Delivering a **Healthy WA**

WA Country Health Service Annual Report 2005-06

Department of Health

Healthy Workforce • Healthy Hospitals • Healthy Partnerships • Healthy Communities • Healthy Resources • Healthy Leadership

Statement of Compliance

To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985,* I hereby submit for your information and presentation to Parliament, the Report of the WA Country Health Service for the year ended 30 June 2006.

This report has been prepared in accordance with the provisions of the *Financial Administration and Audit Act 1985.*

Dr Neale Fong
Director General of Health
Accountable Authority

20 September 2006

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Winston Churchill once said: "There is nothing wrong with change, if it is in the right direction". It is a statement I often relate to as we bring our State's public health system closer to its biggest and most daring reform process ever. Each day is marked by some kind of change and yet, I can emphatically say it is not change for change's sake — but change that progressively steers us in the right direction for a better and healthier future for all West Australians.

Under the stewardship of Chief Executive Officer Christine O'Farrell, the WA Country Health Service (WACHS) successfully achieved its fourth year of operation at the conclusion of 2005-06. The organisation has undoubtedly undergone one of the most significant shifts of the financial year with the announced integration of the South West Area Health Service (SWAHS) into WACHS in December 2005, which effectively created a single, unified country health system for WA. This move has further strengthened the state's vision for a more efficient, integrated and accountable health system through our 10 to 15 year major reform agenda.

Although the WACHS-SWAHS merger was only officially gazetted on 1 July 2006, the inevitable task of organisational change and reconfiguration began immediately, triggering a systemic turning point for rural and regional WA. The transformation of WACHS into one Area Health Service for all of our country consumers will undoubtedly take some years to complete, but it is with great admiration that I say the WACHS (and SWAHS) workforce has exceeded expectations in meeting the challenges this important change has raised.

In addition to the merger, significant progress has also been made in cultivating the potentially groundbreaking vision for country health services established by the *Country Health Services Review* of January 2003. Some powerful and courageous observations of the country health system were made in that the Review called for many key issues to be urgently addressed. These included service erosion, loss of skill and critical mass, workforce shortages, poor coordination and lack of direction.

In response, five of the key Reid Report recommendations directly related to country health services, including Recommendation 19, which fully endorsed the vision set by the *Country Health Services Review*. The other four recommendations were:

- For multipurpose services and integrated district health services to continue being developed in collaboration with local service providers and the Australian Government to provide more comprehensive, accessible and sustainable health services to small rural communities (Recommendation 20)
- Endorsement of the proposal to develop regional hospitals into Regional Resource Centres in Geraldton, Broome, Port Hedland, Kalgoorlie, Bunbury and Albany which would provide more locally-based, accessible hospital care, where clinically appropriate (Recommendation 21)
- To continue exploring opportunities for Telehealth to be a component of the integrated care system, with further development relying on clinical leadership and availability of appropriate bandwidth and other infrastructure (Recommendation 22)
- For formal links to be clearly described between country and metropolitan area health services, to ensure regional patients have timely access to tertiary health care and up-to-date professional expertise. (Recommendation 66).

Director General's Overview

I am delighted to say all five recommendations have either been fully met or well established as ongoing priorities.

The state's major health reform agenda continues to provide the overarching objectives for the WA health system, with our shared mission clearly being to achieve a healthier WA with and for all our consumers and stakeholders. How we achieve that is equally clear — through a consistent and structured approach to all our planning and implementation activities across the organisation around six critical and highly strategic directions: *Healthy* Hospitals, *Healthy* Workforce, *Healthy* Resources, *Healthy* Communities, *Healthy* Partnerships and *Healthy* Leadership.

With the benefit of two years of continual reform, we can confidently look back and see how these key directions are guiding positive change for the WA health system — as well as for many of our strategic partners. In country WA, these have translated into many key projects and initiatives being driven across the WACHS, which are proudly outlined in this annual report.

For example, we have seen significant capital growth in our state's northern-based hospitals and health services, including improvements to hospital services in two of our most critical areas — Halls Creek and Kununurra. Further inland, Quairading Hospital has built a new accident and emergency department (thanks also to a very generous private contribution of around $1 million), construction of the new Moora Hospital has begun and Northam Hospital now has an Outreach Palliative Care Service. On the Midwest coast, the opening of the new Geraldton Health Campus in May was a major highlight while in the south west, Margaret River began upgrading of its facilities and plans for a new $65 million Busselton Hospital redevelopment were announced. Other major capital redevelopments in regional resource centres include Kalgoorlie ($40m), Albany ($26.8m) and Port Hedland ($90m).

Country resources have also been boosted with the acquisition and/or installation of new equipment including:

- new 16-slice Computed Tomography (CT) scanners for Broome, Port Hedland, Northam and Albany
- new ultrasound machines in 10 locations
- thirteen new mobile x-ray machines plus seven general x-ray machines
- new C-arm fluoroscopy units for Nickol Bay and Geraldton
- all radiographer sites fitted with teleradiology capabilities.

During 2005-06 workforce initiatives focusing on building capacity and skill capabilities have also been successful. Allied health has been paid particular attention, with many new occupational and speech therapists, and physiotherapists recruited throughout the WACHS, unique training opportunities such as distance learning being accentuated, and positive strides being made through the innovative *Ocean to Outback* Nurse Graduate Program which offers invaluable insight and hands-on experience for nurse graduates who want to receive training in rural and remote WA.

Child and community health in country WA has also been a focus, with the addition of new staff including Aboriginal Health Workers, child health nurses and health promotion staff that can contribute to early intervention, prevention and primary medical care needs.

A specific workforce highlight has been the successful outcome of major recruitment drives overseas, interstate and in New Zealand, resulting in most medical imaging positions finally being filled in regional WA after years of vacancies.

Initiatives that support healthy communities and greater consumer awareness have included proactive efforts to promote and link in with the very positive *Mentally Healthy* "Act—Belong—Commit" campaign in Albany, Esperance, Geraldton, Kalgoorlie, Karratha and Northam, and an emphasis on collaborative research (e.g. Curtin University's Centre for Behavioural Research in Cancer Control, Wheatbelt Anti-Obesity Campaign, and the Childhood Development Working Party). Projects such as the six-week *Step It Out* program in Derby, which attracted more than

Director General's Overview

300 community participants, have also been very successful this year.

There is no doubt that healthy partnerships are of major value in protecting community health and wellbeing, especially in rural and remote regions where resources and support are widely varying and often scarce. A unique example of this has been in the Kimberley this year, with WACHS and the Australian Customs Service working together to improve the processing of illegal fishers. With funding provided by Customs, the Broome Health Service was able to expand its radiography and clinical service to be better equipped for the growing need for health screening.

Another example was a $1.5 million collaboration with the Australian Government Office of Aboriginal and Torres Strait Islander Health (OATSIH) to improve primary health care services for Aboriginal people living in the Wheatbelt.

Deliberate efforts to further engage general practitioners have also paved the way for mutually beneficial gains across the State, and the growing network of District Health Advisory Councils (DHAC) — which represent country communities throughout Western Australia — gathered momentum with several new advisory groups being established and a particularly constructive and consultative DHAC Annual Conference being held in Perth.

Throughout 2005-06, WACHS has continued to show healthy leadership through its efforts and determination to continuously assess and improve its organisational structure, performance and goals. Two particular examples that have added considerable weight to the reform progress of the WACHS have been:

- an extraordinary one-day Clinical Senate meeting on 31 March 2006 solely dedicated to discussion and debate about existing and potential clinical (and non-clinical) networks, strategic pathways and working partnerships between metropolitan and country health services.
- commencement of the *Foundations for Country Health Services* project to develop a detailed plan in support of the Statewide Clinical Services Framework (published late 2005) and which will continue to evolve in 2006-07 to strengthen the vision, goals and strategic directions set by the *Country Health Services Review* of 2003.

Above all, this year WACHS has reinforced its commitment to a strong set of values and principles that drive the organisation in:

- valuing its employees
- delivering high quality and safe services
- working together with others
- providing innovative and progressive health services
- understanding country communities
- linking people to appropriate services
- delivering accessible and efficient health services.

It is with great pleasure that I present the Achievements and Highlights and Operations Reports of the WACHS in the 2005-06 Annual Report, and thus reiterate the commitment that we all share in improving health care systems and outcomes for all West Australians.

Dr Neale Fong
Director General of Health
Accountable Authority

20 September 2006

Address and location

WACHS - Head Office

189 Wellington Street
EAST PERTH WA 6004

Postal Address
PO Box 6680
EAST PERTH BUSINESS CENTRE WA 6892

☎ (08) 9223 8500
(08) 9223 8599
www.wacountry.health.wa.gov.au

Health care services are provided across the WACHS regional areas:

WACHS - Kimberley

'Yamamoto'
Unit 4, 9 Dampier Terrace,
BROOME WA 6725

Postal Address
Locked Bag 4011
BROOME WA 6725

☎ (08) 9194 1600
(08) 9194 1666

WACHS - Pilbara

Morgans Street
PORT HEDLAND WA 6721

Postal Address
PO Box 63
PORT HEDLAND WA 6721

☎ (08) 9158 1795
(08) 9173 2964

WACHS - Midwest

Shenton Street
GERALDTON WA 6530

Postal Address
PO Box 22
GERALDTON WA 6531

☎ (08) 9956 2209
(08) 9956 2421

WACHS - Wheatbelt

Unit 2 Avon Mall,
178 Fitzgerald Street
NORTHAM WA 6401

Postal Address
PO Box 690
NORTHAM WA 6401

☎ (08) 9622 4350
(08) 9622 4351

WACHS - Goldfields

'The Palms'
68 Piccadilly Street
KALGOORLIE WA 6430

Postal Address
PO Box 716
KALGOORLIE WA 6433

☎ (08) 9080 5710
(08) 9080 5724

WACHS - Great Southern

'Callistemon House'
Warden Avenue
ALBANY WA 6330

Postal Address
PO Box 165
ALBANY WA 6331

☎ (08) 9892 2662
(08) 9842 1095

Services provided

During 2005-06 the WA Country Health Service continued implementing the hospital role delineation framework. The framework focuses on building the capacity of Regional Resource Centres to deliver acute services, and the development of Integrated District Health Services and network health services in smaller towns. This strategic initiative will strengthen the primary health care focus and enable the provision of specialised community and residential care services and aged care services via regional networks.

The WACHS Regional Network Model incorporates the following facility groups:

Regional Resource Centres

Regional Resource Centres provide comprehensive acute care services and support major specialties and sub-specialty services based on regional requirements. Regional Resources Centres are situated in Albany, Broome, Geraldton, Kalgoorlie and Port Hedland.

Integrated District Health Services

Integrated District Health Services provide health care for towns with populations of 4,000 to 12,000 people and have an increased role in the provision of primary and secondary care. Integrated District Health Services are situated in Esperance, Katanning, Moora, Narrogin, Merredin, Northam, Carnarvon, Newman, Nickol Bay (Karratha) , Derby and Kununurra.

Small Health Centres

Health Centres provide health care to small populations of 1,000 to 4,000 people and are focused on emergency care, community based services and residential care. Service models includes Multi Purpose Services. Health Centres are situated in Beverley, Boddington, Bruce Rock, Corrigin, Cunderdin, Dalwallinu, Denmark, Dongara, Dumbleyung, Exmouth, Fitzroy Crossing, Gnowangerup, Goomalling, Halls Creek, Kalbarri, Kellerberrin, Kojonup, Kondinin, Kununoppin, Lake Grace, Laverton, Leonora, Meekatharra, Morawa, Mullewa, Narembeen, Norseman, North Midlands (Three Springs), Northampton, Onslow, Paraburdoo, Pingelly, Plantagenet (Mt Barker), Quairading, Ravensthorpe, Roebourne, Southern Cross, Tom Price, Wagin, Wickham, Wongan Hills, Wyalkatchem, Wyndham and York.

The WACHS administers and manages:

- 57 hospitals
- 21 nursing posts
- 17 aged care facilities
- 39 health centres
- 117 child, community, dental, alcohol and drug, mental and public health facilities
- 502 staff accommodation facilities
- over 19 office and general service buildings and facilities.

In 2005 the WACHS delivered 3,469 live born infants, provided 24,443 same day procedures and discharged 70,058 hospital cases. It also provided 7,755 individual consultations from a community mental health service. During 2005-06 there were 254,158 attendances to its emergency departments. Hospitals in the WACHS provide 1,313 beds (2006).

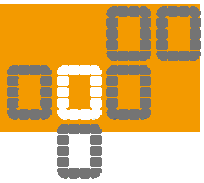
Direct inpatient and medical services, community and public health, and corporate support services are provided and include:

Direct Patient Services

Accident and Emergency
Acute, general and specialist medical and surgical
Renal dialysis
Paediatrics
Obstetrics and gynaecology
Aged and extended care
Mental health
Occupational medicine
Pain management

Medical Support Services

Ambulance
Audiology
Medical imaging
Occupational therapy
Pathology
Pharmacy
Dietetics and nutrition
Physiotherapy
Podiatry
Social work
Speech pathology



Services provided

Community and Support Services

Aged care assessments
Community, child, adolescent and maternal health
Public and environmental health, health promotion
Chronic illness and disease control
Residential aged care
Home and Community Care including home nursing
Community Aged Care
Carer respite
Community mental health
Palliative care
Community aids and appliances
Medical transport
Remote area health

Other Services

Patient Assisted Travel
Tele-health facilities
General administration and service management
Engineering and maintenance
Hotel and catering
Medical records

Your health system

Our purpose

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

Our vision

Our vision is to improve and protect the health of Western 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.

Strategic directions and intentions

Six strategic directions or priority areas were identified by the Department of Health's senior leadership team in December 2004. They are:

- Healthy workforce
- Healthy hospitals
- Healthy partnerships
- Healthy communities
- Healthy resources
- Healthy leadership

These six strategic directions provide the framework for improving the Department of Health and the care of West Australians over the next five years, as we look to delivering a healthier WA.

The six strategic directions form the backbone of an Operational Plan for 2006-07, which was developed in 2005-06 and tabled in Parliament. Specific actions are detailed against each of the strategic directions with planned regular reporting of progress.

Healthy Workforce

The health system workforce is critically important to the delivery of health care. Our intent is to ensure provision and promotion of a healthy working environment, which inspires staff and enables participation in the agenda of "Delivering a Healthy WA".

In 2005-06 there was renewed commitment to ensure that our workforce continues to be vibrant and engaged and that our workforce planning is responsive to local, national and international workforce pressures. The *Healthy Workforce Strategic Framework 2006-16* was developed to underpin appropriate workforce planning as service delivery aligns to a new Clinical Services Framework. The Strategic Framework aims to ensure that workforce shortages are minimised, opportunities are provided for training and professional development and that a high standard of knowledge and skills is achieved and recognised.

Healthy Hospitals

While the continuing reform agenda moves the focus of patient care away from hospitals, a significant proportion of health system activity still relates to hospitals. With hospital activity comes the key task of delivering safe, comprehensive, high quality clinical services to patients.

After extensive consultation the *WA Health Clinical Services Framework 2005-2015* was released in September 2005. Significant elements of this framework include:

- clear role delineation for each of our health services and care facilities
- a description of the bed numbers planned for the metropolitan area
- significant investment in our health service infrastructure including a new tertiary hospital for the south metropolitan region to be developed as a collaborative initiative between Fremantle Hospital and Royal Perth Hospital
- building up our general hospitals
- advancement of country health service role delineation in alignment with metropolitan plans.

Strategic directions and intentions

In 2005-06 Royal Perth Hospital was realigned into the South Metropolitan Area Health Service to enable full engagement of staff in the planning processes for the new tertiary hospital to be built at Murdoch.

PathWest Laboratory Medicine WA was created on 15 July 2005. The pathology laboratories at Royal Perth Hospital, Fremantle Hospital, Sir Charles Gairdner Hospital, remote and rural laboratories and the merged pathology services at King Edward Memorial and Princess Margaret Hospitals were amalgamated to form this new entity. This was in line with a recommendation of the Health Reform Committee. The benefit of the amalgamation is provision of a broader range of clinicians with expertise in their respective specialties working at various sites to share skills and knowledge with colleagues and doctors.

This reinforces our intent to improve access to hospital and health care services based on population needs now and into the future and is part of the significant hospital building and capital redevelopment program over the next 12 years. The result will be better alignment and integration between Department of Health facilities, clinical services and the development of integrated clinical networks.

Healthy Partnerships

The ongoing success of the reform program and the health system as a whole is dependent on strong relations with other health care-related bodies. We rely on such partnerships in the planning and delivery of innovative, cost effective, and high-quality health care services.

Our intent is to create stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals and the Australian Government, all of whom have an interest in the wellbeing of our health system. Capacity building in terms of enhancing contracting skills of Department of Health staff has been a point of focus during 2005-06.

Healthy Communities

Public and community health is a critical part of our health system and includes promotion of health, illness prevention, early detection of disease and access for all people to affordable community-based health care services.

Prevention and promotion services include communicable disease control, cancer prevention and detection, child community and primary health care, health promotion, genomics, preventive health, Aboriginal health, mental health, health policy and clinical reform and the management and development of health information.

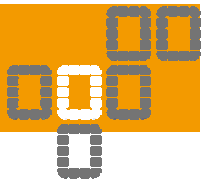
Our intent is to focus on improving lifestyles, working on the prevention of ill health, and implementing a long-term, integrated health promotion program in collaboration with government and non-government agencies, general practitioners and community groups.

Continuing care support services are provided to people with a chronic illness enabling them to remain at home in comfort. The Chronic Disease Discharge Project aims to reduce length of stay in hospital, frequency of readmission, or unplanned admission to hospital for people with a chronic disease. This project has yielded a significant reduction in unplanned admissions for target patients and a reduction in average length of hospital stay on average compared with patients with similar conditions who were not within the project.

Healthy Resources

A key rationale for reform in the WA health system is the need to deliver a sustainable, equitable and accountable health care service to the people of Western Australia.

Our intent is on sustainable resourcing and effective management of health budgets and resources. Accountability for health system resourcing and performance reporting is given focus through specific budget-holder performance agreements introduced in the 2005-06 year.



Strategic directions and intentions

Healthy Leadership

Healthy Leadership is vital to the effectiveness of the health system into the future. Our intent is to continue to develop the leadership capacity and capability within the Department of Health by creating an environment that identifies, nurtures and promotes strong leadership at all levels within health care services.

In this context, the "*Vital Leadership"* and "*Leading 100"* programs were expanded in 2005-06. The focus of these programs is on recognising, developing and supporting our leaders in order to deliver continuing superior health care service and to ensure that the Department of Health has the capacity to identify and respond to changing leadership needs and the delivery of the strategic objectives.

Compliance reports

Enabling legislation

The Department of Health is established by the Governor under section 35 of the *Public Sector Management Act 1994.* The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 43 Acts and 98 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 1964
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
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
Mental Health Act 1996
Mental Health (Consequential Provisions) Act 1996
Nuclear Waste Storage and Transportation (Prohibition) Act 1999
Nurses Act 1992
Occupational Therapists Registration Act 1980
Optometrists Act 1940
Osteopaths Act 1997
Perth Dental Hospital Land Act 1942
Pharmacy Act 1964
Podiatrists Registration Act 1984
Poisons Act 1964
Psychologists Registration Act 1976
Public Dental Hospital Land Act 1934
Queen Elizabeth II Medical Centre Act 1966
Radiation Safety Act 1975
Tobacco Control Act 1990
University Medical School Act 1955
University Medical School Teaching Hospitals Act 1955
Western Australian Bush Nursing Trust Act 1936
Western Australian Bush Nursing Trust Act Amendment Act 1947
White Phosphorous Matches Prohibition Act 1912

Acts passed during 2005-06

Chiropractors Act 2005
Human Tissue and Transplant Amendment Act 2006
Occupational Therapists Act 2005
Optical Dispensers Repeal Act 2006
Optometrists Act 2005
Osteopaths Act 2005
Physiotherapists Act 2005
Podiatrists Act 2005
Psychologists Act 2005
Tobacco Products Control Act 2006

Bills in Parliament at 30 June 2006

Alcohol and Drug Authority Repeal Bill 2005
Dental Bill 2005
Food Bill 2005
Health Amendment Bill 2005
Hospitals and Health Services Amendment Bill 2005
Medical Amendment Bill 2005
Medical Radiation Technologists Bill 2005
Nurses and Midwives Bill 2005

Amalgamation and establishment of Boards

There were no Boards amalgamated or established during 2005-06.

Note: The new WA Country Health Service will be effective from 1 July 2006.

Ministerial directives

The Minister for Health did not issue any directives on the WA Country Health Service operations during 2005-06.

Compliance reports

Statement of compliance with public sector standards

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

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

Human Resource Management

The WA Country Health Service has adopted procedures ensuring compliance with the requirements of the Public Sector Standards for Human Resource Management. Information on compliance requirements is covered in workplace procedure manuals and is emphasised in staff training and induction programs. The Area Health Service has an agency Code of Conduct complimenting the WA Public Sector Codes of Conduct and Ethics.

The WACHS employs mechanisms to assess compliance and maintain its focus on the standards including:

- ensuring duty statements detail compliance responsibility wherever appropriate
- monitoring knowledge via staff surveys
- quality assurance audits conducted by WACHS human resource staff
- independent internal audits performed by the Internal Audit Branch, external auditing agencies such as the Office of the Auditor General
- training programs and workshops
- information gathered from exit interviews
- when required, standards breaches and grievance investigations.

The ACHS accreditation process also reviews compliance with Public Sector Standards and the Codes of Ethics and Conduct.

In 2005-06 the WA Country Health Service received five claims for breach of Public Sector Standards – three for recruitment and selection practice and one each for performance management and grievance resolution. Four were referred to the Office of the Public Sector Standards Commissioner while one is still under review. There were no reports of substantiated breaches of the Public Sector Standards from the concluded claims.

Code of Ethics and Code of Conduct

All WACHS workplaces promote the Codes of Ethics and Conduct and monitor compliance across all sites. New employees are provided with copies of the Codes and they are discussed at orientation and induction courses. Copies of the relevant Codes are also available on the Intranet. Regular training is also provided for all staff to maintain their awareness of the Codes and apply this knowledge to behaviour in the workplace. Staff are required to acknowledge their understanding and acceptance of the Codes.

During 2005-06 the WACHS received 19 complaints alleging non-compliance with the Codes. All were investigated and resolved internally.

The WA Country Health Service has not been investigated or audited by the Office of Public Sector Standards Commissioner for the period to 30 June 2006.

Dr Neale Fong
Director General of Health
Accountable Authority

20 September 2006

Management structure

Accountable authority

The Director General of Health, Neale Fong, in his capacity as Chief Executive Officer, is the accountable authority for the WA Country Health Service.

Pecuniary interests

The senior officers of the WA Country Health Service have declared no pecuniary interests in 2005-06.

Senior officers

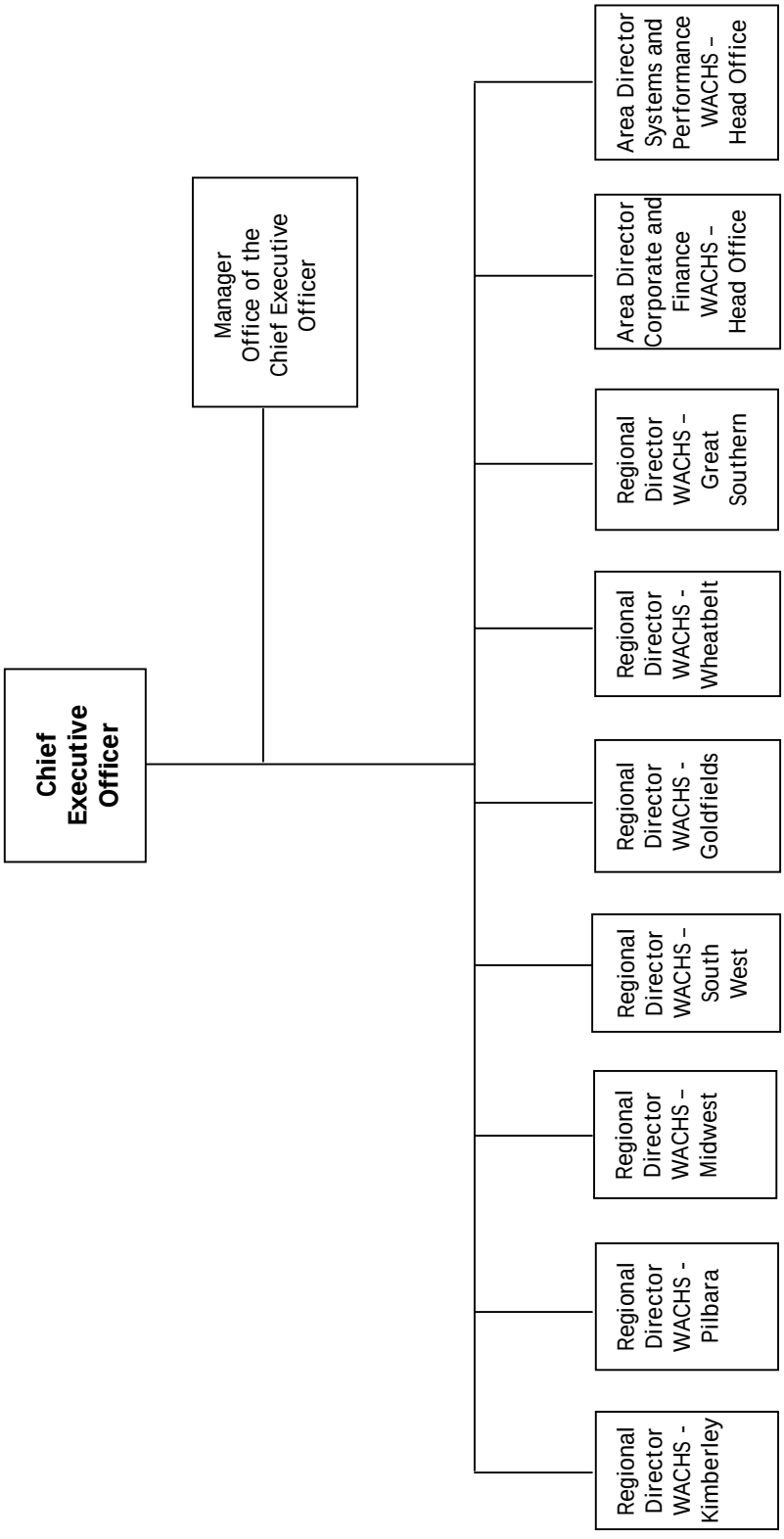
The senior officers of the WA Country Health Service and their areas of responsibility as at 30 June 2006 are listed below:

Table 1: WACHS Senior Officers

Area of Responsibility	Title	Names	Basis of Appointment
WA Country Health Service (WACHS)	Chief Executive Officer	Christine O'Farrell	Contract
WACHS-Goldfields	Regional Director	Geraldine Ennis	Acting
WACHS-Great Southern	Regional Director	Keith Symes	Permanent
WACHS-Kimberley	Regional Director	Kay Atfield	Permanent
WACHS-Midwest	Regional Director	Shane Matthews	Permanent
WACHS-Pilbara	Regional Director	Patrik Mellberg	Permanent
WACHS-Wheatbelt	Regional Director	Tim Shackleton	Permanent
WACHS – South West	Regional Director	Ian Smith	Permanent
WACHS – Head Office Corporate and Finance	Area Director	Jeff Moffet	Permanent
WACHS – Head Office Systems and Performance	Area Director	Martin Cutler	Contract

Management structure

WA Country Health Service Structure as at 30 June 2006



Achievements and highlights

Healthy hospitals

WA Country Health Service

The WA Country Health Service is committed to providing a range of quality health care services, and improving efficiency and access to hospital and health services for the community through the ongoing implementation of the regional network model.

Regional Resource Centres and Integrated District Health Services supported by formal linkages with metropolitan hospitals form the foundation of a network ("hub and spoke") to support local and remote health services in towns, small communities and settlements. This includes a significant hospital building and capital redevelopment program and will result in the better alignment and integration of services to create sustainable rural models.

Healthy hospital priorities include:

- developing the necessary infrastructure to meet the current and future health needs of country communities
- building the capacity of Regional Resource Centres
- developing Integrated District Health Services
- networking health services in smaller towns and strengthening their focus on primary health care.

WACHS - Pilbara

Funding for stage 2 of the replacement of the Port Hedland Regional Resource Centre was increased in December 2005 to $90 million. The business case for this project including accommodation schedules, master planning and cost analysis, is being finalised.

The construction of Karlarra House, a 56-bed residential aged care facility in South Hedland, is continuing with completion scheduled for September 2006.

There has also been a review of options for a private medical model in Exmouth involving the reconfiguration of medical services.

WACHS - Goldfields

Service development planning has commenced to support capital investment in health facilities in the Kalgoorlie Regional Resource Centre and include upgrading community and mental health, emergency and medical imaging, specialist medical services and renal dialysis.

The Esperance Hospital emergency department has been re-modelled providing a dedicated entrance, improving accessibility and privacy for patients, and increasing safety and security for staff.

A comprehensive emergency planning project has been completed with the preparation of emergency manuals for all facilities across the Goldfields. The manuals outline procedures for all emergency situations including any business continuity plans to be implemented in the event of major service failure. A plan has been prepared for monthly emergency exercises to ensure that the plans are regularly tested and updated.

WACHS - Midwest

The new Geraldton Health Campus was completed in 2005-06. The complex process of transition was accomplished with minimal impact to patients and staff, as was the demolition of the old building. The Premier opened the new facility in May 2006.

During 2005-06 an Emergency Response and Disaster Preparedness Committee facilitated the development of a Midwest Emergency Management Strategy, in line with WESTPLAN (the State Emergency Management Response Plan). Local emergency plans have been reviewed and updated and have been made available on the Department of Health Intranet, along with online education and training programs.

Achievements and highlights

Healthy hospitals

During 2005-06 the Geraldton Regional Resource Centre continues to plan for the implementation of the Picture Archiving and Communication System (PACS). This technology provides a framework for viewing and analysing all types of diagnostic images, and furnishes an efficient method for communicating results to referring clinicians.

WACHS - Kimberley

During 2005-06 the Broome Regional Resource Centre commissioned a purpose built facility to house the new 16-slice Computer Tomography (CT) scanner.

The new $8.7 million Halls Creek Hospital opened in October 2005, with eight inpatient beds and four boarder beds. The redevelopment included three new staff accommodation houses, which is an important initiative for recruiting and retaining clinical staff in Halls Creek.

Construction has commenced on the $6.8 million redevelopment of Kununurra Hospital. Redevelopment will provide six new acute beds, additional medical consulting rooms, a remodelled emergency triage area, new workshops and remodelled stores, a new laundry, and a two-chair public dental clinic in a new primary health care building.

The Aged Care Standards and Accreditation Agency has accredited the ten bed high care Kununurra aged care facility for a period of three years. This facility opened in March 2005.

WACHS - Wheatbelt

The newly upgraded Quairading Hospital accident and emergency department was opened on 29 September 2005. This project was made possible through the generous support of a private benefactor who contributed approximately $1 million toward the project cost.

Stage one of the new Moora Hospital was completed in February 2006. Stage two is due for completion by October 2006.

The Wheatbelt Aged Care Unit was established in 2006. The primary role of the Unit is to provide support to service delivery staff in the Wheatbelt to enable the delivery of 'best practice' care for the aged in their homes and in community and residential settings.

Mental health services were expanded to include a new base in Gingin servicing the western and coastal parts of the Wheatbelt. The facility has private therapy rooms and telepsychiatry facilities.

WACHS - Great Southern

Following consultation with relevant stakeholders the construction of a number of community supported mental health residential units has been approved for Albany. These will provide 24-hour support for residents.

During 2005-06 a section of the Katanning Hospital was redeveloped to accommodate community health staff. In addition, two new defibrillators and a new anaesthetic monitor were acquired.

Planning for the new Denmark health and aged care facility continued. The schematic design has been prepared and the new facility is scheduled for completion and occupation in early 2008.

During 2005-06 additional extended care nursing hours were provided in Kojonup to avoid hospitalisation for aged clients and minimise length of stay. The district also organized the transfer of the Well Women's Clinic to a local doctor's surgery capitalizing on more frequent services provided by Royal Flying Doctor Service's female doctor and avoiding duplication.

Plantagenet Cranbrook Multi Purpose Service (MPS) has been operating for one year and this service model has enabled the delivery additional home-based services in the Shires of Cranbrook and Plantagenet.

The employment of a medical pre-admissions nurse at Plantagenet Hospital has resulted in improved assessment and care planning for general medical patients, the fast tracking of admission to hospital, improved patient care and a reduction in average length of stay.

Achievements and highlights

Healthy workforce

The WACHS is committed to providing and promoting a healthy working environment, inspiring and enabling staff to participate in the "Delivering a *Healthy* WA" and "*Country Health Service Review"* agendas. It is essential that the health system have appropriate workforce planning tools to enable the system to prepare the workforce to meet demand, to minimise workforce shortages, to ensure opportunities are provided for professional development, and ensure that a high standard of knowledge and skills is achieved and recognised.

The WACHS workforce priorities include:

- strengthening access to specialist services within rural areas
- developing sustainable services that respond to workforce shortages and changing community expectations
- enhancing workforce attraction and retention initiatives
- introducing nurse practitioners and other different models of service delivery;
- supporting general practitioners to provide procedural services
- developing the clinical training capacity for the WACHS, including undergraduate, graduate (prevocational) and post graduate professional streams
- enhancing vocational training opportunities within WACHS, including traineeships apprenticeships and cadetships
- expanding the use of telehealth for workforce development.

Recruitment

The WACHS has had success with the recruitment of a number of clinical and support staff. These positions enhance leadership and clinical practice throughout the health service:

WACHS - Pilbara

The Pilbara has recruited a specialist anaesthetist and a coordinator of Medical Specialist Services as well as appointing a Regional Medical Administrator.

WACHS - Goldfields

During 2005-06 the Goldfields has increased the number of salaried medical practitioners appointing a public health physician and a general physician, an obstetrician / gynaecologist, a surgeon, a senior psychiatry medical officer and a Regional Director of medical services. Other clinical appointments completed included a podiatrist to meet a long-standing need for public podiatry services in Kalgoorlie and the filling of several long-standing vacancies for mental health professionals in the Kalgoorlie-Boulder Community Mental Health Service.

WACHS - Midwest

The Midwest appointed a Medical Director strengthening medical leadership. Recruitment strategies adopted by the Midwest have resulted in near optimal practitioner levels.

A new paediatrician has been appointed to the Geraldton Health Campus enhancing safety and specialised care for sick and premature babies. Medical Specialists Outreach Assistance Program (MSOAP) funding has supported the expansion of paediatric services to the Murchison district.

WACHS - Kimberley

During 2005-06 a number of allied health positions were created including an additional occupational therapist and an additional speech pathologist for Kununurra/Wyndham. Positions for a social worker, dietician and podiatrist were created, with the social worker and dietician recruited.

The number of Aboriginal Health Workers (AHW) in remote areas has been increased under the Population Health Care Access Program (PHCAP) with six appointed AHW positions (four permanent and two temporary), and another six reception/administrative positions (four appointed permanently). A senior Aboriginal Health Worker has also been employed to focus on promoting healthy lifestyles for Aboriginal men and women.

Achievements and highlights

Healthy workforce

A new regional senior public health nurse position targeting viral hepatitis has been established and filled.

A number of community midwife positions have been established and experienced midwives recruited in the five major Kimberley centres.

The Kimberley has also been successful in recruiting two additional Indigenous Mental Health Workers and is in the process of establishing a senior clinician position for the Child and Adolescent Mental Health team.

Leadership (Professional Development)

The WACHS participated in the Department of Health's "*Leading 100*" and "*WA's Emerging Health Leaders*" programs, with twenty employees successfully completing the program.

The "RoStar" staff rostering system has been successfully implemented across a number of sites in the WACHS.

There were also a number of other significant employee training and skills development programs:

WACHS - Midwest

The initiative "Ocean to Outback Graduate Nursing Program" is promoting the rotation of graduates between sites in the Midwest. This program has resulted in an increased scope of practice for graduate nurses, an exposure to different learning opportunities and guaranteed placements for enrolled and registered nurse graduates within the Midwest.

Midwest sites have implemented a "Health Promoting Health Strategy" targeting in the first instance, the development of a healthy workforce. Initiatives supporting anti smoking strategies, promoting good diet and exercise, and observing respectful partnerships are provided in many sites.

A management enhancement training program supporting skills enhancement and development across the Midwest has also been introduced during 2005-06.

WACHS - Kimberley

A Human Resource Quality Management Committee sponsored by the Regional Director was established in 2005 to ensure compliance with the Australian Council on Health Care Standards (ACHS) EQuIP. The work of this committee promotes continuous improvement and best practice methods in the workforce.

During 2005-06 the Kimberley Aged and Community Care Service developed a recruitment DVD/video targeting potential remote area HACC coordinators and encouraging participation of people who may have low literacy levels. The service has also instigated an indigenous traineeship program.

WACHS - Great Southern

The Great Southern is an active participant in the "Community Development Employment Program" (CDEP). The CDEP is funded for Indigenous community organisations in urban, rural and remote Aboriginal and Torres Strait Islander communities to promote employment and work practices to meet local needs. Activities develop the participant's work and employment skills and provide access to the mainstream labour market.

An award for "Excellence in Preceptorship" was presented to Plantagenet Cranbrook "*Preceptors for Curtin University Nursing Students"* 2005.

The Great Southern has reviewed its current Performance Development program, which assists individuals and teams to focus on the organisation's goals. As a result of the review a new program has been implemented throughout the Great Southern. The new program focuses on:

- building team work and team development
- recognition for jobs well done
- encouraging new ideas
- giving people the chance to participate, to learn, and to have a say.

Achievements and highlights

Healthy workforce

During 2005-06 the Great Southern was allocated funding for a second consultant psychiatrist and a registrar for the Great Southern Mental Health Service (GSMHS). Funding was also allocated to complete the "Clinical Pathways for people with Dementia in Acute care" project.

WACHS - Wheatbelt

During 2005-06 the Wheatbelt Mental Health Service (WMHS) has become an accredited psychiatrist registrar-training site and will provide six-month training rotations for psychiatric registrars.

A Wheatbelt Population Health Leadership Development Program was launched during the year. The program aims to provide career planning and management training for identified future leaders in Population Health.

Achievements and highlights

Healthy partnerships

During 2005-06 the WACHS has continued to increase its focus on creating stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals and the Australian Government, all of whom have an interest in the well being of our health system. The role and function of District Health Advisory Councils has been strengthened to maximise local participation and decision-making.

Strategies to strengthen our partnerships with the community, consumers, and other providers include:

- encouraging and supporting input into advisory forums for service planning, monitoring and review
- establishing mechanisms for community feedback on services
- developing formal Memoranda of Understanding with other service providers.

The WACHS has also formed a partnership with the Office of Aboriginal Health to implement numerous initiatives relating to Aboriginal health improvement, to facilitate collaborations with the Aboriginal Community Controlled Health Services, and to improve service delivery and reduce duplication.

WACHS - Pilbara

The Pilbara has successfully negotiated a partnership with BHP Billiton for the development of the Newman Community Health Centre and staff accommodation. Negotiations between BHP Billiton and WACHS are nearing completion for a "Health Partnership" potentially providing up to $3 million over three years.

The Exmouth Hospital "Nursing Hours per Patient Day" (NHpPD) change project commenced in February 2006. Consultation with staff and the community took place in February and March 2006 leading to a review of nursing hours and reporting lines at the hospital.

During 2005-06 communication and partnerships between the Pilbara Community Drug Service Team and the Departments of Community Development and Justice, and the WA Police have been improved and consolidated.

WACHS - Goldfields

The Goldfields has entered a partnership with the Esperance and Kalgoorlie Group Training Schemes, and the Nooda Ngulegoo Aboriginal Corporation to secure the employment of Aboriginal trainees within Goldfields health facilities. Six trainees were placed during the year, with a further six places committed for the following year.

Partnerships have also been established with Bega Garnbirringu Aboriginal Medical Service and Curtin University for the placement and training of Aboriginal Health Workers and student nurses.

The Kalgoorlie Regional Resource Centre has participated in a partnership for the development of the Eastern Goldfields Regional Reference Site. This partnership involving the Eastern Goldfields Medical Division of General Practice and the Commonwealth Department of Health and Ageing has established a "virtual" private network connecting hospitals, general practices and other service providers. The network enables doctors to access their practice records from remote locations and provides a facility for the electronic preparation and transmission of discharge summaries.

WACHS - Midwest

In partnership with the Geraldton Regional Aboriginal Medical Service (GRAMS), the Midwest has provided midwives to conduct clinics at GRAMS facilities. This has resulted in a greater number of indigenous mothers accessing antenatal and postnatal care.

A partnership between the Geraldton Regional Resource Centre and the Charles Darwin University (formally Northern Territory University) has provided a teaching fellow and student placement coordinator. This officer is responsible for coordinating teaching blocks for external students to facilitate the Enrolled Nurse to Registered Nurse conversion program.

Achievements and highlights

Healthy partnerships

Partnerships between the Midwest, the Combined University Centre for Rural Health, Technical and Further Education (TAFE), St John of God Hospital Geraldton, Geraldton Regional Aboriginal Medical Service and the Midwest Division of General Practice have facilitated successful projects targeting asthma best practice, mental health, undergraduate, postgraduate and community education opportunities, and research fellowships.

A partnership between the Midwest and the Disability Services Commission has enabled the establishment of several disability liaison positions across the Midwest. These officers support and promote consumer linkages to the Disability Services Commission and its services.

WACHS - Kimberley

The Kimberley has established a clinical partnership agreement with the Kimberley Satellite Dialysis Unit providing improved renal dialysis patient consultation and management.

A Memorandum of Understanding (MOU) has been developed with Southern Cross Care WA, the Derby Aboriginal Health Service and the Kimberley Regional Palliative Care Service for employment of registered nurses to provide palliative care services in the home.

The Kimberley was also successful in applying for funding in a partnership with the Kimberley Aboriginal Services Council, Kimberley Renal Dialysis Service and the Kimberley Palliative Care Service to address the palliative needs of renal patients.

The Kununurra/Wyndham shared service agreement with the Ord Valley Aboriginal Medical Service, provides a jointly funded audiology service to clients. This agreement also funds a home care nurse in Kununurra, provides admitting rights at Kununurra Hospital for Ord Valley Aboriginal Health Service (OVAHS) doctors, and allows for their participation in the on-call emergency roster at the hospital.

WACHS - Wheatbelt

The Wheatbelt received funding ($1.5M) from the Commonwealth Office of Aboriginal and Torres Strait Islander Health (OATSIH) to develop and enhance Aboriginal health services, providing improved primary health care to Aboriginal people throughout the Wheatbelt.

Local health advisory groups were established in several Wheatbelt towns including York, Pingelly, Bruce Rock and Kununoppin. The advisory group's focus is on the community and the health service working positively together to improve health outcomes in the local area.

WACHS - Great Southern

The Great Southern was successful in obtaining a partnership grant with the Great Southern Division of General Practice to provide Mental Health First Aid "Train the trainer" courses to eleven staff across the Great Southern. The Great Southern in partnership with the Alzheimer's Association facilitated "Living with Memory Loss" clinics across the area.

The ongoing partnership with McKesson continues to provide a 24-hour 1800 telephone emergency health service (Rural Link) for rural clients. Rural Link provides a service to local clinicians advising them of patients who may require follow up.

The Great Southern in a partnership with arts, mental health, disability and community organisations and with involvement from local artists and people with disabilities, have established the "Unhiding Project". This project creates opportunities for people with disabilities to work alongside contemporary artists and develop work through a range of community projects. The project promotes a welcoming and accessible environment across the local Mount Barker community, resulting in the inclusion of people with disabilities in the life of the community

The Great Southern has also developed a partnership between its Population Health Unit and the Aboriginal Health Service for the promotion of immunisation.

Achievements and highlights

Healthy communities

Improving the health of rural communities is a priority for the WACHS. Work focuses on activities that influence the health of individuals as well as the whole population. It includes improving lifestyles, the prevention of ill health, and the implementation of long-term, integrated health promotion programs. These initiatives involve collaboration with government and non-government agencies, general practitioners and community groups. Priority is given to the improvement of community-based chronic disease management and expanding equitable and accessible services in the community.

The WACHS's priority is improving the health of people in country communities by focusing on:

- Aboriginal health
- mental health
- alcohol and drug abuse
- maternal and child health
- chronic diseases
- patient transport and coordination
- strengthening transport linkages between all parts of the rural health system
- coordinating and strengthening the aero-medical transport service
- providing better support to the road ambulance service and the volunteer ambulance officers
- improving the coordination of and support for patients in transit
- improving community and residential care services to better meet the needs of elderly rural residents.

WACHS - Pilbara

The Pilbara has received *Healthway* funding to implement the "Healthy Communities" program in Newman. The "Healthy Communities" program works with communities to identify a range of community based approaches on priority health issues. Examples include using art, and sporting mentors.

Multi Purpose Services are being progressed at Tom Price, Onslow and Exmouth through an aged care/MPS group. The MPS model of service delivery allows greater flexibility in the delivery of health care services to the community.

During 2005-06 the Pilbara participated in a HIV review across the region. A strategy has been developed from the findings of the review for the long-term management of people with HIV in the Gascoyne area including options for isolating patients when required.

The Pilbara facilitated a six-month general practitioner trial service with Midwest Aero Medical Services for Shark Bay/Denham to improve primary care services and the continuity of care for the community. The trial was evaluated in May 2006.

WACHS - Goldfields

Follow-up to the consultation "yarning sessions" conducted by the Population Health staff with local Aboriginal youth identified that they wished to come together as a group to work towards a more desirable future regarding alcohol and other drug use issues currently impacting on their community. Consequently the Norseman Local Drug Action Group (LDAG) was formed by the youth of the area with mentoring support from population health staff. This group is part of a statewide network of over 70 groups that work towards addressing alcohol and drug issues on a local level.

WACHS - Midwest

During 2005-06 the Midwest Population Health Unit continued its program of community facilitation for health promotion to identify and act on initiatives that reduce the risk of ill health now and into the future.

The Midwest benchmarked residential and community aged care against the Commonwealth Aged Care and HACC Standards, and implemented a comprehensive quality improvement strategy to improve service provision. As a result, the Midwest has demonstrated significant improvement in the delivery of accountable and contemporary aged care, and has developed comprehensive documentation for both residential and community aged care service delivery.

Achievements and highlights

Healthy communities

A partnership with local mining companies and the Karalundi school has established an on-site clinic at the school. The clinic will improve health providing general first aid, school health and immunization services.

Funding is currently being sought to develop a health program for women and children similar to the Murchison Men's Health program.

WACHS - Kimberley

During 2005-06 the Kimberley Public Health Unit hepatitis C nurse has facilitated the commencement of the treatment of hepatitis C under the Commonwealth Highly Specialised Drug program. This allows patients to access treatment locally rather than in Perth.

Community midwives have been appointed to focus on pre-conception, antenatal and postnatal periods. The midwives support healthy pregnancies with positive outcomes for both mothers and babies, working in partnership with Aboriginal health workers, and child and school health nurses.

The "Caring Communities Project", a project promoting access to palliative care services in remote communities via a regional palliative care coordinator and an Aboriginal health worker, was completed during 2005-06.

The Broome Population Health Unit established an integrated Well Women's health clinic with extended hours and a scope of service to improve access for indigenous women to a range of services including sexual health, Pap smears, birth control, breast examination, and menopause advice and information.

The Kimberley has also established the "Kimberley Male Health Network". Initiatives include a regional male health conference, a male outreach project to remote communities, a "male health week" display and regular visits by a male Aboriginal health worker to the Broome prison delivering health promotion information and education to male inmates.

WACHS - Wheatbelt

The "Mentally Healthy WA: Act-Belong-Commit" campaign was officially launched in Northam on 2 November 2005. The campaign aims to improve mental health by increasing individual resilience and community cohesion. It is the result of a consortium of Healthway, the WACHS, LotteryWest and the Centre for Behavioural Research in Cancer Control at Curtin University.

During 2005-06 a childhood development working party was formed in the Wheatbelt to develop an action plan to enable equitable access to child development services and improve service quality and coordination. Also during the year a Wheatbelt Anti-Obesity Working Party was established to develop an action plan to promote the prevention of obesity.

WACHS - Great Southern

During 2005-06 a number of sites across the Great Southern have implemented the "Health Promoting Health Service" initiative. This is an initiative of the World Health Organisation (WHO) to improve the focus on health promotion and wellness. In addition to the existing participating communities of Albany. Mt Barker and Gnowangerup, the communities of Denmark and Katanning have also received funding for the program in 2005-06.

The Albany Regional Resource Centre is the first WHO "Health Promoting Hospital" in WA. The administration has supported its participation in the initiative with the creation of a "Health Promoting Health Service" committee to facilitate the ongoing development of programs to improve lifestyle and promote good health.

The Great Southern participated in "Mental Health Week" joining other service providers in informing the community about mental health and the available programs. Organisations such as Children of Parents with Mental Illness (COPMI), provide opportunities to work collaboratively with families and other service providers, to improve the outcomes for children of people with a mental illness. Other programs promoted were "Friends for Life" an anxiety prevention program, the "Resourceful Adolescent Program" (RAP), "Gateway" suicide prevention, "Healthy Start", "Smart Start" 0 to 4 year olds and the "Bouncing Back" program.

Achievements and highlights

Healthy communities

Participation in the "Mentally Healthy WA" project was launched for the Great Southern in October 2005. This project commenced in 2004-05 and Albany joins the other pilot sites at Esperance, Geraldton, Kalgoorlie, Karratha and Northam/York/Toodyay. The "Mentally Healthy WA" project aims to improve mental health by increasing individual resilience, reframing people's perceptions of mental health and improving community cohesion by fostering links between individuals and organisations. The project will be conducted over several years and will inform best practice in the area of mental health promotion.

The "WHO" Denmark Safe Community initiative continued in 2005-06. This initiative focuses on improving safety and preventing injuries in the Denmark community.

During the year the Great Southern also conducted extensive chemical screening for farmers and families in the Kojonup area.

Partnership agreements between the Great Southern Division of General Practice (GSDGP) and the Population Health Unit have been established for the Commonwealth funded "Bringing Them Home" and the State funded "Building Solid Families" programs. These programs provide services to Aboriginal people from the "Stolen Generation". Funding through OATSIH has also supported partnerships between the GSDGP and Population Health for communicable disease (sexual health promotion).

"Healthy for Life" chronic disease and antenatal programs aiming to encourage Aboriginal women to engage in antenatal care early in pregnancy were also pursued in 2005-06.

Plantagenet Cranbrook in conjunction with local volunteers and a community physiotherapist, collaborated to implement injury prevention walk groups and a walking program for seniors.

The Great Southern participated in the "Healthy Bodies Program 2006" focusing on learning how to change behaviour to improve health and wellbeing.

A joint initiative of the WA Police Service, Local Government, Department of Health and the Drug and Alcohol Office and participating licensees, implemented the "Mount Barker Best Practices Accord". The accord is the culmination of the cooperative and consultative process established by industries and agencies in the area to address the issues of antisocial behaviour, harm reduction, public education and promoting Mount Barker as a safe and social place to have a great night out.

During "Mental Health Week 2005" the Great Southern promoted a number of initiatives including facilitating walks for physical and mental health at schools, and the "Cool Cats Calm Kids" program, which teaches children how to relay their anger and frustration in a way that is less verbal and demonstrative.

In October 2005 the Great Southern conducted a 'Beyond the Blues' depression forum. The forum was successful in raising community awareness about depression. Participants provided feedback, which has assisted planning and advertising of future events and provided ideas for future mental health topics, for example youth and drugs. The forum has also assisted the Rural Community Support Service (RCSS) team in developing partnerships in mental health initiatives with organisations such as the Palmerston Association Drug and Alcohol Rehabilitation Service.

During 2005-06 a Victims of Crime Support Unit was established to provide security and confidentiality for people who have been sexually assaulted. The unit is a multidisciplinary team which includes a mix of clinical and non-clinical skills.

The Albany Regional Resource Centre is a pilot site for the introduction of the Residential Care Line in country WA. This service aims to reduce the number of emergency department attendances and admissions from residential care facilities.

Achievements and highlights

Healthy resources

The health reform program aims to achieve sustainable, equitable and accountable health care service delivery to all communities and is therefore a key priority for the WACHS. The principle focus is on sustainable resourcing and effective management of health budgets. Accountability for health system performance and best practice management of assets, in order to deliver the best health benefits, will be a priority. This will include a continuing focus on safety and quality in our health care services.

Strategies to ensure services are provided in the most cost effective manner include:

- benchmarking
- reviewing the way medical services are provided
- increasing our revenue
- supporting and increasing the range of privately insurable health services available to rural communities.

WACHS - Pilbara

During 2005-06 the Pilbara introduced a new service model in Wickham reducing operating expenditure by $1 million per annum.

A number of local capital projects were monitored during the year including a revised scope for the ward development at Carnarvon Hospital which released funds for alternative purposes, realigning ward consolidation at the Port Hedland Resource Centre, and reassessing expenditure on administration facilities in Port Hedland. The Pilbara also implemented a strategic accommodation replacement and refurbishment program.

WACHS - Goldfields

During 2005-06 the Goldfields introduced a financial management system based on:

- the allocation of unit budgets supported by service delivery plans
- maintaining routine monitoring and reporting against internal budgets
- a negotiated staff establishment level
- a monthly review by the regional Finance and Audit Committee
- monitoring capital expenditure by the Regional Capital Planning Committee.

WACHS - Midwest

The business case for the re-development of the Morawa health care facility has been approved and resulted in the allocation of $9m for this project. The design of the new health centre will support improved patient management and will bring to the community a facility that satisfies the relevant Australian industry Standards. The facility is due to be completed in early 2008.

During 2005-06 a housing complex has been purchased in Meekatharra to address housing cost issues as well as providing safe, secure accommodation. The complex will be shared with the Royal Flying Doctor Service.

WACHS - Kimberley

During 2005-06 the Kimberley developed and introduced the Kimberley Standard Drug List for public health services and Aboriginal controlled health services. It was also able to introduce the Section 100 Pharmaceutical Benefits Scheme medications supplied free to patients across the Kimberley. A new retinal camera with digital capabilities was purchased to enhance the diabetic eye review program.

The Kimberley commenced or completed a number of capital projects including the construction of new housing for remote area nurses at Looma, Warmun and Kalumburu. The refurbishment of the Looma community clinic was completed in October 2005. Construction commenced for the replacement of the Derby Hospital acute wards with completion due December 2006. The completion of the new dental health service facility in Derby was achieved in late March 2006.

WACHS - Great Southern

During 2005-06 the State Government announced the redevelopment of the Albany Regional Resource Centre ($26.8M) and the approval for community supported mental health residential units. The Great Southern also continued the planning processes for the new Denmark health care facility.

Achievements and highlights

Healthy leadership

Creating an environment that identifies, nurtures and promotes strong leadership at all levels within rural health care services and the community, is vital to the effectiveness of the health system into the future. The WACHS focuses on recognising, developing and supporting our leaders in order to create a superior health care service and ensure that all strategic directions move forward.

Our priority is to create strong leadership and a shared vision for excellence through:

- complementing the "WA Health Leadership" programs with additional WACHS initiatives
- strengthening corporate and clinical governance
- the accreditation of our health services.

The WACHS participates in "*Leading 100*" and "*Vital Leaders*" programs promoting overall Healthy Leadership.

WACHS - Pilbara

The appointment of a Medical Director for the Pilbara and the implementation of the Clinical Review Committee has provided opportunities to review sentinel events, data reported in the Australian Incident Management System (AIMS), service provision complaints and clinical governance issues. These resources have strengthened leadership across the Pilbara. The risk management system has been implemented across the Pilbara with service unit risk registers completed.

To improve service management, the South Pilbara district has been realigned under three district centres linking smaller hospitals into a larger management group. Its two separate Population Health Units were amalgamated under a new single management structure.

The Pilbara Executive Team has been re-aligned to compliment the current WACHS structure and functional alignment. The involvement of the North West Mental Health Director (for Pilbara/Kimberley) in the realignment process also facilitated better integration of mental health services with existing services.

WACHS - Goldfields

The Kalgoorlie Regional Resource Centre has developed a leadership skills training program for middle management staff in Kalgoorlie, and this is currently being extended to staff in the south east of the region. A number of staff have also been selected to participate in leadership development programs sponsored by the Department of Health.

WACHS - Midwest

All sites in the Midwest are accredited to ACHS EQuIP standards. Surveys of the Midwest district, Geraldton Health Campus and corporate functions resulted in commendation for leadership in service improvement and innovative development.

The Midwest has promoted the development of an electronic planning tool which delivers transparency and accountability of planning strategies across the organisation. The tool compliments the ACHS EQuIP standards and provides simplified reporting and performance review.

WACHS - Kimberley

The Kimberley made a number of senior appointments in 2005-06 including a Regional Director in August 2005, a district manager in Derby/ Fitzroy Crossing in April 2006, and the appointment of a Director of the North West Mental Health Service in January 2006.

During 2005-06 the Kimberley also implemented a new district service delivery model amalgamating the existing four services into three - Derby and Fitzroy Crossing; Kununurra, Halls Creek and Wyndham; and Broome, delivering more cohesive health services across the Kimberley.

Also in 2005-06 the Kimberley developed an Operational Business Plan 2006-2007 with all districts and divisions developing their own work plans to align with the Statewide Operational Plan. Our vision statement "we STRIVE for improved health in the Kimberley region" is underpinned by the values of service, teamwork, respect, innovation, valuing people and excellence ("STRIVE").

Achievements and highlights

Healthy leadership

WACHS - Great Southern

Managers and staff in the Great Southern have participated in leadership development programs including "*Leading 100*", "*Vital Leadership*", "Building Leadership" and the "Mental Health Leadership" programs.

The Great Southern has supported the accreditation process for a staff member in the Edinburgh Post Natal Depression "Train the Trainer" program. The service has also piloted a program for the early intervention in the management of early psychosis in rural areas.

The Plantagenet Cranbrook Residential Care Coordinator trained as an *Eden Associate* in September 2005. The Eden Alternative is a "culture-change" model that seeks to modify the care environment for the elderly. It identifies the three plagues; *Loneliness, Helplessness* and *Boredom* as the main causes of suffering for the elderly in an aged care environment. The Eden Alternative seeks to eliminate these three plagues by changing the physical and social environment of an aged care facility.

A new position for an advanced practice senior nurse was created during 2005-06 to develop, guide and implement nurse-led initiatives, clinics and advanced clinical practices. One example is the development of nurses trained in the clinical management of patients suffering heart failure.

WACHS - Wheatbelt

The Wheatbelt Southern district was awarded full ACHS accreditation following the organisation wide review in April 2006.

A Wheatbelt Population Health Leadership Development program was launched during 2005-06. The program aims to provide career planning and management training for identified future leaders in population health.

Operations

Introduction

In 2003 the State Government of Western Australia released *Better Planning: Better Services*, its strategic planning framework for the public sector. The framework outlined the five strategic goals for government in this state.

The Government, through its agencies and in partnership with the community and industry, seeks to create the right conditions to achieve its vision of a sustainable Western Australia. These conditions are to be met through an integration of environmental protection, social advancement and economic prosperity across the state.

The five strategic goals, outlined below, are the ideals against which the Department of Health measures its annual operations.

Goal 1: People and Communities

To enhance the quality of life and wellbeing of all people throughout Western Australia.

Goal 2: The Economy

To develop a strong economy that delivers more jobs, more opportunities and greater wealth to West Australians by creating the conditions required for investment and growth.

Goal 3: The Environment

To ensure that Western Australia has an environment in which resources are managed, developed and used sustainably, biological diversity is preserved and habitats protected.

Goal 4: The Regions

To ensure that regional Western Australia is strong and vibrant.

Goal 5: Governance

To govern for all West Australians in an open, effective and efficient manner that also ensures a sustainable future.

Operations: People and communities

Demography

The WA Country Health Service, established in 2004, provides health services across 2,525,306 square kilometres, an area stretching from the Great Southern to the Kimberley and the west coast to the WA/NT/SA border.

The WACHS' 2005 residential population was estimated at 315,200 representing 15.7% of the State's total population of 2,005,237. The number of Aboriginal people living in the WACHS area was estimated at 43,126 in 2005 representing 13.7% of the WACHS population.

The WACHS continues to maintain a higher percentage of children aged 0-14 years than the rest of the State but a lower percentage of people aged 65 years and over. The dependency ratio (the ratio of people aged less than 20 years and more than 64 years to those aged 20 to 64 years) is 0.49 compared with a State ratio of 0.46.

Population projections for 2015 estimate that for the WACHS the population will decrease by 1.3% but maintain a dependency ratio of 0.47, comparable to the existing ratio.

There are many socio-demographic factors to consider when providing services across the WACHS. These factors include the size of communities and towns, the range of occupations and diverse cultures, the availability of employment opportunities, the large distances travelled to access services and the level of infrastructure and services available.

Map 1: WA Country Health Service

The WACHS provides health care services across 97 local government authorities.

Employment

Industries such as agriculture, forestry, fishing, mining, retail, health and community services, education, construction, manufacturing, transport, essential services, and hospitality and tourist services are the main sources of employment in the WACHS area.

Table 2: Population Distribution of the WA Country Health Service

Estimated Total Population				
	2005 Population Percentage	2005 Resident Population	2010 Resident Population Projections	2015 Resident Population Projections
Kimberley	11.5	36,113	40,042	44,151
Pilbara	15.6	49,175	48,117	46,967
Midwest	15.8	49,834	48,753	47,792
Goldfields	17.1	53,941	52,338	50,529
Great Southern	17.1	54,062	54,296	54,629
Wheatbelt	22.9	72,075	69,134	66,340
WACHS TOTAL		315,200	312,680	310,408

Demography

Health Status

Demographic data and information on general health behaviour assists health services to develop and implement service delivery models and programs.

Similar health problems to those seen across the State affect the WACHS population. Heart disease, cancer, asthma, stroke, arthritis, osteoporosis, mental health conditions and injury have a similar prevalence to the State.

While there are many local influences affecting health status, it is generally accepted that specific health risk factors such as smoking, cholesterol levels, diet and exercise are the predominant risk factors affecting health.

Self Reported Health Factors

The WA Health and Wellbeing Surveillance System conducts a continuous survey of Western Australians obtaining self reported information on a number of health risk and lifestyle factors, well-being indicators and health conditions.

During 2005, 2,684 people living in the WACHS area responded to the survey (1,091 males and 1,593 females). The estimates have been adjusted for differences in the age and sex structure of the population.

The prevalence of smoking and obesity across the WACHS continues to be higher for both males and females when compared to the State values. The prevalence of risky and harmful drinking was also higher in males. The prevalence of the other risk behaviours was statistically similar to State values.

In 2005 self-reported doctor-diagnosed health conditions indicated that the prevalence of diabetes, asthma, arthritis and mental health problems was higher for females than reported for males across the WACHS. Males reported higher prevalence of heart disease and injury than females for the WACHS area population while the prevalence of stroke was similar for both males and females.

The prevalence of self-reported doctor-diagnosed health conditions for the WACHS were similar to those reported for other health areas and the State with the exception of a higher prevalence of asthma in females.

Health Service Utilisation

Information on the utilisation of health services is also gathered during the survey. The proportions of WACHS residents attending a health care service within the previous twelve months were:

- primary care services 86.6% of males and 89.2% of females
- mental health services 3.1% of males and 6.0% of females
- dental services 40.3% of males and 46.0% of females
- allied health services 43.1% of males and 49.0% of females
- hospital based services 32.3% males and 29.7% females.

Males and females living in the WACHS areas generally use health services at similar rates to levels of use across the State, except for dental health services where usage rates are below those for the State.

Public Health Programs

Community participation in public health programs aimed at preventing illness and injury is actively implemented by the WACHS. The annual survey, as well as other data collection on public health programs, provides additional information regarding the health of a population.

The inappropriate consumption of alcohol, poor diet and eating habits, a lack of exercise, and the incidence of smoking are life style factors specifically targeted by public health and health promotion campaigns implemented state-wide by the Department of Health. These campaigns are supported regionally by complimentary activities instigated by the WA Country Health Service.

Operations: People and communities

Demography

Mortality

The major causes of death in WA for the period 2000-2004 were ischaemic heart disease, other forms of heart diseases, various cancers, cerebrovascular disease, chronic obstructive pulmonary disease and diabetes. Conditions of these types formed the top 7 to 8 causes of deaths for both genders.

In the WACHS the top ten causes of death were ischaemic heart disease, other forms of heart disease, lung, colorectal and other forms of cancer, cerebrovascular disease, diabetes, chronic obstructive pulmonary disease and allied conditions, adverse effects due to drugs, medicinal and biological substances and transport accidents.

These top ten causes of death accounted for 68.0% of all male deaths in the WACHS during 2000 – 2004 of which ischaemic heart disease at 18.1% was the principal cause of death. The number of male deaths due to diabetes, ischaemic heart disease, other forms of heart disease, chronic obstructive pulmonary disease and allied conditions and transport accidents were greater than expected compared with the State male mortality rate.

For females, these top ten causes of deaths accounted for 65.6% of all female deaths and as for the male population, ischaemic heart disease was the leading cause of death causing 14.5% of deaths during 2000 - 2004. The number of deaths due to other forms of heart disease, diabetes, and ill-defined conditions were greater than expected compared to the respective State female rate. Breast cancer was also a significant cause of female mortality.

Hospitalisation

The main causes for admission to hospital in WA were "Other factors affecting health status" which included conditions such as renal dialysis and chemotherapy. Admissions for "digestive diseases" such as liver disease, hernia and appendicitis, "musculoskeletal diseases" such as arthropathies and rheumatism, "cancer" and "Injury and poisoning" accounted for over 50% of all causes.

In 2004, reported hospitalisation rates for males living in the WACHS areas due to circulatory diseases, respiratory diseases, ill-defined diseases, and injury and poisoning conditions were greater than expected relative to the State male rate. For females living in the WACHS areas, the rate of hospitalisations due to circulatory diseases, musculo-skeletal diseases, respiratory diseases, digestive diseases, complications due to pregnancy, ill-defined conditions, injury and poisoning conditions and other factors affecting health status was greater than expected relative to the State female rate.

References

DOH: Health System Support – Analysis and Performance Reporting, Epidemiology Branch.
Australian Bureau of Statistics
Department of Infrastructure and Planning.

Disability access and inclusion plan outcomes

The *Disabilities Services Act 1993* (amended 2004) was introduced to ensure that people with disabilities have the same opportunities as other West Australians and the WACHS is committed to providing all people with access to facilities and services.

As required under the Act public authorities must develop and implement a Disability Access and Inclusion Plan (DAIP) and must undertake a continuous process of review to ensure the organisation meets the outcomes outlined in the Act.

The WACHS has developed and implemented its DAIP and implemented a number of initiatives to achieve the outcomes outlined in the Act.

OUTCOME 1

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

- The WACHS' Disability Access Committees continually review and develop the WACHS DAIP to ensure it and related policies are current.
- The WACHS encourages people with disabilities to contribute to consumer forums and ensures health service events are accessible to people with disabilities. A number of sites provide suggestion books where staff can lodge issues and service initiatives including those relating to access to services by those with a disability.
- Appropriate patient transport services are made available to people with disabilities to attend appointments at health facilities.

OUTCOME 2

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

- The WACHS conducts a continuous facility auditing process to identify risk, and ensure appropriate access for those with a disability is maintained and correctly identified to all facilities.
- Resources are allocated to upgrade existing facilities for areas such as directional signage, handrails and railings, modifications to toilets and bathrooms, the provision of access ramps and automatic doors, and to ensure appropriate vehicle parking capacity for people with a disability.

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.

- The WACHS develops information resources in accordance with Department of Health guidelines and in appropriate formats suitable for people with disabilities. Information can be provided verbally, in Braille and in electronic formats for sight, hearing and reading impaired people, and information brochures are produced in large fonts with pictures and diagrams.
- Regional areas have identified the communication needs of people with disabilities, especially in conjunction with access to interpreters and compliance with DOH Access Policy and Guidelines. A specific 24-hour emergency telephone consultancy service is also available for people with a mental health disability.
- The WACHS maintains networks with representative organisations to obtain expert advice and information regarding access and disability issues.

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.

- New and existing staff are provided with training resources and staff development opportunities to ensure the needs of people with disabilities are understood, and staff are aware of current issues affecting disability services. The Area Health Service reviews levels of staff awareness in regard to disability service issues, and uses this information to structure training programs.
- Selection criteria for staff positions require applicants to demonstrate awareness of current disability issues.

Disability access and inclusion plan outcomes

OUTCOME 5

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

- The WACHS has implemented appropriate grievance and complaint mechanisms that provide people with disabilities opportunities to raise issues and make formal complaints regarding access to health services or specific circumstances relating to services they have received.

OUTCOME 6

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

- The WACHS' Disability Access Committees include community representatives who have disabilities, and who act as advocates for all people with disabilities.
- Representation on numerous District Health Advisory Councils includes members with disabilities to ensure the interests and concerns of the disabled are considered in health service and facility planning.
- Specific interest groups such as the Council of Official Visitors also provide a mechanism for people with disabilities to pursue issues with the health service provider.
- Community consultative groups and networks ensure people with disabilities are included in decision-making processes.

Operations: People and communities

Cultural diversity and language services outcomes

Recognition of the cultural diversity of communities, and the complexity and diversity of languages is central to the business of the Government of Western Australia. Ensuring that people requiring assistance with the English language are not disadvantaged in obtaining services is vital to equitable access across all communities.

The WA Country Health Service has implemented measures to guide the delivery of services to people from Culturally and Linguistically Diverse Backgrounds (CALD). Initiatives include providing new staff with cultural diversity training in the orientation and induction process, and providing all sites with resources to maintain continuing education in cultural diversity and available language services.

The WACHS undertakes routine audits of its Cultural Diversity and Language Service guidelines and policies ensuring the identification of staff training requirements, especially for those working with interpreters and those encountering health care clients requiring interpreter assistance.

The WACHS maintains a continuous audit of staff skills in:

- cultural diversity and languages other than English and cross-cultural communications
- programs to monitor and evaluate language service policies
- the development of guidelines on the use of telephone and on-site interpreting services.

This information is used to plan training programs across the organisation.

Specific Programs and Initiatives 2005-06

Across the WACHS multi-cultural and language services provided include:

- piloting a trans-cultural training program for mental health
- maintaining community liaison networks especially with Aboriginal Medical Services and with the Multi-Cultural Access Unit
- supporting the use of interpreter services in personal contact, and in one-to-one telephone and conference telephone circumstances
- Aboriginal language services for some dialects and regular liaison with Aboriginal language and health service centres;
- cultural awareness training for new and existing staff
- health worker training where there is a focus on workers with lower literacy skills
- promoting the involvement on health advisory committees of people with ethnic backgrounds
- designing health surveys appropriate to CALD clients in remote communities
- employment of multi-cultural access officers; in particular Aboriginal health care staff for both clinical and non-clinical areas, and staff to cover specific cultural groups where appropriate. A specific example is a Malay liaison officer in Katanning for community mental health services. Multi-cultural staff also assist in the production of cultural and language specific health information resources and newsletters distributed at WACHS facilities
- ensuring the participation of culturally diverse groups in health service planning.

Substantive equality

Please see the Department of Health Annual Report 2005-06.

Youth outcomes

The WA Country Health Service acknowledges the rights and special needs of youth and is committed to the following objectives as outlined in *Action: A State Government Plan for Young People; 2000-03:*

- promoting a positive image of young people
- promoting the broad social health, safety and well being of young people
- better preparing young people for work and adult life
- encouraging employment opportunities for young people
- promoting the development of personal and leadership skills
- encouraging young people to take on roles and responsibilities, which lead to active adult citizenship.

The WACHS endeavours to provide appropriate services, supportive environments and opportunities for young people.

Specific Programs and Initiatives

During 2005-06, the WACHS conducted numerous youth focussed health initiatives to support the social health and well being of young people, promote self esteem and personal confidence, provide opportunities for career development and employment, and generally improve health.

Many programs are developed and coordinated at the local and regional level. However, where appropriate, programs for wider target groups are implemented, for example, the immunization program expansion across a number of WACHS areas providing Varicella-Zoster vaccine (Varicella) to all Year 7 students and immunization against invasive Pneumococcal Disease (Pneumovax) for all Aboriginal youth 15 years and older irrespective of chronic disease status.

WACHS - Kimberley

A growth and development health education program for all students in years 7 and above has been implemented in all Kimberley schools and includes a blood borne virus education session in selected secondary schools.

Three sexual health programs are provided focusing on informed choices and healthy behaviour - "Mooditj Program"; "Growing and Developing Healthy Relationships program"; and "Protective Behaviour program". These programs are delivered across schools and youth groups. Youths 15 years and older are encouraged to participate in the "Well Person" clinical monitoring program for remote areas.

The Kimberley Population Health Unit provided a number of health promotion programs targetting youth such as the "In Touch Project", a school drug and alcohol health promotion program, and the School Drug Expo "Enough is Enough" education initiative.

The North West Mental Health Service youth counsellor participated in "Gatekeeper Suicide Awareness" training and the Child and Adolescent Mental Health team continued its involvement in "Resourceful Adolescent Program" training. Two additional staff were also recruited for the Child and Adolescent Mental Health team during 2005-06.

A partnership between the Kimberley, TAFE and University of Notre Dame has established a local enrolled nursing course.

WACHS - Pilbara

Health promotion programs targeting young people focussed on safe sexual practices, understanding nutrition and physical activity. Specific programs were undertaken for the responsible intake of alcohol with education programs for school students and for employees in businesses serving alcohol.

WACHS - Midwest

The Midwest continues to participate in the RCNA Nursing EXPO annually. The purpose of the EXPO is to profile the nursing profession and the image of nursing, and promote recruitment and retention of the nursing workforce. It also showcases medical equipment and lifestyle options for nurses.

Youth outcomes

Health promotion programs targeting young people focusing on safe sexual practices have also been continued during the year. The "Triple P" - Positive Parenting Program, has been continued during the year. This program aims to influence child health through working with parents.

The Heart Foundation and the Midwest Population Health Unit have cooperated together in a project titled "Up4it" that has worked extensively with youth aged 12 to15 years in the Geraldton area promoting physical activity. There has been a wide range of special physical activities, such as surfing events, basketball competitions and football. Clubs and sporting groups throughout Geraldton have been supported to gain additional sponsorships, thus increasing opportunities for physical activity.

The program titled "Canning Stock Route Challenge", that encourages school children to undertake extra physical activity and to eat a healthy diet, has been implemented in schools throughout the Midwest. This program aims to decrease type 2 diabetes.

WACHS - Goldfields

Following consultations with local Aboriginal youth in Norseman, a Local Drug Action Group was formed by the youth of the area with mentoring from the Population Health Unit staff. This group is part of a State-wide network of over 70 groups that work towards addressing issues on a local level regarding alcohol and drugs. The group has organised a number of events promoting alcohol and drug issues including a disco and a two day workshop in Kalgoorlie titled "Get Connected". This event promoted liaison between local agencies and community members to develop initiatives to resolve local alcohol and drug issues. The group is also planning a family fun day for late 2006.

The Goldfields continued its "Promoting Adolescent Sexual Health – with a twist" (PASH) program that commenced in 2004-05. This program is supported by funding from Family Planning WA. The PASH program enables participants to make informed choices about their own sexual health and participants become peer educators, developing leadership skills which can also assist in other aspects of their lives.

During the year PASH programs have also been introduced in Esperance, Norseman and Ravensthorpe. The Norseman and Ravensthorpe programs have been conducted in the District High Schools in collaboration with the Department of Employment and Training.

In collaboration with the "Mentally Healthy WA" Project and Population Health Unit, an Aboriginal girls 13 to 16 years basketball team, the "Millen Street Mob" was organised in Kalgoorlie Boulder to compete in a local competition. This initiative was developed by the team members and has been supported with uniform sponsorship by community organisations and the Population Health Unit. The initiative aims to improve confidence, self-esteem, and physical and mental health.

A youth survey collecting information regarding attitudes and behaviours when visiting a doctor or nurse on matters of sexual health was conducted in the Goldfields during 2005-06. Health staff recognised that it was important to obtain information about youth perceptions when they needed to discuss sexual health issues with a clinician. Information gathered in the survey led to three local general practitioners undertaking "Youth Friendly" training in Kalgoorlie/Boulder. A number of Goldfields health staff have undertaken Mooditj training providing them with appropriate skills for working with youth.

In 2005-06 the Goldfields provided one of two Western Australian representatives at a Youth Roundtable held in Canberra. This representative was able to advocate locally for inclusive youth environments and for the development of alternative business opportunities for rural youth.

Also during 2005-06 the Goldfields ran a series workshops in the Esperance area under the "Side-by-Side: Respecting Diversity" program, promoting the development of inclusive service delivery for rural community members who are same sex attracted. These workshops were the

Youth outcomes

largest event outside Perth to address this issue, and targeted all government, non-government and community organisations within the Esperance region including Ravensthorpe and Norseman.

WACHS - Great Southern

During 2005-06 the Great Southern "Strong Families" program assisted 22 families. This is an inter-agency program focussed on at risk families requiring multiple agency assistance.

The Great Southern Mental Health Service has developed strong inter-agency links with the district school psychologists and teachers, primary health care services, and the Department of Community Development to provide comprehensive mental health care to schoolchildren across the Great Southern. The service has also developed close liaision networks with child development staff to facilitiate the referral process.

The Child and Adolescent Mental Health Service (CAMHS) staff train facilitators to provide self-esteem and self-image enhancement for children aged 9 to 13 years in Great Southern schools. The mental health prevention and promotion officer provided a "Friends - Parents" program and facilitated in-house clinical groups supporting mental health clients, those clients identified by the school psychologist, and for "COPMI" clients. This officer was also active in the "Healthy Start" program for pre-schoolers in Albany and Gnowangerup.

The CAMHS staff provide training for the "Resourceful Adolescent Program" leaders promoting positive mental health in young people in year 8 at high school. They also present "Smart Start" early intervention education seminars for parents of children aged 0 to 4 years and completed "Thera-play" training to enhance the skills of clinicians in working with younger children.

During 2005-06 the Great Southern Mental Health Service ran the "Gatekeeper" suicide prevention program twice in Albany. In conjunction with general educational programs, the outcome achieved has been to raise awareness of people at risk and to equip people in the community with tools to prevent self-harm and death.

Health staff at Denmark play an integral role in the Denmark Youth Centre Advisory Committee. During 2005-06 the committee in conjunction with the Shire of Denmark focused on the development of a new purpose-built Youth Centre and skate park with site works commencing in May 2006. In April 2006 Denmark staff, in conjunction with other emergency services (police and fire), held a "Mystery Tour" for Years 11 and 12 students from the Agricultural College. This included a visit to the hospital emergency department set up with a mock trauma case, and a visit to the morgue.

During the year the Population Health Unit targeted young dads aged 19 to 30 years to encourage their participation in the "Best Beginnings" program. The unit also supported opportunities for younger staff to participate in the "Great Western Bike Ride" encouraging exposure to a physical and mental challenge, and highlighting careers in health promotion.

The Population Health Unit conducted the "Chlamydia Campaign", targeting young people via school health staff and local media to encourage participation in screening programs at local general practitioners' rooms. The unit also promoted attendance at immunization "catch-up" clinics such as the Meningococcal C Mop Up Campaign to increase immunization coverage.

Walks for physical and mental health were held at schools in Plantagenet and Cranbrook during the "2005 Mental Health Week" and staff also contributed to the "Cool Cats Calm Kids" an anger management program at the local primary school.

The "Beyond the Blues" forum delivered by Plantagenet and Cranbrook health staff was a free event for community members interested in issues relating to depression, an increasingly relevant issue for rural youth. The forum aimed to increase knowledge and awareness about mental health, encourage participation in healthy lifestyles, provide a better understanding on when to act and the

Youth outcomes

importance of committing to a supportive group or network. Health staff also provided guided tours of health services for local schools and encouraged student training, work experience and community order placement at local community organisations.

WACHS - Wheatbelt

Throughout 2005-06 Wheatbelt health staff continued their collaborative relationships with community groups in community-based projects, providing appropriate youth focussed services. Agencies included the Avon Region Youth Network and the 'Respect All People' park. A specific activity for the Wheatbelt in 2005-06 was participation in Youth Week, which aims at developing personal skills for youth, promoting positive images, and coordinating youth activities.

During the year the Wheatbelt maintained a prominent role in a range of school education programs such as:

- Resourceful Adolescent Program
- Triple P - Positive Parenting Program, which aims to influence child health through working with parents
- School Drug Education Program promoting the broad social health, safety and wellbeing of young people
- PASH – Promoting Adolescent Sexual Health
- NEST Enhancement Program – virtual parenting program
- It's Like Wow I'm Changing – mother and daughter program
- Involvement with the School Leavers Committee
- Involvement in the Northam Local Drug Action Group and supporting activities of the Youth –'Respect All People' Park
- Involved in organisation /presentation at Wheatbelt Youth – Drug Summit
- Supporting student nurse placements and new graduate nurses in Narrogin, Northam and Merredin

Operations: The economy

Major capital works

Please refer to the Department of Health Annual Report for financial details of major capital works in the WA Country Health Service.

Capital works projects completed in the WA Country Health Service during 2005-06:

- Warburton clinic replacement
- Halls Creek Multi Purpose Centre
- Halls Creek staff accommodation
- Geraldton Regional Resource Centre
- Looma clinic redevelopment
- Midwest staff accommodation at Coral Bay

Capital works projects in progress in the WA Country Health Service during 2005-06:

- Broome Regional Resource Centre
- Derby hospital acute inpatient ward
- Fitzroy Crossing Multi Purpose Centre
- Kununurra dental health clinic
- Kalgoorlie Regional Resource Centre
- Albany Regional Resource Centre
- Albany Rehabilitation Day Centre refurbishment
- Denmark Multi Purpose Centre
- Morawa Multi Purpose Centre
- Stage 2 Port Hedland Regional Resource Centre
- Staff accommodation in the Pilbara
- Moora Multi Purpose Centre

Operations: The environment

Energy Smart government policy

Please refer to the Department of Health Annual Report for details on the Department's Energy Smart strategies for the Western Australian health system.

Regional development policy

Government agencies are required to report on their contribution to the State's Strategic Planning Framework "Better Planning: Better Services". The Framework outlines five goals including "To ensure that regional Western Australia is strong and vibrant", for which one specific strategic outcome is "Effective health service delivery".

This strategic outcome is complimented by the Government's Regional Development Policy:

Outcome Priorities:

- Better health outcomes for residents of regional Western Australia.
- Substantial improvement in health and health conditions of those who are disadvantaged, including indigenous people.
- Demonstrated improvement in access to safe and sustainable regional health services.
- Greater numbers of health professionals resident in rural areas.

Service Strategies:

- Implement a regional health service system based on strong and effective partnerships between the three levels of government, other human service agencies, the non-government sector and private sector.
- Improve access to safe and sustainable primary and secondary treatment and prevention health services in regions, particularly specialist, general practitioners, community and allied health services, and lifestyle education programs.
- Develop a regional network of health infrastructure that supports delivery of safe and sustainable health services to regions.
- Increase access to support services for regional people with mental illness, their carers and families.
- Develop and strengthen whole of government/community partnerships and initiatives aimed at improving the health and health conditions of indigenous people.
- Encourage the Australian Government and aged care industry to address the shortage of aged care beds.
- Attract and retain general practitioners, nurses, specialists and other health professionals to country areas.

During 2005-06 the WACHS has developed operational strategies and health service delivery objectives to address the Government's regional development policies.

South West Area Health Service Integration

In December 2005 the South West Area Health Service was integrated into the WA Country Health Service creating a single, unified country health system for regional WA. This initiative will enable a more efficient, integrated and accountable system for the delivery of country health services. Operational management arrangements commenced in December 2005, with the legal entity for the new integrated health service taking effect on 1 July 2006.

Country Health Services Review 2003

During 2005-06 the WACHS maintained the reform agenda commenced under the "*Country Health Services Review 2003"*, endorsed by Health Reform Committee Report.

The WACHS is developing a framework for country health clinical services. The framework will reflect input from health service staff, metropolitan clinical leaders and experts, and external organisations.

The development of Multi Purpose Services continued during the year throughout the WACHS with new sites being considered for Tom Price, Onslow and Exmouth. The development of this service delivery model is a collaboration with local communities and service providers, and the Australian Government. Multi Purpose Services provide more comprehensive, accessible and sustainable health services to small rural communities. There are numerous MPS sites across rural WA including Dongara, Augusta, Central Great Southern, Plantagenet/Mt Barker, Laverton/Leonora and Dalwallinu.

During 2005-06 the WACHS has continued exploring the opportunities for the use of Telehealth in delivering health care to patients and clients across the health service. The WACHS and Metropolitan Health Services have also developed formal links to ensure regional patients have timely access to tertiary health care and professional expertise.

Regional development policy

District Health Advisory Councils

The WACHS continues to work closely with the District Health Advisory Councils (DHAC) across the health service. There are 17 established and seven proposed councils across country WA, providing an avenue for community representatives to contribute information and community input to health service planning, and a mechanism for local health service management teams to share information with the community.

The WACHS has also initiated an Annual Conference for council members, bringing together community representatives in a forum supporting the exchange of views and ideas across the region.

Consultation with Country Doctors

An extensive consultation program between the WACHS Chief Executive Officer and country doctors has been initiated with the primary purpose being to hear first hand the issues facing rural doctors in the provision of rural health services and to have a process established to respond to these issues. These consultations were facilitated by the Western Australian Centre for Rural and Remote Medicine (WACRRM).

Capital and Equipment Investment

A number of significant capital investments were progressed during 2005-06. These included the Geraldton, Albany, Kalgoorlie and Port Hedland Regional Resource Centres, and hospital developments at Halls Creek, Moora, Kununurra, Quairading, Margaret River, Busselton and Denmark.

The WACHS has also initiated capital investment for mental health with a new community mental health facility and additional acute capacity in Bunbury, and community supported residential units in Albany, Geraldton, Busselton and Bunbury.

New equipment has included Computer Tomography (CT) scanners installed in Broome, Port Hedland and Busselton, and ordered for Northam and Albany, ultra sound machines for ten rural sites, mobile and general x-ray machines, fluoroscopy equipment for Nickol Bay, and teleradiology capability at all radiographer sites.

Partnerships

The WACHS has continued to develop effective partnerships with other health providers and stakeholders across the region recognising the benefits these arrangements can deliver to country communities.

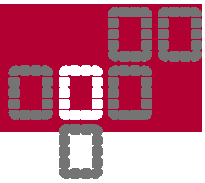
Significant developments during 2005-06 include:

- a sponsorship arrangement with BHP Billiton for health promotion, specialist medicine, allied health and community health in the Pilbara
- numerous health initiative partnerships with rural General Practice Divisions
- MPS development with the Australian Government
- collaboration with Disability Services Commission for community therapy services
- partnerships with Aboriginal health organisations for health care services including renal dialysis and audiology
- partnerships with a number of educational institutions for workforce training and professional development.

In 2005-06 the management of a number of contracts for non-government health service provision was transferred from the Department of Health to the WACHS. These include contracts with the Royal Flying Doctor Service, St John of God Health Care Bunbury, Broome Regional Aboriginal Medical Service, West Australian Centre for Remote and Rural Medicine, Centre for Rural and Remote Oral Health, and country based Home and Community Care providers.

Clinical Senate

Instigated by the WACHS, the Clinical Senate held a one day meeting in March 2006, solely dedicated to discussion and debate about existing and potential clinical and non-clinical networks, strategic pathways and working relationships between metropolitan and country health services.



Regional development policy

ACHS Accreditation

It is the WACHS's objective to have all services within the organisation accredited under ACHS Standards and currently all hospitals are enrolled with a recognised accreditation assessment agency. A number of WACHS (including SWAHS) services have already achieved accreditation and the WA Country Health Service is proactively working with other sites to conduct self- assessments in preparation for accreditation. In addition, the WACHS has put in place processes to address the outcomes of accreditation reviews and self-assessments prior to accreditation surveys.

Health Service Development

The WACHS has implemented a number of health service development initiatives during 2005-06.

The construction of Karlarra House residential care facility in Port Hedland, the establishment of an Aged Care Unit in the Wheatbelt, and a pilot site trial at Albany for the Residential Care Line, which aims to reduce emergency presentations and admissions from residential care facilities, are initiatives in aged care. Wellington district staff in the South West are also collaborating with local aged care providers to deliver more efficient aged care services.

Mental health service initiatives have included expanded services in the South West, Kalgoorlie and the Wheatbelt, and increased use of Telepsychiatry. Specific projects such as the Eastern Goldfields Regional Reference Site, a collaboration with the Eastern Goldfields Mental Health Division of General Practitioners and the Australian Government were also undertaken.

Initiatives to support and improve community mental health have included the "Understanding and building resilience in the South West" project, the "Beyond the Blues" depression forum in the Great Southern, and numerous activities across country areas for "Mental Health Week 2005".

The WACHS has also made a significant number of clinical and allied health appointments in 2005-06. These include medical specialists in anaesthetics, paediatrics, surgery, public health, mental health, gynaecology and obstetrics, and allied health professionals in podiatry, speech and occupational therapy, social work, nutrition and physiotherapy. The number of Aboriginal health workers has also been increased in remote areas.

The WACHS has promoted workplace professional development opportunities with qualification conversion with several tertiary education institutions, and specific projects such as the "Ocean to Outback Graduate Nursing Program" in the Midwest, and "LOOP" in the South West. There is also significant participation by senior and executive management in the Health WA "*Leading 100"* and the "*Vital Leadership"* workforce programs.

Several projects to inform management of current workforce practice have also been implemented. These include the "Nursing Hours per Patient Day" project in the WACHS and community health workforce benchmarking in the South West.

A number of health sites have implemented the "Health Promoting Health Service" program, a WHO initiative to improve the focus on health prevention, promotion and wellness. During the year the development of the "Healthy Communities Program" has continued in a number of country locations.

The "*Foundations for Country Health Services"* project was developed to strengthen the vision, goals and strategic directions set by the "*Country Health Services Review of 2003"*. This project commenced in 2005-06 and will continue in 2006-07

Operations: Governance

Employee profile

The table below shows the number of full-time equivalent staff employed by the WACHS during 2005-06 by category.

Table 3: Total FTE by Category

Category	Definition	Number FTE
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	841
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	11
Agency nursing	Includes nurses engaged on a "contract for service" basis.	68
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	997
Medical salaried	Includes all salary-based medical occupations.	109
Medical support	Includes all Allied Health and scientific/technical related occupations.	422
Nursing	Includes all nursing occupations. Does not include agency nurses.	1,797
Site services	Includes engineering, garden and security-based occupations.	157
Other categories	Includes Aboriginal and ethnic health worker related occupations.	90
Total		**4,492**

Notes FTE categories differ slightly from those reported in previous reports and report the position as at June 2006.

Recruitment

Recruitment Practice

The WACHS is committed to upholding the principles outlined by the Office of the Commissioner for Public Sector Standards. All recruitment and selection processes are undertaken in accordance with the criteria set down in the "Public Sector Standards in Human Resource Management".

A WACHS-wide policy for the recruitment, selection and appointment of staff is applied consistently across the Area Health Service and is updated annually to ensure government and departmental guidelines are followed. Policies are available at all WACHS sites and are accessible via the WACHS Intranet site.

Training is provided on a regular basis to ensure that potential selection panel convenors and members have the necessary skills and understanding to ensure compliance with the Public Sector Standards. All selection panels must have at least one panel member who has attended recruitment, selection and appointment training. Appointments are based on proper assessment of merit and equity.

There is full disclosure of the provisions and entitlements applicable to legislation, awards and employment agreements.

Vacancies are advertised in both print and electronic media. Recruitment campaigns have featured recruitment articles in national newspapers, participation in international recruitment initiatives, especially for medical officers and nursing staff, exposure at career expos especially the Royal College of Nursing Australia Nursing Expo 2005, promotions in educational institution handbooks, and participation in graduate programs.

Recruitment Initiatives

The recruitment of clinical staff, particularly nurses, medical officers, mental health clinicians and allied health professionals has continued as a priority in 2005-06. The WACHS has identified and implemented recruitment strategies in its endeavours to attract clinical staff to positions across the organisation and recruitment officers assist with these initiatives.

Recruitment

Particular achievements in recruitment in the WA Country Health Service during 2005-06 were:

- in the Goldfields, where the number of medical officer positions was increased at the Kalgoorlie Regional Resource Centre with appointments for a new Public Health Physician, Surgeon, General Physician, Obstetrician/Gynaecologist, Senior Medical Officer (Psychiatry) and a Regional Director of Medical Services as well as attracting a podiatrist to Kalgoorlie and filling several long-term vacancies in the Kalgoorlie – Boulder Community Mental Health Service.

- in the Wheatbelt, where the Candidate Management System, an on-line job application receiving system, was implemented. This system is an integral part of the recruitment process and is supported by regular training sessions in interviewing skills and recruitment, selection and appointment. The Wheatbelt was also active in 2005-06 with the sponsorship and appointment of a further four overseas-trained registered nurses and two overseas trained enrolled nurses, bringing a total of 25 sponsored nurses working in the Wheatbelt area.

Staff development

The delivery of quality health care services is directly related to the quality and the skill of the staff the health service employs. The WA Country Health Service is committed to maintaining an environment that encourages staff to seek opportunities for personal and professional growth and development.

The "Workforce Learning and Development Policy and Guidelines" adopted by the WACHS supports professional advancement and personal development throughout the organisation. The policy and guidelines assist in the achievement of the WACHS strategic goals, to promote and utilise the skills, knowledge and attributes of its staff. A number of sites have implemented complimentary workforce programs to address local workforce issues, for example, the "Wheatbelt Workforce Development Program".

Employees are able to access training and development to meet organisational competency requirements and career development objectives. These learning and development opportunities meet strategic and operational goals, employment awards and conditions, public sector standards, legislative and governance requirements. Training is addressed in line with equity principles and quality standards, and preference is given to training providers who deliver services locally. Self directed and on-line learning options are also supported.

The provision of staff training and development opportunities recognises the benefits of staff satisfaction, professional development, communication and networking, and the achievement of health care objectives. Utilising the existing skills, knowledge and attributes of all staff can also contribute greatly to the overall development and performance of the health service.

The WACHS provides a number of mechanisms to assist staff in career and personal development including study leave, financial support for approved development programs, supported placement in approved courses, graduate and undergraduate training programs, and peer support and mentoring programs.

The WACHS has continued to develop the use of Telehealth video conferencing during 2005-06 for staff development and training programs. The organisation also has a number of staff participating in the "*Leading 100*" program.

Some service sites also prepare specific information packages for new employees, for example, in the Kimberley, where employees receive an induction booklet on generic North West employment conditions, local services and facilities, preparation for travelling to remote locations, and tropical weather conditions.

2005-06 Workforce Learning Programs

The WACHS continues to provide mandatory generic staff induction or orientation programs. Topics include fire and emergency procedures, occupational safety and health, infection control (if appropriate), risk management, Public Sector Standards and Codes of Ethics and Conduct, and Freedom of Information. Also included are service accreditation procedures for the Australian Council on Healthcare Standards (ACHS), multi-cultural and indigenous awareness, manual handling, driver education for off-road driving and basic vehicle maintenance, workplace behaviour and bullying, aggression management and interpersonal conflict resolution, customer services and information technology familiarisation and Telehealth.

In addition, specific staff development and training opportunities in 2005-06 included:

- first aid and emergency medical training
- medical information and technology
- performance management
- team building, leadership and management
- ongoing learning and development in various clinical subjects:
  - paediatrics
  - mental health
  - CPR and defibrillation
  - graduate nurse and nursing qualification upgrade programs
  - burn emergency care and management
  - advanced life support
  - post-natal depression
  - triage practice
  - spinal injury management
  - epidural analgesia.

Workers' compensation and rehabilitation

The following table provides information on the number of worker's compensation claims made through the WACHS.

Table 4: Workers' Compensation and Rehabilitation

WACHS	Nursing Services	Administration and clerical	Medical Support	Hotel Services	Maintenance	Medical
Goldfields	5	1	0	5	1	0
Great Southern	8	2	0	15	1	0
Kimberley	9	1	0	7	1	0
Midwest	18	8	2	20	0	0
Pilbara	12	5	1	12	1	0
Wheatbelt	15	5	6	35	4	0
Head Office	0	2	1	0	0	0
Total	**67**	**24**	**10**	**94**	**8**	**0**

Note - Categories include the following:
Administration and Clerical – health project officers, ward clerks, receptionists and clerical staff
Medical Support – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
Hotel Services – cleaners, caterers and patient service assistants
Medical – salaried officers.

During 2005-06 the WACHS continued developing quality assurance and risk management monitoring programs, strategies for occupational safety and health systems, and relevant operational policies and programs. The organisation ensures there is a consistent approach to occupational safety and health and employee rehabilitation.

Occupational safety and health officers have been appointed across the WACHS. These officers are responsible for informing management on workplace safety and occupational health matters, and for performing safety and occupational health audits.

The organisation has implemented clinical governance policies and procedures supported by workplace education and collaboration, the availability of effective information systems and appropriate research.

Occupational Safety and Health Initiatives

The WACHS occupational injury and illness prevention reference group coordinates input from all areas to establish health service wide policies and procedures. These are available on the WACHS website.

The WACHS has adopted the WorkSafe WA "WorkSafe Plan" promoting management practises needed to establish and maintain safe work environments and supports ongoing monitoring programs.

During 2005-06 the WACHS sites have also pursued local initiatives to enhance their occupational safety and health programs. Examples include:

- local development of injury prevention programs in the Kimberley under the control of the risk management coordinator
- setting local injury management performance goals especially for "lost time injuries" and injury incidence rates in the Pilbara
- reviewing of safety management systems in the Midwest.

Workers' compensation and rehabilitation

Across the organisation staff are provided with training in personal security and safety, aggression management, chemical handling, fire and emergency practice, incident and hazard reporting systems, CPR, manual handling and a range of clinical practice issues. This is provided at orientation/induction courses as well as staff refresher courses. "Respectful Workplace Programs", specifically targeting positive relationships in the workplace and managing and resolving workplace bullying, are also provided.

Where appropriate, staff are instructed in off-road driving and general vehicle maintenance, and provided with cyclone preparation instruction and advice. Ergonomic assessments for staff are also provided.

The WACHS staff can access specific programs to promote occupational injury prevention and provide employee rehabilitation. Head office staff have access to occupational safety and health programs, and rehabilitation services through Department of Health based programs.

Occupational Injury Prevention

The WACHS undertakes regular weekly and monthly safety audits to ensure compliance with statutory responsibilities and regularly liaises with RiskCover to keep appraised of current issues and information.

The WACHS has adopted occupational health and safety databases and hazard registers across the Area Health Service, including capacity for pro-active hazard reporting and investigation. "Root Cause Analysis" methodology for investigating clinical incidents has been adopted in many sites to ensure comprehensive investigation of occupational injuries. "WorkSafe" audit tools developed by the Internal Audit Branch are available to all sites and screening programs are conducted as required.

Employee Rehabilitation

The WA Country Health Service provides comprehensive "best practice" rehabilitation programs to assist injured and ill employees back into the workforce. Programs are managed locally at regional and district levels.

The WACHS has numerous accredited Injury Management Coordinators across the organisation. Coordinators provide management for the numerous aspects of a specific rehabilitation programs, developed for injured workers and support early "return-to-work" outcomes.

All facets of rehabilitation programs are reviewed and monitored, including regular RiskCover reports, ensuring that information acquired can inform management of better practices that might be implemented.

The WACHS uses a combination of internal and external rehabilitation program providers and all staff involved in rehabilitation programs undergo training in injury management and are provided with appropriate instruction to undertake their responsibilities.

The organisation provides specific programs to enable employees to return to work, especially those on light or restricted duties. These programs are developed in conjunction with the employee, their doctor, their work supervisor and the Occupational Safety and Health coordinator, and include structured return-to-work programs.

Industrial relations

Department of Health

The Labour Relations Branch provides advice and support to the Department of Health and the Health Services on key industrial relations issues.

Key activities for 2005-06 included the settlement of an extensive work value claim by the Health Services Union (HSU) on behalf of health professionals, and preparations for future rounds of enterprise bargaining.

The Department settled a work value claim for health professionals with the HSU in November 2005, registering a formal agreement in the WA Industrial Relations Commission in December 2005. Employees covered by the agreement include:

- audiologists
- bio-engineers
- clinical perfusionists
- dietitians
- librarians
- medical imaging technologists
- medical scientists
- nuclear medicine technologists
- occupational therapists
- orthoptists
- orthotists and prosthetists
- pharmacists
- physicists
- physiotherapists
- podiatrists
- psychologists
- radiation therapists
- scientific officers
- social workers
- speech pathologists
- ultra-sonographers

The translation of most health professionals into the new classification structure established by the agreement was completed in June 2006. The new classification structure provides greater rewards for health professionals and also increases their capacity for progression. This improved professional recognition will assist in attracting and retaining these important employees.

WA Country Health Service

The WACHS has ensured the industrial relations policies and practices it has implemented complied with all relevant State and Australian Government industrial relations legislation, awards, and industrial and certified employment agreements. Management is required to adopt proactive cooperation and consultation processes between employer, employees and any relevant employee representative bodies.

Specific local industrial issues raised during 2005-06 involved position reclassifications, individual disputes in regard to the application of award and agreement conditions, unfair dismissal and the terms of severance, service structure changes at the Geraldton and Port Hedland Regional Resource Centres and the Roebourne Hospital. The organisation has also commenced a project to examine nursing hours per patient day.

The WACHS experienced no significant industrial disputation during 2005-06.

Evaluations

State Government agencies are required to undertake evaluations of their programs and strategies as part of routine management responsibilities. The dynamic nature of health care service delivery requires providers to operate in an evolving environment and the WACHS is committed to reviewing its various programs and service initiatives against required outcomes, standards and community needs.

Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is a not-for-profit organisation that provides a review and report of performance, assessment and accreditation. The ACHS is an independent authority on the measurement and implementation of quality improvement systems for Australian health care facilities. Standards for evaluation, assessment and accreditation are determined by a council drawn from peak bodies in health and representatives of the Australian Government, State Governments and consumers.

The Evaluation and Quality Improvement Program, known as EQuIP, was developed by the ACHS to assist health care organisations strive for excellence. The ACHS assists health care organisations to prepare for ACHS Accreditation by guiding them through EQuIP. The program provides a framework for establishing and maintaining quality care and services. Effective use of EQuIP requires an integrated organisational approach to quality improvement by assisting health care organisations to:

- improve overall performance
- develop strong leadership
- enjoy a culture of continuous quality improvement
- focus on customers
- focus on outcomes.

ACHS Assessments

The WACHS has continued its ACHS accreditation program in 2005-06. This program comprises standards self-assessments conducted continuously, as well as the formal ACHS standards surveys. Recommendations made following the assessment of standards are implemented to ensure that every opportunity to achieve accreditation is pursued.

Specific accreditation compliance assessments were conducted in a number of sites during the year.

WACHS - Pilbara

ACHS conducted standards compliance surveys across the Pilbara with recommendations to be implemented by June 2006. In particular the quality program has been evaluated in preparation for a further accreditation assessment in November 2006. A standardised process has been implemented throughout the Pilbara to assist in maintaining and developing the Quality Action Plan.

WACHS - Goldfields

ACHS EQuIP assessments were undertaken in Kalgoorlie/Boulder and the South East health districts. Health care facilities within Kalgoorlie/Boulder have maintained accreditation status and facilities at Esperance and Ravensthorpe are preparing for their first standards assessment in 2007. Norseman hospital has already achieved accreditation status. The Goldfields sustains its program of self-assessment to maintain standards and accreditation, and prepare for the routine ACHS surveys.

WACHS - Midwest

During 2005-06 ACHS accreditation surveys and assessments were conducted for the Geraldton Regional Resource Centre, the Central West Mental Health Service, the Midwest health district and the Midwest corporate office. These facilities have previously achieved ACHS accreditation, and following the surveys and the implementation of recommendations, have had accreditation extended for further periods of between one to four years. The Midwest will continue its program of routine self-assessment of standards compliance.

Evaluations

WACHS - Kimberley

The Kimberley conducted an ACHS Standards self-assessment in preparation for a full EQuIP accreditation survey scheduled for March 2007. The self-assessments identified areas of achievement and those that would benefit from an improvement program. The ACHS survey will involve all areas within the Kimberley.

WACHS - Wheatbelt

The ACHS conducted an accreditation survey for the Wheatbelt southern district for compliance with health care standards and the district was successful in being awarded accreditation for a period of four years. The ACHS commended the health service in a number of areas including aged care, mental health, the Australian Incident Monitoring System, its operational plans, and leadership and management initiatives. A number of recommendations were also provided and these are being implemented.

WACHS – Great Southern

The ACHS conducted accreditation surveys for both the lower and central Great Southern areas during June 2006. For lower Great Southern this survey was undertaken to maintain their accredited status. For the central Great Southern this was the initial survey to achieve ACHS accreditation. Survey reports have been prepared including recommendations where appropriate, and the Great Southern will be advised shortly regarding accreditation status. However, post survey discussions indicated positive outcomes.

The WACHS also conducts numerous health and service delivery project evaluations. During 2005-06 numerous sites underwent control compliance audits conducted by the Internal Audit Branch. The audits covered a range of operational, business and administrative processes for compliance with the FAAA and departmental guidelines and government policy as well as areas including accounts payable, payroll and the PATS program. Recommendations resulting from these audits have been presented in Action Plans for the endorsement of the WACHS Executive Management.

WACHS - Pilbara

In compliance with the relevant legislation and operational plans, especially the WorkSafe Plan, the Pilbara conducted an audit of safety, security and fire prevention and control across its workplaces to ensure it provides a safe and healthy environment for staff, visitors and contractors. The audit identified improvements to be progressed, including those specific to legislative compliance.

The Pilbara conducted an audit of central sterilizing service processes to measure compliance with the Australian Standards. Recommendations resulting from the audit have been presented in an action plan for the endorsement of the Infection Control Committee and Pilbara Executive Management.

The "Nursing Hours per Patient Day" project has been implemented to evaluate current use of nursing resources and possible ways to ensure more efficient use. Consultations and meetings with stakeholders and community representatives have been undertaken to examine the results and consider different models of service delivery.

Other evaluation projects in 2005-06 included the West Pilbara Allied Health Outreach Service identifying service gaps with recommendations for implementation, and the introduction of additional impact evaluations for the Canning Stock Route Challenge focusing on years 2, 4 and 6, with pre- and post- participation evaluations and further follow-up evaluations in later years now incorporated.

WACHS - Goldfields

During 2005-06 the Goldfields conducted an organisational review of the Kalgoorlie Regional Resource Centre to assess the effectiveness of the current organisational structure and identify opportunities for improvement. As a result of the findings of the review, a new organisational structure was developed to better deploy senior nursing resources, and to provide a clear focus on clinical and administrative management functions. The revised structure is currently being implemented.

Evaluations

WACHS - Midwest

The Office of the Chief Psychiatrist conducted an assessment of the implementation of clinical governance in the Central West Mental Health Service. A draft report has been prepared and is under consideration for further input prior to finalisation. Strategies will be developed to address the report's recommendations.

WACHS - Kimberley

A six-month evaluation of outputs and priorities of the remote HACC service "Strength from Elders Project" was conducted during 2005-06. Appropriate project priorities have been strengthened with four communities identified for project focus. Project workers have been skilled in the identified project priorities with a further review planned for January 2007.

The ACAT Program has evaluated the level of geriatrician service coordinated by the ACAT in the Kimberley. The number of geriatrician assessments provided per year has increased by more than 100% from 2002-03 to 2005-06. A business case has been developed to increase ACAT clinical support to cope with increased clinical workload.

In conjunction with the ongoing "National Medication Safety Breakthrough Collaborative", the Kimberley continues to evaluate the integration of medication safety initiatives into clinical practice. The review also identified improvements for the implementation of the national medication chart. The medication safety collaborative and its ongoing evaluation has led to a decrease in medication errors, highlighting the need for vigilance in monitoring medications and the reporting of errors, and providing opportunities for clinical review of prescribed medications and medication charts.

WACHS - Wheatbelt

The Wheatbelt southern district conducts routine evaluations of the level of standardisation, integration and effectiveness of the employee induction program as well as the effectiveness of on-going professional development and education opportunities offered to employees. This evaluation process ensures standardisation across all health service provision for southern district new and current employees. The ongoing evaluation is assessed at the completion of each month to evaluate effectiveness and highlight areas of improvement.

The Wheatbelt eastern district has evaluated the HACC program under the Commonwealth MPS "Leading Practice Support Project". The aim was to evaluate the program against best practice methodology. Recommendations have been made regarding the terms of service provision, service delivery, staff and training, program management and effective models of service delivery.

Late in 2005-06 the Wheatbelt eastern district evaluated the implementation of the actions identified in the initial Wheatbelt Aged Care Review in 2005. This report is currently being finalised.

To ensure compliance with disability access standards, the western district of the Wheatbelt developed an audit tool. During 2005-06 the tool has been used in a number of sites with recommendations being made for the development of action plans. Access issues and concerns identified are also discussed at district management meetings and forwarded to the Wheatbelt Executive where appropriate.

A Wheatbelt western district evaluation audit of patient services in 2005-06 identified poor performance in areas such as information provided to patients, discharge planning and patient assessment. Briefing programs have been implemented to inform staff of the evaluation findings and discussions held to initiate change and improve performance. Brochures detailing patient rights and responsibilities and the complaints process have been developed and implemented at all western district sites. Following stakeholder consultation standardised care plan documentation has also been developed.

The Wheatbelt western district has evaluated its complaints management process and developed a complaints tracking system. A questionnaire has also been developed and implemented to obtain feedback from complainants.

Evaluations

The Wheatbelt Workforce Development Program has been evaluated to assess the level of standardisation and integration across the various elements of the program. The evaluation found standardisation across the Wheatbelt sub-programs was satisfactory but requires enhancement and improved integration across some elements of the program. The evaluation also supported changes to the membership and operations of the Wheatbelt Workforce Development Reference Group. A guiding principles document has been formulated as well as a revised operational plan.

An evaluation of support services identified a lack of information and language services available at Wheatbelt western district sites to assist and support our diverse community. A cultural diversity manual was proposed and a project commenced investigating relevant websites and contacting local cultural organisations for advice and to gather appropriate literature. Other health service sites have expressed interest in the manual for integration into their service areas. In addition a locality specific language service and interpreter policy has been developed to meet the needs of the communities in our area.

WACHS - Great Southern

The "Chlamydia Campaign" has been evaluated during 2005-06. The evaluation gauged the level of knowledge of chlamydia in the community, and assessed general practitioner awareness of current screening and treatment recommendations. The evaluation identified areas of poor community and general practitioner knowledge. The Great Southern will continue its public education and information program, promote the Royal Australian College of General Practitioners Red Book protocols for Sexually Transmitted Infection (STI) management, and promote contact tracing supported by the Disease Control Branch.

During 2005-06 the Great Southern assessed the effectiveness of the "Healthy Bodies" (nutrition) program. This was an early evaluation of the program. The evaluation found that most of the participants had improved their diets and subsequently their Body Mass Indices (BMI). It was recommended that the program continue and that further evaluations be conducted.

The provision of St John Ambulance services in Kojonup has been reviewed to identify methods to provide a more efficient service to the community and other stakeholders, resulting in emergency ambulance services being managed centrally.

The Great Southern has evaluated the efficacy of catch-up immunisation clinics conducted across the area. The evaluation found that the clinics are well attended by school-aged students and that immunisation coverage rates have improved in school-aged children. The Great Southern will continue to offer catch-up clinics through school-based promotion and direct contact.

The Great Southern evaluated the effectiveness and value of the Population Health Profile report. The report was widely used and considered useful, and management has requested the Information Collection and Management (ICAM) Branch produce the Population Health Profile report on an ongoing basis.

Freedom of information

During 2005-06 the WA Country Health Service received the following numbers of applications under the Freedom of Information (FOI) guidelines established under the Freedom of Information Act 1992.

Table 5: Freedom of Information

Application	Head Office	Kimberley	Pilbara	Midwest	Goldfields	Great Southern	Wheatbelt
Received in 2005-2006		266	184	79	186	86	213
2004-2005 carried over		11		6	7	15	
Total Received in 2005-2006	**0**	**277**	**184**	**85**	**193**	**101**	**213**
Granted Full Access		259	168	79	177	80	154
Granted Partial / Edited Access [1]			3			7	3
Withdrawn by Applicant		1	1			4	3
Refused		1				1	49
Other [2]		7	7	6			
Carried forward to 2006-2007		9	5		16	9	4

Notes
[1]. Includes the number accessed in accordance with Section S28 of the Act.
[2]. Includes exemptions, deferments or transfers to other Departments or Agencies.

Description of Documents

The types of documents covered in Freedom of Information (FOI) applications received by the WA Country Health Service included:

- administration including minutes of meetings and committee proceedings
- policy and procedure manuals
- finance, accounting and statistics
- equipment and supplies documentation
- works and buildings documentation
- staff and human resource records
- health and hospital services related material
- accreditation and quality assurance documents
- medical and allied health records
- information technology documentation
- health information and pamphlets.

Access to Documents

Access to documents follows the FOI guidelines. Released information can be posted or faxed to applicants or their authorised representative depending on the applicant's request. Arrangements to view medical records are scheduled at times convenient to both parties.

FOI Procedures

The WACHS has adopted procedures in accordance with the *Freedom of Information Act* and guidelines.

Applications are made in writing although where literacy or English language skills are poor, formal verbal representation may also be accepted. Formal application forms can also be provided to assist applicants. The WACHS carries out standard FOI authentication tests prior to processing. Confirmation of receipt of the application for information is provided.

Freedom of information

FOI coordinators liaise with the various service areas and submit to the relevant authorising officer, the applications for consideration and approval. In the case of medical records the applicant may be offered a medical summary of the information as an alternative.

Decisions on applications are made by various senior staff members in both clinical and administrative positions depending on the nature of the information request. The FOI Coordinator provides notice of decisions on access to documents under the *Freedom of Information Act* in writing, and applicants can appeal the decision.

In accordance with the *Freedom of Information Act 1992* the WA Country Health Service has FOI coordinators and officers at numerous sites designated to receive FOI applications. They can provide information regarding the FOI process, the nature and types of documents held.

The sites and designated officers where enquiries and applications can be made:

WACHS Head Office

Chief Executive Office
PO Box 6680
EAST PERTH BUSINESS CENTRE WA 6892

☎ (08) 9223 8522
(08) 9223 8599

WACHS - Kimberley

Health Information Manager
P.O. Box 62
BROOME WA 6725

☎ (08) 9194 2237
(08) 9194 2241

WACHS - Pilbara

FOI Coordinator
PO Box 519
KARRATHA WA 6714

☎ (08) 9143 2341
(08) 9143 2374

WACHS - Midwest

Health Information Manager
PO Box 22
GERALDTON WA 6531

☎ (08) 9956 2214
(08) 9956 2215

WACHS - Wheatbelt

Coordinator Executive Services
PO Box 690
NORTHAM WA 6401

☎ (08) 9622 4350
(08) 9622 4351

WACHS - Goldfields

Health Information Manager
Locked Bag 7
KALGOORLIE WA 6430

☎ (08) 9080 5601
(08) 9080 5444

WACHS - Great Southern

Health Information Manager
PO Box 165
ALBANY WA 6331

☎ (08) 9892 2504
(08) 9842 1095

Recordkeeping

Department of Health

The State Records Commission approved the WA Health Recordkeeping Plan in December 2004 with a compliance date of 2008. Negotiations have continued with the State Records Office regarding approval of the Department of Health's Retention and Disposal Schedule. A multi-year program to ensure compliance with the Recordkeeping Plan is underway.

In addition to the Recordkeeping Plan, the Department of Health has implemented a functional Thesaurus, which will facilitate structured file titling and the application of approved retention and disposal schedules at the time of the file creation.

The Department of Health and its legal entities have also developed additional policies to support appropriate recordkeeping practices including the long-term management of electronic records and the management of non-patient records.

New employees are informed of their obligations under the *State Records Act 2000* through orientation and induction programs. Training is provided to existing staff where required on records systems. Information packages on recordkeeping are also available, describing staff obligations when creating, storing and deleting or disposing of departmental records.

WA Country Health Service

The WACHS has implemented a recordkeeping policy and plan in accordance with the statutory requirements and standards. During 2005-06 monitoring of records handling practice and procedures to ensure compliance with the *State Records Act* and to achieve standardisation across the organisation.

Health service management ensures that all staff are aware of their record keeping responsibilities. Health facility sites carry out regular internal audits to identify issues to be addressed. All new staff receive recordkeeping training at orientation and induction courses and opportunities are provided for existing staff to maintain their competencies in records management.

Specific records management activities occurring across the organisation include:

- the introduction TOPAS numbering
- audits of records storage and archiving
- establishing local health information management committees
- electronic medical imaging reporting
- introduction of the National Inpatient Medication Chart
- trialling new accident and emergency triage forms
- participation in ongoing development of the Mental Health Information systems.

Advertising

The following table lists expenditure on advertising, market research, polling, direct mail and media advertising made by the WA Country Health Service and published in accordance with the requirements of Section 175ZE of the Electoral Act 1907. The total expenditure for Advertising for the WACHS in 2005-06 was $740,799.

Table 6: Advertising

Expenditure Category	Recipient / Organisation	Amount	Total
Advertising Agencies	Marketforce Productions Pty Ltd	$605,741	**$605,741**
Market Research Organisations	Nil		**$0**
Polling Organisations	Nil		**$0**
Direct Mail Organisations	Nil		**$0**
Media Advertising Organisations	Kimberley ECHO	$3,069	
	Warringarri Radio	$110	
	Halls Creek Herald	$519	
	Redwave Media Pty Ltd	$7,507	
	Goolarri Media	$13,316	
	Broome Advertiser	$1,441	
	Northern Guardian	$6,820	
	Port Hedland Chamber of Commerce	$3,375	
	Cape Connection	$198	
	Balloons A Plenty	$50	
	All New Vision Broadcast Television	$999	
	Health Information Management Assoc	$102	
	Nursing Careers Allied Health	$1,634	
	Shire of Exmouth	$30	
	Savills WA Pty Ltd	$22	
	Yamaji News	$230	
	Albany Advertiser	$66	
	Hedland Signs Co	$419	
	Yamatji Media Aboriginal Corporation	$350	
	Australian Business Pages Directory	$193	

Advertising

Expenditure Category	Recipient / Organisation	Amount	Total
Media Advertising Organisations	Australian and New Zealand College of Anaesthetics	$517	
	Australian Physiotherapy Assn	$288	
	Media Decisions WA	$10,765	
	303 Advertising	$52,320	
	Geraldton Newspaper	$4,856	
	Midwest Times	$2,502	
	Safety House Association	$237	
	Australian Business Directory	$104	
	Telecentre Network Mingenew	$35	
	Exmouth Expressions	$20	
	Northern Guardian	$60	
	West Australian Newspaper	$502	
	Albany Advertiser	$1,684	
	All Flags Dot Imagery	$435	
	Beacon Bulletin	$45	
	Boddington Community Newsletter	$38	
	Boddington Health Service	$10	
	BP Jurien Bay	$70	
	Chamber of Commerce	$105	
	Chittering Times	$560	
	Kondinin Calendar	$14	
	Lake Grace Telecentre	$130	
	Lions Club Lake Grace	$47	
	Muka Matters Inc	$23	
	Narkal Notes Inc	$12	
	Nungarin Newslink	$39	
	Pingelly Times	$60	
	Prime Corporate Psychology Services Pty Ltd	$360	
	Pronk, Elise	$64	
	Quairading Telecentre	$20	

Advertising

Expenditure Category	Recipient / Organisation	Amount	Total
Media Advertising Organisations	Rural Press Regional Media (WA) Pty Ltd	$3,135	
	Seabreeze Communications Pty Ltd	$2,376	
	Sensis Pty Ltd	$93	
	Shire Of Trayning	$15	
	South West Printing	$807	
	South West Printing & Publishing Company Ltd	$957	
	Southern Cross Telecentre Inc	$72	
	Telecentre Network - Bruce Rock	$10	
	Telecentre Network (Dalwallinu)	$443	
	Telecentre Network (Kalannie)	$7	
	The Fence Post	$177	
	The Gimlet Newspaper	$12	
	The Pipeline	$31	
	The West Australian	$138	
	The Williams	$42	
	W.A. Police Legacy (INC)	$300	
	Waveline News	$25	
	Wongan Hills Telecentre	$40	
	Wyalkatchem Weekly	$20	
	Albany Advertiser	$1,056	
	Denmark Bulletin & Publish	$170	
	Firey Productions	$310	
	Kojonup Community Newspaper	$57	
	Mi-Tec Media Pty Ltd	$120	
	Orana Cinema Advertising	$4,727	
	South West Printing & Publish	$1,253	
	Weekender	$2,157	
	West Australian Newspapers	$136	**$135,058**

Operations: Governance

Sustainability

Please refer to the Department of Health Annual Report for details on the Department's strategies for sustainability of the Western Australian health system.

Equal employment opportunity outcomes

The State Government is committed to developing a public sector workforce that is representative of the Western Australian community and enables employees to combine work and family responsibilities. In 2001 the Government implemented its "Equity and Diversity Plan for the Public Sector Workforce 2001-2005".

The promotion of equal opportunity and diversity in the workplace and ensuring the absence of discrimination based upon grounds of sex, marital status, pregnancy, family status, race, age, or religion or political conviction is a continuous process adopted by the WACHS.

The contribution that indigenous Australians, people with disabilities, people from culturally diverse backgrounds, youth and women make to the operations of the WACHS is also recognised by the health service.

Goals and objectives for equal opportunity and diversity adopted by the WACHS comply with the *Equal Opportunity Act 1984*, Equal Employment Opportunity (EEO) outcomes, and diversity management plans and initiatives.

Equity and diversity policies and practices for equal opportunity in employment and to ensure the workplace is free of discrimination, and racial and sexual harassment have been implemented by the WACHS.

Procedures have been adopted to deal with events of discrimination or harassment and policy and practice manuals are readily available to all staff. During 2005-06 a number of policies have been reviewed in regard to the WACHS operations including "Prevention of Harassment and Discrimination in the Workplace" and the Public Sector "Code of Conduct". A number of regional areas have conducted "Respectful Workplace" programs.

The WACHS job descriptions contain selection criteria regarding EEO and position application packages contain information pertaining to employee obligations under EEO.

Information regarding equal opportunity and discrimination legislation, the WACHS organisational culture, and avenues of redress are provided at induction and orientation programs. Employees are provided with equity and discrimination information packages including the Code of Conduct. Resources are available either in hardcopy or electronic formats.

Staff surveys and employee exit interviews contain questions regarding issues of discrimination and workplace environments. Staff are encouraged to raise issues relating to equity and diversity, and reporting procedures are widely circulated.

Employee data is collected across the organisation regarding gender, ethnicity and disability, to inform management regarding workplace diversity. Sites also collate data regarding EEO contacts and complaints.

The WACHS has appointed grievance and EEO contact officers and provides training opportunities via the Equal Employment Opportunity Commission. The WACHS senior staff are provided with equity and diversity awareness training sessions.

Corruption prevention

Achieving best practice in the management of risk and preventing corruption that may adversely affect health care services and the welfare of clients, the public and staff is a priority for the WA Country Health Service. The organisation actively promotes its philosophy, that risk management and corruption prevention is the responsibility of all employees.

Corruption Prevention

The WACHS has implemented processes to prevent corruption and comply with the relevant Treasury Instructions on Risk Management and Security and directions provided by the Government on "Fraud Prevention in the Western Australian Public Sector". The WACHS has also adopted corruption prevention policies and procedures complimentary to statutory requirements and government policy.

Regular staff training programs support workforce compliance with the corruption prevention procedures and the Codes of Conduct and Ethics. Operational circulars provided by the Corruption and Crime Commission are provided to staff. During 2005-06 several sites organised instructional briefings from both the Corruption and Crime Commission and the Department of Health's Corporate Governance Unit.

Routine audit programs are conducted across the organisation to ensure compliance with numerous standards and measures it has implemented including the Financial Administration and Audit Act, delegation schedules, accounting standards, records management and building standards. Criminal record screening is also mandatory.

When required, cases of alleged corruption have been investigated internally or referred for external assessment.

Risk Management

The WACHS has aligned its risk management framework and procedures with the *WA Health Risk Management Policy and Framework*. The framework and procedures are designed to minimise preventable adverse incidents and their consequences and manage risk exposure.

The WACHS conducted a review of occupational safety and health and injury management during 2005-06. The review led to the implementation of a number of initiatives including additional resources for OSH coordinators, the ongoing development of clinical incident reporting, risk identification, medication safety and emergency management procedures.

Local risk registers and the Australian Incident Management System are used for risk reporting and analysis, and managing administrative and clinical risk. A number of risk management coordinators have been appointed to positions across the WACHS developing risk management systems and programs. Current insurance coverage is maintained for buildings, equipment and assets, professional and public liability and worker's compensation.

Education and training programs provided for staff on risk management also facilitate improvement in performance and compliance. These programs have been developed with input from all areas and have been published on the WACHS website.

Training subjects include:

- manual handling
- infection control
- driver safety
- handling dangerous goods and dangerous substances
- management of incoming mail and remittances
- use of the internet and electronic mail
- conflict of Interest
- Codes of ethics and conduct
- acceptance of gifts and gratuities
- human ethics and research
- general risk management.

The WACHS has progressed towards achieving ACHS accreditation for both corporate and health care operations. The accreditation process includes an extensive examination of management of risk within the organisation.

Public interest disclosures

Appointments

To enable appropriate and easy reporting access for all Department of Health staff, the following Public Interest Disclosure (PID) officers have been registered with the Office of the Commissioner for Public Sector Standards:

Health Service	PID Officer
Department of Health	Mr Steven Jensen
North Metropolitan Area Health Service	Mr Jon Frame
South Metropolitan Area Health Service	Ms Tracey Bennett Ms Diane Barr Ms Debbie Bridgeford
Women and Children's Health Service	Ms Delys McGuiness
WA Country Health Service	Mr Steve Gregory

To streamline the communication between the Department and the Office of the Commissioner for Public Sector Standards on matters that fall within the jurisdiction of the *Public Interest Disclosure Act 2003*, the Department has appointed Mr Steven Jensen, Acting Manager Accountability, 189 Royal Street, East Perth as the Principal PID officer.

Procedures

The Department of Health has advised and will continually update staff on processes and reporting procedures associated with the *Public Interest Disclosure Act 2003* through global e-mails, and staff induction presentations. The Corporate Governance Directorate also delivered awareness-raising presentations relating to the public interest disclosure legislation in a number of locations.

The Department's internal procedures have been published on the Department's intranet site and can be accessed by all staff. These procedures are compliant with the Public Sector Standards Commission guidelines.

Protection

The Department of Health has ensured all PID officers are fully aware of their obligations of strict confidentiality in all issues related to public interest disclosure matters.

Procedures require that all files and investigation notes are maintained in locked and secure cabinets at all times with strict access to authorised personnel only.

Procedures also require that all efforts be made to ensure maximum confidentiality is maintained in all investigations and follow up action.

Any staff member who attempts to take reprisal action or victimise another officer who has made, or intends to make, a disclosure of public information will be subject to legal action under the *Public Interest Disclosure Act 2003*.

Reports

For the year 2005-06 there was one report made under the PID legislation for the whole of Health.

Public relations and marketing

The WA Country Health Service has undertaken a number of public relations and marketing initiatives in 2005-06.

The promotion of community participation in consumer forums and seminars continues to be a prominent focus of the WACHS. District Health Advisory Councils contribute to local public relations and marketing campaigns on numerous health topics.

During 2005-06 WACHS staff organised and participated in community events such as Hospital Open Days, community fundraising days, Community and Careers Expos, Agricultural Shows and Farm Days, and Women's and Men's Health Expos. WACHS also participated in the 2005 Nurse Expo and in promotional "Awareness Weeks" for numerous health issues such as mental health and diabetes. During the year WACHS hosted the 2nd WA Rural and Remote Allied Health Forum.

The WACHS participated in a range of media and community events promoting local health issues such as youth health services, immunization, cancer screening, blood borne illness, sexually transmitted disease, community health promotion days (e.g. Pit Stop Program) and promoting participation in local health service planning. Events included sessions on local radio and television stations, placing promotional articles in community newspapers, and providing promotional displays and activities at shopping centres, tourist venues, libraries, community fairs and Expos.

WACHS sites also promote health activities among health service staff, other government organisations, and local communities through newsletters, websites and health focused social events.

WACHS health facility events during 2005-06 included:

- The opening of the upgraded accident and emergency facilities at the Quairading Hospital by the Parliamentary Secretary for Health Sue Ellery.
- The opening of the new Geraldton Regional Resource Centre by the Premier in May 2006.
- The opening of the Kununurra Aged Care facility by Carol Martin in July 2005.
- The Wongan Hills community celebrating the 40th birthday of the old Moora Hospital on 22 October 2005 with over 60 current and former staff and many members of the community attending celebrations.

WACHS - Kimberley

During 2005-06 a HACC newsletter was developed and distributed to remote Aboriginal communities in the Kimberley. The region participated in the "Mental Health Awareness Week 2005" with many local activities being organised.

WACHS - Pilbara

In 2005-06 Pilbara health staff participated in health promotion activities at the "Welcome to Port Hedland Night 2005" and Port Hedland Careers Expo.

Specific local health public relations and health promotion events included the " Canning Stock Route Challenge", "responsible server" training for people in alcohol service industries, the "Triple P" Positive Parenting Program, participating in the Carnarvon Youth Festival, and promoting the sentinel monitoring program for vector borne disease.

The Port Hedland Regional Resource Centre has established a Communication Clinical Governance Working Party to monitor the promotion of the health service in the media.

WACHS - Midwest

The Midwest became the first country region to implement a region-wide ban on smoking at all health facilities in the Midwest.

Christine O'Farrell WACHS Chief Executive Officer opened the "Rural e-Health" Forum in Geraldton in May 2006. The forum was a showcase for new national and international developments in medical, diagnostic and telehealth equipment.

Meekatharra nurse Therese Edwards was awarded the "2006 Nursing and Midwifery Excellence Award for the Rural and Remote Enrolled Nurse of the Year".

Public relations and marketing

The Midwest participated in the "International Men's Health Week" in June 2006 to promote unity in the community and highlight men's health issues.

The Midwest hosted five nursing students in a new partnership program with Edith Cowan University designed to help undergraduate students develop working relationships with regional organisations. These arrangements are part of the Rural Excellence Clinical Partnership Program to provide financial support and study assistance to selected students during the completion of their rural clinical training.

Midwest health staff hosted a successful "Drug Action Open Day" in June 2006. This event provided drug and alcohol awareness activities to representatives from community organisations including the Yamatji Regional Council, Geraldton Police, the School Drug Education and Road Awareness programs, Rosella House, and the Department of Community Development.

WACHS - Goldfields

The Goldfields organised a "Health Showcase" at Ravensthorpe in June based on the successful showcase held in Norseman last year. This was an opportunity for the health staff to provide information to the community about the range of services available, and for the community to provide feedback.

The Goldfields District Health Advisory Councils contributed to developing community awareness on a number of health matters, and implemented community surveys in Esperance and Kalgoorlie.

A very successful "Safety and Quality in Health Symposium" was held in Esperance during November 2005, at which visiting experts ran sessions regarding current issues, and where local service providers presented details of activities currently being undertaken.

Health managers have made "report card" presentations to Goldfields Shire and City Councils detailing the activities and achievements of the health service across the Goldfields.

WACHS - Great Southern

The Rural and Remote Mental Health conference was run by the Great Southern Mental Health Team, in Albany, with nationally recognised guest speakers, providing a very high standard of professional development for all mental health clinicians.

The Great Southern launched the "Denmark Healthy Communities" project.

WACHS - Wheatbelt

The Director General of Health and the WACHS Chief Executive Officer visited the Wheatbelt area in May 2006 and conducted meetings with community members, local government representatives, doctors and health service staff at centres across the Wheatbelt.

The Wheatbelt Mental Health Service has become an accredited psychiatrist registrar training site. The WMHS will provide a six-month training rotation for psychiatric registrars and has been allocated trainees for the next 24 months.

A "Harmony Week" seniors event was held in March in Northam for the over 60 years group.

The Wheatbelt hosted the launch of the "Regional Achievement and Community Awards" sponsored by the WA Country Health Service.

Publications

During 2005-06 the WA Country Health Service produced and/or distributed numerous publications. These included items on topical health issues specific to a particular locality or client group, particularly for Aboriginal communities, and those produced for the whole of the Western Australian community. Health service staff also published a number of journal articles.

Publications distributed included:

- local hospital and health service newsletters
- patients' rights and responsibilities and patient information brochures and handbooks
- Departmental and specific program newsletters and brochures on a variety of health and medical subjects
- local information on emergency and accident procedures
- health service planning and needs analysis information
- published articles that may be particularly relevant to an area.

Health facilities and sites use numerous methods and locations to distribute information and publications. Publications are available in hospitals (foyers, nurses' stations, ward bedsides) and in community health facilities, and in a variety of community facilities including doctors' surgeries, public libraries, community and shopping centre notice board displays and local newspapers. Information is also distributed via local radio and television stations, on the intranet, Internet and electronic media.

WACHS regional areas have also produced a number of reports and documents relating to regional needs assessment, the availability of local health services, population health profiles and the results of local health surveys.

In June 2006 the Goldfields published the "*Goldfields South East Reflections"* 2006. This publication documents the achievements over the past two years in response to community health needs and identified issues focussing on workforce development, service delivery, community participation, and responding to community needs.

Published Articles

Mak DB, Johnson GH, Marshall LJ, **Mein JK**. "Control of genital chlamydia infection in the Kimberley Region of Western Australia". *Medical Journal of Australia* 2004 Jan 5; 180(1): 45.

Macrokanis CJ, Hall NL, **Mein JK**. "Irukandji syndrome in northern Western Australia": an emerging health problem. *Medical Journal of Australia* 2004 Dec 6; 181(11-12): 699-702

Tate J, **Mein J**, Freeman H, **Maguire G**. "Australian Grey nomads - health and health preparation of older travellers in remote Australia*". Family Physician* 2006; 1-2:70-2.

Richard B Murray, Sue M Metcalf, Philomena M Lewis, **Jacqueline K Mein** and Ian L McAllister. "Sustaining remote-area programs: retinal camera use by Aboriginal health workers and nurses in a Kimberley partnership". *Medical Journal of Australia 2005 May 16* Vol 182 No. 10.

Lumb R, Ardian M, Waramori G, Syahrial H, Tjitra E, **Maguire GP**, Anstey NM, Kelly PM. "A community based TB Drug susceptibility study in Mimika District, Papua, Indonesia". *The International Journal of Tuberculosis and Lung Disease* 2006; 10(2): 167-171.

Maguire GP, Handojo T, Pain MCF, Kenangalem E, Price RN, Tjitra E, Anstey N. "Lung injury in uncomplicated and severe falciparum malaria: a longitudinal study in Papua, Indonesia". *Journal of Infectious Diseases.* (in press)

Lumb R, Ardian M, Waramori G, Syahrial H, Tjitra E, **Maguire GP**, Anstey NM, Kelly PM. "An Alternative Method for Sputum Storage and Transport for Mycobacterium Tuberculosis Drug Resistance Surveys". *The International Journal of Tuberculosis and Lung Disease* 2006; 10(2): 172-177.

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Martin D, Shephard M, Freeman H, Jones T, Davis E, **Maguire G**. "Point-of-care testing of HbA1c and blood glucose in a remote Aboriginal Australian community". *Medical Journal of Australia* 2005; 182: 524-527

McDonald S, **Maguire G**, Duarte N, Wang X, Hoy H. "Homocysteine, renal disease and cardiovascular disease in a remote Australian Aboriginal community". *Internal Medicine Journal*. 2005; 35 (5): 289-294.

Maguire G. "Assessing asthma severity - How to Treat series - Kimberley chronic disease protocols - prescriptive summary protocols for the management of chronic non-communicable disease in the Kimberley by Aboriginal community-controlled health services and WA Country Health Service – Kimberley". *Australian Rural Doctor*. April 2005 www.healthykimberley.com.au/chronicdisease.html

"Kimberley standard drug list - a minimal standard drug list for imprest stocking at Kimberley remote clinics, WA Country Health Service - Kimberley hospitals and Kimberley Aboriginal community-controlled health services". www.healthykimberley.com.au/druglist.html

Mental Health

Rachel Wright. "Diversity of Health Information Management Roles". Health Information Management Association of Australia National Conference July 2005.

Papers presented at the Rural and Remote Mental Health Conference, Albany 2006.

Glenn Moorey and Cozette Fraser. "Grain for the Brain and Swathing the Crisis-Case Management in a rural setting".

Anna Scott and Yvette Worsfold. "65 to 100 in 30 minutes: Seniors- Does it get any better?"

Grant Giblett and Neil Cock. "ECT in a Rural Service: Towards best practice. An account of the introduction of an ECT service in the GS region, plus a lightning update on modern ECT".

Dr Jacqui Dodds. "Bring the spiritual into Therapy".

Cozette Fraser, "Suburban Men in Rural Settings".

Linda Fellows and Neil Cock. "Approaching Best Practice in Transporting Patients from the Bush: Guidelines for sedation of acutely agitated adult patients prior to transportation".

Dr Neil Cock and Russell Harken. "Great Southern Early Psychosis Program: Limits to best practice".

Ken Clifford. "Mental Health Services in an Aboriginal Health Service: A view from the bunker".

Research and development

During 2005-06 a number of WACHS sites participated in research and development projects.

WACHS - Midwest

In 2005, a fellowship granted by the Combined University for Rural Health enabled the Midwest to participate in a formal evaluation of an innovative Telehealth project. This project, the first of its kind in Australia, provided support, assistance, practical advice and networking opportunities for rural and remote carers through the use of video conferencing. The project encompassed the Midwest, Murchison and Gascoyne regions of Western Australia.

The evaluation goals of the fellowship were to assess the impact of the project on the lives of carers, identify beneficial aspects of the project, evaluate evidence of changes in the carers' coping skills, and to identify features for future sessions. The research demonstrated that videoconferencing can be used effectively to provide practical skills and coping strategies for carers. Evidence gathered demonstrated the value of the project for both carers and HACC coordinators, with the result the program is being integrated onto service delivery across the Midwest.

WACHS - Wheatbelt

A Wheatbelt Health Service Plan development process commenced during the year and the terms of reference for the "Phase 1 - Health Service Modelling" have been finalised and released for tender. This plan, which will comply with the strategic directions proposed under the Foundations for Country Health Services project, aims to develop a "road map" to guide health service development in the Wheatbelt over the next 5 to 10 years.

WACHS - Great Southern

During 2005-06 the Great Southern Mental Health Service Seniors Dementia Advisory Team developed a clinical pathway for dementia patients for use within the acute care setting of rural WA. A pilot of the clinical pathway was conducted in several sites in the Great Southern and early evaluations indicated positive outcomes. The Great Southern Mental Health Service is preparing to implement the pathway across the Great Southern and will support the pathway with a regional education program for staff.

WACHS - Kimberley

Kimberley Policy and Procedure Revision Project Team have researched and revised over 470 clinical protocols, guidelines and procedures in order to meet best practice and accreditation requirements. The clinical protocols and guidelines are sub-sets of the major areas of health delivery in accident and emergency, ambulance, general practice, maternity, Medical Imaging, paediatrics, peri-operative and infection control.

A collaboration with the Kimberley Aboriginal Medical Service Council and associated Aboriginal community-controlled health services, local general practitioners and resident and visiting specialists has developed Kimberley Chronic Disease protocols. The protocols are intended to guide and standardise chronic disease care in the Kimberley in the face of a mobile client group and general population, and the large volume of continually emerging studies and treatments. The protocols cover rheumatic fever, coronary artery disease, chronic lung disease (COPD and Bronchiectasis), diabetes in pregnancy, type 2 diabetes, dyslipidaemia, heart failure, hypertension and rheumatic heart disease.

The Kimberley also continued its participation in Broome with the study of the Irukandji syndrome, which results from stings from a number of poisonous jellyfish.

WACHS - Pilbara

The Pilbara joined in a collaborative project with the Institute of Child Health in researching the relationship in the provision and use of swimming pools and improving child health.

Internal audit controls

Internal Audit has the role of accountability adviser and independent appraiser, reporting directly to the Director General of Health. Audits undertaken were generally planned audits; however, on occasion, management initiated audits or special audits were also carried out. Audits were of a compliance, performance or information system nature. In addition, external consultants were utilised to complete some audits. All audits were conducted to assist senior management in achieving sound managerial control.

All audit reports were considered by the relevant executive and, until December 2005, were also considered by the Department of Health's Audit Committee. From January 2006, a Departmental Audit Sub-Committee was established. The Sub-Committee has an external chair responsible for reporting on any matters of operational importance to the WA Health Audit Committee. The Committee also has oversight of the Strategic Audit Plan and other associated governance issues, to ensure appropriate and timely advice is provided to the Director General. Both the Audit Committee and the Sub-Committee meet on a quarterly basis.

Audits conducted over the year include:

Department of Health:

- Office of Chief Psychiatrist Review
- Office of Chief Psychiatrist: Clinical Governance Review
- Control Review (Drug and Alcohol Office)
- Falls Prevention
- FTE Savings Plan
- InfoHealth Alliance Contract Negotiation
- Investigations Review
- Oracle 11i Implementation
- Oracle 11i Budget Consideration
- Risk Management
- Telecommuting
- Wireless Security and Communications

WA Country Health Service:

- Control/Compliance Reviews
  - Goldfields
  - Kimberley
  - Midwest
  - Pilbara
  - Wheatbelt
- Occupational Safety and Health
  - Pilbara
- Staff Security
  - Pilbara
  - Wheatbelt - Northam Mental Health Clinic
- Clinical Credentialing
- Investigations Review

Pricing policy

The majority of the Department of Health's services are provided free of charge. Some classes of patients are charged fees — for example, patients who have elected to be treated as private patients, or compensable patients (i.e. patients for whom a third party is covering the costs, such as patients covered by worker's compensation or third party motor vehicle insurance). Where fees are charged, the prices are based on legislation, government policy, or a cost-recovery basis.

Health Finance sets a schedule of fees each year to cover patients from whom fees apply. These fees are incorporated into the *Hospital (Service Charges) Regulations 1984* and the *Hospital (Service Charges for Compensable Patients) Determination 2002*.

Dental Health Services utilises fees based on the Australian Government Department of Veterans' Affairs Schedule of fees, with patients charged:

- 50% of the treatment fee if holder of a Health Care Card or Pensioner Concession Card
- 25% of the treatment fee if holder of a pension or an allowance issued by Centrelink or the Department of Veterans' Affairs.

Performance Indicators Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2006

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the WA Country Health Service and fairly represent the performance of the health service for the financial year ended 30 June 2006.

Dr Neale Fong
ACCOUNTABLE AUTHORITY
Director General of Health

27 July 2006

Performance Indicators Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2006

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the WA Country Health Service at 30 June 2006 and its financial performance and cash flows for the year ended on that date. They are in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions;

(ii) the controls exercised by the WA Country Health Service provide reasonable assurance that the receipt, expenditure and investment of moneys, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(iii) the key effectiveness and efficiency performance indicators of the WA Country Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended 30 June 2006.

Scope
The Director General, Department of Health is responsible for keeping proper accounts and maintaining adequate systems of internal control, for preparing the financial statements and performance indicators, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Income Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service and the Notes to the Financial Statements.

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

Summary of my Role
As required by the Act, I have independently audited the accounts, financial statements and performance indicators to express an opinion on the financial statements, controls and performance indicators. This was done by testing selected samples of the evidence. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and 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 performance indicators.

D D R PEARSON
AUDITOR GENERAL
29 September 2006

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

Performance indicators

Introduction

Health is a complex area and is influenced by many factors outside of the provision of health services. Numerous environmental and social factors as well as access to, and use of, other government services have positive or negative effects on the health of the population.

The Key Performance Indicators outlined in the following pages, address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome, which is, through the delivery of its health services, the improvement of the health of the Western Australian community by:

- A reduction in the incidence of preventable disease, injury, disability and premature death and the extent of drug abuse.
- The restoration of the health of people with acute illness.
- An improvement in the quality of life for people with chronic disease and disability.

Different divisions of the Health Services are responsible for specific areas of the three outcomes. The largest proportion of Health Service activity is directed to Outcome 2 (Diagnosis and Treatment). To ascertain the overall performance of the health system all reports must be read. All entities contribute to the whole of health performance.

These entities are:

- Department of Health
- Metropolitan Health Service
- South West Area Health Service
- Peel Health Services
- WA Country Health Service

The different service activities, which relate to the components of the outcome, are outlined below.

Prevention and promotion

- Community and public health services.
- Mental health services.
- Dental health services. (MHS)

Diagnosis and treatment

- Hospital services (emergency, outpatient, inpatient, rehabilitation and community-based post discharge care).
- Community health services (Nursing Posts).
- Mental health services.
- Obstetric services.

Continuing care

- Services for frail aged and disabled people (eg Aged Care Assessments, outpatient services for chronic pain and disability, Nursing Home Type hospital care).
- Services for those with chronic illness.
- Mental health services.
- Dental health services. (MHS)

There are some services, such as Community Health, which address all three of the components.

Results in this section are presented as both Aboriginal and non-Aboriginal population figures where appropriate.

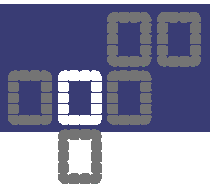
Comparisons across time are provided where possible and appropriate.

Performance Targets

For the 2005-06 reporting period, targets for Effectiveness and Efficiency Key Performance Indicators have been set.

Effectiveness indicator targets have been based on published national averages for performance indicators where available, or from the analysis of previous performance results. Efficiency indicator targets have been constructed with a standard escalation rate applied to the 2004-05 result.

Development of appropriate performance targets will continue for future reporting periods. Issues such as the appropriateness of national or state-wide targets, benchmarking for a rural and remote setting, and the effect on a calculated result or rate from a small population base or a small number of reported events need to be examined closely.



Consumer Price Index (CPI) Deflator Series

The index figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarters and is rebased to reflect a mid-year point of the five year series that appears in the annual reports. The average of the December and March quarters is used, because the full year index series is not available in time for the annual reporting cycle.

The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula.

Cost_n x (100/Index_n) where n is the financial year or calendar year where appropriate. The result will be that financial data is converted to 2003-04 dollars.

Table 7: Consumer price index figures for the financial and calendar years

Calendar year	2000	2001	2002	2003	2004	2005
Index (Base 2003)	90.72	94.57	97.42	100.0	102.4	105.22
Financial year	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Index (Base 2003-04)	92.02	94.81	97.87	100.0	102.48	105.44

Efficiency Indicator Note

All calculations for efficiency indicators include administrative overheads in accordance with relevant Treasurer's Instructions for annual reporting purposes only. These figures are not to be used for any other comparative purpose.

Performance indicators

Outcome 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse

The services, or outputs, of all parts of the Department of Health contribute to the above outcome. Achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. The impact of drug abuse is also monitored.

The outputs of the WA Country Health Service as well as the other divisions of the Department of Health are shown on the table below. The greatest proportion of outputs provided by the WA Country Health Service in this outcome are directed to children. Other health services and divisions of the Department of Health provide more services directed to prevention and surveillance of disease, including those affecting the adult population.

Table 8: Respective Indicators by Health Sector for Outcome 1

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	Dept of Health
The achievement of this component of the health objective involves activities which:					
Reduce the likelihood of onset of disease or injury by:					
Immunisation programs	101A 101B	101A 101B	101A 101B	101A 101B	
Dental screening	105 106				
Safety program					R101
Reduce the risk of long term disability or premature death from injury or illness through:					
Surveillance					R101
Monitoring the incidence of disease in the population to ensure primary health measures are effective:					
	103 104	103 104	103 104	103 104	
Monitoring and surveillance of suicide rates and drug and alcohol use:					
					R101

101A: Percentage of fully immunised children 0 to 6 years

This indicator reports the rate of fully immunised children 0 to 6 years.

Rationale

The community sets a very high priority on ensuring that the health and well being of children is 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 provided by internationally recognised vaccination practices.

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

Performance Targets

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

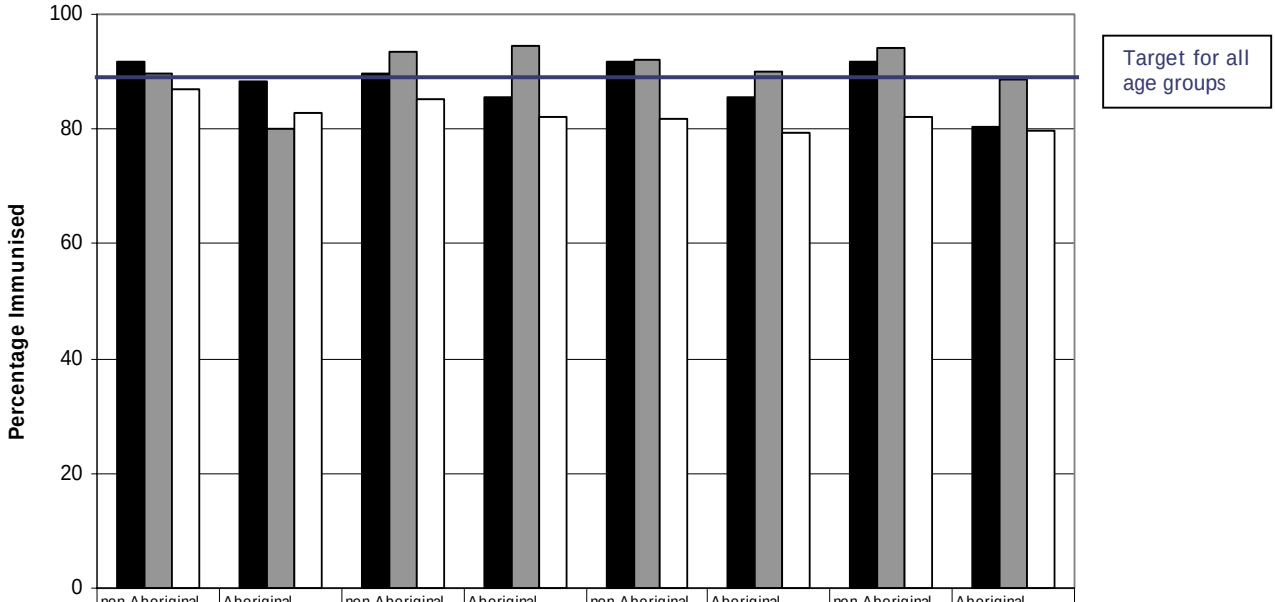
- At least 90% of children fully immunised at 12 months of age.
- At least 90% of children fully immunised at 2 years of age.
- At least 90% of children fully immunised at 6 years of age.

Results

Immunisation rates achieved in 2005 were comparable to prior years with completely immunised non-Aboriginal 12 months and 2 years exceeding the national target. However for the remaining age cohort for non-Aboriginal and all Aboriginal children age groups, immunisation rates remain below the national target. The 2005 reported results are comparable with other reporting areas of Western Australia.

WACHS continues to promote its immunisation programs across rural communities.

Figure 1: Rate of fully immunised children



	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal	non-Aboriginal	Aboriginal
	2002 (Dec Quarter)		2003 (Dec Quarter)		2004 (Dec Quarter)		2005 (Dec Quarter)	
■ 12 months	916	88.2	89.8	85.4	917	85.5	918	80.4
▨ 2 years	89.8	80.1	93.5	94.4	92.1	90.1	94.2	88.6
□ 6 years	86.9	82.7	85.1	82.2	818	79.3	82.3	79.7

Data Sources
Australian Childhood Immunisation Register (ACIR);Australian Bureau of Statistics (ABS) population figures.

101B: Rate of hospitalisations with an infectious disease for which there is an immunisation program

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

Rationale

There are specific communicable diseases that are preventable by vaccine and thus routine vaccination or immunisation programs are recommended by the National Health and Medical Research Council (NHMRC).

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

Measles, mumps and rubella are reported by 0 to 17 year age groups while diphtheria, hepatitis B, whooping cough, poliomyelitis and tetanus are reported by 0 to 12 year age groups.

Performance Targets

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

Results

Results recorded in 2005 are comparable with results in 2004 for hospitalisations for infectious diseases for which there are immunisation programs. Seventeen hospitalisations occurred in 2005 compared to 21 in 2004.

The continued low hospitalisation rates in 2005 for these vaccine-preventable diseases indicate that the provided vaccination and immunisation programs are effective.

Table 9: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0 to 12 years

	2002		2003		2004		2005	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00
Whooping Cough	0.05	0.15	0.07	0.08	0.17	0.76	0.10	0.83
Poliomyelitis	0.00	0.00	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	0.00	0.00

Table 10: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0 to 17 years

	2002		2003		2004		2005	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Measles	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mumps	N/A	N/A	0.01	0.06	0.00	0.00	0.00	0.00
Rubella	N/A	N/A	0.00	0.00	0.01	0.00	0.01	0.00

Note: N/A not reported in this year

Data Sources

Hospital Morbidity Data System; Australian Bureau of Statistics (ABS) population figures.

103: Rate of hospitalisation for gastroenteritis in children 0 to 4 years

This indicator reports the rate of hospitalisation for gastroenteritis in children 0 to 4 years.

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves.

The rate of children who are admitted to hospital per 1,000 population for treatment of gastroenteritis may be an indication of improved primary care or community health strategies, for example, health education. Programs are delivered to ensure there is an understanding of hygiene within homes to assist in preventing gastroenteritis.

It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

The Department of Health is also engaged in the surveillance of enteric diseases. Some forms of gastroenteritis, for example salmonellosis and shigellosis, are notifiable diseases and infection rates are monitored.

Performance Target

Total Population - less than 30.1 per 1000.

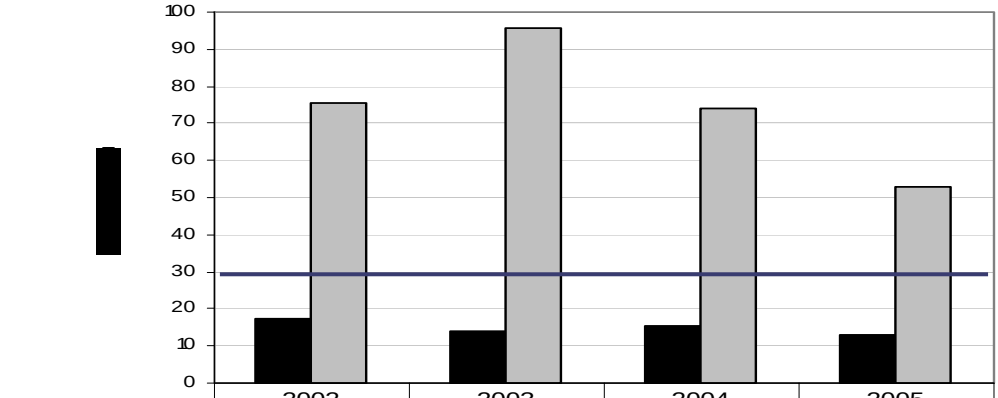
Results

Results for hospitalisation for gastroenteritis per 1000 in 2005 demonstrate improved or comparable performance to prior years, with the rate for all children at its lowest since 2002. WACHS will continue to work in partnership with all health providers to allocate specific resources towards preventing gastroenteritis and similar conditions in rural communities.

Note

This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another Health Service area. This indicator is not necessarily a measure of the performance of the Health Service providing the hospitalisation.

Figure 2: **Rate of hospitalisation per 1000 for gastroenteritis 0 to 4 years**



	2002	2003	2004	2005
Non Aboriginal	17.4	14.1	15.5	13.0
Aboriginal	75.6	95.9	74.2	52.7

Data Sources
Hospital Morbidity Data System; Australian Bureau of Statistics (ABS) population figures.

104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

The rate of children aged 0 to 4 years who are admitted to hospital per 1,000 population for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the rate of all persons admitted for the treatment of acute asthma may be an indication of primary care services or community health strategies, such as health education.

It is important to note, however, that other factors may influence the number of people hospitalised with these respiratory conditions. The conditions are those that have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases in primary or community health.

Performance Targets

Total population

Condition	Age	Target per 1000
Asthma	0-4 yrs	<12.1
	5-12 yrs	<4.0
	13-18 yrs	<2.4
	19-34 yrs	<2.1
	35 plus	<2.7
Bronchitis	0-4	<1.8
Bronchiolitis	0-4	<19.6
Croup	0-4	<7.7

Note

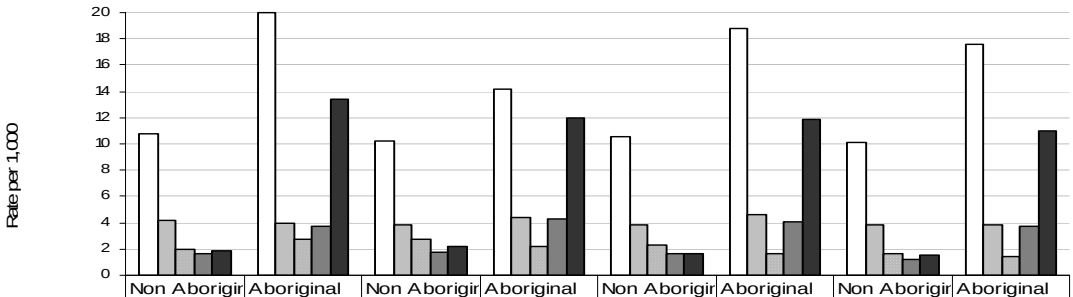
This indicator measures hospital separations of individuals living in a given location who may attend a hospital in their own or another Health Service. The performance of the Health Service providing the hospitalisation is not being measured.

Results

Hospitalisation rates comparable to previous years were achieved for all respiratory conditions for WACHS residents in 2005 with either similar or improved performance to the 2004 results. While the non-Aboriginal results for the respiratory conditions met targets, results for a number of condition groups for Aboriginal populations did not meet the targets.

The WACHS population health service continues to develop and implement specific programs targeting the prevention, management and treatment of respiratory conditions especially for Aboriginal populations. These programs target individuals, families, groups and communities in the rural sector and focuses on the determinants of health. Services are provided locally, as a visiting or outreach service and via telehealth.

Figure 3: Rate of hospitalisation per 1000 for acute asthma (all ages)



	2002		2003		2004		2005	
	Non Aborigir	Aboriginal	Non Aborigir	Aboriginal	Non Aborigir	Aboriginal	Non Aborigir	Aboriginal
0 - 4 years	10.8	20	10.2	14.2	10.6	18.8	10.1	17.6
5 - 12 years	4.2	4	3.8	4.4	3.8	4.6	3.8	3.8
13 - 18 years	2.0	2.7	2.8	2.2	2.3	1.6	1.7	1.4
19 - 34 years	1.7	3.7	1.8	4.3	1.6	4.1	1.2	3.7
35+ years	1.9	13.4	2.2	12	1.7	11.9	1.5	11.0

104: Rate of hospitalisation for respiratory conditions

Figure 4: Rate of hospitalisation per 1000 for acute bronchitis (0 to 4 yrs)

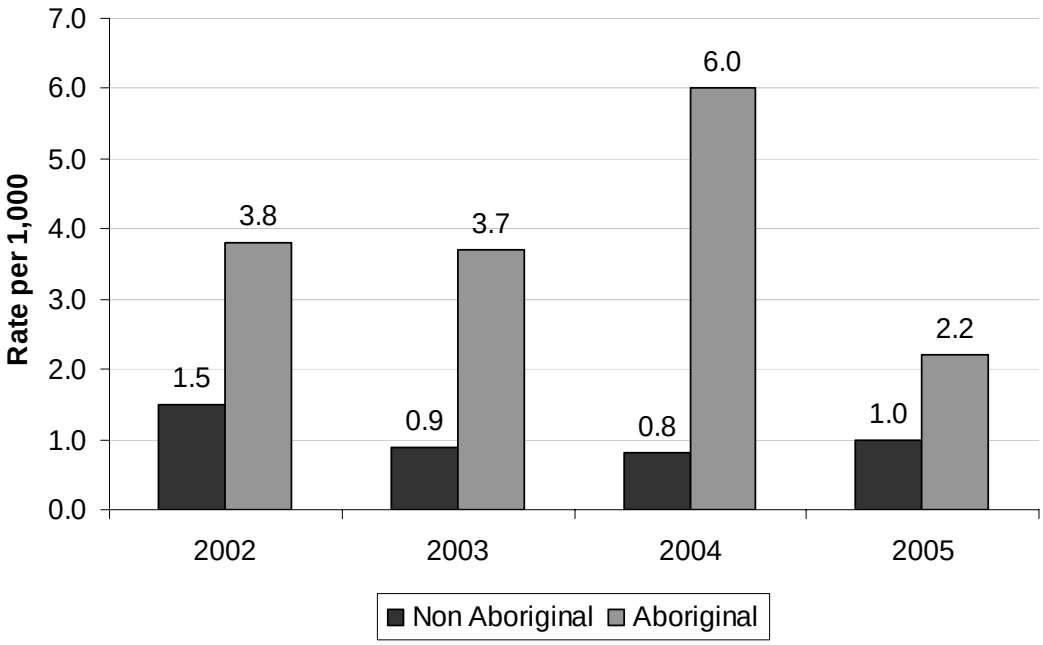
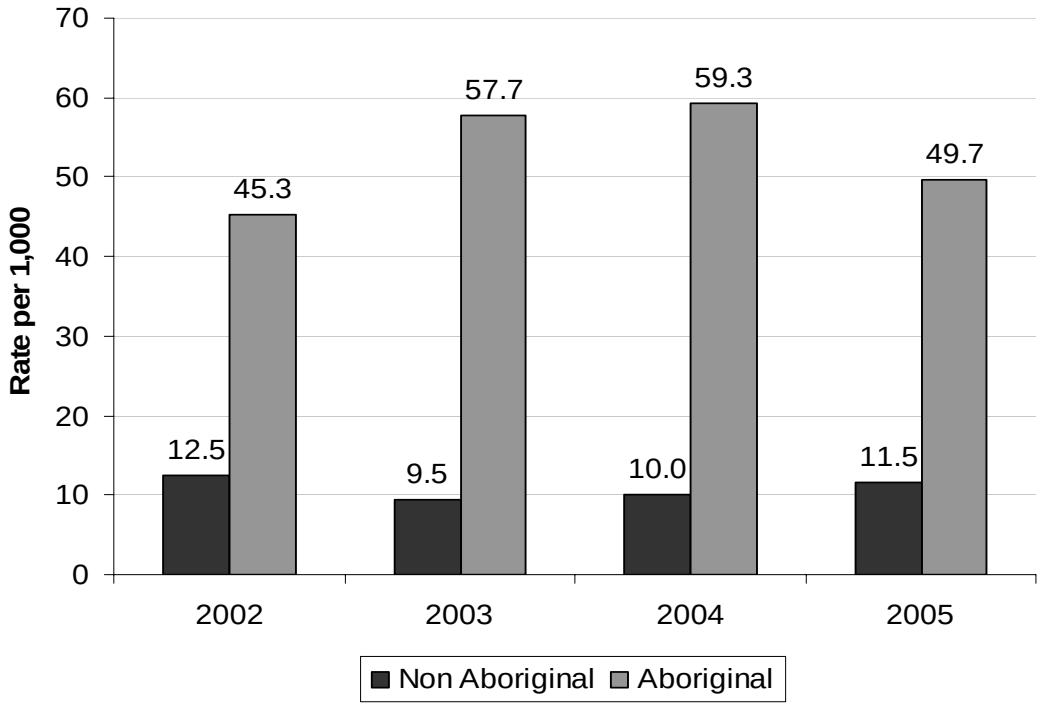
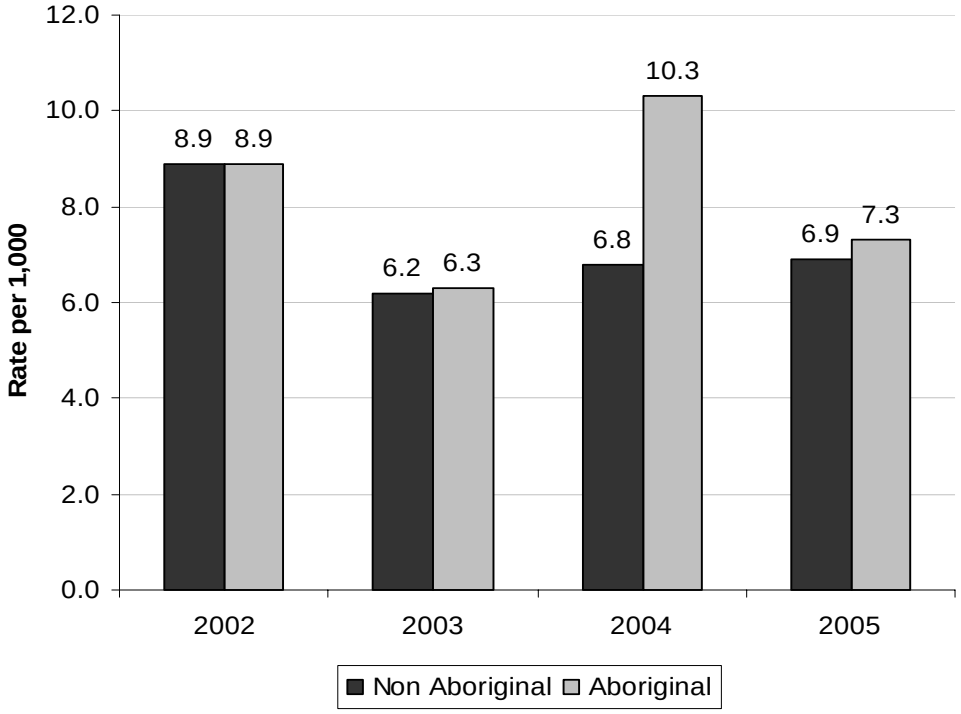


Figure 5: Rate of hospitalisation per 1000 for bronchiolitis (0 to 4yrs)



104: Rate of hospitalisation for respiratory conditions

Figure 6: Rate of hospitalisation per 1000 for croup (0 to 4yrs)



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

110: Average cost per capita of Population Health Units

This indicator reports the cost per capita of the Population Health Units.

Rationale

The Population Health Units consider the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

The Population Health Units support individuals, families and communities to increase control over and improve their health. These services and programs include:

- supporting growth and development; particularly in young children (community health activities)
- promoting healthy environments
- prevention and control of communicable diseases
- injury prevention
- promotion of healthy lifestyle to prevent illness and disability
- support for self-management of chronic disease
- prevention and early detection of cancer.

Table 11: Cost per capita of Population Health Unit

	2003-04	2004-05	2005-06	Target
Actual Cost	$163	$172	$180	≤$183
CPI Adjusted	$163	$168	$171	n/a

Data Source
WACHS Data Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

Outcome 2: Restoring the health of people with acute illness

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

- Ensure people have appropriate and timely access to acute care services when needed so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness does not progress or the effects of injury do not progress further than is acceptable, 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.

Table 12: Respective Indicators by Health Sector for Outcome 2

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	Dept of Health
The achievement of this component of the health objective involves activities which:					
Ensure that people have access to acute care services by:					
Prioritising access to elective surgery.	200		200	200	
Providing timely transport to hospital.					R206
Prioritising access to dental services.	212 213				R207
Provide quality diagnostic services and treatment by:					
Providing appropriate and quality admitted patient services when people are ill or injured.	204 205 206 208	204 205	204 205 206 208	204 205 206 208	R201 R202 R204 R205
Providing timely and appropriate ambulatory services for people who do not require admitted patient care.	201		201 202	202	
Providing appropriate obstetric and neonatal care.	207		207	207	
Provide pathology services for admitted and non-admitted patients	PathWest				

Performance indicators

200: Elective surgery waiting times

This indicator reports the waiting times for elective surgery.

Rationale

The purpose of the Department of Health is to ensure healthier, longer and better lives for all West Australians. Health services strive to improve access to and efficiency in the provision of elective surgery as well as a range of other services. In recognition of the importance of maintaining good health, a range of initiatives has been introduced to ensure that West Australians are provided with timely access to elective surgery. Timely elective surgery ensures that patients have a better chance of being restored to health or to have the quality of their life improved.

Patients who are referred for elective surgery are classified by senior medical staff into one of the following urgency categories based on clinical need. If patients requiring admission to hospital wait for long periods of time, there is potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition.

Performance Targets

Category 1: Admission desirable within 30 days
Category 2: Admission desirable within 90 days
Category 3: Admission desirable within 365 days

Results

Elective surgery activity for 2005-06 was comparable to 2004-05 for admitted cases across all categories. The number of people waiting surgery as at June 30 is also comparable with 2004-05. However the median waiting time for Category 1 and 2 cases remaining while improving exceeds the desirable time. Median waiting times for Category 3 cases remains within the desirable time but has increased.

Note

The AIHW criteria used in the construction of elective surgery waiting lists has been amended for 2005-06 with some procedures added. This reporting rationale conforms with the Australian Council on Healthcare Standards reporting requirements.

Table 13: Cases admitted from the elective surgery waiting list - 2004-06

Category 1 Cases admitted from the elective surgery waiting list

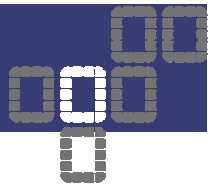
	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Admissions within boundaries	655	89	7	664	87	5
Admissions over boundaries	81	11		101	13	

Category 2 Cases admitted from the elective surgery waiting list

	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Admissions within boundaries	3242	95	10	3046	94	13
Admissions over boundaries	169	5		189	6	

Category 3 Cases admitted from the elective surgery waiting list

	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Admissions within boundaries	3619	97	28	4594	97	28
Admissions over boundaries	129	3		158	3	



200: Elective surgery waiting times

Table 14: Cases remaining on the elective surgery waiting list - 2004-06

Category 1 Cases remaining on the elective surgery waiting list as at 30 June

	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Cases remaining within boundary	17	22	101	26	41	46
Cases remaining over boundary	61	78		38	59	

Category 2 Cases remaining on the elective surgery waiting list as at 30 June

	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Cases remaining within boundary	163	26	278	280	44	110
Cases remaining over boundary	469	74		360	56	

Category 3 Cases remaining on the elective surgery waiting list as at 30 June

	2004-05			2005-06		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Cases remaining within boundary	1228	78	133	1216	71	194
Cases remaining over boundary	342	22		507	29	

Data Source
WA Department of Health.

202: Rate of emergency presentations with a triage score of 4 and 5 not admitted

This indicator reports the rate of emergency presentations with a triage score of 4 and 5 not admitted.

Rationale

When patients attend hospital they are initially assessed in emergency departments where treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency department where many people may present simultaneously. The aim of triage is to ensure that patients are treated in order of their clinical urgency and that patients receive timely care.

While urgency refers principally to time-critical intervention and is not synonymous with severity, more patients triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5. Without care provided by staff in an emergency department, the restoration to health of people with an injury or a sudden illness may take longer or result in death.

This indicator reports the rate of people presenting to the emergency department who were given a triage score of 4 or 5 but did not need to be admitted hospital care ie were restored to health. These emergency departments do not have 24-hour cover by doctors and who are trained in emergency medicine.

Presentations are the number of people attending an emergency department where the assessments include doctor-attended assessments and treatment as well as nursing assessment and treatment. Generally these are people who receive primary care in the emergency department.

Performance Target

Target not appropriate. Emergency presentations will be admitted or not admitted in accordance with their clinical needs.

Result

The percentage of Triage 4 and 5 emergency presentations not admitted to hospital reported in 2005-06 remains comparable to prior years.

Table 15: Rate of emergency presentations with a triage score of 4 and 5 not admitted

	2003-04	2004-05	2005-06
Triage Category 4	87.0%	88.6%	89.8%
Triage Category 5	96.7%	96.7%	96.8%

Data Source
HCARe data systems

204: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition.

Rationale

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation.

Performance Target

Less than the National average reported for 2004 documented in the Report on Government Services 2006.

Results

The recorded rate of readmissions continues to show a decline against the rates reported in the previous three years, and is only marginally above the national average recorded in 2004.

These results demonstrate that the WACHS is committed to ensuring that all its hospitals adopt the highest standards of clinical practice to provide the best level of care to all patients.

Table 16: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2002-03	2003-04	2004-05	2005-06	Target
Unplanned readmission rate	4.6%	4.3%	3.0%	2.9%	<2.8%

Data Source
Hospital Morbidity Data System.
HCARe

205: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Rationale

An unplanned readmission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same condition as the one for which the patient had most recently been discharged.

While it is inevitable that some patients will need to be readmitted to hospital with 28 days, in an unplanned way, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some mental health conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases, readmission to hospital would be planned. A low unplanned readmission percentage suggests good clinical practice is in operation.

Performance Targets

Less than the ACHS national average reported for 2004 of 10%.

Results

WACHS hospitals continue to demonstrate a decline in the rate of unplanned readmissions within 28 days for a mental health condition and are below the national average recorded in 2004.

The continuing improvement in this result is being achieved through a commitment by the WACHS to provide a range of mental health programs and support networks, which are designed to improve the quality of services provided through a range of service models delivered to the community.

Note

The numbers of patients who receive inpatient mental health care are very low, hence small numbers of patients who have unplanned re-admissions can result in large variations to the annual percentage. The Australian Council on HealthCare Standards (ACHS) reports 10% the national average in 2004 for unplanned re-admissions within 28 days, for patients receiving inpatient mental health services.

Table 17: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2002-03	2003-04	2004-05	2005-06	Target
Unplanned readmission rate	10.2%	8.1%	7.6%	5.6%	<10%

Data Source

Hospital Morbidity Data System.

206: Rate of post-operative pulmonary embolism

This indicator reports the rate of post-operative pulmonary embolism.

Rationale

Post-operative patients can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main preventable causes of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A low percentage of cases developing pulmonary embolism post-operatively suggests that the appropriate precautions have been taken.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative pulmonary embolism, a hospital can ensure clinical protocols that minimise such risks are in place and are working. The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Performance Targets

Less than the ACHS reported National average for 2004 of 0.65%.

Results

WACHS hospitals recorded no cases for post-operative pulmonary embolism following surgery in 2005 and continue to demonstrate good clinical practice in surgical treatment and patient care.

Notes

Cases are selected for reporting using the criteria defined by the ACHS. Cases are reported for pulmonary emboli if the post-operative length of stay is at least seven days.

The data capture period for this performance indicator is the 2005 calendar year.

Table 18: Rate of post operative pulmonary embolism

	2002	2003	2004	2005	Target
Post-operative pulmonary embolism	0.15%	0.33%	0.17%	0.0%	<0.65%

Data Source

Hospital Morbidity Data System.

207: Survival rate of live born babies with an APGAR score of four or less five minutes after delivery

This indicator reports the survival rate of live born babies with an APGAR score of four or less five minutes after delivery.

Rationale

A well managed labour will normally result in the birth of a minimally distressed infant. The level of foetal well-being (lack of stress or other complications or conditions) is measured five minutes post delivery by a numerical scoring system (APGAR) through an assessment of heart rate, respiratory effort, muscle tone, reflex irritability and colour.

A high average APGAR score in a hospital will generally indicate that appropriate labour management practices are employed and is also an indication of the wellbeing of the baby.

This indicator reports the survival rates of babies with low APGAR scores at birth (an APGAR score of four or less at five minutes post delivery). A baby with a low APGAR is more likely to have been affected by antenatal or intrapartum events such as maternal haemorrhage, preterm labour or infection.

This indicator measures the survival rate of babies with a low APGAR score and is an elementary measure of how the care in hospital restores the sick or premature baby to health.

Performance Targets

No set target due to low numbers reported in gestational age groups.

Results

Fourteen babies were born in WACHS hospitals during 2005 with an APGAR score of four or less five minutes after delivery, 13 surviving to be discharged home or transferred to another hospital.

Note
There is a direct correlation between the gestational age of babies and the survival rate, with the 37-41 week age bracket generally having the highest survival rates.

Table 19: Survival rate of babies born with an APGAR score of four or less

Gestation period in weeks	2003		2004		2005	
	Babies born (No.)	Survival rate (%)	Babies born (No.)	Survival rate (%)	Babies born (No.)	Survival rate (%)
20-28	1	0	1	0	2	50
29-32	1	100	no event		no event	
33-36	1	100	1	100	no event	
37-41	9	100	9	100	12	100
over 41	no event		no event		no event	
Total all periods	12	91.7	11	90.9	14	92.9

Data Source
WA Midwives' Registry.

208: Survival rates for sentinel conditions

This indicator reports the survival rates for sentinel conditions.

Rationale

The survival rate of patients in hospitals can be affected by many factors. These include the diagnosis, the treatment given or procedure performed, the age, sex and condition of each individual patient including whether the patient had other co-morbid conditions at the time of admission or developed complications while in hospital.

The comparison of 'whole of hospital' survival rates between hospitals may not be appropriate due to differences in mortality associated with different diagnoses and procedures. Three 'sentinel' conditions, therefore, are reported for which the survival rates are to be measured by specified age groups.

For each of these conditions stroke, heart attack (also known as acute myocardial infarction AMI), and fractured hip (also known as fractured neck of femur FNOF), a good recovery is more likely when there is early intervention and appropriate care. Additional co-morbid conditions are more likely to increase with age therefore better comparisons can be made by comparing age brackets rather than the whole population.

This indicator measures the performance of hospitals in restoring the health of people who have had a stroke, AMI or FNOF, by measuring those who survive the illness and are discharged well. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

The survival rates for stroke and AMI decline as expected in the older age groups. High survival rates indicate effective clinical care.

Performance Targets

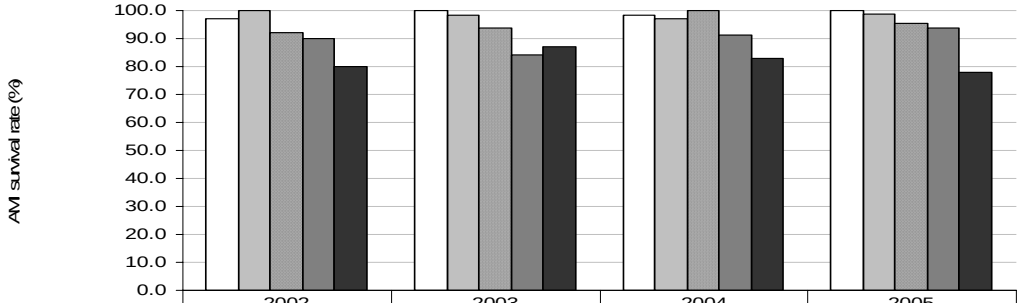
Age range	AMI	Stroke	Fractured neck of femur
0-49 yrs	>97%	>90%	Not reported
50-59 yrs	>97%	>85%	Not reported
60-69 yrs	>95%	>85%	Not reported
70-79 yrs	>90%	>85%	>95%
80+yrs	>80%	>75%	>90%

Results

The survival rates for sentinel conditions show comparable or improved results compared to prior years and met performance targets, with the exception of the 80+ years age group for AMI and stroke.

This is an indication that the clinical practice being provided in the WACHS continues to deliver appropriate outcomes for patients.

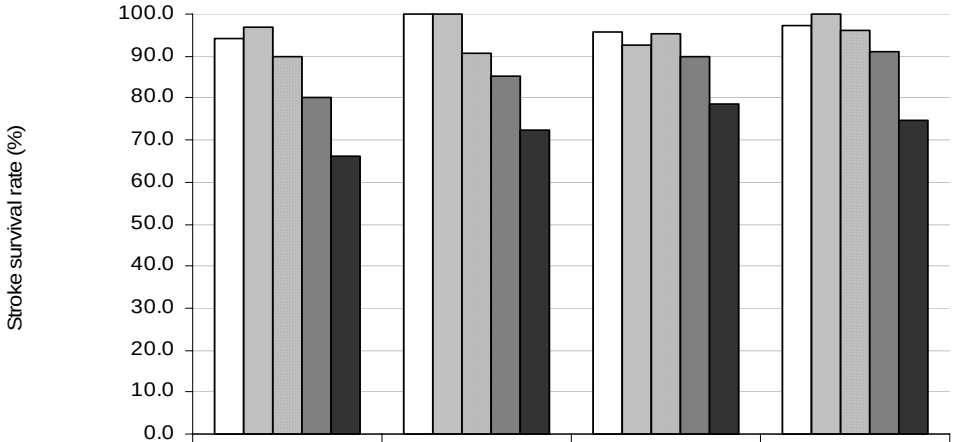
Figure 7: Survival rate for acute myocardial infarction (AMI)



	2002	2003	2004	2005
0-49 years	97.0	100.0	98.5	100
50-59 years	100.0	98.5	97.1	98.6
60-69 years	92.0	93.8	100.0	95.3
70-79 years	90.0	84.1	91.3	93.7
80+ years	80.0	87.0	83.1	77.8

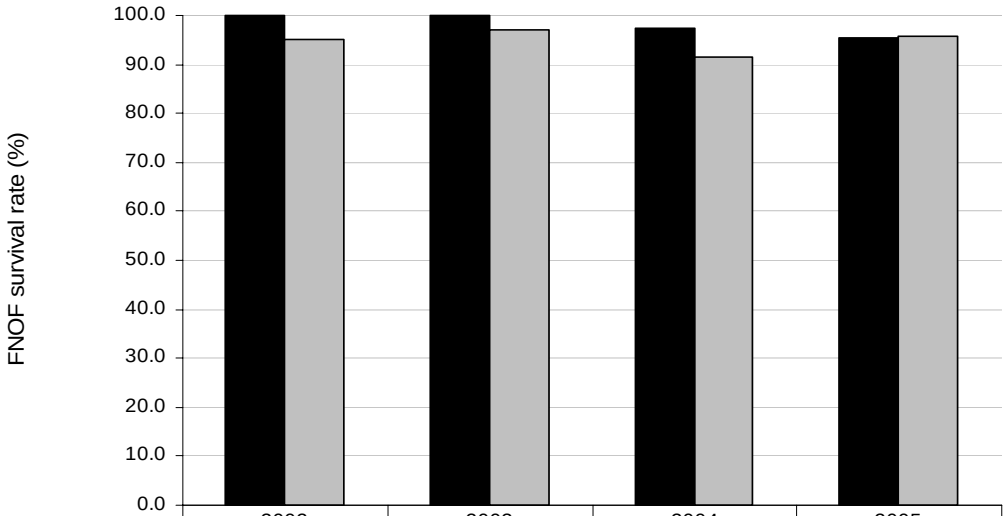
208: Survival rates for sentinel conditions

Figure 8: Survival rate for stroke



	2002	2003	2004	2005
0-49 years	94.0	100.0	95.7	97.2
50-59 years	97.0	100.0	92.5	100
60-69 years	90.0	90.5	95.3	96.2
70-79 years	80.0	85.1	89.7	91.2
80+ years	66.0	72.4	78.6	74.7

Figure 9: Survival rate for fractured neck of femur (FNOF)



	2002	2003	2004	2005
70-79 years	100.0	100.0	97.3	95.5
80+ years	95.0	97.0	91.5	95.7

Data Source
Hospital Morbidity Data System.

221: Average cost per casemix adjusted separation for non-teaching hospitals

This indicator reports average cost per casemix adjusted separation for non-teaching hospitals.

Rationale

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may not necessarily equal the number of casemix adjusted separations. The magnitude of the difference will depend on the complexity of the services provided.

Result

A number of factors have contributed to the higher than estimated cost per casemix adjusted separation in 2005-06. A new round of case weights was applied in 2005-06 with the effect of slightly reducing the acuity levels of inpatient activity across WACHS. This in combination with a slight reduction in inpatient activity at some hospitals, although generally hospital activity remains comparable to prior years, has resulted in a reduction in total number of casemix adjusted separations. Also in 2005-06, additional State-wide overhead costs have been apportioned to WACHS.

Table 20: Average cost per casemix adjusted separation

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$3,360	$3,767	$3,921	$4,517	≤$4,143
CPI adjusted	$3,433	$3,767	$3,826	$4,284	n/a

Data Sources
Hospital Morbidity Data System (HMDS).
WACHS Financial Systems

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

225: Average cost per non-admitted hospital based occasion of service

This indicator reports the average cost per non-admitted hospital based occasion of service.

Rationale

The efficient use of health service resources can help minimise the overall costs of providing health care, or provide for more patients to be treated for the same amount of resources.

It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

Table 21: Average cost per non-admitted hospital based occasion of service

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$133	$154	$174	$170	≤$184
CPI adjusted	$136	$154	$170	$161	n/a

Data Sources
HCARe Non-admitted activity data systems.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

226: Average cost per non-admitted occasion of service in a nursing post

This indicator reports the average cost per non-admitted occasion of service in a nursing post.

Rationale

The efficient use of health service resources can help minimise the overall cost of providing health care, or provide for more patients to be treated for the same amount of resources.

It is important to monitor the unit cost of the non-admitted component of health service provision in order to ensure overall quality and cost effectiveness. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

Table 22: Average cost per nursing post based non-admitted occasion of service

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$106	$126	$128	$135	≤$136
CPI adjusted	$108	$126	$125	$128	n/a

Data Sources
HCARe activity data systems.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

227: Average cost per bed-day for admitted patients (selected small rural hospitals)

This indicator reports the average cost per bed-day for admitted patients (selected small rural hospitals).

Rationale

The use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients. However it is not the accepted method of costing admitted patient activity in a small rural hospital.

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients.

Table 23: Average cost per bed-day for admitted patients in a small hospital

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$568	$691	$719	$724	≤$759
CPI adjusted	$580	$691	$702	$687	n/a

Data Sources
HCARe activity data systems.
WACHS Financial Systems

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

228: Average cost per trip of Patient Assisted Travel Scheme

This indicator reports the average cost per trip of the Patient Assisted Travel Scheme (PATS).

Rationale

The PATS assists permanent country residents to access the nearest medical specialist and specialist medical services.

A subsidy is provided towards the cost of travel and accommodation for patients, and where necessary, an escort for people who have to travel more than 100 kilometres one-way to attend medical appointments. Without this assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Table 24: Average cost per trip of the Patient Assisted Travel Scheme

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$340	$354	$328	$331	≤$347
CPI adjusted	$347	$354	$320	$314	n/a

Data Sources
Local activity data systems.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

229: Average cost per bed-day in an authorised mental health unit

This indicator reports the average cost per bed-day in an authorised mental health unit.

Rationale

The efficient use of hospital resources can help minimise the overall cost of providing health care, or allow more patients to be treated with a similar amount of resources.

Variations in patient characteristics between sites and across time may result in differences in service delivery costs.

In order to ensure quality and cost effectiveness, it is important to monitor the unit cost per bed day of admitted patient care in authorised mental health units. These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders that are by law able to admit people as involuntary patients for psychiatric treatment.

Within the WA Country Health Service there are two authorised units situated in the Albany and Kalgoorlie Regional Resource Centres and the data from each site has been combined.

Table 25: Average cost per bed-day in an authorised mental health unit

	2003-04	2004-05	2005-06	Target
Actual Cost	$724	$877	$816	≤$927
CPI adjusted	$724	$856	$774	n/a

Data Sources
Mental Health Information System.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

Outcome 3: Improving the quality of life of people with chronic illness and disability

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

If a client suffers from a chronic illness they have access to services and support through a range of organisations, including contracted non-government organisations. The arrangements with these organisations are managed through the Department of Health. The effectiveness and efficiency measures for these services are reported by the Department of Health.

The Health Services in general will only come into contact with those clients when they become acute and require acute care. When this care is completed the patient is returned to the community where they can again receive ongoing (continuing) care through the other contracted agencies and services.

To enable people with chronic illness or disability to maintain as much independence in their every day 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 facilities. The intent is to support people in their own home for as long as possible. 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 (eg wheelchairs, walking frames)
- enable people to live as long as possible in the place of their choice supported by, for example, home care services or home delivery of meals
- support families and carers in their roles
- provide access to recreation, education and employment opportunities.

The significant areas of continuing care provided by the Health Services are in the areas of Mental Health, Community Care and Aged Care. The Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allowing them to continue to maintain as close to normal lifestyles as possible.

An important part of ensuring that services are provided to those frail aged who need them is assessment by Aged Care Assessment Teams (ACAT). Without equal access to ACAT assessments appropriate services/aged care may not be provided.

Where a person has a disability, including a younger person, they will receive support through a number of agencies including Disability Services Commission and the Quadriplegic Centre. The DOH also provides assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH. The effectiveness and efficiency indicators for HACC are reported by DOH. The Health Services will provide acute services to those with disabilities under Outcome 2.

Table 26: Respective Indicators by Health Sector for Outcome 3

	Metropolitan Health Service	Peel Health Service	South West Area Health Service	WA Country Health Service	Dept of Health
The achievement of this component of the health objective involves activities which:					
Supporting people with chronic and terminal illness by:					
Providing palliative care services.					R304
Providing support services to people with chronic illnesses and disabilities.	301	301	301	301	R301
Providing appropriate home care services for the frail aged.	304	304	304	304	R302 R303

301: Percent of contacts with community-based public mental health non-admitted services within seven and fourteen days post discharge from public mental health inpatient units

This indicator reports on clients with a principal diagnosis of schizophrenia or bipolar disorder who had contact with community-based public mental health non-admitted services within seven and fourteen days following discharge from public mental health inpatient units.

Rationale

A large proportion of people with a severe and persistent psychiatric illness generally have a chronic or recurrent type illness that results in only partial recovery between acute episodes and a deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on one or more occasions a year with the need for ongoing clinical care from community-based non-admitted services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs that aim to reduce hospital readmission and maximise an individual's independent functioning and quality of life.

This type of care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability and to reduce the likelihood of an unplanned readmission.

A severe and persistent mental illness refers to clients who have psychotic disorders that result in severe and chronic impairment in the conduct of daily life activities. It includes those with a diagnosis of schizophrenia or bipolar disorder.

The time period of seven days has been recommended nationally as an indicative measure of follow up with non-admitted services for people with a severe and persistent mental illness.

Performance Target

There is currently no agreed benchmark for the proportion of clients to be seen within a seven-day period. Consensus among a number of clinicians in Western Australia suggests that targets of 60% threshold for seven-day post discharge contact and 74% threshold for fourteen day post discharge contact are reasonable expectations pending an empirical review of their appropriateness.

Results

In 2005, 57.8% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from public mental health inpatient units received contact with a community-based public mental health non-admitted service within seven days of discharge. A further 18.9% of clients were seen within 8 to 14 days.

Approximately 4% of discharges had no contact within the year. No contact may indicate that referrals, following discharge, were made to the private sector (eg General Practitioners, Private Psychiatrists, Private Psychologists) for which data on contacts is not available.

While the percentage of clients making contact with a community based public mental health non-admitted service within seven-days was below the target, 76.7% of clients were seen within 14 days of discharge achieving the target threshold for this time period.

Table 27: **Percentage of contacts with community-based public mental health non-admitted services within 7 and 14 days post discharge from public mental health inpatient units**

Days to first contact	2003		2004		2005		Target
	%	Cumulative %	%	Cumulative %	%	Cumulative %	Cumulative %
0 - 7 days	59.47	59.47	64.65	64.65	57.80	57.80	60
8 - 14 days	13.15	72.62	10.27	74.92	18.90	76.70	74

Data source
Mental Health Information System, Information Collection and Management, Department of Health WA.

304: Completed assessments as a proportion of accepted Aged Care Assessment Team referrals

This indicator reports the completed assessments against the total number of accepted referrals to an Aged Care Assessment Team (ACAT)

Referred ACAT Clients
An ACAT client is usually an older person who is experiencing difficulty managing at home and/or is considering admission to residential care. However on occasion a younger person may seek ACAT assessment due to long term disability where residential care or community support is considered appropriate.

ACATs receive referrals from any source including self-referral. The ACAT intake process determines the appropriateness of the referral as per the program guidelines. An ACAT comprehensive assessment will determine the older person's eligibility for services including Commonwealth subsidised aged care services. An ACAT client is not a person who requires acute medical services, post acute services or rehabilitation.

Rationale

An ACAT assessment will identify those clients who are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living and whose needs fall within the capacity of subsidised aged care services.

The assessment is the first step in ensuring the ACAT clients gain access to the appropriate services and receive care either in the community or in an institutional setting. The range of services are available to people requiring support to improve or maintain their optimal quality of life. Services to assist people to remain in their own homes are available as well as supported accommodation options.

A completed assessment is when a comprehensive assessment has been undertaken (and full information on the client is recorded) and has resulted in recommendations being made. This includes approvals to access Commonwealth funded programs (eg residential care, community aged care packages and some flexible care options).

If during an assessment the older person is found to require acute medical services, post acute services or rehabilitation services the assessment is recorded as incomplete. The record is also incomplete if during the process the person withdraws, moves to another service or dies before a comprehensive assessment has been completed and recommendations have been made.

Performance Target

Targets are not appropriate for this indicator as assessments are completed as required.

Results

The percentage of completed assessments of the accepted ACAT referrals is comparable to percentages recorded in previous years.

Table 28: Completed assessments as a proportion of accepted ACAT referrals

	2003	2004	2005
Completed assessments as a proportion of accepted ACAT referrals	94.4%	93.6%	92.0%

Data Source
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports.
July to September 2005 and October to December 2005.

303: Average cost per person receiving care from public community-based mental health services

This indicator reports the average cost per person with mental illness under community care.

Rationale

The majority of services provided by community mental health services are for people in an acute phase of a mental illness or who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public mental health patients under community care (non-admitted/ambulatory patients).

Table 29: Average cost per person with a mental illness under community care

	2002-03	2003-04	2004-05	2005-06	Target
Actual Cost	$2,840	$3,043	$2,840	$2,764	≤$3,001
CPI adjusted	$2,902	$3,043	$2,771	$2,621	n/a

Data Sources
Mental Health Information System
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

311: Average cost per ACAT assessment

This indicator measures the average cost per ACAT assessment.

Rationale

People within targeted age groups are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living.

A range of services are available to people requiring support to improve or maintain their optimal quality of life.

The Commonwealth funds the Aged Care Assessment Program based on State health service assessments which determine eligibility for and the level of care required by these aged care services.

Result

There has been a reduction in the number of assessments completed (as well as accepted referrals) during 2005-06 without corresponding expenditure economies. This reflects the resource allocations required by WACHS to provide ACAT services to a small number of clients in remote and rural locations. Factors include travelling to remote communities and the supplementary visits and liaison often required to achieve an appropriate outcome for the client concerned.

Table 30: Average cost per aged care assessment

	2003-04	2004-05	2005-06	Target
Actual Cost	$1,032	$748	$949	≤$791
CPI adjusted	$1,032	$730	$900	n/a

Data Sources
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2005 and October to December 2005.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

312: Average cost per bed-day in specified residential care facilities

This indicator reports the average cost per bed-day in specified residential care facilities.

Rationale

The Department of Health provides care for patients requiring long-term 24-hour nursing care in specialist residential facilities.

The WACHS provides residential care in three State Government Residential Care facilities: Yulanya in the Pilbara Gascoyne, and Numbala Nunga and Kununurra in the Kimberley. The indicator reports the average cost per bed-day of patients who reside in these residential care facilities.

Table 31: Average cost per bed-day in specified residential care facility

	2003-04	2004-05	2005-06	Target
Actual Cost	$236	$291	$318	≤$308
CPI adjusted	$236	$284	$302	n/a

Data Sources
HCARE and local activity data systems.
WACHS Financial Systems.

Note
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce, Office of the Director General and InfoHEALTH have been apportioned to this performance indicator in 2005-06.

Financial Statements Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2006 and the financial position as at 30 June 2006.

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.

P King
Chief Finance Officer
Date: 17 August 2006

N Fong
Accountable Authority
Date: 17 August 2006

Financial Statements Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2006

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the WA Country Health Service at 30 June 2006 and its financial performance and cash flows for the year ended on that date. They are in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions;

(ii) the controls exercised by the WA Country Health Service provide reasonable assurance that the receipt, expenditure and investment of moneys, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(iii) the key effectiveness and efficiency performance indicators of the WA Country Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended 30 June 2006.

Scope
The Director General, Department of Health is responsible for keeping proper accounts and maintaining adequate systems of internal control, for preparing the financial statements and performance indicators, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Income Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement, Schedule of Income and Expenses by Service and the Notes to the Financial Statements.

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

Summary of my Role
As required by the Act, I have independently audited the accounts, financial statements and performance indicators to express an opinion on the financial statements, controls and performance indicators. This was done by testing selected samples of the evidence. Further information on my audit approach is provided in my audit practice statement. Refer "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.pdf".

An audit does not guarantee that every amount and disclosure in the financial statements and 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 performance indicators.

D D R PEARSON
AUDITOR GENERAL
29 September 2006

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

WA Country Health Service

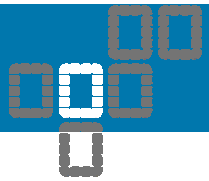
Income Statement

For the year ended 30th June 2006

	Note	2006 $000	2005 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	8	314,458	287,444
Fees for visiting medical practitioners		26,574	26,614
Patient support costs	9	64,429	60,978
Finance costs	10	1,748	1,845
Depreciation and amortisation expense	11	22,433	26,561
Asset impairment losses		-	651
Capital user charge	13	28,454	30,763
Loss on disposal of non-current assets	12	446	2,668
Other expenses	14	53,729	53,957
Total cost of services		512,271	491,481
INCOME			
Revenue			
Patient charges	15	17,066	15,215
Commonwealth grants and contributions	16a	13,704	4,307
Other grants and contributions	16b	4,186	3,406
Donations revenue	17	714	671
Interest revenue		85	114
Other revenues	18	9,347	9,059
Total revenue		45,102	32,772
Total income other than income from State Government		**45,102**	**32,772**
NET COST OF SERVICES		**467,169**	**458,709**
INCOME FROM STATE GOVERNMENT			
Service appropriations	19	464,113	459,598
Assets assumed / (transferred)	20	(2)	476
Liabilities assumed by the Treasurer	21	170	452
Total income from State Government		464,281	460,526
SURPLUS/(DEFICIT) FOR THE PERIOD		(2,888)	1,817

See also note 51 'Schedule of Income and Expenses by Service'

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



WA Country Health Service

Balance Sheet

As at 30th June 2006

	Note	2006 $000	2005 $000
ASSETS			
Current Assets			
Cash and cash equivalents	22	16,104	8,633
Restricted cash and cash equivalents	23	435	497
Receivables	24	7,424	5,515
Amounts receivable for services	25	13,050	14,473
Inventories	26	3,376	3,476
Other current assets	27	609	496
Total Current Assets		40,998	33,090
Non-Current Assets			
Amounts receivable for services	25	42,245	20,831
Property, plant and equipment	28	602,799	469,355
Intangible assets	31	55	10
Other financial assets	30	6	6
Total Non-Current Assets		645,105	490,202
Total Assets		**686,103**	**523,292**
LIABILITIES			
Current Liabilities			
Payables	32	17,905	14,001
Borrowings	33	1,346	1,298
Provisions	34	43,906	39,376
Other current liabilities	35	9,633	5,549
Total Current Liabilities		72,790	60,224
Non-Current Liabilities			
Borrowings	33	25,384	26,730
Provisions	34	9,875	9,034
Total Non-Current Liabilities		35,259	35,764
Total Liabilities		**108,049**	**95,988**
NET ASSETS		**578,054**	**427,304**
EQUITY			
Contributed equity	36	444,669	399,679
Reserves	37	137,594	28,946
Accumulated surplus/(deficiency)	38	(4,209)	(1,321)
TOTAL EQUITY		**578,054**	**427,304**

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

WA Country Health Service

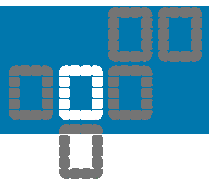
Statement of Changes in Equity

For the year ended 30th June 2006

	Note	2006 $000	2005 $000
Balance of equity at start of period		427,304	396,396
CONTRIBUTED EQUITY	36		
Balance at start of period		399,679	377,093
Capital contribution		45,023	22,284
Other contributions by owners		-	382
Distributions to owners		(33)	(80)
Balance at end of period		**444,669**	**399,679**
RESERVES	37		
Asset Revaluation Reserve			
Balance at start of period		28,946	22,441
Gains/(losses) from asset revaluation		108,648	6,505
Balance at end of period		**137,594**	**28,946**
ACCUMULATED SURPLUS (RETAINED EARNINGS)	38		
Balance at start of period		(1,321)	(3,138)
Surplus/(deficit) for the period		(2,888)	1,817
Balance at end of period		**(4,209)**	**(1,321)**
Balance of equity at end of period		**578,054**	**427,304**
Total income and expense for the period (a)		105,760	8,322

(a) The aggregate net amount attributable to each category of equity is: Deficit $2,888k plus gains from asset revaluation $108,648k (2005: Surplus $1,817k plus gains from asset revaluation $6,505k).

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



WA Country Health Service

Cash Flow Statement

For the year ended 30th June 2006

	Note	2006 $000 Inflows (Outflows)	2005 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		409,237	393,634
Capital contributions		26,756	13,493
Holding account drawdowns		104	34,131
Net cash provided by State Government	39(c)	436,097	441,258
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(142,168)	(143,523)
Employee benefits		(305,926)	(279,159)
GST payments on purchases		(17,578)	(17,488)
Receipts			
Receipts from customers		16,781	14,875
Commonwealth grants and contributions		13,858	4,280
Other grants and contributions		5,304	3,496
Donations		690	501
Interest received		90	107
GST receipts on sales		2,205	926
GST receipts from taxation authority		15,659	16,629
Other receipts		7,579	8,304
Net cash (used in) / provided by operating activities	39(b)	(403,506)	(391,052)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets		(25,226)	(48,051)
Proceeds from sale of non-current physical assets	12	44	73
Net cash (used in) / provided by investing activities		(25,182)	(47,978)
Net increase / (decrease) in cash and cash equivalents		7,409	2,228
Cash and cash equivalents at the beginning of period		9,130	6,902
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	39(a)	16,539	9,130

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 1 First time adoption of Australian equivalents to International Financial Reporting Standards

General

This is the Health Service's first published financial statements prepared under Australian equivalents to International Financial Reporting Standards (AIFRS).

Accounting Standard AASB 1 'First time Adoption of Australian Equivalents to International Financial Reporting Standards' has been applied in preparing these financial statements. Until 30 June 2005, the financial statements of the Health Service had been prepared under the previous Australian Generally Accepted Accounting Principles (AGAAP).

The Australian Accounting Standards Board (AASB) adopted the Standards of the International Accounting Standards Board (IASB) for application to reporting periods beginning on or after 1 January 2005 by issuing AIFRS which comprise a Framework for the Preparation and Presentation of Financial Statements, Australian Accounting Standards and the Urgent Issues Group (UIG) Interpretations.

In accordance with the option provided by AASB 1 paragraph 36A and exercised by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements', financial instrument information prepared under AASB 132 and AASB 139 will apply from 1 July 2005 and consequently comparative information for financial instruments is presented on the previous AGAAP basis. All other comparative information has been prepared under the AIFRS basis.

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard or UIG Interpretation unless specifically permitted by TI 1101 'Application of Australian Accounting Standards and Other Pronouncements'. This TI requires the early adoption of revised AASB 119 'Employee Benefits' as issued in December 2004, AASB 2004-3 'Amendments to Australian Accounting Standards; AASB 2005-3 'Amendments to Australian Accounting Standards [AASB 119]', AASB 2005-4 'Amendments to Australian Accounting Standards [AASB 139, AASB 132, AASB 1, AASB 1023 & AASB 1038]' and AASB 2005-6 'Amendments to Australian Accounting Standards [AASB 3]' to the annual reporting period beginning 1 July 2005. AASB 2005-4 amends AASB 139 'Financial Instruments: Recognition and Measurement' so that the ability to designate financial assets and financial liabilities at fair value is restricted. AASB 2005-6 excludes business combinations involving common control from the scope of AASB 3 'Business Combinations'.

Reconciliations explaining the transition to AIFRS as at 1 July 2004 and 30 June 2005 are provided at note 52 'Reconciliations explaining the transition to AIFRS'.

Note 2 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, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording.

The Financial Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over the Accounting Standards, the Framework, Statements 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 rounded to the nearest thousand dollars ($'000).

The judgements that have been made in the process of applying the Health Service's accounting policies that have the most significant effect on the amounts recognised in the financial statements are disclosed at note 3 'Judgements made by management in applying accounting policies'.

The key assumptions made concerning the future, and other key sources of estimation uncertainty at the reporting 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 4 'Key sources of estimation uncertainty'.

(c) Contributed Equity

UIG interpretation 1038 "Contributions by Owners Made to Wholly-Owned Public Sector Entities" requires transfers in the nature of equity contributions to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital contributions (appropriations) have been designated as contributions by owners by TI 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed Equity.

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. See note 36 'Contributed Equity'.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

(d) Income

Revenue

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.

Rendering of services
Revenue is recognised on delivery of the service to the client.

Interest
Revenue is recognised as the interest accrues.

Service Appropriations
Service Appropriations are recognised as revenues at nominal value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of the appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at the Department of Treasury and Finance. See also note 19 'Service Appropriations'.

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

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

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 reporting 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.

(e) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing above $1,000 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 $1,000 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 cost, the cost is their fair value at the date of acquisition.

Subsequent measurement
After recognition as an asset, the revaluation model is used 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 stated at historical cost less accumulated depreciation and accumulated impairment losses.

Where market 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.

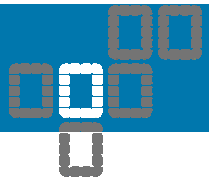
Where market evidence is not available, the fair value of land and buildings is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use assets is determined by reference to the cost of replacing the remaining 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.

The revaluation of land and buildings is provided independently on an annual basis by the Department of Land Information (Valuation Services).

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets. 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 28 'Property, plant and equipment' for further information on revaluations.



WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Depreciation

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

Land is not depreciated. Depreciation on other assets are calculated using the reducing balance method, using rates which are reviewed annually. Expected useful lives for each class of depreciable asset are:

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Medical equipment	4 to 25 years
Other plant and equipment	5 to 50 years

Works of art controlled by the Health Service are classified as property, plant and equipment which are anticipated to have very long and indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and so no depreciation has been recognised.

(f) Intangible Assets

Capitalisation/Expensing of assets

Acquisitions of intangible assets costing over $1,000 and internally generated intangible assets costing over $1,000 are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Income Statement.

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

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

The carrying value of intangible assets is reviewed for impairment annually when the asset is not yet in use, or more frequently when an indicator of impairment arises during the reporting period indicating that the carrying value may not be recoverable.

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life) on the reducing balance basis using rates which are reviewed annually. All intangible assets controlled by the Health Service have a finite useful life and zero residual value. The expected useful lives for each class of intangible asset are:

Computer Software	5 years

Software that is an integral part of the related hardware is treated as property, plant and equipment. Software that is not an integral part of the related hardware is treated as an intangible asset.

(g) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at each reporting 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 Health Service 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 or where the replacement cost is falling. 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 reporting date irrespective of whether there is any indication of impairment.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash 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 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 reporting date.

Refer note 29 'Impairment of assets' for the outcome of impairment reviews and testing.

Refer also to note 2(o) 'Receivables' and note 24 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 from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

(i) Leases

Leases of property, plant and equipment, where the Health Service 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 assets, and are depreciated over the period during which the Health Service is expected to benefit from their use. Minimum lease payments are allocated between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

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

(j) Financial Instruments

The Health Service has two categories of financial instruments:
- Loans and receivables (cash and cash equivalents, receivables); and
- Non trading financial liabilities (payables).

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

The fair value of short-term receivables and payables is the transition 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 (and restricted cash and cash equivalents) assets comprise cash on hand and short-term deposits with original maturities of three months or less, that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(l) Accrued Salaries

Accrued salaries (refer to note 35) 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 Health Service considers the carrying amount of accrued salaries to be equivalent to the net fair value.

(m) Amounts Receivable for Services (Holding Account)

The Health Service receives 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 19 'Service appropriations' and note 25 'Amounts receivable for services'.

(n) Inventories

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

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 26 '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. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service 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 from the date of recognition. See note 2(j) 'Financial instruments' and note 24 'Receivables'.

(p) Payables

Payables are recognised at the amounts payable when the Health Service 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 2(j) 'Financial instruments' and note 32 'Payables'.

(q) Borrowings

All loans are initially recognised at cost being the fair value of the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method. See note 2(j) 'Financial instruments' and note 33 'Borrowings'.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

(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, and are recognised where there is a present legal, equitable or constructive obligation as a result of a past event and when the outflow of economic benefits is probable and can be measured reliably. Provisions are reviewed at each balance date. See note 34 'Provisions'.

Provisions - Employee Benefits

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 reporting 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 end of the reporting 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 reporting date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the reporting 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 Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the reporting date.

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

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

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 Health Service has no liabilities under the Pension or the GSS Schemes. The liabilities for the unfunded Pension Scheme and the unfunded GSS Scheme transfer benefits due to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS Scheme obligations are funded by concurrent contributions made by the Health Service to the GESB. The concurrently funded part of the GSS Scheme is a defined contribution scheme as these contributions extinguish all liabilities in respect of the concurrently funded GSS Scheme obligations.

Employees who are not members of either the Pension or the GSS Schemes become non-contributory members of the West State Superannuation Scheme (WSS), an accumulation scheme. The Health Service makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. The WSS Scheme is a defined contribution scheme as these contributions extinguish all liabilities in respect of the WSS Scheme.

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 2 (t) 'Superannuation expense'.

Deferred Salary Scheme
With the written agreement of the Health Service, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Health Service is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the reporting date and includes related on-costs.

Gratuities
The Health Service is obliged to pay the medical practitioners and nurses for gratuities under Medical Practitioners (WA Country Health Service – North West) AMA Industrial Agreement and the Nurses (WA Government Health Services) Agreement 2001. These groups of employees are entitled to a gratuity payment for each completed year of continuous service in specified regions in Western Australia.

The liability for gratuity payments is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash flows.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

Provisions - Other

Employment on-costs

Employment on-costs, including workers compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'. See note 14 'Other expenses' and note 34 'Provisions'.

(t) Superannuation Expense

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

(a) Defined benefit plans - Change in the unfunded employer's liability (i.e. current service cost and, actuarial gains and losses) assumed by the Treasurer in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme (GSS); and

(b) Defined contribution plans - Employer contributions paid to the GSS and the West State Superannuation Scheme (WSS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS transfer benefits are recognised as expenses. As these liabilities are assumed by the Treasurer (refer note 2(s)), 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 21 'Liabilities assumed by the Treasurer'.

(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 revenues and as assets or expenses as appropriate, at fair value.

(v) Comparative Figures

Comparative figures have been restated on the AIFRS basis except for financial instruments which have been prepared under the previous AGAAP Australian Accounting Standard AAS 33 'Presentation and Disclosure of Financial Instruments'. The transition date to AIFRS for financial instruments is 1 July 2005 in accordance with AASB 1, paragraph 36A and Treasurer's Instruction 1101.

(w) Trust Accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party, such as patients' cash. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

Details of Trust Accounts are reported as a note to the financial statements (refer to Note 7).

(x) Special Purpose Accounts

Special Purpose Accounts are used by the Health Service to account for contributions to which a condition of use has been attached, such as donations, gifts or grants for particular purposes. The Health Service has control of the use of these funds, and can deploy them to meet its objectives, although it has an obligation to only use these funds for the particular purpose for which they were contributed. The use of Special Purpose Accounts enables the contributions to be segregated from the operating funds of the Health Service and to ensure that they are used in a manner that is consistent with the imposed conditions.

Note 3 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.

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

Buildings

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

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

Note 4 Key sources of estimation uncertainty

The key estimates and assumptions made concerning the future, and other key sources of estimation uncertainty at the reporting date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year include:

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

A staff retention factor representing the experience of employee departures and periods of service is used to estimate the non-current long service leave liabilities. This is an average of probabilities that current employees will remain employed until completion of their partially completed LSL cycles (being either 7 years or 10 years). This does not make a distinction between employees have differing terms to full entitlement. The same average probability is equally applied to an employee who is very close to attaining full entitlement as it is to a new employee. The actuarial assessment of the staff retention factor was undertaken in July 2003 and it will be due for re-assessment by the next reporting date.

Note 5 Disclosure of changes in accounting policy and estimates

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard or UIG Interpretation unless specifically permitted by TI 1101 'Application of Australian Accounting Standards and Other Pronouncements'. As referred to in Note 1, TI 1101 has only mandated the early adoption of revised AASB 119, AASB 2004-3, AASB 2005-3, AASB 2005-4 and AASB 2005-6. Consequently, the Health Service has not applied the following Australian Accounting Standards and UIG Interpretations that have been issued but are not yet effective. These will be applied from their application date:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments. The Standard is required to be applied to annual reporting periods beginning on or after 1 January 2007. The Standard is considered to result in increased disclosures of an entity's risks, enhanced disclosure about components of an financial position and performance, and changes to the way of presenting financial statements, but otherwise there is no financial impact.

2) AASB 2005-9 'Amendments to Australian Accounting Standards [AASB 4, AASB 1023, AASB 139 & AASB 132]' (Financial guarantee contracts). The amendment deals with the treatment of financial guarantee contracts, credit insurance contracts, letters of credit or credit derivative default contracts as either an "insurance contract' under AASB 4 'Insurance Contracts' or as a "financial guarantee contract' under AASB 139 'Financial Instruments: Recognition and Measurement'. The Health Service does not undertake these types of transactions resulting in no financial impact when the Standard is first applied. The Standard is required to be applied to annual reporting periods beginning on or after 1 January 2006.

3) UIG Interpretation 4 'Determining whether an Arrangement Contains a Lease'. This Interpretation deals with arrangements that comprise a transaction or a series of linked transactions that may not involve a legal form of a lease but by their nature are deemed to be leases for the purposes of applying AASB 117 'Leases". At reporting date, the Health Service has not entered into any arrangements as specified in the Interpretation resulting in no impact when the Interpretation is first applied. The Interpretation is required to be applied to annual reporting periods beginning on or after 1 January 2006.

The following amendments are not applicable to the Health Service as they will have no impact:

AASB Amendment	Affected Standards
2005-1	AASB 139 (Cash flow hedge accounting of forecast intragroup transactions).
2005-5	'Amendments to Australian Accounting Standards [AASB 1 & AASB 139]'.
2006-1	AASB 121 (Net investment in foreign operations).
UIG 5	'Rights to Interests arising from Decommissioning, Restoration and Environmental Rehabilitation Funds'.
UIG 6	'Liabilities arising from Participating in a Specific Market - Waste Electrical and Electronic Equipment'.
UIG 7	'Applying the Restatement Approach under AASB 129 Financial Reporting in Hyperinflationary Economies'.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 6 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 51. The three key services of the Health Service are:

Prevention and Promotion
Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death. This service primarily focuses on the health and well being of populations, rather than on individuals. The programs define populations that are at-risk and ensure that appropriate interventions are delivered to a large proportion of these at-risk populations.

Diagnosis and Treatment
The objective for the diagnosis and treatment services is to improve the health of Western Australians by restoring the health of people with acute illness (or other health conditions such as pregnancy). The services provided to diagnose and treat patients include emergency services; ambulatory care or outpatient services and services for those people who are admitted to hospitals, oral health services and other supporting services such as patient transport and the supply of highly specialised drugs.

Continuing Care
Continuing care services are provided to people and their carers who require support with moderate to severe functional disabilities and/or a terminal illness to assist in the maintenance or improvement of their quality of life.

Note 7 Administered trust accounts	**2006 $000**	**2005 $000**

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

a) The Health Service administers a trust account for the purpose of holding patients' private moneys.

A summary of the transactions for this trust account is as follows:

Opening Balance	611	630
Add Receipts		
- Patient Deposits	1,215	1,477
- Interest	7	8
	1,833	2,115
Less Payments		
- Patient Withdrawals	1,202	1,503
- Interest / Charges	1	1
Closing Balance	630	611

b) The Health Service administers a trust account for salaried medical practitioners under the rights to private practice scheme.

A summary of the transactions for this trust account is as follows:

Opening Balance	244	382
Add Receipts		
- Fees collected on behalf of medical practitioners	155	179
- Interest	2	4
	401	565
Less Payments		
- Payments to medical practitioners	200	319
- Charges	1	2
Closing Balance	200	244

c) Other trust accounts - not controlled by the Health Service

Accommodation Bonds Account
Staff Development and Diabetes Education Fund

Opening Balance	269	193
Add Receipts		
- Deposits	4	84
- Interest	7	8
	280	285
Less Payments		
- Withdrawals	116	13
- Charges	13	3
Closing Balance	151	269

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 8 Employee benefits expense

	2006 $000	2005 $000
Salaries and wages (a)	256,525	233,878
Superannuation - defined contribution plans (b)	23,099	21,123
Superannuation - defined benefit plans (c) (d)	170	452
Annual leave and time off in lieu leave (e)	29,191	27,538
Long service leave (e)	5,473	4,453
	314,458	287,444

(a) Includes the value of the fringe benefit to the employees plus the fringe benefits tax component.

(b) Defined contribution plans include West State and Gold State (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 21 'Liabilities assumed by the Treasurer'.

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 14 'Other expenses'. The employment on-costs liability is included at note 34 'Provisions'.

Note 9 Patient support costs

Medical supplies and services	19,813	18,582
Domestic charges	4,127	4,105
Fuel, light and power	11,915	10,787
Food supplies	4,971	4,733
Patient transport costs	15,392	14,672
Purchase of external services	8,211	8,099
	64,429	60,978

Note 10 Finance costs

Interest paid	1,748	1,845
	1,748	1,845

Note 11 Depreciation and amortisation expense

Depreciation		
Buildings	15,576	19,279
Leasehold improvements	36	50
Computer equipment	1,182	1,318
Furniture and fittings	156	162
Motor vehicles	657	688
Medical equipment	3,683	3,968
Other plant and equipment	1,127	1,096
	22,417	26,561
Amortisation		
Intangible assets	16	-
Total depreciation and amortisation	22,433	26,561

Note 12 Net gain / (loss) on disposal of non-current assets

Cost of disposal of non-current assets		
Land and buildings	(61)	(123)
Computer equipment	(81)	(438)
Furniture and fittings	(36)	(356)
Motor vehicles	(19)	(25)
Medical equipment	(203)	(1,120)
Other plant and equipment	(90)	(679)
	(490)	(2,741)
Proceeds from disposal of non-current assets:		
Computer equipment	5	2
Furniture and fittings	1	1
Motor vehicles	22	52
Medical equipment	14	3
Other plant and equipment	2	15
	44	73
Net gain/(loss)	(446)	(2,668)

See note 2(h) 'Non-current assets held for sale', and note 28 'Property, plant and equipment'.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

	2006 $000	2005 $000
Note 13 Capital user charge		
	28,454	30,763

The Government applies a levy for the use of its capital for the delivery of services. It is applied at 8% per annum on the net assets of the Health Service, excluding exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

Note 14 Other expenses

Communications	3,672	4,032
Computer services	572	766
Employment on-costs (a)	10,790	10,807
Insurance	2,757	3,286
Legal expenses	582	153
Motor vehicle expenses	3,868	3,472
Operating lease expenses	5,555	5,282
Printing and stationery	2,052	2,329
Rental of property	3,124	2,708
Repairs, maintenance and consumable equipment expense	12,344	17,774
Bad and doubtful debts expense	155	442
Other	8,258	2,906
	53,729	53,957

(a) Includes workers' compensation insurance and other employment on-costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 34 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

(b) Non-current assets available for sale measured at lower of carrying amount and fair value less selling costs.

Note 15 Patient charges

Inpatient charges	13,959	13,121
Outpatient charges	3,107	2,094
	17,066	15,215

Note 16 Grants and contributions

a) Commonwealth grants and contributions		
Grant for nursing homes	3,403	2,986
Australian Taxation Office Diesel Fuel Prior Year Rebate	-	73
Grant for Community Aged Care Program	2,328	413
Grant for RHS	2,951	
Grant for Dept Veterans Affairs Home & Domiciliary Care	197	141
Grant for MSOAP Funding	145	-
Grant for Aged Care Training Program	172	-
Grant for CRC Halls Creek	87	-
Grant for National Respite Carers Program	1,568	-
Grant for Carelink	399	-
Grant for Caring in Communities	81	-
Grant for Numbala Nunga Nursing Home - Fire Safety	125	-
Grant for Assist Care & Housing for the Aged	57	-
Grant for Primary Health Care Access Program	1,381	-
Grant for HIV Treatment	142	-
Grant for Maternal Health - Gascoyne	71	-
Grant for Communicable Diseases	46	-
Grant for Eastern Goldfields Regional Reference Site	87	-
Grant for Patient Care Assistant Training Grants	96	-
Grant for Australian Centralised Immunisation Register	24	-
Grant for Rural Private Access Program	60	-
Grant for Overseas Trained Doctors Upskilling	-	74
Grant for Structured Training and Employment Program	-	104
Grant for Support Aged Care Training Program	-	117
Grant for health training	151	110
Other grants	133	289
	13,704	4,307

WA Country Health Service

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For the year ended 30th June 2006

Note 16 Grants and contributions (continued)

	2006 $000	2005 $000
b) Other grants and contributions		
BHP Billiton - Road Trauma	-	120
Disability Services Commission Community Aids and Equipment Program	994	809
Grant for MSOAP	381	206
Grant for Paed Services WA Country	-	146
Grant for RRAPP	-	186
Grant for Student Nurses	-	55
Disability Services Commission - Therapy assistance	944	858
Healthway - Geraldton Young People & Physical Activity Program	-	133
Healthways - Mens Health	-	81
St John of God - Strong Women, Strong Babies	-	136
University of WA - Cotton Creek	-	82
Disabilty Services Commission - Liaison Funding	132	-
Frontier Services- Aged Care Training	40	-
Rural Clinical School - Rural Clinical School Program	221	-
Aust College for Remote and Rural Medicine -Population Health MO	355	-
Community Health Workforce Development	36	-
HealthWays	134	-
BHP - Contribution to Yulanya Bus	31	-
WACRRM	364	-
Pilbara Development Commission - Partnership Program	34	-
Dept of Justice - Roebourne Prison	35	-
Dept of Education - Traineeships	27	-
BHP - Contribution to Newman CHS upgrades	50	-
Healthway - Up4It project	119	-
Shire of Plantagenet	71	-
Grant for CUCHR	20	-
Other grants	198	594
	4,186	3,406

Note 17 Donations revenue

General public contributions	450	372
Geraldton Hospital Auxiliary	45	27
National Medication Collaborative	-	19
Nursing Home Education	-	29
Palliative Care Donations	-	12
Palliative Care WA for assets	-	3
Plantagenet Village Homes for assets	-	18
Shire of Plantagenet for assets	-	92
Shire of Cranbrook for assets	-	35
Telethon Trust for Paediatric Ward upgrade	-	15
Variety Club of Australia	75	49
Southern Aboriginal Corporation for Bus and Caravan	24	-
Est. Late Philip Johnson for Plantagent Cranbrook HS equipment	100	-
Ravensthorpe Joint Venture for Oxylog Ventilators	20	-
	714	671

Note 18 Other revenues

Recoveries	1,849	1,314
Use of hospital facilities	2,651	3,262
Rent from properties	228	398
Boarders' accommodation	2,910	2,468
Other	1,709	1,617
	9,347	9,059

Note 19 Service appropriations

Appropriation revenue received during the year:		
Service appropriations	464,113	459,598

Service appropriations are accrual amounts reflecting the net 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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

	2006 $000	2005 $000
Note 20 Assets assumed / (transferred)		
The following assets have been assumed from / (transferred to) other state government agencies during the financial year:		
- Land and buildings	(14)	-
- Plant and equipment	12	476
Total assets assumed / (transferred)	(2)	476

Where the Treasurer or other entity has assumed a liability, the Health Service recognises revenues equivalent to the amount of the liability assumed and an expense relating to the nature of the event or events that initially gave rise to the liability. From 1 July 2002 non-discretionary non-reciprocal transfers of net assets (i.e. restructuring of administrative arrangements) have been classified as Contributions by Owners (CBOs) under TI 955 and are taken directly to equity.

Note 21 Liabilities assumed by the Treasurer

The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	170	452

The assumption of the superannuation liability by the Treasurer is a notional income to match the notional superannuation expense reported in respect of current employees who are members of the Pension Scheme and current employees who have a transfer benefit entitlement under the Gold State Superannuation Scheme (The notional superannuation expense is disclosed at note 8 'Employee benefits expense').

Note 22 Cash and cash equivalents

Cash on hand	52	46
Cash at bank - general	14,256	6,750
Cash at bank - donations	1,744	1,762
Term deposits	52	75
	16,104	8,633

Note 23 Restricted cash and cash equivalents

Cash assets held for specific purposes		
Cash at bank	33	35
Deposits at call	402	462
	435	497

Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

Note 24 Receivables

Current		
Patient fee debtors	1,481	1,282
Other receivables	5,247	3,486
Less: Allowance for impairment of receivables	(422)	(508)
	6,306	4,260
GST receivable	1,118	1,255
	7,424	5,515

See also note 2(o) 'Receivables' and note 50 'Financial instruments'.

Note 25 Amounts receivable for services

Current	13,050	14,473
Non-current	42,245	20,831
	55,295	35,304
Balance at start of the year	35,304	36,850
Credit to holding account	24,661	33,045
Less holding account drawdown	(4,670)	(34,591)
Balance at end of the year	55,295	35,304

This asset represents the non-cash component of service appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(m) Amounts Receivable for Services (Holding Account).

Note 26 Inventories

Current		
Supply stores - at cost	1,346	1,749
Pharmaceutical stores - at cost	1,299	1,135
Engineering stores - at cost	731	592
	3,376	3,476

See also note 2(n) Inventories

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

	2006 $000	2005 $000
Note 27 Other current assets		
Prepayments	609	496
	609	496
Note 28 Property, plant and equipment		
Land		
At fair value	34,329	23,717
	34,329	23,717
Buildings		
Clinical:		
At fair value	439,376	334,457
Accumulated depreciation	-	(17,166)
	439,376	317,291
Non-Clinical:		
At fair value	54,447	37,891
Accumulated depreciation	-	(1,472)
	54,447	36,419
Total land and buildings	528,152	377,427
Leasehold improvements		
At cost	295	250
Accumulated depreciation	(161)	(125)
	134	125
Computer equipment		
At cost	6,626	6,133
Accumulated depreciation	(4,009)	(3,068)
	2,617	3,065
Furniture and fittings		
At cost	2,043	1,728
Accumulated depreciation	(517)	(385)
	1,526	1,343
Motor vehicles		
At cost	3,518	3,161
Accumulated depreciation	(2,231)	(1,612)
	1,287	1,549
Medical equipment		
At cost	32,826	28,065
Accumulated depreciation	(11,365)	(8,898)
Accumulated impairment losses	(360)	(651)
	21,101	18,516
Other plant and equipment		
At cost	11,037	9,059
Accumulated depreciation	(3,227)	(2,385)
	7,810	6,674
Works in progress		
Buildings under construction (at cost)	39,558	59,053
Other Work in Progress (at cost)	551	1,546
	40,109	60,599
Art Works		
At cost	63	57
	63	57
Total of property, plant and equipment	602,799	469,355

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

Note 28 Property, plant and equipment (continued)

Land and buildings were revalued as at 1 July 2005 by the Department of Land Information (Valuation Services). These valuations were recognised at 30 June 2006. In undertaking the revaluation, fair value was determined by reference to market values for land: $25,088,000 and buildings: $54,447,000. For the remaining balance, fair value was determined on the basis of current use for land and by reference to depreciated replacement cost for buildings. See note 2(e) 'Property, Plant and Equipment'.

Comprehensive valuations were performed for clinical buildings during the year ended 30 June 2004. These buildings were subsequently revalued at 30 June 2006 by means of applying a building cost index to their depreciated replacement costs.

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

	2006 $000	2005 $000
Land		
Carrying amount at start of year	23,717	23,064
Additions	236	768
Disposals	(26)	(117)
Transfer from/(to) other reporting entities	(20)	-
Revaluation increments / (decrements)	10,422	2
Carrying amount at end of year	34,329	23,717
Buildings		
Carrying amount at start of year	353,710	360,759
Additions	1,503	2,077
Transfers from work in progress	56,022	4,710
Disposals	(35)	(86)
Transfer from/(to) other reporting entities	(27)	-
Revaluation increments / (decrements)	98,226	6,503
Depreciation	(15,576)	(19,279)
Transfer between asset classes	-	(974)
Carrying amount at end of year	493,823	353,710
Leasehold improvements		
Carrying amount at start of year	125	175
Additions	45	-
Depreciation	(36)	(50)
Carrying amount at end of year	134	125
Computer equipment		
Carrying amount at start of year	3,065	3,757
Additions	803	1,134
Transfers from work in progress	38	6
Disposals	(81)	(491)
Transfer from/(to) other reporting entities	4	-
Depreciation	(1,182)	(1,318)
Transfer between asset classes	(30)	(10)
Write-off of assets	-	(13)
Carrying amount at end of year	2,617	3,065
Furniture and fittings		
Carrying amount at start of year	1,343	1,672
Additions	367	185
Transfers from work in progress	29	-
Disposals	(36)	(353)
Depreciation	(156)	(161)
Transfer between asset classes	(21)	-
Carrying amount at end of year	1,526	1,343
Motor vehicles		
Carrying amount at start of year	1,549	1,673
Additions	414	586
Disposals	(19)	(22)
Depreciation	(657)	(688)
Carrying amount at end of year	1,287	1,549

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 28 Property, plant and equipment (continued)

	2006 $000	2005 $000
Medical equipment		
Carrying amount at start of year	18,516	19,610
Additions	5,252	3,281
Transfers from work in progress	1,227	467
Disposals	(203)	(1,126)
Transfer from/(to) other reporting entities	(8)	-
Impairment losses (a)	-	(651)
Impairment losses reversed (a)	291	-
Depreciation	(3,683)	(3,968)
Transfer between asset classes	-	974
Write-down of assets	(291)	(71)
Carrying amount at end of year	21,101	18,516
Other plant and equipment		
Carrying amount at start of year	6,674	5,667
Additions	1,710	1,626
Transfers from work in progress	604	1,159
Disposals	(90)	(623)
Transfer from/(to) other reporting entities	16	-
Depreciation	(1,127)	(1,096)
Transfer between asset classes	23	-
Write-off of assets	-	(59)
Carrying amount at end of year	7,810	6,674
Works in progress		
Carrying amount at start of year	60,599	18,465
Additions	37,525	48,695
Transfers to other asset classes	(57,929)	(6,342)
Write-down of assets	(86)	(219)
Carrying amount at end of year	40,109	60,599
Art Works		
Carrying amount at start of year	57	60
Additions	6	-
Disposals	-	(3)
Carrying amount at end of year	63	57
Total property, plant and equipment		
Carrying amount at start of year	469,355	434,902
Additions	47,861	58,352
Disposals	(490)	(2,821)
Transfer from/(to) other reporting entities	(35)	-
Revaluation increments / (decrements)	108,648	6,505
Impairment losses (a)	-	(651)
Impairment losses reversed (a)	291	-
Depreciation	(22,417)	(26,560)
Write-down of assets	(377)	(362)
Transfer between asset classes (see note 31)	(28)	(10)
Transfers from work in progress (see note 31)	(9)	-
Carrying amount at end of year	602,799	469,355

(a) Recognised in Income Statement. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised in the Income Statement. Where an asset at fair value is written down to recoverable amount, the loss is accounted for as a revaluation

Note 29 Impairment of Assets

There were no indications of impairment to property, plant and equipment, and intangible assets at 30 June 2006.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period and at reporting date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2006 have either been classified as assets held for sale or written off.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

Note 30 Other financial assets	2006 $000	2005 $000
Shares in Mount Barker Cooperative Ltd at cost	6	6

Note 31 Intangible assets

Computer software		
At cost	127	29
Accumulated amortisation	(72)	(19)
	55	10

Reconciliation

Reconciliation of the carrying amount of intangible assets at the beginning and end of the current financial year is set out below.

Computer software		
Carrying amount at start of year	10	-
Additions	27	-
Transfers from work in progress	9	-
Disposals	(3)	-
Amortisation expense	(16)	-
Transfer between asset classes	28	10
Carrying amount at end of year	55	10

(a) Recognised in Income Statement.

Note 32 Payables

Current		
Trade creditors	8,322	6,494
Accrued expenses	9,364	7,276
Accrued interest	219	231
	17,905	14,001

See also note 2(p) 'Payables' and note 50 'Financial instruments'.

Note 33 Borrowings

Current		
Western Australian Treasury Corporation loans	515	503
Department of Treasury and Finance loans	831	795
	1,346	1,298
Non-current		
Western Australian Treasury Corporation loans	9,578	10,093
Department of Treasury and Finance loans	15,806	16,637
	25,384	26,730
Total borrowings	26,730	28,028

Western Australian Treasury Corporation (WATC) loans		
Balance at start of year	10,596	11,088
Less repayments this year	(503)	(492)
Balance at end of year	10,093	10,596

The debt is held in a portfolio of loans managed by the Department of Health. Repayments of the debt are made by the Department of Health on behalf of the Health Service.

Department of Treasury and Finance loans		
Balance at start of year	17,432	18,193
Less repayments this year	(795)	(761)
Balance at end of year	16,637	17,432

This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury and Finance by the Department of Health on behalf of the Health Service. Interest rates are linked to the State's debt servicing costs.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 34 Provisions	2006 $000	2005 $000
Current		
Employee benefits provision		
Annual leave (a)	24,080	22,298
Time off in lieu leave (a)	7,551	6,732
Long service leave (b)	10,979	9,227
Deferred salary scheme	380	215
Gratuities	916	904
	43,906	39,376
Non-current		
Employee benefits provision		
Long service leave (b)	9,232	8,639
Gratuities	643	395
	9,875	9,034
Total Provisions	53,781	48,410

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after reporting date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of reporting date	20,988	19,206
More than 12 months after reporting date	10,643	9,823
	31,631	29,029

(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 reporting date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of reporting date	4,435	4,264
More than 12 months after reporting date	15,776	13,603
	20,211	17,867

(c) The settlement of annual and long service leave liabilities give rise to the payment of employment on-costs including workers compensation premiums. The provision is the present value of expected future payments. The associated expense, apart from the unwinding of the discount (finance cost), is included at note 14 'Other expenses'.

Note 35 Other liabilities		
Current		
Accrued salaries	8,044	5,276
Income received in advance	1,588	272
Refundable deposits	1	1
	9,633	5,549

Note 36 Contributed equity

Equity represents the residual interest in the net assets of the Health Service. The Government holds the equity interest in the Health Service on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets.

Balance at start of the year	399,679	377,093
Contributions by owners		
Capital contributions (a)	45,023	22,284
Transfer of buildings from the Department of Health (a)	-	382
Distribution to owners		
Net assets transferred to Government (b)	(33)	(80)
Balance at end of year	444,669	399,679

(a) Capital Contributions (appropriations) and non-discretionary (non-reciprocal) transfers of net assets from other State government agencies have been designated as contributions by owners in Treasurer's Instruction TI 955 'Contribution by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity. UIG Interpretation 1038 'Contribution by Owners Made to Wholly-Owned Public Sector Entities' requires that where the transferee accounts for a transfer as a contribution by owner, the transferor must account for the transfer as a distribution to owners.

(b) TI 955 requires non-reciprocal transfers of net assets to Government to be accounted for a distribution to owners.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 37 Reserves	2006 $000	2005 $000
Asset revaluation reserve (a):		
Balance at start of year	28,946	22,441
Net revaluation increments / (decrements) :		
Land	10,422	2
Buildings	98,226	6,503
Balance at end of year	137,594	28,946

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

(b) Any increment is credited directly to the asset revaluation reserve, except to the extent that any increment reverses a revaluation decrement previously recognised as an expense.

Note 38 Accumulated surplus/(deficit) (Retained Earnings)

Balance at start of year	(1,321)	(3,138)
Result for the period	(2,888)	1,817
Balance at end of year	(4,209)	(1,321)

Note 39 Notes to the Cash Flow Statement

a) **Reconciliation of cash**

Cash assets at the end of the financial year as shown in the Cash Flow Statement are reconciled to the related items in the Balance Sheet as follows:

Cash and cash equivalents (see note 22)	16,104	8,633
Restricted cash and cash equivalents (see note 23)	435	497
	16,539	9,130

b) **Reconciliation of net cost of services to net cash flows used in operating activities**

Net cash used in operating activities (Cash Flow Statement)	(403,506)	(391,052)
Increase/(decrease) in assets:		
GST receivable	(137)	(464)
Other current receivables	1,961	410
Inventories	(100)	(218)
Prepayments	112	296
Decrease/(increase) in liabilities:		
Doubtful debts provision	86	(6)
Payables	(3,904)	2,075
Accrued salaries	(2,768)	(1,250)
Current provisions	(4,530)	(5,447)
Non-current provisions	(841)	(1,094)
Income received in advance	(1,316)	26
Non-cash items:		
Depreciation and amortisation expense (note 11)	(22,433)	(26,561)
Net gain / (loss) from disposal of non-current assets (note 12)	(446)	(2,668)
Interest paid by Department of Health	(1,759)	(1,845)
Capital user charge paid by Department of Health (note 13)	(28,454)	(30,763)
Other expenses paid by Department of Health	-	38
Donation of non-current assets	24	178
Asset impairment losses	-	(651)
Superannuation liabilities assumed by the Treasurer (note 21)	(170)	(452)
Adjustment for other non-cash items	1,012	739
Net cost of services (Income Statement)	(467,169)	(458,709)

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 39 Notes to the Cash Flow Statement (continued)

c) **Notional cash flows**	2006 $000	2005 $000
Service appropriations as per Income Statement	464,113	459,598
Capital appropriations credited directly to Contributed Equity (Refer Note 36)	45,023	22,284
Holding account drawdowns credited to Amounts Receivable for Services (Refer Note 25)	4,670	34,591
	513,806	516,473
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Cash Flow Statement:		
Interest paid to WA Treasury Corporation	(644)	(677)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(503)	(492)
Interest paid to Department of Treasury & Finance	(1,115)	(1,168)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(795)	(761)
Capital user charge	(28,454)	(30,763)
Accrual appropriations	(24,661)	(33,045)
Capital works expenditure	(21,535)	(7,799)
Other non cash adjustments to service appropriations	(2)	(509)
	(77,709)	(75,215)
Cash Flows from State Government as per Cash Flow Statement	436,097	441,258

At the reporting date, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 40 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	335	239
b) Public and other property written off.	139	77
All of the amounts above were written off under the authority of the Accountable Authority.		
c) Gifts of public property provided by the Health Service.	45	-

Note 41 Losses of public monies and other property

Losses of public moneys and public or other property through theft or default	3	38
Less amount recovered	-	35
Net losses	3	3

Note 42 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority

The Director General of Health is the Accountable Authority for WA Country Health Service. The Director General of Health's remuneration is paid by the Department of Health.

Remuneration of senior officers

The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total of fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:

	2006	2005
$20,001 - $30,000	-	1
$50,001 - $60,000	1	1
$90,001 - $100,000	-	2
$110,001 - $120,000	-	1
$120,001 - $130,000	2	3
$130,001 - $140,000	3	1
$140,001 - $150,000	3	1
$160,001 - $170,000	-	1
$220,001 - $230,000	-	1
$230,001 - $240,000	1	-
Total	10	12
	$000	$000
The total remuneration of senior officers is:	1,380	1,346

The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.

Number of senior officers presently employed who are members of the Pension Scheme:	-	3

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2006

	2006 $000	2005 $000
Note 43 Remuneration of auditor		
Remuneration to the Auditor General for the financial year is as follows:		
Auditing the accounts, financial statements and performance indicators	479	435
Note 44 Commitments		
a) **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	44,622	53,793
Later than 1 year, and not later than 5 years	24,970	18,738
Later than 5 years	2,640	-
	72,232	72,531
The capital commitments include amounts for:		
- Buildings	68,464	66,542
b) **Operating lease commitments:**		
Commitments in relation to leases contracted for at the reporting date but not recognised in the financial statements, are payable as follows:		
Within 1 year	1,580	3,703
Later than 1 year, and not later than 5 years	2,672	2,048
Later than 5 years	212	-
	4,464	5,751
Representing:		
Non-cancellable operating leases	4,464	5,751
c) **Other expenditure commitments:**		
Other expenditure commitments contracted for at the reporting date but not recognised as liabilities, are payable as follows:		
Within 1 year	-	50
	-	50
These commitments are all inclusive of GST.		
Note 45 Contingent liabilities and contingent assets		
Contingent Liabilities		
In addition to the liabilities incorporated in the financial statements, the Health Service has the following contingent liabilities:		
Pending litigation that are not recoverable from Riskcover insurance and may affect the financial position of the Health Service	9,250	5,775
Number of claims	6	9

Note 46 Events occurring after reporting date

Effective from July 1, 2006 WA Country Health Service and South West Health Board were abolished with the issuing of the Hospitals and Health Services (Reorganisation of Hospital Boards) Notice 2006. The two Health Services were amalgamated to form the new "WA Country Health Service".

Note 47 Related bodies

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

The Health Service had no related bodies during the reporting period.

Note 48 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service and is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the reporting period.

WA Country Health Service
Notes to the Financial Statements
For the year ended 30th June 2006

Note 49 Explanatory Statement

(A) Significant variances between actual results for 2005 and 2006

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services ($20m).

	Note	2006 Actual $000	2005 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	314,458	287,444	27,014
Fees for visiting medical practitioners		26,574	26,614	(40)
Patient support costs		64,429	60,978	3,451
Finance costs		1,748	1,845	(97)
Depreciation and amortisation expense	(b)	22,433	26,561	(4,128)
Asset impairment losses	(c)	-	651	(651)
Capital user charge		28,454	30,763	(2,309)
Loss on disposal of non-current assets	(d)	446	2,668	(2,222)
Other expenses		53,729	53,957	(228)
Revenues				
Patient charges	(e)	17,066	15,215	1,851
Commonwealth grants and contributions	(f)	13,704	4,307	9,397
Other grants and contributions	(g)	4,186	3,406	780
Donations revenue	(h)	714	671	43
Interest revenue	(i)	85	114	(29)
Other revenues		9,347	9,059	288
Service appropriations		464,113	459,598	4,515
Assets assumed / (transferred)	(j)	(2)	476	(478)
Liabilities assumed by the Treasurer	(k)	170	452	(282)

(a) Employee benefits expense

Employee benefits expenses increased due to award increases, the introduction and/or extension of salaried medical service models at various regional hospitals and the expansion of various services and programs.

(b) Depreciation and amortisation expense

2004-05 depreciation included the accelerated depreciation of the old Geraldton Regional Hospital reflecting its reassessed useful life due to commissioning of the replacement facility in August 2005.

(c) Asset impairment losses

An impairment loss was recognised in 2004-05 as a consequence of the introduction of new depreciation rates with effect from from 2005-06.

(d) Loss on disposal of non-current assets

The 2004-05 loss was principally attributable to an extensive review and write-down of assets that had exceeded their useful lives.

(e) Patient charges

Patient charges increased due to a combination of an increase in fees and charges' rates, and the reclassification of charges associated with radiology services previously recognised as Other Revenues (use of facilities).

(f) Commonwealth grants and contributions

Commonwealth grants and contributions are variable from year to year. In addition to the usual variations, grants for a number of Commonwealth programs that were previously paid to the Department of Health are now being paid direct from the Commonwealth to the WA Country Health Service. The various grants are itemised in Note 16(a).

WA Country Health Service
Notes to the Financial Statements
For the year ended 30th June 2006

Note 49 Explanatory Statement (continued)

(g) Other grants and contributions

Grants and contributions from other agencies are variable from year to year. The various grants are itemised in Note 16(b).

(h) Donations revenue

Donations revenue is largely uncontrollable and can vary significantly from year to year.

(i) Interest revenue

Reduction in interest revenue is due to the effects of rationalising separate bank account arrangements and the completion of a capital works program at Quairading hospital where privately donated funds had been held in a health service trust account.

(j) Assets assumed / (transferred)

Assets associated with the Telehealth program ($434k) were transferred to the WA Country Health Service during 2004-05 when the management of the program transferred from the Department of Health.

(k) Liabilities assumed by the Treasurer

Represents the reduced actuarially determined value of entitlements assumed by the Treasurer in relation to the State's Pension Scheme, as advised by the Government Employees Superannuation Board.

(B) Significant variations between estimates and actual results for 2006

Significant variations between the estimates and actual results for income and expenses are detailed below. Significant variations are considered to be those greater than 10% of budget.

	Note	2006 Actual $000	2006 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	314,458	299,058	15,400
Other goods and services	(b)	197,813	203,171	(5,358)
Total expenses		512,271	502,229	10,042
Less: Revenues	(c)	(45,102)	(30,898)	(14,204)
Net cost of services		467,169	471,331	(4,162)

(a) Employee benefits expense

Employee expenses varied due to additional funding being made available to the WA Country Health Service during the financial year for services that were not included in the initial allocation and to meet the additional costs associated with an award increase for allied health professionals.

(b) Other goods and services

Other Goods and Services expenses varied due to:
(i) additional funding being made available for services that were not included in the initial allocation; and
(ii) funding for a service agreement with the Royal Flying Doctor Service that was included in the initial allocation was returned to the Department of Health following a decision to retain some contract management functions in the Department.

(c) Revenues

Funding associated with a number of Commonwealth Programs previously paid by the Commonwealth to the Department of Health are now paid directly to the WA Country Health Service.

Note 50 Financial instruments

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

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

Credit risk
The Health Service trades only with recognised, creditworthy third parties. The Health Service 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 Health Service's exposure to bad debts is minimal. There are no significant concentrations of credit risk.

Liquidity risk
The Health Service 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.

Cash flow interest rate risk
The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations, cash and cash equivalents and restricted cash. The Health Service's borrowings are all obtained through the Western Australian Treasury Corporation (WATC) and the Department of Treasury and Finance (DTF). The borrowings are at fixed rates with varying maturities. The risk is managed by WATC and DTF through portfolio diversification and variation in maturity dates. Cash and cash equivalents and restricted cash are held in interest bearing bank accounts.

b) **Financial instrument disclosures**

Financial instrument information for the year ended 2005 has been prepared under the previous AGAAP Australian Accounting Standard AAS 33 'Presentation and Disclosure of Financial Instruments'. Financial instrument information from 1 July 2005 has been prepared under AASB 132 'Financial Instruments: Presentation' and AASB 139 'Financial instruments: Recognition and Measurement'. See also note 2 (v) 'Comparative figures'.

Interest rate risk exposure
The following table details the Health Service's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate	Variable interest rate	Fixed interest rate maturities						Non-interest bearing	Total
			Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years		
2006	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets										
Cash and cash equivalents	4.0%	1,787	52	-					14,265	16,104
Restricted cash and cash equivalents	5.3%	435	-	-					-	435
Receivables									7,424	7,424
Amounts Receivable for Services									55,295	55,295
		2,222	52	-	-	-	-	-	76,984	79,258
Financial Liabilities										
Payables									17,905	17,905
Borrowings										
- W A Treasury Corporation loans	6.5%		515	526	538	550	563	7,401		10,093
- Department of Treasury & Finance loans	6.0%		831	872	915	954	995	12,070		16,637
		-	1,346	1,398	1,453	1,504	1,558	19,471	17,905	44,635
Net financial assets / (liabilities)		2,222	(1,294)	(1,398)	(1,453)	(1,504)	(1,558)	(19,471)	59,079	34,623

Note 50 Financial instruments (continued)

2005	Weighted average effective interest rate	Variable interest rate	Fixed interest rate maturities 1 year or less	1 to 5 years	Over 5 years	Non-interest bearing	Total
	%	$000	$000	$000	$000	$000	$000
Financial Assets							
Cash and cash equivalents	4.2%	8,633	-	-	-	-	8,633
Restricted cash and cash equivalents	4.8%	497	-	-	-	-	497
Receivables						5,515	5,515
Amounts Receivable for Services						35,304	35,304
		9,130	-	-	-	40,819	49,949
Financial Liabilities							
Payables						14,001	14,001
Borrowings							
- W A Treasury Corporation loans	6.0%		503	2,129	7,964		10,596
- Department of Treasury & Finance loans	6.5%		795	3,564	13,074		17,433
		-	1,298	5,693	21,038	14,001	42,030
Net financial assets / (liabilities)		9,130	(1,298)	(5,693)	(21,038)	26,818	7,919

Notes to the Financial Statements

For the year ended 30th June 2006

Note 51 Schedule of Income and Expenses by Services

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000	2006 $000	2005 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	35,911	33,228	249,774	228,978	28,773	25,238	314,458	287,444
Fees for visiting medical practitioners	241	224	25,775	25,663	558	727	26,574	26,614
Patient support costs	7,358	7,049	51,176	48,575	5,895	5,354	64,429	60,978
Finance costs	200	213	1,388	1,469	160	163	1,748	1,845
Depreciation and amortisation expense	2,561	3,070	17,819	21,158	2,053	2,333	22,433	26,561
Asset impairment losses	-	75	-	518	-	57	-	651
Capital user charge	3,249	3,556	22,601	24,506	2,604	2,701	28,454	30,763
Loss on disposal of non-current assets	51	309	354	2,125	41	234	446	2,668
Other expenses	6,136	6,238	42,677	42,982	4,916	4,737	53,729	53,957
Total cost of services	55,707	53,962	411,564	395,974	45,000	41,544	512,271	491,481
INCOME								
Patient charges	1,857	1,671	13,711	12,258	1,498	1,286	17,066	15,215
Commonwealth grants and contributions	1,491	473	11,010	3,471	1,203	363	13,704	4,307
Other grants and contributions	456	374	3,363	2,743	367	289	4,186	3,406
Donations revenue	77	74	574	541	63	56	714	671
Interest revenue	8	12	69	91	8	11	85	114
Other revenues	1,016	994	7,510	7,299	821	766	9,347	9,059
Total income other than income from State Government	4,905	3,598	36,237	26,403	3,960	2,771	45,102	32,772
NET COST OF SERVICES	**50,802**	**50,364**	**375,327**	**369,571**	**41,040**	**38,773**	**467,169**	**458,709**
INCOME FROM STATE GOVERNMENT								
Service appropriations	50,495	50,464	372,869	370,298	40,749	38,836	464,113	459,598
Assets assumed / (transferred)	(0)	52	(2)	384	(0)	40	(2)	476
Liabilities assumed by the Treasurer	18	50	137	365	15	37	170	452
Total income from State Government	50,513	50,566	373,004	371,047	40,764	38,913	464,281	460,526
SURPLUS/(DEFICIT) FOR THE PERIOD	**(289)**	**202**	**(2,323)**	**1,476**	**(276)**	**140**	**(2,888)**	**1,817**

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS)

Reconciliation of equity at the date of transition to AIFRS: 1 July 2004

	Previous AGAAP 1 July 2004	Adjustments, Employee benefits	Asset Impairment	Reclassification, computer software	Total Adjustments	AIFRS 1 July 2004
	$000	$000	$000	$000	$000	$000
ASSETS						
Current Assets						
Cash and cash equivalents	6,408	-	-	-	-	6,408
Restricted cash and cash equivalents	494	-	-	-	-	494
Receivables	5,576	-	-	-	-	5,576
Amounts receivable for services	30,701	-	-	-	-	30,701
Inventories	3,694	-	-	-	-	3,694
Other current assets	200	-	-	-	-	200
Total Current Assets	47,073	-	-	-	-	47,073
Non-Current Assets						
Amounts receivable for services	6,149	-	-	-	-	6,149
Property, plant and equipment	434,902	-	-	-	-	434,902
Other financial assets	6	-	-	-	-	6
Total Non-Current Assets	441,057	-	-	-	-	441,057
Total Assets	488,130	-	-	-	-	488,130

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS)

Reconciliation of equity at the date of transition to AIFRS: 1 July 2004

	Previous AGAAP 1 July 2004	Adjustments, Employee benefits	Asset Impairment	Reclassification, computer software	Total Adjustments	AIFRS 1 July 2004
	$000	$000	$000	$000	$000	$000
LIABILITIES						
Current Liabilities						
Payables	16,075	-	-	-	-	16,075
Borrowings	1,240	-	-	-	-	1,240
Provisions	34,490	(561)	-	-	(561)	33,929
Other current liabilities	4,508	-	-	-	-	4,508
Total Current Liabilities	56,313	(561)	-	-	(561)	55,752
Non-Current Liabilities						
Borrowings	28,041	-	-	-	-	28,041
Provisions	7,940	-	-	-	-	7,940
Total Non-Current Liabilities	35,981	-	-	-	-	35,981
Total Liabilities	92,294	(561)	-	-	(561)	91,733
NET ASSETS	395,836	561	-	-	561	396,397
EQUITY						
Contributed equity	377,093	-	-	-	-	377,093
Reserves	22,441	-	-	-	-	22,441
Accumulated surplus /(deficiency)	(3,698)	561	-	-	561	(3,137)
TOTAL EQUITY	395,836	561	-	-	561	396,397

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS) (continued)

Reconciliation of Income Statement for the year ended 30 June 2005

	AGAAP 30 June 2005	Adjustments, Employee benefits	Impairment losses	Adjustment, Other	Total Adjustments	AIFRS 30 June 2005
	$000	$000	$000	$000	$000	$000
COST OF SERVICES						
Expenses						
Employee benefits expense	298,459	(208)	-	(10,807)	(11,015)	287,444
Fees for visiting medical practitioners	26,614	-	-	-	-	26,614
Patient support costs	60,978	-	-	-	-	60,978
Finance costs	1,845	-	-	-	-	1,845
Depreciation and amortisation expense	26,561	-	-	-	-	26,561
Asset impairment losses	-	-	651	-	651	651
Capital user charge	30,763	-	-	-	-	30,763
Carrying amount of non-current assets disposed of	2,741	-	-	(2,741)	(2,741)	-
Loss on disposal of non-current assets	-	-	-	2,668	2,668	2,668
Other expenses	43,150	-	-	10,807	10,807	53,957
Total cost of services	491,111	(208)	651	(73)	370	491,481
INCOME						
Revenue						
Patient charges	15,215	-	-	-	-	15,215
Commonwealth grants and contributions	4,307	-	-	-	-	4,307
Other grants and contributions	3,406	-	-	-	-	3,406
Donations revenue	671	-	-	-	-	671
Interest revenue	114	-	-	-	-	114
Proceeds from disposal of non-current assets	73	-	-	(73)	(73)	-
Other revenues	9,059	-	-	-	-	9,059
Total Income other than income from State Government	32,845	-	-	(73)	(73)	32,772
NET COST OF SERVICES	458,266	(208)	651	-	443	458,709
INCOME FROM STATE GOVERNMENT						
Service appropriations	459,598	-	-	-	-	459,598
Assets assumed / (transferred)	476	-	-	-	-	476
Liabilities assumed by the Treasurer	452	-	-	-	-	452
Total income from State Government	460,526	-	-	-	-	460,526
SURPLUS/(DEFICIT) FOR THE PERIOD	2,260	208	(651)	-	(443)	1,817

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS) (continued)

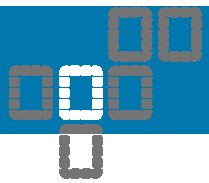
Reconciliation of equity at the end of the last reporting period under previous AGAAP : 30 June 2005

	AGAAP 30 June 2005	Adjustments, Employee benefits	Asset Impairment	Reclassification, computer software	Total Adjustments	AIFRS 30 June 2005
	$000	$000	$000	$000	$000	$000
ASSETS						
Current Assets						
Cash and cash equivalents	8,633	-	-	-	-	8,633
Restricted cash and cash equivalents	497	-	-	-	-	497
Receivables	5,515	-	-	-	-	5,515
Amounts receivable for services	14,473	-	-	-	-	14,473
Inventories	3,476	-	-	-	-	3,476
Other current assets	496	-	-	-	-	496
Total Current Assets	33,090	-	-	-	-	33,090
Non-Current Assets						
Amounts receivable for services	20,831	-	-	-	-	20,831
Property, plant and equipment	470,016	-	(651)	(10)	(661)	469,355
Intangible assets	-	-	-	10	10	10
Other financial assets	6	-	-	-	-	6
Total Non-Current Assets	490,853	-	(651)	-	(651)	490,202
Total Assets	523,943	-	(651)	-	(651)	523,292

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS) (continued)

Reconciliation of equity at the end of the last reporting period under previous AGAAP : 30 June 2005

	AGAAP 30 June 2005	Adjustments, Employee benefits	Asset Impairment	Reclassification, computer software	Total Adjustments	AIFRS 30 June 2005
	$000	$000	$000	$000	$000	$000
LIABILITIES						
Current Liabilities						
Payables	14,001	-	-	-	-	14,001
Borrowings	1,298	-	-	-	-	1,298
Provisions	40,144	(768)	-	-	(768)	39,376
Other current liabilities	5,549	-	-	-	-	5,549
Total Current Liabilities	60,992	(768)	-	-	(768)	60,224
Non-Current Liabilities						
Borrowings	26,730	-	-	-	-	26,730
Provisions	9,034	-	-	-	-	9,034
Total Non-Current Liabilities	35,764	-	-	-	-	35,764
Total Liabilities	96,756	(768)	-	-	(768)	95,988
NET ASSETS	427,187	768	(651)	-	117	427,304
EQUITY						
Contributed equity	399,679	-	-	-	-	399,679
Reserves	28,946	-	-	-	-	28,946
Accumulated surplus /(deficiency)	(1,438)	768	(651)	-	117	(1,321)
TOTAL EQUITY	427,187	768	(651)	-	117	427,304



Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS) (continued)

Reconciliation of Cash Flow Statement for the year ended 30 June 2005

	AGAAP 30 June 2005	Adjustments	AIFRS 30 June 2005
	$000	$000	$000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations	393,634	-	393,634
Capital contributions	13,493	-	13,493
Holding account drawdowns	34,131	-	34,131
Net cash provided by State Government	441,258	-	441,258
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services	(132,716)	(10,807)	(143,523)
Employee benefits	(289,966)	10,807	(279,159)
GST payments on purchases	(17,488)	-	(17,488)
Receipts			
Receipts from customers	14,875	-	14,875
Commonwealth grants and contributions	4,280	-	4,280
Other grants and subsidies	3,496	-	3,496
Donations	501	-	501
Interest received	107	-	107
GST receipts on sales	926	-	926
GST receipts from taxation authority	16,629	-	16,629
Other receipts	8,304	-	8,304
Net cash (used in) / provided by operating activities	(391,052)	-	(391,052)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets	(48,051)	-	(48,051)
Proceeds from sale of non-current physical assets	73	-	73
Net cash (used in) / provided by investing activities	(47,978)	-	(47,978)
Net increase / (decrease) in cash and cash equivalents	2,228	-	2,228
Cash and cash equivalents at the beginning of the period	6,902	-	6,902
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	9,130	-	9,130

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2006

Note 52 Reconciliations explaining the transition to Australian equivalents to International Financial Reporting Standards (AIFRS) (continued)

Notes to the reconciliations

(a) Employee benefits

AASB 119 requires that all employee benefits expected to be settled more than 12 months after the end of the reporting date is measured at the present value of amounts expected to be paid when the liabilities are settled. Under AGAAP, all annual leave and long service leave entitlements (unconditional long service leave) were measured at nominal amounts.

Employment on-costs are not included in employee benefits under AGAAP or AIFRS. However, under AGAAP employee benefits and on-costs are disclosed together on the face of the Income Statement as Employee costs. Under AIFRS employee benefits will be the equivalent item disclosed on the face. On-costs are transferred to other expenses.

Adjustments to opening Balance Sheet (1July 2004)
There has been a decrease in employee benefits provision of $ 561K and a corresponding increase in accumulated surplus/(deficit).

Adjustments to 30 June 2005 Balance Sheet
There has been a decrease in employee benefits provision of $ 768K and a corresponding increase in accumulated surplus/(deficit).

Adjustments to the Income Statement for the period ended 30 June 2005
The present value measurement has resulted in a decrease in employee benefits expense of $ 208K.

Adjustments to the Cash Flow Statement for the period ended 30 June 2005
Employment on-costs payments have been reclassified from employee benefits payments to supplies and services payments $ 10,807K.

(b) Impairment of assets

An impairment loss of $ 651K existed for medical equipment, where the depreciated replacement costs were higher than the carrying amounts.

Adjustments to 30 June 2005 Balance Sheet

There has been a decrease in medical equipment of $ 651K and a corresponding decrease in accumulated surplus/(deficit).

Adjustments to the Income Statement for the period ended 30 June 2005
An impairment loss of $ 651K has ben recognised as expense. This has decreased the surplus by $ 651K.

(c) Intangible assets

AASB 138 requires that software not integral to the operation of a computer must be disclosed as intangible assets. Intangible assets must be disclosed on the balance sheet. All software has previously been classified as property, plant and equipment (computer equipment and software).

Adjustments to 30 June 2005 Balance Sheet
The Health Service has transferred $ 10K in software from property, plant and equipment to intangible assets.

Adjustments to the Income Statement for the period ended 30 June 2005
There was no net impact on the surplus for the year.

(d) Net gain on disposal of non-current assets

Under AGAAP the disposal of non-current assets is disclosed on the gross basis. That is, the proceeds of disposal are revenue and the carrying amounts of assets disposed of are expense. The disposal of non-current assets is disclosed on the net basis (gains or losses) under AIFRS.

Adjustments to the Income Statement for the period ended 30 June 2005
The carrying amounts of assets disposed of was previously recognised as expense. This has been derecognised $ 2,741K.

The proceeds of disposal of non-current assets was previously recognised as income. This has been derecognised $ 73K.

A loss on the disposal of non-current assets of $ 2,668K has been recognised as expense.

Appendices

Appendix 1: Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on HealthCare Standards
ATSI	Aboriginal and Torres Strait Islander
BMI	Body Mass Index
CALD	Culturally and Linguistically Diverse
COPMI	Children of Parents with Mental Illness
CPI	Consumer Price Index
CPR	Cardiac Pulmonary Resuscitation
CRROH	Centre for Rural and Remote Oral Health
DAIP	Disability Access and Inclusion Plan
DIA	Department of Indigenous Affairs
DOH	Department of Health
DPC	Department of Premier and Cabinet
DSC	Disability Services Commission
DVA	Department of Veterans' Affairs
ED	Emergency Department
EEO	Equal Employment Opportunity
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HIV	Human Immunodeficiency Virus
HMDS	Hospital Morbidity Data System
HRIT	Health Reform Implementation Taskforce
ICMD	Information Collection and Management Directorate
MOU	Memorandum of Understanding
NGO	Non Government Organisation
NHpPD	Nursing Hours per Patient Day
OAG	Office of the Auditor General
OAH	Office of Aboriginal Health
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OMH	Office of Mental Health
OPSSC	Office of the Public Sector Standards Commissioner
OSH	Occupational Safety and Health
PBS	Pharmaceutical Benefits Scheme
PID	Public Interest Disclosure
RFDS	Royal Flying Doctor Service
STI	Sexually Transmitted Infection
SWAHS	South West Area Health Service
TI	Treasury Instruction
UWA	University of WA
VMP	Visiting Medical Practitioner
WACHS	WA Country Health Service

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