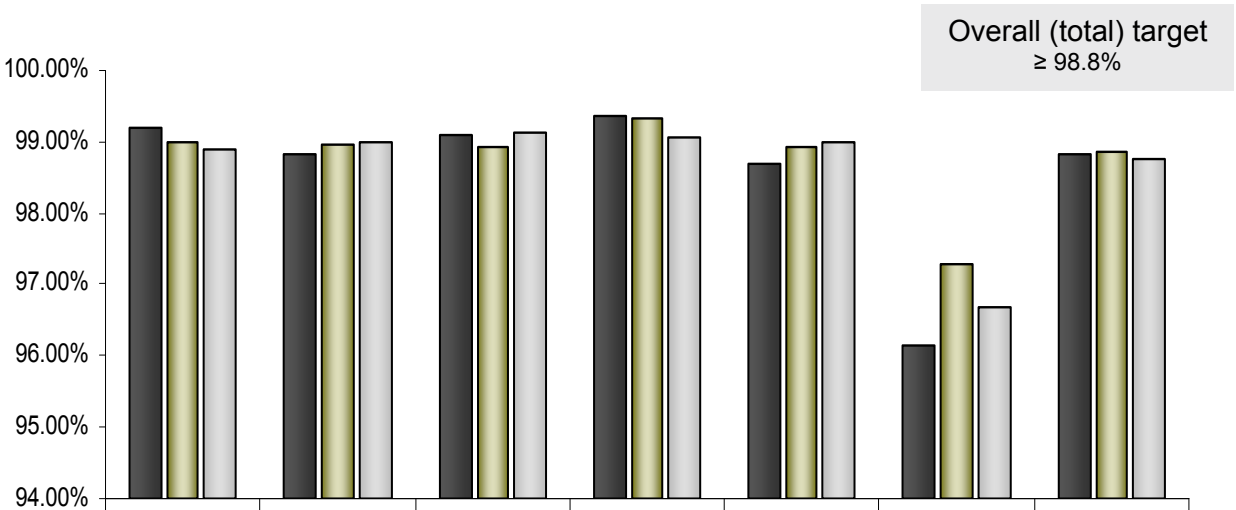
The performance indicator shows the percentage of all separations for patients admitted to hospitals (excluding inter-hospital transfers) directly funded under a contractual arrangement from Department of Health appropriation that are discharged home. The contracts which are in the scope for this performance 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 2008, the overall percentage of privately managed public patients discharged home was 98.75 per cent and comparable to prior years.

Figure 2: Proportion of privately managed public patients discharged to home



	<40	40-49	50-59	60-69	70-79	80+	Total
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%
2008	98.91%	99.01%	99.12%	99.06%	98.99%	96.67%	98.75%

Data Source
Hospital Morbidity Data System

R1-51: Unplanned readmission rate for the same or related condition 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 this annual report.

A low unplanned 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 0.5 per cent and is within target.

Table 4: Unplanned readmission rate for the same or related condition for privately managed public patients

	2005	2006	2007	2008	Target
Unplanned readmission rate	0.5%	0.9%	0.6%	0.5%	< 2.3%

Data Sources
Department of Health, unpublished.
Target – 2007 national average published in the Report on Government Services 2009

R1-53: 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 of patients with these conditions.

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

Results

In 2008 stroke was 81.9 per cent, heart attack 96.6 per cent and hip fractures 94.2 per cent.

The survival rate for stroke in 2008 was below the target range. Heart attack and hip fractures were above target.

Table 5: Survival rates for sentinel conditions of privately managed public patients

Condition	2004	2005	2006	2007	2008	Target
Stroke	83.3%	82.9%	80.3%	85.9%	81.9%	≥ 84%
Heart attack	92.5%	92.9%	91.6%	94.6%	96.6%	≥ 93%
Hip fractures	85.5%	93.3%	98.2%	98.0%	94.2%	≥ 94%

Data Source
Hospital Morbidity Data System.

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

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 proportion of patients with cancer who access the admitted palliative care program.

Results

In 2007, 72.6 per cent of people with cancer accessed admitted palliative care services. The proportion of patients accessing admitted palliative care services has steadily increased over time.

Table 6: Proportion of people with cancer accessing admitted palliative care services

	2004	2005	2006	2007	2008	Target
Individuals with a palliation episode(s)	2122	2208	2302	2685	2553	
Number of cancer deaths	3341	3432	3570	3697	Not available	
Proportion of patients using palliative care services	63.5%	64.3%	64.5%	72.6%	Not available	63%

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

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

RS1-50: 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 2008-09, the average cost of public admitted patient treatment episodes in private hospitals was $2,516. This exceeds the target due to the additional costs incurred especially in relation to clinically-based services.

Table 7: Average cost of public patient treatment episodes in private hospitals – admitted patients

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$2,253	$2,416	$2,120	$2,485	$2,516	$2,305
CPI adjusted	$2,198	$2,291	$1,955	$2,292	$2,516	

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

Notes
The information is reported in this way to preserve the confidentiality of private contracts.
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

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 $75.41 and was over the target of $68. This is above the target due to underestimation in the target-setting process but is consistent with previous years.

Table 8: Cost per capita of supporting treatment of patients in public hospitals

	2006-07	2007-08	2008-09	Target
Actual cost	$73.36	$72.12	$75.41	$68.00
CPI adjusted	$67.65	$64.20	$75.41	

Data sources
Oracle Financial System.
ABS population statistics.

Note
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS3-00: Average cost per home-based hospital care day

Rationale

Hospital at the Home (HATH) is a recognised method of providing acute medical care for some patients in their home environment. Silver Chain delivers contracted HATH, Post Acute Care (PAC) and Community nursing as part of the home-based hospital care program.

Results

The average cost per home-based hospital care day was $328 and was over target. Start up funding for the Friend in Need-Emergency (FINE) program was allocated in 2008-09 after the budget/target process was completed.

Table 9: Average cost per Hospital in the Home patient day

	2007-08	2008-09	Target
Actual cost	$309	$328	$202
CPI adjusted	$275	$328	

Data sources
Oracle Financial System.
Dept of Health unpublished.

Note
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

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 2008-09 the cost per client receiving palliative care services was $4,869 and is above target due to underestimation in the target-setting process but is consistent with prior years.

Table 10: Average cost per client receiving palliative care services (contracts only)

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$3,708	$4,275	$4,279	$4,946	$4,869	$3,469
CPI adjusted	$3,618	$4,054	$3,946	$4,402	$4,869	

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

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS6-50: 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 2008-09, the average cost of public non-admitted patient treatment episodes in private hospitals was $355 and is over target. This indicator includes emergency and other non-admitted patient services.

Table 11: Average cost of public non-admitted patient treatment episodes in private hospitals

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$258	$323	$354	$253	$355	$342
CPI adjusted	$252	$306	$326	$225	$355	

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

Notes
The information is reported in this way to preserve the confidentiality of private contracts.
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

R7-50: Response times for patient transport services

Rationale

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

The St John Ambulance contract requires rapid response to emergencies in the metropolitan area and major regional centres. 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.

The Royal Flying Doctor Service Western Operations provides aero-medical inter-hospital patient transport for patients in rural and remote areas to be transferred from one hospital to a facility offering more extensive services; this may be another rural hospital or a metropolitan hospital.

Results

St John Ambulance - the average response time was 10 minutes and has met the target. Royal Flying Doctor Service Western Operations – 65.4 per cent of flights departed within 75 minutes. This is below target, but with the additional aircraft funded in the 2008-09 and 2009-10 State budgets, an improvement in future years is expected.

Table 12: Response times for St John Ambulance Priority 1 calls

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Average waiting time (minutes)	9.9	9.8	9.6	10.0	10.0	10.0

Table 13: Response times for Royal Flying Doctor Service Western Operations Priority 1 calls

	2008-09	Target
Priority 1 - life threatening emergency	65.4%	80% of flights to depart within 75 minutes

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

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 cost per capita for transfer by St John's Ambulance or Royal Flying Doctor Service.

Results

The cost per capita of St Johns Ambulance and Royal Flying Doctor is $37.48. This exceeds the target due to additional funding being allocated to the Royal Flying Doctor Service for new and replacement aircraft after the 2008-09 budget process was completed.

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

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$17.35	$18.85	$24.41	$26.41	$37.48	$27.00
CPI adjusted	$16.93	$17.88	$22.51	$23.51	$37.48	

Data Source
Department of Health, Unpublished.

Notes
Due to methodology changes in 2006-07, data for previous years cannot be compared.
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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 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 incorporating prevention, early identification and promotion include:

- programs for early detection of developmental issues in children and appropriate referral for intervention;
- early identification of disease and disabling conditions (lung cancer and Ischaemic heart disease) with appropriate intervention referrals;
- programs which support self-management by people with diagnosed conditions and disease (diabetic and asthma education); and
- monitoring the incidence of disease in the population to determine the effectiveness of primary health measures.

Dental health services are also reported in this outcome.

R2-50: 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 1998 to 2007 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

Data for 2007 is not available at time of publishing.

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

Table 15: Person years of life lost from selected preventable diseases and injury WA 1998-2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Target
Lung cancer	3.4	3.5	3.3	3.2	3.3	3.3	2.9	2.9	2.8	Data not available	3.0
Ischaemic Heart Disease	6.9	6.4	5.7	6.1	5.6	4.6	4.8	4.7	4.3	Data not available	5.0
Suicide	6.2	5.1	5.5	5.4	5.1	4.3	3.5	4.0	3.3	Data not available	3.7
Falls	0.3	0.4	0.3	0.4	0.3	0.2	0.3	0.3	0.3	Data not available	0.3
Melanoma	0.7	0.7	0.6	0.7	0.7	0.8	1.0	1.0	0.8	Data not available	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.

d. 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

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

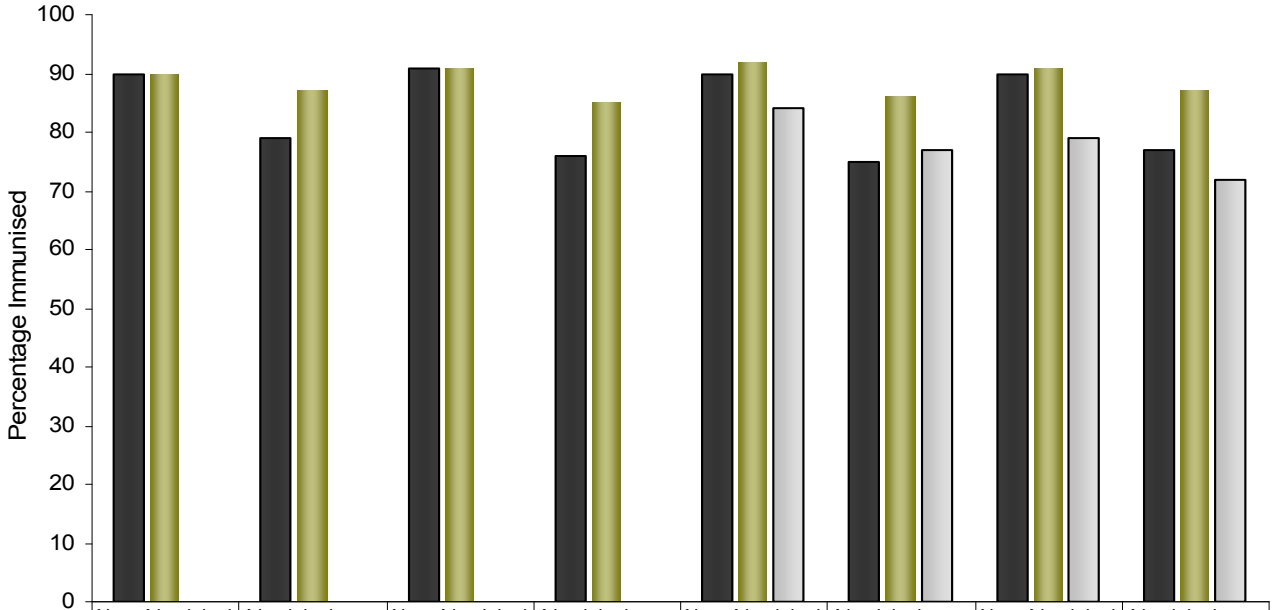
The agreed targets in the National Childhood Immunisation Program are as follows:

- At least 90 per cent of children fully immunised at 12 months of age.
- At least 90 per cent of children fully immunised at 2 years of age.
- At least 90 per cent 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 3: Percentage of fully immunised children at 12 months, 2 and 5 years



	Non-Aboriginal 2005 (Dec Quarter)	Aboriginal 2005 (Dec Quarter)	Non-Aboriginal 2006 (Dec Quarter)	Aboriginal 2006 (Dec Quarter)	Non-Aboriginal 2007 (Dec Quarter)	Aboriginal 2007 (Dec Quarter)	Non-Aboriginal 2008 (Dec Quarter)	Aboriginal 2008 (Dec Quarter)
12 months	90	79	91	76	90	75	90	77
2 years	90	87	91	85	92	86	91	87
5 years					84	77	79	72

Data Sources
Australian Childhood Immunisation Register
Australian Bureau of Statistics population figures.

Note
Reporting the five year age group as per the National Childhood Immunisation Program commenced in 2007.

R2-52: Rate of hospitalisations for selected potentially preventable diseases

Rationale

Department of Health divisions provide numerous health promotion, prevention and protection strategies and initiatives aimed at optimising health and well-being, and preventing disease, illness and injury. To provide additional information about the effect of these programs, the rates of hospitalisation for treatment of some of these preventable diseases are monitored.

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

Results

In 2008, there were 29 hospitalisations for whooping cough. 19 of these admissions were non-Aboriginal children and 10 Aboriginal.

There were four admissions for mumps with three for aboriginal children and one non-aboriginal child. There was also one admission of a non-Aboriginal child with measles.

While the hospitalisation rates reported in 2008 are increased on the rate reported in prior years, the increased occurrence of pertussis is consistent with nationally reported increased rates. This result appears due to adults who have forgone immunisation boosters becoming infected and passing the disease to babies.

WA Health is working with other states on implementing a national immunisation campaign to encourage adults, especially those caring for young children, to maintain their immunisations.

Table 16: Rate of hospitalisations per 100,000 with an infectious disease for which there is an immunisation program – 0-12 years

	2006		2007		2008	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.00	0.00	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.30	0.00	0.00	0.00
Whooping cough	3.12	4.56	0.61	9.31	5.77	33.0
Poliomyelitis	0.00	0.00	0.00	0.00	0.00	0.00
Tetanus	0.00	0.00	0.00	0.00	0.00	0.00

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

	2006		2007		2008	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Measles	0.44	0.00	0.00	0.00	0.21	0.00
Mumps	0.00	0.00	0.00	3.30	0.21	7.10
Rubella	0.00	0.00	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

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 Service Annual Report.

Results

The number of patients on the oral waiting list as at the end of June 2009 was 1883. The numbers on the dental waiting list have increased from the previous year. This is due to increases in the number of 'General Practice' and 'Other' specialist patients entering the waitlist in 2008-09.

The number of eligible patients receiving treatment was 8803 which is slightly less than those receiving treatment in 2007-08.

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

Table 18: Number of eligible patients from the OHCWA waiting list who were offered treatment during 2008-09.

Dental speciality	Number of patients on waiting list at 30 June 2009					Eligible patients offered treatment					
	2005	2006	2007	2008	2009	2004-05	2005-06	2006-07	2007-08	2008-09	Target
General practice	581	163	30	248	667	716	960	1,010	865	1541	865
Oral surgery	892	843	854	407	183	2,707	2,405	2,400	2395	2271	2395
Orthodontics	3,503	1,314	906	735	522	1959	5,216**	3,287	2877	2927	2877
Paedodontics	194	174	177	61	81	1168	755	543	846	670	846
Periodontics	648	328	407	63	64	797	941	469	874	604	874
Other*	804	729	581	212	366	767	423	855	1140	790	1140
Total	6,622	3,551	2,955	1726	**1883**	8,114	10,700	8,564	8997	**8803**	8997

* 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, health promotion and health protection 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.

The role of the 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.

Results

The cost per capita of providing preventive interventions, health promotion and health protection activities for 2008-09 was $63.41 per West Australian. This was over the target due to additional funding of programs after the target was set.

Table 19: Cost per capita of providing preventive interventions health promotion and health protection activities

	2008-09	Target
Actual cost	$63.41	$49.00
CPI adjusted	$63.41	

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

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS9-50: Average cost per dental service provided by OHCWA and CRROH

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.

Centre for Rural and Remote Oral Health (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 $127 and above target. Average cost per dental service is $125 and over target due to the addition of statewide overheads being applied after the 2008-09 target-setting process.

Table 20: Average cost per dental treatment item – OHCWA

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$96.93	$93.80	$106	$119	$127	$120
CPI adjusted	$94.58	$88.96	$98.01	$106	$127	

Data Sources
Department of Health, Unpublished.
OHCWA Database.

Notes
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Table 21: Average cost per dental service provided by CRROH

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$54.03	$65.24	$66.42	$91.67	$125	$66.00
CPI adjusted	$52.72	$61.87	$61.25	$81.60	$125	

Data Source
Department of Health, Unpublished.

Notes
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

The achievement of this outcome of the health objective involves provision of services and programs that improve and enhance the wellbeing and the environment of 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 to enable normal patterns of living.

Support is provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential institutions. This involves the provision of clinical and other services which:

- ensure that people experience the minimum of pain and discomfort from their chronic illness or disability;
- maintain the optimal level of physical and social functioning;
- prevent or slow down the progression of the illness or disability;
- make available aids and appliances that maintain, as far as possible, independent living (for example; wheelchairs);
- enable people to live, as long as possible, in the place of their choice supported by, for example, home care services or home delivery of meals;
- support families and carers in their roles; and
- provide access to recreation, education and employment opportunities.

Significant services are provided for people with a chronic illness or disability by the Area Health Services principally in the areas of Mental Health, Community Care and Aged Care. Services and programs provide people with chronic illness and disability choices regarding their lifestyle and accommodation.

A person with a disability, including a younger person, can also receive support through a number of other agencies including the Disability Services Commission and the Quadriplegic Centre. The DOH and Area Health Services also provide assistance to those with disabilities through the provision of Home and Community Care (HACC) services. This program is administered through the DOH and the effectiveness and efficiency indicators for HACC are reported in the Department of Health Annual Report.

R3-02: Percentage of clients maintaining or improving functional ability while in transition care

Rationale

Transition care programs (TCP) are designed to help older peoples' independence and confidence at the end of a hospital stay by assisting them to maintain or improve their functional ability. Non-government organisations are contracted for TCP in rural and metropolitan locations.

These programs provide the person with more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and assists them and their family to access longer term care arrangements which can include a return to home rather than entry to permanent residential aged care.

Persons entering TCP must be assessed by an Aged Care Assessment Team and be eligible to receive at least low level permanent residential aged care. The person must enter the program directly upon discharge from hospital.

This indicator measures the percentage of transitional care clients whose functional ability was either maintained or improved during their stay in the program. This improvement is measured using the Modified Barthel Index assessment recorded at TCP entry and exit.

Results

In 2008-09 the percentage of clients that either maintained or improved during their stay in the program was 71 per cent.

Table 22: Percentage of clients maintaining or improving functional ability while in transition care

	2008-09	Target
Percentage of clients maintaining or improving functional ability	71%	64%

Data Source
DOH unpublished

R3-50: Rate per 1,000 HACC target population who receive 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 V2.0 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 2008-09 estimated rate (per 1,000 HACC target population) of 316 was less than the target rate of 358.

The revised HACC minimum data set now counts both the care recipient and their carer on one record. This has the effect of reducing the total number of clients.

Table 23: Rate per 1,000 HACC target population who receive HACC services

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Rate per 1,000 HACC target population	349	355	349	347	316	358

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).

Notes
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

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 to 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. This survey was conducted by an independent non-government agency.

Response rate	91.4 per cent
Population size	57,314 clients
Sample size	1,416 clients
Selection of sample	WA HACC Minimum Data Set was used to select a sample for this survey.

Sampling error rate ± 3.0 per cent for the 95 per cent confidence level.

Results

Surveys were completed and returned by 1,102 clients. The responses indicated that:

- 82.6 per cent of clients agreed that the service helped them to be independent. While this percentage is slightly under the target of 85 per cent it remains a significant and positive result.
- 83.9 per cent of clients agreed the service improves their quality of life. This is slightly below 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 24: HACC program survey results

Survey question	Agree	Target
The program helps you to be more independent	82.6%	85.0%
The program improves your quality of life	83.9%	85.0%

Data Source
Edith Cowan University's Survey Research Centre (ECUSRC) – May 2009 survey.

R3-52: Proportion of people with a mental illness receiving non-clinical community 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, 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.

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.

Results

The proportion of people with a mental illness receiving non-clinical community-based support from non-government organisations was 52.7 per cent in 2008-09. This result is lower than the set target, but has improved from 2007-08 when the target group was expanded to be more inclusive.

Table 25: Proportion of people with a mental illness receiving non-clinical community support from non-government organisations

	2005-06	2006-07	2007-08	2008-09	Target
Proportion of people with a mental illness receiving non-clinical community support from non-government organisations	58.9%	65.4%	45.8%	52.7%	65%

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

RS10-00: Average cost per person of HACC services delivered to people 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 V2.0 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 $2,775 was higher than the target.

The revised HACC minimum data set now counts both the care recipient and their carer on one record. This has the effect of reducing the total number of clients. 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 26: Average cost of HACC services per person with long term disability

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$1,900	$2,000	$2,176	$2,354	$2,775	$2,439
CPI adjusted	$1,854	$1,897	$2,007	$2,095	$2,775	

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

Notes
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 community based, non-government and local government organisations and funding allocated to the Department of Health and WA Country Health Service.
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS10-01: Average cost per transition care day

Rationale

Transition care programs (TCP) are designed to help older peoples' independence and confidence at the end of a hospital stay by assisting them to maintain or improve their functional ability. Non-government organisations are contracted for TCP in rural and metropolitan locations.

A TCP provides the person with more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and assist them and their family to access longer term care arrangements which can include a return to home rather than entry to permanent residential aged care.

This indicator measures the average cost of a transition care day provided by non-government contracted services.

Results

In 2008-09 the average cost per TPC day was $222 and slightly above target.

Table 27: Average cost per TPC day

	2007-08	2008-09	Target
Actual cost	$192	$222	$217
CPI adjusted	$171	$222	

Data Sources
Department of Health, Unpublished.
Oracle Financial System.

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS10-50: 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 2008-09 was $125 and above target due to the underestimation of expenditure in the target-setting process.

Table 28: Average cost per day of care for non-acute admitted continuing care

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$33.09	$34.61	$37.29	$91.31	$125	$105
CPI adjusted	$32.29	$32.82	$34.39	$81.28	$125	

Data Source
Department of Health, Unpublished.

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS11-50: Average cost per hour for non-clinical community support provided by non-government organisations to people with a mental illness

Rationale

The aim of community based non-clinical support programs is to support clients with a mental illness 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, 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 client's home or in the local community. The range of services provided is dependent on the needs and goals of the individual.

Results

The average cost per hour to provide non-clinical community support to an individual with a mental illness was $60.98 per person. This result is lower than the target as more hours of service were provided with the available funds than was estimated.

Table 29: Average cost per hour for non-clinical community support provided by non-government organisations to people with a mental illness

	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$57.72	$62.47	$57.92	$60.98	$66.00
CPI adjusted	$54.74	$57.61	$51.56	$60.98	

Data Source
Mental Health Division, Department of Health.

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied to 2008-09.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS13-50: Average Department of Health subsidy per bedday provided to support people with mental illness living in community residential accommodation provided by non-government organisations

Rationale

Non-government organisations provide accommodation in staffed residential units for people affected by mental illness who require support to live in the community. Residential care facilities provide support with self-management of personal care and daily living activities as well as initiate appropriate treatment and rehabilitation to improve the quality of life for these clients.

This accommodation support is available to adults with a mental illness, including older persons with complex mental health issues and significant behavioural problems. These clients are unable to live independently in the community without the aid of government subsidies to provide appropriate care.

Results

In 2008-09 the bedday cost was $164. The overestimation in setting the target has resulted in the expenditure being significantly lower than the target.

Table 30: Average Department of Health subsidy per bedday provided to support people with mental illness living in community residential accommodation provided by non-government organisations

	2008-09	Target
Actual cost	$164	$237
CPI adjusted	$164	

Data Source
Mental Health Division, Department of Health.

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS13-51: Average Department of Health subsidy per person to support residents in metropolitan licensed private psychiatric hostels

Rationale

Private licensed psychiatric hostels provide personal care support services to residential clients with a mental illness 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 private 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 subsidy per person for eligible residents in metropolitan licensed private psychiatric hostels for 2008-09 was $5,889. This result is above the target due to the addition of statewide overheads being applied after the 2008-09 target-setting process.

Table 31: Average Department of Health subsidy per person to support residents in metropolitan licensed private psychiatric hostels

	2008-09	Target
Actual cost	$5,889	$5,454
CPI adjusted	$5,889	

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

Notes
The target was set as part of the Government Budget Statements process.
Statewide overheads have been applied.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

RS14-50: 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 is 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 a variety of different providers. The services reported in this indicator are not as easily defined as other indicators in Outcome 3.

Results

In 2008-09, the average cost to support patients who suffer specific chronic illness and other clients who require continuing care was $42.24 per patient and is slightly above the target.

Table 32: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care

	2004-05	2005-06	2006-07	2007-08	2008-09	Target
Actual cost	$18.58	$36.60	$39.54	$44.58	$42.24	$41.00
CPI adjusted	$18.13	$34.73	$36.46	$39.68	$42.24	

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

Notes
Statewide overhead costs have been applied from 2005-06.
The target was set as part of the Government Budget Statements process.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Significant Issues and Trends

Overview

Work to drive reform of the Western Australian health system has continued during 2008-09. This reform is carried out in an environment requiring expenditure restraint while at the same time providing for the increasing demands on hospitals and other health services.

Federal Partnership

In 2008-09, the Western Australian Government has continued to work in collaboration with the Commonwealth Government on the implementation of national health-related election commitments. This has seen the State receive funding to assist in reducing elective surgery waiting times, establish General Practitioner (GP) Super Clinics, increase transition care capacity and support nurses to re-enter the workforce.

A major step towards a sustainable health care system is workforce reform. A single national registration and accreditation Scheme for ten health professions is under development, with a significant contribution its formation from WA Health, for implementation across the jurisdictions.

To enable a better, more connected health care system, the development of a national electronic health records system has continued with support from the State Government, Commonwealth Government and other States and Territories.

In 2008-09 the Western Australian Government has continued to contribute funding and worked in collaboration with the Australian Commission on Safety and Quality in Health Care. The Department of Health (DOH) has been involved in designing and implementing initiatives to broadly improve the safety and quality of health care services in public hospitals and across the health system.

The State has also satisfactorily fulfilled statistical and financial reporting obligations under the Australian Health Care Agreement 2003-2008, and has significantly exceeded the requirement to match growth in Commonwealth funding over the five-year period of the Agreement.

December 2008 saw the signing of the new National Healthcare Agreement and several National Partnership Agreements between the Commonwealth and Western Australia. Through these agreements, the State will access Commonwealth funding for a package of reforms to aid public hospitals, health workforce, Indigenous health, sub-acute care and preventive health.

In particular, with focus on prevention and management of chronic disease, the State Government has been integrating its local programs around lifestyle, risk modification and self management with national level initiatives, such as the “Measure Up” campaign which aims to reduce the risk factors for chronic disease such as some cancers, heart disease and type 2 diabetes.

The National Mental Health Policy 2008 now agreed by all Health Ministers was developed in conjunction with the State Government, Commonwealth Government and other States and Territories. This Policy provides a strategic vision for further whole-of-government mental health reform in Australia. The Fourth National Mental Health Plan 2009-2014 is being drafted and, when finalised, will provide a framework for the provision of mental health services.

Aboriginal Health

Indigenous Australians experience the worst health of any one identifiable cultural group in Australia and on 2 October 2008, the Council of Australian Governments (COAG) agreed to six ambitious targets for closing the life expectancy gap between Indigenous and non-Indigenous Australians in urban, rural and remote areas. The health sector agreed to two targets:

- to close the gap in life expectancy within a generation; and
- to halve the gap in mortality rates for Indigenous children under five within a decade.

Overview (continued)

In signing the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, the Commonwealth and State and Territory governments committed to a $1.5b undertaking over the next four years (2009-10 to 2013-14) to address five priority areas to achieve improved health outcomes. The Western Australian Government is commitment is to undertake new expenditures totalling $117.44 million over the four years, building on WA Health's current effort and commitment to making the health of Aboriginal people everybody's business.

The Western Australian Government recognises that achieving improvement in Aboriginal health status is complex and challenging. Significant improvement in health outcomes will only be achieved if better and more relevant health services are delivered and accompanied by actions in other key service areas such as housing, education, employment and economic development.

The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* is one of the seven National Partnership Agreements which have a specific focus on Indigenous Australians and each is inter-related with the other. The other agreements are the Intergovernmental Agreement on Federal Financial Relations, National Indigenous Reform Agreement, National Partnership Economic Agreement, National Partnership Remote Indigenous Housing, National Partnership Indigenous Early Childhood Development and the National Partnership Remote Service Delivery which enable a whole of Government approach to achieve the agreed outcomes.

The *National Partnership Agreement* on Closing the Gap in Indigenous Health Outcomes targets five priority areas:

- preventive health: to reduce the factors that contribute to chronic disease through effective anti-smoking campaigns and integrated alcohol, drug and mental health services;
- primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services;
- hospital and hospital-related care: to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management;
- Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and co-ordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target, and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services; and
- Sustainability: to increase the number of Aboriginal and Torres Strait Islander people employed in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs.

The initiatives complement the range of services already in place aimed at improving the health status of Indigenous people and are consistent with broader Western Australian Government and Commonwealth policy directions for Indigenous health.

The State Government also recognises that the initiatives it implements will not succeed unless pursued in partnership with the Aboriginal community. WA Health is committed to ensuring Aboriginal community involvement is central to achieving improved health outcomes for Aboriginal individuals, families and communities.

Implementation of the five priorities will advance all of the Service Delivery Principles for Indigenous Australians detailed in the COAG National Indigenous Reform Agreement, which are;

Overview (continued)

- Indigenous engagement: engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services;
- Sustainability: programs and services should be directed and resourced over an adequate period of time to meet the COAG targets;
- Access: programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs;
- Integration: There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services; and
- Accountability: programs and services should have regular and transparent performance monitoring, review and evaluation.

The overall governance and oversight of the delivery of the health implementation plan will be through the Aboriginal Health Partnership Group comprising high level representatives from the Aboriginal Health Council of WA, the WA Area Health Services, other Aboriginal community organisations, State, Territory, Commonwealth and local governments, and the Divisions of General Practice.

Detailed regional plans and strategies will be developed, monitored and reviewed by nine Regional Aboriginal Health Planning Forums including two Perth North Metropolitan and South Metropolitan Area Health Service forums and seven country regional forums (Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Great Southern and South West).

The Aboriginal Health Planning Forums will be the mechanism through which the COAG objectives will be developed in detail to achieve regional objectives in closing the gap for all Aboriginal Western Australians.

A state-wide Aboriginal Health Implementation Team will be established from within the Office of Aboriginal Health to underpin the work of the Area Health Services (WACHS, NMAHS, SMAHS and CAHS) to achieve the agreed outcomes. On 3 July 2008, the COAG agreed in principle to address the needs of Indigenous children in their early years.

The National Partnership Agreement for Indigenous Early Childhood Development commits the Commonwealth Government and the State and Territory Governments to work together to improve early childhood outcomes of Indigenous children by addressing the high levels of disadvantage they currently experience and give them the best start in life.

There is a shared commitment to improvements in Indigenous child mortality, enhanced access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services. These service initiatives focus on quality early learning, child care and parent and family support, parenting support services, early childhood education, child care and the early years of schooling.

WA Health Conference 2008

The WA Health Conference and the 'Healthy WA Awards' provided formal mechanisms for the health system to support and reward innovation and continuous improvement. This public acknowledgement of the efforts of the innovators in WA Health provides an important mechanism for dissemination of information on innovations being developed and/or implemented in the health system.

Examples of WA Health attainment, innovation and care improvement were presented by WA Health staff during concurrent sessions at the conference.

The Healthy WA Awards 2008

At the 2008 WA Health Conference eight outstanding individuals and organisations were recognised for making significant contributions to the health system of Western Australia.

Overview (continued)

Winners and finalists were awarded in categories that mirrored six strategic directions for projects that had the potential to be implemented statewide. The winners of the Healthy WA Awards for 2008 were:

- *Healthy Resources:* Royal Perth Hospital for developing a statewide database for the care of patients with chronic kidney disease;
- *Healthy Partnerships:* The Child and Adolescent Community Health metropolitan-wide Aboriginal Health Team, who respond to the needs of Aboriginal and Torres Strait Islander children and their families;
- *Healthy Hospitals:* Osborne Park Hospital for its introduction of a medication reconciliation project to improve medication safety;
- *Healthy Leadership:* The metropolitan Child Development Service for their work providing a coordinated and integrated range of assessment, early intervention and therapy services to children with, or at risk of, developmental delay;
- *Healthy Workforce:* The Office of the Chief Nursing Officer for its Assistants in Nursing (AIN) program to help fight nursing shortages, and to Fremantle Hospital and Health Services who introduced the assistants in three wards to support enrolled and registered nurses to deliver patient care; and
- *Healthy Communities:* The South Metropolitan Area Mental Health Service for its multi-systemic therapy program, providing specialist community-based services at Rockingham and Hillarys to the families of children and adolescents with severe behavioural disorders.

Additionally two special awards presented were:

- The Director General's Choice Award: For significant contribution to patient care - the Women and Newborn Health Service for its work developing DVDs to support mothers from culturally and linguistically-diverse backgrounds, including the Ethiopian, Sudanese and Iraqi communities; and
- The Peter Baldwin Memorial Award for achievement in human resources to Tracy Bennett from the South Metropolitan Area Health Service.

Significant issues and achievements 2008-09

Innovation and leadership

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 health needs of a diverse population.

Workforce

Meeting the challenges of changing population demographics, accelerating retirement rates and workforce sustainability, while positioning as an employer of choice, WA Health continues with planning and strategic actions including:

- Programs such as the Community Residency Program, the Expanded Specialists Training Program and Upskilling of Overseas Trained Specialists Program which will progress the provision and accreditation of vocational and pre-vocational training to maintain viability of both community and hospital-based medical workforces;
- Funding for a series of undergraduate and post-graduate clinical specialisation scholarships;
- Re-entry and refresher programs for approximately 150 nurses per annum to facilitate their re-entry into the workforce;
- The Statewide Simulation Plan to address all levels of conformity that will ensure access to both metropolitan and rural healthcare professionals;
- Commenced planning of the community based child care centre at Rockingham General Hospital which will deliver a family friendly work environment as part of WA Health's Child Care Strategy;
- Completed a gap analysis of Podiatry, Midwives, Physiotherapy and Occupational Therapy needs; and
- A media campaign between December 2008 and June 2009 to address the ongoing nurse shortage. This has resulted in an increased level of expression of interest in nursing and applications for re-entry into the workforce.

Aboriginal Health

The Office of Aboriginal Health (OAH) represents WA Health on the National Aboriginal and Torres Strait Islander Health Workforce Working Group. This Group is currently undertaking significant work - such as the establishment of the National Aboriginal and Torres Strait Islander Health Worker Association, the review and development of a national scope of practice for Aboriginal and Torres Strait Islander Health Workers, and will play a lead role in the development of accreditation and registration of Aboriginal and Torres Strait Islander Health Workers from 2012.

A joint initiative of the Office of Aboriginal Health and WA Country Heath Service has been established to assess the current competencies of Aboriginal health workers across WA. This will provide information to guide opportunities for up-skilling of the existing Aboriginal health worker workforce, and identify areas for career progression

Increasing the Aboriginal and Torres Strait Islanders health workforce is a key focus area of the National Health Workforce Strategic Framework. At a State level, the Office of Aboriginal Health:

- in collaboration with the Department of Education & Training (DET) launched an Aboriginal Primary Health Care Vocational Education and Training (VET) in School Program in Term 2, 2009. The VET program enrolled 9 students and the focus of the program will shift to Cert II Health Support Services. This year DET are planning additional pilots in the metropolitan, Kimberley and possibly Pilbara regions; and

- has supported PathWest to roll out an Aboriginal Laboratory Technician traineeship pilot program. This program was launched in April 2009 in South Hedland, Kalgoorlie and Esperance. Currently PathWest is hosting one trainee from each of these pilot sites. The Swan TAFE is negotiating to implement the PathWest program

A Reconciliation Action Plan (RAP) was developed which includes the following initiatives to strengthen partnerships and create new ways of working with Aboriginal and Torres Strait Islander people:

- Establishment of a working group of Aboriginal and non–Aboriginal staff members to monitor and report to Corporate Executive on the progress of implementing the RAP;
- Supporting and consulting the WA Aboriginal and Torres Strait Islander Health Worker Association, including providing funding for the inaugural Aboriginal and Torres Strait Islander Health Worker conference;
- Participation by DOH staff at NAIDOC and National Reconciliation Week events;
- Establishment and development of the metropolitan inter-agency forum for DOH Aboriginal employees to improve sector networking and sharing of information on Aboriginal health issues and priorities;
- Development of orientation programs for staff that include cultural awareness training and acknowledgement of Aboriginal and Torres Strait Islander culture; and
- Continuing the reform of industrial award conditions in support of Aboriginal and Torres Strait Islander employees by including Cultural/Ceremonial leave provisions in Health Department industrial awards.

Health Information Network

Coded health information is critical for health service planning, clinical research, resource allocation, funding and reimbursement, epidemiological studies and clinical benchmarking. Clinical coders translate written clinical notes about patient care into code format based on the international statistical classification of diseases and health related problems. The Health Information Network has led statewide initiatives to increase the number of clinical coders employed in the WA Health system in order to keep pace with current and future demands.

Nursing and Midwifery Office

The first Acute Care Assistants in Nursing (ACAIN) training program that commenced at Fremantle Hospital in February 2008 has led to 127 ACAINs currently being employed across WA Health. The continued training and further employment of ACAINs will be implemented following the development of a sustainable employment and training model.

Directors of Nursing have received applications for the Hospital Nurses Support Fund from nurses. The fund is intended to make the working lives of nurses and midwives more satisfying and their public hospital workplaces more attractive. The Hospital Nurses Support Fund was established in 2008-09 as an election commitment of the State Government.

Registered Nurses who graduated in 2008 were recruited to WA Health through the 'Graduate Nurse Connect' application system. Numbers recruited increased by 15 per cent from 586 in 2007 to 676 in 2008. Commencement for the 2010 intake has begun and Graduate Nurse Connect has extended recruitment to include Enrolled Nurses.

WA Health awarded 635 recipients 'Postgraduate Specialisation Scholarships' which are available annually to nurses and midwives. These scholarships acknowledge their ongoing commitment and dedication to the health of the community and aid professional development and maintenance of the high standards in the nursing / midwifery workforce. The Undergraduate nursing and midwifery scholarships were awarded to assist students and midwives to complete their undergraduate degrees and assist Enrolled Nurses to advance to become Registered Nurses.

Innovation and leadership (continued)

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, quality health care to the WA community. The annual Safety and Quality Investment for Reform (SQuIRe) program workshop was held in October 2008.

The Institute for Healthy Leadership

The Institute of Healthy Leadership conducted a range of leadership development programs as part of WA Health's strategy to build leadership capacity and capability as integral components of the health system reforms.

The Institute works with the Area Health Services and training and educational service providers to deliver multi-level, high quality, leadership programs for WA Health employees.

Three programs assist in building a greater pool of future senior leaders for WA Health:

- The *Emerging Leaders* program that enhances the leadership ability of senior managers and lead clinicians by assisting them to deliver service improvement in their respective workplace. In the 2008 100 staff participated in the program and a further 20 senior managers, policy staff and lead clinicians were selected to participate in the revised and improved 2009 program;
- The *Delivering the Future Leadership* program that targets potential future directors and executive directors by providing high-level leadership training. Twenty participants graduated in September 2008, with a further 12 participants in the 18 month program in 2009; and
- The *Graduate Development* Program with 10 new graduates participating in the 2009 program.

A series of Delivering Service Improvement workshops were also offered to participants of our previous leadership programs which focused on project management and service improvement concepts and methodologies.

The Institute has also offered opportunities for staff to participate in mentoring, team development, action learning sets, shadowing, exposure to other sectors, systems and leaders and a series of master classes.

A staff intranet website and newsletter were also made available to staff to promote WA Health's commitment to Healthy Leadership.

The Office of Aboriginal Health and Institute for Healthy Leadership are reforming the WA Health Graduate Development Program to encourage more Aboriginal applicants to apply for careers in the public health sector.

Hospitals and health services

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

Emergency care management

The Four Hour Rule Program was launched in April 2009. This program will fundamentally change the way WA Health manages unplanned and emergency patient care. The aim of the program is to improve the patient experience and quality of care by reducing delays in the emergency department (ED) and streamlining processes, particularly for admission to and discharge from the hospital.

The program will be rolled out over three years and will ultimately aim to ensure that 98 per cent of patients arriving in EDs are seen and admitted, discharged or transferred within a four-hour timeframe, unless required to remain in the ED for clinical reasons. This is a major change process, which is why each site will have a two year period to reach the target.

The Four Hour Rule program is not just limited to the ED. It will provide the platform for a redesign process across all hospital services in WA Health. The program will build on existing efforts to redesign services, and will deliver a series of improvements across the whole patient journey.

In April 2009 Stage 1 of the redesign process to implement the Four Hour Rule program commenced at:

- Fremantle Hospital;
- Princess Margaret Hospital for Children;
- Royal Perth Hospital; and
- Sir Charles Gairdner Hospital.

Another initiative to aid reduction in ED traffic is the 'Friend in Need – Emergency' (FINE) scheme which aims to reduce pressure on emergency departments by providing alternative care arrangements to hospitalisation for older and chronically-ill patients, and provide service liaison staff in the EDs to ensure timely arrangement of service delivery in the community.

The FINE scheme has an allocation of $84 million over four years and commenced with an initial $3 million commitment in 2008-09 to:

- expand the capacity of Silver Chain's "Hospital at the Home" (HATH) services; and
- enable immediate expansion of flexible home care packages availability through the North Metropolitan Area Health Service (NMAHS) and the South Metropolitan Area Health Service (SMAHS).

Elective Surgery

The Elective Wait List Advocate Committee was formally established in January 2009 to oversee elective surgery wait lists and make them more transparent to the Western Australian public.

This new six-member committee operates as an independent advocate to oversee elective surgery waiting lists. The committee reviews and advises on the state of, and matters relating to, the elective surgery waiting list and follows up patients' complaints if they have not been resolved by individual health services.

The committee can also identify areas of high demand within the health system and works with hospital and departmental managers to ensure patients have their surgery scheduled appropriately.

The committee is led by distinguished neurosurgeon Professor Bryant Stokes as committee chair and includes independent medical advisors, two community appointees, one consumer representative and one DOH representative.

The Health System Improvement Unit coordinated and facilitated Western Australia's additional elective surgery activity under the Commonwealth's Elective Surgery Blitz Program Stage One. WA received funding of $15.4 million for the calendar year

Hospitals and health services (continued)

2008 to conduct an additional 2,720 elective surgery cases above the 2007 base figure. A total of 3,727 cases were achieved, 37 per cent above the target.

Chief Medical Officer

The DOH with the State Health Research Advisory Council has selected twelve projects following a competitive review for Round 3 Research Translation Projects which will commence in 2009-2010. The funding will facilitate the translation of research outcomes into effective health care with economic benefits to complement the WA Health reform process.

In accordance with the *National Health and Medical Research Council Act 1992*, the Chief Medical Officer is a member of the National Health and Medical Research Council. The DOH remains committed to the application and implementation of health and medical research.

The Chief Medical Officer is a member of the WA Medical Board and acts as an interface between Board and the DOH.

Technology is considered to be one of the most significant drivers of increased healthcare expenditure. The DOH has formed a state advisory committee on technology to consider high cost technology adoption into clinical practice within Western Australia.

At the South-West Health Campus in Bunbury a radiation oncology facility to improve services to patients in the South-West growth corridor has been approved. Planning has commenced and architects have been appointed.

During 2008-09 funding for chemotherapy and radiotherapy outpatient services at metropolitan and 13 regional hospitals has been provided by the State Government. Consultation with the Cancer Council of WA, the Cancer and Palliative Care Network and medical specialists has begun on the best means to utilise funding to improve facilities, staffing and generally increase the capacity to serve more cancer patients.

Assistance for palliative and cancer patient support services has commenced with the establishment of a Palliative Services Project Fund that will improve the capacity of successful existing programs and innovative projects to help find imaginative new ways to deliver palliative services to Western Australians. A special focus of the Fund will be on providing palliative care to patients in Indigenous and remote communities. Consultations with the WA Cancer and Palliative Care Network, the Cancer Council of WA, cancer practitioners and patient groups were conducted to determine the best way to set priorities and allocate funds.

A highly qualified team of cancer nurse coordinators is developing an effective statewide service to strengthen education and provide a mentorship program. The team is now internally recognised and has published two articles in the Australian Journal of Cancer Nursing and has led Australia in developing the first cancer coordination conference. Minimal staff turnover has been experienced as a result.

Public Health

The Public Health Division (PHD) has coordinated the development of a new Clinical and Related Waste Policy for all DOH facilities. The policy has been distributed across the Department for consultation.

In establishing a WA Health Language Service Network an advisory group has been formed to improve the provision of language services to ensure equitable access to high quality health care, services and programs for people with no or low English language proficiencies.

The Advisory Group is composed of stakeholders from key WA Health Services, non-government organisations and has consumer representation. It will progress the key recommendations from the ‘Review of Language Services in WA Health System’ final report.

Hospitals and health services (continued)

Mental Health

Construction of a new 20 bed adult and 10 bed older adult mental health inpatient unit at Rockingham General Hospital is underway. Services are expected to be operational in April 2010.

Facility planning and contract documentation for the new 14 bed Broome Mental Health Inpatient Unit is underway, and the tender process is expected to commence in early 2010 to coincide with the work program for Stage 1 of the Broome Hospital redevelopment project.

The Community Supported Residential Units at Bentley have been completed and residents have been moving in since December 2008.

Community Supported Residential Units in Osborne Park and Middle Swan are scheduled for completion in 2009.

Planning is underway to replace the Community Supported Residential Units in Kalamunda and Peel, both with 25 beds, and deliver an alternative accommodation service model for these communities.

Capital works for Community Options group homes in Mount Claremont, with 7 beds opened in July 2009.

The Mental Health Senior Bed Management Team was established to undertake a systems view of patient flow processes in terms of need, access and service delivery. The aim is to improve patient flow and co-ordination between EDs and Mental Health Services to ensure the optimum management of mental health patients in ED, which includes timely decision making and discharge or transfer to a more appropriate setting.

Assertive Patient Flow Coordinators have been employed to ensure patients receive timely access to appropriate care and move safely and efficiently through the health system without unnecessary delay.

Initiatives to address postnatal depression have continued with:

- implementation of the Indigenous Perinatal Mental Health Service expansion project in Carnarvon;
- implementation of the culturally and linguistically diverse Perinatal Mental Health Service expansion project in the Perth metropolitan area;
- implementation of the Practical Support Service expansion project at two Western Australian sites – metropolitan (Belmont/Victoria Park) and rural (Australind/Eaton);
- pilot of the Perinatal Anxiety Training Module; and
- roll-out of the Feeling Attached Training Module and development of a health professionals perinatal mental health website.

The State Government has commenced drafting legislation to be submitted to Parliament for the establishment of a new statutory Office of Commissioner for Mental Health and Wellbeing. The roles and functions of the independent Commissioner for Mental Health and Wellbeing are currently being developed.

The DOH has commenced work to develop the State Mental Health Policy and Mental Health Strategic Plan 2010-2020 for Western Australia. It is envisaged that the State Mental Health Policy document will articulate an overarching whole of Government, whole of community policy framework and a shared long term vision for mental health in Western Australia. External consultants were appointed in February 2009 to assist with this work, to be completed by February 2010.

Safety and Quality

The Office of Safety and Quality has strengthened its framework to facilitate improved safety and quality in hospitals in the following key areas:

- The Safety and Quality Investment for Reform (SQuIRe) program has been revised and updated to improve infrastructure to support safety and quality activities and Clinical Practice Improvement (CPI) in WA hospitals;

Hospitals and Health services (continued)

- Phase Two of the SQuIRe program commenced and will retain a focus on the eight mandated CPI programs - Acute Myocardial Infarction, Venous Thromboembolism, Pressure Ulcers, Falls Prevention, Medication Reconciliation, Central Line Associated Blood Stream Infections Surgical Site Infections, and Hand Hygiene; and
- Supported the development of a standardised Paediatric Inpatient Medication Chart for WA hospitals in line with the decision by Australian Health Ministers in December 2008.

Sentinel events and clinical incident management continues with:

- the review and update of sentinel event notification and reporting processes;
- providing focus reports on areas of occurrence of clinical incidents to assist in the production of patient safety alerts. This is achieved by working in collaboration with specialist groups (e.g. WA Medication Safety Group, Aged Care Network); and
- completing consultation with Area Health Services on a business case for procurement of a new Clinical Incident Management System.

To encourage patients, carers and the community to participate in their health care decisions, the Patient First Program has expanded to include the Patient First Ambassador Project, a peer support initiative to promote the program in place at Sir Charles Gairdner Hospital to other metropolitan and rural hospitals.

Aboriginal Health

The Office of Aboriginal Health (OAH) auspice the Aboriginal Maternal and Child Health Advisory Group (AMCHAG), tasked with developing the Aboriginal Maternal and Child Health Action Plan (AMCHAP). The AMCHAG identified key priorities and service gaps to develop culturally appropriate strategies to address improvements in the long term health and wellbeing of Aboriginal mothers and their children. Key messages from the Health Consumers' Council Aboriginal Reference Group, the Aboriginal Women's Reference Group and broader consultative process are embedded in the AMCHAP. It is also expected that these messages will underpin service design and delivery.

The WA Aboriginal Primary Care Advisory Group has been established to meet whole of system responsibilities to improve Aboriginal and Torres Strait Islander primary health care and to develop an agreed coordinated approach to increasing access to primary care.

The OAH has current contractual arrangements with a number of non-governmental service providers state-wide to deliver primary, environmental and health promotion activities.

Infrastructure

The infrastructure program to expand Western Australian public hospitals has continued with the following actions:

- Planning to articulate the role of Royal Perth Hospital in the adult tertiary network that includes the new Fiona Stanley and Sir Charles Gairdner Hospitals has commenced;
- Construction of Stage 1 of Fiona Stanley Hospital has commenced and is expected to be completed by December 2013. The hospital will provide state-of-the-art tertiary facilities for the State, as well as secondary level facilities primarily for residents of the inner southern suburbs;
- Planning for the new children's and women's hospital alongside Sir Charles Gairdner Hospital has commenced;
- Expansion of services and facilities at Joondalup Health Campus has been approved, with construction commencing in mid 2009;
- Planning for the new Midland Health Campus to replace Swan District Hospital is well-advanced;
- Planning for the construction of the new Albany Hospital has commenced;
- Construction of the Regional Resource Centre at Kalgoorlie commenced in March 2009; and
- The Government announced its decision to rebuild the existing Busselton Hospital on the existing site.

Communities and partnerships

The Department of Health provides and supports numerous health promotion illness prevention and health protection programs that focus on both individuals and communities. These programs provide 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. Strong partnerships benefit the community.

Consumer, Carer and Community Engagement

The Consumer, Carer and Community Engagement Working Group assists WA Health to review, plan and implement engagement strategies arising from the WA Health Consumer, Carer and Community Engagement Framework. The Framework was developed to assist WA Health staff to implement meaningful and effective consumer, carer and community engagement strategies.

During 2008-09 an audit of current engagement strategies was undertaken and showed more than 240 engagement activities were underway across WA Health demonstrating a statewide adoption of the Framework. Progress will be monitored and reassessed in early 2009-10.

Home and Community Care

A WA Home and Community Care (HACC) Assessment Framework has been developed and one component of the Framework is Access Networks. Discussion has commenced with the community care sector prior to the development of a detailed implementation plan.

Demonstration projects were operating in Esperance, the Kimberley and the City of Swan. Information gathered is being evaluated with results being used to develop the HACC Assessment Framework and to support the wider rollout of Access Networks across the State.

During 2008-09 the 110 WA HACC providers across the State are implementing the Wellness model of care that promotes enablement and independence of the client. In the Kimberley, regional workshops were run to identify key challenges for HACC providers to the indigenous population and devise approaches to ensure appropriateness and acceptance of the model of care.

Resources have been developed to support the Wellness approach, including:

- workshops in the fundamentals of the approach and assessment strategies;
- assessment tools and support plans;
- provider self-assessment benchmarking to ascertain their readiness to adopt wellness; and
- progress mapping and web site materials

Project work has commenced to guide providers in implementing the wellness concept in areas such as centre based day care, transport, home maintenance and gardening.

Discussions have commenced with organisations such as TAFE WA to review the Certificate III Community Aged Care course content and with Carers WA to develop a Wellness Guide for Carers.

Chief Medical Officer

The *Surrogacy Act 2008* (Surrogacy Act) was proclaimed in March 2009 to regulate altruistic surrogacy arrangements and allow for the transfer of legal parentage for children born through surrogacy in WA. The Reproductive Technology Unit worked closely with DOH legal officers and the Reproductive Technology Council (RTC) to advise the Minister for Health, to ensure the details of the Act were consistent with other legislation, in particular the *Human Reproductive Technology Act 1991,* which was amended to allow eligible parties to access in vitro fertilisation (IVF) for a surrogacy arrangement.

Communities and partnerships (continued)

Regulation of surrogacy was considered important to protect all parties involved in a surrogacy arrangement, particularly the best interests of any child born from such an arrangement. Under the Surrogacy Act, the RTC is required to approve a surrogacy arrangement before fertility clinics provide any artificial fertilisation procedures.

The Surrogacy Act regulates activities allowing altruistic surrogacy arrangements in WA, through:

- the comprehensive assessment and approval process for people seeking to have a child through a surrogacy arrangement;
- allowing access to IVF for a woman who has agreed to bear a child for a woman or couple who would be eligible for IVF;
- provision for the transfer of legal parentage via a Family Court order to make the arranged parents the legal parents of a child.

This legislation enables fertility clinics in WA to assist those previously unable to have children for medical reasons to create a child through surrogacy.

The DOH, in partnership with the Office of the Public Advocate, is progressing law reform to enable people to plan for future medical and lifestyle decision-making if they are unable to make decisions for themselves in the future. The Acts *Amendment* (*Consent to Medical) Act 2008* will amend the *Guardianship and Administration Act 1990*, *the Civil Liability Act 2002*, and the *Criminal Code*.

Key partnerships with leading primary health care providers have been developed through the establishment of the Primary Care Network. This will engage the direction for primary health care for the State.

During 2008-09 the Chief Medical Officer has been instrumental in the contribution by the State to the Australian Primary Health Reform for the National Primary Health Care Strategy, building on the consultative work by the health networks.

Initialisation of grants to After Hours General Practices is aimed at increasing access for the public to medical services after hours. To expand the after hours GP practices funding allocation of $8.4million over 4 years has been made.

In collaboration with the Area Health Services the Health Networks Branch led the development and publication of a Clinical Policy Framework.

Health Networks Branch has continued funding (through the Australian Better Health Initiative) to the WA Country Health Service (WACHS) for coordination of self management support, including development and implementation of programs for patients in six regions. The Self-Management Framework for long-term conditions has been drafted, and will incorporate pathways from the chronic disease models of care developed by the Health Networks Branch and referenced below.

Implementation of the Metropolitan Healthy Lifestyles Project, designed 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 commenced in July 2008. There are four metropolitan service delivery centres. By February 2009, over 600 patients had been assisted to make healthy behaviour changes through referral to risk modification programs or services.

The DOH in partnership with the Injury Control Council of WA has developed resources to support secondary falls prevention education within health services and hospitals. These were available for testing at the statewide ‘No Falls Day’ events on 1 April 2009. Those resources deemed useful were provided to the DOH publications warehouse and bill-boarded on the Stay on your Feet WA (SOYFWA®) website that supports the statewide SOYFWA® Resource Information Centre.

Communities and partnerships (continued)

Models of Care

Models of Care that aim to improve service design and delivery have been endorsed for implementation in the areas of:

- Chronic Kidney Disease;
- Diabetes;
- Chronic Obstructive Pulmonary Disease; and
- Heart Failure.

The Health Networks have developed guidelines to support the implementation of the models of care.

The engagement strategy for implementation of the models of care in the North Metropolitan Area Health Service is nearing completion. The principles used in the North Metropolitan Area Health Service will inform and support the implementation in WA Country Health Service and South Metropolitan Area Health Service.

Extensive work to roll-out the maternity services policy continued in 2008-09. Clear engagement and partnership have been developed with Area Health Services through prioritisation for the recommendations of the implementation.

The WoundsWest project has provided support to several aspects of the following Models of Care:

- Burn Injury Model of Care with telehealth and wound care technology;
- Clinically Coordinated Patient Transfer Model of Service Delivery with telehealth support to traumatic wound care advice that may assist appropriate transfer; and
- Falls Prevention Model of Care with lower limb vascular wound care technology.

Genomics

General Practice education initiatives were undertaken in partnership with the Osborne Division of General Practice and the Perth Primary Care Network as part of the West Australian Familial Hypercholesterolaemia program (FHWA).

This year the Office of Public Health Genomics has achieved Royal Australian College of General Practitioners accreditation for education related to familial hypercholesterolaemia and Family Health History education modules.

Data Linkage

To facilitate research on road safety, Data Linkage Unit, in cooperation with Main Roads Western Australia, has linked crash reports with WA Health data to help agencies that are researching programs to reduce road trauma. Actions included:

- 2007 crash reports linkage completed;
- Data from 1996-2000 completed to expand the archive;
- Data Linkage participation in road safety advisory groups and collaboration with academic and public service road safety analysts; and
- Evaluating injury severity using linked data were presented at a National Road Safety Forum in October 2008.

Data Linkage Unit also completed Stage 1 of linking data to Insurance Commission of Western Australia (ICWA) Road Injury Claims for 1985 to 2007 to WA Health and will be commencing Stage 2 in late 2009.

Workforce

Working groups initiated by the Workforce Education and Training Branch in collaboration with education and training providers and relevant public sector agencies have developed strategies that included:

- innovative approaches to clinical placements; and
- development of a strategic framework for progressing inter-professional learning in WA.

Negotiations between the health and education sectors have led to the formalised arrangements for the sharing of data between these sectors. Information on student flows will enable improved workforce planning within health.

Communities and partnerships (continued)

Aboriginal Health

A formal Trans-Tasman relationship between the Office of Aboriginal Health of Western Australia and Te Kete Hauora (Maori Health Directorate) of the Ministry of Health New Zealand has been established and as part of the leadership exchange program a Senior Maori Manager from NZ Ministry of Health has also been appointed.

A five-year work plan has been established to support the Trans-Tasman agreement identifying four key areas of work:

- Trans-Tasman strategic alliances;
- Reducing health inequalities;
- Primary and preventative health care; and
- Indigenous health workforce development.

The Office of Aboriginal Health, WA Country Health Service (WACHS), Aboriginal Health Council of WA, WA GP Network and Office of Aboriginal and Torres Strait Islander Health WA Branch are reshaping the previous Partnership Agreement to better reflect the changes in Commonwealth and State Governments and their new policy directions, with particular reference to the COAG agenda.

To increase access to primary care services, a Memorandum of Understanding was signed and commenced in April 2009 with an Office of Aboriginal Health staff member located at WA GP Network to help develop and implement an Aboriginal Access Program.

Public Health

The DOH, through strong relationships, has risen to the challenges of two public health crises, the Ashmore Reef refugee incident and the H1N1 influenza outbreak. DOH Public Affairs Branch effectively liaised with other agencies to manage communications that maximised public understanding of both events, deliver appropriate public health messages and limit public concern.

In light of the recent H1N1 (swine flu) challenge WA Health continues the implementation of the WA Health Management Plan for Pandemic Influenza. Significant items include:

- Key Communicable Disease Control Directorate Human Epidemic Operations Centre roles and responsibilities have been defined;
- WESTPLAN-Human Epidemic: the Communications Plan and the WA State Distribution Plan have been revised and a Home Care Guide developed;
- Development of a whole of government pandemic influenza website: integration of pandemic influenza planning into mainstream epidemic planning and management; and
- Ongoing development of national operational policies and plans through the activities of the Inter-jurisdictional Pandemic Planning Working Group (IPPWG) & Australian Health Protection Committee / National Immunisation Committee (pandemic influenza).

The 'Healthy Options WA: Food and Nutrition Policy for WA Health Services and Facilities' was updated at the Minister for Health's request and re-released in May 2009. The policy aims to increase the availability of affordable and nutritious food and drinks to health service employees and visitors to WA Health services and facilities. The amended policy was implemented in all WA Health services from May 2009, with mandatory compliance required by 1 October 2009.

Chief Psychiatrist

The Chief Psychiatrist has implemented monitoring in relation to 54 non-government organisations (NGOs) funded to provide mental health services. All NGO's will undergo annual self-assessments, against the Standards in Care Outcomes for Non-Government Organisations with 22 undergoing comprehensive reviews. The first round of self-assessments has been completed and the second round has begun. The Comprehensive Review Methodology has also been piloted.

Health Direct

Most of the major medical specialties are now using 'Outpatient Direct' to cancel and reschedule outpatient appointments. In addition, 'Outpatient Direct' has begun cancelling hospital tests and procedures not required by patients who have cancelled appointments, reducing the workload of hospitals.

Communities and partnerships (continued)

The WA Food for Health Policy to promote and provide direction for the development of the food system in Western Australia is being developed. The vision for food for health in WA is for 'a safe, nutritious, affordable and sustainable food supply for Western Australia'. The population-wide strategy aims to improve health and reduce the burden of diet-related disease. The five priority health outcome areas include food safety, diet quality, food security, healthy food economy and a sustainable food supply.

Health promotion and illness prevention programs for childhood obesity have been implemented through contracts with non-government organisations. Key programs that will have an impact on childhood obesity directly or indirectly included those where:

- The Australian Red Cross expanded its delivery of the FOODcents program to disadvantaged families;
- In May 2009, there were 261 certified Crunch&Sip® schools across WA;
- The 'Parental Guidance Recommended' program has been expanded to include a physical activity component, with a new food preparation and menu planning component currently in development;
- The 'Unplug and Play' campaign was conducted in February / March 2009. It consisted of statewide and regional press advertising, and metropolitan and regional radio advertising, with the support of parental resources. Evaluation results show this campaign was well received by the target audience and has achieved its aim of encouraging parents to decrease their children's sedentary behaviour;
- The School Breakfast Program has expanded to 301 schools. The associated website went 'live' in January 2009. All schools have received nutrition resources and 240 schools are undertaking physical activity programs as a result of the program; and
- The 'Make Tracks2 School' program was successfully conducted in Oct/Nov 2008, in partnership with the Department of Planning and Infrastructure and the Premier's Physical Activity Taskforce. Approximately 4800 students from 54 schools participated.

As part of the Australian Better Health Initiative (ABHI) Healthy School Canteens project, the Department of Education and Training (DET), with DOH funding, has implemented a healthy school canteen policy across the state.

Additionally, DOH and DET have collaborated in the nationwide consultations that have been held on behalf of the Department of Health and Ageing by Flinders Partners (DOHA) to develop an agreed national food categorisation system to underpin school canteen guidelines. Draft guidelines have been developed and training programs are being piloted.

Healthy School Coordinators have been employed in each of the four metropolitan zones and seven regions. These positions are working with targeted schools, focusing on nutrition and physical activity initiatives with the long term view of preventing childhood obesity and preventing children becoming overweight.

WA's Nutrition, Physical Activity and Healthy Weight Congress, funded through existing contracts, was held in Fremantle in March 2009 with 200 participants. This represented a successful collaboration between a number of non-government agencies and the DOH.

Major chronic disease prevention and healthy lifestyle promotion campaigns and programs are delivered by various contracted non-government organisations throughout the year. These include:

- The 'Draw the Line' adult healthy weight campaign, funded by the DOH and managed by the Heart Foundation, was launched in February 2009. This mass media campaign aims to prevent unhealthy weight gain among Western Australian adults;
- The latest phase of the Find Thirty® every day campaign commenced in May 2009 with previously used television, print and media advertisements. The campaign's priority target group is adults 25 to 54 years of age, particularly those adults with lower socio economic status profiles, those living in regional areas and Aboriginal adults who are inactive or insufficiently active for good health;

Communities and partnerships (continued)

- The Go for 2&5® campaign, including the new 'Rolf Harris' veggie character, was developed and launched in September 2008. Media activity occurred in September/October 2008 and again in February 2009. Additional media 'bursts' occurred in March/April and May/June 2009. Evaluation results showed high awareness of the campaign, strong levels of correct message 'take out' and personal relevance, and increased consideration of personal fruit and vegetable consumption by the target group;
- The 'My Healthy Balance' on-line adult healthy weight program was launched in July 2008. The program has been widely promoted with 1569 registered participants / participants completing the program since the launch. Early evaluation results are positive; and
- The Make Smoking History campaign was conducted with three major phases: 'Smoke-Free home and car' in September 2008, 'Everybody Knows' in Jan 2009 and 'Who will you leave behind?' in May 2009.

The Smoke Free WA Health Working Party has commenced the implementation of the Communication Framework, which is based on the Smoke Free evaluation findings. As a result:

- the Smoke Free Policy and guidelines have been reviewed and updated to reflect the current stage of the policy;
- the Smoke Free website has been revised and now includes a copy of the Smoke Free evaluation report;
- existing resources including information brochures have been revised and made available on the Smoke free website; and
- new resources are being developed to support Area Health Services to implement the policy and continue to promote the message at their local sites.

The Public Health Division has also continued the health impact assessments of major resource developments and issues affecting the Swan River, including mosquito-borne disease. Achievements include:

- A discussion paper and call for submissions for the review of funding for health-driven Local Government mosquito management has been written and was circulated to stakeholders in early 2009;
- New legislation for the design, construction, operation, management and maintenance of aquatic facilities across Western Australia is proceeding;
- Amendment of the Health (Pesticides) Regulations 1956 to remove outdated regulations related to the use of organochlorines and provide for implementation of photo identification on licenses is continuing with the second draft being received. The new Regulations will also be updated consistent with the new Public Health Act; and
- An audit of the safe storage of strychnine and 1080 products by licensed Doggers was completed in May 2009.

Tobacco Control

Western Australia's Quitline is managed and funded by the Tobacco Control Branch. The Quitline is a 24-hour telephone service available to smokers wanting to quit, those supporting others in quitting and provides access to general information and written resources.

The Quitline counselling service is delivered by the Alcohol and Drug Information Service (ADIS), through the Drug and Alcohol Office.

Referral services have been introduced to provide Quitline access to priority population groups within WA including:

- the Royal Perth Hospital Cardiac Rehabilitation Unit for patients with existing cardiac conditions;
- the Peel and Rockingham Kwinana Mental Health Service for patients with a mental illness;
- the Asthma Foundation's (NAPS program) Pregnancy Quitline referral service through antenatal clinics at King Edward Memorial Hospital (KEMH), Armadale and Kaleeya Hospitals provided to pregnant women and their partners; and
- due to the increase in referrals to the Quitline, the resulting call-backs made have more than doubled in the 2008-09 year.

Resources

Genomics

Biobank community consultations on the protection and health benefits of deoxyribonucleic acid (DNA) sample collections held in WA Biobanks were held in August and November 2008. Innovative community forums were held with members of genetic support groups and interested citizens drawn from the WA community. Participants were provided with a range of perspectives on the issues and they have produced a set of recommendations for how biobanks should operate in WA. The recommendations have been considered and incorporated in the development of a governance and legal framework for biobanking in WA.

Epidemiology

In collaboration with the Office of Safety and Quality, the Epidemiology Branch has demonstrated that the DOH has the capability to sequentially measure health care outcomes using the Variable Life Adjusted Display (VLAD) methodology. Development of the VLAD methodology will allow the establishment of an early alert mechanism for adverse events in WA hospitals.

Information on prevalence of chronic disease, risk factors and trends over time was released by the Health and Wellbeing Surveillance System (HWSS). The HWSS is an ongoing data collection system and information from the HWSS is used throughout the health system, both within the Department and the wider health community, to assist in the evaluation of projects and initiatives, to track changes in chronic disease and risk factors, and to inform the Operational Plan and the Strategic directions of the DOH.

The Geospatial Information System section within the Epidemiology Branch collaborated with the Environmental Health Directorate to develop a spatial database and intranet application to manage a range of information associated with the initial Esperance lead contamination investigation. The application was widely used by the investigation team and has proven to be a very useful tool for the project. Due to its versatility and efficiency, the Department of Planning and Infrastructure plan to implement the system in a secured internet application for the Esperance Clean-up and Recovery project for the purpose of data management, result dissemination and reporting of the additional sampling and cleaning during 2009 and 2010.

WoundsWest

WoundsWest is piloting a new electronic referral, documentation and imaging system for WA Health. This application will interface with the WA Country Health Service, other hospital applications and external health care providers i.e. Silver Chain, general practitioners and aged care facilities facilitating continuity of patient care, and monitoring of clinical outcomes for patients with wounds. Consultants via the telephone-based WoundsWest Advisory Service are currently piloting this system in selected country sites to support clinicians managing patients with complex and chronic wounds.

Health Information

The world's first Public Hospital Activity website for Western Australians was released on the DOH's Internet site in February 2009. The website provides daily and weekly bed activity data, consumer information about ED services and other health services.

The WA Health Performance quarterly reports and monthly elective surgery reports are also now published on the DOH's Internet website.

The Western Australian Cancer Registry (WACR) has implemented a new database called Cancer Information System (CanIS) in November 2008 with all historic data incorporated. A web-based application system, Clinical Cancer Data System (CanIS+), which allows clinical staff to input additional clinical information into the CanIS database is nearing completion of the preliminary analysis phase.

The Mental Health Clinical Information System, known as PSOLIS, has launched a new reporting capability to allow mental health services much broader visibility of their data. Patient and service information can be reported and aggregated on demand via a web browser. Reports can be constructed, published and emailed as required with data ranging from client-detail to statewide aggregations.

Resources (continued)

Health services providing maternity care in WA are required by the *Health Act 1911* to provide their staff with a method of collecting and providing data on the process and outcomes of maternity care to a woman and her infant/s. The current method has been improved by a new information system called STORK that enables midwives to support clinical care and meet mandatory reporting requirements. Originally developed for KEMH, STORK has been implemented in Bunbury and Kaleeya hospitals during 2008-09 and implementation planning is currently underway for Armadale.

STORK records pregnancy, labour, birth, neonatal and postnatal information and communicates this to Child Health Nurses, GP's, home visiting midwifery services and state data collection and statistical facilities.

At Sir Charles Gardiner, Royal Perth and Fremantle hospitals the Clinical Pathology Order Entry (CPOE) system has been introduced to enable medical and nursing staff to directly order patient tests, thus eliminating the need to prepare and process paper requests.

In 2006, WA Health commenced a 10-year program to implement eHealthWA, a major reform initiative designed to provide a modern, integrated platform to facilitate the delivery of world-class health services. In 2008-09 eHealthWA has progressed with:

- a business case for the eHealthWA Program completed for submission to the Expenditure and Economic Review Committee (EERC);
- release of the tender for Portal & Interoperability systems;
- the Pharmacy application contract signed;
- a program Management Office established;
- assessment for the replacement patient administration system completed;
- assessment of the iSOFT Clinical Manager (iCM) application completed;
- existing clinical applications being identified for renovation;
- a global data store being designed;
- progression of the storage infrastructure upgrade for existing clinical applications;
- upgrading of data centre port capacity undertaken;
- progression of WACHS' HCARE Clinical Management System infrastructure consolidation; and
- upgrading of the Shared Mail (email) environment.

Priorities for 2009-10

WA Health's Strategic Directions 2005-10 will continue to drive health care in 2009-10. Priorities for 2009-10 are detailed below.

Workforce and Leadership

The Healthy Workforce Strategic Framework 2006-16 continues to inform future health workforce planning and strategic deployment and 2009-10 strategies are:

- To support the increased numbers of junior doctors entering WA Health, a business case is to be developed that ensures supervision, clinical training and continued education needs are met; and
- Mapping of the demographics of all disciplines in the specialist medical workforce to create a framework that aims at reducing the constraints affecting the specialist workforce and developing strategies to support the growing demand and supply projections in the next five to15 years.

Leadership programs are to continue to have a multi-sectoral, multi-professional and system-wide focus and will also address the specific needs of staff through tailored professional development programs.

The Office of Aboriginal Health will:

- Develop a framework guide to better attract, select and retain Aboriginal people across WA Health;
- Collaborate with CAHS, WACHS, NMAHS and SMAHS to develop a policy to focus on placement of Aboriginal students in clinical setting within the workplace;
- Co-locate a Program Officer to the Office of Chief Nurse to increase the number of Aboriginal Enrolled Nurses' and Nurses Working trained and employed in WA Health through collaborative partnerships such Curtin University and Maar Mooditj;
- Implement an Aboriginal Open Space Leadership forum through the Leadership Institute to encourage and support emerging Aboriginal Leaders for the health sector and succession planning for the current leadership; and
- Finalise the developed draft policy/guide on cultural maintenance training for consultation and implementation in 2010.

The Office of Aboriginal Health will continue the work towards the establishment of the National Aboriginal and Torres Strait Islander Health Worker Association, the review and development of a national scope of practice for Aboriginal and Torres Strait Islander Health Workers and will play a lead role in the development of accreditation and registration of Aboriginal and Torres Strait Islander Health Workers in 2012.

Hospitals and health services

During 2009-10 implementation of the Four Hour Rule Program continues with:

- Stage 2: Rockingham General Hospital, Armadale-Kelmscott Memorial Hospital, Swan District Hospital, Graylands Hospital, Selby-Lemnos, Bunbury Regional Resource Center (RRC) and Joondalup Health Campus to commence in October 2009; and
- Stage 3: Kalgoorlie RRC, Albany RRC, Broome RRC, Geraldton RRC, Port Hedland RRC, Nickol Bay hospital, KEMH and Peel Health Campus to commence in April 2010.

The 'Friend in Need – Emergency' (FINE) scheme will develop across three interlinked components:

- Community based non-inpatient acute and complex care for patients and carers where their care needs can be safely and effectively managed in the community;
- A strengthened network of care coordination (case management) that includes complex care coordination; and
- Community based flexible care packages purchased from private providers.

Key deliverables of the Patient First Program in 2009-2010 will include:

- evaluating and developing materials to meet the requirements of special needs groups; and
- a report on the evaluation of the Patient First booklet.

Priorities for 2009-10 (continued)

Construction of Mental Health facilities will continue with:

- Completion of the acute mental health inpatient facility for adults and older people in Rockingham General Hospital scheduled for December 2009 with orientation for staff to commence in January 2010 and operations commencement scheduled for mid-2010;
- Construction of the Broome Mental Health Inpatient Unit to commence following completion of a tender process. Construction is scheduled for completion by mid 2010;
- Middle Swan Community Supported Residential Units scheduled for completion in late 2009;
- Construction for Community Options group homes in Stirling, with 8 beds, are scheduled for completion by January 2010 and Bentley, with 7 beds is scheduled for completion in July 2010;
- Construction of the transitional accommodation facility in Fremantle for 16 homeless young people and a facility in East Perth for 34 homeless people with a mental illness is scheduled for completion by late 2009; and
- Planning for a 22 place Intermediate Care facility in Joondalup is currently underway and construction is scheduled to commence in mid-2010.

Planning, design and forward works for the construction of the radiation oncology facility for the South-West Health Campus will commence.

Continued implementation of the recommendations from the Anaphylaxis Expert Working Committee report with:

- an anaphylaxis training program to staff at WA schools and child care services;
- an awareness campaign to schools, child care services, health professionals and the general public; and
- the supply of adrenaline auto-injectors to WA schools and child care services.

Communities and partnerships

During 2009-10 implementation of the WA Aboriginal Primary Care Action Plan premised on an agreed coordinated approach to increasing access to primary care, improving the patient's journey, improving the care pathways, and developing balanced set of core services will continue. Five Standards have been developed to provide a comprehensive guide to addressing Aboriginal-specific primary health care.

- Standard 1 - The provision of coordinated community development, advocacy and health promotion activities aimed at improving health outcomes for Aboriginal people.
- Standard 2 - Increase primary health care access for the diagnosis and management of Aboriginal people with chronic conditions.
- Standard 3 - An integrated approach between the primary and tertiary care sectors to the prevention and management of chronic conditions within the Aboriginal population
- Standard 4 - Optimising both financial and physical resources to address Aboriginal chronic health conditions.
- Standard 5 - Enhance the capacity of the Primary health care workforce to address prevention and management of chronic conditions.

In 2009-10 a State-wide engagement and communication strategy including the formation of an Aboriginal Men's Health Reference Group and Aboriginal Men's Health Inter-agency Group to establish an Aboriginal Men's Health portfolio in WA Health will occur. A State-wide Aboriginal Men's Health Forum and expansion of the Pit Stop Health program across WA communities through a proposed small grants initiative and community ambassador program, will be undertaken.

Implementation of the WA Suicide Prevention Strategy to commence by the end of 2009 with a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.

Initiatives to address postnatal depression will continue with:

- data collection and analysis for the evaluation of the indigenous, culturally and linguistically diverse and practical support perinatal mental health service expansion projects;

- an Indigenous perinatal mental health worker will be recruited and trained for the Indigenous Perinatal Mental Health Service expansion project in Carnarvon; and
- a 'train the trainer' manual will be developed and courses conducted to ensure the sustainability of the Perinatal Anxiety Training Program.

Work will commence to implement the new Mental Health Act subsequent to passing of the Mental Health Bill. The proposed Mental Health Act is based on the review of the old *Mental Health Act 1996* (completed in 2004) and the six month report of the proposed Mental Health and Wellbeing Commissioner will be tabled in parliament to enshrine the rights of mentally ill people and ensure that they are treated with respect and dignity.

SolarisCare Foundation complementary support services for cancer patients in regional areas will commence and services in the metropolitan area will be expanded.

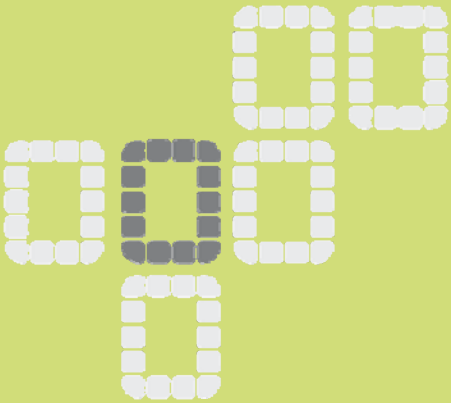
Falls prevention through the 'Stay on Your Feet WA' program continues with:

- Stay On Your Feet® Week Community events to be held in September 2009;
- Development of the Falls Prevention Model of Care Recommendations Implementation Plan; and
- On-going development, implementation and evaluation of the Falls Linkage Independence Program (FLIP).

Resources

Work will continue to progress on the development and implementation of eHealthWA projects including:

- full funding release for the eHealthWA program;
- complete iPharmacy rollout throughout the metropolitan region;
- commencement of the iPharmacy country rollout;
- implementation of an Identity and Access Management Application;
- design of a new Patient Master Index and establishment of business governance to maintain its integrity;
- design of a new Provider Master Index and establishment of business governance to maintain its integrity;
- developing data migration strategies for key enterprise systems;
- cleansing Patient Administration System data;
- completing planning for the early implementation of a replacement Patient Administration System;
- completing the deployment of Clinical Pathology Order Entry (CPOE) for Pathology:
- beginning renovation of appropriate Legacy Systems;
- completing the design of the global data store;
- awarding the Portal & Interoperability tender;
- designing, building and testing a Clinician Portal;
- designing, building and testing a GP Portal; and
- designing, building and testing a Summary Health Record.



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 2008-09 was $2,190,330.

Table 33: Total expenditure for Advertising

Summary of Advertising	Amount ($)
Advertising Agencies	1,773,139
Media Advertising Organisations	93,134
Polling	Nil
Market Research Organisations	181,024
Direct Mail Organisations	143,033
Total Advertising Expenditure	**2,190,330**

Recipient / Organisation	Amount ($)
Advertising Organisation	
303 Group Pty Ltd	271,996
Adcorp Australia Ltd	118,316
BigRedSky Ltd	508
Convenience Advertising (Aust) Pty Ltd	24,120
Digital Analogue	666
F Maietta Nominees Pty Ltd	349
Gatecrasher Advertising Pty Ltd	34,186
George Kate Richter	1,216
HMA Blaze Pty Ltd	10,261
Marketforce Advertising	2,514
Marketforce Express	3,003
Media Decisions WA	1,109,488
Mitchell and Partners Australia Pty Ltd	196,516
Advertising Agencies Total	**1,773,139**
Direct Mail Organisations	
Australia Post	100
Packcentre Marketing Services Pty Ltd	131,028
Salmat Print on Demand Pty Ltd	5,705
Specialist Mail Service	5,429
Toll Priority	448
University of Western Australia	323
Direct Mail Organisations Total	**143,033**

Recipient / Organisation	Amount ($)
Market Research Organisations	
303 Group Pty Ltd	16,421
Best Practice Australia Pty Ltd	6,673
Buu Trun Quach	12,645
Campbell Research and Consulting Pty Ltd	17,273
Cancer Australia	31,103
Chemistry Centre (WA)	63,636
J L MacDonald & N R MacDonald	1,000
Patterson Market Research	17,273
WA AIDS Council Inc	15,000
Market Research Organisations Total	**181,024**
Media Advertising Organisations	
A M A Services WA Pty Ltd	795
Albany Advertiser	598
Australian Government Directory	500
British Balls Magazine	520
Curtin Student Guild	1,890
Curtin University of Technology	155
Department of the Premier and Cabinet	563
Edith Cowan University Student Guild	682
Go West Handbook Pty Ltd	1,560
Health Information Manual	139
Internet Business Corporation Ltd	60,155
Medical Forum Magazine	4,725
State Law Publisher	10,136
Travellers Information Radio 88FM	2,618
WA AIDS Council Inc	8,098
Media Advertising Organisations Total	**93,134**

Corruption Prevention

In 2008-09 WA Health continued to review its existing strategies and develop and implement new strategies to assist effective accountability mechanisms and prevent corruption and misconduct.

Fraud & Corruption Control

The Fraud and Corruption Control Committee continues to meet on a quarterly basis. This Committee considers relevant corruption control initiatives, trends relating to reported misconduct issues and other relevant fraud indicators.

Reporting of Misconduct

All allegations of misconduct across the Public Sector are required to be reported to the Corruption and Crime Commission (CCC). Within WA Health, this reporting is facilitated centrally through the Corporate Governance Directorate. 408 conduct matters were reported to the Corporate Governance Directorate, 260 were reportable to the CCC and were investigated by WA Health. This was an increase from 2007-08 when 337 conduct matters were reported with 127 being reportable to the CCC, a 105 per cent increase in reportable matters from WA Health. The incidence of reported misconduct within WA Health is rising, with this agency being responsible for 13 per cent of all Public Sector Agency reports to the CCC (compared to seven per cent during 2007-08). It is noted that these variations reflect increased knowledge about misconduct and improved reporting systems, rather than an actual increase in acts of misconduct being committed.

Policy Development

Appropriate governance policy issues continue to be considered, with two main achievements attained during 2008-09, namely the approval of the WA Health Code of Conduct and the WA Health Misconduct and Discipline Policy.

Awareness Raising

A number of initiatives have been undertaken to assist in identifying and dealing with misconduct. These have included:

- Creation of an Ethics Education Coordinator within the Corporate Governance Directorate. The main purpose of this newly created position is to raise awareness across the public health sector of a number of ethical issues, including misconduct and the *Public Interest Disclosure Act 2003*; and
- Developing an intelligence resource within the Corporate Governance Directorate, which will be used to identify possible trends in misconduct / areas of risk, and to then direct either ethical education, internal audit or any other appropriate management response to these identified trends.

An ethical advisory line (a '1800' number) has recently been established. This is designed to facilitate staff being able to confidentially contact the Corporate Governance Directorate to either gain advice or to report inappropriate behaviour. An appropriate marketing strategy is currently being developed.

Information awareness raising sessions have been held at sites across WA Health, with over 900 staff attending during 2008-09. In addition, information relating to misconduct has also been included in staff induction programmes.

A Corporate Governance Compendium has recently been released. This Compendium, which is aimed at middle managers, has been designed to provide information on a range of governance issues, with subjects covered including misconduct, conflict of interest, freedom of information, criminal records screening and public interest disclosure legislation. Chapters for this compendium will be issued on a regular basis and will be informed by the Public Sector Commission's Accountable and Ethical Decision Making program.

'Promoting Integrity and Reporting Misconduct' brochures were forwarded to all staff members of WA Health, with relevant posters distributed across the sector in December 2008.

A training programme has been established to increase the skill level of staff who may be tasked with undertaking an administrative inquiry. Five courses (with over 50 participants) have been held, with more courses scheduled for 2009-10.

A Public Interest Disclosure Witness Support process has been established.

Risk Management Treatment

Misconduct and corruption risk has been included for mandatory assessment by all units in the annual WA Health Significant Risk Assessments survey and is acknowledged and addressed in the annual Significant Risk Register.

Disability Access and Inclusion Plan

The *Disability Service 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 2008-09, the Department of Health provided a range of programs and initiatives to meet disability access outcomes.

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 Environmental Health Directorate (EHD) endorses the Department of Health's current Disability Plan. Community Groups use the lecture theatre and seminar room facilities at Grace Vaughan House. All community groups are advised of the facilities available at Grace Vaughan House for people with disabilities.
- In 2008-09 the public consultations held by Office of Public Health Genomics were purposely held at The Niche, a facility designed for access and use by people with disabilities. Information materials for these events were provided in multiple formats including visual, tactile and orally presented materials. Transport was provided for people with disabilities who were unable to drive to this venue.

Outcome 2
People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority.

- Access for people with disabilities is available at Grace Vaughan House, including specific parking spaces, flat ramp access at the entrance to the building and to lifts and toilets (male and female).
- The new Health Information Network (HIN) premises at Walters Drive, Osborne Park has purposefully designed access for people with disabilities, including toilets, showers and parking. Currently in progress is the installation of two electronic lifts on the ground floor to allow wheelchair access throughout the floors occupied by HIN.
- All new office leases and refurbishments ensure appropriate access and signage in accordance with the Disability Access and Inclusion Plan.

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:

- WA Health has incorporated, into a website template, the common user elements documented by the Public Sector Commission with regard to usability and accessibility.
- In the Environmental Health Directorate, a range of publications and resources are available and can be provided upon request in either hard copy format or via the public health website.

Outcome 4
People with disabilities receive the same level and quality of service from the staff of the relevant public authority as other people receive from that authority:

- Employees of the EHD have knowledge of disability services and are aware of the need to provide services and facilities specific to the needs of people with disabilities.
- In the EHD, one employee with a disability has a modified workstation and working hours to assist her to remain in the workforce. A specific plan to assist her in the case of an evacuation has been developed.
- The WA Cancer and Palliative Care Network assists people with disabilities to remain in the workforce by providing formal rehabilitation and work experience opportunities.

Outcome 5
People with disabilities have the same opportunities as other people to make complaints to the relevant public authority:

- Complaints can be lodged via written correspondence, telephone, or in person.

Outcome 6
People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority:

- The EHD conducts seminars and other functions in appropriate venues with access to people with disabilities such as the Seminar Room and the Lecture Theatre at Grace Vaughan House.

Employee Profile

The table below shows the number of full-time equivalent (FTE) staff employed by the Department of Health year-to-date June 2009 by category.

Table 34: Total Department of Health FTE by category

Category	Definition	2007-08	2008-09
Administration & clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	742	960
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.	50	52
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	n/a
Dental nursing	Includes registered dental nurses and dental clinic assistants.	n/a	n/a
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	3	2
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	9	15
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	1	3
Medical support	Includes all Allied Health and scientific/technical related occupations.	27	41
Nursing	Includes all nursing occupations. Does not include agency nurses.	24	29
Site services	Includes engineering, garden and security-based occupations.	n/a	0
Other categories	Captures Aboriginal and ethnic health worker related occupations.	n/a	0
Total		**856**	**1,102**

Notes
The Department of Health includes Royal St Divisions (Director General Division (Council of Official Visitors, Corporate Governance, Chief Psychiatrist, Legal and Legislative and Aboriginal Health), Chief Medical Officer, Development, Health Finance, Health Information Network, Innovation & Health System Reform, Mental Health Division and Public Health Division and Information Management & Reporting).
2007-08 reported data has been realigned to reflect 2008-09 FTE definitions.
The FTE profile for Health Corporate Network for 2007-08 and 2008-09 has been included in the Metropolitan Health Service Annual Report. The Metropolitan Health Service 2008-09 Annual Report has been adjusted accordingly.

Freedom of Information

For the year ending 30 June 2009, the Department of Health received 79 formal applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 35: Freedom of information applications 2008-09

Applications	Number
Carried over from 2007-08	5
Received in 2008-09	74
Total applications received in 2008-09	**79**
Granted full access	28
Granted partial or edited access	17
Withdrawn	6
Refused	8
In progress	5
Transferred and other	15

Includes the number accessed in accordance with section s 28 of the *Freedom of Information Act 1992* (WA).
Includes exemptions, deferments or transfers to other departments/agencies.

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

- reports on health programs and projects;
- health circulars, policies, standards and 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.

Arrangements for giving members of the public access to the documents:

- The most efficient and direct method of discovering and accessing the wide range of Departmental publications is via the internet website (www.health.wa.gov.au). The website has a search facility for accessing documents pertaining to specific health subjects and a directory for links to other health-related websites;
- There are also links to an extensive range of public health services provided in WA including links to the various public hospitals; and
- Members of the public who do not have internet access can access some hard copy documents for free or at nominal cost. Enquiries should be made with the Departmental Branch that is most closely related to the matter of interest. Alternatively a general enquiry may be made to the Freedom of Information ("FOI") Coordinator on telephone (08) 9222 6412.

The Department of Health's procedures for dealing with applications under the *Freedom of Information Act 1992*. An FOI application must:

- be in writing;
- give an Australian address to which notices can be sent;
- be lodged at the Department of Health, Western Australia;
- give enough information to enable the requested document/s to be identified; and
- be lodged with an application fee of $30, unless the request is only for personal information about the applicant.

An application for amendment of personal information must:

- give enough details to enable the document that contains the information to be identified;
- give details of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out of date or misleading;
- give the applicant's reasons for holding that belief; and
- give details of the amendment that the applicant wishes to have made.

The *Freedom of Information Act 1992* allows for charges to be levied for providing access to documents. General processing charges are $30.00 per hour. However the spirit and intent of the Act is to provide access to documents at the lowest reasonable cost.

Under the *Freedom of Information Act 1992*, the Department of Health has the right to refuse access to parts or all of a document if the text satisfies certain exemption provisions. However, in accordance with the spirit and intent of the Act, access is provided wherever possible. The applicant has rights of appeal if he / she is dissatisfied with the process or reasoning leading to an adverse access decision.

Enquiries regarding access to documents and amendment of personal information can be made to the Senior Policy Officer (FOI) on (08) 9222 6412.

Applications can be lodged:

In person:
Department of Health
Corporate Governance Directorate
189 Royal Street
EAST PERTH WA 6004

By mail:
Department of Health, Western Australia
PO Box 8172
Perth Business Centre WA 6849.

Or by Fax:
(08) 9222 2398

Industrial Relations

The Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations and significant workforce management issues for the Metropolitan Health Service, WA Country Health Service and associated health services within WA Health.

Key activities for 2008-09 included the negotiation of new industrial agreements for health professional, administrative and technical staff, and Aboriginal and Ethnic Health Workers.

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.

All audits completed are considered by the relevant executive (generally through the local audit liaison meetings), and are also considered at the WA Health Audit Committee. This Audit Committee has external and internal representation, and has an external Chair and Deputy Chair. The Audit Committee, which also has oversight over the Strategic Audit Plan, meets on at least a quarterly basis.

Thirty nine internal audits were completed during the reporting period, and covered in the following table.

Table 36: Completed Audits

Audit	Area audited
Alesco (Pre-implementation & Security)	Health Corporate Network
Leave Liability	Health Corporate Network
Pharmacy Issues	WA Health
Clinical Credentialing	WA Health
Registration (Nursing & Allied Health)	North Metropolitan Area Health Service and South Metropolitan Area Health Service
Complaints Management	Office of Health Review and Child and Adolescent Health Service
HR Data Cleansing	Health Corporate Network
Sterilisation Management	North Metropolitan Area Health Service and WA Country Health Service
AP Finance	Health Corporate Network
Governance (Senior Executive & Health Information)	WA Health
Community Midwifery	North Metropolitan Area Health Service
Financial Returns	Health Corporate Network
Accounts Payable	Health Corporate Network
Fixed Assets	Health Corporate Network
Employment Services	Health Corporate Network
Working With Children Checks	Health Corporate Network and Child and Adolescent Health Service
Supply Warehousing & Distribution	Health Corporate Network
Accounts Receivable	Health Corporate Network
Financial Returns	South Metropolitan Area Health Service, North Metropolitan Area Health Service, Child and Adolescent Health Service
Special Purpose Accounts	WA Health
Integrity of Risk Management	WA Health
Provision of HR Shared Services	WA Health
IT General Controls, Payroll	Health Corporate Network
Patient Private Property Review	North Metropolitan Area Health Service

Major Capital Works

The following tables show major capital works in progress and works completed during 2008-09.

Table 37: Major capital works in progress

Project	Expected Completion Date	Approved Funding 2008-09 Budget ($000)	Estimated Total Cost ($000)
Albany Regional Resource Centre - Redevelopment Stage 1	June 2014	4,850	44,104
Armadale Kelmscott Hospital - Development	June 2013	8,650	15,970
Bentley Hospital - Development	June 2015	0	10,341
Broome Mental Health - 14 bed unit - Controlled	August 2011	6,000	9,422
Broome Regional Resource Centre - Redevelopment Stage 1	January 2010	11,692	42,000
Busselton Integrated District Health Service - Replacement	May 2014	9,288	77,400
Carnarvon Integrated District Health Service Redevelopment	Deferred	0	6,000
Carnarvon Sobering Up Centre	June 2011	0	500
Carryover - Various	June 2011	164	1,857
Central Tertiary Hospital - Development Stage 1	December 2015	1,728	378,442
Commonwealth Elective Surgery Initiative (Elective Surgery Blitz)	December 2009	2,100	2,800
Community Health Facilities Expansion Statewide	June 2010	0	6,202
Corporate and Shared Services Reform - HCN - Controlled	May 2011	3,452	29,832
Corporate Shared Services Upgrade HRIS	May 2011	2,100	7,024
Country - Staff Accommodation- Stage 4	October 2011	5,000	10,000
Country - Transport Initiatives	June 2012	517	3,326
Country Staff Accommodation - Stage 3	June 2011	5,800	27,666
Eastern Wheatbelt District incl. Merredin Development & Restructuring	June 2013	0	9,000
Equipment Replacement Program	June 2013	38,755	241,400
Esperance Integrated District Health Service - Redevelopment	June 2013	0	13,000
Fremantle Hospital - Holding	June 2012	5,240	15,000
Fremantle Hospital - Reconfiguration Stage 1	December 2014	0	13,211
GP Super Clinics - Administered	TBA	5,000	10,000
Graylands Hospital - Development Stage 1	December 2014	0	16,084
Graylands Hospital - Redevelopment Planning	September 2009	300	600
Harvey Hospital - Redevelopment	December 2016	630	6,200
Hedland Regional Resource Centre - Replacement Stage 2	September 2011	55,766	114,000
Information and Communication Technology	June 2017	27,722	326,227
Infrastructure Planning	June 2009	1,000	13,239
Joondalup Health Campus - Development Stage 1	February 2013	49,337	119,007
Joondalup Health Campus Inpatient Mental Health Unit - Controlled	June 2009	2,991	12,315

Major Capital Works (continued)

Project	Expected Completion Date	Approved Funding 2008-09 Budget ($000)	Estimated Total Cost ($000)
Kalamunda Hospital - Redevelopment Stage 2	March 2015	2,750	15,439
Kalgoorlie Regional Resource Centre - Redevelopment Stage 1	December 2013	2,800	40,000
Kalumburu - Health Clinic	November 2008	0	1,300
Kimberley - Renal Services	June 2009	632	1,400
Kimberley - Various Health Project Developments	June 2010	675	45,300
King Edward Memorial Hospital - Holding	June 2012	6,097	18,101
King Edward Memorial Hospital Lift upgrade B Block lifts 4, 5, 6.	December 2009	0	500
Land Acquisition	June 2010	0	5,750
Mandatory Reporting Of Child Sexual Abuse	June 2010	20	20
Mandurah Community Health Centre - Development Stage 2	May 2010	3,018	3,418
Minor Buildings Works	June 2017	23,000	253,430
Neonatal Medical Equipment - Controlled	June 2010	350	875
New Swan Health Campus (Buildings)	April 2015	6,550	181,200
Osborne Park Hospital - Reconfiguration Stage 1	December 2012	3,500	79,039
PathWest	August 2011	4,499	71,400
Peel Health Campus - Development Stage 1	November 2011	0	3,444
Pharmacy Management Application PMA - Controlled	TBA	5,430	8,773
Picture Archive and Communication System - Stage 1 Metropolitan and Country	September 2009	0	6,500
Princess Margaret Hospital - Holding	June 2013	5,900	10,398
Princess Margaret Hospital - Redevelopment / Replacement	TBA June 2016	0	206,799
Princess Margaret Hospital PMCCU - Controlled	December 2009	4,110	4,650
QE11 Medical Centre contribution to Research Centre	April 2012	11,635	25,000
Rockingham Kwinana Hospital - Redevelopment Stage 1	February 2010	59,772	115,243
Royal Perth Hospital - Holding	June 2011	500	9,825
Royal Perth Hospital Emergency Department Expansion - Administered	July 2009	0	5,983
Shenton Park - Holding	September 2010	2,726	5,000
South West Health Campus - Intensive Care Unit	TBA June 2010	300	300
South West Health Campus - New Radiotherapy Facility	June 2011	800	8,500
Southern Tertiary Hospital - New Stage 1	December 2013	84,305	1,761,500
Upper Great Southern District (inc Narrogin) - Development & Restructuring	September 2012	0	9,000
WA Comprehensive Cancer Centre - Central Campus Stage 2 (WACCC)	September 2012	4,478	65,399
WACHS & SWAHS Rural Various - 12 Year program for allocation	June 2015	0	20,853
WACHS PACS - Regional Resource Centre - Controlled	June 2010	2,830	6,500
Wyndham Multi Purpose Centre - Development	February 2010	3,937	4,500

Major Capital Works (continued)

Table 38: Major capitals works completed in 2008-09

Project	Project Start Date	Project Completion Date	Approved Cost 2008-09 Budget ($000)	Final Cost ($000)
ICT Shared Services - Relocation	July 2005	June 2009	0	379
King Edward Memorial Hospital - emergency generator	July 2007	December 2008	350	400
King Edward Memorial Hospital fire safety system	July 2007	December 2008	0	250
King Edward Memorial Hospital Negative Pressure Respiratory Isolation Rooms - Controlled	August 2007	September 2008	700	900
Mental Health Initiatives - Controlled	July 2007	June 2009	0	7,980
Morawa and Perenjori Multi Purpose Centre - Replacement	October 2005	May 2008	910	9,130
Murray District Health Centre	August 2006	September 2008	3,800	5,470
Nickol Bay Hospital Roof Replacement - Controlled	July 2007	October 2008	2,350	2,500
North Perth Dental Extension	September 2003	November 2008	0	300
Pathways Home program	July 2006	June 2008	0	23,000
Princess Margaret Hosp Procedure Room	July 2007	June 2008	0	600
SCGH Neurosciences Unit	July 2005	December 2007	0	5,505
South West Health Campus - Inpatient Mental Health Unit Expansion - Controlled	November 2005	November 2007	72	6,584
South West Health Campus - New Mental Health Clinic - Controlled	November 2005	November 2007	43	3,274
Statewide condition audit	2001/02	June 2007	0	17,502

Notes
The above information is based upon the 2008-09 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 2008-09 Budget papers.
Some project descriptions have been altered over time to ensure consistency.
Completion timeframes are based upon a combination of known dates and financial closure.
Projects completed in prior year that do not have a cash flow in 2008-09 are included.

Substantive Equality

The WA Health Substantive Equality Implementation Committee was formed in September 2008 to guide the development and implementation of substantive equality within WA Health over five years to 2013.

Members of the Implementation Committee represent all areas of WA Health and are senior officers from a clinical or operational area who are in a position to be able to influence how services are delivered.

All WA Health services are currently undertaking a substantive equality needs and impact assessment.

Pricing Policy

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

Under the Australian Health Care Agreement, where a Medicare eligible patient elects to receive medical treatment as a public patient in a public hospital, or publicly contracted bed in a private hospital, they will be treated 'free of charge'.

The exceptions to this pricing policy are patients convalescing in a public hospital for more than 35 continuous days, who no longer require acute care and are deemed to be Nursing Home Type Patients, and may then 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 this pricing policy for the above chargeable classes of patients is that pharmaceutical items supplied 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 health indexation costs to health funds.

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 Australian Health Care Agreement, eligible patients who have entered into 'third party' arrangements with compensable insurers are known as compensable patients. This cohort of compensable patients may include among other groups, 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 charges are to be recouped from the Department of Veterans' Affairs.

In summary, the majority of hospital 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. These public hospital fees and charges are reviewed annually and increased each financial year in accordance with Ministerial and other approval processes. The exceptions to this general rule are pharmaceuticals and nursing home type patients, which are increased on advice from the Commonwealth Department of Health and Ageing.

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

- 50 per cent of the treatment fee if the patient is the holder of a Health Care Card or Pensioner Concession Card; or
- 25 per cent 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 an allowance from Centrelink or the Department of Veterans' Affairs.

Recordkeeping

The *State Records Act 2000* was established to mandate standardised statutory record keeping practices for every Government agency including records creation policy, record security and the responsibilities of all staff. Government agency practice is subject to the provisions of the Act and the standards and policies, and Government agencies are subject to scrutiny by the State Records Commission.

In 2008-09 the Department of Health continues to progress the WA Health Recordkeeping Plan.

Performance Indicators for recordkeeping have been developed around the broad areas of quality, quantity, responsiveness and participation. Examples of measures include:

- The number of staff who have successfully completed the Recordkeeping Awareness Training;
- The number of documents electronically saved into WA Health's electronic document management system - TRIM;
- The number of files created within 24 hours of receiving a request; and
- The number of users using the Electronic Document and Records Management System (EDRMS).

WA Health's recordkeeping system is evaluated through an online survey of staff. The information gathered from such surveys informs training requirements and recordkeeping system improvements.

Further, calls to the Information Communications Technology Service are recorded in a problem tracking and resolution database for record keeping purposes.

Other initiatives undertaken by the Department of Health as part of its requirement to maintain compliance with WA Health's Recordkeeping Plan are:

In the Office of Population Health Genomics, the efficiency and effectiveness of the Branch's recordkeeping is under continuous quality improvement review by undertaking the following:

- New staff members are given instructions as part of the induction program about standard operating procedures with regard to recordkeeping practices.
- The record keeping training program is reviewed annually. As part of the induction program, new staff members are asked to sign off against their understanding and agreement to comply with the record keeping plan.
- Records are reviewed annually to ensure compliance with the agency's recordkeeping plan.
- All documents comply with a standard naming nomenclature. The storage of all corporate documents (hard and electronic copies) is managed by one administrative staff member for consistency and compliance.

In 2009, the Human Resources Branch, Business Unit, updated the Department of Health new employee induction programme. The mandatory on-line corporate induction includes a section on records management and the employee responsibility. An induction session has been introduced, which also refers to the requirements in accordance with the record keeping standards.

All Development Division staff are encouraged to complete the on-line Recordkeeping Awareness Training.

In the Project Development Directorate, all employees attend the Department of Health formal induction program. All employees are also inducted into Development Division formally through an induction booklet. Record keeping is an important part of this induction. All internal policies are developed in line with the WA Health Recordkeeping Plan.

Recruitment

The Department of Health focused on developing initiatives to strengthen workforce attraction and retention strategies whilst continuing to undertake recruitment and selection processes in accordance with the Public Sector Standards in Human Resource Management.

The following are a brief summary of recruitment initiatives undertaken by the Department of Health in 2008-09.

Career Expos

WA Health had representatives at the following Careers Expos in 2009:

- Career, Education and Employment Expo, 15-17 May 2009, where 700 Nursing and Midwifery Careers Pathways booklets were distributed;
- Royal College of Nursing Australia Nursing and Health Expo, 24 May 2009; and
- National Careers Expo, 19-20 June 2009

Nursing and Midwifery Marketing Campaign 'Nursing it can take you anywhere' was developed in 2008-09 to attract students into nursing and encourage re-entrants back into nursing and midwifery. The campaign has seen a 15 per cent increase in university enrolments in nursing programs.

Nursing and Midwifery Careers Day

The Department of Health held a Nursing and Midwifery Careers Day on the 6 April 2009 which 131 high school students from metropolitan high schools attended. This allowed the opportunity for the department to promote opportunities in nursing and midwifery in WA Health to the potential future workforce.

Work Experience Program

The Department of Health, in collaboration with Edith Cowan University, held two 'hands on learning' programs targeted at Year 10 students considering a career in nursing.

Mental Health Workforce Taskforce

The Mental Health Workforce Taskforce was established in 2008 to develop statewide attraction and retention strategies to reduce staff shortages and to enhance professional practice in the delivery of mental health services. The strategies implemented in 2008-09 included:

- Targeted advertising in United Kingdom (UK) journals and interviews conducted in the UK for vacant nursing positions in mental health services, as part of general health nursing recruitment;
- Attendance at an interstate nursing expo in November 2008, to conduct interviews for vacant nursing positions in mental health services;
- Offering relocation reimbursements of up to $20,000 for new staff recruited from overseas and interstate locations;
- Offering scholarships for allied health professionals working in mental health settings to undertake postgraduate mental health courses; and
- Development of a WA Mental Health Core Competency Framework to guide professional development training priorities that enhance professional practice in line with the National Practice Standards for the Mental Health workforce.

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.

Department of Health (DOH) staff are encouraged to develop their skills and knowledge base through activities, training programs and events. Staff participate in an annual cycle of performance development planning, which links to formal and informal learning opportunities to maximise potential and increase performance.

The DOH provides a suite of internal training courses, including corporate Induction; interview and application skills; business etiquette and professionalism; corporate governance awareness; occupational safety and health; time management and interpersonal communication skills as well as a number of sessions on information technology applications and records management (TRIM).

Following is a brief summary of other staff development initiatives undertaken by the Department of Health as part of its commitment to developing staff skills and knowledge to achieve strategic objectives.

The Disaster Preparedness and Management Unit (DPMU) formal training opportunities include Emergency Management Australia courses, and private sector courses in relevant subjects. Other less formal staff development opportunities attended by DPMU staff include conferences, participation in exercises and the Major Incident Management Course.

All staff members in the Office of Population Health Genomics attended the Joint Human Genetics Society of Australasia and Genome-related Research and Public Health International Conference in Perth and a satellite seminar on Challenges for Society in the Genetic Information Age during May 2009. Staff attended nine postgraduate training courses at local or interstate academic institutions and five Department of Health training programs to improve computer and policy skills. Accreditation for training GPs through the Royal Australasian College of General Practitioners (RACGP) was completed by four staff members. Thirteen staff participated in at least one professional development seminar or workshop during the year.

The Project Development Directorate (PDD) offered both formal and informal induction for all new staff. All staff are on formal performance agreements which outline the objectives and the deliverables for their positions. The individual staff member's goals for their own professional development are agreed at the beginning of the year and are also included in the performance agreement and every effort is made to ensure that these agreements are fulfilled.

Staff in the Mental Health Division have taken a variety of development courses over the year including 'Train Your Mind to be Focused', 'Calm and Clear', 'Working with the Media', 'The Public Sector Management Program', 'Managing Aggressive Clients' and 'Happiness and its Causes'.

The Corporate Governance Directorate staff's ongoing career development includes attending professional organisations' courses such as:

- CPA: 'Reporting & Professional Practice' and 'Financial Accounting';
- Institute of Internal Auditors: 'Standards & Regulations Update' and 'Tackling Emerging Issues';
- IPAA: 'Statistics & Their Uses';
- National Institute of Auditors: 'Government Accounting Masterclass'; and
- AIM: 'Strategic Business Planning'.

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 39: Workers' compensation and rehabilitation claims 2008-09

Employee category	Number of claims in 2008-09
Nursing Services / Dental Care Assistants	Nil
Administration and Clerical	7
Medical Support	Nil
Hotel Services	Nil
Maintenance / Supply (HCN)	1
Medical (salaried)	Nil
Total	**8**

Occupational injury and illness prevention
Programs provided in 2008-09 include:
Occupational Safety and Health (OSH) induction for all new staff;

- Ergonomic advice;
- On-site workstations ergonomic advice on request;
- A website with an interactive program on office-based ergonomics; and
- Risk assessments and site inspections for various worksites as requested.

Employee rehabilitation
Programs provided in 2008-09 include:

- An active injury management policy and program to facilitate early return to work;
- An injury management coordinator facilitating injury management;
- Contact with injured workers and medical practitioners, provision of alternative duties and amended duties as required;
- Collaboration with medical practitioners and injured workers, rehabilitation providers and Insurer RiskCover; and
- Liaison with vocational rehabilitation providers to assist in the graduated return to work program for an injured worker.

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.

WA Health is committed to providing a safe workplace to achieve high standards in safety and health for its employees, contractors and visitors.

All areas of WA Health will comply with, or exceed Occupational Safety and Health (OSH) legal requirements and will develop and implement safe systems and work practices that reflect its commitment to safety and health.
To achieve this, WA Health management:

- Promote a culture that integrates safety as a core value into all aspects of work;
- Develop and implement an effective OSH management system;
- Take all practical measures to identify hazards, assess risks and to control risks;
- Thoroughly investigate all incidents/accidents to prevent recurrences;
- Ensure that management and supervisory staff accept responsibility to provide and maintain safe systems of work where employees are not exposed to hazards;
- Inform all employees of their duty of care and empower them to take responsibility for the safety and health of themselves and others;
- Communicate, consult and cooperate with employees and OSH representatives to ensure that all practical measures are undertaken to improve OSH performance;
- Establish an OSH Plan with measurable objectives and targets to ensure continuous improvement in safety and health performance; and
- Provide training, time, resources and financial support to enable implementation of this policy.

The responsibility for implementing this policy lies with the Director General.

Mechanism for consultation with employees on OSH matters

Consultation between management and employees allows decisions on managing workplace Safety and Health to be based on information gained from an holistic approach. A consequence of this co-operative approach ensures a greater commitment to the decisions that are made resulting from all concerned participating and having ownership of the process. It is intended that "The OSH Committee, including the employee representatives, forms the key to OSH consultation within (WA Health). The Committee members' appointment, location and details are communicated to all employees. The members are accessible and effectively utilised by both management and employees in the discussion and resolution of OSH issues.

The OSH Committee meets bi-monthly to discuss and resolve OSH issues, review hazard and incident reports, and review progress against the OSH Business Plan.

Compliance with the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*

The DOH acknowledges and actively promotes the philosophy of consultation and co-operation between the Employer and Employee; indeed it is the fostering and the

Occupational Safety & Health and Injury Management Performance (continued)

development of this alliance, which will lead the Department of Health to achieve best practice in injury management.

DOH carries out all its injury management obligations within the guidelines set out under the *Workers Compensation and Injury Management Act 1981* and the WorkCover Injury Management Code of Practise 2005. Whilst adherence to the aforementioned Act and code of practice is a minimum standard requirement, it is the view and vision of The DOH 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 DOH to strive towards leadership in injury management within the Health sector.

Self evaluation of occupational safety and health managements systems

Riskcover audited WA Health's injury management systems in 2008 the recommendations of the audit led to development of a more comprehensive injury management system.

Table 40: Occupational safety and health incidence and severity

Fatalities	Lost time injury/disease incidence rate	Lost time injury/disease severity rate	Percentage of injured workers returned to work within 28 days	Percentage of managers trained in OSH and injury management responsibilities
Nil	0	8%	Not available	65%

Patient Evaluation of Health Services 2008-09

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.

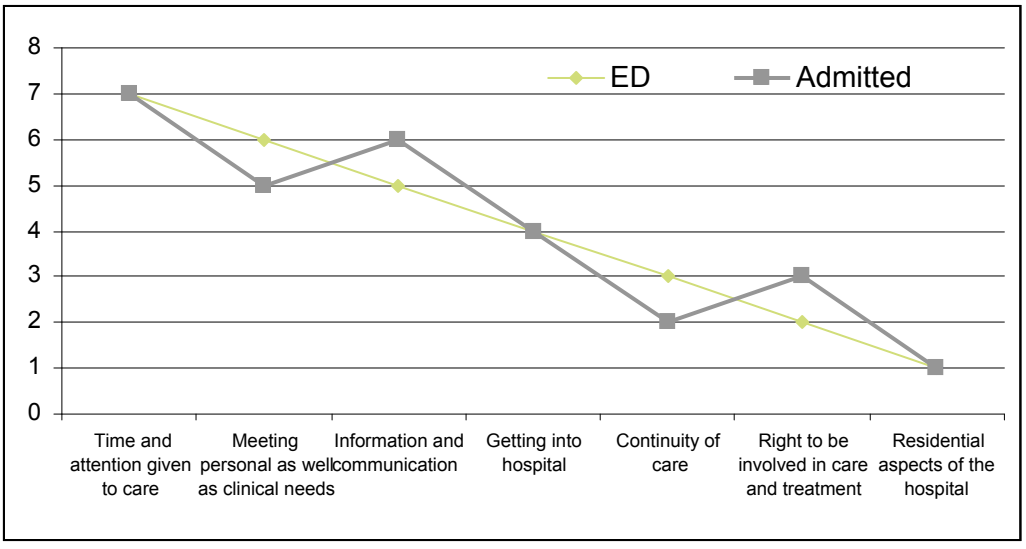
Every year since 1997, the Patient Evaluation of Health Services (PEHS) surveys thousands of patients and asks about their experiences in the health system. Since 2004-05, surveys have been completed by telephone survey with the exception of some special patient groups. This has attracted excellent response rates of over 85% with participation rates of over 90%. These high response rates lend more weight to the results which can be assumed to be representative, reliable and valid.

This year, 6863 admitted patients and 1593 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 same day or one or more nights and maternity patients. The surveys were conducted between February and June 2009.

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 may 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. The figure below presents the results.

Figure 4: The mean score of patient ranked aspects of health care ranked from most important (7) to least important (1), PEHS 2008-09



For both the admitted and emergency patients surveyed, 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 2008-09 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 2008-09 Results for Admitted Patients

The following table shows the comparison of the Scales Scores, Overall Indicator of Satisfaction and Outcome Scores of admitted adults and children.

Table 41: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score for admitted adults and children, PEHS 2008-09

Scales, Overall Indicator of Satisfaction and Outcome Score	Adult 16-75 years	Children 0-15 years
Getting into hospital	65.8↑	60.6
Time and attention paid to patients' care	87.5↑	86.0
Information and Communication	83.4	83.1
Meeting personal as well as clinical needs	90.9	90.1
Continuity of Care	71.8	69.8
Involved in decisions about your care and treatment	70.3	71.7
Food and Residential aspects	63.4	61.9
Overall indicator of satisfaction	78.1	77.3
Outcome score	85.5↓	88.6

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

Admitted adults have scale scores significantly higher than admitted children for 'Getting into hospital' and 'Time and attention paid to patients' care'. The outcome score was significantly lower for admitted adults when compared with admitted children.

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 the following table.

Table 42: Mean Scale Scores, Overall Indicators of Satisfaction and Outcome Score for admitted patients by hospital peer groups, PEHS 2008-09

Scales, Overall Indicator of Satisfaction and Outcome Score	All admitted	Tertiary	Non-Tertiary Metro	Regional Resource Centre	Integrated District Health Service	Other service location
Getting into hospital	64.0	61.3	65.6	63.0	68.4	66.4
Time and attention paid to patients' care	87.0	85.6↓	87.9	87.2	87.7	88.7
Information and Communication	83.3	82.1	83.7	83.3	84.3	85.6
Meeting personal as well as clinical needs	90.6	89.4	91.5	90.5	91.7	92.8
Continuity of Care	71.1	69.2	71.6	71.2	72.2	76.6↑
Involved in decisions about your care and treatment	70.8	70.6	70.6	70.1	70.9	73.6
Food and Residential aspects	62.9	58.8↓	64.2	63.5	66.6	71.3↑
Overall indicator of satisfaction	77.8	76.2↓	78.6	77.8	79.4	80.8↑
Outcome score	86.6	85.0	86.8	86.8	89.4	88.2

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

Tertiary hospitals have scale scores significantly lower for 'Time and attention paid to patients' care' and 'Food and residential aspects' than all other peer groups.
Other service locations have scales scores significantly higher for 'Continuity of care' and 'Food and residential aspects' than all other peer groups.

The 'Overall indicator of satisfaction' was significantly higher for Other service locations and significantly lower for Tertiary hospitals when compared with all other peer groups.

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

The 'Outcome score' 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 2008-09 with 2007-08 and 2006-07

Results of this year's survey have been calculated and compared with the results from 2007-08 and 2006-07 and the following table presents the results.

Table 43: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2007-08 compared with 2007-08 and 2006-07 for patients admitted 0 or more nights

Scales, Overall Indicator of Satisfaction and Outcome Score	2008-09	2007-08	2006-07
Getting into hospital	64.0	66.2↑	67.4↑
Time and attention paid to patients' care	87.0	87.1	88.1↑
Information and Communication	83.3	82.2	83.0
Meeting personal as well as clinical needs	90.6	90.5	91.2
Continuity of Care	71.1	71.9	71.3
Involved in decisions about your care and treatment	70.8	73.7↑	74.0↑
Food and Residential aspects	62.9	61.6↓	63.7
Overall indicator of satisfaction	77.8	78.2	79.0↑
Outcome score	86.6	86.3	87.7↑

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the 2008-09 comparison score

When the 2006-07 results are compared with 2008-09 scale scores were significantly higher for 'Getting into hospital', 'Time and attention paid to patients' care', 'Involved in decisions about your care and treatment', the 'Overall indicator of satisfaction' and 'Outcome score'.

'Getting into hospital', 'Involved in decisions about your care and treatment' scale scores were significantly higher for 2007-08 when compared with 2008-09. 'Food and residential aspect' scales were significantly lower for 2007-08 when compared with 2008-09.

The 2008-09 Results for Maternity Patients

Results of this year's survey have been calculated and compared with the results from 2005-06 and the following table presents the results.

Table 44: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2008-09 compared with 2005-06 for Maternity patients

Mean Scale Scores	2008-09	2005-06
Time and attention paid to patients' care	87.1	87.7
Information and Communication	81.4	80.7
Meeting personal as well as clinical needs	91.5	91.7
Continuity of Care	84.1	84.5
Involved in decisions about your care and treatment	76.7↓	80.6
Food and Residential aspects	67.9	67.0

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than the 2008-09 score

'Involved in decisions about your care and treatment' was significantly lower in 2008-09 when compared with 2005-06. All other scales are not significantly different.

Figure 5: Overall indicator of satisfaction and outcome score for maternity patients, 2008-09 compared with 2005-06

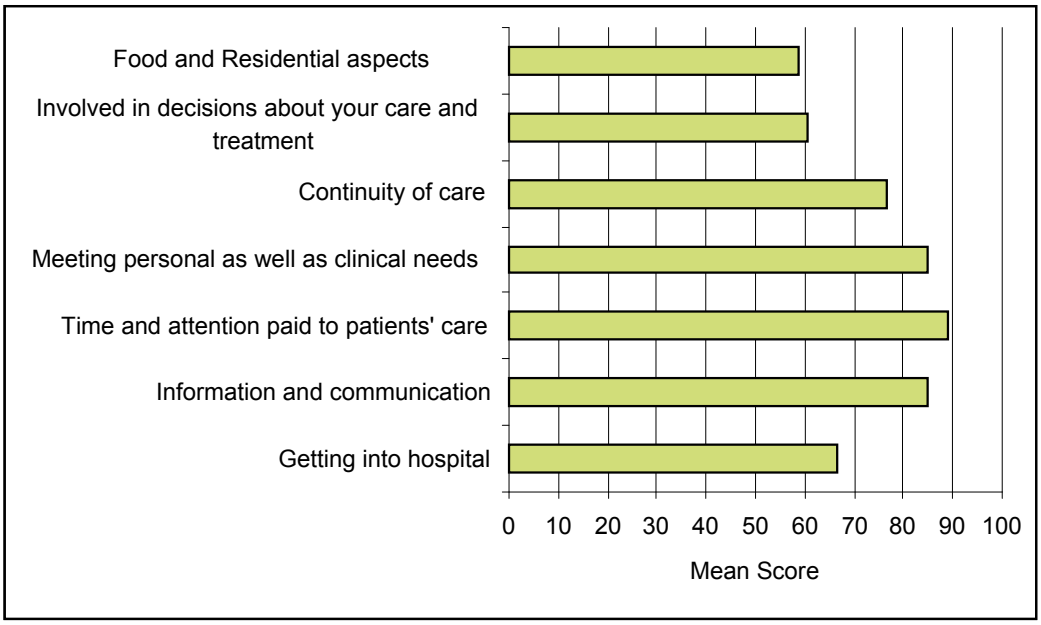
* Indicates the mean score is significantly higher than the comparison group

The 'Overall indicator of satisfaction' is significantly higher in 2008-09 when compared with 2005-06.

The 2008-09 Results for Emergency Patients

Patients who attended the Emergency Department at Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital or Princess Margaret Hospital were surveyed about their experience. The figure below presents the combined scale scores for these four hospitals.

Figure 6: Mean Scale Scores for Emergency patients, PEHS 2008-09



The three highest scale scores align with the three most important aspects of health care as ranked by patients; 'Time and Attention Given to Patients' Care' ranked most important (with an average state score of 89.1), 'Meeting Personal as well as Clinical Needs' ranked second most important (with an average state score of 84.7) and 'Information and Communication' ranked third most important (with an average state score of 84.8). The 'Residential aspects' show the lowest levels of satisfaction which is also the least important to these patients.

Comparison of 2008-09 with 2007-08 and 2004-05

Results of this year's survey have been calculated and compared with the same hospital results from 2007-08 and 2004-05. The following table presents the results.

Table 45: Mean Scale Scores, Overall Indicator of Satisfaction and Outcome Score 2008-09 compared with 2007-08 and 2004-05 for emergency patients

Mean Scale Scores	2008-09	2007-08	2004-05
Getting into hospital	66.7	66.1	66.9
Time and attention paid to patients' care	89.1	87.4	86.6↓
Information and Communication	84.8	84.9	83.8
Meeting personal as well as clinical needs	84.7	83.2	83.4↓
Continuity of Care	76.7	76.7	75.2
Involved in decisions about your care and treatment	60.4	56.8	58.0
Food and Residential aspects	58.7	58.1	62.2↑
Overall indicator of satisfaction	77.4	75.9	76.0↓
Outcome score	85.5	86.6	84.1

↓ ↑ Indicates that the mean scale score is statistically significantly lower or higher than 2008-09 comparison score

'Time and attention paid to patients' care' and 'Meeting personal as well as clinical needs' were significantly lower for 2004-05 when compared with 2008-09. These two aspects of health care provision are also the two most important aspects of health care as ranked by the patient which indicates that efforts have been made in the areas that are most important to Emergency patients. The 'Overall indicator of satisfaction' is also significantly lower for 2004-05 when compared with 2008-09.

'Food and residential aspect' scales were significantly higher for 2004-05 when compared with 2008-09.

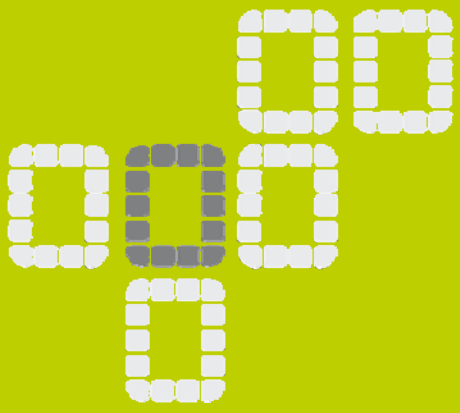
Conclusions
Maternity patients have a high level of satisfaction, scores exceeding 80, for four of the six scales. The overall indicator of satisfaction has seen a significant improvement when compared with 2005-06.

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 2008-09. The outcome scores are higher than the overall indicator of satisfaction. 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 8456 people were interviewed by telephone and answered questions about their hospital stay.

Admitted patient satisfaction exceeds the average level of 80 for three of the seven scales. 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.



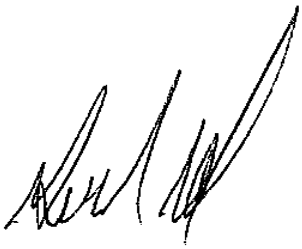
Financial Statements

Certification Statement

DEPARTMENT OF HEALTH
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2009

The accompanying financial statements of the Department of Health have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2009 and financial position as at 30 June 2009.

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.



Brett Roach
Acting Chief Finance Officer
Department of Health

Date: 17 September 2009

Dr Peter Flett
Accountable Authority
Department of Health

Date: 17 September 2009

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 2009

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 2009, and the Income Statement, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service, and Summary of Consolidated Account Appropriations and Income Estimates for the year then ended, 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 www.audit.wa.gov.au/pubs/AuditPracStatement_Feb09.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.

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Audit Opinion (continued)

Department of Health
Financial Statements and Key Performance Indicators for the year ended 30 June 2009

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 2009 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 2009.

COLIN MURPHY
AUDITOR GENERAL
21 September 2009

Financial Statements

Department of Health

Income Statement

For the year ended 30 June 2009

	Note	2009 $000	2008 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	8	82,470	71,444
Contracts for services	9	664,340	597,788
Supplies and services	10	64,284	74,682
Grants and subsidies	11	20,560	18,963
Depreciation expense	12	3,673	3,861
Finance costs	13	7,644	7,640
Loss on disposal of non-current assets	14	11	145
Other expenses	15	23,766	17,240
Contribution to Hospital Fund	16	70,000	103,930
Total cost of services		**936,748**	**895,693**
INCOME			
Revenue			
User charges and fees		6,210	4,277
Commonwealth grants and contributions	17	171,551	165,220
Other revenue		9,526	7,940
Total revenue		**187,287**	**177,437**
Total income other than income from State Government		**187,287**	**177,437**
NET COST OF SERVICES		**749,461**	**718,256**
INCOME FROM STATE GOVERNMENT			
Service appropriation	18a	755,198	666,404
Liabilities assumed by the Treasurer	18b	-	132
Assets assumed/(transferred)	18c	(20,354)	2
Resources received free of charge	18d	4,099	1,938
Royalties for Regions Fund	18e	5,674	-
Total income from State Government		**744,617**	**668,476**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(4,844)**	**(49,780)**

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

Department of Health

Balance Sheet

As at 30 June 2009

	Note	2009 $000	2008 $000
ASSETS			
Current Assets			
Cash and cash equivalents	19	9,296	5
Restricted cash and cash equivalents	20	8,971	12,544
Inventories	21	20,444	7,202
Receivables	22	8,581	2,706
Other current assets	24	3	154
Total Current Assets		47,295	22,611
Non-Current Assets			
Restricted cash and cash equivalents	20	935	670
Amounts receivable for services	23	47,421	41,391
Property, plant and equipment	25	161,895	179,598
Total Non-Current Assets		210,251	221,659
Total Assets		**257,546**	**244,270**
LIABILITIES			
Current Liabilities			
Payables	27	53,333	48,496
Provisions	28	17,531	13,312
Borrowings	29	2,804	42,296
Total Current Liabilities		73,668	104,104
Non-Current Liabilities			
Provisions	28	2,127	3,412
Borrowings	29	31,488	34,292
Total Non-Current Liabilities		33,615	37,704
Total Liabilities		**107,283**	**141,808**
NET ASSETS		**150,263**	**102,462**
EQUITY			
Contributed equity	30	75,505	27,491
Reserves	30	244,214	239,583
Accumulated deficiency	30	(169,456)	(164,612)
TOTAL EQUITY		**150,263**	**102,462**

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 2009

	Note	2009 $000	2008 $000
Balance of equity at start of period		102,462	120,964
CONTRIBUTED EQUITY	30		
Balance at start of period		27,491	16,743
Capital contribution		48,014	10,748
Balance at end of period		**75,505**	**27,491**
RESERVES	30		
Asset Revaluation Reserve			
Balance at start of period		239,583	219,053
Gains from asset revaluation		4,631	20,530
Balance at end of period		**244,214**	**239,583**
ACCUMULATED DEFICENCY	30		
Balance at start of period		(164,612)	(114,832)
Deficit for the period		(4,844)	(49,780)
Balance at end of period		**(169,456)**	**(164,612)**
Balance of equity at end of period		**150,263**	**102,462**
Total income and expense for the period (a)		(213)	(29,250)

(a) The aggregate net amount attributable to each category of equity is: Deficit $4,844,000 plus gains from asset revaluation $4,631,000 (2008: deficit $49,780,000 plus gain from asset revaluation $20,530,000).

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 2009

	Note	2009 $000 Inflows (Outflows)	2008 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		749,167	660,518
Capital contributions	30	48,014	10,748
Royalties for Regions Fund		5,674	-
Net cash provided by State Government		802,855	671,266
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(79,537)	(70,363)
Supplies and services		(756,697)	(659,662)
Grants and subsidies		(20,560)	(18,963)
Finance costs		(7,492)	(7,641)
Contribution to Hospital Fund		(70,000)	(103,930)
GST payments to taxation authority		-	(4)
Other payments		2	-
Receipts			
User charges and fees		6,245	7,526
Commonwealth grants and contributions	17	171,551	165,220
Other receipts		3,616	4,705
Net cash (used in) / provided by operating activities	31b	(752,872)	(683,112)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payment for purchase of non-current physical assets		(1,704)	(7,347)
Net cash (used in) / provided by investing activities		(1,704)	(7,347)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(42,296)	(4,327)
Net cash (used in) / provided by financing activities		(42,296)	(4,327)
Net increase / (decrease) in cash and cash equivalents		5,983	(23,520)
Cash and cash equivalents at the beginning of period		13,219	36,738
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	31a	19,202	13,219

The Cash Flow Statement 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 2009

	Admitted Patients Services		Specialised Mental Health		Home-Based Hospital Programs		Palliative Care		Emergency Department		Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection	
	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
COST OF SERVICES																
Expenses																
Employee benefits expense	44,536	37,975	-	-	-	-	861	1,010	-	-	-	-	-	-	32,959	27,611
Contracts for services	235,563	212,862	-	-	8,299	5,851	20,535	18,470	-	-	41,876	40,128	78,593	54,994	45,030	51,209
Supplies and services	15,508	14,550	-	-	-	-	47	53	-	-	-	-	-	-	46,787	58,366
Grants and subsidies	16,862	15,648	-	-	-	-	133	5	-	-	-	-	-	-	2,648	2,575
Depreciation expense	3,000	2,949	-	-	-	-	-	-	-	-	-	-	-	-	404	662
Finance costs	5,956	5,948	-	-	-	-	73	74	-	-	1,615	1,618	-	-	-	-
Loss on disposal of non-current assets	6	21	-	-	-	-	-	-	-	-	-	-	-	-	5	121
Other expenses	16,752	11,642	-	-	-	-	54	64	-	-	-	1	-	-	5,106	4,442
Contribution to Hospital Fund	42,001	62,279	3,500	6,228	700	1,038	-	-	2,801	4,152	11,200	17,645	-	-	3,498	5,191
Total cost of services	380,184	363,874	3,500	6,228	8,999	6,889	21,703	19,676	2,801	4,152	54,691	59,392	78,593	54,994	136,437	150,177
INCOME																
Revenue																
User charges and fees	2,248	1,690	-	-	-	-	1	2	-	-	-	-	-	-	3,380	2,244
Commonwealth grants and contributions	1,702	1,153	286	-	-	-	678	576	-	87	405	296	-	-	62,180	64,921
Other revenue	5,567	4,292	-	-	-	-	-		-	-	-		-	-	392	123
Total income other than income from State Government	9,517	7,135	286	-	-	-	679	578	-	87	405	296	-	-	65,952	67,288
NET COST OF SERVICES	370,667	356,739	3,214	6,228	8,999	6,889	21,024	19,098	2,801	4,065	54,286	59,096	78,593	54,994	70,485	82,889
INCOME FROM STATE GOVERNMENT																
Service appropriation	380,382	313,211	3,417	6,664	8,888	6,664	20,673	19,992	2,654	6,664	51,412	59,977	77,621	53,312	70,887	79,968
Liabilities assumed by the Treasurer	-	132	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Assets assumed/(transferred)	(8,503)	(7)	(797)	-	(133)	-	-	-	(664)	-	(1,860)	-	-	-	(7,467)	9
Resources received free of charge	1,305	757	12	-	30	19	71	39	9	-	176	97	266	136	243	349
Royalties for Regions Fund	-	-	-	-	-	-	-	-	-	-	-	-	5,674	-	-	-
Total income from State Government	373,184	314,093	2,632	6,664	8,785	6,683	20,744	20,031	1,999	6,664	49,728	60,074	83,561	53,448	63,663	80,326
SURPLUS/(DEFICIT) FOR THE PERIOD	2,517	(42,646)	(582)	436	(214)	(206)	(280)	933	(802)	2,599	(4,558)	978	4,968	(1,546)	(6,822)	(2,563)

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 2009

	Dental Health		Aged & Continuing Care		Community Mental Health		Residential Care		Residential Mental Health Care		Chronic Illness Support		TOTAL	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
COST OF SERVICES														
Expenses														
Employee benefits expense	-	-	1,039	666	-	-	-	-	-	-	3,075	4,182	82,470	71,444
Contracts for services	10,710	9,529	186,132	159,218	9,092	7,842	-	10,013	11,116	8,312	17,394	19,360	664,340	597,788
Supplies and services	-	-	7	9	-	-	-	-	-	-	1,935	1,704	64,284	74,682
Grants and subsidies	-	-	-	-	-	-	-	-	-	-	917	735	20,560	18,963
Depreciation expense	-	-	-	-	-	-	-	-	-	-	269	250	3,673	3,861
Finance costs	-	-	-	-	-	-	-	-	-	-	-	-	7,644	7,640
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-	-	-	-	3	11	145
Other expenses	-	-	24	33	-	-	-	-	-	-	1,830	1,058	23,766	17,240
Contribution to Hospital Fund	1,400	2,076	700	1,038	2,800	4,152	1,400	-	-	-	-	131	70,000	103,930
Total cost of services	12,110	11,605	187,902	160,964	11,892	11,994	1,400	10,013	11,116	8,312	25,420	27,423	936,748	895,693
INCOME														
Revenue														
User charges and fees	-	-	176	-	-	-	-	-	-	-	405	341	6,210	4,277
Commonwealth grants and contributions	-	-	105,950	97,587	-	600	-	-	350	-	-	-	171,551	165,220
Other revenue	-	-	2		3,326	3,248	-	-	-	-	239	277	9,526	7,940
Total income other than income from State Government	-	-	106,128	97,587	3,326	3,848	-	-	350	-	644	618	187,287	177,437
NET COST OF SERVICES	12,110	11,605	81,774	63,377	8,566	8,146	1,400	10,013	10,766	8,312	24,776	26,805	749,461	718,256
INCOME FROM STATE GOVERNMENT														
Service appropriation	11,960	13,328	81,389	59,976	9,479	6,664	1,383	6,664	10,929	6,664	24,124	26,656	755,198	666,404
Liabilities assumed by the Treasurer	-	-	-	-	-	-	-	-	-	-	-	-	-	132
Assets assumed/(transferred)	(266)	-	(133)	-	(531)	-	-	-	-	-	-	-	(20,354)	2
Resources received free of charge	1,549	19	279	407	33	19	5	19	38	19	83	58	4,099	1,938
Royalties for Regions Fund	-	-	-	-	-	-	-	-	-	-	-	-	5,674	-
Total income from State Government	13,243	13,347	81,535	60,383	8,981	6,683	1,388	6,683	10,967	6,683	24,207	26,714	744,617	668,476
SURPLUS/(DEFICIT) FOR THE PERIOD	1,133	1,742	(239)	(2,994)	415	(1,463)	(12)	(3,330)	201	(1,629)	(569)	(91)	(4,844)	(49,780)

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 Assets and Liabilities by Service

As at 30 June 2009

	Admitted Patients Services		Home-Based Hospital Programs		Palliative Care		Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection		Dental Health	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
ASSETS														
Current assets	12,039	1,296	301	-	697	45	1,500	56	668	-	25,967	12,118	1,285	-
Non-current assets	182,153	183,363	-	-	199	69	1,995	-	-	-	13,141	22,695	-	89
Total Assets	194,192	184,659	301	-	896	114	3,495	56	668	-	39,108	34,813	1,285	89
LIABILITIES														
Current liabilities	41,867	70,599	433	-	1,978	1,560	6,331	13,837	2,971	-	14,489	13,556	1,964	-
Non-current liabilities	26,261	29,151	-	-	292	339	6,050	6,603	-	-	910	1,349	-	-
Total Liabilities	68,128	99,750	433	-	2,270	1,899	12,381	20,440	2,971	-	15,399	14,905	1,964	-
NET ASSETS	126,064	84,909	(132)	-	(1,374)	(1,785)	(8,886)	(20,384)	(2,303)	-	23,709	19,908	(679)	89

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

Department of Health

Schedule of Assets and Liabilities by Service

As at 30 June 2009

	Aged & Continuing Care		Community Mental Health		Residential Care		Residential Mental Health Care		Chronic Illness Support		TOTAL	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
ASSETS												
Current assets	3,718	9,027	-	46	-	-	-	-	1,120	23	47,295	22,611
Non-current assets	111	-	-	-	-	201	-	-	12,652	15,242	210,251	221,659
Total Assets	3,829	9,027	-	46	-	201	-	-	13,772	15,265	257,546	244,270
LIABILITIES												
Current liabilities	1,910	497	22	27	-	419	384	352	1,319	3,257	73,668	104,104
Non-current liabilities	12	47	-	-	-	-		-	90	215	33,615	37,704
Total Liabilities	1,922	544	22	27	-	419	384	352	1,409	3,472	107,283	141,808
NET ASSETS	1,907	8,483	(22)	19	-	(218)	(384)	(352)	12,363	11,793	150,263	102,462

The Schedule of Assets and Liabilities 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 2009

	2009 Estimate $000	2009 Actual $000	Variance $000	2009 Actual $000	2008 Actual $000	Variance $000
DELIVERY OF SERVICES						
Item 71 Net amount appropriated to deliver services	754,969	797,190	42,221	797,190	703,948	93,242
Section 25 transfer of service appropriation		641	641	641	356	285
Item 72 Contribution to Hospital Fund	3,027,043	3,171,821	144,778	3,171,821	2,804,682	367,139
Amount Authorised by Other Statutes						
- Salaries and Allowances Act 1975	560	632	72	632	613	19
- Lotteries Commission Act 1990	91,381	102,000	10,619	102,000	95,228	6,772
Total appropriations provided to deliver services	3,873,953	4,072,284	198,331	4,072,284	3,604,827	467,457
CAPITAL						
Item 152 Capital Contribution	214,608	153,015	(61,593)	153,015	157,730	(4,715)
GRAND TOTAL	4,088,561	4,225,299	136,738	4,225,299	3,762,557	462,742
Details of Expenses by Service						
Admitted Patient	2,504,401	2,707,946	203,545	2,707,946	2,385,770	322,176
Specialised Mental Health	194,937	203,015	8,078	203,015	177,016	25,999
Home-Based Hospital Programs	18,145	40,265	22,120	40,265	26,221	14,044
Palliative Care	18,250	20,566	2,316	20,566	18,962	1,604
Emergency Department	147,061	163,326	16,265	163,326	144,111	19,215
Non-Admitted Patient	643,772	679,172	35,400	679,172	610,838	68,334
Patient Transport	72,492	100,385	27,893	100,385	71,497	28,888
Prevention, Promotion & Protection	274,736	324,244	49,508	324,244	324,628	(384)
Dental Health	63,380	70,728	7,348	70,728	63,999	6,729
Aged & Continuing Care	221,839	234,959	13,120	234,959	202,813	32,146
Community Mental Health	188,689	175,999	(12,690)	175,999	160,902	15,097
Residential Care	84,256	77,934	(6,322)	77,934	82,690	(4,756)
Residential Mental Health Care	13,329	11,356	(1,973)	11,356	8,301	3,055
Chronic Illness Support	34,925	45,767	10,842	45,767	44,239	1,528
Drug & Alcohol	54,929	50,248	(4,681)	50,248	47,887	2,361
Total Cost of Services	4,535,141	4,905,910	370,769	4,905,910	4,369,874	536,036
Less Total income	(651,150)	(878,079)	(226,929)	(878,079)	(726,667)	(151,412)
Net Cost of Services	3,883,991	4,027,831	143,840	4,027,831	3,643,207	384,624
Adjustments (a)	(10,038)	44,453	54,491	44,453	(38,608)	83,061
Total appropriations provided to deliver services	3,873,953	4,072,284	198,331	4,072,284	3,604,599	467,685
Capital Expenditure						
Purchase of non-current physical assets	490,433	360,490	(129,943)	360,490	232,145	128,345
Repayment of borrowings	53,617	51,876	(1,741)	51,876	13,619	38,257
Adjustments for other funding sources (b)	(329,442)	(259,351)	70,091	(259,351)	(88,034)	(171,317)
Capital Contribution (appropriation)	214,608	153,015	(61,593)	153,015	157,730	(4,715)
DETAILS OF INCOME ESTIMATES						
Income disclosed as Administered Income	972,463	981,763	9,300	981,763	920,868	60,895

(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, $9.848 million Royalties for Regions Fund and $6.327 million notional revenue from Government.

(b) Adjustments comprise $86.969 million funding for capital works administered by the Department of Treasury and Finance, $91.904 million funding for Fiona Stanley Hospital, $2.900 million Royalties for Regions Fund, $21.590 million Commonwealth grants and include movements in cash balances and other accrual items such as receivables and payables.

Note 36 'Explanatory statement' provides details of any significant variations between estimates and actual results for 2009 and between actual results for 2008 and 2009.

NOTES TO THE FINANCIAL STATEMENTS
For the year ended 30 June 2009

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.

Note 2 Australian equivalents to International Financial Reporting Standards

General
The Department's financial statements for the year ended 30 June 2009 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 2009.

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 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 assets and liabilities' and note 46 'Administered income and expenses'.

Note 3 Summary of significant accounting policies (continued)

(d) Contributed equity

AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities' requires transfers, other than as a result of a restructure of administrative arrangements, 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 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, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. See note 30 '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 18 '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 2008-2009 Budget Statements, the Department retained $181.412 million in 2009 ($177.452 million in 2008) 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 25 Property, plant and equipment' 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.

Asset Revaluation Reserve
The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets as described in note 25 'Property, plant & equipment'.

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

In order to apply this policy, the following methods are utilised :
* Land - not depreciated
* Buildings - diminishing value
* Plant and Equipment - diminishing value with a straight line switch

Under the diminishing value with a straight line switch method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed, and adjusted if appropriate, annually. 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) 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.

Note 3 Summary of significant accounting policies (continued)

(g) Impairment of assets (continued)

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

See note 26 'Impairment of Assets' for the outcome of impairment reviews and testing.
See note 3(o) 'Receivables' and note 22 'Receivables' for impairment of receivables.

(h) Non-Current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately 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.

(i) 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 items.

(j) Financial Instruments

In addition to cash, the Department has two categories of financial instrument:

- Loans and receivables; and
- Financial liabilities measured at amortised cost.

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

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.

(k) 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.

(l) Accrued salaries

The accrued salaries suspense account (refer note 20 'Restricted cash and cash equivalents') consists of amounts paid annually into a suspense account over a period of 10 financial years to largely meet the additional cash outflow in each eleventh year when 27 pay days occur in that year instead of the normal 26. No interest is received on this account.

Accrued salaries (refer note 27 'Payables') represent the amount due to staff but unpaid at the end of the financial year, as the pay date for 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.

Note 3 **Summary of significant accounting policies (continued)**

(m) 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 23 'Amounts receivable for services' and note 18 'Income from State Government'.

(n) Inventories

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

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

See note 21 'Inventories'.

(o) 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.

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(j) 'Financial Instruments' and note 22 'Receivables'.

(p) Payables

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

See note 3(j) 'Financial Instruments' and note 27 'Payables'.

(q) 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 29 '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(j) 'Financial instruments'.

(r) Borrowing costs

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

(s) 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 28 '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.

Note 3 Summary of significant accounting policies (continued)

(s) Provisions (continued)

(i) Annual Leave and Long Service Leave (continued)
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(t) 'Superannuation Expense'.

(iii) Deferred Salary Scheme
The provision for deferred leave relates to the Department's employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. In the fifth year they will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. The provision recognises the value of salary set aside for employees to be used in the fifth year. 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. Deferred leave is reported as a non-current provision until the fifth year.

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 15 'Other expenses' and note 28 'Provisions'.

(t) Superannuation expense

The following elements are included in calculating the superannuation expense in the Income Statement:

(i) Defined benefit plans - For 2007-08, the 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 were 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 - For 2007-08, 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(s)(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 18 'Income from State Government'. Commencing in 2008-09, the reporting of annual movements in these notional liabilities has been discontinued and is no longer recognised in the Income Statement.

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.

Note 3 Summary of significant accounting policies (continued)

(u) 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.

(v) 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 2008 that impacted on the Department:

Review of AAS 27 'Financial Reporting by Local Governments', AAS 29 'Financial Reporting by Government Departments and AAS 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';

AASB 1050 'Administered Items';

AASB 1052 'Disaggregated Disclosures';

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];

Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'.

The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and revised topic-based Standards and Interpretation. These requirements remain substantively unchanged. The new and revised Standards and Interpretation make some modifications to disclosures and provide additional guidance, otherwise there is no financial impact.

Note 6 Disclosure of changes in accounting policy and estimates (continued)

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	
1048	'Interpretation and Application of Standards' (issued September 2008)
1049	'Whole of Government and General Government Sector Financial Reporting' (revised - October 2007)
1051	'Land Under Roads'
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]' – paragraphs 1- 8
2008-10	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets [AASB 7 & AASB 139]'
2008-12	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets – Effective Date and Transition [AASB 7, AASB 139 & AASB 2008-10]'
2009-3	'Amendments to Australian Accounting Standards – Embedded Derivatives [AASB 139 & Interpretation 9]'
Interpretation 4	'Determining whether an Arrangement contains a Lease' (revised – February 2007)
Interpretation 12	'Service Concession Arrangements'
Interpretation 13	'Customer Loyalty Programmes'
Interpretation 14	AASB 119 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'
Interpretation 129	'Service Concession Arrangements: Disclosures'

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 early 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:

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
AASB 2008-13 'Amendments to Australian Accounting Standards arising from AASB Interpretation 17 – Distributions of Non-cash Assets to Owners [AASB 5 & AASB 110]. This Standard amends AASB 5 'Non-current Assets Held for Sale and Discontinued Operations' in respect of the classification, presentation and measurement of non-current assets held for distribution to owners in their capacity as owners. This may impact on the presentation and classification of Crown land held by the Department where the Crown land is to be sold by the Department for Planning and Infrastructure. The Department does not expect any financial impact when the Standard is first applied prospectively.	1 July 2009
AASB 2009-2 'Amendments to Australian Accounting Standards – Improving Disclosures about Financial Instruments [AASB 4, AASB 7, AASB 1023 & AASB 1038]'. This Standard amends AASB 7 and will require enhanced disclosures about fair value measurements and liquidity risk with respect to financial instruments. The Department does not expect any financial impact when the Standard is first applied.	1 January 2009

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 assets and liabilities' and note 46 'Administered income and expenses'.

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, non-specialised mental health and obstetric care.

Specialised Mental Health Services
Specialised mental health services are defined as those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder, and relate to the component of specialised mental health services that provide admitted patient care in authorised hospitals and specialist mental health inpatient units located within general hospitals.

Home-Based Hospital Programs
Home-based hospital programs describe care services that are provided under the numerous home-based care programs implemented by WA Health. They provide short-term acute services in the patient's home for conditions that traditionally required hospital admission and inpatient treatment. Home-based hospital care is based on daily home visits by nurses, with medical governance usually by a hospital-based doctor. Patients who may receive these 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. Programs include 'Hospital in the Home' (HITH), 'Rehabilitation in the Home' (RITH) and 'Mental Health in the Home' (MITH), and are provided by Area Health Services and contracted non-government providers.

Palliative Care
Palliative care services describe inpatient and home-based multidisciplinary care and support for terminally ill people and their families and carers provided by contracted non-government providers. Education and advisory services are also available to assist professionals, particularly those in rural areas.

Emergency Department Services
Emergency department services are provided across the metropolitan areas and describe care 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 to hospital or in treatment without admission. Not all metropolitan public hospitals have an emergency department and rural emergency services are included under the Non-Admitted services.

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 rural country hospitals.

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

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

Dental Health 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 Westem Australia to holders of a Health Care Card. Services are provided through govemment funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

Note 7 Services of the Department (continued)

Aged and Continuing Care
Aged and continuing care services include:
• the Home and Community Care (HACC) program providing services such as domestic assistance, social support, nursing care, respite care, food services and home maintenance that aims to support people who live at home and whose capacity for independent living is at risk of premature admission to long-term residential care;

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

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

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.

Community Mental Health
Community mental health comprises a range of community-based services for people with mental health disorders. These services include emergency assessment and treatment, case management and day programs provided in a clinic or the home. Services are provided by government agencies and non-government organisations.

Residential Care
Residential care services are provided for people assessed as no longer being able to live at home. Services include nursing home care provided by the State, nursing home type care provided in public hospitals and hostel care.

Residential Mental Health Care
Residential mental health care describes the services contracted from non-government organisations which provide 'home type' or nursing home or hostel residential care to people with a long-term mental health condition.

Chronic Illness Support
Chronic illness support services provide people with a chronic condition with treatment and preventive care to enable them to remain healthy at home. Services include the Chronic Disease Management Program which aims to reduce unplanned/avoidable hospital admissions and presentations to emergency departments as well as reducing length of stay for patients requiring inpatient care, and non-government organisation contracts that provide community members with services and support for a range of chronic conditions and illnesses.

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.

Note 8 Employee benefits expense

	2009 $000	2008 $000
Salaries and wages [(a)]	65,688	58,834
Superannuation - defined contribution plans [(b)]	6,545	5,488
Superannuation - defined benefit plans [(c)(d)]	-	132
Annual leave [(e)]	7,736	5,421
Long service leave [(e)]	2,501	1,569
	82,470	71,444

(a) Fringe benefit to the employee plus the fringe benefits tax component are included at note 15 '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 18 'Income from State Government'). Commencing in 2008-09, the reporting of notional superannuation expense and equivalent notional income has been discontinued.
(e) Includes a superannuation contribution component.

Employment on-costs are included at note 15 'Other expenses'. The employment on-costs liability is included in at note 28 'Provisions'.

		2009 $000	2008 $000
Note 9	**Contracts for services**		
	Public patients in private services	190,576	171,203
	Home and community care	167,830	155,099
	Patient transport service	78,618	53,965
	Other aged care services	44,903	42,968
	Mental health	47,540	40,367
	Blood and organs	27,576	26,131
	Aboriginal health	19,465	19,030
	Other contracts	87,831	89,025
		664,340	597,788
Note 10	**Supplies and services**		
	Medical supplies	51,033	64,575
	Other consumables	2,210	4,427
	Operating lease rentals	11,018	5,674
	Other	23	6
		64,284	74,682
Note 11	**Grants and subsidies**		
	Recurrent		
	Research and development grants	13,590	9,587
	Spectacle subsidy scheme	2,687	2,472
	Other	4,283	6,904
		20,560	18,963
Note 12	**Depreciation expense**		
	Buildings	924	798
	Leased buildings	2,249	2,455
	Computer equipment	192	247
	Plant and equipment	305	358
	Furniture and fittings	3	3
		3,673	3,861
Note 13	**Finance costs**		
	Finance lease finance charges	7,339	7,354
	Interest on Treasury loans	305	286
		7,644	7,640
Note 14	**Net gain / (loss) on disposal of non-current assets**		
	Costs of disposal of non-current assets		
	- Plant and equipment	(11)	(145)
	See also note 3(h) 'Non-current assets classified as held for sale' and Note 25 'Property, plant and equipment'.		
Note 15	**Other expenses**		
	Promotional expenses	564	1,037
	Advertising	2,867	825
	Communication	1,879	1,503
	Computer related expenses	1,629	1,289
	Travel related expenses	1,942	1,617
	Legal expenses	927	900
	Employment on-costs [(a)]	3,825	4,093
	Scholarships	1,845	1,264
	Insurance	-	167
	Doubtful debts expense	73	12
	Repairs and maintenance	4,008	1,137
	Other	4,207	3,396
		23,766	17,240

(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 28 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

		2009 $000	2008 $000
Note 16	**Contribution to Hospital Fund**	70,000	103,930
	$70.0m ($103.9m in 2008) was paid as a contribution to Hospital Fund, an administered trust account of the Department, to fund expenditure in the Health Services.		
Note 17	**Commonwealth grants and contributions**		
	Cash grants	171,551	165,220
Note 18	**Income from State Government**		
	(a) Service appropriations [(a)]		
	Amount appropriated to deliver services	754,566	665,791
	Amount authorised by other statutes		
	- Salaries and Allowances Act 1975	632	613
		755,198	666,404
	(b) Liabilities assumed by the Treasurer		
	The following liabilities have been assumed by the Treasurer during the financial year:		
	- Superannuation [(b)]	-	132
	(c) Assets assumed/(transferred)		
	The following assets have been assumed from/(transferred to) other state government agencies during the financial year: [(c)]		
	- Transfer of land to Metropolitan Health Services for the Fiona Stanley Hospital	(16,200)	-
	- Transfer of remote clinics to WA Country Health Service	(7,068)	-
	- Transfer of computer equipment to Metropolitan Health Services	(6,155)	-
	- Transfer of works in progress from Metropolitan Health Services	9,069	-
	- Transfer of equipment	-	2
		(20,354)	2
	(d) Resources received free of charge [(d)]		
	Determined on the basis of the following estimates provided by agencies:		
	Department of Education & Training - accommodation	1,508	1,456
	Landgate (valuation services) - valuation, aerial photography and maps	1,993	36
	State Solicitor's Office - legal service	598	446
		4,099	1,938
	(e) Royalties for Regions Fund [(e)]		
	- Regional Community Services Account	5,674	-

(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) In 2007-2008, the assumption of the superannuation liability by the Treasurer was a notional income to match the notional superannuation expense reported in respect of current employees who were members of the Pension Scheme and current employees who had a transfer benefit entitlement under the Gold State Superannuation scheme. (The notional superannuation expense is disclosed at note 8 'Employee benefits expense'). Commencing in 2008-09, the reporting of the notional superannuation expense and equivalent notional income has been discontinued.

(c) Discretionary transfers of assets between State Government agencies are reported as assets assumed/(transferred) under Income from State Government. Non-discretionary non-reciprocal transfers of net assets, other than those resulting from a restructure of administrative arrangements, have been classified as Contributions by Owners (CBOs) under Treasurer's Instruction 955 and are taken directly to equity.

(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 measured and which would have been purchased if they were not donated, and those fair values shall be recognised as assets or expenses, as applicable. Where the contribution of assets or services are in the nature of contributions by owners, the Department makes an adjustment direct to equity.

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

		2009 $000	2008 $000
Note 19	**Cash and cash equivalents**		
	Operating bank account	9,248	-
	Cash on hand	48	5
		9,296	5
Note 20	**Restricted cash and cash equivalents**		
	Current		
	Commonwealth Trust Accounts [(a)]	8,971	12,544
	Non-Current		
	Accrued Salaries Suspense Account [(b)]	935	670
		9,906	13,214

(a) Cash held in the account is to be used only for the specific purposes stipulated by Commonwealth Government for public health outcome funding agreement (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, clinical handover program, bring nurses back program and health networks branch.

(b) 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 21	**Inventories**		
	Current		
	Engineering supplies (at cost)	179	160
	Drug supplies (at cost)	20,265	7,042
		20,444	7,202

See also note 3(n) 'Inventories'.

Note 22	**Receivables**		
	Current		
	Receivables	8,116	2,315
	Less: Allowance for impairment of receivables	(46)	(11)
	Accrued Revenue	511	402
		8,581	2,706
	Reconciliation of changes in the allowance for impairment of receivables:		
	Balance at start of year	11	10
	Doubtful debts expense recognised in the income statement	73	12
	Amounts written off during the year	(38)	(11)
	Balance at end of year	46	11

See also note 3(o) 'Receivables' and note 47 'Financial instruments'.

Note 23	**Amounts receivable for services**		
	Current	-	-
	Non-current	47,421	41,391
		47,421	41,391
	Balance at start of the year	41,391	35,505
	Credit to holding account	6,030	5,886
	Balance at end of the year	47,421	41,391

Represents the non-cash component of service appropriations (see note 3(m) 'Amounts receivable for services (holding account)'. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 24	**Other current assets**		
	Prepayments	3	154

		2009 $000	2008 $000
Note 25	**Property, plant and equipment**		
	Land		
	At fair value	42,656	58,998
	Buildings		
	At fair value	61,463	28,654
	Accumulated depreciation	-	(734)
		61,463	27,920
	Leased buildings		
	At fair value	45,899	84,910
	Accumulated depreciation	-	-
		45,899	84,910
	Computer equipment		
	At cost	3,029	3,211
	Accumulated depreciation	(2,819)	(2,834)
		210	377
	Furniture and fittings		
	At cost	57	165
	Accumulated depreciation	(30)	(34)
		27	131
	Other plant and equipment		
	At cost	3,115	2,744
	Accumulated depreciation	(1,917)	(1,648)
		1,198	1,096
	Works in progress		
	Buildings under construction (at cost)	10,153	-
	Other Work in Progress (at cost)	289	6,166
		10,442	6,166
	Total of property, plant and equipment	161,895	179,597

Land and buildings were revalued as at 1 July 2008 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2009 and recognised at 30 June 2009. In undertaking the revaluation, fair value was determined by reference to market values for land: $394,650. 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'.

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the reporting period are set out below.

Land		
Carrying amount at the start of year	58,998	45,542
Transfers from/(to) Health Services	(16,200)	-
Revaluation	(142)	13,456
Carrying amount at the end of year	42,656	58,998
Buildings		
Carrying amount at the start of year	27,920	26,600
Additions	-	49
Transfers between asset classes	38,852	-
Transfers from/(to) Health Services	(7,068)	-
Other Disposals	-	(102)
Revaluation	2,683	2,171
Depreciation	(924)	(798)
Carrying amount at the end of year	61,463	27,920
Leased buildings		
Carrying amount at the start of year	84,910	82,435
Additions	-	27
Transfers between asset classes	(38,852)	-
Revaluation	2,090	4,903
Depreciation	(2,249)	(2,455)
Carrying amount at the end of year	45,899	84,910

	2009 $000	2008 $000
Note 25 Property, plant and equipment (continued)		
Computer Equipment		
Carrying amount at the start of year	377	445
Additions	25	181
Other Disposals	-	(2)
Depreciation	(192)	(247)
Carrying amount at the end of year[(a)]	210	377
Furniture & fittings		
Carrying amount at the start of year	131	38
Additions	-	101
Transfers between asset classes	(96)	(5)
Other Disposals	(5)	-
Depreciation	(3)	(3)
Carrying amount at the end of year	27	131
Other Plant & equipment		
Carrying amount at the start of year	1,096	659
Additions	413	824
Transfers between asset classes	-	5
Transfers from/(to) Health Services	-	2
Other Disposals	(6)	(36)
Depreciation	(305)	(358)
Carrying amount at the end of year	1,198	1,096
Works in progress		
Carrying amount at the start of year	6,166	116
Additions	1,266	6,166
Transfers between asset classes	96	-
Transfers from/(to) Health Services	2,914	-
Write-down of assets	-	(116)
Carrying amount at the end of year	10,442	6,166
Total property, plant and equipment		
Carrying amount at the start of year	179,598	155,835
Additions	1,704	7,348
Transfers from/(to) Health Services	(20,354)	2
Other Disposals	(11)	(140)
Write-down of assets	-	(116)
Revaluation	4,631	20,530
Depreciation	(3,673)	(3,861)
Carrying amount at the end of year	161,895	179,598

Note 26 Impairment of Assets

There were no indications of impairment to property, plant and equipment and intangible assets at 30 June 2009.

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 2009 have either been classified as assets held for sale or written off.

Note 27 Payables

Current		
Trade payables	25,911	6,459
Accrued salaries	1,659	2,194
Accrued expenses	25,739	39,821
Interest payable	24	22
	53,333	48,496

See also note 3(p) 'Payables' and note 47 'Financial Instruments'.

		2009 $000	2008 $000
Note 28	**Provisions**		
	Current		
	Employee benefits provision		
	Annual leave[(a)]	8,691	6,925
	Long service leave[(b)]	8,737	6,292
	Deferred salary scheme	103	95
		17,531	13,312
	Non-current		
	Employee benefits provision		
	Long service leave[(b)]	2,127	3,412
	Total	19,658	16,724

(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	6,193	4,882
More than 12 months after balance sheet date	2,498	2,043
	8,691	6,925

(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	2,267	1,748
More than 12 months after balance sheet date	8,587	7,956
	10,864	9,704

(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 15 'Other expenses'.

Note 29	**Borrowings**		
	Current		
	Treasury loans	290	277
	Finance lease liabilities (secured)	2,514	42,019
	Total current	2,804	42,296
	Non-current		
	Treasury loans	3,986	4,276
	Finance lease liabilities (secured)	27,502	30,016
	Total non-current	31,488	34,292

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 25)	45,899	84,910

Note 30	**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	27,491	16,743
Contributions by owners		
Capital contributions [(a)]	48,014	10,748
Balance at end of the year	75,505	27,491

(a) Under the Treasurer's Instruction 955 'Contributions by Owners Made to Wholly Owned Public Sector Entities' Capital Contributions (appropriations) have been designated as contributions by owners in accordance with AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'.

		2009 $000	2008 $000
Note 30	**Equity (continued)**		
	Reserves		
	Asset revaluation reserve		
	Balance at the start of the year	239,583	219,053
	Net revaluation increments/(decrements)		
	- Land	(142)	13,456
	- Buildings	4,773	7,074
	Balance at the end of the year	244,214	239,583
	Accumulated deficiency		
	Balance at the start of the year	(164,612)	(114,832)
	Result for the period	(4,844)	(49,780)
	Balance at the end of the year	(169,456)	(164,612)
Note 31	**Notes to the Cash Flow Statement**		
	(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 (see note 19)	9,296	5
	Restricted cash and cash equivalents (see note 20)	9,906	13,214
		19,202	13,219
	(b) Reconciliation of net cost of services to net cash flows used in operating activities		
	Net cost of services (Income Statement)	(749,461)	(718,256)
	Non-cash items:		
	Depreciation expense	3,673	3,861
	Doubtful debts expense	73	11
	Superannuation liability assumed by Treasurer	-	132
	Resources received free of charge	4,099	1,938
	Gain/(loss) of disposal of non current assets	11	145
	Write-down of assets	-	116
	Other	2	(8)
	(Increase)/decrease in assets:		
	Inventories	(13,243)	(902)
	Receivables	(5,948)	3
	Other assets	151	8
	Increase/(decrease) in liabilities:		
	Payables	4,837	28,890
	Provisions	2,934	949
	Net cash used in operating activities	(752,872)	(683,112)
	At the balance sheet date, the Department had fully drawn on all financing facilities, details of which are disclosed in the financial statements.		
Note 32	**Resources provided free of charge**		
	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	100
	Department of Planning & Infrastructure - on site waste water disposal review	141	115
	Department of the Attorney General - meat inspection at Karnet Prison, health surveillance of correctional services	100	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	205	300
	Others	287	775
		833	1,558

	2009 $000	2008 $000
Note 33 Commitments		
(a) Finance lease commitments		
Minimum lease payment commitments in relation to finance leases are payable as follows:		
Within 1 year	5,024	67,804
Later than 1 year and not later than 5 years	20,095	20,095
Later than 5 years	17,763	22,786
Minimum finance lease payments	42,882	110,686
Less: Future finance charges	12,866	38,650
Present value of finance lease liabilities	30,016	72,035
Included in the financial statements as:		
Current (Note 29 'Borrowings')	2,514	42,019
Non-current (Note 29 'Borrowings')	27,502	30,016
	30,016	72,035

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	10,068	7,866
Later than 1 year and not later than 5 years	7,562	8,408
	17,630	16,274

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	630,761	571,364
Later than 1 year and not later than 5 years	1,308,592	1,571,246
Later than 5 years and not later than 10 years	2,214,821	1,785,760
Later than 10 years	4,557,218	98,148
	8,711,392	4,026,518

(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	2,147	1,316
Later than 1 year and not later than 5 years	20	-
	2,167	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	1,922	3,691
Later than 1 year and not later than 5 years	2,573	3,742
	4,495	7,433

Note 34 Contingent liabilities and contingent assets	2009 $000	2008 $000
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	4	290
Number of claims	1	1

(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 35 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 36 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 2009 - Total appropriation to deliver services:

	2009 Estimate $000	2009 Actual $000	Variance $000
(a) Appropriations			
Net amount appropriated to deliver services	754,969	797,190	42,221
The variance is due to approved funding for award increases in 2008-09, additional funding for Royal Flying Doctor Service, election commitments and other priority funding.			
Contribution to Hospital Fund	3,027,043	3,171,821	144,778
The variance is due to additional funding through the Commonwealth-State Australian Health Care Agreement, increased hospital activity and funding for cost pressures in the Pilbara region, award increases in 2008-09, election commitments and other priority funding.			
Lotteries Commission Act 1990	91,381	102,000	10,619
The variance is due to additional revenue from improved lottery sales.			
(b) Total Cost of Services			
Admitted Patient	2,504,401	2,707,946	203,545
2008-09 actual reflects the additional expense level approved from additional funding for privately contracted public patient activity and the allocation of elective surgery funding.			
Specialised Mental Health	194,937	203,015	8,078
2008-09 actual reflects the additional funding to King Edward Memorial Hospital and the Bentley sub-acute unit.			

Note 36 Explanatory statement (continued)

Significant variances between estimates and actual for 2009 - Total appropriation to deliver services:

	2009 Estimate $000	2009 Actual $000	Variance $000
Home-Based Hospital Programs	18,145	40,265	22,120
During 2008-09 funding for the Friend in Need-Emergency (FINE) program was allocated to this service. In addition, expenditure for the Metropolitan Health Service 'Hospital in the Home' (HITH) program was realigned from other services to better reflect the cost of services provided.			
Palliative Care	18,250	20,566	2,316
During 2008-09 the increase in Palliative Care expenditure is due to election commitment funding to assist palliative and cancer patient services.			
Emergency Department	147,061	163,326	16,265
Actual expenditure in 2008-09 reflects the recruitment of additional staff and agreed industrial award cost increases.			
Non-Admitted Patient	643,772	679,172	35,400
Actual expenditure reflects the increased cost of providing both non-admitted patient services in public hospitals and contracted non-admitted services delivered by private providers.			
Patient Transport	72,492	100,385	27,893
Additional funding from the Royalties for Regions programme and election commitments for the Patient Assisted Transport Scheme and to the Royal Flying Doctor Service to increase capital expenditure and funding for increased patient transport services.			
Prevention, Promotion & Protection	274,736	324,244	49,508
Increased expenditure reflects the additional Commonwealth Immunisation Program funding.			
Dental Health	63,380	70,728	7,348
Actual expenditure reflects the increased expense level approved for 2008-09 to address the impact of agreed staff remuneration packages.			
Aged and Continuing Care	221,839	234,959	13,120
2008-09 actual expenditure reflects the additional funding for the Friend in Need-Emergency (FINE) program that was allocated to Metropolitan Health Service Transition Care Programs (TPC).			
Community Mental Health	188,689	175,999	(12,690)
The decrease in expenditure in 2008-09 actual reflects the new community services not being fully implemented due to the lack of available and qualified candidates to fill staffing positions.			
Residential Care	84,256	77,934	(6,322)
While the 2008-09 estimate reflects the allocation of non-government residential care facility development programs, the 2008-09 actual costs are an allocated overhead.			
Residential Mental Health Care	13,329	11,356	(1,973)
Due to delays in construction and the commencement of service provision, the full budget allocation for 2008-09 was not utilised.			
Chronic Illness Support	34,925	45,767	10,842
2008-09 actual Includes funding provided to the Quadraplegic Centre which was not included in the service estimate.			
(c) Total Income	(651,150)	(878,079)	(226,929)
Increased revenue compared to estimate was mainly due to additional Commonwealth funding, patient revenue and recoveries.			
(d) Adjustments	(10,038)	44,453	54,491
The actual Net Cost of Service is greater than the budgeted appropriation to deliver health services due to a net budget deficit and includes movement in cash balances, accrual items such as receivables, payables, $9.848 million Royalties for Regions Fund and $6.327 million notional revenue from Government.			

Note 36 Explanatory statement (continued)

	2009 Estimate $000	2009 Actual $000	Variance $000
Significant variances between estimates and actual for 2009 - Capital Contribution:			
(a) Capital Contribution	214,608	153,015	(61,593)
The change in actual expenditure compared to the original estimate reflects the timing of expenditure for the revised capital works program.			
Significant variances between estimates and actual for 2009 - Capital Expenditure:			
(a) Purchase of non-current physical assets	490,433	360,490	(129,943)
The variance from estimate for purchase of non-current physical assets reflects the timing of expenditure for the revised capital works program.			
(b) Adjustments for other funding sources	(329,442)	(259,351)	70,091
Variance in adjustments, which include funding for capital works administered by the Department of Treasury and Finance, funding for Fiona Stanley Hospital, Commonwealth grants and movements in cash balances and other accrual items such as receivables and payables, reflects Health's revised capital works program.			

	2009 Actual $000	2008 Actual $000	Variance $000
Significant variances between actual for 2008 and 2009 - Total appropriation to deliver services:			
(a) Appropriations			
Net amount appropriated to deliver services	797,190	703,948	93,242
Increased health and reform activities, increased funding for industrial award increases in 2008-09, election commitments 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	3,171,821	2,804,682	367,139
Variance is attributed to additional funding through the Commonwealth-State Australian Health Care Agreement, increased hospital activity and funding for cost pressures in the Pilbara region, increased health and reform activities, election commitments and other priority funding, industrial award increases in 2008-09, as well as additional cost pressures in delivering health reforms and initiatives.			
Lotteries Commission Act 1990	102,000	95,228	6,772
Higher revenue reflects more revenue from improved lottery sales compared to the previous financial year.			
(b) Total Cost of Services			
Admitted Patient	2,707,946	2,385,770	322,176
2008-09 reflects the additional expense level approved from additional funding for privately contracted public patient activity and the allocation of elective surgery funding.			
Specialised Mental Health	203,015	177,016	25,999
Increased expenditure between 2007-08 and 2008-09 reflects additional funding to King Edward Memorial Hospital and the Bentley sub-acute unit.			
Home-Based Hospital Programs	40,265	26,221	14,044
During 2008-09 funding for the Friend in Need-Emergency (FINE) program was allocated to this service. In addition, expenditure for the Metropolitan Health Service 'Hospital in the Home' (HITH) program was realigned from other services to better reflect the cost of services provided.			
Emergency Department	163,326	144,111	19,215
The 2008-09 expenditure increase compared to 2007-08 reflects additional staff recruitment and agreed industrial award cost increases in 2008-09.			

Note 36 Explanatory statement (continued)

	2009 Actual $000	2008 Actual $000	Variance $000
Significant variances between actual for 2008 and 2009 - Total appropriation to deliver services:			
Non-admitted Patient	679,172	610,838	68,334
Increased 2008-09 expenditure compared to 2007-08 reflects the increased costs of providing both non-admitted patient services in public hospitals and contracted non-admitted services delivered by private providers.			
Patient Transport	100,385	71,497	28,888
Additional funding from the Royalties for Regions programme and election commitments for the Patient Assisted Transport Scheme and to the Royal Flying Doctor Service to increase capital expenditure and funding for increased patient transport services.			
Dental Health	70,728	63,999	6,729
Actual expenditure reflects the expense level approved for 2008-09 to address the impact of agreed staff remuneration packages.			
Aged and Continuing Care	234,959	202,813	32,146
Increased expenditure in 2008-09 reflects approved additional spend'ng for Home and Community Care (HACC) services.			
Community Mental Health	175,999	160,902	15,097
2008-09 actual reflects the expense level approved to fund additional community mental health programs.			
Residential Mental Health Care	11,356	8,301	3,055
Increased expenditure in 2008-09 compared to 2007-08 reflects the funding support for new and additional residential services in 2008-09.			
(c) Total Income	(878,079)	(726,667)	(151,412)
Increased revenue compared to 2007-08 was mainly due to additional Commonwealth revenue, patient revenue and recoveries from use of facilities.			
(d) Adjustments	44,453	(38,608)	83,061
Compared to 2007-08, the Net Cost of Service is greater than appropriation provided to deliver services and cash movement to fund operational activities.			
Significant variances between actual for 2008 and 2009 - Capital Contribution:			
(a) Capital Contribution	153,015	157,730	(4,715)
The variance compared to 2007-08 is consistent with approved revisions to the Health capital works program.			
Significant variances between actual for 2008 and 2009 - Capital Expenditure:			
(a) Purchase of non-current physical assets	360,490	232,145	128,345
The increase in the purchase of non-current physical assets compared to 2007-08 is consistent with approved revisions to the Health capital works program.			
(b) Adjustments for other funding sources	(259,351)	(88,034)	(171,317)
The variance reflects the change in capital contribution in 2008-09 compared to 2007-08 along with the capital works expenditure between the two years.			

Note 37 Remuneration of senior officers

The number of senior officers, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

	2009	2008
$30,001 - $40,000	1	-
$50,001 - $60,000	1	-
$90,001 - $100,000	1	-
$120,001 - $130,000	-	1
$140,001 - $150,000	1	-
$150,001 - $160,000	1	
$170,001 - $180,000	-	1
$210,001 - $220,000	-	2
$230,001 - $240,000	1	-
$330,001 - $340,000	1	-
$390,001 - $400,000	-	1
$410,001 - $420,000	1	-
$480,001 - $490,000	1	-
$490,001 - $500,000	-	1
$500,001 - $510,000	-	1
$610,001 - $620,000	1	-
	10	7

	$000	$000
The total remuneration of senior officers is:	2,582	2,126

The $610,000 - $620,000 remuneration band (2009) includes a $55,000 backpayment, of which $33,000 relates to the prior year.

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 38 Remuneration of auditor

Remuneration payable to the Auditor General in respect of the audit for the current financial year is as follows:

Auditing the accounts, financial statements and performance indicators	300	290

This expense is included at Note 15 'Other expenses'.

Note 39 Supplementary financial information

During the financial year the Department has written off debts and inventory under the authority of:

The Accountable Officer	36	71
The Minister for Health	186	-
	222	71

Note 40 Related bodies

A related body is a body which receive more than half its funding and resources from the Department and is subject to operational control by the Department.

The Department had no related bodies during the financial year.

Note 41 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	11,401	9,145
Public health	6,098	6,516
Mental health	39	32
	17,538	15,693

	2009 $000	2008 $000
Note 42 Other statement of receipts and payments		
Commonwealth Grant - Christmas and Cocos Island		
Balance at the start of the year	23	-
Receipts		
Commonwealth grant	522	1,304
Payments		
Retainer fee	30	30
Purchase of WA Health Services	515	1,251
	545	1,281
Balance at the end of the year	-	23

Note 43 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.

Balance at the start of the year	26,506	15,309
Receipts	471,148	337,491
Payments	351,085	326,294
Balance at the end of the year	146,569	26,506

Note 44 Private Trust Account

Peel Health Campus Service Agreement Trust Fund

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

The purpose of the trust fund is to hold in trust, moneys received from the 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.

Balance at the start of the year	610	572
Receipts	40	38
Balance at the end of the year	650	610

Note 45 Administered assets and liabilities

Current Assets		
Cash assets	139,085	54,458
Receivables	85	259
Total administered current assets	139,170	54,717
Current Liabilities		
Payables	1	1,712
Total administered current liabilities	1	1,712

Health services are statutory authorities in their own right. Accordingly, the Department only administers funds appropriated to health services.

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2009

Note 46 Disclosure of Administered Income and Expenses

	Admitted Patients Services		Specialised Mental Health		Home-Based Hospital Programs		Palliative Care		Emergency Department		Non-Admitted Patients		Patient Transport		Prevention, Promotion & Protection	
	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008
	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
COST OF SERVICES																
Expenses																
Appropriations transferred to:																
Metropolitan Health *Services*	1,917,625	1,640,249	170,703	153,259	28,636	18,803	-	-	155,489	138,010	417,457	382,322	1,684	-	94,916	89,972
WA Country Health *Services*	441,638	378,291	13,585	12,215	-	-	1,873	1,451	3,324	2,277	174,567	158,802	18,930	16,482	65,913	65,367
WA Alcohol and Drug Authority	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Quadriplegic Centre	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
QEII Medical Centre Trust	394	391	38	38	6	5	-	-	33	33	90	94	-	-	22	22
Total administered expenses	2,359,657	2,018,931	184,326	165,512	28,642	18,808	1,873	1,451	158,846	140,320	592,114	541,218	20,614	16,482	160,851	155,361
Income																
Service Appropriations from Government for transfer	1,967,378	1,701,112	183,506	154,668	28,470	17,366	687	-	70,281	124,282	559,798	488,267	12,597	13,227	141,255	128,740
Capital Contributions from Government for transfer	259,342	168,064	3,977	6,965	510	517	53	42	14,623	12,417	33,066	32,701	2,226	988	6,063	6,608
Royalties for Regions Fund - Recurrent	-	-	-	-	-	-	-	-	-	-	-	-	4,174	-	-	-
Royalties for Regions Fund - Capital	2,004	-	-	-	-	-	-	-	-	-	896	-	-	-	-	-
Commonwealth grants and contributions	166,750	113,551	-	-	-	-	1,200	1,767	76,485	1,398	7,793	9,175	2,299	2,435	10,223	10,102
Contribution to Hospital Fund from Department of Healt	42,000	62,357	3,500	5,197	700	1,039	-	-	2,800	4,157	11,200	16,629	-	-	3,500	5,197
Other revenue	-	-	-		-		-	-	-		-	-	-	-	5,528	5,961
Total administered income	2,437,474	2,045,084	190,983	166,830	29,680	18,922	1,940	1,809	164,189	142,254	612,753	546,772	21,296	16,650	166,569	156,608

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2009

Note 46 Disclosure of Administered Income and Expenses

	Dental Health		Aged & Continuing Care		Community Mental Health		Residential Care		Chronic Illness Support		Drug & Alcohol Abuse		TOTAL	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
Expenses														
Appropriations transferred to:														
Metropolitan Health Services	55,070	50,794	30,595	27,141	118,869	126,319	160	209	6,719	6,570	-	-	2,997,923	2,633,648
WA Country Health Services	23	1,823	18,314	16,685	34,322	33,066	70,772	66,001	-	-	-	-	843,261	752,460
WA Alcohol and Drug Authority	-	-	-	-	-	-	-	-	-	-	47,838	45,203	47,838	45,203
Quadriplegic Centre	-	-	7,510	6,850	-	-	-	-	-	-	-	-	7,510	6,850
QEII Medical Centre Trust	12	12	7	7	26	27	-	-	1	2	-	-	629	631
Total administered expenses	55,105	52,629	56,426	50,683	153,217	159,412	70,932	66,210	6,720	6,572	47,838	45,203	3,897,161	3,438,792
Income														
Service Appropriations from Government for transfer	52,232	46,922	32,567	25,390	150,817	133,365	69,760	61,857	5,115	5,069	42,623	38,157	3,317,086	2,938,422
Capital Contributions from Government for transfer	2,153	4,311	1,194	1,323	4,974	24,813	2,305	2,211	102	139	-	-	330,588	261,099
Royalties for Regions Fund - Recurrent	-	-	-	-	-	-	-	-	-	-	-	-	4,174	-
	-	-	-	-	-	-	-	-	-	-	-	-	2,900	-
Commonwealth grants and contributions	1,276	-	24,004	23,233	102	618	-	518	1,749	1,398	7,114	8,031	298,995	172,226
Contribution to Hospital Fund from Department of Health	1,400	2,079	700	1,039	2,800	4,157	1,400	2,079	-	-	-	-	70,000	103,930
Other revenue	-	-	-	-	-	-	-	-	-	-	428	304	5,956	6,265
Total administered income	57,061	53,312	58,465	50,985	158,693	162,953	73,465	66,665	6,966	6,606	50,165	46,492	4,029,699	3,481,942

Department of Health

Notes to the Financial Statements

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Note 47 Financial instruments

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

Financial instruments held by the Department are cash and cash equivalents, restricted cash and cash equivalents, finance leases, 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 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 47(c) 'Financial Instruments Disclosure' and Note 22 'Receivables'.

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

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

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

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

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Department's income or the value of its holdings of financial instruments. The Department does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). Other than as detailed in the Interest rate sensitivity analysis table at Note 47(c), the Department is not exposed to interest rate risk because all cash and cash equivalents and restricted cash are non-interest bearing, and have no borrowings other than the Treasury loans and finance leases (fixed interest rate).

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

	2009 $000	2008 $000
Financial Assets		
Cash and cash equivalents	9,296	5
Restricted cash and cash equivalents	9,906	13,214
Loans and receivables	56,002	44,097
Financial Liabilities		
Financial liabilities measured at amortised cost	87,625	125,084

c) **Financial Instrument disclosures**

Credit Risk and Interest Rate Risk Exposures

The following tables disclose the Department's maximum exposure to credit risk, interest rate exposures and the ageing analysis of financial assets. The Department's maximum exposure to credit risk at the balance sheet date is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Department.

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

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.

Interest rate exposures and ageing analysis of financial assets

			Interest rate exposure		Past due but not impaired						
	Weighted average effective interest rate	Carrying amount	Variable interest rate	Non-interest bearing	Up to 3 months	3-12 months	1-2 years	2-3 years	3-4 years	4-5 years	Impaired financial assets
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets											
2009											
Cash and cash equivalents	-	9,296		9,296							
Restricted cash and cash equivalents	-	9,906		9,906							
Receivables	-	8,581		8,581	2,352	132	6	-	-	-	46
Amounts receivable for services	-	47,421		47,421							
		75,203	-	75,203	2,352	132	6	-	-	-	46
2008											
Cash and cash equivalents	-	5		5							
Restricted cash and cash equivalents	-	13,214		13,214							
Receivables	-	2,706		2,706	637	180	36				11
Amounts receivable for services	-	41,391		41,391							
		57,316	-	57,316	637	180	36	-	-	-	11

Department of Health

Notes to the Financial Statements

For the year ended 30 June 2009

c) **Financial Instrument disclosures (continued)**

Liquidity Risk

The following table details the contractual maturity analysis for financial liabilities. The contractual maturity amounts are representative of the undiscounted amounts at the balance sheet date. The table includes both interest and principal cash flows. An adjustment has been made where material.

Interest rate exposures and maturity analysis of financial liabilities

			Interest rate exposure		Maturity dates						
	Weighted average effective interest rate	Carrying amount	Variable interest rate	Non-interest bearing	Up to 3 months	3-12 months	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Liabilities											
2009											
Payables		53,333		53,333							
Borrowings											
- W A Treasury loans	6.9%	4,276			73	218	303	318	332	347	2,685
- Finance lease liabilities	9.2%	30,015			-	2,514	2,733	2,971	3,230	3,512	15,055
		87,625	-	53,333	73	2,732	3,036	3,289	3,562	3,859	17,740
2008											
Payables		48,496		48,496							
Borrowings											
- W A Treasury loans	6.4%	4,554			69	208	290	304	318	332	3,033
- Finance lease liabilities	9.6%	72,034			40,285	1,734	2,514	2,733	2,971	3,230	18,567
		125,084	-	48,496	40,354	1,942	2,804	3,037	3,289	3,562	21,600

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	
2009	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Liabilities					
Borrowings					
- W A Treasury loans	4,276	43	43	(43)	(43)
- Finance lease liabilities	30,015	300	300	(300)	(300)

		-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)

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.

Appendices

Appendix 1: Abbreviations

ABHI	Australian Better Health Initiative
ACAiN	Acute Care Assistants in Nursing
AMCHAG	Aboriginal Maternal and Child Health Advisory Group
AMCHAP	Aboriginal Maternal and Child Health Action Plan
CAHS	Child and Adolescent Health Service
CanIS	Cancer Information System
CanIS^{+}	Clinical Cancer Data System
CPI	Clinical Practice Improvement
CPI	Consumer Price Index
COAG	Council of Australian Governments
CRROH	The Centre for Rural and Remote Oral Health
CPOE	Clinical Pathology Order Entry
DAIP	Disability Access and Inclusion Plan
DG	Director General of Health
DOH	Department of Health
DOHA	Department of Health and Ageing
DPMU	Disaster Preparedness and Management Unit
DET	Department of Education and Training
ED	Emergency Department
EDRMS	Electronic Document Record Management System
FHWA	Familial Hypercholesterolaemia of Western Australia
FINE	Friend in Need - Emergency
FLIP	Falls Linkage Independence Program
FMA	*Financial Management Act 2006*
GBS	Government Budget Statements
GP	General Practitioner
HACC	Home and Community Care
HATHA	Hospital at the home
HCC	Health Consumers' Council of Western Australia
HCN	Health Corporate Network
HRIT	Health Reform Implementation Taskforce
ICCWA	Insurance Commission of Western Australia
ICT	Information Communications Technology
IPPWG	Inter-jurisdictional Pandemic Planning Working Group

KPI	Key Performance Indicators
KEMH	King Edward Memorial Hospital
NMAHS	North Metropolitan Area Health Service
OAH	Office of Aboriginal Health
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
PAC	Post acute care
PHD	Public Health Division
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
RAP	Reconciliation Action Plan
RFDSWO	Royal Flying Doctor Service Western Operations
RPH	Royal Perth Hospital
RTC	Reproductive Technology Council
SAP	Sustainability Action Plan
SCGH	Sir Charles Gairdner Hospital
SOYFWA	Stay on your feet Western Australia
SQuIRe	Safety and Quality Investment in Reform
STI	Sexually Transmitted Infection
StJAA	St John Ambulance Australia
TCP	Transition care Programs
TI	Treasurer's Instruction
WACHS	WA Country Health Service
WACR	Western Australian Council Registry
WLB	Work Life Balance
VLAD	Variable Life Adjusted Display