2007-2008

WA Country Health Service

Annual Report

ANNUAL REPORT

WA Country Health Service

Annual Report 2007-08

WA Country Health Service
189 Wellington Street, East Perth
Western Australia 6004
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Fax: (08) 9223 8599

Website: www.wacountry.health.wa.gov.au

Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Report of the WA Country Health Service for the year ended 30 June 2008.

This report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

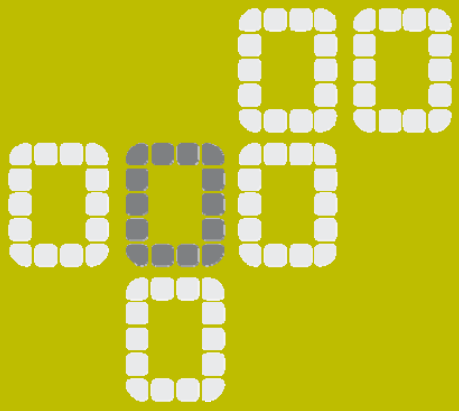
Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH
Accountable Authority

26th September 2008

Contents

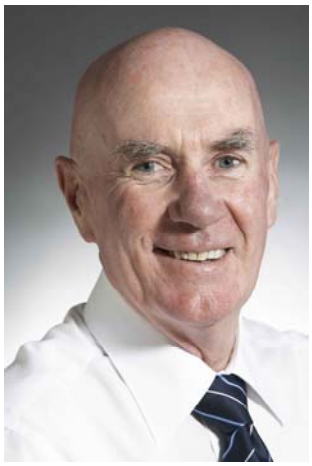
Illustrations

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



Overview of Agency

Executive Summary



The WA Country Health Service continues to strive to meet the unique challenges of providing safe, high-quality and sustainable health care to a changing rural community. These challenges include workforce and skills shortages, the increasing demand for health services, issues associated with isolation and transport, and the urgent need to improve the health status of Aboriginal people in rural and remote Western Australia.

Emerging technologies and new and innovative models of care are integral to our progress over the past year across the six priority areas: healthy workforce; healthy hospitals, health services and infrastructure; healthy partnerships; healthy communities; healthy resources and healthy leadership.

Our progress during the past year includes:

Healthy Workforce

A Medical Workforce Unit has been established to direct focused efforts into recruiting and retaining the rural medical workforce. This year also saw the inaugural appointment of a Medical Services Reform Director to implement a medical workforce strategic plan. During 2007-08 a particular priority has been the continued development of the nurse practitioner role in rural and remote locations. Visiting specialist services have been increased across a number of regions under the WA Country Health Service Specialist Services Plan and the Medical Specialist Outreach Assistance Program. For the first time, all seven regions have a visiting specialist geriatric service.

Healthy hospitals, health services, and infrastructure

A number of key capital infrastructure projects were completed or started during 2007-08 under the $600 million WA Country Health Service (WACHS) capital investment program commenced in 2004. New facilities include the Fitzroy Crossing Hospital and Morawa Health Centre, while upgrades or redevelopments have been completed at Carnarvon Hospital, Derby Hospital and Dental Clinic, and Bunbury's Acute Psychiatric Unit. Community Supported Residential Units for patients with a mental illness were opened in Albany, Geraldton and Bunbury. Work began on a new hospital at Port Hedland. The 'Hospital-in-the-Home' program has been expanded during 2007-08 and is now available in six of the seven WA Country Health Service regions to increase the access of rural patients to home-based care services.

Investment in country medical imaging continued with considerable progress made towards the roll-out of computed radiography and the Picture Archiving and Communication System to all regional resource centres. New ultrasound machines were installed in Geraldton and Albany, and new mammography units installed in Kalgoorlie and Albany. Clinical care via telehealth has been enhanced, with burns management services offered in partnership with Princess Margaret Hospital and Royal Perth Hospital, and the successful completion of a trial for delivering oncology education and clinical services to regional hospitals.

Healthy Communities

The WA Country Health Service has continued to pursue a range of initiatives to prevent ill-health and promote a healthy lifestyle in rural Western Australia, including the "Act Belong Commit" campaign, the "Stay on Your Feet" campaign, the "Pit Stop" men's health promotion package and the Wheatbelt's women's checkout health campaign. WACHS implemented the WA Health Smoke Free policy on January 1, 2008. "Healthy school" coordinators have been employed in each of the seven regions to promote the benefits of physical activity and good nutrition.

For the first time, a trachoma screening program was offered in the Goldfields, the Kimberley and the Pilbara. Our focus continues on maintaining the independence of elderly people in the community through the provision of a range of residential and community based services. Aged care managers have been appointed in each region to better coordinate the planning and delivery of aged care services. Cancer support services have been enhanced with the appointment of seven regional cancer nurse

coordinators and the piloting of a program in the Great Southern to extend specialist cancer care beyond the metropolitan area.

Healthy Partnerships

The WA Country Health Service continues to forge stronger links and partnerships with those with an interest in the well-being of our country health system. A key achievement is the five-year plan developed, in partnership with the Royal Flying Doctor Service, to identify and implement an effective and efficient aero medical service to meet the growing demand for inter-hospital transport.

In another significant development, WACHS commenced negotiations with Royal Darwin Hospital and Northern Territory Health to enable Royal Darwin Hospital to accept inter-hospital patient transfers from the Kimberley so patients who would otherwise need to be flown to Perth can receive emergency treatment and acute care closer to home. The Area Health Service also continued to work with the St John Ambulance Association to support and evaluate the Rural Paramedic Support Project in the Kimberley and the Pilbara to address difficulties in volunteer recruitment.

Significantly, there are now 24 District Health Advisory Councils throughout Western Australia that continue to build a consumer, carer and community influence by contributing to the improvement of service safety, quality and access, two-way communication and advocacy, and health service planning made more relevant by their contribution.

Healthy Resources

In 2007-08 performance agreements were established for all executives in the WA Country Health Service Leadership Team and a periodic performance reporting system has been introduced to monitor and evaluate progress against key organisation-wide indicators.

In addition to the ongoing capital works program mentioned earlier, more than $3million was approved during the year for new equipment, including sterilisers, ultrasound and radiology equipment to be installed across the WA Country Health Service.

Healthy Leadership

The WA Country Health Service continues to foster leadership at all levels, and a number of key executives participated in leadership programs offered by the Institute for Healthy Leadership during the past year. The opportunity to enhance the contribution and response of the WA Country Health Service to improving the health of our indigenous community was acknowledged with the establishment of the office of the Area Director of Aboriginal Health.

Conclusion

I would like to extend my thanks to Kim Snowball for his efforts and leadership in his first year as the Chief Executive Officer of the WA Country Health Service. Importantly, I would like to acknowledge the sheer hard work of all WA Country Health Service staff. I congratulate each of you for your commitment and dedication to improving health care for Western Australians living in rural and remote areas of our vast state.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

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.

Address and Location

WACHS - Area Office
189 Wellington Street, EAST PERTH WA 6004
Postal Address
PO Box 6680
EAST PERTH BUSINESS CENTRE, WA 6892
Phone: (08) 9223 8500
Fax: (08) 9223 8599
Internet: www.wacountry.health.wa.gov.au

WACHS - Kimberley
Unit 4, 9 Dampier Terrace, BROOME WA 6725
Postal Address
Locked Bag 4011, BROOME WA 6725
Phone: (08) 9194 1600
Fax: (08) 9194 1666

WACHS - Pilbara
Morgan Street, PORT HEDLAND WA 6721
Postal Address
PO Box 63, PORT HEDLAND WA 6721
Phone: (08) 9158 1795
Fax: (08) 9158 1472

WACHS – Mid West
Shenton Street, GERALDTON WA 6530
Postal Address
PO Box 22, GERALDTON WA 6531
Phone: (08) 9956 2209
Fax: (08) 9956 2421

WACHS - Wheatbelt
Unit 2, Avon Mall
178 Fitzgerald Street, NORTHAM WA 6401
Postal Address
PO Box 690, NORTHAM WA 6401
Phone: (08) 9622 4350
Fax: (08) 9622 4351

WACHS - Goldfields
The Palms
68 Piccadilly Street, KALGOORLIE WA 6430
Postal Address
PO Box 716, KALGOORLIE WA 6433
Phone: (08) 9080 5710
Fax: (08) 9080 5724

WACHS – Great Southern
Callistemon House
Warden Avenue, ALBANY WA 6331
Postal Address
PO Box 165, ALBANY WA 6331
Phone: (08) 9892 2662
Fax: (08) 9842 1095

WACHS – South West
Fourth floor, Bunbury Tower
61 Victoria Street, BUNBURY WA 6230
Postal Address
As above
Phone: (08) 9781 2350
Fax: (08) 9781 2381

Service Framework

Better Planning: Better Futures

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

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

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

Goal 1:
Better services

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

Goal 2:
Jobs and economic development

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

Goal 3:
Lifestyle and environment

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

Goal 4:
Regional development

Ensuring that regional Western Australia is strong and vibrant.

Goal 5:
Governance and public sector improvement

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

WA health outcomes and strategic directions

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

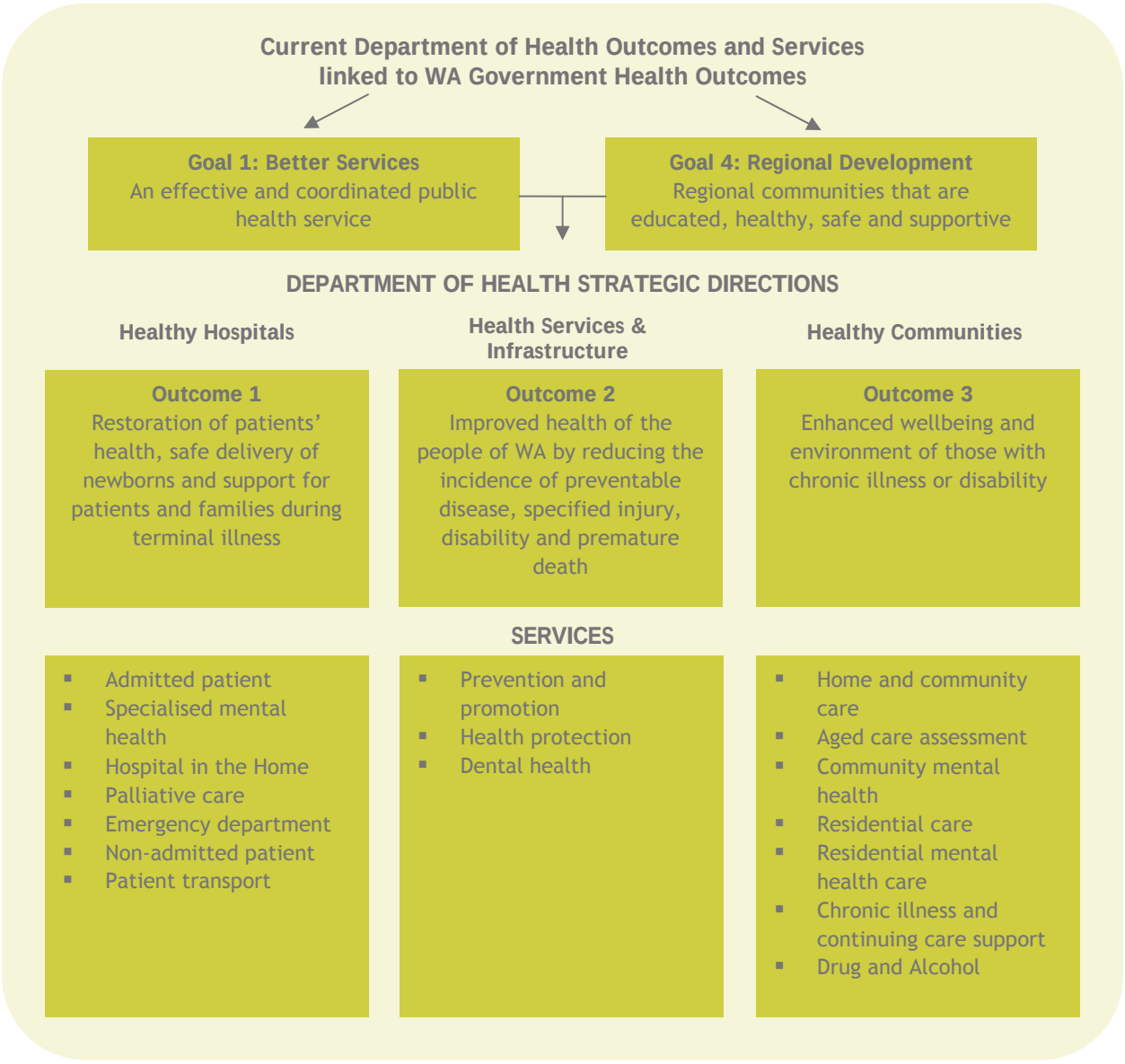
Figure 1 shows the relationship between the Government's and WA Health's desired outcomes.

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

Refer to next page for Figure 1

Service Framework (continued)

Figure 1: Department of Health strategic directions



Services Provided

The WA Country Health Service has continued to consolidate the service reforms recommended in the hospital and health service role delineation framework and the strategic directions detailed in the 'Foundations for Country Health Services" report. These initiatives continue the primary health care focus and the provision of services via regional network model.

The WA Country Health Service 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, Bunbury, 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 Busselton, Carnarvon, Collie, Derby, Esperance, Katanning, Kununurra, Margaret River, Merredin, Moora, Narrogin, Newman, Nickol Bay (Karratha), Northam and Warren (Manjimup).

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. WACHS health centres are situated in Augusta, Beverley, Boddington, Bruce Rock, Boyup Brook, Bridgetown, Corrigin, Cunderdin, Dalwallinu, Denmark, Donnybrook, Dumbleyung, Exmouth, Fitzroy Crossing, Gnowangerup, Goomalling, Halls Creek, Kellerberrin, Kojonup, Kondinin, Kununoppin, Lake Grace, Laverton, Leonora, Meekatharra, Morawa, Mullewa, Nannup, Narembeen, Norseman, North Midlands (Three Springs), Northampton, Onslow, Paraburdoo, Pemberton, Pingelly, Plantagenet (Mt Barker), Quairading, Ravensthorpe, Roebourne, Southern Cross, Tom Price, Wagin, Wickham, Wongan Hills, Wyalkatchem, Wyndham, Yarloop and York. There are also three Multi-Purpose Centres at Dongara, Kalbarri and Jurien.

The WACHS administers and manages:

- 71 hospitals (including 29 Multi Purpose Service sites);
- 22 nursing posts;
- 34 aged care facilities (including 3 Nursing Homes);
- 312 child, community, dental, alcohol and drug, mental and public health facilities and units;
- 510 staff accommodation facilities;
- 23 office and general service buildings and facilities; and
- in addition, WACHS operates 35 nursing posts and health centres where services are provided to the community under contract by the Silver Chain Nursing Association.

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

Direct patient services

- Accident and Emergency Medicine
- Acute medical
- Acute surgical
- Anaesthetics
- Antenatal classes
- Cardiology
- Renal dialysis
- Dermatology
- Ear, nose and throat
- Endocrinology
- Extended care
- Gastroenterology
- Genetics
- Gynaecology
- Nephrology
- Nursing home type
- Obstetrics
- Occupational medicine
- Oncology

Services Provided (continued)

Direct patient services (continued)

- Ophthalmology
- Orthopaedics
- Pacemaker clinic
- Paediatrics
- Podiatry
- Psychiatric services
- Rheumatology
- Same day surgery
- Urology

Medical support services

- Audiology
- Dietetics
- Medical imaging
- Occupational therapy
- Pathology
- Pharmacy
- Physiotherapy
- Podiatry
- Respiratory medicine
- Social work
- Speech pathology
- Sexual health

Community and support services

- Aged care assessment
- Child and maternal health
- Community health
- Community mental health
- Public health
- Hospital in the Home
- Palliative care
- Health promotion

Other services

- Administration
- Corporate services
- Engineering/maintenance
- Hotel services
- Medical records
- Patient transport

Compliance Reports

The Department of Health is established by the Governor under section 35 of the Public Sector Management Act 1994. The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 40 Acts and 101 sets of subsidiary legislation.

Acts administered

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

Acts passed during 2007-08

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

Bills in Parliament as at 30 June 2008

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

Amalgamation and establishment of Boards

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

Statement of Compliance with Public Sector Standards

In the administration of the WA Country Health Service, I have complied with the Public Sector Standards in Human Resource Management, the Western Australian Public Sector Code of Ethics and our Code of Conduct. I am satisfied that the procedures and internal processes I have implemented and overseen for the WA Country Health Service support this statement.

Human Resource Management

To ensure compliance with the requirements of the Public Sector Standards for Human Resource Management and to encourage best practice, the WA Country Health Service (WACHS) conducts regular reviews of the relevant policies and procedures it has adopted.

The WACHS employs mechanisms to assess compliance with its policies and procedures, and maintains a focus on the Public Sector Standards for Human Resource Management by ensuring:

- duty statements detail compliance responsibility;
- staff knowledge surveys are conducted;
- participating in compliance audits performed by the Internal Audit Branch and external auditing agencies such as the Office of the Auditor General;
- training programs and workshops are conducted; and
- support for investigations on breaches and grievances when required.

Information on compliance requirements is included in workplace procedure manuals and is emphasised in staff training and induction programs.

In 2007-08 the WA Country Health Service received five claims for breach of Public Sector Standards, all for recruitment and selection practice. Two were either withdrawn or resolved within the agency while three were referred to the Office of the Public Sector Standards Commissioner (OPSSC) for investigation and appropriate action where required.

Code of Ethics and Code of Conduct

Compliance with the Public Sector Codes of Ethics and Conduct and the Department of Health's Code of Conduct is promoted strongly across the WACHS.

Attendees at orientation and induction courses are provided with hardcopies of the relevant documents and the relevant Codes are available on the Intranet. Staff surveys are undertaken to assess the level of knowledge in the workplace and staff are required to acknowledge their understanding and acceptance of the Codes.

During 2007-08 the WACHS received 71 complaints alleging non-compliance with the Codes for a range of ethics and conduct issues, for example, inappropriate behaviour in the workplace, verbal abuse of fellow workers, and misuse of vehicles, equipment and computer networks. Following investigation four were referred to external agencies including the OPSSC, for resolution and recommendations for action, where appropriate. The remainder were resolved internally.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Accountable Authority

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

Pecuniary Interests

Senior officers of the WA Country Health Service have declared no pecuniary interests in 2007-08.

Senior Officers

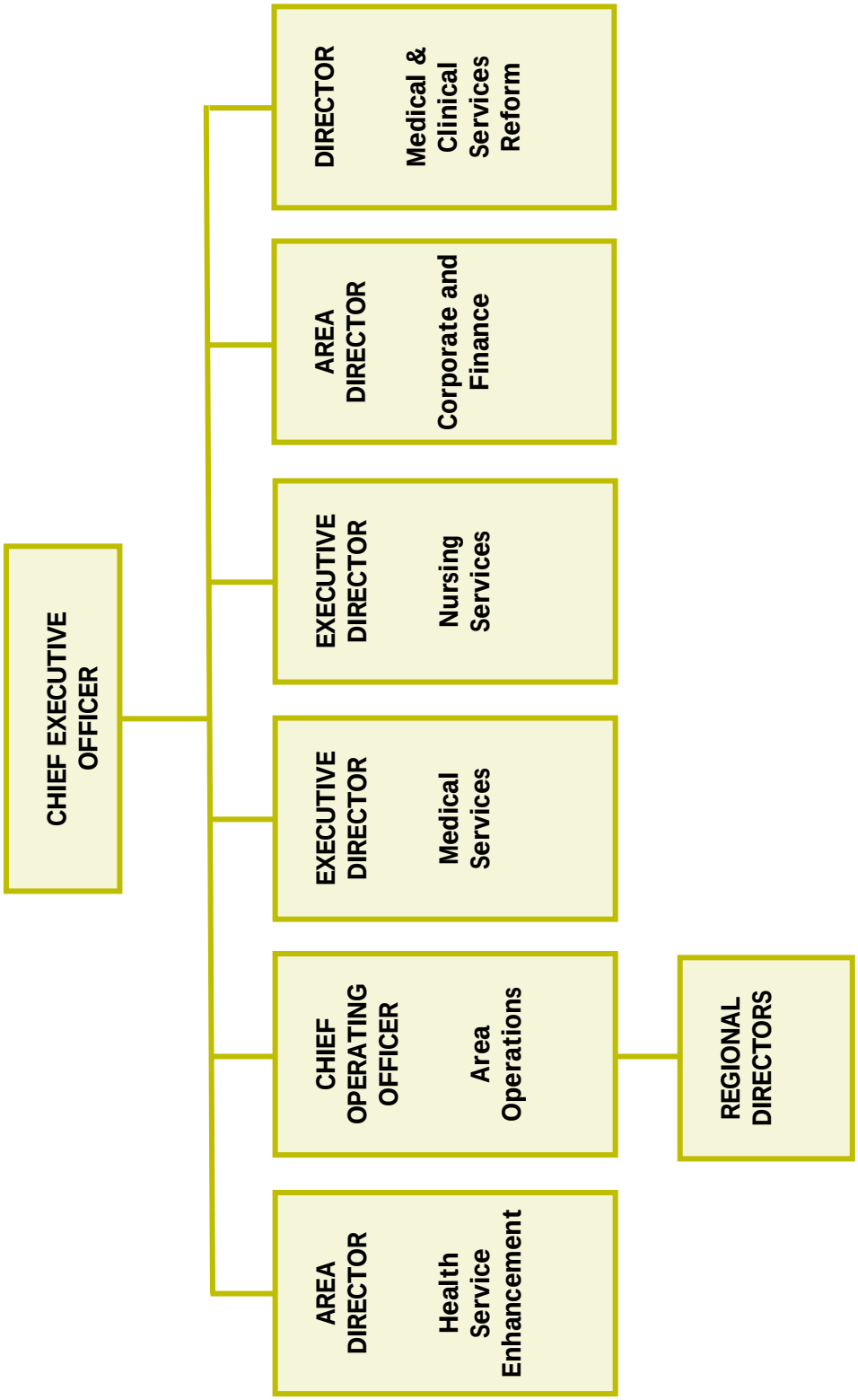
The senior officers as at 30 June 2008 for the WA Country Health Service and their areas of responsibility are listed below:

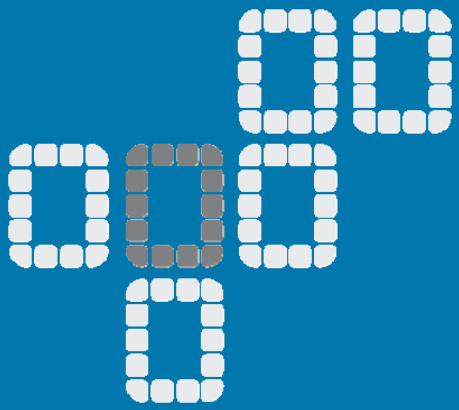
Table 1: WACHS Senior Officers as at 30 June 2008

Area of responsibility	Title	Name
WA Country Health Service (WACHS)	**Chief Executive Officer**	**Kim Snowball**
WACHS Area Operations	A/Chief Operating Officer	Jeff Moffet
WACHS Corporate and Finance	A/Area Director	Ken Mills
WACHS Health Service Enhancement	A/Area Director	Noel Carlin
WACHS Nursing Services	A/Executive Director	Karen Bradley
WACHS Medical Services	Executive Director	Geoff Masters
WACHS Clinical Services	Director Medical & Clinical Services Reform	Felicity Jeffries
Regional Operations	A/Regional Director Kimberley	Catherine Stoddart
Regional Operations	Regional Director Pilbara	Patrick Melberg
Regional Operations	Regional Director Mid West	Shane Matthews
Regional Operations	Regional Director Goldfields	Geraldine Ennis
Regional Operations	A/Regional Director Wheatbelt	John Fielding
Regional Operations	Regional Director Great Southern	Robert Pulsford
Regional Operations	Regional Director South West	Ian Smith

Management Structure

WA Country Health Service structure (June 2008)





Key Performance Indicators

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

Dr Peter Flett
ACCOUNTABLE AUTHORITY
Acting Director General of Health

17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

Audit Opinion (continued)

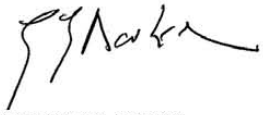
WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion
In my opinion,

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

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

(iii) the key performance indicators of the 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 2008.



GLEN CLARKE
ACTING AUDITOR GENERAL
23 September 2008

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Introduction

The health of the West Australian community has many determinants, including the provision of health services, access to and use of other government services and numerous environmental and social factors.

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 improvement of the health of the Western Australian community. This overarching goal is divided into three health outcomes:

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

All health entities contribute to the achievement of these outcomes, with different health service divisions taking responsibility for specific areas. While the largest proportion of health service activity is directed to Outcome 1 (particularly within the Metropolitan Health Service (MHS)), some health services within the WA Country Health Service (WACHS) have proportionally more activity directed to delivering Outcome 3. Therefore, to ascertain the overall performance of the health system all of the following annual reports must be read in conjunction:

- Department of Health
- Metropolitan Health Service
- WA Country Health Service
- Drug & Alcohol Office

Peel Health Service

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

Table 2: Service activities in relation to the health outcomes

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

Comparative Results

Where possible comparative results to prior years are provided.

Performance Targets

Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages for the indicators where available, or from the analysis of previous performance results. Efficiency indicator targets are those contributing to the State-wide targets published in the 2007-08 Government Budget Statements (GBS) for estimated expenditure for 2007-08.

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

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

Table 3: consumer price index figures for the financial year

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

Efficiency Indicators

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

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

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

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

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

Outcome 1	WA Country Health Service	Department of Health	Metropolitan Health Service
Restoration of patients' health	1-00 1-02 1-03 1-20	R1-50 R1-51	1-00 1-02 1-03
Timely access to admitted hospital care	1-01		1-01 1-08
Provide safe services	1-05	R1-52 R1-53	1-05
Safe delivery of newborns	1-06		1-06
Timely emergency care	1-07		1-07
Provide palliative care services		R1-54	

1-00: Proportion of patients discharged to home after admitted hospital treatment

This indicator reports the proportion of patients discharged to home after admitted hospital treatment.

Rationale

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

The performance indicator shows the percentage of all separations for patients admitted to WA Country Health Service public hospitals (excluding inter-hospital transfers) that are discharged home after hospital treatment.

An important indicator of how well patients have been restored to health (as well as survival rate) is that they are not readmitted to hospital for treatment of the same condition within a short time of discharge. Therefore this indicator should be examined in conjunction with KPI 1-02 and KPI 1-03.

As the normal ageing process tends to decrease a patient's chances of returning home, the figures are presented in ten-year age groups for the 2007 year. Data includes those patients separated after episodes of acute illness, rehabilitation, psycho-geriatric care and geriatric evaluation and management but excludes other care types.

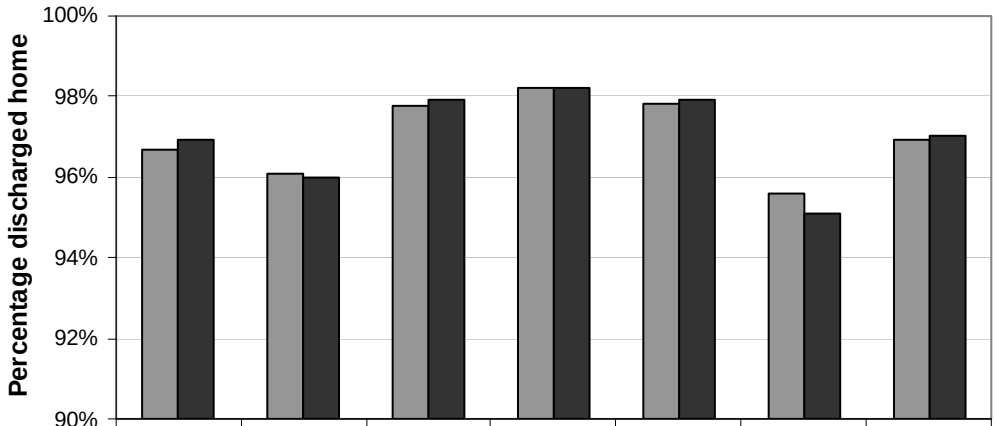
Results

The overall proportion for all ages of public patients discharged home from country hospitals was 97.0% and within target.

The results for the age cohorts demonstrate that the probability of being restored to health (discharged home after hospitalisation) is generally reduced with age.

Figure 2: Proportion of patients discharged to home after admitted hospital treatment

Overall (total) target ≥96.8%



	<40	40-49	50-59	60-69	70-79	80+	All ages
2006	96.7%	96.1%	97.7%	98.2%	97.8%	95.6%	96.9%
2007	96.9%	96.0%	97.9%	98.2%	97.9%	95.1%	97.0%

Data source
Hospital Morbidity Data System

1-01: Elective surgery waiting times

This indicator reports the waiting times for those elective surgery patients remaining as at 30 June 2008.

Rationale

For health services to be effective, access to them needs to be provided on the basis of clinical need. If patients requiring admission to hospital wait for long periods of time, there is the potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition. After surgery, some types of patients will be restored to health, while for others surgery will improve the quality of life.

Patients who are referred for elective surgery are classified by senior medical staff into one of the following urgency categories based on the likelihood of the condition becoming an emergency if not seen within the recommended time frame.

Performance targets

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

Results

There were increased over boundary cases remaining as at 30 June 2008 for all categories across WACHS compared to 30 June 2007. In some areas, workforce availability impacted on waiting times during the year. The Area Health Service continues to work to improve the process for managing its elective surgery waitlists to enable more people to receive surgical treatment in country locations.

Table 5: People remaining on the elective surgery waiting list – 30 June 2008

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	82	59	25	424	73	39	2338	97	110
People remaining over boundary	56	41		156	27		79	3	

Table 6: People remaining on the elective surgery waiting list – 30 June 2007

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	49	66	17	433	83	31	1886	97	90
People remaining over boundary	25	34		86	17		67	3	

Data source
Patient Electronic Referral Liaison System

1-02: 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 within 28 days. 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. This indicator should be considered in conjunction with the indicator KPI 1-00.

Results

The unplanned readmission rate for WACHS is 2.8%.

WACHS hospitals continue to monitor their performance to ensure that the highest standards of clinical practice and discharge planning have been adopted to deliver the best level of care to all patients.

Table 7: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2006-07	2007-08	Target
Unplanned readmission rate	3.0%	2.8%	**<2.8%**

Data source
Hospital Morbidity Data System
Report on Government Services 2008 National average (Target)

1-03: 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 or related mental health 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 within 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.

Results

The WA Country Health Service has recorded an unplanned readmission rate of 6.7% and met the benchmark for unplanned readmissions for a related mental health condition.

The WACHS is committed to providing a range of mental health programs and support networks designed to provide quality mental health services to the community to prevent unplanned readmissions whenever possible.

Table 8: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2006-07	2007-08	Target
Unplanned readmission rate	5.2%	6.7%	**<10%**

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in a previous admission within 28 days.

For the WA Country Health Service, 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.

Data source
Hospital Morbidity Data System

1-05: 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. This includes the diagnosis, the treatment given or procedure performed and the age, sex and condition of each individual patient. Other factors include 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. Therefore, three 'sentinel' procedures have been selected for which the survival rates are to be measured by specified age groups. These are stroke, heart attack (also known as acute myocardial infarction or AMI) and fractured hip (also known as fractured neck of femur or FNOF). For each of these conditions a good recovery is more likely when there is early intervention and appropriate care. Patients with these conditions are also more like to develop additional co-morbid conditions, and therefore better comparisons can be made, if comparing particular age groups, rather than the whole population.

This indicator measures the hospitals' performance in relation to restoring the health of people who have had a stroke, myocardial infarction or fractured neck of femur by measuring those who survive the illness and are discharged. Following acute admission, some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation.

Results

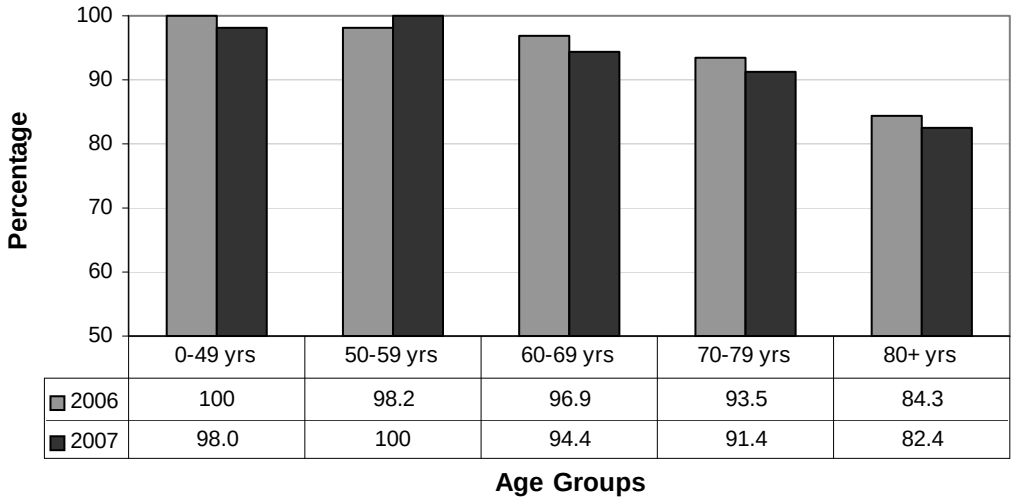
The reported survival rates for sentinel conditions met performance targets for AMI in all age cohorts except 60-69 yrs, for stroke in all age cohorts except 70-79 yrs and for FNOF for both reported age cohorts.

The performances recorded in this indicator demonstrate that WACHS continues to deliver quality clinical care in its hospitals.

Note: in the WA Country Health Service patient numbers for these conditions are generally low and therefore any variations in patient outcomes for these conditions can cause large variations to the annual percentage.

Performance Targets
0-49 years - >97%
50-59 years - >97%
60-69 years - >95%
70-79 years - >90%
80+years - >80%

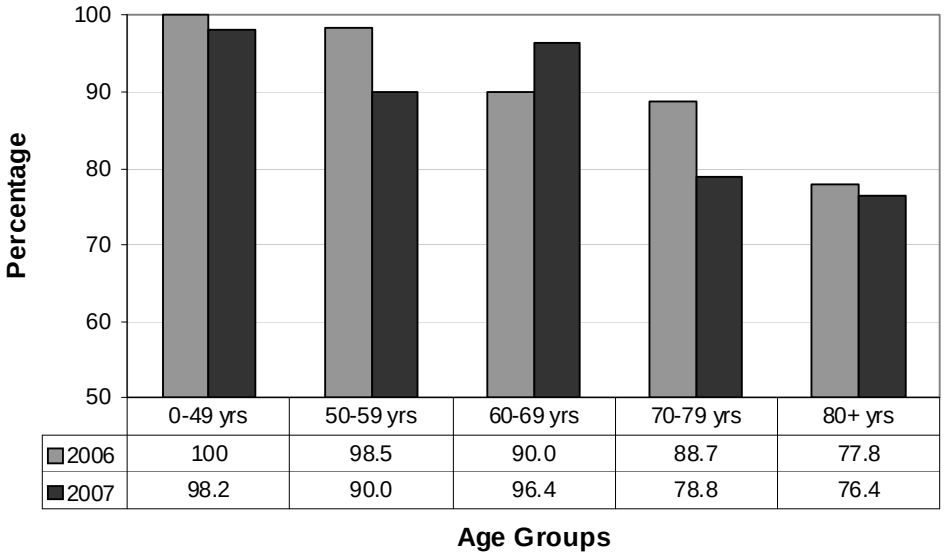
Figure 3: Survival rate for acute myocardial infarction (AMI)



	0-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80+ yrs
2006	100	98.2	96.9	93.5	84.3
2007	98.0	100	94.4	91.4	82.4

Figure 4: Survival rate for stroke

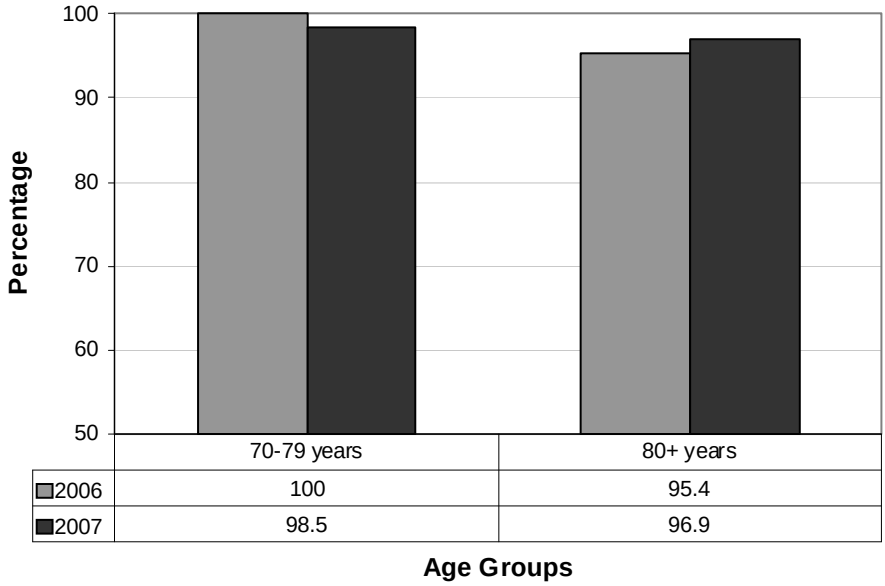
Performance Targets
0-49 years - >90%
50-59 years - >85%
60-69 years - >85%
70-79 years - >85%
80+years - >75%



	0-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80+ yrs
2006	100	98.5	90.0	88.7	77.8
2007	98.2	90.0	96.4	78.8	76.4

Figure 5: Survival rate for fractured neck of femur (FNOF)

Performance Targets
70-79 years - >95%
80+years - >90%



	70-79 years	80+ years
2006	100	95.4
2007	98.5	96.9

Data source
Hospital Morbidity Data System

1-06: Percentage of live births with an APGAR score of three or less five minutes post delivery

This indicator reports the proportion of live births with an APGAR score of 3 or lower, 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 also is an indication of the wellbeing of the baby.

This indicator reports on the number and percentage of babies with a low APGAR score at birth (an APGAR score of 3 or less at 5 minutes post delivery). A baby with a low APGAR is more likely to be premature with immature lungs or its mother had a difficult delivery than one with a higher score.

Results

The recorded proportions for babies born 0-1499 grams and 2000-2499 grams did not meet the national targets. There were 11 babies born in WACHS facilities with an APGAR score of three or less five minute post delivery with a total of 4,888 babies born for all weights in WACHS hospitals.

Note
Factors other than hospital maternity services can influence APGAR scores within birth weight categories - for example antenatal care, multiple births and socioeconomic factors. Small numbers of babies included in this indicator can result in large variations to recorded proportions.

Table 9: Percentage of live births with an APGAR score of three or less five minutes post delivery

Birthweight (grams)	Proportion of babies %		Target (National)
	2006	2007	
0 - 1499	36.4	38.5	≤13.8
1500 - 1999	0.0	0.0	≤1.1
2000 - 2499	1.2	0.6	≤0.5
2500 and over	0.1	0.1	≤0.1

Data source
Midwives Notification System
Text: Report on Government Services 2008

1-07: Proportion of emergency department presentations seen within recommended times

This indicator reports the proportion of emergency department patients seen within recommended times.

Rationale

When patients first enter an Emergency Department, they are assessed by specially trained nursing staff who judge how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition. Treatment within recommended times should assist in the restoration to health either during the emergency visit or the admission to hospital which may follow emergency department care.

A patient is allocated a triage code between 1 and 5 that indicates their urgency (see below). This code provides an indication of how quickly patients should be reviewed by medical staff.

The triage process and scores are recognised by the Australian College for Emergency Medicine and recommended for prioritising those who present to an Emergency Department. In a busy Emergency Department when several people present at the same time, the service aims for the best outcome for all. Treatment should be within the recommended time of the triage category allocated.

This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) and is reported for those sites that meet the criteria to be designated an emergency department. For WACHS only Bunbury has a designated emergency department.

Results

Only attendances for Triage category 5 were seen within the recommended threshold. The Triage 1 result relates to three emergency department cases where the unmet target time is related to a data management issue rather than a clinical matter.

The Bunbury emergency department continues to experience increasing activity workload which can directly impact triage time percentages.

Table 10: Proportion of emergency department presentations seen within recommended times

	Threshold	2006-07	2007-08
Triage category 1 (within 2 mins)	100%	100%	97%
Triage category 2 (within 10 mins)	80%	75%	61%
Triage category 3 (within 30 mins)	75%	61%	50%
Triage category 4 (within 60 mins)	70%	63%	47%
Triage category 5 (within 2 hours)	70%	88%	74%

Data source
Emergency Department Data Collection, Information Management and Reporting and TOPAS

1-20: Rate of emergency presentations with a triage score of four and five not admitted

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

Rationale

When patients attend hospitals they are initially received in the emergency service where assessment, treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency service where 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 the emergency service, 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 an emergency service given a triage score of 4 or 5 who were assessed, and treated but did not need admitted hospital care That is, they were restored to health. It does not include patients whose sickness or injury requires admitted hospital care.

This indicator reports the number of emergency service presentations to a WACHS hospital where the patient is not subsequently admitted. The numbers of presentations include doctor attended assessments and treatment as well as nursing assessment and treatment.

Performance target

A target has not been set as emergency presentations will be admitted or not admitted in accordance with their clinical needs.

Results

In 2007-08 the percentage of Triage 4 and 5 emergency presentations not admitted to WACHS hospitals was 92.0% and 97.7% respectively. Compared to 2006-07 Triage 4 attendances have increased 15.5% and Triage 5 attendances by 3.4% in 2007-08.

Table 11: Rate of emergency presentation with a triage score of four and 5 not admitted

	2006-07	2007-08
Triage 4 not admitted	90.1%	92.0%
Triage 5 not admitted	97.0%	97.7%

Data source
Emergency Department Data Collection, Information Collection and Management

S1-01: 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 for reporting hospital activity is a recognised methodology for adjusting actual activity data to reflect the complexity of health care provided against the resources allocated. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complex service provided.

WA hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) to which cost weights are allocated.

This indicator measures the average cost of a casemix-adjusted separation in non-teaching hospitals. Separate results are reported for teaching and non-teaching sites as it is expected that the level of case acuity will be higher at teaching sites than that at non-teaching sites.

Results

The WACHS recorded a cost per casemix adjusted separation of $4,302, within the prescribed target.

Table 12: Average cost per casemix adjusted separation for non-teaching hospitals

	2006-07	2007-08	Target
Actual cost	$4,240	$4,302	**$4,421**
CPI adjusted cost	$3,910	$3,829	

Notes
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.
This indicator does not include specialised mental health unit activity. (see KPIs 2-00)

Data sources
Hospital Morbidity Data System (HMDS)
WACHS Financial Systems

S1-20: Average cost per bed-day for admitted patients (selected small rural hospitals)

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

Rationale

While 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, it is not the accepted method of costing admitted activity in small rural hospitals.

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

Accordingly these hospitals report patient costs by bed-days. This indicator measures the cost per bed-day for admitted patients.

Results

The WACHS recorded a cost per small hospital bedday of $1,297 exceeding the target.

Commencing 2006-07, WACHS has separately reported small hospital acute and residential care bedday in KPIs S1-20 and S14-00. During this period, WACHS has been refining the activity counting criteria and the definitions for an acute and residential care bedday, and as a result of the continuing refinements, the activity estimations used in defining the performance target may not reflect current activity configuration.

Table 13: Average cost per bed day for admitted patients (selected small rural hospitals)

	2006-07	2007-08	Target
Actual cost	$1,275	$1,297	**$883**
CPI adjusted cost	$1,176	$1,155	

Data sources
HCARe activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S2-00: Average cost per bed-day in specialised mental health units

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

Rationale

The variations in care and episode characteristics for patients receiving admitted mental health care compared to other types of admitted care can result in differences in the service costs. It has therefore been recognised that for quality and cost effectiveness for the services provided under admitted mental health activity is better reported separately to other admitted activity and for beddays provided rather by a weighted separation.

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.

This indicator measures the average cost per bed day in specialised mental health units and for WACHS includes authorised units in Albany, Kalgoorlie and Bunbury.

Results

The WACHS recorded a cost per mental health unit bedday of $1,113. This result exceeds the target but is indicative of slightly reduced activity at the Bunbury Regional Resource Centre where full resourcing was maintained while the additional capacity at the new mental health inpatient facility was established.

Table 14: Average cost per bed day in an specialised mental health units

	2006-07	2007-08	Target
Actual cost	$982	$1,113	**$1,017**
CPI adjusted cost	$906	$991	

Data sources
Mental Health Information System
WACHS Financial Systems

Notes
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.
The WA Country Health Service has three authorised units situated in the Bunbury, Albany and Kalgoorlie Regional Resource Centres.

S6-20: Average cost per non-admitted hospital based occasion of service for rural hospitals

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

Rationale

Variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs. 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.

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

Results

The WACHS recorded a cost per non-admitted hospital based occasion of service of $160. This result reflects increased non-admitted activity across most sites in WACHS.

Table 15: Average cost per non-admitted hospital based occasion of service for rural hospitals

	2006-07	2007-08	Target
Actual cost	$174	$160	**$176**
CPI adjusted cost	$160	$142	

Data sources
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S6-21: 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

Variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs. It is important to monitor the unit cost of this non-admitted activity provided at these specialised service units, which often provide the only health service facility in rural or remote localities in order to ensure their overall quality and cost effectiveness.

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

Results

The WACHS recorded a cost per non-admitted occasion of service in a nursing post of $147.

Table 16: Average cost per non-admitted occasion of service in a nursing post

	2006-07	2007-08	Target
Actual cost	$139	$147	**$143**
CPI adjusted cost	$128	$131	

Data sources
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S7-20: 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 aim of PATS is to allow 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 the patient. Assistance is provided to the residents of Peel living between 70kms and 100kms from Perth, subject to certain conditions. Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Results

The WACHS recorded a cost per PATS trip of $346, exceeding the target. The higher cost of the PATS supported travel is a reflection of the continued increased costs associated with travel to and from rural and remote areas.

Table 17: Average cost per trip of Patient Assisted Travel

	2006-07	2007-08	Target
Actual cost	$327	$346	**$304**
CPI adjusted cost	$302	$308	

Data sources
PATS activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

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

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

1. Increase the likelihood of optimal health and wellbeing by:
   - Providing programs which support the optimal physical, social and emotional development of infants and children.
   - Encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury by:
   - Delivering immunisation programs.
   - Delivering safety programs.
   - Encouraging healthy lifestyles (e.g. diet and exercise).
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - Programs for early detection of developmental issues in children and appropriate referral for intervention.
   - Early identification and intervention of disease and disabling conditions (breast and cervical cancer screening, screening of newborns) with appropriate referrals.
   - Programs which support self-management by people with diagnosed conditions and disease (diabetic education).
4. Monitor the incidence of disease in the population to determine the effectiveness of primary health measures.

Table 18: Key Performance Indicators for Outcome 2 by reporting entity.

Outcome 2	WA Country Health Service	Department of Health	Metropolitan Health Service
Prevention and promotion activities	2-01 2-02	R2-50	2-00 2-01 2-02
Protection from diseases	R2-51 R2-52	R2-51 R2-52	
Access to Dental health services		R2-53	2-03 2-04 2-05 2-06

Notes
WACHS population health units deliver both health prevention and promotion services as well as health protection services.

This section contains population-based indicators. The residential postcode of the individual receiving the service allows for epidemiological comparisons and is not the postcode of the location where the service was provided. Performance measurement for these indicators is provided for both Aboriginal and non-Aboriginal populations.

2-01: Rate of hospitalisation for gastroenteritis in children (0-4 years)

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

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in the 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 number 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. 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.

Health promotion and prevention programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis. WACHS also supports a number of Environmental Health Workers that work in Aboriginal communities and with Aboriginal Medical Services.

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.

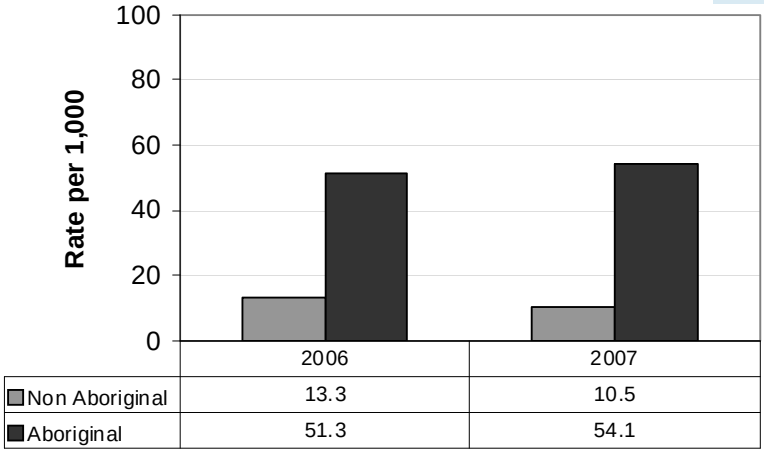
Results

In 2007 WACHS reported hospitalisation rates for gastroenteritis in non-Aboriginal children 0-4yrs of 10.5 per 1000, within target, while a rate of 54.1 per 1000 was recorded in Aboriginal children 0-4yrs exceeding the target and a slightly higher rate than reported in 2006.

WACHS continues its work with health and infrastructure providers to deliver environmental and community health programs aimed at preventing gastroenteritis and similar conditions in rural and remote locations, especially Aboriginal communities.

Figure 6: Rate of hospitalisation for gastroenteritis in children (0-4 years)

Total population target
≤ 19.9 per 1000



	2006	2007
Non Aboriginal	13.3	10.5
Aboriginal	51.3	54.1

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.

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

2-02: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

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

It is important to note however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones 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.

Results

The recorded rates for 2007 of hospitalisation for respiratory conditions in non-Aboriginal populations across WACHS met the targets for the respiratory conditions reported.

The reported results for WACHS Aboriginal populations failed to meet the targets for the respiratory conditions in all but asthma for 5-12 yrs and croup.

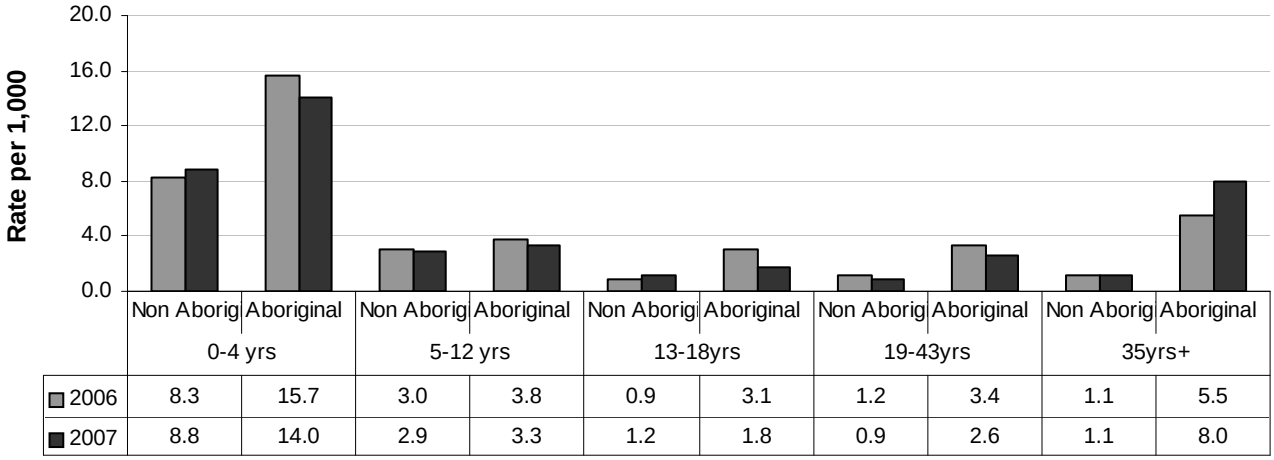
WACHS continues to develop and implement specific programs targeting the prevention, management and treatment of respiratory conditions especially in Aboriginal populations. Programs target individuals, families, groups and communities and focus on the determinants of poor health. Services are provided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

Performance targets

Condition	Age	Rate per 1000 total population
Asthma	0-4 yrs	<10.6
	5-12 yrs	<3.9
	13-18 yrs	<1.5
	19-34 yrs	<1.5
	35 plus	<1.8
Bronchitis	0-4	<1.3
Bronchiolitis	0-4	<18.9
Croup	0-4	<6.7

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

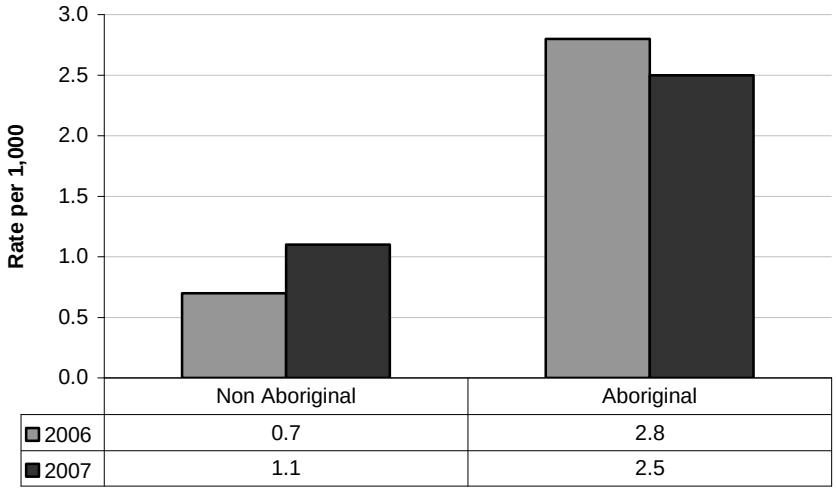
Figure 7: Rate of hospitalisation per 1000 for acute asthma (all ages)



	Non Aborig 0-4 yrs	Aboriginal 0-4 yrs	Non Aborig 5-12 yrs	Aboriginal 5-12 yrs	Non Aborig 13-18yrs	Aboriginal 13-18yrs	Non Aborig 19-43yrs	Aboriginal 19-43yrs	Non Aborig 35yrs+	Aboriginal 35yrs+
2006	8.3	15.7	3.0	3.8	0.9	3.1	1.2	3.4	1.1	5.5
2007	8.8	14.0	2.9	3.3	1.2	1.8	0.9	2.6	1.1	8.0

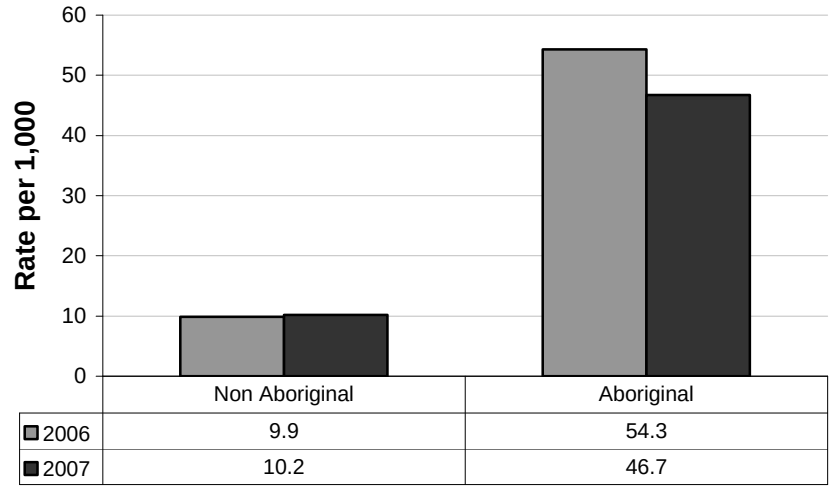
2-02: Rate of hospitalisation for respiratory conditions (continued)

Figure 8: Rate of hospitalisation per 1000 for acute bronchitis (0 to 4 yrs)



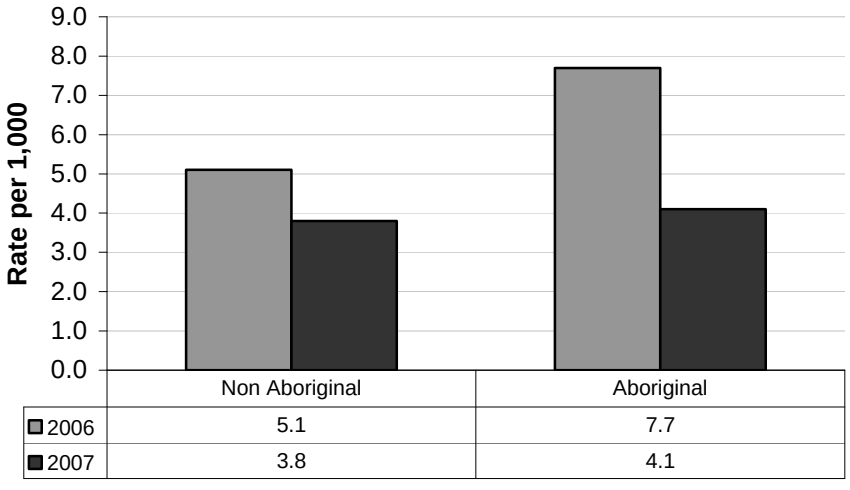
	Non Aboriginal	Aboriginal
2006	0.7	2.8
2007	1.1	2.5

Figure 9: Rate of hospitalisation per 1000 for bronchiolitis (0 to 4yrs)



	Non Aboriginal	Aboriginal
2006	9.9	54.3
2007	10.2	46.7

Figure 10: Rate of hospitalisation per 1000 for croup (0 to 4yrs)



	Non Aboriginal	Aboriginal
2006	5.1	7.7
2007	3.8	4.1

Data sources
Hospital Morbidity Data System
Australian Bureau of Statistics population figures

R2-51: Percentage of fully immunised children at 12 and 24 months

This indicator reports the proportion of fully immunised children at 12 and 24 months.

Rationale

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

This indicator measures the rate of complete immunisation against particular diseases, by age group, of the resident Health Service child population.

The benchmark percentages for immunisations are the agreed targets in the National Childhood Immunisation Program as follows:

At least 90% of children fully immunised at 12, 24 and 60 months.

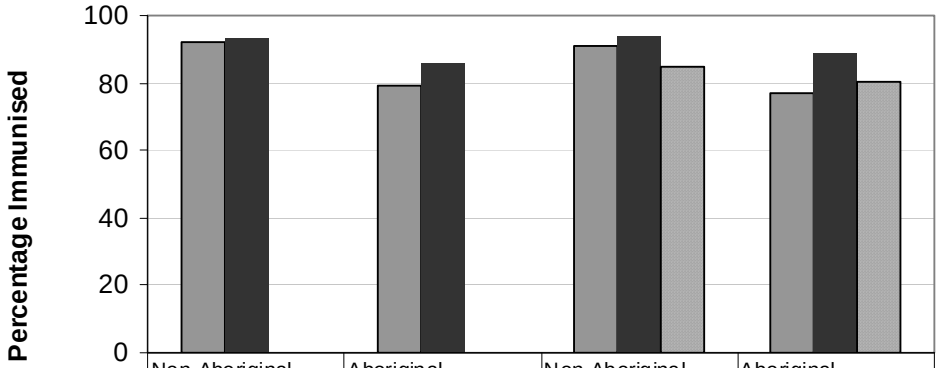
Rates of hospitalisation for infectious diseases or treatment for complications of these diseases are shown in R2-52. Without an immunisation program there is likely to be higher rates of hospitalisation or more disability and death resulting from the diseases.

Results

Immunisation percentages for non-Aboriginal children achieved in 2007 for WACHS for fully immunised children at 12 months and 24 months exceeded the national targets but failed to reach the benchmark for non-Aboriginal children at 60 months. The recorded immunisation percentages for Aboriginal children remain below the national benchmark although the percentage for Aboriginal children at 24 months has increased compared to the 2006 result.

WACHS continues to promote its immunisation programs across rural communities with specific attention given to Aboriginal communities.

Figure 11: Percentage of fully immunised children at 12, 24 and 60 months



	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal
	2006 (Dec Quarter)		2007 (Dec Quarter)	
12-15 months	92.0	79.1	91.1	77.3
24-27 months	93.5	86.3	93.7	89.1
60-63 months			84.7	80.4

Data sources
Australian Childhood Immunisation Register (ACIR)
Australian Bureau of Statistics (ABS) population figures

Note
The age cohort 60 months has been introduced in 2007 as a nationally reported age indicator for immunisation.

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

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

Rationale

To provide additional information about the effect of the immunisation program, the rates of hospitalisation for treatment of the infectious diseases measles, mumps, diphtheria, pertussis, poliomyelitis, rubella, hepatitis B and tetanus are reported. Cases are identified by the principal diagnosis recorded for a hospital admission for these infectious diseases.

Performance targets

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

Results

WACHS recorded a single hospitalisation for mumps in 2007 in the Aboriginal population realising a rate of 5 per 100,000 for the respective Aboriginal age cohort. No other cases of hospitalisation in WACHS were recorded for a immunisable infectious disease in 2007.

The absence of reported hospitalisations for infectious diseases for which there is an immunisation program continues to demonstrate effective vaccination and immunisation programs provided by the WACHS.

Table 19: Rate of hospitalisation for immunisable diseases per 100,000.

	2006-07		2007-08	
	Aboriginal	Non-aboriginal	Aboriginal	Non-aboriginal
Pertussis	0.0	1.0	0.0	0.0
Mumps	0.0	0.0	5.0	0.0

Data sources
Hospital Morbidity Data System
Australian Bureau of Statistics population figures

S8-00: Cost per capita of Population Health units

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

Rationale

Population health considers 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.

Population health units support individuals, families and communities to increase control over and improve their health. In rural locations Population Health units provide both Health Prevention and Promotion, and Health Protection services and programs including:

- Supporting growth and development, particularly in young children (community health activities);
- Promoting healthy environments
- Prevention and control of communicable diseases
- Injury prevention
- Immunization
- Promotion of healthy lifestyle to prevent illness and disability
- Support for self-management of chronic disease
- Prevention and early detection of cancer

Results

The WACHS recorded a cost per capita for WACHS Population Health Units of $164.

Table 20: Cost per capita of population health units

	2006-07	2007-08	Target
Actual cost	$161	$164	**$157**
CPI adjusted cost	$148	$146	

Data source
Australian Bureau of Statistics
WACHS Finance Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

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

The achievement of this component of the health objective involves provision of services and programs that improve and enhance the wellbeing and the environment for people with chronic illness or disability. To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided to enable normal patterns of living. Support is provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential institutions. This involves the provision of clinical and other services which:

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

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

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

Table 21: Key Performance Indicators for Outcome 3 by reporting entity.

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

Note
Area Health Services will also provide acute services to those with disabilities under Outcome 1.

3-00: 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 mental illness 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 mental 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.

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

Results

In 2007, 52.9% of discharges with a mental illness from public mental health inpatient units received contact from a community-based public mental health non-admitted service within seven days of discharge. A further 11.1% of clients were seen within 8 to 14 days.

These results are lower than the set targets as the client group has been expanded to be more inclusive.

Approximately 14% of discharges had no contact within the year. However clients in this reporting category may be seen by private sector clinicians (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) following discharge for which "contact made" data is not available. In addition to these clinical services clients have access to non-clinical support services reported under the Department of Health KPI R3-52.

Note: Commencing in 2007 this indicator has been expanded to include all mental health conditions precluding prior year comparative analysis.

Table 22: 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.

Days to first contact	2007		Target
	%	Cumulative %	
0-7 days	52.9%	52.9%	**60%**
8-14 days	11.1%	64.0%	**70%**

Data source
Mental Health Information System, Data Collection and Analysis-Inpatient and Mental Health, Information Management and Reporting, Department of Health WA

3-20: Aged care resident/carer satisfaction survey

This indicator reports resident satisfaction with the residential aged care services they receive in WACHS facilities.

Rationale

The WA Country Health Service cares for patients who require long term care involving 24 hour nursing care.

This indicator measures resident satisfaction with the residential aged care services they receive in WACHS facilities. The survey is conducted with the resident wherever possible or if not appropriate, with their nominated guardian or carer. Survey results will be reported for both the specified residential aged care facility residents and other aged care residents.

WACHS residential care services include high dependency, high dependency respite, low dependency and low dependency respite provided to nursing home residents, nursing home type residents in hospital and hostel residents. The provision of non-acute permanent care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

As planned, WACHS concentrated its surveying resources in 2007-08 on developing and implementing a pilot survey focussed on Aboriginal aged care clients in WACHS facilities. Extensive consultation was conducted with the Health Consumer's Council of WA, the Office of Aboriginal Health and with focus groups canvassing aboriginal people living in residential care where possible. These consultations have aided the development of a revised survey tool to ensure the range of questions would address the current needs of ATSI people.

However this task proved a challenge as a great number in the client group were not able to respond due to cognitive deficits. This has lead to only 37% of possible respondents where 28 residents were interviewed in four facilities across WACHS.

Results

In general terms there were only two out of 33 questions put to respondents where the satisfaction percentage fell below 50%. In relation to information sharing about changes in care and choice of foods the majority of residents indicated that more could be done to take their wishes into account.

The pilot survey results in 2007-08 have informed WACHS that more work will need to be undertaken in future years to conduct the survey under appropriate survey methods that will effectively capture information about Aboriginal client satisfaction with WACHS residential care services.

Data source
WACHS and the Epidemiology Branch, Department of Health

S12-00: Average cost per completed ACAT assessment

This indicator measures the average cost per ACAT assessment.

Rationale

Aged people 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.

Some of these services specifically relate to funded programs that require an assessment by an Aged Care Assessment Teams (ACAT), without which access to the appropriate aged care service programs cannot be progressed.

This indicator measures the average cost per completed assessment provided by an ACAT.

Results

WACHS recorded a cost per completed ACAT assessment in 2007-08 of $1,102 exceeding the prescribed target.

WACHS provides resources appropriate to delivering ACAT services to rural and remote locations. This entails sufficient expenditure to service remote locations as well as the additional costs associated with multiple assessment contacts for small client numbers living in remote settings.

Table 23: Average cost per completed ACAT assessment

	2006-07	2007-08	Target
Actual cost	$1,145	$1,102	**$785**
CPI adjusted cost	$1,056	$981	

Data sources
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to December 2007 and January to March 2008.
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S13-00: 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 health problem or who are receiving post-acute care. This indicator gives a measure of the cost of treatment for public psychiatric patients under community management (non-admitted/ambulatory patients).

Results

The WACHS recorded a cost per person receiving community health services of $3,391 exceeding the target. This result reflects additional costs incurred in relation to clinically based services.
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Table 24: Average cost per person receiving care from public community based mental health services

	2006-07	2007-08	Target
Actual cost	$3,321	$3,391	**$3,070**
CPI adjusted cost	$3,063	$3,019	

Data source
Mental Health Information System
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08

S14-20: Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents

This indicator reports the cost per residential aged care bedday provided in WA Country Health Service facilities.

Rationale

The WA Country Health Service provides residential care for patients who require long term care involving 24 hour nursing and support care.

The provision of non-acute permanent residential care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

WACHS residential care services include permanent high dependency, high dependency respite, permanent low dependency and low dependency respite, nursing home type care in hospital, and hostel and flexible care.

This indicator reports the cost per residential aged care beddays for residents of the specified residential aged care facilities in the Kimberley at Numbala Nunga and Kununurra, and in the Pilbara at Karlarra and for all other WACHS residential aged care services.

Results

The WACHS recorded a cost per residential care bedday of $366.

Commencing 2006-07, WACHS has separately reported small hospital acute and residential care bedday in KPIs S1-20 and S14-00. During this period, WACHS has been refining the activity counting criteria and the definitions for an acute and residential care bedday, and as result of the continuing refinements, the activity estimations used in defining the performance target may not reflect current activity configuration.

Table 25: Average cost per bed day for specified residential care facilities, flexible care (hostels) and nursing home type residents

	2006-07	2007-08	Target
Actual cost	$337	$366	**$396**
CPI adjusted cost	$311	$326	

Data sources
WACHS HCARe data warehouse
WACHS Financial Systems

Notes
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2007-08.

Significant Issues and Trends

Overview

During 2007-08 the WA Country Health Service has continued the implementation of its strategic plan for the period 2007-2010 "Foundations for Country Health Services".

'Foundations' sets out the service configuration and structure for the WA Country Health Service (WACHS) that will best deliver the range of health care services to meet the needs of a changing rural community, respond to the numerous service resourcing and capacity issues, and take advantage of emerging clinical and patient care technologies and practices.

WACHS' three strategic direction are:

Networking health services

To effectively connect people and services, whether within regions, between regions, with metropolitan hospitals, or among the different country service providers, is vital to improve both access to health services and the efficiency and effectiveness of those services. Priority areas for achieving this objective include further advancement of the regional hospital role delineation project, implementing effective service planning and management to deliver coordinated and responsive services, developing greater collaboration between clinical and other staff across regions, and ensuring effective emergency care across WACHS.

Building healthier communities

Priorities remain to increase resource allocation for disease and injury prevention, early intervention and smarter management of chronic disease, to provide more home and community based service delivery especially to maintain the health and independence of older people, to develop mental health, alcohol and drug abuse response capacity, and to improve Aboriginal health.

Strengthening and modernising the country health system

In the face of the challenges of increasing demand for high quality and accessible services combined with workforce shortages, WACHS conducts management and system support evaluations across the health service to highlight areas of duplication and identify opportunities for new and innovative ways to enhance the efficiency and effectiveness of WACHS' healthcare operations and support systems.

Service trends

There are a number of significant service and demographic trends that impact upon service delivery in country areas, and provide a challenge to the provision of efficient and effective health care. Many of these trends have remained unchanged over the past year.

The population projection for WA country regions remains at an estimated growth rate of 13% between 2001 and 2011 and change variables affecting rural and remote populations have continued where the delivery of services is especially affected by the growth in mining areas, the South West and coastal towns, an increase in the ageing population who experience a higher incidence of chronic disease and ill-health, and the significant and persistent disparity in health status between the Aboriginal and non-Aboriginal populations.

Workforce shortages continue across most clinical medical disciplines essential for the provision of effective and efficient health care services where the reliance on a multi-skilled generalist medical workforce remains. Other issues such as recruitment and retention of skilled staff, providing professional and peer support, distance and access factors, and managing low levels of activity in combination with community expectations for locally accessible specialised healthcare, are service delivery issues that continue to pose challenges to WACHS.

WACHS continues to manage its service delivery within its resource allocation. However this remains an extremely challenging task for the Area Health Service as it endeavours to meet the demand for health care services, to address workforce issues, and manage the increasing costs of medical practice and technology, innovation, transport and isolation.

Activity

During 2007-08 WACHS recorded a significant increase of over 10% in the provision of non-admitted services including emergency service activity compared to 2006-07. For the calendar year 2007, the WACHS hospitals delivered 4,888 live born infants, provided 9,115 same day procedures and discharged 94,913 cases. During 2007-08 WACHS provided 70,512 acute and 202,833 residential occupied beddays from its small hospitals and 63,909 weighted separations from its larger hospitals. WACHS delivered 86,834 individual community mental health service consultations from its mental health services or contracted providers.

Major Achievements 2007-08

Healthy workforce

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

WA Country Health Service workforce initiatives in 2007-08 continue to focus on planning, attraction and retention, the development of innovative workforce models, cultivating partnerships with other employers and providers, and striving to be an employer of choice.

Specialist services

Visiting specialist services have been increased across a number of regions under the WACHS Specialist Services Plan and the Medical Specialist Outreach Assistance Program. The Great Southern has increased visiting specialist services in the fields of vascular surgery, cardiology orthopaedics, palliative care, rheumatology, sleeping disorders, geriatrics and obstetrics, in the Kimberley there has been increased services in obstetrics, gynaecology and ophthalmology, and in the Mid West the numbers of specialist oncologists servicing the region has increased. For the first time, all seven regions have a visiting specialist geriatric service.

Nurse practitioners

All country hospitals have been designated as emergency care nurse practitioner sites and 21 sites are receiving remote area nurse practitioner status with practice protocols endorsed. The creation of nurse practitioner positions and the recruitment of staff to fill these positions is progressing, with four nurse practitioners appointed for remote areas. A further 2 nurse practitioner positions in emergency care have been created, with recruitment to fill these positions progressing in 2008-09.

Graduate nurses

Placements for recruited graduate nurses across WACHS have increased to 58 (YTD February) in 2008, an increase of 11% compared to 2007. A total of 85 placements have been allocated for graduates in 2008 which can be filled through the recruitment program as well as alternative selection programs.

Medical workforce

During 2007-08 WACHS established a Medical Workforce Unit to coordinate and facilitate the recruitment and induction of medical staff to salaried positions within the WACHS. Also during the year a medical clinical reform director position was been established to implement a medical workforce strategic plan.

Physicians and medical officers have been recruited to newly created positions in the Kimberley, the Pilbara and the Mid West. A new registrar position has been created for the South West.

Telehealth

A state-wide Telehealth structure has been approved with the establishment in May 2008 of a Telehealth Development Group under the leadership of the WACHS Chief Executive Officer and reporting to the Operations Review Committee of the State Health Executive Forum.

Inpatient therapy

The Bunbury Inpatient Therapy Team has been expanded, enabling the development of referral processes and a program of therapy groups across inpatient, rehabilitation and community services.

Staff attraction and retention

WACHS continues to participate in the development of community, regional, state and national initiatives for a sustainable rural health workforce. The establishment of programs and innovative workforce models that address expected workforce gaps and skills shortages remains a priority for WACHS.

Initiatives to attract and retain nursing staff have continued across WACHS, and include programs such as the:

- "Kimberley Rotation";
- "Ocean to Outback";
- "Country to Coast";
- "Crocs to Rocks"; and
- "Nursing with Adventure".

These programs aim to offer nurses greater work satisfaction with exposure to a diverse range of sites and work areas.

Healthy workforce (continued)

Aboriginal health services

Indigenous health services in WACHS - Wheatbelt have been expanded through the recruitment of a podiatrist, a social worker and Aboriginal health workers in Dalwallinu, Merredin, Moora, Narrogin/Pingelly, Northam and Quairading.

Emergency services

Management of the emergency on-call system has been enhanced in the Eastern Wheatbelt with the employment of two doctors in partnership with private practices in Merredin and Bruce Rock.

Elective surgery

WACHS received an allocation from stage one of the Commonwealth Government's Elective Surgery Wait List Reduction Plan where WA Health has received funding for additional elective surgery procedures for 2008 specifically for patients who have waited longer than is clinically appropriate.

Healthy hospitals, health services, and infrastructure

The WA Country Health Service provides a range of health care services through its regional network model of service delivery. It is committed to ensuring that services are accessible, innovative and responsive to community needs, are efficient, and of the highest quality.

Hospital in the home

The 'Hospital in the Home' program has been operating in Albany, Bunbury and Geraldton. A review of the HITH service in WACHS - Great Southern has been completed and forms the basis for the expansion of HITH programs to other country regions including the implementation of consistent reporting mechanisms for home-based care services. Six WA Country Health Service regions have 'Hospital in the Home' (HITH) programs increasing the access of rural patients to this type of service. A network for rural HITH staff has been established to provide collegiate support and advice as new services are implemented at additional sites.

Aboriginal health

A survey of Indigenous aged care residents residing in WACHS facilities was conducted in June 2008 in the Pilbara, Kimberley and Mid West. Results will inform strategies for improvement in the delivery of care to Indigenous aged care residents.

Emergency services

Improved processes for the management and coordination of the transfer of critically ill patients from country emergency services to an appropriate health facility have been trialled in WACHS - South West in collaboration with the Royal Flying Doctor Service and St John Ambulance. The trial involves telephone clinical coordination provided by emergency medicine specialists, assisting medical and nursing staff in the assessment of seriously ill patients, the determination of hospitalisation and transfer requirements, and liaison with the receiving metropolitan hospital and the transporting agency.

Accreditation

The Australian Council on Healthcare Standards (ACHS) is an independent authority on the measurement and implementation of quality improvement systems for Australian health care facilities. The ACHS provides a quality improvement framework, the Evaluation and Quality Improvement Program (EQuIP), to assist health care organisations continuously measure their performance and strive for excellence. In a four year cycle the organisations alternate, annually, between self-assessments and external audits. The ACHS program provides health services with recommendations for improvement.

During 2007-08 WACHS regions underwent routine accreditation reviews and audits conducted by the ACHS or undertook self assessments to commence or maintain their accreditation status.

Capital and infrastructure projects

Numerous capital projects were completed during 2007-08 including:

- Derby Acute Inpatient Ward and Ambulatory Care Centre;
- Fitzroy Crossing Multi-Purpose Centre and Dental clinic;

- Kununurra Hospital Ward expansion, dental clinic and support services;
- Morawa and Perenjori Multi-Purpose Centre;
- Carnarvon Hospital stage 1 – upgrade to existing maternity and palliative care wards and roof replacement to general ward; and
- Bunbury dental clinic and South West Health Campus inpatient mental health unit and mental health clinic.

During 2007-08 medical imaging capabilities across WACHS were improved with:

- Computed radiology was installed at Geraldton, Carnarvon and Northam;
- New laser imagers installed at Newman, Esperance, Kalgoorlie and Karratha;
- Installation of new ultrasound machines in Geraldton, Albany (2), Karratha, Port Hedland and Tom Price (equipment upgrade);
- New ultrasound tables at Geraldton, Newman, Derby and Katanning; and
- Mammography units in Kalgoorlie and Albany.

The country clinical equipment upgrade program has commenced, including:

- provision of bariatric beds to all Regional Resource Centres to improve services for overweight patients;
- replacement of sterilisers at Bunbury, Kalgoorlie and Port Hedland Regional Resource Centres and at Busselton Hospital; and
- expansion of the bed replacement program for country hospitals.

Telehealth burns management

Telehealth burns management services have been expanded to all country regions in a partnership between the WACHS, and Princess Margaret and Royal Perth Hospitals.

Aged care

During 2007-08 WACHS completed the establishment of Aged Care Coordination Units in each of its regions. The primary role of these units is to build an effective aged care network to better coordinate the planning and delivery of aged care services.

WACHS - Pilbara has taken over the management of the Western Desert home and Community Care (HACC) program and is working with communities to establish community-owned HACC projects.

Risk screening

Risk screening of non-Indigenous patients aged 65 years and over and Indigenous patients aged 45 years and over, has commenced in all WACHS Regional Resource Centre emergency services under the Council of Australian Governments *Improving Care for Older Patients in Public Hospitals* initiative. Patients with a positive risk screen are referred for comprehensive assessment and follow up to prevent avoidable hospital admissions or to access coordinated care if admission is necessary.

Homelink

A rural home link service with a 1800 telephone contact number will be operational during 2008, enabling better coordinated discharge planning for country patients who are leaving metropolitan hospitals. The rural home link service will be supported by 'Hospital in the Home' services based in the regions.

Patient support services

During 2007-08 the "Meet and Assist" service was integrated within the Aboriginal Liaison Service. These services provided 220 airport pickups between May 2007 and April 2008 and supported patient attendance for 497 hospital appointments. Two Aboriginal health workers have been appointed and routinely visit each of the Aboriginal hostels in Perth providing assistance on health-related issues.

To support these new patient services initiatives, accommodation has been secured at Thorburn House, at the Royal Perth Rehabilitation Hospital establishing a centre to assist with the discharge planning of country patients. The new facility will be operational in 2008. The integrated Aboriginal Liaison and Meet and Assist service will be co-located in the centre with additional rural nurses to extend the service to non-Indigenous rural patients.

Patient assisted travel scheme

The new Patient Assisted Travel Scheme (PATS) database is a web based data management system for WACHS. The system is designed so data can be extracted for a specific region, a combination of regions or for all of WACHS. The system has also been structured to replicate the PATS management V3.0 database with improved functionality.

There have also been improvements to PATS application forms and updated guidelines for PATS were implemented in January 2008.

WACHS – Pilbara, one of the major users of the PATS, now coordinates patient travel centrally from Port Hedland. This has increased the efficiency of PATS administration and client services in WACHS - Pilbara.

Healthy communities

Initiatives to improve the health of people living in country WA focus on activities that influence the health of individuals as well as the whole population. Goals include improving lifestyles, the prevention of ill health, and the implementation of long-term, integrated health promotion programs.

Initiatives developed by WACHS during 2007-08 followed extensive collaboration and consultation with government and non-government agencies, general practitioners and healthcare service provision stakeholders.

Transitional care

WACHS has been allocated sixty flexible places under the Transition Care Program (TCP). These places are divided evenly between the Mid West, South West and Great Southern, and are provided in partnership with private service providers who will deliver the required services. These programs commenced in the South West in September 2007, in the Mid West in February 2008 and in the Great Southern in March 2008.

Transition care is a Commonwealth / State program that targets frail older people at the conclusion of a hospital stay and provides time-limited, goal-oriented therapeutic care in a non-hospital environment while assisting the patient to make long-term care arrangements. It is expected that the TCP will reduce extended hospital stays, reduce the rate of hospital readmission, and minimise premature admission to residential aged care.

The appointment of Aged Care Managers in each region has enhanced aged care service coordination and supported the implementation of risk screening of all older patients accessing emergency departments.

Health promotion

Health promotion programs targeting children and high-risk groups in country areas have continued during 2007-08 and include:

- support across WACHS for the school canteens traffic light policy;
- an infant feeding pilot project in the Wheatbelt; and
- engagement with two Goldfields Indigenous communities (Ninga Mia and Coolgardie) to provide nutritional advice and information to support purchase and preparation of healthy food.

Australian better health initiative

Under the Australian Better Health Initiative funding has been provided to support the implementation of the 'healthier schools' programs, focusing on physical activity and nutrition. "Healthy school" coordinators have been employed in each of the seven regions to facilitate implementation.

Brief intervention

WACHS has implemented 'brief intervention' strategies to support the WACHS alcohol and tobacco brief intervention policy endorsed in June 2007. During 2007-08 WACHS has worked with the Drug and Alcohol Office, the National Drug Research Institute and the Western Australian Tobacco Control Branch to develop resources including a training program, to assist the implementation of this policy and created Brief Intervention Project Officer positions in each region.

WoundsWest

WACHS is participating in a number of Statewide WoundsWest projects that have been completed or are progressing:

- the state-wide wound prevalence survey has been completed and distributed to all health services;
- the core Wound Management module and the first of four sub-specialty modules are available online, with another two planned for 2008;
- recruitment for a WoundsWest Consultant Team is progressing; and
- a wound imaging and documentation system is in development.

Smoke Free WA

WACHS implemented the WA Health Smoke Free policy on January 1, 2008. All WACHS health facilities are non-smoking for patients, employees, visitors, volunteers and contractors. The policy is applicable to any health service building, grounds and other facilities (including cars), and while officers are representing WACHS in any official capacity.

Mental health

The 'Act Belong Commit' campaign under the "Mentally Healthy Western Australia" health promotion program was successfully implemented in Albany, Esperance, Kalgoorlie, Geraldton, Karratha, Northam and Toodyay. This

program aims to improve mental health through encouraging people to undertake activities that build individual resilience and community cohesion.

A number of Statewide initiatives to address postnatal depression were implemented and benefited WACHS-based service delivery including:

- the 'Beyond the Boundaries' Perinatal Mental Health Symposium held to promote perinatal mental health to the broader WA Health sector;
- a culturally appropriate perinatal mental health training module for Indigenous Health Workers was developed and delivered at Marr Mooditj Aboriginal Health Training College; and
- a new service model, frameworks and service agreements to enhance postnatal depression services for Iraqi, Sudanese and Ethiopian communities in Western Australia were developed.

The Statewide Clinical and Service Enhancement Program (SCSEP), the primary provider of telepsychiatry has relocated to new premises enabling it to double its capacity (four purpose fit studios) which contributed to a 21% increase in videoconferencing activity. As part of the Pathways Home project, video-conferencing equipment has been installed in an additional 58 centres across the State to expand telepsychiatry services. These services include specialist mental health services to clients and professional development opportunities for country mental health service staff. A further project has begun which will explore the delivery of telepsychiatry services through the use of videoconferencing equipment being installed in clients' homes.

WACHS – Kimberley has implemented the 'Headspace' program to address the region's complex and high levels of youth mental health needs. The program focuses on enhancing the delivery and coordination of services within the town of Broome, and the development of early intervention, awareness raising and community education programs in a whole-of-Kimberley context. A venue has been established where young people are able to access counselling and support services which will reflect the social, economic and geographic diversity of the region, and promote social recovery in culturally appropriate ways. The focus will be on promotion, prevention and early intervention, with treatment being provided by the "Better Outcomes for Mental Health" program.

Under the Western Australia's Mental Health Strategy the establishment of additional community supported accommodation services for people with severe mental illness living in WA is a priority. Under this initiative during 2007-08 the construction of residential units in Albany, Busselton, Bunbury and Geraldton was completed and residents will move in during 2008. These units will provide daily rehabilitation and clinical support to residents and help minimise the risk of hospitalisation for people with severe and persistent mental illness.

'Stay on your Feet'

The WA Country Health Service continues to prioritise its community based activities for the "Stay On Your Feet" (SOYF) program across the Area Health Service including programs and activities contributing to SOYF promotion week.

Residential care line

The Residential Care Line has been trialled in the Great Southern, South West and Mid West regions providing a telephone advice and outreach service to residential aged care facilities in the major regional centres. This line assists residential care facilities to better manage sick elderly patients and thereby decreasing unnecessary presentations to hospitals and emergency services.

Home and community care

The WA Country Health Service is participating in the trial of single access points under the Home and Community Care (HACC) program in the Goldfields and Kimberley. This project is a key initiative aiming to build on current infrastructure and services to make it easier for people to find out about and access community care services. The work to improve access to community care involves the identification of entry points (Access Points) that can be easily identified by people seeking services.

Pit Stop: men's health program

The 'Pit Stop' men's health promotion package has been updated and distributed to all country regions. This program encourages men to get regular health check-ups, and has included Indigenous communities in Coonana, Leonora and Norseman. The package relates body functions to mechanics, likening parts of the body to an engine.

Cancer care

In 2003 the Health Reform Committee (Reid) recommended a review of cancer service delivery in Western Australia. A comprehensive review was undertaken in 2005 by the WA Cancer Services taskforce.

The result was the development of the WA Health Cancer Services Framework, a state funded initiative supported by the Minister for Health, and aimed at improving health outcomes

Healthy communities (continued)

Cancer care (continued)

for cancer patients throughout the state. The WA Cancer and Palliative Care Network was established to implement the recommended initiatives.

It is recognised that patients from rural and remote areas, and especially patients being treated in rural and remote areas of WA, have a range of poorer outcomes in the treatment of cancer, including mortality, morbidity, access and completion of appropriate treatments and access to information. (WA Health Cancer Services Framework, 2005)

A number of initiatives have been put in place to improve services and patient outcomes.

Rural Cancer Nurse Coordinators

Currently seven regional coordinators with a metropolitan-based rural cancer nurse coordinator have been appointed. The key role of these positions is to streamline and coordinate the patients' cancer journey and provide a point of contact and support for rural, regional and remote patients and their families. These roles also promote sharing of information, thus encouraging a seamless service between rural and metropolitan areas.

CanNet (Cancer Service Networks National Demonstration Program)

CanNet is an initiative led by the WA Cancer and Palliative Care Network which aims to improve the cancer journey and outcomes of people affected by cancer. The development program is being piloted in the WACHS - Great Southern and aims to extend specialist cancer care out of the current metropolitan centric model through the establishment of a cancer service network. A cancer network will increase the capacity of rural health care providers in this region to contribute to the delivery of cancer care. Opportunities to expand the initiative to other areas during the course of the project will be explored.

CaMen

This CaMen project commenced in April 2007 and targets rural health workers who are interested in cancer care and aims to develop their knowledge and skills within a professional mentoring environment. The program consists of a 3-5 day supervised clinical attachment alongside cancer care specialists.

Virtual visiting program

WACHS offers a Virtual Visiting Program which allows inpatients to communicate with their families via videoconferencing. This provides social and emotional support for both the patients and their significant others.

Videoconferencing is also being used by some medical staff to conduct follow-up appointments. This reduces the number of times a rural patient needs to come to the metropolitan area. This service provides significant benefits to patients, both financial and emotional.

Wheatbelt "checkout" health promotion

The 'Women's Checkout' health promotion program, encouraging women to get regular health check-ups was successfully piloted in Wongan Hills, and a resource manual has been developed and distributed across the Wheatbelt region.

Healthy belt program

The 'Healthy Belt' lifestyle program, which aims to teach people how to maintain a healthy weight, was implemented in eight Wheatbelt towns.

Health promoting hospitals

The Health Promoting Hospitals Framework has been introduced in several sites in the Great Southern including Denmark, Gnowangerup, Mount Barker and Albany. The Goldfields Health Promotion Training Package is being reviewed and training sessions will be held for health service staff throughout 2008.

Adolescent sexual health

A Youth Coordinator has been employed in Esperance to pilot the Promoting Adolescent Sexual Health initiative and facilitate young carers groups.

Trachoma screening

In August 2007, a concurrent trachoma screening program was completed for the first time in the Goldfields, Kimberley and Pilbara, maximising the opportunity to screen transient populations.

Aged care

The Aged Care Assessment Team (ACAT) quality framework to identify and promote good practice across Western Australia has been completed and has been provided to all ACATs. The ACAT Quality and Training Reference Group was formed to implement the Western Australian training and quality frameworks and met on a quarterly basis providing a forum for the development and implementation of quality and training initiatives.

The ACAT Managers Group was developed and met twice in 2007-08, providing an avenue for

the development, promotion and implementation of operational management initiatives, particularly in reference to timeliness, quality and consistency of assessments.

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

Chronic disease

The South West Chronic Disease Self Management pilot has been evaluated and projects have commenced in the Great Southern, Mid West and Wheatbelt to develop regional models of chronic disease management, including care and referral pathways with linkages with other key service providers such as general practitioners.

WACHS – Great Southern continence advisor

A Continence Advisor position has been established in the Great Southern to provide an advanced level of practice and care for patients with continence problems.

Healthy partnerships

The WA Country Health Service continues to create stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals, the Commonwealth Government, and those with an interest in the well being of our health system. Of particular importance to WACHS' health service planning and service delivery is the role and contribution of the District Health Advisory Councils in maximising local participation and involvement in decision-making.

Patient transfer - Kimberley

During 2007-08 the WA Country Health Service commenced negotiations with Royal Darwin Hospital and Northern Territory Health to develop mutually acceptable clinical and business protocols to enable Royal Darwin Hospital to accept inter-hospital patient transfer from the Kimberley. This arrangement will support better patient outcomes and realise some cost savings.

Telehealth

The range of Telehealth clinical services to all country regions has been expanded through partnerships between the WACHS, and the Princess Margaret and Royal Perth Hospitals, and includes an expansion of the burns management service to all country regions.

Satellite dialysis unit Busselton

The dialysis unit in Busselton began operations in April 2008. This is a partnership between WACHS South West and St John of God Hospital Bunbury.

Combined Universities Centre for Rural Health

In partnership with the Combined Universities Centre for Rural Health (CUCRH) in Geraldton, WACHS has provided funding for three rural Aged Care fellowships for primary health care professionals. The fellowships will commence in 2008-09.

Royal Flying Doctor Service

In partnership with the Royal Flying Doctor Service, WACHS has developed a five year plan to identify and implement the most effective and efficient aero-medical service configuration to meet expected demand for inter-hospital transport.

Ambulance services

In partnership with the St John Ambulance Association, the WA Country Health Service is supporting and evaluating the Rural Paramedic Support project in the Kimberley and Pilbara. This project aims to support volunteer ambulance centres in the country that have trouble recruiting sufficient volunteers.

Exmouth MPS

During 2006-07 the Exmouth community in partnership with WACHS – Mid West developed the Exmouth Multi Purpose Service (MPS) model. The Exmouth MPS commenced operations on the 1st of June 2008. The model promotes a collaborative approach to health funding, and service planning and delivery between the Commonwealth and State Governments and the community. It enables more flexibility in determining the mix of health services to be provided to the community at the local health service level.

Healthy partnerships (continued)

WA health networks

The WA Country Health Service has executive representation on each of the WA Health Networks Executive Advisory Groups. These WACHS Executives have a pivotal role in informing the strategic policy directions from a rural and remote perspective.

Mental health

WACHS – Kimberley developed a partnership with the Kimberley Division of General Practice (KDGP) to provide additional primary care services to the 'Headspace' program assisting patients access resources dedicated to adolescent mental health referrals. As a consortium member Kimberley Mental Health and Drug Service provide "on the ground" youth, and drug and alcohol counsellors to enhance an accessible, effective and sustainable service for youth with mental illness and drug and alcohol related issues in the Kimberley region.

Rural Health West

During 2007-08, in partnership with Rural Health West, WACHS has implemented the following initiatives:

- a GP obstetric mentoring scheme;
- assisting country units to apply for local training accreditation;
- supporting rural and remote practitioners through Telehealth; and
- development of a defined procedural GP Obstetric training pathway.

District health advisory councils

The WA Country Health Service continues our commitment to consultation through our community and consultation strategy which provides two way communication and advocacy between the Area Health Service and local community members. The 24 District Health Advisory Councils (DHAC) continue to build a consumer, carer and community influence within WACHS by contributing to the improvement of service safety, quality and access, two-way communication and advocacy. Health service planning is made more relevant by their contribution. The Wheatbelt and some towns have Local Health Advisory Councils in each site, enabling them to inform the DHAC of local priorities.

Improved dental services in three sites, appointment of a health service liaison person in a Regional Resource Centre, coordination of community responses in several sites, the welcoming of new staff and presentation of service certificates to staff are some of the DHAC achievements for this period.

Aboriginal health

During 2007-08 WACHS continued to explore opportunities to generate innovative concepts and developments for Aboriginal health that will generate better health outcomes for Aboriginal people. Strong alignment and linkage with the Office of Aboriginal Health (OAH) facilitates the development and implementation of aboriginal health strategies, operational plans and policy development.

The new Federal Government has flagged improvement in health status of Aboriginal people as a priority for the Commonwealth in partnership with the States. The OAH is leading WA's engagement with the Commonwealth to ensure the implementation of aboriginal health initiatives in WA compliments the Commonwealth Aboriginal Health agenda.

Further to any new initiatives that the Commonwealth/State relationship might deliver, WACHS is maintaining its ongoing commitment to accomplishing a 'mainstream' health service quality improvement strategy to increase service access and quality for Aboriginal people in WA.

However, a number of challenges face WACHS in achieving its outcomes for Aboriginal health. These include:

- Developing achievable and sustainable local aboriginal health services and Aboriginal and Torres Straight Islander community governance models and arrangements.
- Establishing Aboriginal Community Partnership Models for service provision where appropriate (for example, Fitzroy Valley partnership model).
- Promoting and supporting a sustainable WACHS ATSI workforce.
- Developing an effective WACHS regional workplace environment for ATSI workers including peer support and infrastructure, whereby the value of core training and life skills of ATSI workers is valued and utilised.
- Understanding and appreciating the socio-economic status of the ATSI community in regard to program/service development, policy development and formulation, ATSI workforce development and sustainability, appropriate resource allocation and development, and implementing appropriate ATSI workforce recruitment and retention strategies.

Healthy resources

A priority for the WA Country Health Service is a sustainable, equitable and accountable health care service to deliver the best health benefit in a safe and quality assured environment. WACHS has adopted effective and efficient administration and management practices to ensure the best use of the resources available is made to support the best health outcome for country people.

Health networks

During 2007-08 the health networks grew to 17 with three new networks established – the Genomics Network, the Acute Services Network, and the Women's and Newborns Network. Clinicians and relevant staff from WACHS are members of the health networks.

The Networks are now integral to health reform by leading system-wide changes. Each Network clinical lead continues to embrace their role as a "change champion" and has led innovative, robust and sustainable engagement that looks at health care from a patient-centered approach. Endorsement for their key roles across WA Health has seen the formalizing of the WA Leads Forum as a sub-committee of the State Health Executive Forum.

The Networks are developing or have developed evidence based models of care for their speciality areas. This process features extensive stakeholder consultation to ensure the 'models' meet the needs and aspirations of the broader community. Over 20 models of care have been developed across the variety of speciality areas. These outline a patient-centred approach to the continuum of care for the relevant health conditions or for a population-based health care framework.

Performance agreements

For 2007-08 performance agreements were established for all area, regional, program and executive directors in the WACHS Leadership Team to ensure that the services, outputs and outcomes delivered by each are aligned with WACHS strategic and operational goals and objectives.

Performance monitoring

A periodic performance reporting system was implemented across WACHS to monitor and evaluate progress against the annual WACHS operational plan and to identify performance against key organisation-wide indicators.

Capital and Equipment programs

During 2007-08 WACHS completed a number of capital works projects in Fitzroy Crossing, Kununurra, Morawa/Perenjori, Carnarvon and Bunbury with developments continuing for the Broome Dental Clinic, and Busselton and Albany hospitals.

In addition over $3 million was approved during the year for equipment purchases or replacements including sterilisers, ultrasound machines, diagnostic scopes, computed radiology and bed acquisition and replacement programs.

Healthy leadership

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

The Institute for Healthy Leadership

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

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

In December 2007 the Institute commissioned the following leadership programs:

- *Service Improvement Workshops*
  These workshops provide basic training in health service improvement principles and methods;
- *Emerging Leaders Development Program*
  This program is jointly run by Curtin University of Technology and Edith Cowan University; and
- *Delivering the Future Leadership Development Program*
  This program for potential successor directors and executive directors within WA Health is delivered by UWA Business School in partnership with a commercial management training organisation.

In addition six two-day workshops have been offered where participants develop their own personal development plans and receive support and mentoring from the Director General and a State Health Executive Forum leader.

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

- *Graduate Development Program;*
- *Executive Development; and*
- *Masterclasses.*

During 2007-08 over 50 WACHS staff have participated in leadership programs coordinated by the Institute for Healthy Leadership with 18 in the *Emerging Leaders Development p*rogram, 20 attending the Service Improvement Workshops, and 12 senior executives participating in the *Future Leadership* and *Master Class* programs, which include individual coaching.

In addition to the programs provided through the Institute during 2007-08, the work of the WACHS coordinator for Learning and Development has provided a number of innovative leadership and executive development opportunities across the Area Health Service including:

- Six 'Diploma of Business Management' units have been delivered in 12 rural locations, with 500 clinical leaders and mid level managers taking part in formal education relating to change and project management, team building, conflict resolution, leadership and performance review;
- Regional medical and corporate executives have taken up 40 places at "management refresher" workshops conducted during their regular Perth visits; and
- a further 50 WACHS senior rural managers have participated in leadership workshops provided by WACHS, as an adjunct to participating in Department of Premier and Cabinet on-line 360 degree Leadership Skills Feedback Survey and personal Coaching program.

Aged care

Each region of WACHS has created a manager of Aged Care Services position. The manager is responsible for providing clinical and managerial leadership at the regional executive level and for the planning, development, co-ordination and evaluation of community aged and continuing care services in each region.

Aboriginal health leadership

The WACHS Aboriginal Health landscape has changed for the better with the establishment of the full-time Area Director of Aboriginal Health and support office which offers added value and enhancement to WACHS contribution and response to our indigenous community.

Management workshops

WACHS - Goldfields has completed a series of management workshops aimed at familiarising newly-appointed managers with operational knowledge and skills in management policy procedure and practices within the region.

Telehealth

Commencing February 2008, Telehealth became a key program responsibility of the WACHS Chief Executive Officer, a member of the State Health Executive Forum. This has raised Telehealth's profile and accountability within WA Health.

Priorities for 2008-09

WA Health's Strategic Directions 2005-10 and recommendations and directions provided by the Health Reform process to deliver a 'Healthy WA' will continue to drive health care in 2008-09.

Priorities for 2008-09 for the strategic directions are detailed below.

Healthy workforce

The WA Country Health Service will continue to develop and deliver models of health care that address the current workforce and skills environments. The Area Health Service has emphasized the provision of capacity for further education, training and leadership skilling, innovative workforce planning, work redesign and service delivery modelling, and family friendly work environments.

Key areas of focus and priority for WACHS remain staff attraction and retention initiatives, promoting work-life balance and family friendly workplace initiatives. These include child care strategies, developing workforce innovation, increasing the recruitment of Indigenous health professionals, workforce re-engineering (for example, nurse practitioner roles), and transition planning for future workforce requirements. Strategies to assess workforce satisfaction and promote leadership and management skills also remain priorities.

Healthy hospitals, health services and infrastructure

During 2008-09 WACHS will continue its approved capital works program including:

- Busselton Integrated District Hospital;
- Hedland Regional Resource Centre; and
- Broome Regional Resource Centre and Mental Health Unit.

The WACHS will expand the Nurse Practitioner service model in country regions though continued recruitment strategies and extension to other clinical specialties including renal nursing.

The WACHS will enhance medical imaging capabilities in regional areas with the implementation of computed radiography in a further six sites, installation of a 16-slice computed tomography scanner at Kalgoorlie and new general x-ray equipment for three sites in the Kimberley.

The WACHS will establish an Ambulatory Care Framework for hospital in the home and post acute care at all regional centres and some peripheral sites across the health service. The framework will facilitate and increase utilisation of the services and improve demand management, including earlier discharging of country patients from metropolitan hospitals.

The WACHS, in partnership with the Commonwealth Government, will enhance Telehealth through the expansion of bandwidth to designated rural locations. Health services will also review and upgrade Local and Wide Area Networks, investigate and expand support equipment for videoconferencing and review cost benefits related to Telehealth enabled services.

The WACHS will implement a standardised medical emergency response procedure for all South West sites to improve the safety and quality of patient care across all sites.

WACHS – Mid West and Wheatbelt will implement home monitoring for mental health patients, and for aged-care patients in the WACHS - Mid West.

Diagnostic services for wound management will be extended across the WACHS.

Administration of the Patient Assisted Travel Scheme (PATS) will be improved through the establishment of dedicated PATS units in each region.

The WA Country Health Service will complete negotiations with the Royal Darwin Hospital and Northern Territory Health and commence transfer of some types of patient requiring higher levels of care from the Kimberley to Royal Darwin Hospital.

In partnership with the St John Ambulance Association, WACHS will support and evaluate the Rural Paramedic Support project in the Kimberley and the Pilbara. This project aims to support volunteer ambulance centres in the country that have trouble recruiting sufficient volunteers.

Priorities for 2008-09 (continued)

Healthy hospitals, health services and infrastructure (continued)

Area Health Services will continue to implement the Food and Nutrition Policy for WA Health's services and facilities to provide healthier food and drinks in all Western Australian health services by December 2008.

Dental Health Services are scheduled to complete construction of the Broome Dental Clinic by December 2008.

The WACHS will develop and implement transfer protocols between South West residential aged care facilities, Emergency Departments and the Aged Care Assessment Team (ACAT), to provide uninterrupted care for older clients.

The WoundsWest project will continue:

- a pilot wound prevalence survey;
- investigation of methods to audit implementation and effectiveness of evidence-based wound management;
- development and 'go live' of online satellite wound education modules 2-6;
- completion of the Indigenous wound management improvement initiative;
- recruitment and pilot of WoundsWest Consultant Team to provide a clinical support resource for health practitioners state-wide; and
- evaluation of a wound imaging and documentation system pilot and recommendations for statewide rollout.

The WACHS will develop a regional urological/continence key stakeholders network.

The WACHS will strengthen chronic disease management at a regional, district and community level by:

- developing base-training in chronic disease self management models in all country regions, with Master Trainer capacity identified;
- developing a chronic disease management framework including a chronic disease self-management program and service options in each region; and
- exploring new technologies and models of care for self-management and partnered care (case management) incorporating the Health Network pathways.

Healthy partnerships

The WACHS will implement the Health Promotion Strategic Framework 2007-2011. This will include implementing the Western Australia 'Healthy Schools' project in all regions, developing and supporting the Bicycle User Group in Geraldton, and the Walking School Bus program in the WAVHS – Mid West. WACHS - Wheatbelt will develop an Indigenous child safety flip chart.

Innovative alcohol abuse management strategies for country regions will be developed and introduced by the WACHS. These include local alcohol accords in some regions, training in responsible service of alcohol and development of an alcohol action plan in collaboration with the Drug and Alcohol Office.

Healthy communities

The WACHS will pilot a model in the Bunbury Regional Resource Centre to admit patients to regional and district hospitals for detoxification from alcohol and drugs. The WACHS will work in partnership with local community drug service teams and Indigenous services to ensure that patients have an appropriate plan for ongoing treatment.

The Goldfields Health Promotion Training package will be rolled out across the WACHS.

The introduction of Brief Intervention strategies to manage alcohol, tobacco and other drug issues, including screening, motivational interviewing and referrals into all health service sites across WACHS will be completed.

The WACHS will further support mental health promotion, including the 'Act Belong Commit' campaign by dedicating 0.5 full-time equivalent staff for the Pilbara, Goldfields, Mid West and Wheatbelt.

The 'Bright Start Parenting' program will be implemented in Geraldton and a retinal screening program will be introduced in the WACHS - Goldfields.

Access to population health information will be enhanced for country regions with the development of the WACHS Population Health Internet sites, and the further development and distribution of the WACHS Population Health newsletter

The WACHS will enhance screening programs targeting Indigenous health issues, including extending the trachoma screening program in endemic regions to include the Central Lands (Ngaanyatjarra Health Service) and trichiasis screening in endemic regions for Indigenous populations aged over 40 years. The WACHS will also maintain three regional sexually transmitted disease infection control teams targeting populations at risk, and establish an ear health program in Goldfields Indigenous communities to prevent middle ear infection.

An Aboriginal Healthy Lifestyle Coordinator will be appointed in the Goldfields region to support the development and implementation of community plans to address chronic disease issues.

Initiatives to address postnatal depression will continue through:

- implementation of the Indigenous Perinatal Mental Health Service expansion project in Carnarvon; and
- implementation of the Practical Support Service expansion project in a rural site at Australind/Eaton;

Visiting geriatric specialist services are to be expanded to all country regions to strengthen residential aged care services and skills.

A residential outreach service model is to be developed in the WACHS - South West to improve relationships with non-government residential aged care facilities and general practice. It is anticipated that improved relationships will build capacity, provide more timely care to clients and help avoid Emergency Department assessment and ambulance transfers.

A culturally appropriate satisfaction survey will be developed for Aboriginal and Torres Strait Islander residents in country hospitals and facilities. The aim is to identify needs and gaps to enhance care and communication.

Visiting geriatric specialist services will be expanded to the Great Southern, Goldfields and South West to strengthen residential aged care services and skills.

Healthy resources

Training and support will be provided to ACAT to continue the implementation of a framework promoting good practice across Western Australia.

During 2008-09 the Health Networks will work closely with Area Health Services and other WA Health Divisions to implement the models of care which will result in significant system-wide change over the next 5-10 years.

Healthy leadership

The WA Country Health Service will continue to promote the Institute for Healthy Leadership's various leadership and personal development programs with its staff, and provide opportunities and support for any interested staff who wish to apply for program participation.

WACHS will also continue to promote local and regional professional and personal development strategies implemented by the Area Health Service Coordinator for learning and development and by regional management structures.

Operations

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 2007-08 was $1,657,958.

Table 26: Advertising

Summary of Advertising	Amount ($)
Advertising Agencies	1,598,779
Market Research Organisations	Nil
Polling	Nil
Direct Mail Organisations	Nil
Media Advertising Organisations	59,179

Expenditure Category	Recipient / Organisation	Amount ($)	Total ($)
Advertising Agencies			
	900 Degrees Ltd	275	
	Albany Advertiser	5,553	
	Australian College of Emergency Care	387	
	Australian Nursing Solutions	6,600	
	Britel Enterprises	505	
	Clinical One Pty Ltd	29,700	
	Creston Investments Pty Ltd	689	
	Hays	4,411	
	IDJ Publications	325	
	Leejay (WA)	76	
	Marketforce Exrpess	439,136	
	Marketforce Productions	1,022,073	
	Marsh Agencies Pty Ltd	214	
	Medacs Healthcare	57,812	
	Media Decisions	515	
	Newman Mail	3,750	
	Nursing Post Pty Ltd	6,731	
	Pelican Graphics	235	
	Pindan Printing	110	
	Port Hedland Chamber of Commerce and Industry	6,284	
	RANZOG	227	
	Red Wave Media	189	
	Rural Press Regional Media (WA) Pty Ltd	709	
	Sabah H Creations	438	
	Seabreeze Communications	5,317	
	Seton Australia	5,560	
	Strang Signs	47	
	Total Publishing	545	
	WACHS Advertising	366	**1,598,779**

Market Research Organisations			
			Nil
Polling Organisations			
			Nil
Direct Mail Organisations			
			Nil
Media Advertising Organisations			
	Albany Advertiser	6,828	
	Albany Chamber of Commerce and Industry	1,058	
	Australian Business Pages Directory	643	
	Benchmark Publishing	484	
	BK Signs	457	
	Boddington Community Newsletter	35	
	Caama Radio	770	
	Cancer Council WA	103	
	Chittering Times	513	
	Countrywide Media Pty Ltd	3,036	
	Craytales Magazine	90	
	Crime and Community Watch	692	
	Cunderdin Telecentre	44	
	Denmark Bulletin	220	
	Dowerin Telecentre	53	
	Elite Publishing Pty Ltd	595	
	Endeavour Newspaper Inc	22	
	Fence Post	90	
	Fridge Magnet Factory	1,994	
	Geraldton Newspapers Ltd	1,976	
	Gimlet Newspaper	16	
	Gnowangerup Telecentre	79	
	Gogo Media	768	
	Grand Publishing Pty Ltd	545	
	Great Southern Herald	1,238	
	Jurien Bay Telecentre	140	
	Kimberley Echo	1,859	
	Kojonup Community Newspaper	40	
	Kojonup Newsagency	82	
	Lake Grace Telecentre	280	
	Lions Club Lake Grace	50	
	Marie Stopes Australia	1,053	
	Market Creations	1,379	
	Marsh Agencies	295	
	Media Decisions WA	1,033	
	Midwest Times	280	
	Mingenew Lions	975	
	Morawa Telecentre	195	

Advertising (continued)

Expenditure Category	Recipient / Organisation	Amount ($)	Total ($)
Media Advertising Organisations (continued)			
	Muka Matters Inc	32	
	The National Emergency Relief Guide	426	
	National Fire Fighter News	396	
	Northampton Community News	10	
	Northern Guardian	1,733	
	Not Only Signs	135	
	The Nursing Post	2,276	
	Nyabing News	37	
	Pingelly Times	68	
	Radiowest Broadcasters Pty Ltd	2,510	
	Red Wave Media	4,554	
	Rural Press Regional Media (WA) Pty Ltd	3,954	
	Safe Healthy Community Review	495	
	Safety House Association	315	
	Safety Lines	418	
	Seabreeze Communications Pty Ltd	2,975	
	Seek Limited	369	
	Sensis Pty Ltd	578	
	Shire of Trayning	17	
	South West Printing & Publishing Company Ltd	804	
	Telecentre Network - Bruce Rock	66	
	Telecentre Network - Dalwallinu	850	
	Underprivileged Children's Guide	424	
	Volunteer Organisations Guide	438	
	Volunteer Rescue Magazine	385	
	Weekender	2,316	
	The West Australian	191	
	Wiltshire Publishers Pty Ltd	549	
	Wongan Hills Telecentre	110	
	Workplace Health and Safety Journal	495	
	Wyalkatchem Weekly	100	
	Yamaji News	972	
	York & Districts Community Matters	66	
	York Telecentre	105	**59,179**

Corruption Prevention

Government agencies are required to specifically consider the risk of corruption and misconduct by staff, and to report on risk reduction strategies in place within the agency. Within WA Health, the existence of an effective accountability mechanism is fundamental to good corporate governance.

This year WA Health carried out a total of 337 investigations of alleged misconduct.

Strategies have been introduced across WA Health in 2007-08 to assist the prevention of corruption and include:

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

WA Country Health Service

The achievement of best practice in the management of risk and preventing corruption and the promotion of employee responsibility for identifying, minimising and preventing risk and corruption remains a priority for WACHS.

During 2007-08 WACHS has consolidated its efforts in this work with the creation and appointment of a senior management position, Manager Governance and Strategic Support. This position has been established to oversee corruption control initiatives and to manage the investigation of incidents of corruption and misconduct. The position is also responsible for the development and delivery of training programs to educate staff about key governance issues.

WACHS has also maintained its corruption prevention processes to comply with the relevant 'Risk Management and Security' Treasury Instructions, the directions provided by the Government on "Fraud Prevention in the Western Australian Public Sector", and the relevant legislation, and authority delegation schedules, accounting standards, and Australian Council on Healthcare Standards accreditation requirements.

WACHS staff have participated in corruption prevention training programs and briefing sessions offered by the CCC and the Department's Corporate Governance Unit. Staff are regularly reminded of the responsibilities under the Codes of Conduct and Ethics, their duty to act ethically, and must acknowledge the relevant codes and procedures governing employee behaviour especially regarding the policies on the acceptable use of computers and the Internet. WACHS maintains thorough records of alleged misconduct to identify particular risk areas and develop prevention strategies.

Disability Access and Inclusion Plan

The *Disabilities Services Act 1993, (*amended 2004), ensures that people with disabilities have the same opportunities as other West Australians, and the WA Country Health Service is committed to providing all people with access to facilities and services.

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

The WA Country Health Service (WACHS) established its Disability Access and Inclusion Planning Committee in February 2006 comprising of regional and corporate office representatives to oversee the 2006-2009 WACHS wide DAIP. This DAIP is complimented by plans developed and implemented at the regional level.

Outcome 1:

People with disabilities have the same opportunities as other people to access the services of, and events organised by, the relevant public authority. In 2007-08:

- The WACHS Site Audit Tool for Sites, Facilities and Processes has been developed for assessing WACHS non-residential facilities to ensure appropriate access for people with a disability and compliance with the relevant Australian Standards and Guidelines;
- The WA Country Health Service ensures contractual documentation stipulates that external service providers must observe and apply the DOH (where appropriate) and WACHS DAIP requirements for ensuring services are accessible to all community members;
- The Disability Services Commission Accessible Events Checklist is incorporated into WACHS event organising guidelines and appropriate venues are selected to permit access for people with a disability;
- All WACHS regions provide annual resource allocations for service and facility improvements to improve access for people with a disability including improved parking, lighting, facility access and seating at health care facilities. For example during 2007-08, facilities at Mt Barker, Cranbrook, Fitzroy Crossing, Derby, Albany, Kununoppin and Katanning had improvements carried out;
- The Albany Hospital has undertaken a Disability Access Audit and will progress identified gaps in 2008-09; and
- WACHS regions have implemented a number of initiatives aimed at improving service access for people with a disability and informing the community of these initiatives. A particular example in 2007-08 is demonstrated in the Wheatbelt where health services now display Disability Services Commission DAIP posters, ensure staff have access to WACHS -Wheatbelt DAIP brochures in either hardcopy or via the WA Health intranet, have kept the region's District Health Advisory Councils and Local Health Advisory Groups advised regarding the DAIP, made available to employees the DAIP DVD "You Can Make a Difference to Customer Relations for People with Disabilities" via the WA Health intranet and has ensured the dissemination of information regarding alternative formats for health publications and documents.

Outcome 2:

People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority. In 2007-08:

- All new and existing health facilities being modified for WACHS must comply with Australian Standards and Guidelines for access for people with disabilities and the Area Health Service ensures building and modification contracts specify compliance with WACHS and DOH DAIP;
- Facility audits in WACHS – Mid West are underway with progress reports submitted to Regional Executive Committee. Audits teams include occupational therapists, facilities management or representative, and where possible, consumers with a disability; and
- WACHS regions have implemented regional DAIP committees to provide advice on aspects of access for people with a disability. Members often include WACHS management, occupational therapy and social work staff, and representatives of the Disability Services Commission and consumers, including 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 are able to access it. In 2007-08:

- WACHS ensures that Internet and Intranet publications, and printed materials to appropriate for people with a disability;
- The Midwest Aged and Community Care Directorate networks with disability agencies to promote services and work collaboratively to provide support to consumers and carers. This is further enhanced through combined activities promoting services and providing information to key target groups, for example, the 'CAN DO' Expo held in Geraldton in May 2008, but accessible by the whole region;
- All WACHS health service and health promotion information is regularly reviewed to ensure that appropriate written style and presentation is used and that materials are adapted to make them suitable for all client groups, including appropriate presentations for Aboriginal community members. Wherever possible, alternative formats for hearing and sight impaired persons are available and their availability is advertised in health service facilities. A particular example is the use of the Better Hearing kits that ensure first line client contact is appropriate and respectful; and
- WACHS employs Aboriginal health workers, for example in the Kimberley Aged and Community Service, who have skills and local knowledge that facilitate health and disability access information sharing in an appropriate manner. This includes, where necessary, translation skills.

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. In 2007-08:

- WACHS induction training includes information regarding the WACHS DAIP and issues relating to access to services for people with a disability. When appropriate, regular in-service education includes updates on the DAIP and access issues, and training organisers involve local DSC officers in education programs. Where a health service consumer with a disability needs access to services, staff can access information that will help them address the client's needs;
- Position selection criteria require applicants demonstrate awareness of current disability issues; and
- The Midwest Aged and Community Care Directorate, networking with disability agencies, promotes services and works collaboratively to provide support to people with disabilities and their carers. This collaboration has resulted in the development of the Carer Registry Project "FACES" a web-based system to link people with a disability with a carer to provide support and assistance.

Outcome 5:

People with disabilities have the same opportunities as other people to make complaints to the relevant public authority. In 2007-08:

- A complaints poster has been produced for all health service consumers. Information is available in appropriate formats for people with a disability;
- All disability access and inclusion related complaints reported in WACHS regions are brought to the attention of regional disability access and inclusion committees;
- Regional complaints processes are constantly reviewed and updated to ensure consistent standards for addressing consumer concerns;
- A Consumer Liaison Officer at Geraldton Hospital has been appointed to assist with prompt resolution of complaints;
- Complaints are accepted either in written or verbal form, or via disability advocates. Every endeavour is made for complaints to be fully investigated and responded to within 30 days;
- Information on Advocare is made available at WACHS health service sites allowing concerns to be reported to an external body if required. During the year Advocare staff may visit country communities to inform people in the hospital and broader community of advocacy services provided by the organisation;
- During client assessments and care planning, Kimberley Aged and Community Services staff always provide information to clients about their rights and responsibilities. This includes information about making a complaint and who can receive a complaint; and
- WACHS distributed information about DSC Local Area Coordinators who provide advocacy for people with disabilities to give feedback to health services.

Outcome 6:

People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority. In 2007-08:

- Advertisements were placed in the local media including the Disability Services Newsletter, seeking expressions of interest for community representatives to join the WACHS Disability Access and Inclusion committees, and District and Local Health Advisory Groups, whenever necessary;
- The "Think Respite" forum held in May 2008 in Geraldton provided an opportunity to consult with consumers, carers and service providers from WACHS - Mid West. The forum included representatives from the Disability Services sector, people with a disability and their carers;

Disability Access and Inclusion Plan (continued)

- WACHS Health Advisory Committees utilise appropriate disability services resources to advise and inform health services regarding issues relevant to people with a disability and their access to services; and
- WACHS makes particular effort to ensure that in the process of any community consultations, every assistance is provided to enable people with a disability and their carers to contribute should they wish.

Employee Profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. The table below shows the average number of full-time equivalent staff employed by WACHS year-to-date June 2008 by category.

Table 27: Total FTE by Category

Category	Definition	2006-07 FTE	2007-08 FTE
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	1,048	1,115
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	21	28
Agency nursing	Includes nurses engaged on a "contract for service" basis.	80	115
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	n/a	0
Dental nursing	Includes dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,234	1,264
Medical	Includes salary and sessional based medical occupations.	179	189
Medical support	Includes all Allied Health and scientific/technical related occupations.	554	583
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,310	2,372
Site services	Includes engineering, garden and security-based occupations.	178	175
Other categories	Includes Aboriginal and ethnic health worker related occupations.	75	85
Total		**5,679**	**5,926**

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

Freedom of Information

For the year ending 30 June 2008, the WA Country Health Service received 1,866 formal applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 28: Freedom of information applications 2007-08

Applications	Number
Carried over from 2006-07	74
Received in 2007-08	1,792
Total applications received in 2007-08	1,866
Granted: full access	1,726
Granted: partial or edited access	18
Withdrawn	21
Refused	34
In progress	33
Transferred and other	34

The types of documents held by the WA Country Health Service include:

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

Industrial Relations

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

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

WA Country Health Service

The WA Country Health Service ensures its industrial relations policies and practices comply with all relevant State and Commonwealth industrial relations legislation, awards, and industrial and certified employment agreements. The Area Health Service has adopted proactive cooperation and consultation processes with its employees and any relevant representative industrial body.

The WACHS experienced no significant industrial disputation during 2007-08.

Sustainability

Please see the Department of Health Annual Report 2007-08.

Substantive Equality

Please see the Department of Health Annual Report 2007-08.

Internal Audit Controls

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

Department of Health

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

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

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

Please see the Department of Health 2007-08 Annual Report for the full list of audits.

WA Country Health Service

The WACHS has adopted sound procedures and internal controls designed to provide reasonable assurance in regard to achieving the Area Health Service's objectives, in particular those related to:

- effectiveness and efficiency of operations;
- reliability of financial and operations reporting;
- compliance with applicable legal requirements and community expectations;
- stewardship of public resources; and
- minimisation of exposure to adverse events.

To enhance corporate governance within the Area Health Service, the WACHS Audit Committee has recognised the need for formal processes to be implemented to ensure that administrative functions performed by all departments are being properly controlled. To this end the WACHS Operational Plan includes a performance measure that states 100% of all 'Extreme' and 'High' risk rated Internal Audit Committee recommendations are implemented within the agreed timeframe.

Major Capital Works

Please refer to the 2007-08 Department of Health Annual Report for financial details of major capital works in the WA Country Health Service.

Capital works projects completed in the WACHS during 2007-08	Capital works projects in progress in the WACHS during 2007-08
▪ Bunbury Replacement Dental Clinic	▪ Albany Regional Resource Centre Redevelopment Stage 1
▪ Carnarvon Integrated District Health Service Redevelopment stage 1	▪ Broome Regional Resource Centre Redevelopment Stage 1
▪ Kununurra Integrated District Health Service Development	▪ Busselton Integrated District Health Service Replacement
▪ Morawa and Perenjori Multi Purpose Centre Replacement	▪ Carnarvon Sobering Up Centre
▪ South West Health Campus Inpatient Mental Health Unit Expansion	▪ Country Staff Accommodation - Stage 3
▪ South West Health Campus New Mental Health Clinic	▪ Denmark Multi Purpose Centre Replacement
	▪ Harvey Hospital Redevelopment
	▪ Hedland Regional Resource Centre Replacement Stage 2
	▪ Kimberley - Various Health Project Developments
	▪ South West Health Campus Intensive Care Unit
	▪ South West Health Campus New Radiotherapy Facility
	▪ Wyndham Multi Purpose Centre Development

Pricing Policy

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

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

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

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

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

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

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

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

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

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

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

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

Recordkeeping

As part of WA Health, the WA Country Health Service is included by the Department of Health's approved Record Keeping Plan.

During the year an internal audit review was conducted identifying a number of opportunities for improvement in record keeping practices. These particularly related to the development of specialised records management expertise within the WA Country Health Service, and design and delivery of a training program to improve understanding, and adherence to record keeping policies.

A senior position of Records Project Manager is currently being established. This position will have specific responsibility for reviewing records management policy, systems and practices within WACHS. A key component of this role will be development and delivery of training for staff involved in records creation and handling

Recruitment

All WA Country Health Service recruitment and selection processes are undertaken in accordance with the criteria set down in the "Public Sector Standards in Human Resource Management".

WA Country Health Service 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 to ensure government and departmental guidelines are followed.

Policies are available at all WACHS sites and are accessible via the WACHS Intranet site. Positions are offered for permanent and contract appointment, and where appropriate, via temporary placement on expressions of interest.

The Health Corporate Network coordinates the recruitment process on behalf of the WACHS. Vacancies are advertised in both print and electronic media. Recruitment campaigns have been conducted in local and national newspapers and on radio. Recruitment has been undertaken internationally, especially for medical officers and nursing staff, at career expos, via promotions in educational institution handbooks, and through participation in graduate recruitment programs.

Training to ensure potential selection panel convenors and members have the necessary selection skills and an understanding of Public Sector Standards is provided regularly and selection panels must have at least one member who has attended the appropriate training.

WACHS has also provided educational sessions to staff on Job Application Skills, addressing Selection Criteria and Curriculum Vitae creation and has these resources available to staff via the Learning and Development Website.

Recruitment initiatives

The recruitment of clinical staff continued to be the focus of WACHS recruitment initiatives in 2007-08.

WACHS continues to enhance its attraction and retention packages especially in the area of accommodation to improve the success of their recruitment drives. A number of accommodation acquisitions were undertaken during the year.

WACHS has effectively used the regional rotation and migration programs such as the 'Crocs to Rocks', 'Ocean to Outback' and the "Nursing Careers with Adventure" programs as well as temporary overseas sponsorship programs to augment staff recruitment.

During 2007-08 WACHS also increased the number of graduate nurses across the Area Health Service.

2007-08 also saw the establishment of the whole of WACHS Clinical Workforce Unit which focuses on strengthening the clinical workforce through developing consistent and coordinated approaches to clinical recruitment and organisational development opportunities with the aim of making positioning WACHS as a "workplace of career of choice".

Staff Development

A high quality, skilful and adaptable workforce is vital if the WA Country Health Service is to deliver the required health services to country WA, and if the organisation is to achieve its strategic objectives. WACHS is committed to maintaining an environment that encourages staff to seek opportunities for personal and professional growth and development.

During 2007-08 particular initiatives have been implemented across WACHS.

The appointment of a coordinator for Learning and Development to further the opportunities for training and education for WACHS has resulted in the implementation of a number of innovative training strategies during 2007-08. These include extensive development of e-learning materials; cost effective, state-wide licenses for on line training resources; and partnership arrangements for specialists to travel and train in rural sites. This new "travelling trainer" strategy has seen the use of contracts with eight subject matter experts willing to deliver their expert training to staff at 20 or more rural sites. This has expanded equity of access to training, whilst also reducing staff travel costs.

The Regional Learning and Development Network which comprised mostly nurse educators who provide local coaching and professional support to rural nursing staff, was further extended this year to include specialist trainers in Manual Handling and Management of Aggression. These trainers were able to meet together, to enhance their own skills and discuss educational best practice in their special field.

Employees are now better able to access training and development to meet service competency requirements, career development objectives, and strategic and operational goals with the introduction of the e-learning strategy and investment in information technology for all regional Learning and Development teams. Training in vital computer applications such as Rostar, Hcare and Oracle is now possible at very small sites, and the cost of competency assessment is now reduced, with the knowledge components graded on-line before skills assessments are undertaken.

In order to support retention of the workforce, WACHS has focused on leadership development by instigating a comprehensive program of Diploma level workshops in five management competencies. Each workshop has been delivered to emerging and existing leaders at several sites in every region – reducing travel costs and greatly extending access to career development opportunities. This program also provides access to formal academic qualifications for those staff who previously or currently participate in the "*Leading 100*" programs. Executive development has also been targeted this year with briefings to executive teams visiting Perth, and a management refresher program for Medical Directors.

Ongoing investment in training scholarships has seen 120 rural clinicians attend Advanced Life Support in Obstetrics (ALSO) training in Perth, in addition to innovative training for Enrolled Nurses via Internet from Curtin University. A major investment in simulation equipment has established the environment for complex multidisciplinary clinical team training to occur in regional sites. This has been impossible to source in the past, being both cost-prohibitive and with specialists unavailable to travel. The new training environment will increase skills and confidence of rural staff to deal with complex, but infrequent, clinical incidents.

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.

WACHS continues to develop telehealth video conferencing for staff development and training programs whilst extending its Intranet site to provide access to on-line training resources.

WACHS provides mandatory staff induction through regional orientation programs, which have been redesigned this year to increase core skills training and assessment while providing local information packages for new employees on such topics as remote area travel, local services and tropical weather conditions.

Staff Development (continued)

Mandatory induction programs include topics such as:

- fire and emergency procedures;
- occupational safety and health;
- infection control;
- risk management;
- Public Sector Standards and Codes of Ethics and Conduct;
- manual handling;
- workplace behaviour and bullying; and
- information technology familiarisation and Telehealth.

Established training opportunities also continued in 2007-08 and included workshops on over 100 subjects including:

- Advanced life support;
- Aged care;
- Burn emergency care;
- Certificate III in aged care;
- Change management;
- Chemical, biological and radiological management;
- Conflict and negotiation;
- Dementia care;
- Diabetes management;
- Driver safety;
- First aid and emergency medical training;
- Governance – corporate and clinical;
- Leadership and management;
- Management of aggression;
- Mental health;
- OSH for managers;
- Paediatrics – assessment and life support;
- Performance management;
- Post-natal depression;
- Preceptor training;
- Remote area nursing;
- Safety and quality;
- Safety representatives;
- Team building;
- Transfusion management;
- Triage practice; and
- Training and education for a range of clinical disciplines.

The extension of access to training and development opportunities is reflected in staff satisfaction, workforce retention, and the achievement of health care objectives.

Workers' Compensation and Rehabilitation

The WA Country Health Service is committed to providing its staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services.

Occupational safety and health initiatives

The Safety Management System adopted by WACHS is based on the Western Australian 'WorkSafe Plan' and "Occupational Safety and Health Act 1984". This system promotes all aspects of Occupational Safety and Health (OSH) in the day-to-day practices of all WACHS staff.

WACHS maintains a continuous process to develop its OSH policies and strategies, quality assurance and risk monitoring programs including its reporting programs, and ensures consistent approaches to OSH and employee rehabilitation throughout the Area Health Service.

The main elements of the Safety Management System are:

- the recognition of management responsibility for OSH duty of care;
- the integration of OSH requirements and responsibilities across the organisation;
- adopting standard hazard management practises and procedures including hazard assessment throughout the workplace;
- providing mechanisms for staff to raise OSH issues through OSH elected representatives and site/regional safety committees; and
- providing compulsory training identified by risk assessments for all staff, especially safety officers and senior management.

WACHS designated OSH managers and staff form the Area Health Service's OSH Reference Group. This group provides regular performance data on OSH and injury management to regional and Corporate Office executives. Regional OSH coordinators are responsible for informing management on workplace occupational safety and health matters, and for OSH audits. Coordinators provide advice on specific training initiatives for WACHS staff. Specific training areas relevant to WACHS include off-road driving and general vehicle maintenance courses applicable to conditions in remote areas and providing instructions on preparing for cyclones.

Occupational injury prevention and rehabilitation

WACHS provides timely and effective intervention for WACHS employees who have injured themselves at work, or those employees who have injuries that may affect their ability to undertake their duties. WACHS ensures injured employees receive their entitlements and can access 'best practice' injury management interventions and rehabilitation programs. These include structured 'return to work' programs. Programs are developed in conjunction with the employee, medical advice, their immediate work supervisor and the OSH coordinator.

Both internal and external rehabilitation providers are used by WACHS and all staff involved in rehabilitation programs undertake injury management training and appropriate instruction regarding their responsibilities to their staff. The WACHS uses OSH databases and hazard registers that provide incident information, pro-active hazard reporting and investigation. "Root Cause Analysis" methodology for investigating clinical incidents has been adopted to ensure comprehensive investigation of occupational injuries.

This table provides information on the number of worker's compensation claims made during 2007-08 within the WA Country Health Service.

Table 29: Workers' compensation claims

Employee category	Claims
Nursing Services/Dental Care Assistants	103
Administration and Clerical	25
Medical Support	22
Hotel Services	127
Maintenance	26
Medical (salaried)	3
Total	**306**

Notes:
1. "Administration and clerical" includes administration staff and executives, ward clerks, receptionists and clerical staff.
2. "Medical support" includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.
3. "Hotel services" includes cleaners, caterers and patient service assistants.

Occupational Safety & Health and Injury Management Performance

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

All areas of WA Health comply with or exceed OSH legal requirements, and are continuously developing and implementing safe systems and work practices that reflect commitment to safety and health.

The WA Country Health Service is committed to assisting injured workers to return to work as soon as medically appropriate and will adhere to the requirements of the *Workers Compensation and Injury Management Act 1981* in the event of a work related injury or illness.

WACHS has a documented Injury Management System in place which meets the requirements of the *Worker's Compensation and Injury Management Act* 1981**.** The supporting policy and procedure are available to all employees on-line or from their line manager and details are provided to employees during WACHS Orientation training.

The WACHS Injury Management System is implemented through:

- Workers compensation staff in each region who ensure that injured employees receive their entitlements and injury management intervention; and
- area injury management coordinators who coordinate the return to work programs for those employees with workplace and non-work related injuries.

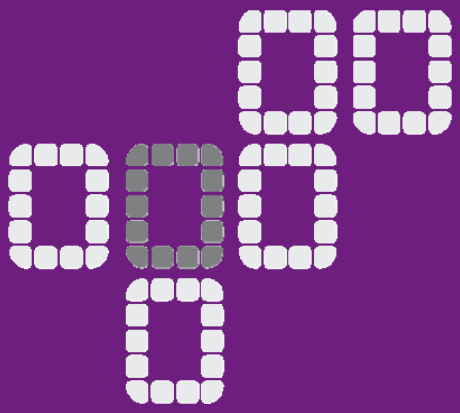
Where appropriate, WACHS will engage appropriately qualified and WorkCover accredited rehabilitation providers to assist in the process of facilitating employees who are injured at work to return to gainful employment.

An appointed accredited rehabilitation provider will liaise with all involved parties to establish and monitor an injury management program as soon as practicable in consultation with the treating doctor, supervisory staff and the injured employee to match capabilities with available duties.

WACHS has established Occupational Safety and Health Committees in each region as part of a formal consultative process. The membership is stipulated in an agreed terms of reference and is consistent with the *Occupational Safety and Health Act 1984***.** Supporting policies and procedures exist to further support the WACHS Safety Management System, including a formal OSH issue resolution procedure.

Table 30: Occupational safety and health and injury management performance

Fatalities	Lost time injury/disease incidence rate	Lost time injury/disease incidence rate
0	2.42	14.57



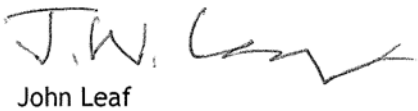
Financial Statements

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2008

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2008 and the financial position as at 30 June 2008.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.



John Leaf
Chief Finance Officer
WA Country Health Service

Date: 17 September 2008

Dr Peter Flett
Accountable Authority
WA Country Health Service

Date: 17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

Audit Opinion (continued)

WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion

In my opinion,

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

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

(iii) the key performance indicators of the 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 2008.

GLEN CLARKE
ACTING AUDITOR GENERAL
23 September 2008

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Financial Statements

WA Country Health Service

Income Statement

For the year ended 30th June 2008

	Note	2008 $000	2007 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	475,152	418,275
Fees for visiting medical practitioners		47,190	44,087
Patient support costs	8	101,281	95,445
Finance costs	9	1,705	1,757
Depreciation and amortisation expense	10	27,120	26,667
Asset impairment losses		-	374
Capital user charge	11	-	52,625
Loss on disposal of non-current assets	12	331	-
Repairs, maintenance and consumable equipment		23,403	21,757
Other expenses	13	70,143	61,297
Total cost of services		**746,325**	**722,284**
INCOME			
Revenue			
Patient charges	14	28,628	25,111
Commonwealth grants and contributions	15	15,912	15,396
Other grants and contributions	15	7,068	7,434
Donations revenue	16	963	1,072
Interest revenue		143	129
Other revenues	17	16,952	15,321
Total revenue		69,666	64,463
Total income other than income from State Government		**69,666**	**64,463**
NET COST OF SERVICES		**676,659**	**657,821**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	679,068	660,595
Assets assumed / (transferred)	19	(3,521)	20
Liabilities assumed by the Treasurer	20	817	854
Total income from State Government		**676,364**	**661,469**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(295)**	**3,648**

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 2008

	Note	2008	2007
ASSETS		**$000**	**$000**
Current Assets			
Cash and cash equivalents	21	21,279	17,885
Restricted cash and cash equivalents	22	560	442
Receivables	23	13,255	13,343
Amounts receivable for services	24	-	8,386
Inventories	25	3,518	3,581
Other current assets	26	1,865	844
Total Current Assets		40,477	44,481
Non-Current Assets			
Amounts receivable for services	24	135,285	87,945
Property, plant and equipment	27	877,818	781,269
Intangible assets	29	74	96
Other financial assets	30	6	6
Total Non-Current Assets		1,013,183	869,316
Total Assets		**1,053,660**	**913,797**
LIABILITIES			
Current Liabilities			
Payables	31	54,227	40,540
Borrowings	32	1,603	1,547
Provisions	33	66,430	60,298
Other current liabilities	34	139	485
Total Current Liabilities		122,399	102,870
Non-Current Liabilities			
Borrowings	32	24,934	26,537
Provisions	33	12,841	12,186
Total Non-Current Liabilities		37,775	38,723
Total Liabilities		**160,174**	**141,593**
NET ASSETS		**893,486**	**772,204**
EQUITY			
Contributed equity	35	850,583	781,023
Reserves	36	52,017	-
Accumulated surplus/(deficiency)	37	(9,114)	(8,819)
TOTAL EQUITY		**893,486**	**772,204**

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 2008

	Note	2008 $000	2007 $000
Balance of equity at start of period		772,204	-
CONTRIBUTED EQUITY	35		
Balance at start of period		781,023	-
Capital contribution		69,560	58,904
Other contributions by owners		-	722,119
Balance at end of period		**850,583**	**781,023**
RESERVES	36		
Asset Revaluation Reserve			
Balance at start of period		-	-
Gains/(losses) from asset revaluation		52,017	-
Balance at end of period		**52,017**	**-**
ACCUMULATED SURPLUS	37		
Balance at start of period		(8,819)	-
Change in accounting policy		-	(12,467)
Restated balance at start of period		(8,819)	(12,467)
Surplus/(deficit) for the period		(295)	3,648
Balance at end of period		**(9,114)**	**(8,819)**
Balance of equity at end of period		**893,486**	**772,204**
Total income and expense for the period (a)		51,722	3,648

(a) The aggregate net amount attributable to each category of equity is: deficit $295,000 plus gains from asset revaluation $52,017,000 (2007: surplus $3,648,000).

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 2008

	Note	2008 $000 Inflows (Outflows)	2007 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		636,826	573,832
Capital contributions		56,774	50,417
Holding account drawdowns		1,569	-
Net cash provided by State Government	38(c)	695,169	624,249
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(229,460)	(218,235)
Employee benefits		(467,508)	(413,561)
Finance costs		-	(12)
GST payments on purchases		(28,493)	(23,460)
Other payments		935	-
Receipts			
Receipts from customers		28,148	23,897
Commonwealth grants and contributions		15,912	15,396
Other grants and subsidies		6,569	6,391
Donations		963	895
Interest received		144	129
GST receipts on sales		2,529	2,520
GST refunds from taxation authority		24,933	18,388
Other receipts		17,730	14,110
Net cash (used in) / provided by operating activities	38(b)	(627,599)	(573,542)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets		(64,799)	(51,180)
Proceeds from sale of non-current physical assets	12	740	-
Net cash (used in) / provided by investing activities		(64,058)	(51,180)
Net increase / (decrease) in cash and cash equivalents		3,511	(473)
Cash and cash equivalents at the beginning of period		18,327	18,800
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	38(a)	21,838	18,327

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

Note 1 Australian equivalents to International Financial Reporting Standards

General

The Health Service's financial statements for the year ended 30 June 2008 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the Health Service has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the Australian Accounting Standards Board (AASB) and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the Health Service for the annual reporting period ended 30 June 2008.

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 Management Act and the Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over the Accounting Standards, the Framework, 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 and all values are 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 balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 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 Treasurer's Instruction (TI) 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed Equity.

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. (See note 35 'Contributed Equity')

(d) Income

Revenue recognition

Revenue is measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership control transfer to the purchaser and can be measured reliably.

Rendering of services
Revenue is recognised on delivery of the service to the client.

(d) Income (continued)

Interest
Revenue is recognised as the interest accrues. The effective interest method, which is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset, is used where applicable.

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 appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at Treasury (See note 18 '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 balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains

Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(e) Borrowing Costs

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

(f) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Income Statement (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
All items of property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal 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-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market buying values determined by reference to recent market transactions.

Where market-based evidence is not available, the fair value of land and buildings (clinical sites) 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, ie. the depreciated replacement cost.

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

Independent valuations of land and buildings are provided annually by the Western Australian Land Information Authority (Valuation Services) and recognised with sufficient regularity to ensure that the carrying amount does not differ materially from the asset's fair value at the balance sheet date.

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated useful life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

Refer to note 27 'Property, plant and equipment' for further information on revaluations.

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

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.

(f) Property, Plant and Equipment (continued)

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	4 to 7 years
Furniture and fittings	10 to 15 years
Motor vehicles	4 to 10 years
Medical equipment	5 to 25 years
Other plant and equipment	5 to 25 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.

(g) Intangible Assets

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

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

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life) on the diminishing value 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.

(h) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at each balance sheet date. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. As the 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, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at each balance sheet date irrespective of whether there is any indication of impairment.

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

(i) Non-current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

(j) 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 apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(k) Financial Instruments

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

These have been disaggregated into the following classes:

Financial Assets
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services

Financial Liabilities
* Payables
* WATC borrowings
* Other borrowings

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

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

(l) Cash and Cash Equivalents

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

(m) Accrued Salaries

Accrued salaries (refer note 31) represent the amount due to employees 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 its net fair value.

(n) 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 18 'Service appropriations' and note 24 'Amounts receivable for services'.

(o) 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 25 ' Inventories')

(p) Receivables

Receivables are recognised and carried at original invoice amount less an allowance for any 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(k) 'Financial instruments' and note 23 'Receivables')

(q) 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(k) 'Financial instruments and note 31 'Payables'.

(r) 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(k) 'Financial instruments' and note 32 'Borrowings')

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at each balance sheet date. See note 33 'Provisions'.

(s) Provisions (continued)

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 balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet 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.

Deferred Leave
The provision for deferred leave relates to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. In the fifth year they will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the balance sheet date and includes related on-costs. Deferred leave is reported as a non-current provision until the fifth year.

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 commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The Health Service makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

The GESB makes all benefit payments in respect of the Pension and GSS Schemes, and is recouped by the Treasurer for the employer's share .

(See also note 2(t) 'Superannuation Expense')

Gratuities
The Health Service is obliged to pay the medical practitioners and nurses for gratuities under their respective industrial agreements. 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 balance sheet 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 balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

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 oncosts 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 13 'Other expenses' and note 33 '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 (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS 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 20 'Liabilities assumed by the Treasurer')

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided in the current year.

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

(u) Resources Received Free of Charge or for Nominal Cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(v) Comparative Figures

Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

(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 49).

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 and aboriginal communities 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.

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 balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year 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

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 10.6%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2007 that impacted on the Health Service:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments and while there is no financial impact, the changes have resulted in increased disclosures, both quantitative and qualitative, of the Health Service's exposure to risks, including enhanced disclosure regarding components of the Health Service's financial position and performance, and changes to the way of presenting certain items in the notes to the financial statements.

The following Australian Accounting Standards and Interpretations are not applicable to the Health Service as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretations	
101	'Presentation of Financial Statements' (relating to the changes made to the Standard issued in October 2006)
2005-10	'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'
2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11 [AASB 2]'
2007-4	'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. The amendments arise as a result of the AASB decision to make available all options that currently exist under IFRSs and that certain additional Australian disclosures should be eliminated. The Treasurer's instructions have been amended to maintain the existing practice when the Standard was first applied and as a consequence there is no financial impact.
2007-5	'Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102]'
2007-7	'Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'
ERR	Erratum 'Proportionate Consolidation [AASB 101, AASB 107, AASB 121, AASB 127, Interpretation 113]'
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'
Interpretation 1003	'Australian Petroleum Resource Rent Tax'

Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets. The change in asset capitalisation policy does not apply to land and buildings.

Retrospective application of the change in accounting policy has resulted in assets below the $5,000 threshold amounting to $12,467,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The amounts of adjustments for each of the financial periods prior to 2006-07 have not been disclosed, as it is impracticable to trace back acquisitions, disposals, depreciation and amortisation of these assets.

The comparatives for property, plant and equipment, depreciation and amortisation expense, loss on disposal of non-current assets, and repairs, maintenance and consumable equipment expense have been restated to disclose the effect of the policy change (See note 39 'Voluntary changes in accounting policy').

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the Health Service has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued and which may impact the Health Service but are not yet effective. Where applicable, the Health Service plans to apply these Standards and Interpretations from their application date:

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

Title	Operative for reporting periods beginning on/after
AASB 101 'Presentation of Financial Statements' (September 2007). This Standard has been revised and will change the structure of the financial statements. These changes will require that owner changes in equity are presented separately from non-owner changes in equity. The Health Service does not expect any financial impact when the Standard is first applied.	1 January 2009
Review of AAS 27 'Financial Reporting by Local Governments', 29 'Financial Reporting by Government Departments' and 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:	
AASB 1004 'Contributions' (December 2007).	1 July 2008
AASB 1050 'Administered Items' (December 2007).	1 July 2008
AASB 1051 'Land Under Roads' (December 2007).	1 July 2008
AASB 1052 'Disaggregated Disclosures' (December 2007).	1 July 2008
AASB 2007-9 'Amendments to Australian Accounting Standards arising from the review of AASs 27, 29 and 31 [AASB 3, AASB 5, AASB 8, AASB 101, AASB 114, AASB 116, AASB 127 & AASB 137] (December 2007).	1 July 2008
Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities (revised) (December 2007).	1 July 2008
The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and existing topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 only apply to government departments. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance (for example, Australian Guidance to AASB 116 'Property, Plant and Equipment' in relation to heritage and cultural assets has been introduced), otherwise, there will be no financial impact.	
AASB 3 'Business Combinations' (March 2008)	1 July 2009
AASB 8 'Operating Segments'	1 January 2009
AASB 123 'Borrowing Costs' (June 2007). This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. The Health Service already capitalises borrowing costs directly attributable to buildings under construction, therefore, this will be no impact on the financial statements when the Standard is first applied.	1 January 2009
AASB 127 'Consolidated and Separate Financial Statements' (March 2008)	1 July 2009
AASB 1049 'Whole of Government and General Government Sector Financial Reporting'	1 July 2008
AASB 2007-2 'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1 to 8	1 January 2008
AASB 2007-3 'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'	1 January 2009
AASB 2007-6 'Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'	1 January 2009
AASB 2007-8 'Amendments to Australian Accounting Standards arising from AASB 101'	1 January 2009
AASB 2008-1 'Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations'	1 January 2009
AASB 2008-2 'Amendments to Australian Accounting Standards – Puttable Financial Instruments and Obligations arising on Liquidation [AASB 7, AASB 101, AASB 132, AASB 139 & Interpretation 2]'	1 January 2009

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

Title	Operative for reporting periods beginning on/after
AASB 2008-3 'Amendments to Australian Accounting Standards arising from AASB 3 and AASB 127 [AASBs 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138, 139 and Interpretations 9 & 107]'	1 July 2009
Interpretation 4 'Determining whether an Arrangement contains a Lease' (February	1 January 2008
Interpretation 12 'Service Concession Arrangements'	1 January 2008
Interpretation 13 'Customer Loyalty Programmes'	1 July 2008
Interpretation 14 'AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'	1 January 2008
Interpretation 129 'Service Concession Arrangements: Disclosures'	1 January 2008

Note 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 52. The key services of the Health Service are:

Admitted Patient Services
Admitted patient services are provided for the care of inpatients in public hospitals (excluding specialised mental health wards) and public patients treated in private facilities under contract to WA Health. Care during an admission to hospital can be for periods of one or more days. Care includes medical and surgical treatment, renal dialysis, oncology services, mental health and obstetric care.

Specialised Mental Health Services
Specialised mental health services include authorised mental health units that are hospitals or hospital wards devoted to the specialised treatment and care of patients with psychiatric, mental or behavioural disorders. Specialised mental health care is also provided in designated mental health wards in acute hospitals.

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

Non-admitted Patient Services
Medical officers, nurses and allied health staff provide non-admitted services. Services include outpatient health and medical care as well as similar emergency services as described for metropolitan emergency department but provided in smaller country hospitals.

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

Prevention and Promotion Services
Prevention and promotion services include genomics, the management and development of health information, Aboriginal health, breast screening services, child and community health and health promotion.

Home and Community Care Services
Home and Community Care (HACC) provides services that support people who live at home and whose capacity for independent living is at risk of premature admission to long-term residential care. Services include domestic assistance, social support, nursing care, respite care, food services and home maintenance.

Aged Care Assessment Services
Aged care assessment services determine eligibility for, and the level of care required by frail aged people. They include assessments for those who require permanent care in an appropriate residential aged care facility including the Care Awaiting Placement program, and eligibility for community-based aged care services.

Community Mental Health Services
Community mental health care provides a range of community-based services for people with mental health disorders, which may include emergency assessment and treatment; case management, psycho-geriatric assessment and day programs provided in either a clinic or home environment. Service providers include both government and non-government service agencies. Contracted non-government non-clinical services also provide support to long-term mental health patients living in the community.

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

Note 7 Employee benefits expense	2008 $000	2007 $000
Salaries and wages (a)	392,624	343,539
Superannuation - defined contribution plans (b)	34,256	31,040
Superannuation - defined benefit plans (c) (d)	817	854
Annual leave and time off in lieu leave (e)	40,574	36,410
Long service leave (e)	6,881	6,433
	475,152	418,275

(a) Includes the value of the fringe benefit to the employees. The fringe benefits tax component is included at note 13 'Other expenses'.

(b) Defined contribution plans include West State, Gold State and GESB Super Scheme (contributions paid).

(c) Defined benefit plans include Pension scheme and Gold State (pre-transfer benefit).

(d) An equivalent notional income is also recognised. (See note 2(t) Superannuation expense and note 20 'Liabilities assumed by the Treasurer')

Decrease in liabilities in respect of the GSS transfer benefits occurred in 2007-08. In accordance with Treasurer's Instruction TI 1102, where there have been decreases in liabilities (i.e. actuarial gains exceed the current service cost for the period), the net gains should not be included in superannuation expense.

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 13 'Other expenses'. The employment on-costs liability is included at note 33 'Provisions'.

Note 8 Patient support costs		
Medical supplies and services	40,593	37,360
Domestic charges	5,923	5,778
Fuel, light and power	13,656	13,761
Food supplies	8,002	7,098
Patient transport costs	20,457	18,598
Purchase of external services	12,650	12,849
	101,281	95,445

Note 9 Finance costs		
Interest paid	1,705	1,757

Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	19,506	17,956
Leasehold improvements	196	110
Computer equipment	206	268
Furniture and fittings	144	126
Motor vehicles	554	675
Medical equipment	5,216	5,911
Other plant and equipment	1,276	1,590
	27,098	26,637
Amortisation		
Intangible assets	22	30
Total depreciation and amortisation	27,120	26,667

Note 11 Capital user charge		
	-	52,625

The charge was a levy applied by Government for the use of its capital. The final charge was levied in 2006-07.

Note 12 Net gain / (loss) on disposal of non-current assets	2008 $000	2007 $000
Cost of disposal of non-current assets		
Property, plant and equipment	(1,071)	-
Proceeds from disposal of non-current assets:		
Property, plant and equipment	740	-
Net gain/(loss)	(331)	-

See note 27 'Property, plant and equipment'.

Note 13 Other expenses

Communications	5,431	4,755
Computer services	741	989
Employment on-costs (a)	18,257	15,606
Insurance	2,851	3,884
Legal expenses	35	661
Motor vehicle expenses	4,976	4,620
Operating lease expenses	7,962	7,550
Printing and stationery	2,962	2,636
Rental of property	9,624	4,268
Doubtful debts expense	736	381
Purchase of external services	6,242	5,019
Other	10,326	10,928
	70,143	61,297

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

Note 14 Patient charges

Inpatient charges	20,454	19,018
Outpatient charges	8,174	6,094
	28,628	25,111

Note 15 Grants and contributions

Commonwealth grants and contributions		
Nursing homes	3,701	3,656
Grant for National Respite Carers Program	928	1,451
Grant for Regional Health Services	4,325	3,615
Grant for Community Aged Care Program	727	497
Grant for Primary Health Care Access Program - Kimberley	1,439	1,404
Grant for Carelink	355	444
Grant for Dept Veterans Affairs - Home & Domiciliary Care	133	181
Grant for Aged Care Training Program	250	515
Grant for Medical Specialists Outreach Assistance Program	52	203
Grant for HIV Treatment	-	145
Grant for Aboriginal Health	608	114
Grant for Training Hotel Services Staff - Dept Education & Training	-	113
Office of Aboriginal and Torres Strait Islander Health - Wheatbelt	1,022	1,713
Customs	245	191
WA Alcohol and Drug Authority - Pilbara	(152)	95
Healthy for Life	1,074	434
Mobile Respite Program	112	89
Kimberley Paediatrics	152	-
Extended Specialist Training	100	-
Clever Networks	169	-
Respite for Young Carers and Carers of Young Disabled	30	24
Other grants	642	512
	15,912	15,396

Note 15 Grants and contributions (continued)	2008 $000	2007 $000
Other grants and contributions		
Disability Services Commission - Community Aids and Equipment Program	1,563	1,462
Disability Services Commission - Therapy Services	119	1,896
Grants for Medical Specialists Outreach Assistance Program	782	635
Western Australian Centre for Rural and Remote Medicine	80	276
Great Southern GP Network - For Ante Natal Program& Office relocation	108	219
Healthways	206	100
BHP Billiton	764	935
Great Southern Development Commission	-	754
Grant for Pilbara Development Commission - Wickham Hostel Upgrade	-	154
Dampier Peninsular Project	149	-
Bush Medivac - Dept of Industry	1,630	-
Regional Health Service Program	138	-
Pilbara Visiting Specialist Services Funding	480	-
Other grants	1,049	1,003
	7,068	7,434

Note 16 Donations revenue

General public contributions	735	505
Hospital Auxiliaries	98	57
Deceased estates	130	337
Abbotts Australia - Pumps	-	173
	963	1,072

Note 17 Other revenues

Recoveries	5,282	4,473
Use of hospital facilities	1,259	2,463
Rent from residential properties	294	287
Boarders' accommodation	3,702	3,270
Other	6,415	4,828
	16,952	15,321

Note 18 Service appropriations

Appropriation revenue received during the year:		
Service appropriations	679,068	660,595

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.

Note 19 Assets assumed / (transferred)

The following assets have been assumed from / (transferred to) other state government agencies during the financial year:

- Building for dental clinic	(3,316)	-
- Plant and equipment	(205)	20
Total assets assumed / (transferred)	(3,521)	20

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 under Treasurer's Instruction 955 and are taken directly to equity. Discretionary non-reciprocal transfer of assets between State Government agencies are reported as Assets assumed/ (transferred).

Note 20 Liabilities assumed by the Treasurer	2008 $000	2007 $000
The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	817	854

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 7 'Employee benefits expense').

Note 21 Cash and cash equivalents

Cash on hand	170	172
Cash at bank - general	18,642	15,520
Cash at bank - donations	2,414	2,129
Other short - term deposits	53	64
	21,279	17,885

Note 22 Restricted cash and cash equivalents

Cash assets held for specific purposes		
Cash at bank	560	442
	560	442

Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

Note 23 Receivables

Current		
Patient fee debtors	4,772	3,759
Other receivables	4,371	4,554
Less: Allowance for impairment of receivables	(986)	(452)
Accrued revenue	2,647	3,127
	10,804	10,988
GST receivable	2,451	2,355
	13,255	13,343

Reconciliation of changes in the allowance for impairment of receivables:

Balance at start of year	452	429
Doubtful debts expense recognised in the income statement	736	381
Amounts written off during the year	(202)	(358)
Balance at end of year	986	452

Credit Risk

Ageing of receivables past due but not impaired based on the information provided to senior management, at the balance sheet date:

Not more than 1 year	4,046	3,402
More than 1 year	646	427
	4,692	3,829

Receivables individually determined as impaired at the balance sheet date:

Carrying amount, before deducting any impairment loss	1,594	315
Impairment loss	(815)	(315)
	779	0

The Health Service does not hold any collateral as security or other credit enhancements relating to receivables.

See also note 2(p) 'Receivables' and note 51 'Financial instruments'.

	2008 $000	2007 $000
Note 24 Amounts receivable for services		
Current	-	8,386
Non-current	135,285	87,945
	135,285	96,331

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(n) 'Amounts receivable for services'.

Note 25 Inventories		
Current		
Supply stores - at cost	1,666	1,686
Pharmaceutical stores - at cost	1,264	1,291
Engineering stores - at cost	588	604
	3,518	3,581

See note 2(o) 'Inventories'.

Note 26 Other current assets		
Prepayments	1,442	844
Other current assets	423	-
	1,865	844

Note 27 Property, plant and equipment		
Land		
At fair value (a)	109,918	71,659
	109,918	71,659
Buildings		
Clinical:		
At fair value	590,079	583,495
Accumulated depreciation	(2,421)	(19,311)
	587,658	564,184
Non-Clinical:		
At fair value	90,889	66,695
Accumulated depreciation	(544)	(420)
	90,345	66,275
Total land and buildings	787,921	702,118
Leasehold improvements		
At cost	945	830
Accumulated depreciation	(306)	(110)
	639	720
Computer equipment		
At cost	961	766
Accumulated depreciation	(446)	(250)
	515	516
Furniture and fittings		
At cost	1,874	1,414
Accumulated depreciation	(264)	(123)
	1,610	1,291
Motor vehicles		
At cost	1,915	1,638
Accumulated depreciation	(1,222)	(675)
	693	963
Medical equipment		
At cost	37,370	29,462
Accumulated depreciation	(10,906)	(5,901)
Accumulated impairment losses	(374)	(374)
	26,090	23,187

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Other plant and equipment		
At cost	12,029	11,789
Accumulated depreciation	(2,591)	(1,575)
	9,438	10,214
Works in progress		
Buildings under construction (at cost)	50,551	41,593
Other Work in Progress (at cost)	289	601
	50,840	42,194
Art Works		
At cost	72	66
Total of property, plant and equipment	877,818	781,269

(a) Land and buildings were revalued as at 1 July 2007 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2008 and recognised at 30 June 2008. In undertaking the revaluation, fair value was determined by reference to market values for land: $57,353,000 and buildings: $75,142,000. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See note 2(f) 'Property, Plant and Equipment'.

Valuation Services, the Office of the Auditor General and the Department of Treasury and Finance assessed the valuations globally to ensure that the valuations provided (as at 1 July 2007) were compliant with fair value at 30 June 2008.

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

Land		
Carrying amount at start of year	71,659	-
Assets transferred in on commencement	-	70,172
Additions	-	942
Transfers from Work in Progress	98	545
Disposals	(234)	-
Revaluation increments / (decrements)	38,395	-
Carrying amount at end of year	109,918	71,659
Buildings		
Carrying amount at start of year	630,459	-
Assets transferred in on commencement	-	591,540
Additions	853	5,004
Transfers from Work in Progress	51,642	51,721
Disposals	(510)	-
Transfer from/(to) other reporting entities	(237)	-
Revaluation increments / (decrements)	13,622	-
Depreciation	(19,506)	(17,956)
Transfer between asset classes	1,680	150
Carrying amount at end of year	678,003	630,459
Leasehold improvements		
Carrying amount at start of year	720	-
Assets transferred in on commencement	-	433
Transfers from work in progress	115	397
Depreciation	(196)	(110)
Carrying amount at end of year	639	720
Computer equipment		
Carrying amount at start of year	516	-
Assets transferred in on commencement	-	526
Additions	150	244
Transfers from Work in Progress	58	10
Disposals	(8)	-
Depreciation	(206)	(268)
Transfer between asset classes	5	4
Carrying amount at end of year	515	516

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Furniture and fittings		
Carrying amount at start of year	1,291	-
Assets transferred in on commencement	-	925
Additions	246	507
Transfers from Work in Progress	16	-
Transfer from/(to) other reporting entities	3	-
Depreciation	(144)	(126)
Transfer between asset classes	198	(15)
Carrying amount at end of year	1,610	1,291
Motor vehicles		
Carrying amount at start of year	963	-
Assets transferred in on commencement	-	1,284
Additions	230	354
Transfers from Work in Progress	85	-
Depreciation	(554)	(675)
Transfer between asset classes	(31)	-
Carrying amount at end of year	693	963
Medical equipment		
Carrying amount at start of year	23,187	-
Assets transferred in on commencement	-	20,739
Additions	5,735	8,490
Transfers from Work in Progress	1,033	76
Disposals	(256)	-
Transfer from/(to) other reporting entities	37	-
Impairment losses (a)	-	(374)
Depreciation	(5,216)	(5,911)
Transfer between asset classes	1,570	167
Carrying amount at end of year	26,090	23,187
Other plant and equipment		
Carrying amount at start of year	10,214	-
Assets transferred in on commencement	-	8,133
Additions	3,572	3,210
Transfers from Work in Progress	181	439
Disposals	(64)	-
Transfer from/(to) other reporting entities	233	20
Depreciation	(1,276)	(1,590)
Transfer between asset classes	(3,422)	2
Carrying amount at end of year	9,438	10,214
Works in progress		
Carrying amount at start of year	42,194	-
Assets transferred in on commencement	-	44,762
Additions	65,191	51,546
Write-down of assets	-	(617)
Transfers from Work in Progress	(53,229)	(53,188)
Transfer from/(to) other reporting entities	(3,316)	-
Transfer between asset classes	-	(309)
Carrying amount at end of year	50,840	42,194
Art Works		
Carrying amount at start of year	66	-
Assets transferred in on commencement	-	66
Additions	6	-
Carrying amount at end of year	72	66

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Total property, plant and equipment		
Carrying amount at start of year	781,269	-
Assets transferred in on commencement	-	738,580
Additions	75,982	70,297
Write-down of assets	-	(617)
Disposals	(1,072)	-
Transfer from/(to) other reporting entities	(3,280)	20
Revaluation increments / (decrements)	52,017	-
Impairment losses (a)	-	(374)
Depreciation	(27,098)	(26,637)
Carrying amount at end of year	877,818	781,269

(a) Impairment loss recognised in the Income Statement.

Note 28 Impairment of Assets

There were no indications of impairment to property, plant and equipment, and intangible assets at 30 June 2008.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period and at balance sheet date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2008 have either been classified as assets held for sale or written off.

Note 29 Intangible assets

Computer software		
At cost	126	126
Accumulated amortisation	(52)	(30)
	74	96

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	96	-
Assets transferred in on commencement	-	93
Additions	-	33
Amortisation expense	(22)	(30)
Carrying amount at end of year	74	96

(a) Impairment loss recognised in Income Statement.

Note 30 Other financial assets

Shares in Mount Barker Cooperative Ltd at cost	6	6

Note 31 Payables

Current		
Trade creditors	17,424	12,428
Accrued expenses	27,378	18,714
Accrued salaries	9,219	9,179
Accrued interest	206	219
	54,227	40,540

(See also note 2(q) 'Payables' and note 51 'Financial instruments')

Note 32 Borrowings	2008 $000	2007 $000
Current		
Western Australian Treasury Corporation loans (a)	564	551
Department of Treasury and Finance loans (b)	1,039	996
	1,603	1,547
Non-current		
Western Australian Treasury Corporation loans (a)	8,913	9,477
Department of Treasury and Finance loans (b)	16,021	17,060
	24,934	26,537
Total borrowings	26,537	28,084

(a) 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.

(b) 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 Government's debt servicing costs.

(c) Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

Note 33 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	35,695	32,521
Time off in lieu leave (a)	11,858	10,574
Long service leave (b)	17,378	15,805
Deferred salary scheme	380	299
Gratuities	1,119	1,099
	66,430	60,298
Non-current		
Employee benefits provision		
Long service leave (b)	12,191	11,282
Deferred salary scheme	351	413
Gratuities	299	491
	12,841	12,186
Total Provisions	79,271	72,484

(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 balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	31,672	28,655
More than 12 months after balance sheet date	15,881	14,440
	47,553	43,095

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	6,437	6,482
More than 12 months after balance sheet date	23,132	20,605
	29,569	27,087

(c) The settlement of annual and long service leave liabilities give rise to the payment of employment on-costs including workers compensation insurance. 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 13 'Other expenses'.

Note 34 Other liabilities	2008 $000	2007 $000
Current		
Income received in advance	47	545
Refundable deposits	0	(114)
Other	92	54
	139	485

Note 35 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	781,023	-
Contributions by owners		
Capital contributions (a)	69,560	58,904
Transfer of net assets from other agencies (a) (b)	-	722,119
Total contributions by owners	69,560	781,023
Balance at end of year	850,583	781,023

(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 955 'Contribution by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity.

(b) 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. Consequently, non-discretionary (non-reciprocal) transfers of net assets to other State government agencies are distribution to owners and are debited directly to equity.

Note 36 Reserves

Asset revaluation reserve (a)		
Balance at start of year	-	-
Net revaluation increments / (decrements) (b) (c) :		
Land	38,395	-
Buildings	13,622	-
Balance at end of year	52,017	-

(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.

(c) Any decrement is recognised as an expense in the Income Statement, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.

Note 37 Accumulated surplus/(deficit)

Balance at start of year	(8,819)	-
Result for the period	(295)	3,648
Change in accounting policy	-	(12,467)
Balance at end of year	(9,114)	(8,819)

Note 38 Notes to the Cash Flow Statement	2008 $000	2007 $000
a) Reconciliation of cash		
Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:		
Cash and cash equivalents (see note 21)	21,279	17,885
Restricted cash and cash equivalents (see note 22)	560	442
	21,838	18,327
b) Reconciliation of net cash flows to net cost of services used in operating activities		
Net cash used in operating activities (Cash Flow Statement)	(627,599)	(573,542)
Increase/(decrease) in assets:		
GST receivable	96	1,238
Other current receivables	830	2,333
Inventories	(63)	(411)
Prepayments	1,021	142
Decrease/(increase) in liabilities:		
Doubtful debts provision	(534)	(23)
Payables	(13,687)	(2,516)
Current provisions	(6,131)	(4,308)
Non-current provisions	(656)	844
Income received in advance	499	1,043
Other liabilities	(153)	59
Non-cash items:		
Depreciation and amortisation expense (note 10)	(27,120)	(26,667)
Net gain / (loss) from disposal of non-current assets (note 12)	(331)	-
Interest paid by Department of Health	(1,718)	(1,776)
Capital user charge paid by Department of Health (note 11)	-	(52,625)
Asset Impairment Losses	-	(374)
Superannuation liabilities assumed by the Treasurer (note 20)	(817)	(854)
Write down of property, plant and equipment (note 27)	-	(617)
Adjustment for other non-cash items	(296)	233
Net cost of services (Income Statement)	(676,659)	(657,821)
c) Notional cash flows		
Service appropriations as per Income Statement	679,068	660,595
Capital contributions credited directly to Contributed Equity (Refer Note 35)	69,560	58,904
Holding account drawdowns credited to Amounts Receivable for Services	1,569	11,929
	750,197	731,428
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	(640)	(651)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(551)	(539)
Interest paid to Department of Treasury & Finance	(1,078)	(1,125)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(996)	(950)
Capital user charge	-	(52,625)
Accrual appropriations	(40,524)	(32,375)
Capital works expenditure	(11,239)	(18,928)
Other non cash adjustments to service appropriations	-	14
	(55,028)	(107,179)
Cash Flows from State Government as per Cash Flow Statement	695,169	624,249

At the balance sheet date, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 39 Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets (See note 5 'Voluntary changes in accounting policy'). Retrospective application of the change in accounting policy has resulted in an amount of $12,468,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006.The adjustments relating to the 2006-07 financial year are as follows:

Reconciliation of equity at the end of the last reporting period under previous asset capitalisation policy : 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Assets			
Current Assets	44,481	-	44,481
Non-Current Assets (a) (b)	881,287	(11,971)	869,316
Total Assets	925,768	(11,971)	913,797
Liabilities			
Current Liabilities	102,870	-	102,870
Non-Current Liabilities	38,723	-	38,723
Total Liabilities	141,593	-	141,593
Total Equity (c)	784,175	(11,971)	772,204
Accumulated surplus/(deficiency)			
Opening balance	-	(12,467)	(12,467)
Surplus/(Deficit) for the period	3,152	496	3,648
Closing balance	3,152	(11,971)	(8,819)
(a) Property, plant and equipment	793,233	(11,964)	781,269
(b) Intangible assets	103	(7)	96
(c) Accumulated surplus/(deficiency)	3,152	(11,971)	(8,819)

Reconciliation of income statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Expenses (a)	722,735	(451)	722,284
Total income other than income from State Government	64,418	45	64,463
Net cost of services	658,317	(496)	657,821
Income from State Government	661,469	-	661,469
Surplus/(Deficit) for the period	3,153	496	3,648
(a) Depreciation and amortisation expense	29,791	(3,124)	26,667
Loss on disposal of non-current assets	307	(307)	-
Repairs, maintenance and consumable equipment	18,777	2,980	21,757
	48,875	(451)	48,424

Note 39 Voluntary changes in accounting policy (continued)

Reconciliation of cash flow statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Cash flows from State Government	624,249	-	624,249
Utilised as follows:			
Net cash (used in) / provided by -			
Operating activities (a)	(570,607)	(2,935)	(573,542)
Investing activities (b)	(54,115)	2,935	(51,180)
Net increase / (decrease) in cash and cash equivalents	(473)	-	(473)
Cash and cash equivalents at the beginning of period	18,800	-	18,800
Cash and cash equivalents at the end of period	18,327	-	18,327
(a) Payments for supplies and services	(215,255)	(2,980)	(218,235)
(a) Other receipts	14,065	45	14,110
(b) Payments for purchase of non-current physical assets	(54,160)	2,980	(51,180)
(b) Payments for purchase of non-current physical assets	45	(45)	-

Note 40 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off under the authority of the Accountable Authority.	329	324
b) Public and other property written off under the authority of the Accountable Authority.	22	106
c) Revenue and debts written off under the authority of the Minister.	-	-
d) Public and other property written off under the authority of the Minister.	-	146
e) Gifts of public property provided by the Health Service.	-	-

Note 41 Losses of public moneys and other property

Losses of public moneys and public or other property through theft or default	3	4
Less amount recovered	-	-
Net losses	3	4

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 remuneration of the Director General of Health is paid by the Department of Health.

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

	2008	2007
$170,001 - $180,000	1	-
$500,001 - $510,000	1	-
$610,000 - $620,000	-	1
Total	2	1

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:

	2008	2007
$50,001 - $60,000	2	-
$60,001 - $70,000	1	-
$70,001 - $80,000	1	1
$80,001 - $90,000	1	-
$90,001 - $100,000	1	-
$110,001 - $120,000	1	1
$120,001 - $130,000	-	2
$130,001 - $140,000	1	2
$140,001 - $150,000	1	2
$150,001 - $160,000	3	3
$160,001 - $170,000	1	1
$170,001 - $180,000	2	3
$300,001 - $310,000	-	1
$320,001 - $330,000	1	-
Total	16	16
	$000	**$000**
The total remuneration of senior officers is:	2,157	2,449

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.

Note 43 Remuneration of auditor

Remuneration payable to the Auditor General for the financial year is as follows:

Auditing the accounts, financial statements and performance indicators	620	570

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	117,401	58,008
Later than 1 year, and not later than 5 years	72,879	20,156
Later than 5 years	-	-
	190,280	78,164
The capital commitments include amounts for:		
- Buildings	189,626	77,776

The capital expenditure commitments are all inclusive of GST.

Note 44 Commitments (continued)	2008 $000	2007 $000

b) **Operating lease commitments:**

Commitments in relation to non-cancellable leases contracted for at the balance sheet date but not recognised in the financial statements, are payable as follows:

Within 1 year	8,219	4,095
Later than 1 year, and not later than 5 years	10,009	6,637
Later than 5 years	40	66
	18,268	10,798

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

The operating lease commitments are all inclusive of GST.

c) **Other expenditure commitments:**

Other expenditure commitments contracted for at the balance sheet date but not recognised as liabilities, are payable as follows:

Within 1 year	567	338
Later than 1 year, and not later than 5 years	166	-
Later than 5 years	-	-
	733	338

The other expenditure 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:

(a) Litigation in progress

Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service	9,700	1,100
Number of claims	3	3

Contaminated Sites

Under the Contaminated Sites Act 2003, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the balance sheet date, the Health Service has eight reported contaminated sites. Two sites have been classified as "possibly contaminated - investigation required". The Health Service is unable to assess the likely outcome of the classification process, and accordingly, it is not practicable to estimate the potential financial effect or to identify the uncertainties relating to the amount or timing of any outflows. Whilst there is no possibility of reimbursement of any future expenses that may be incurred in the remediation of these sites, the Health Service may apply for funding from the Contaminated Sites Management Account to undertake further investigative work or to meet remediation costs that may be required.

Note 46 Events occurring after balance sheet date

There were no events occurring after the balance sheet date which had significant financial effects on these financial statements.

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 financial year.

	2008 $000	2007 $000

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 financial year.

Note 49 Administered trust accounts

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	690	722
Add Receipts		
- Patient Deposits	1,756	1,269
- Interest	5	5
	2,452	1,996
Less Payments		
- Patient Withdrawals	(1,644)	(1,306)
- Interest / Charges	(1)	-
Closing Balance	807	690

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	204	200
Add Receipts		
- Fees collected on behalf of medical practitioners	152	212
- Interest	2	2
	358	414
Less Payments		
- Payments to medical practitioners	(149)	(208)
- Charges	(6)	(2)
Closing Balance	203	204

c) Other trust accounts - not controlled by the Health Service

Accommodation Bonds Account	-	147
Staff Development and Diabetes Education Fund	4	4
	4	151
Opening Balance		
	4	151
Add Receipts		
- Interest	-	1
	4	152
Less Payments		
- Withdrawals	-	(148)
Closing Balance	4	4

Notes to the Financial Statements

For the year ended 30th June 2008

Note 50 Explanatory Statement

(A) Significant variances between actual results for 2007 and 2008

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.

	Note	2008 Actual $000	2007 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	475,152	418,275	56,877
Fees for visiting medical practitioners		47,190	44,087	3,103
Patient support costs	(b)	101,281	95,445	5,836
Finance costs		1,705	1,757	(52)
Depreciation and amortisation expense		27,120	26,667	453
Asset impairment losses		-	374	(374)
Capital user charge	(c)	-	52,625	(52,625)
Loss on disposal of non-current assets		331	-	331
Other expenses		70,143	61,297	8,846
Income				
Patient charges	(d)	28,628	25,111	3,517
Commonwealth grants and contributions		15,912	15,396	516
Other grants and contributions		7,068	7,434	(366)
Donations revenue		963	1,072	(109)
Interest revenue		143	129	14
Other revenues	(e)	16,952	15,321	1,631
Service appropriations		679,068	660,595	18,472
Assets assumed / (transferred)	(f)	(3,521)	20	(3,541)
Liabilities assumed by the Treasurer		817	854	(37)

(a) Employee benefits expense

The significant factors contributing to the growth in employee expenses were:

(i) Increased costs associated with industrial award increases for all employee categories, including the flow on effect on employee superannuation ($37m).

(ii) impact on employee benefit expenses resulting from FTE increases across WACHS during 2007/08 ($21m), including agency nursing and locum medical staff.

(b) Patient support costs

Patient support costs have increased due to the combined effect of significant increases in admitted and non admitted patient activity during 2007/08 and escalating costs for goods and services including food, drugs, patient supplies and patient transport.

(c) Capital user charge

Capital user charges were levies applied by Government for the use of its capital. The final charge was levied in 2006-07.

(d) Patient charges

Additional patient revenues have resulted from increases in fees and charges together with continued gains from targetted revenue initiatives and the flow on effects of new radiology contracting arrangements.

(e) Other revenues

Additional Other Revenues increased due to additional RiskCover performance adjustments ($1.2m) and various other miscellaneous revenues $0.4m.

(f) Assets assumed / (transferred)

Medical equipment supporting the Telehealth program and a dental clinic were transferred to the Metropolitan Health Service during 2007/08.

Note 50 Explanatory Statement (continued)

(B) Significant variations between estimates and actual results for 2008

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 the budget estimates.

	Note	2008 Actual $000	2008 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	475,152	409,253	65,899
Other goods and services		271,174	276,612	(5,438)
Total expenses		746,326	685,865	60,461
Less: Revenues	(b)	(69,666)	(58,252)	(11,414)
Net cost of services		676,660	627,613	49,047

(a) Employee benefits expense
The variance in employee benefits is attributable to cost of award increases ($15m) in excess of initial budget estimates and various continuing and new services ($53m) for which funding was not included in the initial budget but was the subject of subsequent budget adjustment.

(b) Revenues
(i) Various revenue sources not reflected in the initial budget allocation and for which budget adjustments were received during 2007/08, including RiskCover performance and investment returns ($4.4m), Commonwealth Programs ($2.7m);

(ii) Additional revenues received from targetted private patient initiatives ($1.6m) and specific purpose grants ($1.4m).

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments

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

Financial instruments held by the WA Country Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, 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
Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service. The Health Service measures credit risk on a fair value basis and monitors risk on a regular basis.

The maximum exposure to credit risk at balance sheet date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment as shown in the table at Note 51(c).

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, 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.

Provision for impairment of financial assets is calculated based on past experience, and current and expected changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 23 'Receivables'.

Liquidity risk
The Health Service is exposed to liquidity risk through its normal course of operations. Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due.

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.

Market risk
The Health Service does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations. The Health Service's borrowings are all obtained through the Western Australian Treasury Corporation (WATC) and the Department of Treasury and Finance (DTF) and are at fixed rates with varying maturities. The risk is managed by WATC through portfolio diversification and variation in maturity dates.

Other than as detailed in the Interest rate sensitivity analysis table at note 51(c), the Health Service is not exposed to interest rate risk because apart from restricted cash and minor amounts of cash and cash equivalents, all other cash and cash equivalents are non-interest bearing and its borrowings are limited to those with WATC and DTF.

b) **Categories of financial instruments**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows:

	2008 $000	2007 $000
Financial Assets		
Cash and cash equivalents	21,279	17,885
Restricted cash and cash equivalents	560	442
Other financial assets	6	6
Loans and receivables (a)	146,090	107,319
Financial Liabilities		
Financial liabilities measured at amortised cost	80,763	68,624

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk, liquidity risk and interest rate risk exposure

The following table details the exposure to liquidity risk and interest rate risk as at the balance sheet date. The Health Service's maximum exposure to credit risk at the balance sheet date is the carrying amount of the financial assets as shown on the following table. The table is based on information provided to senior management of the Health Service. The contractual maturity amounts in the table are representative of the undiscounted amounts at the balance sheet date. An adjustment for discounting has been made where material.

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2008	**%**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Financial Assets										
Cash and cash equivalents	0.5%	1,951	19,232	96						21,279
Restricted cash and cash equivalents	6.8%	560	-							560
Other financial assets		6	-							6
Receivables (a)			10,804							10,804
Amounts receivable for services			135,286							135,286
		2,517	165,322	96	-	-	-	-	-	167,935
Financial Liabilities										
Payables			54,227							54,227
Borrowings										
- W A Treasury Corporation loans	6.4%			564	576	589	603	616	6,528	9,476
- Department of Treasury & Finance loans	6.1%			1,039	1,087	1,137	1,192	1,244	11,361	17,060
		-	54,227	1,603	1,663	1,726	1,795	1,860	17,888	80,763

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments (continued)

	Weighted average effective interest rate	Variable interest rate		Contractual maturity dates						
			Non-interest bearing	Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2007	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets										
Cash and cash equivalents	0.4%	2,129	15,692	33	31					17,885
Restricted cash and cash equivalents	5.8%	442	-							442
Other financial assets		6	-							6
Receivables (a)			10,988							10,988
Amounts receivable for services			96,330							96,330
		2,577	123,010	33	31	-	-	-	-	125,651
Financial Liabilities										
Payables			40,540							40,540
Borrowings										
- W A Treasury Corporation loans	6.0%			551	564	576	589	603	7,145	10,028
- Department of Treasury & Finance loans	6.1%			996	1,045	1,090	1,137	1,193	12,595	18,056
		-	40,540	1,547	1,609	1,666	1,726	1,795	19,740	68,624

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

The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments (continued)

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the balance sheet date on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-1% change		+1% change	
As at 30th June 2008	**Carrying Amount $000**	**Profit $000**	**Equity $000**	**Profit $000**	**Equity $000**
Financial Assets					
Cash and cash equivalents	21,279	(20)	(20)	20	20
Restricted cash and cash equivalents	560	(6)	(6)	6	6
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	9,476	95	95	(95)	(95)
- Department of Treasury & Finance	17,060	171	171	(171)	(171)
Total Increase/(Decrease)		240	240	(240)	(240)

		-1% change		+1% change	
As at 30th June 2007	**Carrying Amount $000**	**Profit $000**	**Equity $000**	**Profit $000**	**Equity $000**
Financial Assets					
Cash and cash equivalents	17,885	(22)	(22)	22	22 22
Restricted cash and cash equivalents	442	(4)	(4)	4	4
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	10,028	100	100	(100)	(100)
- Department of Treasury & Finance	18,056	181	181	(181)	(181)
Total Increase/(Decrease)		255	255	(255)	(255)

Fair values

All financial assets and liabilities recognised in the balance sheet, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 52 Schedule of Income and Expenses by Services

	Admitted Patient Services		Specialised Mental Health		Palliative Care		Non-Admitted Patient		Patient Transport		Prevention & Promotion	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES												
Expenses												
Employee benefits expense	223,707	196,318	6,713	5,007	1,053	995	97,178	85,160	11,017	9,697	50,889	44,714
Fees for visiting medical practitioners	30,256	29,230	65	28	5	21	14,355	12,910	68	83	210	230
Patient support costs	47,684	44,798	1,431	1,142	224	227	20,714	19,432	2,348	2,213	10,847	10,203
Finance costs	803	824	24	21	4	4	349	359	40	41	183	188
Depreciation and amortisation expense	12,767	12,516	383	319	60	63	5,547	5,429	629	618	2,905	2,851
Asset impairment losses	-	175	-	4	-	1	-	76	-	9	-	40
Capital user charge	-	24,700	-	630	-	125	-	10,714	-	1,220	-	5,626
Loss on disposal of non-current assets	156	-	5	-	1	-	68	-	8	-	34	-
Repairs, maintenance and consumable equipment	11,018	10,212	331	260	52	52	4,786	4,430	543	504	2,506	2,325
Other expenses	33,025	28,770	991	734	155	146	14,346	12,480	1,626	1,421	7,513	6,552
Total cost of services	359,416	347,543	9,943	8,145	1,554	1,634	157,343	150,990	16,279	15,806	75,087	72,729
INCOME												
Revenue												
Patient charges	14,196	12,886	95	96	47	-	8,665	7,612	145	-	355	209
Commonwealth grants and contributions	764	783	10	2	2	-	458	627	122	83	8,679	7,708
Other grants and contributions	903	1,245	7	1	53	38	1,240	1,583	24	7	2,528	2,102
Donations revenue	453	481	14	4	2	1	197	226	22	9	103	142
Interest revenue	68	58	2	-	-	-	29	27	3	1	15	17
Other revenues	7,981	6,869	239	56	38	21	3,467	3,235	393	124	1,816	2,027
Total income other than income from State Government	24,365	22,322	367	159	142	60	14,056	13,310	709	224	13,496	12,205
NET COST OF SERVICES	**335,051**	**325,221**	**9,576**	**7,986**	**1,412**	**1,574**	**143,287**	**137,680**	**15,570**	**15,582**	**61,591**	**60,524**
INCOME FROM STATE GOVERNMENT												
Service appropriations	336,289	326,579	9,606	8,020	1,415	1,580	143,824	138,258	15,620	15,646	61,783	60,790
Assets assumed / (transferred)	(1,744)	11	(50)	-	(7)	-	(746)	4	(81)	-	(320)	2
Liabilities assumed by the Treasurer	405	422	12	10	2	2	173	179	19	20	74	79
Total income from State Government	334,950	327,012	9,568	8,030	1,410	1,582	143,251	138,441	15,558	15,666	61,537	60,871
SURPLUS/(DEFICIT) FOR THE PERIOD	**(101)**	**1,791**	**(8)**	**44**	**(2)**	**8**	**(36)**	**761**	**(12)**	**84**	**(54)**	**347**

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 52 Schedule of Income and Expenses by Services

	Home & Community Care		Aged Care Assessment		Community Mental Health		Residential Care		Total	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	11,715	9,629	2,432	2,242	21,273	19,121	49,175	45,392	475,152	418,275
Fees for visiting medical practitioners	117	68	86	107	850	477	1,178	933	47,190	44,087
Patient support costs	2,497	2,197	518	512	4,535	4,363	10,483	10,358	101,281	95,445
Finance costs	42	40	9	9	75	80	176	191	1,705	1,757
Depreciation and amortisation expense	669	614	139	143	1,214	1,219	2,807	2,895	27,120	26,667
Asset impairment losses	-	9	-	2	-	17	-	41	-	374
Capital user charge	-	1,212	-	282	-	2,406	-	5,710	-	52,625
Loss on disposal of non-current assets	8	-	2	-	15	-	34	-	331	-
Repairs, maintenance and consumable equipment	577	501	120	117	1,048	995	2,422	2,361	23,403	21,757
Other expenses	1,729	1,411	359	329	3,140	2,802	7,259	6,652	70,143	61,297
Total cost of services	17,354	15,681	3,665	3,743	32,150	31,480	73,534	74,533	746,325	722,284
INCOME										
Revenue										
Patient charges	40	34	1	-	216	-	4,868	4,274	28,628	25,111
Commonwealth grants and contributions	4,316	5,172	4	12	871	959	686	50	15,912	15,396
Other grants and contributions	20	21	14	10	242	121	2,037	2,306	7,068	7,434
Donations revenue	24	55	5	5	43	19	100	130	963	1,072
Interest revenue	4	6	1	2	6	2	15	16	143	129
Other revenues	418	783	86	78	760	272	1,754	1,856	16,952	15,321
Total income other than income from State Government	4,822	6,071	111	107	2,138	1,373	9,460	8,632	69,666	64,463
NET COST OF SERVICES	**12,532**	**9,610**	**3,554**	**3,636**	**30,012**	**30,107**	**64,074**	**65,901**	**676,659**	**657,821**
INCOME FROM STATE GOVERNMENT										
Service appropriations	12,571	9,656	3,566	3,651	30,112	30,233	64,282	66,182	679,068	660,595
Assets assumed / (transferred)	(65)	-	(18)	-	(156)	1	(334)	2	(3,521)	20
Liabilities assumed by the Treasurer	15	12	4	5	36	39	77	86	817	854
Total income from State Government	12,521	9,668	3,552	3,656	29,992	30,273	64,025	66,270	676,364	661,469
SURPLUS/(DEFICIT) FOR THE PERIOD	**(11)**	**58**	**(2)**	**20**	**(20)**	**166**	**(49)**	**369**	**(295)**	**3,648**

Appendices

Appendix 1: Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on HealthCare Standards
AMI	Acute Myocardial Infarction
ATSI	Aboriginal and Torres Strait Islander
ATSN	Apprenticeship and Traineeship Support Network
CALD	Culturally and Linguistically Diverse
CCC	Corruption and Crime Commission
COAG	Council of Australian Governments
CPI	Consumer Price Index
CPR	Cardiac Pulmonary Resuscitation
CRSU	Community Supported Residential Units
DAIP	Disability Access and Inclusion Plan
DHAC	District Health Advisory Council
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
EQUIP	Evaluation and Quality Improvement Program
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HCN	Health Corporate Network
HMDS	Hospital Morbidity Data System
HRIT	Health Reform Implementation Taskforce
LHAG	Local Health Advisory Group
MOU	Memorandum of Understanding
MPS	Multi-Purpose Service
NGO	Non Government Organisation
NICS	National Institute of Clinical Studies

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
PATS	Patient Assisted Travel Scheme
RFDS	Royal Flying Doctor Service
SOYF	Stay on Your Feet
SQuIRe	Safety and Quality Investment in Reform
TI	Treasury Instruction
UWA	University of WA
VMP	Visiting Medical Practitioner
WACHS	WA Country Health Service

Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Report of the WA Country Health Service for the year ended 30 June 2008.

This report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

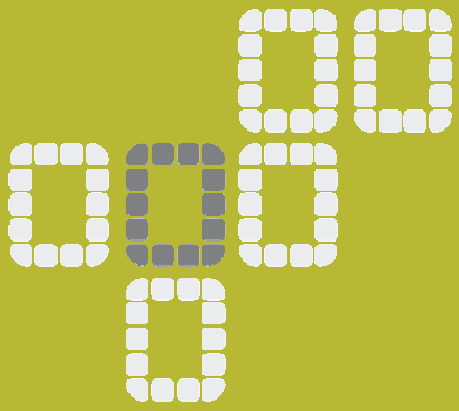
Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH
Accountable Authority

26th September 2008

Contents

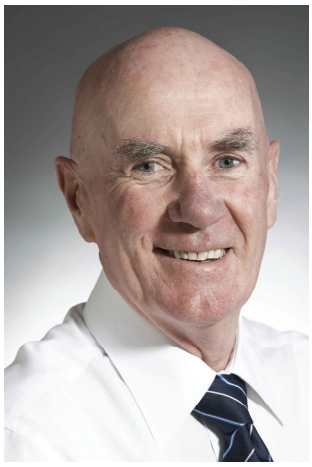
Illustrations

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



Overview of Agency

Executive Summary



The WA Country Health Service continues to strive to meet the unique challenges of providing safe, high-quality and sustainable health care to a changing rural community. These challenges include workforce and skills shortages, the increasing demand for health services, issues associated with isolation and transport, and the urgent need to improve the health status of Aboriginal people in rural and remote Western Australia.

Emerging technologies and new and innovative models of care are integral to our progress over the past year across the six priority areas: healthy workforce; healthy hospitals, health services and infrastructure; healthy partnerships; healthy communities; healthy resources and healthy leadership.

Our progress during the past year includes:

Healthy Workforce

A Medical Workforce Unit has been established to direct focused efforts into recruiting and retaining the rural medical workforce. This year also saw the inaugural appointment of a Medical Services Reform Director to implement a medical workforce strategic plan. During 2007-08 a particular priority has been the continued development of the nurse practitioner role in rural and remote locations. Visiting specialist services have been increased across a number of regions under the WA Country Health Service Specialist Services Plan and the Medical Specialist Outreach Assistance Program. For the first time, all seven regions have a visiting specialist geriatric service.

Healthy hospitals, health services, and infrastructure

A number of key capital infrastructure projects were completed or started during 2007-08 under the $600 million WA Country Health Service (WACHS) capital investment program commenced in 2004. New facilities include the Fitzroy Crossing Hospital and Morawa Health Centre, while upgrades or redevelopments have been completed at Carnarvon Hospital, Derby Hospital and Dental Clinic, and Bunbury's Acute Psychiatric Unit. Community Supported Residential Units for patients with a mental illness were opened in Albany, Geraldton and Bunbury. Work began on a new hospital at Port Hedland. The 'Hospital-in-the-Home' program has been expanded during 2007-08 and is now available in six of the seven WA Country Health Service regions to increase the access of rural patients to home-based care services.

Investment in country medical imaging continued with considerable progress made towards the roll-out of computed radiography and the Picture Archiving and Communication System to all regional resource centres. New ultrasound machines were installed in Geraldton and Albany, and new mammography units installed in Kalgoorlie and Albany. Clinical care via telehealth has been enhanced, with burns management services offered in partnership with Princess Margaret Hospital and Royal Perth Hospital, and the successful completion of a trial for delivering oncology education and clinical services to regional hospitals.

Healthy Communities

The WA Country Health Service has continued to pursue a range of initiatives to prevent ill-health and promote a healthy lifestyle in rural Western Australia, including the "Act Belong Commit" campaign, the "Stay on Your Feet" campaign, the "Pit Stop" men's health promotion package and the Wheatbelt's women's checkout health campaign. WACHS implemented the WA Health Smoke Free policy on January 1, 2008. "Healthy school" coordinators have been employed in each of the seven regions to promote the benefits of physical activity and good nutrition.

For the first time, a trachoma screening program was offered in the Goldfields, the Kimberley and the Pilbara. Our focus continues on maintaining the independence of elderly people in the community through the provision of a range of residential and community based services. Aged care managers have been appointed in each region to better coordinate the planning and delivery of aged care services. Cancer support services have been enhanced with the appointment of seven regional cancer nurse

coordinators and the piloting of a program in the Great Southern to extend specialist cancer care beyond the metropolitan area.

Healthy Partnerships

The WA Country Health Service continues to forge stronger links and partnerships with those with an interest in the well-being of our country health system. A key achievement is the five-year plan developed, in partnership with the Royal Flying Doctor Service, to identify and implement an effective and efficient aero medical service to meet the growing demand for inter-hospital transport.

In another significant development, WACHS commenced negotiations with Royal Darwin Hospital and Northern Territory Health to enable Royal Darwin Hospital to accept inter-hospital patient transfers from the Kimberley so patients who would otherwise need to be flown to Perth can receive emergency treatment and acute care closer to home. The Area Health Service also continued to work with the St John Ambulance Association to support and evaluate the Rural Paramedic Support Project in the Kimberley and the Pilbara to address difficulties in volunteer recruitment.

Significantly, there are now 24 District Health Advisory Councils throughout Western Australia that continue to build a consumer, carer and community influence by contributing to the improvement of service safety, quality and access, two-way communication and advocacy, and health service planning made more relevant by their contribution.

Healthy Resources

In 2007-08 performance agreements were established for all executives in the WA Country Health Service Leadership Team and a periodic performance reporting system has been introduced to monitor and evaluate progress against key organisation-wide indicators.

In addition to the ongoing capital works program mentioned earlier, more than $3million was approved during the year for new equipment, including sterilisers, ultrasound and radiology equipment to be installed across the WA Country Health Service.

Healthy Leadership

The WA Country Health Service continues to foster leadership at all levels, and a number of key executives participated in leadership programs offered by the Institute for Healthy Leadership during the past year. The opportunity to enhance the contribution and response of the WA Country Health Service to improving the health of our indigenous community was acknowledged with the establishment of the office of the Area Director of Aboriginal Health.

Conclusion

I would like to extend my thanks to Kim Snowball for his efforts and leadership in his first year as the Chief Executive Officer of the WA Country Health Service. Importantly, I would like to acknowledge the sheer hard work of all WA Country Health Service staff. I congratulate each of you for your commitment and dedication to improving health care for Western Australians living in rural and remote areas of our vast state.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

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.

Address and Location

WACHS - Area Office
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PO Box 6680
EAST PERTH BUSINESS CENTRE, WA 6892
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Fax: (08) 9223 8599
Internet: www.wacountry.health.wa.gov.au

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Postal Address
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Phone: (08) 9158 1795
Fax: (08) 9158 1472

WACHS – Mid West
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PO Box 690, NORTHAM WA 6401
Phone: (08) 9622 4350
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WACHS - Goldfields
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Fax: (08) 9080 5724

WACHS – Great Southern
Callistemon House
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Postal Address
PO Box 165, ALBANY WA 6331
Phone: (08) 9892 2662
Fax: (08) 9842 1095

WACHS – South West
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Postal Address
As above
Phone: (08) 9781 2350
Fax: (08) 9781 2381

Service Framework

Better Planning: Better Futures

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

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

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

Goal 1:
Better services

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

Goal 2:
Jobs and economic development

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

Goal 3:
Lifestyle and environment

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

Goal 4:
Regional development

Ensuring that regional Western Australia is strong and vibrant.

Goal 5:
Governance and public sector improvement

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

WA health outcomes and strategic directions

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

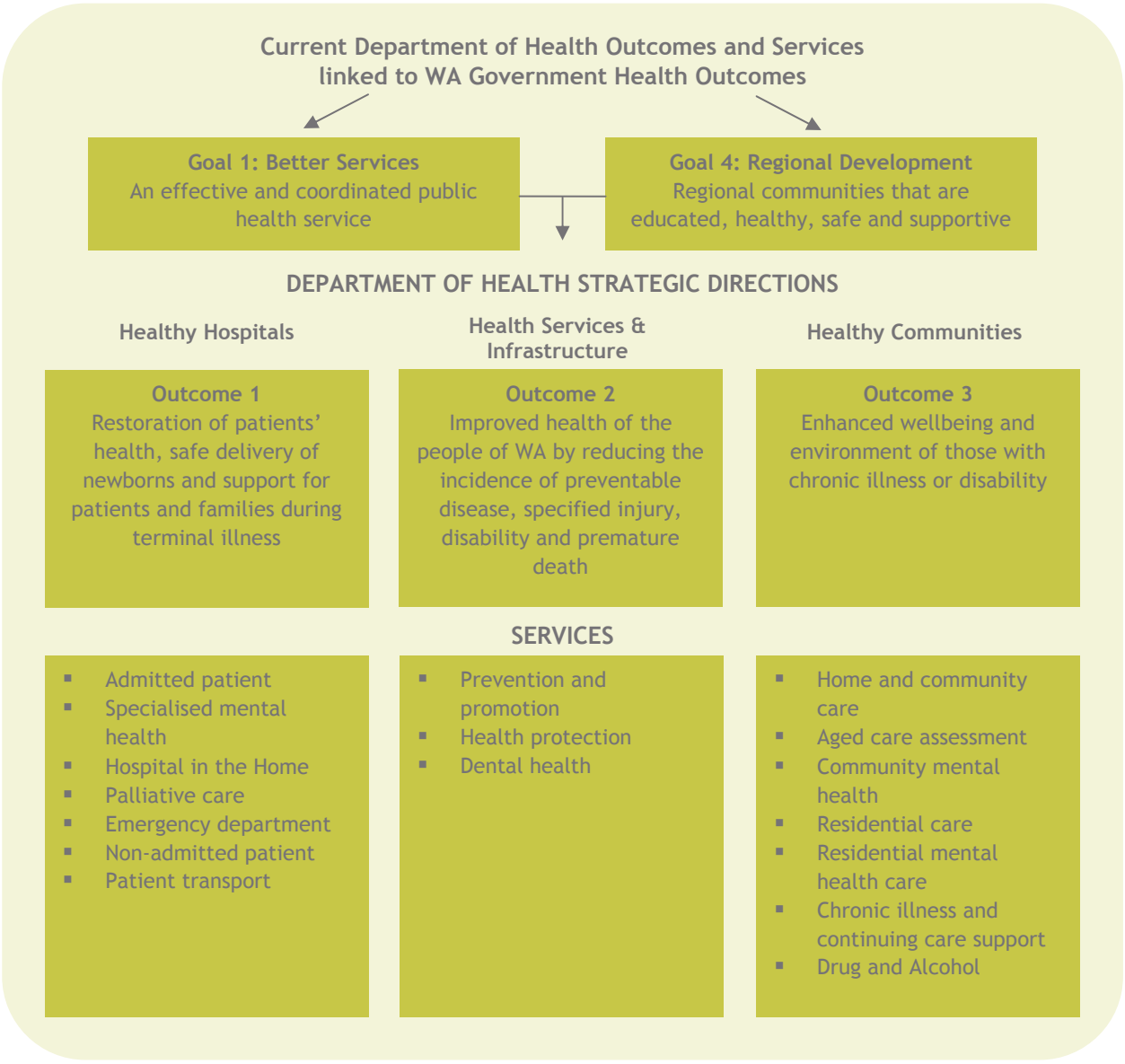
Figure 1 shows the relationship between the Government's and WA Health's desired outcomes.

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

Refer to next page for Figure 1

Service Framework (continued)

Figure 1: Department of Health strategic directions



Services Provided

The WA Country Health Service has continued to consolidate the service reforms recommended in the hospital and health service role delineation framework and the strategic directions detailed in the 'Foundations for Country Health Services" report. These initiatives continue the primary health care focus and the provision of services via regional network model.

The WA Country Health Service 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, Bunbury, 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 Busselton, Carnarvon, Collie, Derby, Esperance, Katanning, Kununurra, Margaret River, Merredin, Moora, Narrogin, Newman, Nickol Bay (Karratha), Northam and Warren (Manjimup).

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. WACHS health centres are situated in Augusta, Beverley, Boddington, Bruce Rock, Boyup Brook, Bridgetown, Corrigin, Cunderdin, Dalwallinu, Denmark, Donnybrook, Dumbleyung, Exmouth, Fitzroy Crossing, Gnowangerup, Goomalling, Halls Creek, Kellerberrin, Kojonup, Kondinin, Kununoppin, Lake Grace, Laverton, Leonora, Meekatharra, Morawa, Mullewa, Nannup, Narembeen, Norseman, North Midlands (Three Springs), Northampton, Onslow, Paraburdoo, Pemberton, Pingelly, Plantagenet (Mt Barker), Quairading, Ravensthorpe, Roebourne, Southern Cross, Tom Price, Wagin, Wickham, Wongan Hills, Wyalkatchem, Wyndham, Yarloop and York. There are also three Multi-Purpose Centres at Dongara, Kalbarri and Jurien.

The WACHS administers and manages:

- 71 hospitals (including 29 Multi Purpose Service sites);
- 22 nursing posts;
- 34 aged care facilities (including 3 Nursing Homes);
- 312 child, community, dental, alcohol and drug, mental and public health facilities and units;
- 510 staff accommodation facilities;
- 23 office and general service buildings and facilities; and
- in addition, WACHS operates 35 nursing posts and health centres where services are provided to the community under contract by the Silver Chain Nursing Association.

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

Direct patient services

- Accident and Emergency Medicine
- Acute medical
- Acute surgical
- Anaesthetics
- Antenatal classes
- Cardiology
- Renal dialysis
- Dermatology
- Ear, nose and throat
- Endocrinology
- Extended care
- Gastroenterology
- Genetics
- Gynaecology
- Nephrology
- Nursing home type
- Obstetrics
- Occupational medicine
- Oncology

Services Provided (continued)

Direct patient services (continued)

- Ophthalmology
- Orthopaedics
- Pacemaker clinic
- Paediatrics
- Podiatry
- Psychiatric services
- Rheumatology
- Same day surgery
- Urology

Medical support services

- Audiology
- Dietetics
- Medical imaging
- Occupational therapy
- Pathology
- Pharmacy
- Physiotherapy
- Podiatry
- Respiratory medicine
- Social work
- Speech pathology
- Sexual health

Community and support services

- Aged care assessment
- Child and maternal health
- Community health
- Community mental health
- Public health
- Hospital in the Home
- Palliative care
- Health promotion

Other services

- Administration
- Corporate services
- Engineering/maintenance
- Hotel services
- Medical records
- Patient transport

Compliance Reports

The Department of Health is established by the Governor under section 35 of the Public Sector Management Act 1994. The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 40 Acts and 101 sets of subsidiary legislation.

Acts administered

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

Acts passed during 2007-08

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

Bills in Parliament as at 30 June 2008

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

Amalgamation and establishment of Boards

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

Statement of Compliance with Public Sector Standards

In the administration of the WA Country Health Service, I have complied with the Public Sector Standards in Human Resource Management, the Western Australian Public Sector Code of Ethics and our Code of Conduct. I am satisfied that the procedures and internal processes I have implemented and overseen for the WA Country Health Service support this statement.

Human Resource Management

To ensure compliance with the requirements of the Public Sector Standards for Human Resource Management and to encourage best practice, the WA Country Health Service (WACHS) conducts regular reviews of the relevant policies and procedures it has adopted.

The WACHS employs mechanisms to assess compliance with its policies and procedures, and maintains a focus on the Public Sector Standards for Human Resource Management by ensuring:

- duty statements detail compliance responsibility;
- staff knowledge surveys are conducted;
- participating in compliance audits performed by the Internal Audit Branch and external auditing agencies such as the Office of the Auditor General;
- training programs and workshops are conducted; and
- support for investigations on breaches and grievances when required.

Information on compliance requirements is included in workplace procedure manuals and is emphasised in staff training and induction programs.

In 2007-08 the WA Country Health Service received five claims for breach of Public Sector Standards, all for recruitment and selection practice. Two were either withdrawn or resolved within the agency while three were referred to the Office of the Public Sector Standards Commissioner (OPSSC) for investigation and appropriate action where required.

Code of Ethics and Code of Conduct

Compliance with the Public Sector Codes of Ethics and Conduct and the Department of Health's Code of Conduct is promoted strongly across the WACHS.

Attendees at orientation and induction courses are provided with hardcopies of the relevant documents and the relevant Codes are available on the Intranet. Staff surveys are undertaken to assess the level of knowledge in the workplace and staff are required to acknowledge their understanding and acceptance of the Codes.

During 2007-08 the WACHS received 71 complaints alleging non-compliance with the Codes for a range of ethics and conduct issues, for example, inappropriate behaviour in the workplace, verbal abuse of fellow workers, and misuse of vehicles, equipment and computer networks. Following investigation four were referred to external agencies including the OPSSC, for resolution and recommendations for action, where appropriate. The remainder were resolved internally.

Dr Peter Flett
ACTING DIRECTOR GENERAL OF HEALTH

26th September 2008

Accountable Authority

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

Pecuniary Interests

Senior officers of the WA Country Health Service have declared no pecuniary interests in 2007-08.

Senior Officers

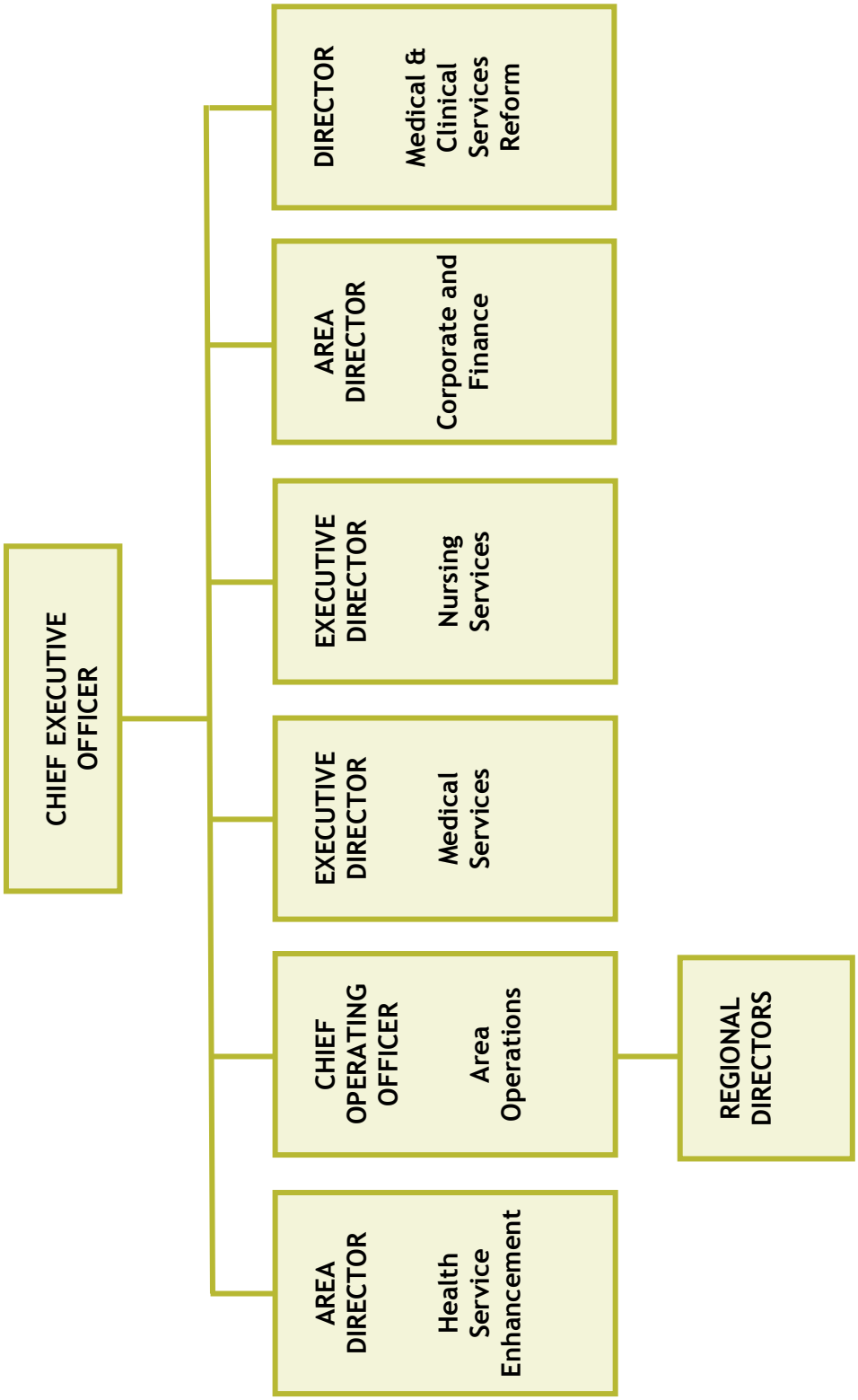
The senior officers as at 30 June 2008 for the WA Country Health Service and their areas of responsibility are listed below:

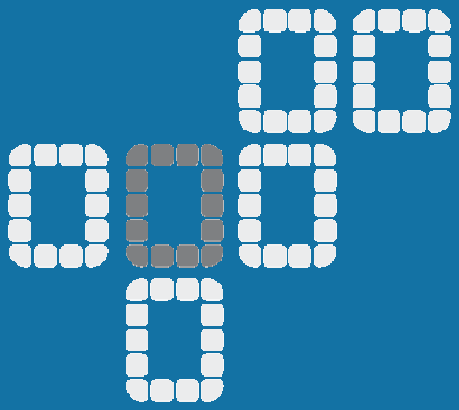
Table 1: WACHS Senior Officers as at 30 June 2008

Area of responsibility	Title	Name
WA Country Health Service (WACHS)	**Chief Executive Officer**	**Kim Snowball**
WACHS Area Operations	A/Chief Operating Officer	Jeff Moffet
WACHS Corporate and Finance	A/Area Director	Ken Mills
WACHS Health Service Enhancement	A/Area Director	Noel Carlin
WACHS Nursing Services	A/Executive Director	Karen Bradley
WACHS Medical Services	Executive Director	Geoff Masters
WACHS Clinical Services	Director Medical & Clinical Services Reform	Felicity Jeffries
Regional Operations	A/Regional Director Kimberley	Catherine Stoddart
Regional Operations	Regional Director Pilbara	Patrick Melberg
Regional Operations	Regional Director Mid West	Shane Matthews
Regional Operations	Regional Director Goldfields	Geraldine Ennis
Regional Operations	A/Regional Director Wheatbelt	John Fielding
Regional Operations	Regional Director Great Southern	Robert Pulsford
Regional Operations	Regional Director South West	Ian Smith

Management Structure

WA Country Health Service structure (June 2008)





Key Performance Indicators

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

Dr Peter Flett
ACCOUNTABLE AUTHORITY
Acting Director General of Health

17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

Audit Opinion (continued)

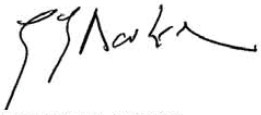
WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion
In my opinion,

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

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

(iii) the key performance indicators of the 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 2008.



GLEN CLARKE
ACTING AUDITOR GENERAL
23 September 2008

Page 2 of 2

Introduction

The health of the West Australian community has many determinants, including the provision of health services, access to and use of other government services and numerous environmental and social factors.

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 improvement of the health of the Western Australian community. This overarching goal is divided into three health outcomes:

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

All health entities contribute to the achievement of these outcomes, with different health service divisions taking responsibility for specific areas. While the largest proportion of health service activity is directed to Outcome 1 (particularly within the Metropolitan Health Service (MHS)), some health services within the WA Country Health Service (WACHS) have proportionally more activity directed to delivering Outcome 3. Therefore, to ascertain the overall performance of the health system all of the following annual reports must be read in conjunction:

- Department of Health
- Metropolitan Health Service
- WA Country Health Service
- Drug & Alcohol Office

Peel Health Service

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

Table 2: Service activities in relation to the health outcomes

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

Comparative Results

Where possible comparative results to prior years are provided.

Performance Targets

Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages for the indicators where available, or from the analysis of previous performance results. Efficiency indicator targets are those contributing to the State-wide targets published in the 2007-08 Government Budget Statements (GBS) for estimated expenditure for 2007-08.

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

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

Table 3: consumer price index figures for the financial year

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

Efficiency Indicators

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

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

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

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

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

Outcome 1	WA Country Health Service	Department of Health	Metropolitan Health Service
Restoration of patients' health	1-00 1-02 1-03 1-20	R1-50 R1-51	1-00 1-02 1-03
Timely access to admitted hospital care	1-01		1-01 1-08
Provide safe services	1-05	R1-52 R1-53	1-05
Safe delivery of newborns	1-06		1-06
Timely emergency care	1-07		1-07
Provide palliative care services		R1-54	

1-00: Proportion of patients discharged to home after admitted hospital treatment

This indicator reports the proportion of patients discharged to home after admitted hospital treatment.

Rationale

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

The performance indicator shows the percentage of all separations for patients admitted to WA Country Health Service public hospitals (excluding inter-hospital transfers) that are discharged home after hospital treatment.

An important indicator of how well patients have been restored to health (as well as survival rate) is that they are not readmitted to hospital for treatment of the same condition within a short time of discharge. Therefore this indicator should be examined in conjunction with KPI 1-02 and KPI 1-03.

As the normal ageing process tends to decrease a patient's chances of returning home, the figures are presented in ten-year age groups for the 2007 year. Data includes those patients separated after episodes of acute illness, rehabilitation, psycho-geriatric care and geriatric evaluation and management but excludes other care types.

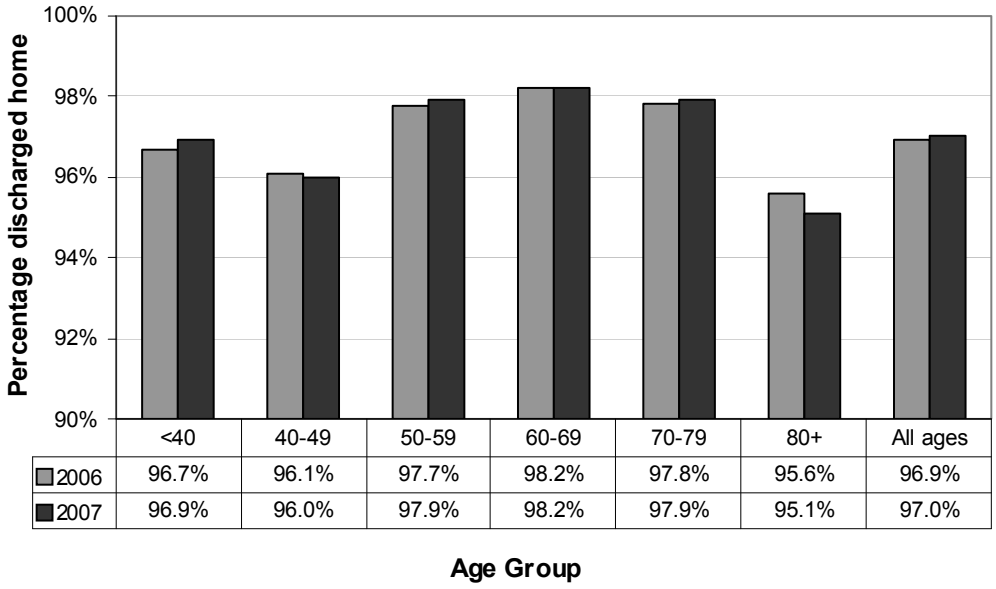
Results

The overall proportion for all ages of public patients discharged home from country hospitals was 97.0% and within target.

The results for the age cohorts demonstrate that the probability of being restored to health (discharged home after hospitalisation) is generally reduced with age.

Figure 2: Proportion of patients discharged to home after admitted hospital treatment

Overall (total) target ≥96.8%



	<40	40-49	50-59	60-69	70-79	80+	All ages
2006	96.7%	96.1%	97.7%	98.2%	97.8%	95.6%	96.9%
2007	96.9%	96.0%	97.9%	98.2%	97.9%	95.1%	97.0%

Data source
Hospital Morbidity Data System

1-01: Elective surgery waiting times

This indicator reports the waiting times for those elective surgery patients remaining as at 30 June 2008.

Rationale

For health services to be effective, access to them needs to be provided on the basis of clinical need. If patients requiring admission to hospital wait for long periods of time, there is the potential for them to experience an increased degree of pain, dysfunction and disability relating to their condition. After surgery, some types of patients will be restored to health, while for others surgery will improve the quality of life.

Patients who are referred for elective surgery are classified by senior medical staff into one of the following urgency categories based on the likelihood of the condition becoming an emergency if not seen within the recommended time frame.

Performance targets

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

Results

There were increased over boundary cases remaining as at 30 June 2008 for all categories across WACHS compared to 30 June 2007. In some areas, workforce availability impacted on waiting times during the year. The Area Health Service continues to work to improve the process for managing its elective surgery waitlists to enable more people to receive surgical treatment in country locations.

Table 5: People remaining on the elective surgery waiting list - 30 June 2008

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	82	59	25	424	73	39	2338	97	110
People remaining over boundary	56	41		156	27		79	3	

Table 6: People remaining on the elective surgery waiting list - 30 June 2007

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
People remaining within boundary	49	66	17	433	83	31	1886	97	90
People remaining over boundary	25	34		86	17		67	3	

Data source
Patient Electronic Referral Liaison System

1-02: 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 within 28 days. 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. This indicator should be considered in conjunction with the indicator KPI 1-00.

Results

The unplanned readmission rate for WACHS is 2.8%.

WACHS hospitals continue to monitor their performance to ensure that the highest standards of clinical practice and discharge planning have been adopted to deliver the best level of care to all patients.

Table 7: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2006-07	2007-08	Target
Unplanned readmission rate	3.0%	2.8%	**<2.8%**

Data source
Hospital Morbidity Data System
Report on Government Services 2008 National average (Target)

1-03: 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 or related mental health 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 within 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.

Results

The WA Country Health Service has recorded an unplanned readmission rate of 6.7% and met the benchmark for unplanned readmissions for a related mental health condition.

The WACHS is committed to providing a range of mental health programs and support networks designed to provide quality mental health services to the community to prevent unplanned readmissions whenever possible.

Table 8: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2006-07	2007-08	Target
Unplanned readmission rate	5.2%	6.7%	**<10%**

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in a previous admission within 28 days.

For the WA Country Health Service, 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.

Data source
Hospital Morbidity Data System

1-05: 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. This includes the diagnosis, the treatment given or procedure performed and the age, sex and condition of each individual patient. Other factors include 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. Therefore, three 'sentinel' procedures have been selected for which the survival rates are to be measured by specified age groups. These are stroke, heart attack (also known as acute myocardial infarction or AMI) and fractured hip (also known as fractured neck of femur or FNOF). For each of these conditions a good recovery is more likely when there is early intervention and appropriate care. Patients with these conditions are also more like to develop additional co-morbid conditions, and therefore better comparisons can be made, if comparing particular age groups, rather than the whole population.

This indicator measures the hospitals' performance in relation to restoring the health of people who have had a stroke, myocardial infarction or fractured neck of femur by measuring those who survive the illness and are discharged. Following acute admission, some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation.

Results

The reported survival rates for sentinel conditions met performance targets for AMI in all age cohorts except 60-69 yrs, for stroke in all age cohorts except 70-79 yrs and for FNOF for both reported age cohorts.

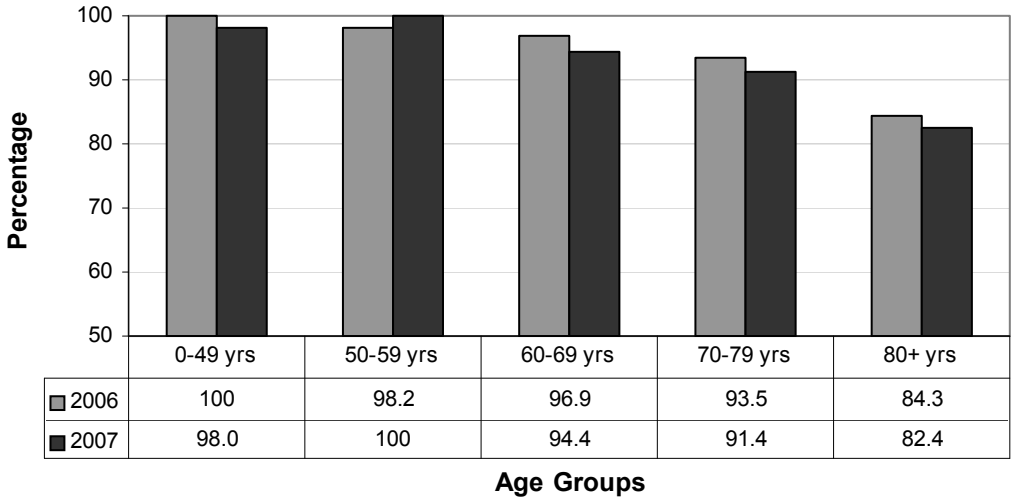
The performances recorded in this indicator demonstrate that WACHS continues to deliver quality clinical care in its hospitals.

Note: in the WA Country Health Service patient numbers for these conditions are generally low and therefore any variations in patient outcomes for these conditions can cause large variations to the annual percentage.

Figure 3: Survival rate for acute myocardial infarction (AMI)

Performance Targets

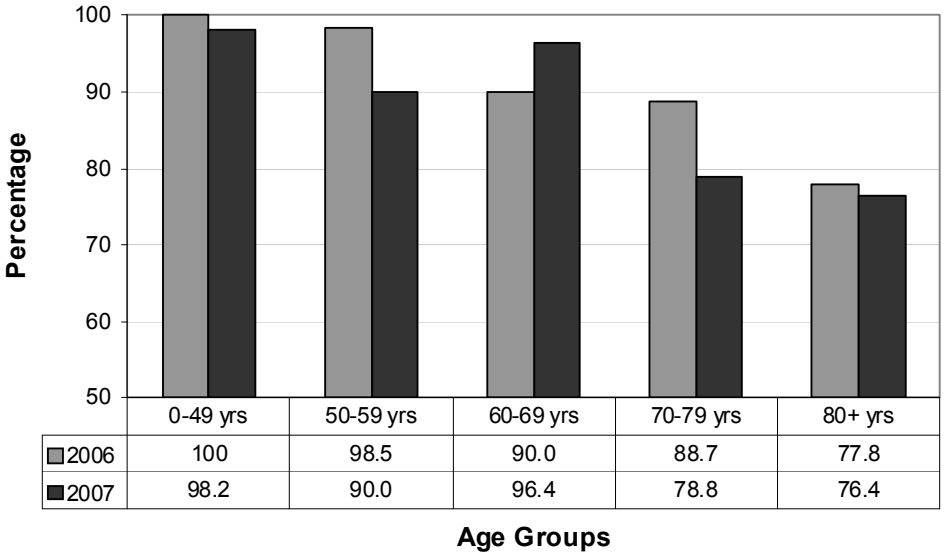
0-49 years - >97%
50-59 years - >97%
60-69 years - >95%
70-79 years - >90%
80+years - >80%



	0-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80+ yrs
2006	100	98.2	96.9	93.5	84.3
2007	98.0	100	94.4	91.4	82.4

Figure 4: Survival rate for stroke

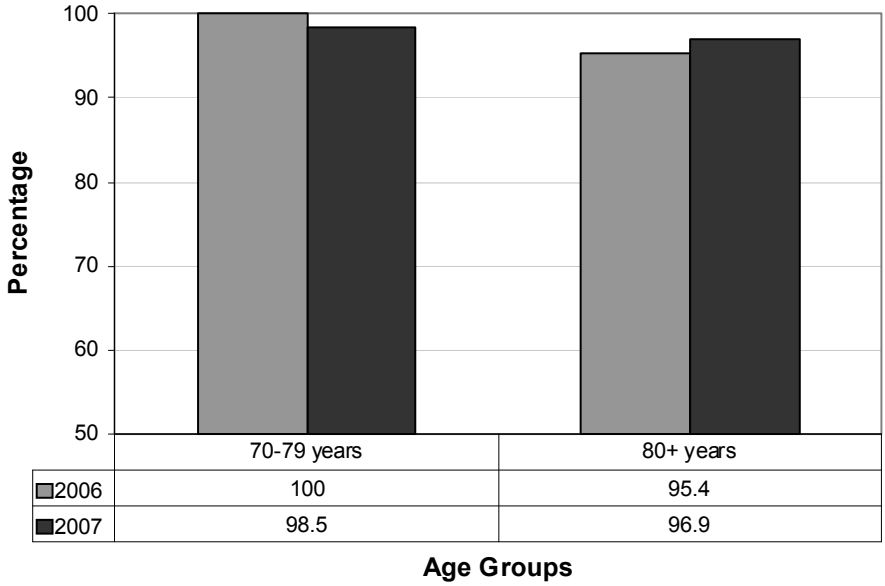
Performance Targets
0-49 years - >90%
50-59 years - >85%
60-69 years - >85%
70-79 years - >85%
80+years - >75%



	0-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80+ yrs
2006	100	98.5	90.0	88.7	77.8
2007	98.2	90.0	96.4	78.8	76.4

Figure 5: Survival rate for fractured neck of femur (FNOF)

Performance Targets
70-79 years - >95%
80+years - >90%



	70-79 years	80+ years
2006	100	95.4
2007	98.5	96.9

Data source
Hospital Morbidity Data System

1-06: Percentage of live births with an APGAR score of three or less five minutes post delivery

This indicator reports the proportion of live births with an APGAR score of 3 or lower, 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 also is an indication of the wellbeing of the baby.

This indicator reports on the number and percentage of babies with a low APGAR score at birth (an APGAR score of 3 or less at 5 minutes post delivery). A baby with a low APGAR is more likely to be premature with immature lungs or its mother had a difficult delivery than one with a higher score.

Results

The recorded proportions for babies born 0-1499 grams and 2000-2499 grams did not meet the national targets. There were 11 babies born in WACHS facilities with an APGAR score of three or less five minute post delivery with a total of 4,888 babies born for all weights in WACHS hospitals.

Note
Factors other than hospital maternity services can influence APGAR scores within birth weight categories - for example antenatal care, multiple births and socioeconomic factors. Small numbers of babies included in this indicator can result in large variations to recorded proportions.

Table 9: Percentage of live births with an APGAR score of three or less five minutes post delivery

Birthweight (grams)	Proportion of babies %		Target (National)
	2006	2007	
0 - 1499	36.4	38.5	≤13.8
1500 - 1999	0.0	0.0	≤1.1
2000 - 2499	1.2	0.6	≤0.5
2500 and over	0.1	0.1	≤0.1

Data source
Midwives Notification System
Text: Report on Government Services 2008

1-07: Proportion of emergency department presentations seen within recommended times

This indicator reports the proportion of emergency department patients seen within recommended times.

Rationale

When patients first enter an Emergency Department, they are assessed by specially trained nursing staff who judge how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition. Treatment within recommended times should assist in the restoration to health either during the emergency visit or the admission to hospital which may follow emergency department care.

A patient is allocated a triage code between 1 and 5 that indicates their urgency (see below). This code provides an indication of how quickly patients should be reviewed by medical staff.

The triage process and scores are recognised by the Australian College for Emergency Medicine and recommended for prioritising those who present to an Emergency Department. In a busy Emergency Department when several people present at the same time, the service aims for the best outcome for all. Treatment should be within the recommended time of the triage category allocated.

This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) and is reported for those sites that meet the criteria to be designated an emergency department. For WACHS only Bunbury has a designated emergency department.

Results

Only attendances for Triage category 5 were seen within the recommended threshold. The Triage 1 result relates to three emergency department cases where the unmet target time is related to a data management issue rather than a clinical matter.

The Bunbury emergency department continues to experience increasing activity workload which can directly impact triage time percentages.

Table 10: Proportion of emergency department presentations seen within recommended times

	Threshold	2006-07	2007-08
Triage category 1 (within 2 mins)	100%	100%	97%
Triage category 2 (within 10 mins)	80%	75%	61%
Triage category 3 (within 30 mins)	75%	61%	50%
Triage category 4 (within 60 mins)	70%	63%	47%
Triage category 5 (within 2 hours)	70%	88%	74%

Data source
Emergency Department Data Collection, Information Management and Reporting and TOPAS

1-20: Rate of emergency presentations with a triage score of four and five not admitted

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

Rationale

When patients attend hospitals they are initially received in the emergency service where assessment, treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency service where 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 the emergency service, 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 an emergency service given a triage score of 4 or 5 who were assessed, and treated but did not need admitted hospital care That is, they were restored to health. It does not include patients whose sickness or injury requires admitted hospital care.

This indicator reports the number of emergency service presentations to a WACHS hospital where the patient is not subsequently admitted. The numbers of presentations include doctor attended assessments and treatment as well as nursing assessment and treatment.

Performance target

A target has not been set as emergency presentations will be admitted or not admitted in accordance with their clinical needs.

Results

In 2007-08 the percentage of Triage 4 and 5 emergency presentations not admitted to WACHS hospitals was 92.0% and 97.7% respectively. Compared to 2006-07 Triage 4 attendances have increased 15.5% and Triage 5 attendances by 3.4% in 2007-08.

Table 11: Rate of emergency presentation with a triage score of four and 5 not admitted

	2006-07	2007-08
Triage 4 not admitted	90.1%	92.0%
Triage 5 not admitted	97.0%	97.7%

Data source
Emergency Department Data Collection, Information Collection and Management

S1-01: 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 for reporting hospital activity is a recognised methodology for adjusting actual activity data to reflect the complexity of health care provided against the resources allocated. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complex service provided.

WA hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) to which cost weights are allocated.

This indicator measures the average cost of a casemix-adjusted separation in non-teaching hospitals. Separate results are reported for teaching and non-teaching sites as it is expected that the level of case acuity will be higher at teaching sites than that at non-teaching sites.

Results

The WACHS recorded a cost per casemix adjusted separation of $4,302, within the prescribed target.

Table 12: Average cost per casemix adjusted separation for non-teaching hospitals

	2006-07	2007-08	Target
Actual cost	$4,240	$4,302	**$4,421**
CPI adjusted cost	$3,910	$3,829	

Notes
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.
This indicator does not include specialised mental health unit activity. (see KPIs 2-00)

Data sources
Hospital Morbidity Data System (HMDS)
WACHS Financial Systems

S1-20: Average cost per bed-day for admitted patients (selected small rural hospitals)

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

Rationale

While 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, it is not the accepted method of costing admitted activity in small rural hospitals.

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

Accordingly these hospitals report patient costs by bed-days. This indicator measures the cost per bed-day for admitted patients.

Results

The WACHS recorded a cost per small hospital bedday of $1,297 exceeding the target.

Commencing 2006-07, WACHS has separately reported small hospital acute and residential care bedday in KPIs S1-20 and S14-00. During this period, WACHS has been refining the activity counting criteria and the definitions for an acute and residential care bedday, and as a result of the continuing refinements, the activity estimations used in defining the performance target may not reflect current activity configuration.

Table 13: Average cost per bed day for admitted patients (selected small rural hospitals)

	2006-07	2007-08	Target
Actual cost	$1,275	$1,297	**$883**
CPI adjusted cost	$1,176	$1,155	

Data sources
HCARe activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S2-00: Average cost per bed-day in specialised mental health units

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

Rationale

The variations in care and episode characteristics for patients receiving admitted mental health care compared to other types of admitted care can result in differences in the service costs. It has therefore been recognised that for quality and cost effectiveness for the services provided under admitted mental health activity is better reported separately to other admitted activity and for beddays provided rather by a weighted separation.

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.

This indicator measures the average cost per bed day in specialised mental health units and for WACHS includes authorised units in Albany, Kalgoorlie and Bunbury.

Results

The WACHS recorded a cost per mental health unit bedday of $1,113. This result exceeds the target but is indicative of slightly reduced activity at the Bunbury Regional Resource Centre where full resourcing was maintained while the additional capacity at the new mental health inpatient facility was established.

Table 14: Average cost per bed day in an specialised mental health units

	2006-07	2007-08	Target
Actual cost	$982	$1,113	**$1,017**
CPI adjusted cost	$906	$991	

Data sources
Mental Health Information System
WACHS Financial Systems

Notes
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.
The WA Country Health Service has three authorised units situated in the Bunbury, Albany and Kalgoorlie Regional Resource Centres.

S6-20: Average cost per non-admitted hospital based occasion of service for rural hospitals

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

Rationale

Variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs. 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.

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

Results

The WACHS recorded a cost per non-admitted hospital based occasion of service of $160. This result reflects increased non-admitted activity across most sites in WACHS.

Table 15: Average cost per non-admitted hospital based occasion of service for rural hospitals

	2006-07	2007-08	Target
Actual cost	$174	$160	**$176**
CPI adjusted cost	$160	$142	

Data sources
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S6-21: 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

Variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs. It is important to monitor the unit cost of this non-admitted activity provided at these specialised service units, which often provide the only health service facility in rural or remote localities in order to ensure their overall quality and cost effectiveness.

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

Results

The WACHS recorded a cost per non-admitted occasion of service in a nursing post of $147.

Table 16: Average cost per non-admitted occasion of service in a nursing post

	2006-07	2007-08	Target
Actual cost	$139	$147	**$143**
CPI adjusted cost	$128	$131	

Data sources
HCARe and site non-admitted activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S7-20: 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 aim of PATS is to allow 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 the patient. Assistance is provided to the residents of Peel living between 70kms and 100kms from Perth, subject to certain conditions. Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Results

The WACHS recorded a cost per PATS trip of $346, exceeding the target. The higher cost of the PATS supported travel is a reflection of the continued increased costs associated with travel to and from rural and remote areas.

Table 17: Average cost per trip of Patient Assisted Travel

	2006-07	2007-08	Target
Actual cost	$327	$346	**$304**
CPI adjusted cost	$302	$308	

Data sources
PATS activity data systems
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

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

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

1. Increase the likelihood of optimal health and wellbeing by:
   - Providing programs which support the optimal physical, social and emotional development of infants and children.
   - Encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury by:
   - Delivering immunisation programs.
   - Delivering safety programs.
   - Encouraging healthy lifestyles (e.g. diet and exercise).
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - Programs for early detection of developmental issues in children and appropriate referral for intervention.
   - Early identification and intervention of disease and disabling conditions (breast and cervical cancer screening, screening of newborns) with appropriate referrals.
   - Programs which support self-management by people with diagnosed conditions and disease (diabetic education).
4. Monitor the incidence of disease in the population to determine the effectiveness of primary health measures.

Table 18: Key Performance Indicators for Outcome 2 by reporting entity.

Outcome 2	WA Country Health Service	Department of Health	Metropolitan Health Service
Prevention and promotion activities	2-01 2-02	R2-50	2-00 2-01 2-02
Protection from diseases	R2-51 R2-52	R2-51 R2-52	
Access to Dental health services		R2-53	2-03 2-04 2-05 2-06

Notes
WACHS population health units deliver both health prevention and promotion services as well as health protection services.

This section contains population-based indicators. The residential postcode of the individual receiving the service allows for epidemiological comparisons and is not the postcode of the location where the service was provided. Performance measurement for these indicators is provided for both Aboriginal and non-Aboriginal populations.

2-01: Rate of hospitalisation for gastroenteritis in children (0-4 years)

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

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in the 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 number 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. 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.

Health promotion and prevention programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis. WACHS also supports a number of Environmental Health Workers that work in Aboriginal communities and with Aboriginal Medical Services.

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.

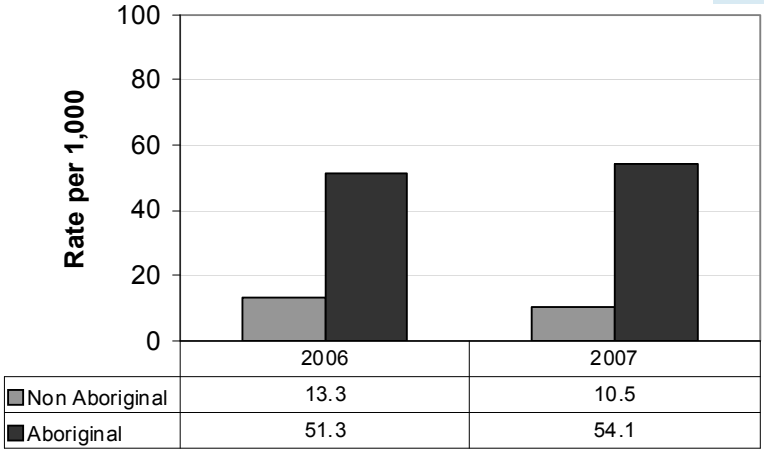
Results

In 2007 WACHS reported hospitalisation rates for gastroenteritis in non-Aboriginal children 0-4yrs of 10.5 per 1000, within target, while a rate of 54.1 per 1000 was recorded in Aboriginal children 0-4yrs exceeding the target and a slightly higher rate than reported in 2006.

WACHS continues its work with health and infrastructure providers to deliver environmental and community health programs aimed at preventing gastroenteritis and similar conditions in rural and remote locations, especially Aboriginal communities.

Figure 6: Rate of hospitalisation for gastroenteritis in children (0-4 years)

Total population target
≤ 19.9 per 1000



	2006	2007
Non Aboriginal	13.3	10.5
Aboriginal	51.3	54.1

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.

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

2-02: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale

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

It is important to note however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones 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.

Results

The recorded rates for 2007 of hospitalisation for respiratory conditions in non-Aboriginal populations across WACHS met the targets for the respiratory conditions reported.

The reported results for WACHS Aboriginal populations failed to meet the targets for the respiratory conditions in all but asthma for 5-12 yrs and croup.

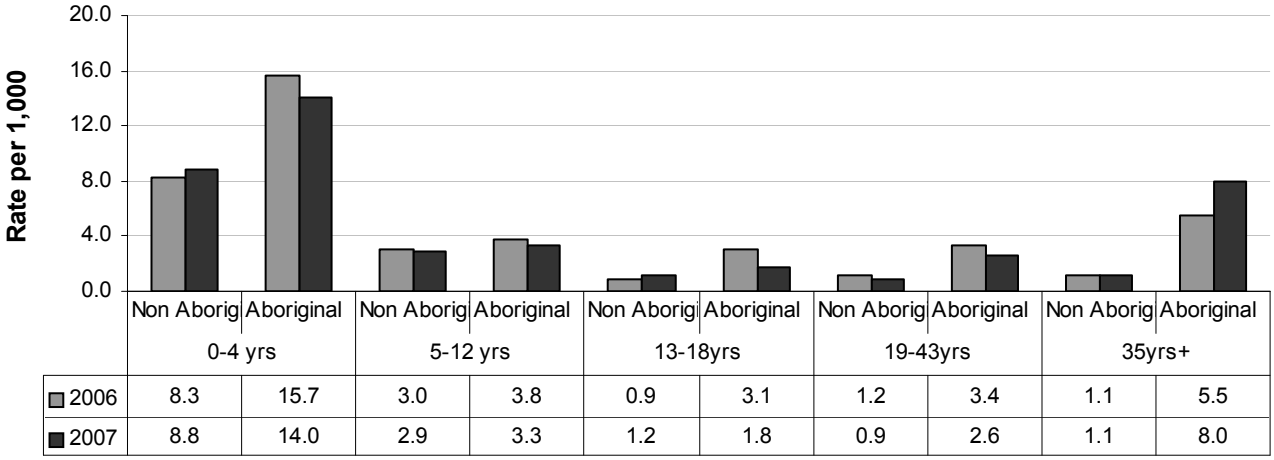
WACHS continues to develop and implement specific programs targeting the prevention, management and treatment of respiratory conditions especially in Aboriginal populations. Programs target individuals, families, groups and communities and focus on the determinants of poor health. Services are provided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

Performance targets

Condition	Age	Rate per 1000 total population
Asthma	0-4 yrs	<10.6
	5-12 yrs	<3.9
	13-18 yrs	<1.5
	19-34 yrs	<1.5
	35 plus	<1.8
Bronchitis	0-4	<1.3
Bronchiolitis	0-4	<18.9
Croup	0-4	<6.7

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

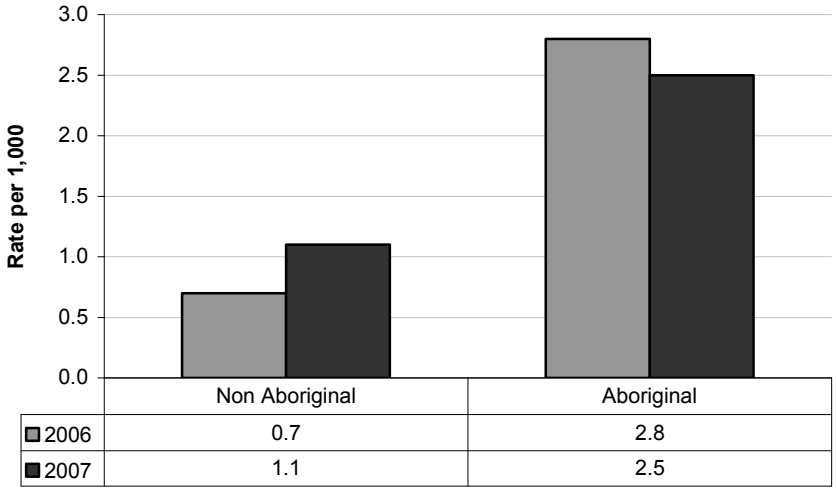
Figure 7: Rate of hospitalisation per 1000 for acute asthma (all ages)



	Non Aborig	Aboriginal	Non Aborig	Aboriginal	Non Aborig	Aboriginal	Non Aborig	Aboriginal	Non Aborig	Aboriginal
	0-4 yrs		5-12 yrs		13-18yrs		19-43yrs		35yrs+	
2006	8.3	15.7	3.0	3.8	0.9	3.1	1.2	3.4	1.1	5.5
2007	8.8	14.0	2.9	3.3	1.2	1.8	0.9	2.6	1.1	8.0

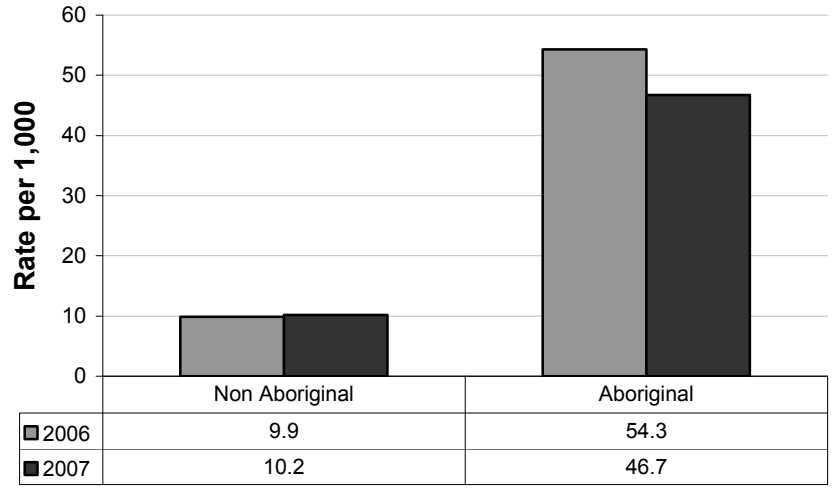
2-02: Rate of hospitalisation for respiratory conditions (continued)

Figure 8: Rate of hospitalisation per 1000 for acute bronchitis (0 to 4 yrs)



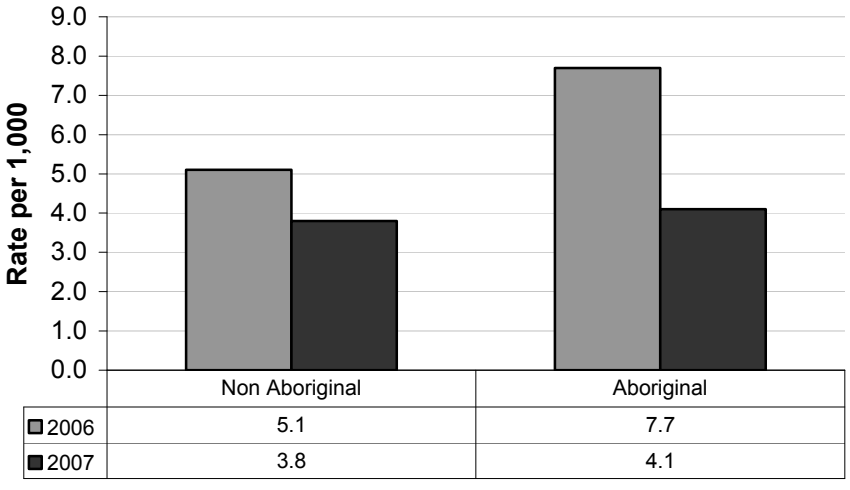
	Non Aboriginal	Aboriginal
2006	0.7	2.8
2007	1.1	2.5

Figure 9: Rate of hospitalisation per 1000 for bronchiolitis (0 to 4yrs)



	Non Aboriginal	Aboriginal
2006	9.9	54.3
2007	10.2	46.7

Figure 10: Rate of hospitalisation per 1000 for croup (0 to 4yrs)



	Non Aboriginal	Aboriginal
2006	5.1	7.7
2007	3.8	4.1

Data sources
Hospital Morbidity Data System
Australian Bureau of Statistics population figures

R2-51: Percentage of fully immunised children at 12 and 24 months

This indicator reports the proportion of fully immunised children at 12 and 24 months.

Rationale

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

This indicator measures the rate of complete immunisation against particular diseases, by age group, of the resident Health Service child population.

The benchmark percentages for immunisations are the agreed targets in the National Childhood Immunisation Program as follows:

At least 90% of children fully immunised at 12, 24 and 60 months.

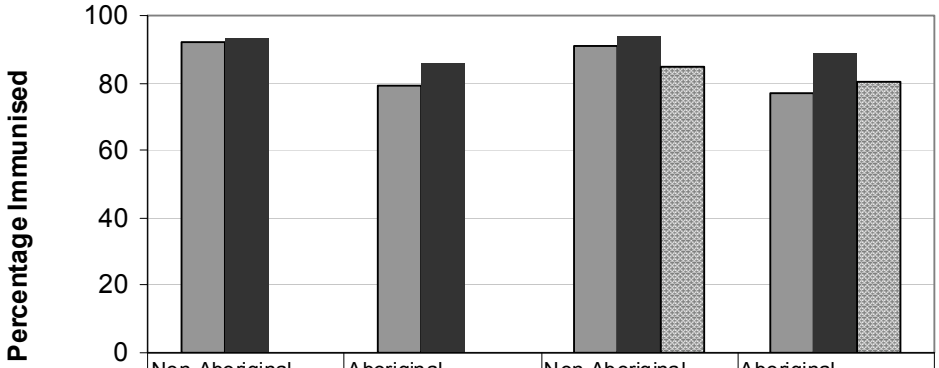
Rates of hospitalisation for infectious diseases or treatment for complications of these diseases are shown in R2-52. Without an immunisation program there is likely to be higher rates of hospitalisation or more disability and death resulting from the diseases.

Results

Immunisation percentages for non-Aboriginal children achieved in 2007 for WACHS for fully immunised children at 12 months and 24 months exceeded the national targets but failed to reach the benchmark for non-Aboriginal children at 60 months. The recorded immunisation percentages for Aboriginal children remain below the national benchmark although the percentage for Aboriginal children at 24 months has increased compared to the 2006 result.

WACHS continues to promote its immunisation programs across rural communities with specific attention given to Aboriginal communities.

Figure 11: Percentage of fully immunised children at 12, 24 and 60 months



	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal
	2006 (Dec Quarter)		2007 (Dec Quarter)	
12-15 months	92.0	79.1	91.1	77.3
24-27 months	93.5	86.3	93.7	89.1
60-63 months			84.7	80.4

Data sources
Australian Childhood Immunisation Register (ACIR)
Australian Bureau of Statistics (ABS) population figures

Note
The age cohort 60 months has been introduced in 2007 as a nationally reported age indicator for immunisation.

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

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

Rationale

To provide additional information about the effect of the immunisation program, the rates of hospitalisation for treatment of the infectious diseases measles, mumps, diphtheria, pertussis, poliomyelitis, rubella, hepatitis B and tetanus are reported. Cases are identified by the principal diagnosis recorded for a hospital admission for these infectious diseases.

Performance targets

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

Results

WACHS recorded a single hospitalisation for mumps in 2007 in the Aboriginal population realising a rate of 5 per 100,000 for the respective Aboriginal age cohort. No other cases of hospitalisation in WACHS were recorded for a immunisable infectious disease in 2007.

The absence of reported hospitalisations for infectious diseases for which there is an immunisation program continues to demonstrate effective vaccination and immunisation programs provided by the WACHS.

Table 19: Rate of hospitalisation for immunisable diseases per 100,000.

	2006-07		2007-08	
	Aboriginal	Non-aboriginal	Aboriginal	Non-aboriginal
Pertussis	0.0	1.0	0.0	0.0
Mumps	0.0	0.0	5.0	0.0

Data sources
Hospital Morbidity Data System
Australian Bureau of Statistics population figures

S8-00: Cost per capita of Population Health units

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

Rationale

Population health considers 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.

Population health units support individuals, families and communities to increase control over and improve their health. In rural locations Population Health units provide both Health Prevention and Promotion, and Health Protection services and programs including:

- Supporting growth and development, particularly in young children (community health activities);
- Promoting healthy environments
- Prevention and control of communicable diseases
- Injury prevention
- Immunization
- Promotion of healthy lifestyle to prevent illness and disability
- Support for self-management of chronic disease
- Prevention and early detection of cancer

Results

The WACHS recorded a cost per capita for WACHS Population Health Units of $164.

Table 20: Cost per capita of population health units

	2006-07	2007-08	Target
Actual cost	$161	$164	**$157**
CPI adjusted cost	$148	$146	

Data source
Australian Bureau of Statistics
WACHS Finance Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

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

The achievement of this component of the health objective involves provision of services and programs that improve and enhance the wellbeing and the environment for people with chronic illness or disability. To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided to enable normal patterns of living. Support is provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential institutions. This involves the provision of clinical and other services which:

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

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

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

Table 21: Key Performance Indicators for Outcome 3 by reporting entity.

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

Note
Area Health Services will also provide acute services to those with disabilities under Outcome 1.

3-00: 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 mental illness 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 mental 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.

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

Results

In 2007, 52.9% of discharges with a mental illness from public mental health inpatient units received contact from a community-based public mental health non-admitted service within seven days of discharge. A further 11.1% of clients were seen within 8 to 14 days.

These results are lower than the set targets as the client group has been expanded to be more inclusive.

Approximately 14% of discharges had no contact within the year. However clients in this reporting category may be seen by private sector clinicians (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) following discharge for which "contact made" data is not available. In addition to these clinical services clients have access to non-clinical support services reported under the Department of Health KPI R3-52.

Note: Commencing in 2007 this indicator has been expanded to include all mental health conditions precluding prior year comparative analysis.

Table 22: 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.

Days to first contact	2007		Target
	%	Cumulative %	
0-7 days	52.9%	52.9%	**60%**
8-14 days	11.1%	64.0%	**70%**

Data source
Mental Health Information System, Data Collection and Analysis-Inpatient and Mental Health, Information Management and Reporting, Department of Health WA

3-20: Aged care resident/carer satisfaction survey

This indicator reports resident satisfaction with the residential aged care services they receive in WACHS facilities.

Rationale

The WA Country Health Service cares for patients who require long term care involving 24 hour nursing care.

This indicator measures resident satisfaction with the residential aged care services they receive in WACHS facilities. The survey is conducted with the resident wherever possible or if not appropriate, with their nominated guardian or carer. Survey results will be reported for both the specified residential aged care facility residents and other aged care residents.

WACHS residential care services include high dependency, high dependency respite, low dependency and low dependency respite provided to nursing home residents, nursing home type residents in hospital and hostel residents. The provision of non-acute permanent care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

As planned, WACHS concentrated its surveying resources in 2007-08 on developing and implementing a pilot survey focussed on Aboriginal aged care clients in WACHS facilities. Extensive consultation was conducted with the Health Consumer's Council of WA, the Office of Aboriginal Health and with focus groups canvassing aboriginal people living in residential care where possible. These consultations have aided the development of a revised survey tool to ensure the range of questions would address the current needs of ATSI people.

However this task proved a challenge as a great number in the client group were not able to respond due to cognitive deficits. This has lead to only 37% of possible respondents where 28 residents were interviewed in four facilities across WACHS.

Results

In general terms there were only two out of 33 questions put to respondents where the satisfaction percentage fell below 50%. In relation to information sharing about changes in care and choice of foods the majority of residents indicated that more could be done to take their wishes into account.

The pilot survey results in 2007-08 have informed WACHS that more work will need to be undertaken in future years to conduct the survey under appropriate survey methods that will effectively capture information about Aboriginal client satisfaction with WACHS residential care services.

Data source
WACHS and the Epidemiology Branch, Department of Health

S12-00: Average cost per completed ACAT assessment

This indicator measures the average cost per ACAT assessment.

Rationale

Aged people 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.

Some of these services specifically relate to funded programs that require an assessment by an Aged Care Assessment Teams (ACAT), without which access to the appropriate aged care service programs cannot be progressed.

This indicator measures the average cost per completed assessment provided by an ACAT.

Results

WACHS recorded a cost per completed ACAT assessment in 2007-08 of $1,102 exceeding the prescribed target.

WACHS provides resources appropriate to delivering ACAT services to rural and remote locations. This entails sufficient expenditure to service remote locations as well as the additional costs associated with multiple assessment contacts for small client numbers living in remote settings.

Table 23: Average cost per completed ACAT assessment

	2006-07	2007-08	Target
Actual cost	$1,145	$1,102	**$785**
CPI adjusted cost	$1,056	$981	

Data sources
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to December 2007 and January to March 2008.
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08.

S13-00: 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 health problem or who are receiving post-acute care. This indicator gives a measure of the cost of treatment for public psychiatric patients under community management (non-admitted/ambulatory patients).

Results

The WACHS recorded a cost per person receiving community health services of $3,391 exceeding the target. This result reflects additional costs incurred in relation to clinically based services.
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Table 24: Average cost per person receiving care from public community based mental health services

	2006-07	2007-08	Target
Actual cost	$3,321	$3,391	**$3,070**
CPI adjusted cost	$3,063	$3,019	

Data source
Mental Health Information System
WACHS Financial Systems

Note
Statewide corporate costs have been apportioned to this key performance indicator in 2007-08

S14-20: Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents

This indicator reports the cost per residential aged care bedday provided in WA Country Health Service facilities.

Rationale

The WA Country Health Service provides residential care for patients who require long term care involving 24 hour nursing and support care.

The provision of non-acute permanent residential care is a significant activity provided to rural clients across the WA Country Health Service where access to local alternative private or non-government providers may be limited.

WACHS residential care services include permanent high dependency, high dependency respite, permanent low dependency and low dependency respite, nursing home type care in hospital, and hostel and flexible care.

This indicator reports the cost per residential aged care beddays for residents of the specified residential aged care facilities in the Kimberley at Numbala Nunga and Kununurra, and in the Pilbara at Karlarra and for all other WACHS residential aged care services.

Results

The WACHS recorded a cost per residential care bedday of $366.

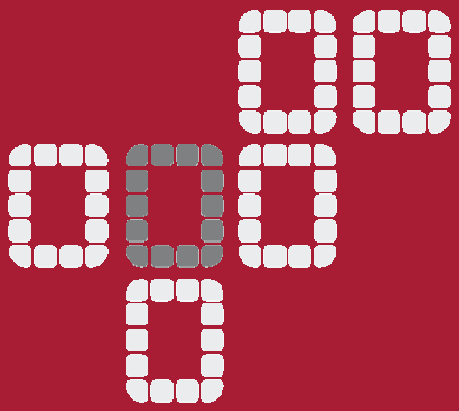
Commencing 2006-07, WACHS has separately reported small hospital acute and residential care bedday in KPIs S1-20 and S14-00. During this period, WACHS has been refining the activity counting criteria and the definitions for an acute and residential care bedday, and as result of the continuing refinements, the activity estimations used in defining the performance target may not reflect current activity configuration.

Table 25: Average cost per bed day for specified residential care facilities, flexible care (hostels) and nursing home type residents

	2006-07	2007-08	Target
Actual cost	$337	$366	**$396**
CPI adjusted cost	$311	$326	

Data sources
WACHS HCARe data warehouse
WACHS Financial Systems

Notes
Overhead costs for Health Corporate Network, Health Reform Implementation Taskforce and InfoHEALTH have been apportioned to this key performance indicator in 2007-08.



Significant Issues and Trends

Overview

During 2007-08 the WA Country Health Service has continued the implementation of its strategic plan for the period 2007-2010 "Foundations for Country Health Services".

'Foundations' sets out the service configuration and structure for the WA Country Health Service (WACHS) that will best deliver the range of health care services to meet the needs of a changing rural community, respond to the numerous service resourcing and capacity issues, and take advantage of emerging clinical and patient care technologies and practices.

WACHS' three strategic direction are:

Networking health services

To effectively connect people and services, whether within regions, between regions, with metropolitan hospitals, or among the different country service providers, is vital to improve both access to health services and the efficiency and effectiveness of those services. Priority areas for achieving this objective include further advancement of the regional hospital role delineation project, implementing effective service planning and management to deliver coordinated and responsive services, developing greater collaboration between clinical and other staff across regions, and ensuring effective emergency care across WACHS.

Building healthier communities

Priorities remain to increase resource allocation for disease and injury prevention, early intervention and smarter management of chronic disease, to provide more home and community based service delivery especially to maintain the health and independence of older people, to develop mental health, alcohol and drug abuse response capacity, and to improve Aboriginal health.

Strengthening and modernising the country health system

In the face of the challenges of increasing demand for high quality and accessible services combined with workforce shortages, WACHS conducts management and system support evaluations across the health service to highlight areas of duplication and identify opportunities for new and innovative ways to enhance the efficiency and effectiveness of WACHS' healthcare operations and support systems.

Service trends

There are a number of significant service and demographic trends that impact upon service delivery in country areas, and provide a challenge to the provision of efficient and effective health care. Many of these trends have remained unchanged over the past year.

The population projection for WA country regions remains at an estimated growth rate of 13% between 2001 and 2011 and change variables affecting rural and remote populations have continued where the delivery of services is especially affected by the growth in mining areas, the South West and coastal towns, an increase in the ageing population who experience a higher incidence of chronic disease and ill-health, and the significant and persistent disparity in health status between the Aboriginal and non-Aboriginal populations.

Workforce shortages continue across most clinical medical disciplines essential for the provision of effective and efficient health care services where the reliance on a multi-skilled generalist medical workforce remains. Other issues such as recruitment and retention of skilled staff, providing professional and peer support, distance and access factors, and managing low levels of activity in combination with community expectations for locally accessible specialised healthcare, are service delivery issues that continue to pose challenges to WACHS.

WACHS continues to manage its service delivery within its resource allocation. However this remains an extremely challenging task for the Area Health Service as it endeavours to meet the demand for health care services, to address workforce issues, and manage the increasing costs of medical practice and technology, innovation, transport and isolation.

Activity

During 2007-08 WACHS recorded a significant increase of over 10% in the provision of non-admitted services including emergency service activity compared to 2006-07. For the calendar year 2007, the WACHS hospitals delivered 4,888 live born infants, provided 9,115 same day procedures and discharged 94,913 cases. During 2007-08 WACHS provided 70,512 acute and 202,833 residential occupied beddays from its small hospitals and 63,909 weighted separations from its larger hospitals. WACHS delivered 86,834 individual community mental health service consultations from its mental health services or contracted providers.

Major Achievements 2007-08

Healthy workforce

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

WA Country Health Service workforce initiatives in 2007-08 continue to focus on planning, attraction and retention, the development of innovative workforce models, cultivating partnerships with other employers and providers, and striving to be an employer of choice.

Specialist services

Visiting specialist services have been increased across a number of regions under the WACHS Specialist Services Plan and the Medical Specialist Outreach Assistance Program. The Great Southern has increased visiting specialist services in the fields of vascular surgery, cardiology orthopaedics, palliative care, rheumatology, sleeping disorders, geriatrics and obstetrics, in the Kimberley there has been increased services in obstetrics, gynaecology and ophthalmology, and in the Mid West the numbers of specialist oncologists servicing the region has increased. For the first time, all seven regions have a visiting specialist geriatric service.

Nurse practitioners

All country hospitals have been designated as emergency care nurse practitioner sites and 21 sites are receiving remote area nurse practitioner status with practice protocols endorsed. The creation of nurse practitioner positions and the recruitment of staff to fill these positions is progressing, with four nurse practitioners appointed for remote areas. A further 2 nurse practitioner positions in emergency care have been created, with recruitment to fill these positions progressing in 2008-09.

Graduate nurses

Placements for recruited graduate nurses across WACHS have increased to 58 (YTD February) in 2008, an increase of 11% compared to 2007. A total of 85 placements have been allocated for graduates in 2008 which can be filled through the recruitment program as well as alternative selection programs.

Medical workforce

During 2007-08 WACHS established a Medical Workforce Unit to coordinate and facilitate the recruitment and induction of medical staff to salaried positions within the WACHS. Also during the year a medical clinical reform director position was been established to implement a medical workforce strategic plan.

Physicians and medical officers have been recruited to newly created positions in the Kimberley, the Pilbara and the Mid West. A new registrar position has been created for the South West.

Telehealth

A state-wide Telehealth structure has been approved with the establishment in May 2008 of a Telehealth Development Group under the leadership of the WACHS Chief Executive Officer and reporting to the Operations Review Committee of the State Health Executive Forum.

Inpatient therapy

The Bunbury Inpatient Therapy Team has been expanded, enabling the development of referral processes and a program of therapy groups across inpatient, rehabilitation and community services.

Staff attraction and retention

WACHS continues to participate in the development of community, regional, state and national initiatives for a sustainable rural health workforce. The establishment of programs and innovative workforce models that address expected workforce gaps and skills shortages remains a priority for WACHS.

Initiatives to attract and retain nursing staff have continued across WACHS, and include programs such as the:

- "Kimberley Rotation";
- "Ocean to Outback";
- "Country to Coast";
- "Crocs to Rocks"; and
- "Nursing with Adventure".

These programs aim to offer nurses greater work satisfaction with exposure to a diverse range of sites and work areas.

Healthy workforce (continued)

Aboriginal health services

Indigenous health services in WACHS - Wheatbelt have been expanded through the recruitment of a podiatrist, a social worker and Aboriginal health workers in Dalwallinu, Merredin, Moora, Narrogin/Pingelly, Northam and Quairading.

Emergency services

Management of the emergency on-call system has been enhanced in the Eastern Wheatbelt with the employment of two doctors in partnership with private practices in Merredin and Bruce Rock.

Elective surgery

WACHS received an allocation from stage one of the Commonwealth Government's Elective Surgery Wait List Reduction Plan where WA Health has received funding for additional elective surgery procedures for 2008 specifically for patients who have waited longer than is clinically appropriate.

Healthy hospitals, health services, and infrastructure

The WA Country Health Service provides a range of health care services through its regional network model of service delivery. It is committed to ensuring that services are accessible, innovative and responsive to community needs, are efficient, and of the highest quality.

Hospital in the home

The 'Hospital in the Home' program has been operating in Albany, Bunbury and Geraldton. A review of the HITH service in WACHS - Great Southern has been completed and forms the basis for the expansion of HITH programs to other country regions including the implementation of consistent reporting mechanisms for home-based care services. Six WA Country Health Service regions have 'Hospital in the Home' (HITH) programs increasing the access of rural patients to this type of service. A network for rural HITH staff has been established to provide collegiate support and advice as new services are implemented at additional sites.

Aboriginal health

A survey of Indigenous aged care residents residing in WACHS facilities was conducted in June 2008 in the Pilbara, Kimberley and Mid West. Results will inform strategies for improvement in the delivery of care to Indigenous aged care residents.

Emergency services

Improved processes for the management and coordination of the transfer of critically ill patients from country emergency services to an appropriate health facility have been trialled in WACHS - South West in collaboration with the Royal Flying Doctor Service and St John Ambulance. The trial involves telephone clinical coordination provided by emergency medicine specialists, assisting medical and nursing staff in the assessment of seriously ill patients, the determination of hospitalisation and transfer requirements, and liaison with the receiving metropolitan hospital and the transporting agency.

Accreditation

The Australian Council on Healthcare Standards (ACHS) is an independent authority on the measurement and implementation of quality improvement systems for Australian health care facilities. The ACHS provides a quality improvement framework, the Evaluation and Quality Improvement Program (EQuIP), to assist health care organisations continuously measure their performance and strive for excellence. In a four year cycle the organisations alternate, annually, between self-assessments and external audits. The ACHS program provides health services with recommendations for improvement.

During 2007-08 WACHS regions underwent routine accreditation reviews and audits conducted by the ACHS or undertook self assessments to commence or maintain their accreditation status.

Capital and infrastructure projects

Numerous capital projects were completed during 2007-08 including:

- Derby Acute Inpatient Ward and Ambulatory Care Centre;
- Fitzroy Crossing Multi-Purpose Centre and Dental clinic;

- Kununurra Hospital Ward expansion, dental clinic and support services;
- Morawa and Perenjori Multi-Purpose Centre;
- Carnarvon Hospital stage 1 – upgrade to existing maternity and palliative care wards and roof replacement to general ward; and
- Bunbury dental clinic and South West Health Campus inpatient mental health unit and mental health clinic.

During 2007-08 medical imaging capabilities across WACHS were improved with:

- Computed radiology was installed at Geraldton, Carnarvon and Northam;
- New laser imagers installed at Newman, Esperance, Kalgoorlie and Karratha;
- Installation of new ultrasound machines in Geraldton, Albany (2), Karratha, Port Hedland and Tom Price (equipment upgrade);
- New ultrasound tables at Geraldton, Newman, Derby and Katanning; and
- Mammography units in Kalgoorlie and Albany.

The country clinical equipment upgrade program has commenced, including:

- provision of bariatric beds to all Regional Resource Centres to improve services for overweight patients;
- replacement of sterilisers at Bunbury, Kalgoorlie and Port Hedland Regional Resource Centres and at Busselton Hospital; and
- expansion of the bed replacement program for country hospitals.

Telehealth burns management

Telehealth burns management services have been expanded to all country regions in a partnership between the WACHS, and Princess Margaret and Royal Perth Hospitals.

Aged care

During 2007-08 WACHS completed the establishment of Aged Care Coordination Units in each of its regions. The primary role of these units is to build an effective aged care network to better coordinate the planning and delivery of aged care services.

WACHS - Pilbara has taken over the management of the Western Desert home and Community Care (HACC) program and is working with communities to establish community-owned HACC projects.

Risk screening

Risk screening of non-Indigenous patients aged 65 years and over and Indigenous patients aged 45 years and over, has commenced in all WACHS Regional Resource Centre emergency services under the Council of Australian Governments *Improving Care for Older Patients in Public Hospitals* initiative. Patients with a positive risk screen are referred for comprehensive assessment and follow up to prevent avoidable hospital admissions or to access coordinated care if admission is necessary.

Homelink

A rural home link service with a 1800 telephone contact number will be operational during 2008, enabling better coordinated discharge planning for country patients who are leaving metropolitan hospitals. The rural home link service will be supported by 'Hospital in the Home' services based in the regions.

Patient support services

During 2007-08 the "Meet and Assist" service was integrated within the Aboriginal Liaison Service. These services provided 220 airport pickups between May 2007 and April 2008 and supported patient attendance for 497 hospital appointments. Two Aboriginal health workers have been appointed and routinely visit each of the Aboriginal hostels in Perth providing assistance on health-related issues.

To support these new patient services initiatives, accommodation has been secured at Thorburn House, at the Royal Perth Rehabilitation Hospital establishing a centre to assist with the discharge planning of country patients. The new facility will be operational in 2008. The integrated Aboriginal Liaison and Meet and Assist service will be co-located in the centre with additional rural nurses to extend the service to non-Indigenous rural patients.

Patient assisted travel scheme

The new Patient Assisted Travel Scheme (PATS) database is a web based data management system for WACHS. The system is designed so data can be extracted for a specific region, a combination of regions or for all of WACHS. The system has also been structured to replicate the PATS management V3.0 database with improved functionality.

There have also been improvements to PATS application forms and updated guidelines for PATS were implemented in January 2008.

WACHS – Pilbara, one of the major users of the PATS, now coordinates patient travel centrally from Port Hedland. This has increased the efficiency of PATS administration and client services in WACHS - Pilbara.

Healthy communities

Initiatives to improve the health of people living in country WA focus on activities that influence the health of individuals as well as the whole population. Goals include improving lifestyles, the prevention of ill health, and the implementation of long-term, integrated health promotion programs.

Initiatives developed by WACHS during 2007-08 followed extensive collaboration and consultation with government and non-government agencies, general practitioners and healthcare service provision stakeholders.

Transitional care

WACHS has been allocated sixty flexible places under the Transition Care Program (TCP). These places are divided evenly between the Mid West, South West and Great Southern, and are provided in partnership with private service providers who will deliver the required services. These programs commenced in the South West in September 2007, in the Mid West in February 2008 and in the Great Southern in March 2008.

Transition care is a Commonwealth / State program that targets frail older people at the conclusion of a hospital stay and provides time-limited, goal-oriented therapeutic care in a non-hospital environment while assisting the patient to make long-term care arrangements. It is expected that the TCP will reduce extended hospital stays, reduce the rate of hospital readmission, and minimise premature admission to residential aged care.

The appointment of Aged Care Managers in each region has enhanced aged care service coordination and supported the implementation of risk screening of all older patients accessing emergency departments.

Health promotion

Health promotion programs targeting children and high-risk groups in country areas have continued during 2007-08 and include:

- support across WACHS for the school canteens traffic light policy;
- an infant feeding pilot project in the Wheatbelt; and
- engagement with two Goldfields Indigenous communities (Ninga Mia and Coolgardie) to provide nutritional advice and information to support purchase and preparation of healthy food.

Australian better health initiative

Under the Australian Better Health Initiative funding has been provided to support the implementation of the 'healthier schools' programs, focusing on physical activity and nutrition. "Healthy school" coordinators have been employed in each of the seven regions to facilitate implementation.

Brief intervention

WACHS has implemented 'brief intervention' strategies to support the WACHS alcohol and tobacco brief intervention policy endorsed in June 2007. During 2007-08 WACHS has worked with the Drug and Alcohol Office, the National Drug Research Institute and the Western Australian Tobacco Control Branch to develop resources including a training program, to assist the implementation of this policy and created Brief Intervention Project Officer positions in each region.

WoundsWest

WACHS is participating in a number of Statewide WoundsWest projects that have been completed or are progressing:

- the state-wide wound prevalence survey has been completed and distributed to all health services;
- the core Wound Management module and the first of four sub-specialty modules are available online, with another two planned for 2008;
- recruitment for a WoundsWest Consultant Team is progressing; and
- a wound imaging and documentation system is in development.

Smoke Free WA

WACHS implemented the WA Health Smoke Free policy on January 1, 2008. All WACHS health facilities are non-smoking for patients, employees, visitors, volunteers and contractors. The policy is applicable to any health service building, grounds and other facilities (including cars), and while officers are representing WACHS in any official capacity.

Mental health

The 'Act Belong Commit' campaign under the "Mentally Healthy Western Australia" health promotion program was successfully implemented in Albany, Esperance, Kalgoorlie, Geraldton, Karratha, Northam and Toodyay. This

program aims to improve mental health through encouraging people to undertake activities that build individual resilience and community cohesion.

A number of Statewide initiatives to address postnatal depression were implemented and benefited WACHS-based service delivery including:

- the 'Beyond the Boundaries' Perinatal Mental Health Symposium held to promote perinatal mental health to the broader WA Health sector;
- a culturally appropriate perinatal mental health training module for Indigenous Health Workers was developed and delivered at Marr Mooditj Aboriginal Health Training College; and
- a new service model, frameworks and service agreements to enhance postnatal depression services for Iraqi, Sudanese and Ethiopian communities in Western Australia were developed.

The Statewide Clinical and Service Enhancement Program (SCSEP), the primary provider of telepsychiatry has relocated to new premises enabling it to double its capacity (four purpose fit studios) which contributed to a 21% increase in videoconferencing activity. As part of the Pathways Home project, video-conferencing equipment has been installed in an additional 58 centres across the State to expand telepsychiatry services. These services include specialist mental health services to clients and professional development opportunities for country mental health service staff. A further project has begun which will explore the delivery of telepsychiatry services through the use of videoconferencing equipment being installed in clients' homes.

WACHS – Kimberley has implemented the 'Headspace' program to address the region's complex and high levels of youth mental health needs. The program focuses on enhancing the delivery and coordination of services within the town of Broome, and the development of early intervention, awareness raising and community education programs in a whole-of-Kimberley context. A venue has been established where young people are able to access counselling and support services which will reflect the social, economic and geographic diversity of the region, and promote social recovery in culturally appropriate ways. The focus will be on promotion, prevention and early intervention, with treatment being provided by the "Better Outcomes for Mental Health" program.

Under the Western Australia's Mental Health Strategy the establishment of additional community supported accommodation services for people with severe mental illness living in WA is a priority. Under this initiative during 2007-08 the construction of residential units in Albany, Busselton, Bunbury and Geraldton was completed and residents will move in during 2008. These units will provide daily rehabilitation and clinical support to residents and help minimise the risk of hospitalisation for people with severe and persistent mental illness.

'Stay on your Feet'

The WA Country Health Service continues to prioritise its community based activities for the "Stay On Your Feet" (SOYF) program across the Area Health Service including programs and activities contributing to SOYF promotion week.

Residential care line

The Residential Care Line has been trialled in the Great Southern, South West and Mid West regions providing a telephone advice and outreach service to residential aged care facilities in the major regional centres. This line assists residential care facilities to better manage sick elderly patients and thereby decreasing unnecessary presentations to hospitals and emergency services.

Home and community care

The WA Country Health Service is participating in the trial of single access points under the Home and Community Care (HACC) program in the Goldfields and Kimberley. This project is a key initiative aiming to build on current infrastructure and services to make it easier for people to find out about and access community care services. The work to improve access to community care involves the identification of entry points (Access Points) that can be easily identified by people seeking services.

Pit Stop: men's health program

The 'Pit Stop' men's health promotion package has been updated and distributed to all country regions. This program encourages men to get regular health check-ups, and has included Indigenous communities in Coonana, Leonora and Norseman. The package relates body functions to mechanics, likening parts of the body to an engine.

Cancer care

In 2003 the Health Reform Committee (Reid) recommended a review of cancer service delivery in Western Australia. A comprehensive review was undertaken in 2005 by the WA Cancer Services taskforce.

The result was the development of the WA Health Cancer Services Framework, a state funded initiative supported by the Minister for Health, and aimed at improving health outcomes

Healthy communities (continued)

Cancer care (continued)

for cancer patients throughout the state. The WA Cancer and Palliative Care Network was established to implement the recommended initiatives.

It is recognised that patients from rural and remote areas, and especially patients being treated in rural and remote areas of WA, have a range of poorer outcomes in the treatment of cancer, including mortality, morbidity, access and completion of appropriate treatments and access to information. (WA Health Cancer Services Framework, 2005)

A number of initiatives have been put in place to improve services and patient outcomes.

Rural Cancer Nurse Coordinators

Currently seven regional coordinators with a metropolitan-based rural cancer nurse coordinator have been appointed. The key role of these positions is to streamline and coordinate the patients' cancer journey and provide a point of contact and support for rural, regional and remote patients and their families. These roles also promote sharing of information, thus encouraging a seamless service between rural and metropolitan areas.

CanNet (Cancer Service Networks National Demonstration Program)

CanNet is an initiative led by the WA Cancer and Palliative Care Network which aims to improve the cancer journey and outcomes of people affected by cancer. The development program is being piloted in the WACHS - Great Southern and aims to extend specialist cancer care out of the current metropolitan centric model through the establishment of a cancer service network. A cancer network will increase the capacity of rural health care providers in this region to contribute to the delivery of cancer care. Opportunities to expand the initiative to other areas during the course of the project will be explored.

CaMen

This CaMen project commenced in April 2007 and targets rural health workers who are interested in cancer care and aims to develop their knowledge and skills within a professional mentoring environment. The program consists of a 3-5 day supervised clinical attachment alongside cancer care specialists.

Virtual visiting program

WACHS offers a Virtual Visiting Program which allows inpatients to communicate with their families via videoconferencing. This provides social and emotional support for both the patients and their significant others.

Videoconferencing is also being used by some medical staff to conduct follow-up appointments. This reduces the number of times a rural patient needs to come to the metropolitan area. This service provides significant benefits to patients, both financial and emotional.

Wheatbelt "checkout" health promotion

The 'Women's Checkout' health promotion program, encouraging women to get regular health check-ups was successfully piloted in Wongan Hills, and a resource manual has been developed and distributed across the Wheatbelt region.

Healthy belt program

The 'Healthy Belt' lifestyle program, which aims to teach people how to maintain a healthy weight, was implemented in eight Wheatbelt towns.

Health promoting hospitals

The Health Promoting Hospitals Framework has been introduced in several sites in the Great Southern including Denmark, Gnowangerup, Mount Barker and Albany. The Goldfields Health Promotion Training Package is being reviewed and training sessions will be held for health service staff throughout 2008.

Adolescent sexual health

A Youth Coordinator has been employed in Esperance to pilot the Promoting Adolescent Sexual Health initiative and facilitate young carers groups.

Trachoma screening

In August 2007, a concurrent trachoma screening program was completed for the first time in the Goldfields, Kimberley and Pilbara, maximising the opportunity to screen transient populations.

Aged care

The Aged Care Assessment Team (ACAT) quality framework to identify and promote good practice across Western Australia has been completed and has been provided to all ACATs. The ACAT Quality and Training Reference Group was formed to implement the Western Australian training and quality frameworks and met on a quarterly basis providing a forum for the development and implementation of quality and training initiatives.

The ACAT Managers Group was developed and met twice in 2007-08, providing an avenue for

the development, promotion and implementation of operational management initiatives, particularly in reference to timeliness, quality and consistency of assessments.

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

Chronic disease

The South West Chronic Disease Self Management pilot has been evaluated and projects have commenced in the Great Southern, Mid West and Wheatbelt to develop regional models of chronic disease management, including care and referral pathways with linkages with other key service providers such as general practitioners.

WACHS – Great Southern continence advisor

A Continence Advisor position has been established in the Great Southern to provide an advanced level of practice and care for patients with continence problems.

Healthy partnerships

The WA Country Health Service continues to create stronger links and partnerships with other government agencies, non-government organisations, consumers, community groups, private providers, health professionals, the Commonwealth Government, and those with an interest in the well being of our health system. Of particular importance to WACHS' health service planning and service delivery is the role and contribution of the District Health Advisory Councils in maximising local participation and involvement in decision-making.

Patient transfer - Kimberley

During 2007-08 the WA Country Health Service commenced negotiations with Royal Darwin Hospital and Northern Territory Health to develop mutually acceptable clinical and business protocols to enable Royal Darwin Hospital to accept inter-hospital patient transfer from the Kimberley. This arrangement will support better patient outcomes and realise some cost savings.

Telehealth

The range of Telehealth clinical services to all country regions has been expanded through partnerships between the WACHS, and the Princess Margaret and Royal Perth Hospitals, and includes an expansion of the burns management service to all country regions.

Satellite dialysis unit Busselton

The dialysis unit in Busselton began operations in April 2008. This is a partnership between WACHS South West and St John of God Hospital Bunbury.

Combined Universities Centre for Rural Health

In partnership with the Combined Universities Centre for Rural Health (CUCRH) in Geraldton, WACHS has provided funding for three rural Aged Care fellowships for primary health care professionals. The fellowships will commence in 2008-09.

Royal Flying Doctor Service

In partnership with the Royal Flying Doctor Service, WACHS has developed a five year plan to identify and implement the most effective and efficient aero-medical service configuration to meet expected demand for inter-hospital transport.

Ambulance services

In partnership with the St John Ambulance Association, the WA Country Health Service is supporting and evaluating the Rural Paramedic Support project in the Kimberley and Pilbara. This project aims to support volunteer ambulance centres in the country that have trouble recruiting sufficient volunteers.

Exmouth MPS

During 2006-07 the Exmouth community in partnership with WACHS – Mid West developed the Exmouth Multi Purpose Service (MPS) model. The Exmouth MPS commenced operations on the 1st of June 2008. The model promotes a collaborative approach to health funding, and service planning and delivery between the Commonwealth and State Governments and the community. It enables more flexibility in determining the mix of health services to be provided to the community at the local health service level.

Healthy partnerships (continued)

WA health networks

The WA Country Health Service has executive representation on each of the WA Health Networks Executive Advisory Groups. These WACHS Executives have a pivotal role in informing the strategic policy directions from a rural and remote perspective.

Mental health

WACHS – Kimberley developed a partnership with the Kimberley Division of General Practice (KDGP) to provide additional primary care services to the 'Headspace' program assisting patients access resources dedicated to adolescent mental health referrals. As a consortium member Kimberley Mental Health and Drug Service provide "on the ground" youth, and drug and alcohol counsellors to enhance an accessible, effective and sustainable service for youth with mental illness and drug and alcohol related issues in the Kimberley region.

Rural Health West

During 2007-08, in partnership with Rural Health West, WACHS has implemented the following initiatives:

- a GP obstetric mentoring scheme;
- assisting country units to apply for local training accreditation;
- supporting rural and remote practitioners through Telehealth; and
- development of a defined procedural GP Obstetric training pathway.

District health advisory councils

The WA Country Health Service continues our commitment to consultation through our community and consultation strategy which provides two way communication and advocacy between the Area Health Service and local community members. The 24 District Health Advisory Councils (DHAC) continue to build a consumer, carer and community influence within WACHS by contributing to the improvement of service safety, quality and access, two-way communication and advocacy. Health service planning is made more relevant by their contribution. The Wheatbelt and some towns have Local Health Advisory Councils in each site, enabling them to inform the DHAC of local priorities.

Improved dental services in three sites, appointment of a health service liaison person in a Regional Resource Centre, coordination of community responses in several sites, the welcoming of new staff and presentation of service certificates to staff are some of the DHAC achievements for this period.

Aboriginal health

During 2007-08 WACHS continued to explore opportunities to generate innovative concepts and developments for Aboriginal health that will generate better health outcomes for Aboriginal people. Strong alignment and linkage with the Office of Aboriginal Health (OAH) facilitates the development and implementation of aboriginal health strategies, operational plans and policy development.

The new Federal Government has flagged improvement in health status of Aboriginal people as a priority for the Commonwealth in partnership with the States. The OAH is leading WA's engagement with the Commonwealth to ensure the implementation of aboriginal health initiatives in WA compliments the Commonwealth Aboriginal Health agenda.

Further to any new initiatives that the Commonwealth/State relationship might deliver, WACHS is maintaining its ongoing commitment to accomplishing a 'mainstream' health service quality improvement strategy to increase service access and quality for Aboriginal people in WA.

However, a number of challenges face WACHS in achieving its outcomes for Aboriginal health. These include:

- Developing achievable and sustainable local aboriginal health services and Aboriginal and Torres Straight Islander community governance models and arrangements.
- Establishing Aboriginal Community Partnership Models for service provision where appropriate (for example, Fitzroy Valley partnership model).
- Promoting and supporting a sustainable WACHS ATSI workforce.
- Developing an effective WACHS regional workplace environment for ATSI workers including peer support and infrastructure, whereby the value of core training and life skills of ATSI workers is valued and utilised.
- Understanding and appreciating the socio-economic status of the ATSI community in regard to program/service development, policy development and formulation, ATSI workforce development and sustainability, appropriate resource allocation and development, and implementing appropriate ATSI workforce recruitment and retention strategies.

Healthy resources

A priority for the WA Country Health Service is a sustainable, equitable and accountable health care service to deliver the best health benefit in a safe and quality assured environment. WACHS has adopted effective and efficient administration and management practices to ensure the best use of the resources available is made to support the best health outcome for country people.

Health networks

During 2007-08 the health networks grew to 17 with three new networks established – the Genomics Network, the Acute Services Network, and the Women's and Newborns Network. Clinicians and relevant staff from WACHS are members of the health networks.

The Networks are now integral to health reform by leading system-wide changes. Each Network clinical lead continues to embrace their role as a "change champion" and has led innovative, robust and sustainable engagement that looks at health care from a patient-centered approach. Endorsement for their key roles across WA Health has seen the formalizing of the WA Leads Forum as a sub-committee of the State Health Executive Forum.

The Networks are developing or have developed evidence based models of care for their speciality areas. This process features extensive stakeholder consultation to ensure the 'models' meet the needs and aspirations of the broader community. Over 20 models of care have been developed across the variety of speciality areas. These outline a patient-centred approach to the continuum of care for the relevant health conditions or for a population-based health care framework.

Performance agreements

For 2007-08 performance agreements were established for all area, regional, program and executive directors in the WACHS Leadership Team to ensure that the services, outputs and outcomes delivered by each are aligned with WACHS strategic and operational goals and objectives.

Performance monitoring

A periodic performance reporting system was implemented across WACHS to monitor and evaluate progress against the annual WACHS operational plan and to identify performance against key organisation-wide indicators.

Capital and Equipment programs

During 2007-08 WACHS completed a number of capital works projects in Fitzroy Crossing, Kununurra, Morawa/Perenjori, Carnarvon and Bunbury with developments continuing for the Broome Dental Clinic, and Busselton and Albany hospitals.

In addition over $3 million was approved during the year for equipment purchases or replacements including sterilisers, ultrasound machines, diagnostic scopes, computed radiology and bed acquisition and replacement programs.

Healthy leadership

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

The Institute for Healthy Leadership

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

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

In December 2007 the Institute commissioned the following leadership programs:

- *Service Improvement Workshops*
  These workshops provide basic training in health service improvement principles and methods;
- *Emerging Leaders Development Program*
  This program is jointly run by Curtin University of Technology and Edith Cowan University; and
- *Delivering the Future Leadership Development Program*
  This program for potential successor directors and executive directors within WA Health is delivered by UWA Business School in partnership with a commercial management training organisation.

In addition six two-day workshops have been offered where participants develop their own personal development plans and receive support and mentoring from the Director General and a State Health Executive Forum leader.

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

- *Graduate Development Program;*
- *Executive Development; and*
- *Masterclasses.*

During 2007-08 over 50 WACHS staff have participated in leadership programs coordinated by the Institute for Healthy Leadership with 18 in the *Emerging Leaders Development p*rogram, 20 attending the Service Improvement Workshops, and 12 senior executives participating in the *Future Leadership* and *Master Class* programs, which include individual coaching.

In addition to the programs provided through the Institute during 2007-08, the work of the WACHS coordinator for Learning and Development has provided a number of innovative leadership and executive development opportunities across the Area Health Service including:

- Six 'Diploma of Business Management' units have been delivered in 12 rural locations, with 500 clinical leaders and mid level managers taking part in formal education relating to change and project management, team building, conflict resolution, leadership and performance review;
- Regional medical and corporate executives have taken up 40 places at "management refresher" workshops conducted during their regular Perth visits; and
- a further 50 WACHS senior rural managers have participated in leadership workshops provided by WACHS, as an adjunct to participating in Department of Premier and Cabinet on-line 360 degree Leadership Skills Feedback Survey and personal Coaching program.

Aged care

Each region of WACHS has created a manager of Aged Care Services position. The manager is responsible for providing clinical and managerial leadership at the regional executive level and for the planning, development, co-ordination and evaluation of community aged and continuing care services in each region.

Aboriginal health leadership

The WACHS Aboriginal Health landscape has changed for the better with the establishment of the full-time Area Director of Aboriginal Health and support office which offers added value and enhancement to WACHS contribution and response to our indigenous community.

Management workshops

WACHS - Goldfields has completed a series of management workshops aimed at familiarising newly-appointed managers with operational knowledge and skills in management policy procedure and practices within the region.

Telehealth

Commencing February 2008, Telehealth became a key program responsibility of the WACHS Chief Executive Officer, a member of the State Health Executive Forum. This has raised Telehealth's profile and accountability within WA Health.

Priorities for 2008-09

WA Health's Strategic Directions 2005-10 and recommendations and directions provided by the Health Reform process to deliver a 'Healthy WA' will continue to drive health care in 2008-09.

Priorities for 2008-09 for the strategic directions are detailed below.

Healthy workforce

The WA Country Health Service will continue to develop and deliver models of health care that address the current workforce and skills environments. The Area Health Service has emphasized the provision of capacity for further education, training and leadership skilling, innovative workforce planning, work redesign and service delivery modelling, and family friendly work environments.

Key areas of focus and priority for WACHS remain staff attraction and retention initiatives, promoting work-life balance and family friendly workplace initiatives. These include child care strategies, developing workforce innovation, increasing the recruitment of Indigenous health professionals, workforce re-engineering (for example, nurse practitioner roles), and transition planning for future workforce requirements. Strategies to assess workforce satisfaction and promote leadership and management skills also remain priorities.

Healthy hospitals, health services and infrastructure

During 2008-09 WACHS will continue its approved capital works program including:

- Busselton Integrated District Hospital;
- Hedland Regional Resource Centre; and
- Broome Regional Resource Centre and Mental Health Unit.

The WACHS will expand the Nurse Practitioner service model in country regions though continued recruitment strategies and extension to other clinical specialties including renal nursing.

The WACHS will enhance medical imaging capabilities in regional areas with the implementation of computed radiography in a further six sites, installation of a 16-slice computed tomography scanner at Kalgoorlie and new general x-ray equipment for three sites in the Kimberley.

The WACHS will establish an Ambulatory Care Framework for hospital in the home and post acute care at all regional centres and some peripheral sites across the health service. The framework will facilitate and increase utilisation of the services and improve demand management, including earlier discharging of country patients from metropolitan hospitals.

The WACHS, in partnership with the Commonwealth Government, will enhance Telehealth through the expansion of bandwidth to designated rural locations. Health services will also review and upgrade Local and Wide Area Networks, investigate and expand support equipment for videoconferencing and review cost benefits related to Telehealth enabled services.

The WACHS will implement a standardised medical emergency response procedure for all South West sites to improve the safety and quality of patient care across all sites.

WACHS – Mid West and Wheatbelt will implement home monitoring for mental health patients, and for aged-care patients in the WACHS - Mid West.

Diagnostic services for wound management will be extended across the WACHS.

Administration of the Patient Assisted Travel Scheme (PATS) will be improved through the establishment of dedicated PATS units in each region.

The WA Country Health Service will complete negotiations with the Royal Darwin Hospital and Northern Territory Health and commence transfer of some types of patient requiring higher levels of care from the Kimberley to Royal Darwin Hospital.

In partnership with the St John Ambulance Association, WACHS will support and evaluate the Rural Paramedic Support project in the Kimberley and the Pilbara. This project aims to support volunteer ambulance centres in the country that have trouble recruiting sufficient volunteers.

Priorities for 2008-09 (continued)

Healthy hospitals, health services and infrastructure (continued)

Area Health Services will continue to implement the Food and Nutrition Policy for WA Health's services and facilities to provide healthier food and drinks in all Western Australian health services by December 2008.

Dental Health Services are scheduled to complete construction of the Broome Dental Clinic by December 2008.

The WACHS will develop and implement transfer protocols between South West residential aged care facilities, Emergency Departments and the Aged Care Assessment Team (ACAT), to provide uninterrupted care for older clients.

The WoundsWest project will continue:

- a pilot wound prevalence survey;
- investigation of methods to audit implementation and effectiveness of evidence-based wound management;
- development and 'go live' of online satellite wound education modules 2-6;
- completion of the Indigenous wound management improvement initiative;
- recruitment and pilot of WoundsWest Consultant Team to provide a clinical support resource for health practitioners state-wide; and
- evaluation of a wound imaging and documentation system pilot and recommendations for statewide rollout.

The WACHS will develop a regional urological/continence key stakeholders network.

The WACHS will strengthen chronic disease management at a regional, district and community level by:

- developing base-training in chronic disease self management models in all country regions, with Master Trainer capacity identified;
- developing a chronic disease management framework including a chronic disease self-management program and service options in each region; and
- exploring new technologies and models of care for self-management and partnered care (case management) incorporating the Health Network pathways.

Healthy partnerships

The WACHS will implement the Health Promotion Strategic Framework 2007-2011. This will include implementing the Western Australia 'Healthy Schools' project in all regions, developing and supporting the Bicycle User Group in Geraldton, and the Walking School Bus program in the WAVHS – Mid West. WACHS - Wheatbelt will develop an Indigenous child safety flip chart.

Innovative alcohol abuse management strategies for country regions will be developed and introduced by the WACHS. These include local alcohol accords in some regions, training in responsible service of alcohol and development of an alcohol action plan in collaboration with the Drug and Alcohol Office.

Healthy communities

The WACHS will pilot a model in the Bunbury Regional Resource Centre to admit patients to regional and district hospitals for detoxification from alcohol and drugs. The WACHS will work in partnership with local community drug service teams and Indigenous services to ensure that patients have an appropriate plan for ongoing treatment.

The Goldfields Health Promotion Training package will be rolled out across the WACHS.

The introduction of Brief Intervention strategies to manage alcohol, tobacco and other drug issues, including screening, motivational interviewing and referrals into all health service sites across WACHS will be completed.

The WACHS will further support mental health promotion, including the 'Act Belong Commit' campaign by dedicating 0.5 full-time equivalent staff for the Pilbara, Goldfields, Mid West and Wheatbelt.

The 'Bright Start Parenting' program will be implemented in Geraldton and a retinal screening program will be introduced in the WACHS - Goldfields.

Access to population health information will be enhanced for country regions with the development of the WACHS Population Health Internet sites, and the further development and distribution of the WACHS Population Health newsletter

The WACHS will enhance screening programs targeting Indigenous health issues, including extending the trachoma screening program in endemic regions to include the Central Lands (Ngaanyatjarra Health Service) and trichiasis screening in endemic regions for Indigenous populations aged over 40 years. The WACHS will also maintain three regional sexually transmitted disease infection control teams targeting populations at risk, and establish an ear health program in Goldfields Indigenous communities to prevent middle ear infection.

An Aboriginal Healthy Lifestyle Coordinator will be appointed in the Goldfields region to support the development and implementation of community plans to address chronic disease issues.

Initiatives to address postnatal depression will continue through:

- implementation of the Indigenous Perinatal Mental Health Service expansion project in Carnarvon; and
- implementation of the Practical Support Service expansion project in a rural site at Australind/Eaton;

Visiting geriatric specialist services are to be expanded to all country regions to strengthen residential aged care services and skills.

A residential outreach service model is to be developed in the WACHS - South West to improve relationships with non-government residential aged care facilities and general practice. It is anticipated that improved relationships will build capacity, provide more timely care to clients and help avoid Emergency Department assessment and ambulance transfers.

A culturally appropriate satisfaction survey will be developed for Aboriginal and Torres Strait Islander residents in country hospitals and facilities. The aim is to identify needs and gaps to enhance care and communication.

Visiting geriatric specialist services will be expanded to the Great Southern, Goldfields and South West to strengthen residential aged care services and skills.

Healthy resources

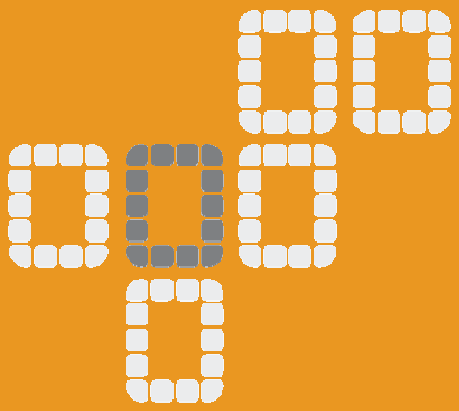
Training and support will be provided to ACAT to continue the implementation of a framework promoting good practice across Western Australia.

During 2008-09 the Health Networks will work closely with Area Health Services and other WA Health Divisions to implement the models of care which will result in significant system-wide change over the next 5-10 years.

Healthy leadership

The WA Country Health Service will continue to promote the Institute for Healthy Leadership's various leadership and personal development programs with its staff, and provide opportunities and support for any interested staff who wish to apply for program participation.

WACHS will also continue to promote local and regional professional and personal development strategies implemented by the Area Health Service Coordinator for learning and development and by regional management structures.



Operations

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 2007-08 was $1,657,958.

Table 26: Advertising

Summary of Advertising	Amount ($)
Advertising Agencies	1,598,779
Market Research Organisations	Nil
Polling	Nil
Direct Mail Organisations	Nil
Media Advertising Organisations	59,179

Expenditure Category	Recipient / Organisation	Amount ($)	Total ($)
Advertising Agencies			
	900 Degrees Ltd	275	
	Albany Advertiser	5,553	
	Australian College of Emergency Care	387	
	Australian Nursing Solutions	6,600	
	Britel Enterprises	505	
	Clinical One Pty Ltd	29,700	
	Creston Investments Pty Ltd	689	
	Hays	4,411	
	IDJ Publications	325	
	Leejay (WA)	76	
	Marketforce Exrpess	439,136	
	Marketforce Productions	1,022,073	
	Marsh Agencies Pty Ltd	214	
	Medacs Healthcare	57,812	
	Media Decisions	515	
	Newman Mail	3,750	
	Nursing Post Pty Ltd	6,731	
	Pelican Graphics	235	
	Pindan Printing	110	
	Port Hedland Chamber of Commerce and Industry	6,284	
	RANZOG	227	
	Red Wave Media	189	
	Rural Press Regional Media (WA) Pty Ltd	709	
	Sabah H Creations	438	
	Seabreeze Communications	5,317	
	Seton Australia	5,560	
	Strang Signs	47	
	Total Publishing	545	
	WACHS Advertising	366	**1,598,779**

Market Research Organisations			
			Nil
Polling Organisations			
			Nil
Direct Mail Organisations			
			Nil
Media Advertising Organisations			
	Albany Advertiser	6,828	
	Albany Chamber of Commerce and Industry	1,058	
	Australian Business Pages Directory	643	
	Benchmark Publishing	484	
	BK Signs	457	
	Boddington Community Newsletter	35	
	Caama Radio	770	
	Cancer Council WA	103	
	Chittering Times	513	
	Countrywide Media Pty Ltd	3,036	
	Craytales Magazine	90	
	Crime and Community Watch	692	
	Cunderdin Telecentre	44	
	Denmark Bulletin	220	
	Dowerin Telecentre	53	
	Elite Publishing Pty Ltd	595	
	Endeavour Newspaper Inc	22	
	Fence Post	90	
	Fridge Magnet Factory	1,994	
	Geraldton Newspapers Ltd	1,976	
	Gimlet Newspaper	16	
	Gnowangerup Telecentre	79	
	Gogo Media	768	
	Grand Publishing Pty Ltd	545	
	Great Southern Herald	1,238	
	Jurien Bay Telecentre	140	
	Kimberley Echo	1,859	
	Kojonup Community Newspaper	40	
	Kojonup Newsagency	82	
	Lake Grace Telecentre	280	
	Lions Club Lake Grace	50	
	Marie Stopes Australia	1,053	
	Market Creations	1,379	
	Marsh Agencies	295	
	Media Decisions WA	1,033	
	Midwest Times	280	
	Mingenew Lions	975	
	Morawa Telecentre	195	

Advertising (continued)

Expenditure Category	Recipient / Organisation	Amount ($)	Total ($)
Media Advertising Organisations (continued)			
	Muka Matters Inc	32	
	The National Emergency Relief Guide	426	
	National Fire Fighter News	396	
	Northampton Community News	10	
	Northern Guardian	1,733	
	Not Only Signs	135	
	The Nursing Post	2,276	
	Nyabing News	37	
	Pingelly Times	68	
	Radiowest Broadcasters Pty Ltd	2,510	
	Red Wave Media	4,554	
	Rural Press Regional Media (WA) Pty Ltd	3,954	
	Safe Healthy Community Review	495	
	Safety House Association	315	
	Safety Lines	418	
	Seabreeze Communications Pty Ltd	2,975	
	Seek Limited	369	
	Sensis Pty Ltd	578	
	Shire of Trayning	17	
	South West Printing & Publishing Company Ltd	804	
	Telecentre Network - Bruce Rock	66	
	Telecentre Network - Dalwallinu	850	
	Underprivileged Children's Guide	424	
	Volunteer Organisations Guide	438	
	Volunteer Rescue Magazine	385	
	Weekender	2,316	
	The West Australian	191	
	Wiltshire Publishers Pty Ltd	549	
	Wongan Hills Telecentre	110	
	Workplace Health and Safety Journal	495	
	Wyalkatchem Weekly	100	
	Yamaji News	972	
	York & Districts Community Matters	66	
	York Telecentre	105	**59,179**

Corruption Prevention

Government agencies are required to specifically consider the risk of corruption and misconduct by staff, and to report on risk reduction strategies in place within the agency. Within WA Health, the existence of an effective accountability mechanism is fundamental to good corporate governance.

This year WA Health carried out a total of 337 investigations of alleged misconduct.

Strategies have been introduced across WA Health in 2007-08 to assist the prevention of corruption and include:

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

WA Country Health Service

The achievement of best practice in the management of risk and preventing corruption and the promotion of employee responsibility for identifying, minimising and preventing risk and corruption remains a priority for WACHS.

During 2007-08 WACHS has consolidated its efforts in this work with the creation and appointment of a senior management position, Manager Governance and Strategic Support. This position has been established to oversee corruption control initiatives and to manage the investigation of incidents of corruption and misconduct. The position is also responsible for the development and delivery of training programs to educate staff about key governance issues.

WACHS has also maintained its corruption prevention processes to comply with the relevant 'Risk Management and Security' Treasury Instructions, the directions provided by the Government on "Fraud Prevention in the Western Australian Public Sector", and the relevant legislation, and authority delegation schedules, accounting standards, and Australian Council on Healthcare Standards accreditation requirements.

WACHS staff have participated in corruption prevention training programs and briefing sessions offered by the CCC and the Department's Corporate Governance Unit. Staff are regularly reminded of the responsibilities under the Codes of Conduct and Ethics, their duty to act ethically, and must acknowledge the relevant codes and procedures governing employee behaviour especially regarding the policies on the acceptable use of computers and the Internet. WACHS maintains thorough records of alleged misconduct to identify particular risk areas and develop prevention strategies.

Disability Access and Inclusion Plan

The *Disabilities Services Act 1993, (*amended 2004), ensures that people with disabilities have the same opportunities as other West Australians, and the WA Country Health Service is committed to providing all people with access to facilities and services.

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

The WA Country Health Service (WACHS) established its Disability Access and Inclusion Planning Committee in February 2006 comprising of regional and corporate office representatives to oversee the 2006-2009 WACHS wide DAIP. This DAIP is complimented by plans developed and implemented at the regional level.

Outcome 1:

People with disabilities have the same opportunities as other people to access the services of, and events organised by, the relevant public authority. In 2007-08:

- The WACHS Site Audit Tool for Sites, Facilities and Processes has been developed for assessing WACHS non-residential facilities to ensure appropriate access for people with a disability and compliance with the relevant Australian Standards and Guidelines;
- The WA Country Health Service ensures contractual documentation stipulates that external service providers must observe and apply the DOH (where appropriate) and WACHS DAIP requirements for ensuring services are accessible to all community members;
- The Disability Services Commission Accessible Events Checklist is incorporated into WACHS event organising guidelines and appropriate venues are selected to permit access for people with a disability;
- All WACHS regions provide annual resource allocations for service and facility improvements to improve access for people with a disability including improved parking, lighting, facility access and seating at health care facilities. For example during 2007-08, facilities at Mt Barker, Cranbrook, Fitzroy Crossing, Derby, Albany, Kununoppin and Katanning had improvements carried out;
- The Albany Hospital has undertaken a Disability Access Audit and will progress identified gaps in 2008-09; and
- WACHS regions have implemented a number of initiatives aimed at improving service access for people with a disability and informing the community of these initiatives. A particular example in 2007-08 is demonstrated in the Wheatbelt where health services now display Disability Services Commission DAIP posters, ensure staff have access to WACHS -Wheatbelt DAIP brochures in either hardcopy or via the WA Health intranet, have kept the region's District Health Advisory Councils and Local Health Advisory Groups advised regarding the DAIP, made available to employees the DAIP DVD "You Can Make a Difference to Customer Relations for People with Disabilities" via the WA Health intranet and has ensured the dissemination of information regarding alternative formats for health publications and documents.

Outcome 2:

People with disabilities have the same opportunities as other people to access the buildings and other facilities of the relevant public authority. In 2007-08:

- All new and existing health facilities being modified for WACHS must comply with Australian Standards and Guidelines for access for people with disabilities and the Area Health Service ensures building and modification contracts specify compliance with WACHS and DOH DAIP;
- Facility audits in WACHS – Mid West are underway with progress reports submitted to Regional Executive Committee. Audits teams include occupational therapists, facilities management or representative, and where possible, consumers with a disability; and
- WACHS regions have implemented regional DAIP committees to provide advice on aspects of access for people with a disability. Members often include WACHS management, occupational therapy and social work staff, and representatives of the Disability Services Commission and consumers, including 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 are able to access it. In 2007-08:

- WACHS ensures that Internet and Intranet publications, and printed materials to appropriate for people with a disability;
- The Midwest Aged and Community Care Directorate networks with disability agencies to promote services and work collaboratively to provide support to consumers and carers. This is further enhanced through combined activities promoting services and providing information to key target groups, for example, the 'CAN DO' Expo held in Geraldton in May 2008, but accessible by the whole region;
- All WACHS health service and health promotion information is regularly reviewed to ensure that appropriate written style and presentation is used and that materials are adapted to make them suitable for all client groups, including appropriate presentations for Aboriginal community members. Wherever possible, alternative formats for hearing and sight impaired persons are available and their availability is advertised in health service facilities. A particular example is the use of the Better Hearing kits that ensure first line client contact is appropriate and respectful; and
- WACHS employs Aboriginal health workers, for example in the Kimberley Aged and Community Service, who have skills and local knowledge that facilitate health and disability access information sharing in an appropriate manner. This includes, where necessary, translation skills.

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. In 2007-08:

- WACHS induction training includes information regarding the WACHS DAIP and issues relating to access to services for people with a disability. When appropriate, regular in-service education includes updates on the DAIP and access issues, and training organisers involve local DSC officers in education programs. Where a health service consumer with a disability needs access to services, staff can access information that will help them address the client's needs;
- Position selection criteria require applicants demonstrate awareness of current disability issues; and
- The Midwest Aged and Community Care Directorate, networking with disability agencies, promotes services and works collaboratively to provide support to people with disabilities and their carers. This collaboration has resulted in the development of the Carer Registry Project "FACES" a web-based system to link people with a disability with a carer to provide support and assistance.

Outcome 5:

People with disabilities have the same opportunities as other people to make complaints to the relevant public authority. In 2007-08:

- A complaints poster has been produced for all health service consumers. Information is available in appropriate formats for people with a disability;
- All disability access and inclusion related complaints reported in WACHS regions are brought to the attention of regional disability access and inclusion committees;
- Regional complaints processes are constantly reviewed and updated to ensure consistent standards for addressing consumer concerns;
- A Consumer Liaison Officer at Geraldton Hospital has been appointed to assist with prompt resolution of complaints;
- Complaints are accepted either in written or verbal form, or via disability advocates. Every endeavour is made for complaints to be fully investigated and responded to within 30 days;
- Information on Advocare is made available at WACHS health service sites allowing concerns to be reported to an external body if required. During the year Advocare staff may visit country communities to inform people in the hospital and broader community of advocacy services provided by the organisation;
- During client assessments and care planning, Kimberley Aged and Community Services staff always provide information to clients about their rights and responsibilities. This includes information about making a complaint and who can receive a complaint; and
- WACHS distributed information about DSC Local Area Coordinators who provide advocacy for people with disabilities to give feedback to health services.

Outcome 6:

People with disabilities have the same opportunities as other people to participate in any public consultation by the relevant public authority. In 2007-08:

- Advertisements were placed in the local media including the Disability Services Newsletter, seeking expressions of interest for community representatives to join the WACHS Disability Access and Inclusion committees, and District and Local Health Advisory Groups, whenever necessary;
- The "Think Respite" forum held in May 2008 in Geraldton provided an opportunity to consult with consumers, carers and service providers from WACHS - Mid West. The forum included representatives from the Disability Services sector, people with a disability and their carers;

Disability Access and Inclusion Plan (continued)

- WACHS Health Advisory Committees utilise appropriate disability services resources to advise and inform health services regarding issues relevant to people with a disability and their access to services; and
- WACHS makes particular effort to ensure that in the process of any community consultations, every assistance is provided to enable people with a disability and their carers to contribute should they wish.

Employee Profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. The table below shows the average number of full-time equivalent staff employed by WACHS year-to-date June 2008 by category.

Table 27: Total FTE by Category

Category	Definition	2006-07 FTE	2007-08 FTE
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	1,048	1,115
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	21	28
Agency nursing	Includes nurses engaged on a "contract for service" basis.	80	115
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	n/a	0
Dental nursing	Includes dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,234	1,264
Medical	Includes salary and sessional based medical occupations.	179	189
Medical support	Includes all Allied Health and scientific/technical related occupations.	554	583
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,310	2,372
Site services	Includes engineering, garden and security-based occupations.	178	175
Other categories	Includes Aboriginal and ethnic health worker related occupations.	75	85
Total		**5,679**	**5,926**

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

Freedom of Information

For the year ending 30 June 2008, the WA Country Health Service received 1,866 formal applications for access to information in accordance with the *Freedom of Information Act 1992*.

Table 28: Freedom of information applications 2007-08

Applications	Number
Carried over from 2006-07	74
Received in 2007-08	1,792
Total applications received in 2007-08	1,866
Granted: full access	1,726
Granted: partial or edited access	18
Withdrawn	21
Refused	34
In progress	33
Transferred and other	34

The types of documents held by the WA Country Health Service include:

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

Industrial Relations

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

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

WA Country Health Service

The WA Country Health Service ensures its industrial relations policies and practices comply with all relevant State and Commonwealth industrial relations legislation, awards, and industrial and certified employment agreements. The Area Health Service has adopted proactive cooperation and consultation processes with its employees and any relevant representative industrial body.

The WACHS experienced no significant industrial disputation during 2007-08.

Sustainability

Please see the Department of Health Annual Report 2007-08.

Substantive Equality

Please see the Department of Health Annual Report 2007-08.

Internal Audit Controls

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

Department of Health

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

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

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

Please see the Department of Health 2007-08 Annual Report for the full list of audits.

WA Country Health Service

The WACHS has adopted sound procedures and internal controls designed to provide reasonable assurance in regard to achieving the Area Health Service's objectives, in particular those related to:

- effectiveness and efficiency of operations;
- reliability of financial and operations reporting;
- compliance with applicable legal requirements and community expectations;
- stewardship of public resources; and
- minimisation of exposure to adverse events.

To enhance corporate governance within the Area Health Service, the WACHS Audit Committee has recognised the need for formal processes to be implemented to ensure that administrative functions performed by all departments are being properly controlled. To this end the WACHS Operational Plan includes a performance measure that states 100% of all 'Extreme' and 'High' risk rated Internal Audit Committee recommendations are implemented within the agreed timeframe.

Major Capital Works

Please refer to the 2007-08 Department of Health Annual Report for financial details of major capital works in the WA Country Health Service.

Capital works projects completed in the WACHS during 2007-08	Capital works projects in progress in the WACHS during 2007-08
▪ Bunbury Replacement Dental Clinic	▪ Albany Regional Resource Centre Redevelopment Stage 1
▪ Carnarvon Integrated District Health Service Redevelopment stage 1	▪ Broome Regional Resource Centre Redevelopment Stage 1
▪ Kununurra Integrated District Health Service Development	▪ Busselton Integrated District Health Service Replacement
▪ Morawa and Perenjori Multi Purpose Centre Replacement	▪ Carnarvon Sobering Up Centre
▪ South West Health Campus Inpatient Mental Health Unit Expansion	▪ Country Staff Accommodation - Stage 3
▪ South West Health Campus New Mental Health Clinic	▪ Denmark Multi Purpose Centre Replacement
	▪ Harvey Hospital Redevelopment
	▪ Hedland Regional Resource Centre Replacement Stage 2
	▪ Kimberley - Various Health Project Developments
	▪ South West Health Campus Intensive Care Unit
	▪ South West Health Campus New Radiotherapy Facility
	▪ Wyndham Multi Purpose Centre Development

Pricing Policy

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

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

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

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

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

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

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

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

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

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

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

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

Recordkeeping

As part of WA Health, the WA Country Health Service is included by the Department of Health's approved Record Keeping Plan.

During the year an internal audit review was conducted identifying a number of opportunities for improvement in record keeping practices. These particularly related to the development of specialised records management expertise within the WA Country Health Service, and design and delivery of a training program to improve understanding, and adherence to record keeping policies.

A senior position of Records Project Manager is currently being established. This position will have specific responsibility for reviewing records management policy, systems and practices within WACHS. A key component of this role will be development and delivery of training for staff involved in records creation and handling

Recruitment

All WA Country Health Service recruitment and selection processes are undertaken in accordance with the criteria set down in the "Public Sector Standards in Human Resource Management".

WA Country Health Service 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 to ensure government and departmental guidelines are followed.

Policies are available at all WACHS sites and are accessible via the WACHS Intranet site. Positions are offered for permanent and contract appointment, and where appropriate, via temporary placement on expressions of interest.

The Health Corporate Network coordinates the recruitment process on behalf of the WACHS. Vacancies are advertised in both print and electronic media. Recruitment campaigns have been conducted in local and national newspapers and on radio. Recruitment has been undertaken internationally, especially for medical officers and nursing staff, at career expos, via promotions in educational institution handbooks, and through participation in graduate recruitment programs.

Training to ensure potential selection panel convenors and members have the necessary selection skills and an understanding of Public Sector Standards is provided regularly and selection panels must have at least one member who has attended the appropriate training.

WACHS has also provided educational sessions to staff on Job Application Skills, addressing Selection Criteria and Curriculum Vitae creation and has these resources available to staff via the Learning and Development Website.

Recruitment initiatives

The recruitment of clinical staff continued to be the focus of WACHS recruitment initiatives in 2007-08.

WACHS continues to enhance its attraction and retention packages especially in the area of accommodation to improve the success of their recruitment drives. A number of accommodation acquisitions were undertaken during the year.

WACHS has effectively used the regional rotation and migration programs such as the 'Crocs to Rocks', 'Ocean to Outback' and the "Nursing Careers with Adventure" programs as well as temporary overseas sponsorship programs to augment staff recruitment.

During 2007-08 WACHS also increased the number of graduate nurses across the Area Health Service.

2007-08 also saw the establishment of the whole of WACHS Clinical Workforce Unit which focuses on strengthening the clinical workforce through developing consistent and coordinated approaches to clinical recruitment and organisational development opportunities with the aim of making positioning WACHS as a "workplace of career of choice".

Staff Development

A high quality, skilful and adaptable workforce is vital if the WA Country Health Service is to deliver the required health services to country WA, and if the organisation is to achieve its strategic objectives. WACHS is committed to maintaining an environment that encourages staff to seek opportunities for personal and professional growth and development.

During 2007-08 particular initiatives have been implemented across WACHS.

The appointment of a coordinator for Learning and Development to further the opportunities for training and education for WACHS has resulted in the implementation of a number of innovative training strategies during 2007-08. These include extensive development of e-learning materials; cost effective, state-wide licenses for on line training resources; and partnership arrangements for specialists to travel and train in rural sites. This new "travelling trainer" strategy has seen the use of contracts with eight subject matter experts willing to deliver their expert training to staff at 20 or more rural sites. This has expanded equity of access to training, whilst also reducing staff travel costs.

The Regional Learning and Development Network which comprised mostly nurse educators who provide local coaching and professional support to rural nursing staff, was further extended this year to include specialist trainers in Manual Handling and Management of Aggression. These trainers were able to meet together, to enhance their own skills and discuss educational best practice in their special field.

Employees are now better able to access training and development to meet service competency requirements, career development objectives, and strategic and operational goals with the introduction of the e-learning strategy and investment in information technology for all regional Learning and Development teams. Training in vital computer applications such as Rostar, Hcare and Oracle is now possible at very small sites, and the cost of competency assessment is now reduced, with the knowledge components graded on-line before skills assessments are undertaken.

In order to support retention of the workforce, WACHS has focused on leadership development by instigating a comprehensive program of Diploma level workshops in five management competencies. Each workshop has been delivered to emerging and existing leaders at several sites in every region – reducing travel costs and greatly extending access to career development opportunities. This program also provides access to formal academic qualifications for those staff who previously or currently participate in the "*Leading 100*" programs. Executive development has also been targeted this year with briefings to executive teams visiting Perth, and a management refresher program for Medical Directors.

Ongoing investment in training scholarships has seen 120 rural clinicians attend Advanced Life Support in Obstetrics (ALSO) training in Perth, in addition to innovative training for Enrolled Nurses via Internet from Curtin University. A major investment in simulation equipment has established the environment for complex multidisciplinary clinical team training to occur in regional sites. This has been impossible to source in the past, being both cost-prohibitive and with specialists unavailable to travel. The new training environment will increase skills and confidence of rural staff to deal with complex, but infrequent, clinical incidents.

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.

WACHS continues to develop telehealth video conferencing for staff development and training programs whilst extending its Intranet site to provide access to on-line training resources.

WACHS provides mandatory staff induction through regional orientation programs, which have been redesigned this year to increase core skills training and assessment while providing local information packages for new employees on such topics as remote area travel, local services and tropical weather conditions.

Staff Development (continued)

Mandatory induction programs include topics such as:

- fire and emergency procedures;
- occupational safety and health;
- infection control;
- risk management;
- Public Sector Standards and Codes of Ethics and Conduct;
- manual handling;
- workplace behaviour and bullying; and
- information technology familiarisation and Telehealth.

Established training opportunities also continued in 2007-08 and included workshops on over 100 subjects including:

- Advanced life support;
- Aged care;
- Burn emergency care;
- Certificate III in aged care;
- Change management;
- Chemical, biological and radiological management;
- Conflict and negotiation;
- Dementia care;
- Diabetes management;
- Driver safety;
- First aid and emergency medical training;
- Governance – corporate and clinical;
- Leadership and management;
- Management of aggression;
- Mental health;
- OSH for managers;
- Paediatrics – assessment and life support;
- Performance management;
- Post-natal depression;
- Preceptor training;
- Remote area nursing;
- Safety and quality;
- Safety representatives;
- Team building;
- Transfusion management;
- Triage practice; and
- Training and education for a range of clinical disciplines.

The extension of access to training and development opportunities is reflected in staff satisfaction, workforce retention, and the achievement of health care objectives.

Workers' Compensation and Rehabilitation

The WA Country Health Service is committed to providing its staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services.

Occupational safety and health initiatives

The Safety Management System adopted by WACHS is based on the Western Australian 'WorkSafe Plan' and "Occupational Safety and Health Act 1984". This system promotes all aspects of Occupational Safety and Health (OSH) in the day-to-day practices of all WACHS staff.

WACHS maintains a continuous process to develop its OSH policies and strategies, quality assurance and risk monitoring programs including its reporting programs, and ensures consistent approaches to OSH and employee rehabilitation throughout the Area Health Service.

The main elements of the Safety Management System are:

- the recognition of management responsibility for OSH duty of care;
- the integration of OSH requirements and responsibilities across the organisation;
- adopting standard hazard management practises and procedures including hazard assessment throughout the workplace;
- providing mechanisms for staff to raise OSH issues through OSH elected representatives and site/regional safety committees; and
- providing compulsory training identified by risk assessments for all staff, especially safety officers and senior management.

WACHS designated OSH managers and staff form the Area Health Service's OSH Reference Group. This group provides regular performance data on OSH and injury management to regional and Corporate Office executives. Regional OSH coordinators are responsible for informing management on workplace occupational safety and health matters, and for OSH audits. Coordinators provide advice on specific training initiatives for WACHS staff. Specific training areas relevant to WACHS include off-road driving and general vehicle maintenance courses applicable to conditions in remote areas and providing instructions on preparing for cyclones.

Occupational injury prevention and rehabilitation

WACHS provides timely and effective intervention for WACHS employees who have injured themselves at work, or those employees who have injuries that may affect their ability to undertake their duties. WACHS ensures injured employees receive their entitlements and can access 'best practice' injury management interventions and rehabilitation programs. These include structured 'return to work' programs. Programs are developed in conjunction with the employee, medical advice, their immediate work supervisor and the OSH coordinator.

Both internal and external rehabilitation providers are used by WACHS and all staff involved in rehabilitation programs undertake injury management training and appropriate instruction regarding their responsibilities to their staff. The WACHS uses OSH databases and hazard registers that provide incident information, pro-active hazard reporting and investigation. "Root Cause Analysis" methodology for investigating clinical incidents has been adopted to ensure comprehensive investigation of occupational injuries.

This table provides information on the number of worker's compensation claims made during 2007-08 within the WA Country Health Service.

Table 29: Workers' compensation claims

Employee category	Claims
Nursing Services/Dental Care Assistants	103
Administration and Clerical	25
Medical Support	22
Hotel Services	127
Maintenance	26
Medical (salaried)	3
Total	**306**

Notes:
1. "Administration and clerical" includes administration staff and executives, ward clerks, receptionists and clerical staff.
2. "Medical support" includes physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers.
3. "Hotel services" includes cleaners, caterers and patient service assistants.

Occupational Safety & Health and Injury Management Performance

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

All areas of WA Health comply with or exceed OSH legal requirements, and are continuously developing and implementing safe systems and work practices that reflect commitment to safety and health.

The WA Country Health Service is committed to assisting injured workers to return to work as soon as medically appropriate and will adhere to the requirements of the *Workers Compensation and Injury Management Act 1981* in the event of a work related injury or illness.

WACHS has a documented Injury Management System in place which meets the requirements of the *Worker's Compensation and Injury Management Act* 1981. The supporting policy and procedure are available to all employees on-line or from their line manager and details are provided to employees during WACHS Orientation training.

The WACHS Injury Management System is implemented through:

- Workers compensation staff in each region who ensure that injured employees receive their entitlements and injury management intervention; and
- area injury management coordinators who coordinate the return to work programs for those employees with workplace and non-work related injuries.

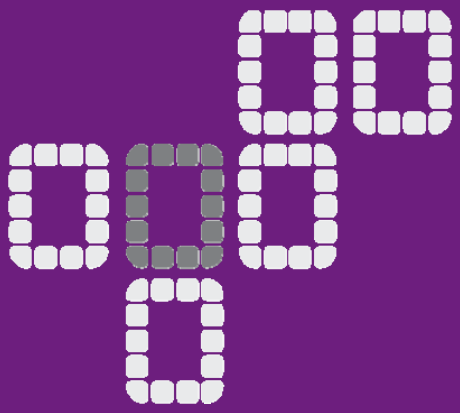
Where appropriate, WACHS will engage appropriately qualified and WorkCover accredited rehabilitation providers to assist in the process of facilitating employees who are injured at work to return to gainful employment.

An appointed accredited rehabilitation provider will liaise with all involved parties to establish and monitor an injury management program as soon as practicable in consultation with the treating doctor, supervisory staff and the injured employee to match capabilities with available duties.

WACHS has established Occupational Safety and Health Committees in each region as part of a formal consultative process. The membership is stipulated in an agreed terms of reference and is consistent with the *Occupational Safety and Health Act 1984*. Supporting policies and procedures exist to further support the WACHS Safety Management System, including a formal OSH issue resolution procedure.

Table 30: Occupational safety and health and injury management performance

Fatalities	Lost time injury/disease incidence rate	Lost time injury/disease incidence rate
0	2.42	14.57



Financial Statements

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2008

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2008 and the financial position as at 30 June 2008.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

John Leaf
Chief Finance Officer
WA Country Health Service

Date: 17 September 2008

Dr Peter Flett
Accountable Authority
WA Country Health Service

Date: 17 September 2008

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2008

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

The financial statements comprise the Balance Sheet as at 30 June 2008, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement of the WA Country Health Service for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

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

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

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

Audit Opinion (continued)

WA Country Health Service
Financial Statements and Key Performance Indicators for the year ended 30 June 2008

Audit Opinion

In my opinion,

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

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

(iii) the key performance indicators of the 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 2008.

GLEN CLARKE
ACTING AUDITOR GENERAL
23 September 2008

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Financial Statements

WA Country Health Service

Income Statement

For the year ended 30th June 2008

	Note	2008 $000	2007 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	475,152	418,275
Fees for visiting medical practitioners		47,190	44,087
Patient support costs	8	101,281	95,445
Finance costs	9	1,705	1,757
Depreciation and amortisation expense	10	27,120	26,667
Asset impairment losses		-	374
Capital user charge	11	-	52,625
Loss on disposal of non-current assets	12	331	-
Repairs, maintenance and consumable equipment		23,403	21,757
Other expenses	13	70,143	61,297
Total cost of services		**746,325**	**722,284**
INCOME			
Revenue			
Patient charges	14	28,628	25,111
Commonwealth grants and contributions	15	15,912	15,396
Other grants and contributions	15	7,068	7,434
Donations revenue	16	963	1,072
Interest revenue		143	129
Other revenues	17	16,952	15,321
Total revenue		69,666	64,463
Total income other than income from State Government		**69,666**	**64,463**
NET COST OF SERVICES		**676,659**	**657,821**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	679,068	660,595
Assets assumed / (transferred)	19	(3,521)	20
Liabilities assumed by the Treasurer	20	817	854
Total income from State Government		**676,364**	**661,469**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(295)**	**3,648**

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 2008

	Note	2008 $000	2007 $000
ASSETS			
Current Assets			
Cash and cash equivalents	21	21,279	17,885
Restricted cash and cash equivalents	22	560	442
Receivables	23	13,255	13,343
Amounts receivable for services	24	-	8,386
Inventories	25	3,518	3,581
Other current assets	26	1,865	844
Total Current Assets		40,477	44,481
Non-Current Assets			
Amounts receivable for services	24	135,285	87,945
Property, plant and equipment	27	877,818	781,269
Intangible assets	29	74	96
Other financial assets	30	6	6
Total Non-Current Assets		1,013,183	869,316
Total Assets		**1,053,660**	**913,797**
LIABILITIES			
Current Liabilities			
Payables	31	54,227	40,540
Borrowings	32	1,603	1,547
Provisions	33	66,430	60,298
Other current liabilities	34	139	485
Total Current Liabilities		122,399	102,870
Non-Current Liabilities			
Borrowings	32	24,934	26,537
Provisions	33	12,841	12,186
Total Non-Current Liabilities		37,775	38,723
Total Liabilities		**160,174**	**141,593**
NET ASSETS		**893,486**	**772,204**
EQUITY			
Contributed equity	35	850,583	781,023
Reserves	36	52,017	-
Accumulated surplus/(deficiency)	37	(9,114)	(8,819)
TOTAL EQUITY		**893,486**	**772,204**

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 2008

	Note	2008 $000	2007 $000
Balance of equity at start of period		772,204	-
CONTRIBUTED EQUITY	35		
Balance at start of period		781,023	-
Capital contribution		69,560	58,904
Other contributions by owners		-	722,119
Balance at end of period		**850,583**	**781,023**
RESERVES	36		
Asset Revaluation Reserve			
Balance at start of period		-	-
Gains/(losses) from asset revaluation		52,017	-
Balance at end of period		**52,017**	**-**
ACCUMULATED SURPLUS	37		
Balance at start of period		(8,819)	-
Change in accounting policy		-	(12,467)
Restated balance at start of period		(8,819)	(12,467)
Surplus/(deficit) for the period		(295)	3,648
Balance at end of period		**(9,114)**	**(8,819)**
Balance of equity at end of period		**893,486**	**772,204**
Total income and expense for the period (a)		51,722	3,648

(a) The aggregate net amount attributable to each category of equity is: deficit $295,000 plus gains from asset revaluation $52,017,000 (2007: surplus $3,648,000).

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 2008

	Note	2008 $000 Inflows (Outflows)	2007 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		636,826	573,832
Capital contributions		56,774	50,417
Holding account drawdowns		1,569	-
Net cash provided by State Government	38(c)	695,169	624,249
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(229,460)	(218,235)
Employee benefits		(467,508)	(413,561)
Finance costs		-	(12)
GST payments on purchases		(28,493)	(23,460)
Other payments		935	-
Receipts			
Receipts from customers		28,148	23,897
Commonwealth grants and contributions		15,912	15,396
Other grants and subsidies		6,569	6,391
Donations		963	895
Interest received		144	129
GST receipts on sales		2,529	2,520
GST refunds from taxation authority		24,933	18,388
Other receipts		17,730	14,110
Net cash (used in) / provided by operating activities	38(b)	(627,599)	(573,542)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets		(64,799)	(51,180)
Proceeds from sale of non-current physical assets	12	740	-
Net cash (used in) / provided by investing activities		(64,058)	(51,180)
Net increase / (decrease) in cash and cash equivalents		3,511	(473)
Cash and cash equivalents at the beginning of period		18,327	18,800
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	38(a)	21,838	18,327

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

Note 1 Australian equivalents to International Financial Reporting Standards

General

The Health Service's financial statements for the year ended 30 June 2008 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the Health Service has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the Australian Accounting Standards Board (AASB) and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the Health Service for the annual reporting period ended 30 June 2008.

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 Management Act and the Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over the Accounting Standards, the Framework, 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 and all values are 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 balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 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 Treasurer's Instruction (TI) 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to Contributed Equity.

Transfer of net assets to/from other agencies are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal. (See note 35 'Contributed Equity')

(d) Income

Revenue recognition

Revenue is measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership control transfer to the purchaser and can be measured reliably.

Rendering of services
Revenue is recognised on delivery of the service to the client.

(d) Income (continued)

Interest
Revenue is recognised as the interest accrues. The effective interest method, which is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset, is used where applicable.

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 appropriated funds at the time those funds are deposited to the bank account or credited to the holding account held at Treasury (See note 18 '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 balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains

Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets and some revaluations of non-current assets.

(e) Borrowing Costs

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

(f) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Income Statement (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
All items of property, plant and equipment are initially recognised at cost.

For items of property, plant and equipment acquired at no cost or for nominal 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-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market buying values determined by reference to recent market transactions.

Where market-based evidence is not available, the fair value of land and buildings (clinical sites) 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, ie. the depreciated replacement cost.

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

Independent valuations of land and buildings are provided annually by the Western Australian Land Information Authority (Valuation Services) and recognised with sufficient regularity to ensure that the carrying amount does not differ materially from the asset's fair value at the balance sheet date.

The most significant assumptions in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated useful life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

Refer to note 27 'Property, plant and equipment' for further information on revaluations.

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

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.

(f) Property, Plant and Equipment (continued)

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	4 to 7 years
Furniture and fittings	10 to 15 years
Motor vehicles	4 to 10 years
Medical equipment	5 to 25 years
Other plant and equipment	5 to 25 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.

(g) Intangible Assets

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

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

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life) on the diminishing value 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.

(h) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at each balance sheet date. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. As the 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, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

Intangible assets with an indefinite useful life and intangible assets not yet available for use are tested for impairment at each balance sheet date irrespective of whether there is any indication of impairment.

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

(i) Non-current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

(j) 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 apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(k) Financial Instruments

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

These have been disaggregated into the following classes:

Financial Assets
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services

Financial Liabilities
* Payables
* WATC borrowings
* Other borrowings

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

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

(l) Cash and Cash Equivalents

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

(m) Accrued Salaries

Accrued salaries (refer note 31) represent the amount due to employees 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 its net fair value.

(n) 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 18 'Service appropriations' and note 24 'Amounts receivable for services'.

(o) 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 25 ' Inventories')

(p) Receivables

Receivables are recognised and carried at original invoice amount less an allowance for any 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(k) 'Financial instruments' and note 23 'Receivables')

(q) 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(k) 'Financial instruments and note 31 'Payables'.

(r) 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(k) 'Financial instruments' and note 32 'Borrowings')

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at each balance sheet date. See note 33 ‘Provisions’.

(s) Provisions (continued)

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 balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet 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.

Deferred Leave
The provision for deferred leave relates to Health Service employees who have entered into an agreement to self-fund an additional twelve months leave in the fifth year of the agreement. In the fifth year they will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. The provision recognises the value of salary set aside for employees to be used in the fifth year. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the balance sheet date and includes related on-costs. Deferred leave is reported as a non-current provision until the fifth year.

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 commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The Health Service makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

The GESB makes all benefit payments in respect of the Pension and GSS Schemes, and is recouped by the Treasurer for the employer's share .

(See also note 2(t) 'Superannuation Expense')

Gratuities
The Health Service is obliged to pay the medical practitioners and nurses for gratuities under their respective industrial agreements. 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 balance sheet 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 balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

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 oncosts 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 13 'Other expenses' and note 33 '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 (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - in order to reflect the true cost of services, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS 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 20 'Liabilities assumed by the Treasurer')

The superannuation expense does not include payment of pensions to retirees, as this does not constitute part of the cost of services provided in the current year.

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

(u) Resources Received Free of Charge or for Nominal Cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(v) Comparative Figures

Comparative figures are, where appropriate, reclassified to be comparable with the figures presented in the current financial year.

(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 49).

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 and aboriginal communities 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.

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 balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year 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

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 10.6%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2007 that impacted on the Health Service:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments and while there is no financial impact, the changes have resulted in increased disclosures, both quantitative and qualitative, of the Health Service's exposure to risks, including enhanced disclosure regarding components of the Health Service's financial position and performance, and changes to the way of presenting certain items in the notes to the financial statements.

The following Australian Accounting Standards and Interpretations are not applicable to the Health Service as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretations	
101	'Presentation of Financial Statements' (relating to the changes made to the Standard issued in October 2006)
2005-10	'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'
2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11 [AASB 2]'
2007-4	'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. The amendments arise as a result of the AASB decision to make available all options that currently exist under IFRSs and that certain additional Australian disclosures should be eliminated. The Treasurer's instructions have been amended to maintain the existing practice when the Standard was first applied and as a consequence there is no financial impact.
2007-5	'Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102]'
2007-7	'Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'
ERR	Erratum 'Proportionate Consolidation [AASB 101, AASB 107, AASB 121, AASB 127, Interpretation 113]'
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'
Interpretation 1003	'Australian Petroleum Resource Rent Tax'

Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets. The change in asset capitalisation policy does not apply to land and buildings.

Retrospective application of the change in accounting policy has resulted in assets below the $5,000 threshold amounting to $12,467,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The amounts of adjustments for each of the financial periods prior to 2006-07 have not been disclosed, as it is impracticable to trace back acquisitions, disposals, depreciation and amortisation of these assets.

The comparatives for property, plant and equipment, depreciation and amortisation expense, loss on disposal of non-current assets, and repairs, maintenance and consumable equipment expense have been restated to disclose the effect of the policy change (See note 39 'Voluntary changes in accounting policy').

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the Health Service has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued and which may impact the Health Service but are not yet effective. Where applicable, the Health Service plans to apply these Standards and Interpretations from their application date:

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

Title	Operative for reporting periods beginning on/after
AASB 101 'Presentation of Financial Statements' (September 2007). This Standard has been revised and will change the structure of the financial statements. These changes will require that owner changes in equity are presented separately from non-owner changes in equity. The Health Service does not expect any financial impact when the Standard is first applied.	1 January 2009
Review of AAS 27 'Financial Reporting by Local Governments', 29 'Financial Reporting by Government Departments' and 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:	
AASB 1004 'Contributions' (December 2007).	1 July 2008
AASB 1050 'Administered Items' (December 2007).	1 July 2008
AASB 1051 'Land Under Roads' (December 2007).	1 July 2008
AASB 1052 'Disaggregated Disclosures' (December 2007).	1 July 2008
AASB 2007-9 'Amendments to Australian Accounting Standards arising from the review of AASs 27, 29 and 31 [AASB 3, AASB 5, AASB 8, AASB 101, AASB 114, AASB 116, AASB 127 & AASB 137] (December 2007).	1 July 2008
Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities (revised) (December 2007).	1 July 2008
The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and existing topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 only apply to government departments. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance (for example, Australian Guidance to AASB 116 'Property, Plant and Equipment' in relation to heritage and cultural assets has been introduced), otherwise, there will be no financial impact.	
AASB 3 'Business Combinations' (March 2008)	1 July 2009
AASB 8 'Operating Segments'	1 January 2009
AASB 123 'Borrowing Costs' (June 2007). This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. The Health Service already capitalises borrowing costs directly attributable to buildings under construction, therefore, this will be no impact on the financial statements when the Standard is first applied.	1 January 2009
AASB 127 'Consolidated and Separate Financial Statements' (March 2008)	1 July 2009
AASB 1049 'Whole of Government and General Government Sector Financial Reporting'	1 July 2008
AASB 2007-2 'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1 to 8	1 January 2008
AASB 2007-3 'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'	1 January 2009
AASB 2007-6 'Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'	1 January 2009
AASB 2007-8 'Amendments to Australian Accounting Standards arising from AASB 101'	1 January 2009
AASB 2008-1 'Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations'	1 January 2009
AASB 2008-2 'Amendments to Australian Accounting Standards – Puttable Financial Instruments and Obligations arising on Liquidation [AASB 7, AASB 101, AASB 132, AASB 139 & Interpretation 2]'	1 January 2009

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

Title	Operative for reporting periods beginning on/after
AASB 2008-3 'Amendments to Australian Accounting Standards arising from AASB 3 and AASB 127 [AASBs 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138, 139 and Interpretations 9 & 107]'	1 July 2009
Interpretation 4 'Determining whether an Arrangement contains a Lease' (February	1 January 2008
Interpretation 12 'Service Concession Arrangements'	1 January 2008
Interpretation 13 'Customer Loyalty Programmes'	1 July 2008
Interpretation 14 'AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'	1 January 2008
Interpretation 129 'Service Concession Arrangements: Disclosures'	1 January 2008

Note 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 52. The key services of the Health Service are:

Admitted Patient Services
Admitted patient services are provided for the care of inpatients in public hospitals (excluding specialised mental health wards) and public patients treated in private facilities under contract to WA Health. Care during an admission to hospital can be for periods of one or more days. Care includes medical and surgical treatment, renal dialysis, oncology services, mental health and obstetric care.

Specialised Mental Health Services
Specialised mental health services include authorised mental health units that are hospitals or hospital wards devoted to the specialised treatment and care of patients with psychiatric, mental or behavioural disorders. Specialised mental health care is also provided in designated mental health wards in acute hospitals.

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

Non-admitted Patient Services
Medical officers, nurses and allied health staff provide non-admitted services. Services include outpatient health and medical care as well as similar emergency services as described for metropolitan emergency department but provided in smaller country hospitals.

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

Prevention and Promotion Services
Prevention and promotion services include genomics, the management and development of health information, Aboriginal health, breast screening services, child and community health and health promotion.

Home and Community Care Services
Home and Community Care (HACC) provides services that support people who live at home and whose capacity for independent living is at risk of premature admission to long-term residential care. Services include domestic assistance, social support, nursing care, respite care, food services and home maintenance.

Aged Care Assessment Services
Aged care assessment services determine eligibility for, and the level of care required by frail aged people. They include assessments for those who require permanent care in an appropriate residential aged care facility including the Care Awaiting Placement program, and eligibility for community-based aged care services.

Community Mental Health Services
Community mental health care provides a range of community-based services for people with mental health disorders, which may include emergency assessment and treatment; case management, psycho-geriatric assessment and day programs provided in either a clinic or home environment. Service providers include both government and non-government service agencies. Contracted non-government non-clinical services also provide support to long-term mental health patients living in the community.

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

Note 7 Employee benefits expense	2008 $000	2007 $000
Salaries and wages (a)	392,624	343,539
Superannuation - defined contribution plans (b)	34,256	31,040
Superannuation - defined benefit plans (c) (d)	817	854
Annual leave and time off in lieu leave (e)	40,574	36,410
Long service leave (e)	6,881	6,433
	475,152	418,275

(a) Includes the value of the fringe benefit to the employees. The fringe benefits tax component is included at note 13 'Other expenses'.

(b) Defined contribution plans include West State, Gold State and GESB Super Scheme (contributions paid).

(c) Defined benefit plans include Pension scheme and Gold State (pre-transfer benefit).

(d) An equivalent notional income is also recognised. (See note 2(t) Superannuation expense and note 20 'Liabilities assumed by the Treasurer')

Decrease in liabilities in respect of the GSS transfer benefits occurred in 2007-08. In accordance with Treasurer's Instruction TI 1102, where there have been decreases in liabilities (i.e. actuarial gains exceed the current service cost for the period), the net gains should not be included in superannuation expense.

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 13 'Other expenses'. The employment on-costs liability is included at note 33 'Provisions'.

Note 8 Patient support costs		
Medical supplies and services	40,593	37,360
Domestic charges	5,923	5,778
Fuel, light and power	13,656	13,761
Food supplies	8,002	7,098
Patient transport costs	20,457	18,598
Purchase of external services	12,650	12,849
	101,281	95,445

Note 9 Finance costs		
Interest paid	1,705	1,757

Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	19,506	17,956
Leasehold improvements	196	110
Computer equipment	206	268
Furniture and fittings	144	126
Motor vehicles	554	675
Medical equipment	5,216	5,911
Other plant and equipment	1,276	1,590
	27,098	26,637
Amortisation		
Intangible assets	22	30
Total depreciation and amortisation	27,120	26,667

Note 11 Capital user charge		
	-	52,625

The charge was a levy applied by Government for the use of its capital. The final charge was levied in 2006-07.

Note 12 Net gain / (loss) on disposal of non-current assets	2008 $000	2007 $000
Cost of disposal of non-current assets		
Property, plant and equipment	(1,071)	-
Proceeds from disposal of non-current assets:		
Property, plant and equipment	740	-
Net gain/(loss)	(331)	-

See note 27 'Property, plant and equipment'.

Note 13 Other expenses

Communications	5,431	4,755
Computer services	741	989
Employment on-costs (a)	18,257	15,606
Insurance	2,851	3,884
Legal expenses	35	661
Motor vehicle expenses	4,976	4,620
Operating lease expenses	7,962	7,550
Printing and stationery	2,962	2,636
Rental of property	9,624	4,268
Doubtful debts expense	736	381
Purchase of external services	6,242	5,019
Other	10,326	10,928
	70,143	61,297

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

Note 14 Patient charges

Inpatient charges	20,454	19,018
Outpatient charges	8,174	6,094
	28,628	25,111

Note 15 Grants and contributions

Commonwealth grants and contributions		
Nursing homes	3,701	3,656
Grant for National Respite Carers Program	928	1,451
Grant for Regional Health Services	4,325	3,615
Grant for Community Aged Care Program	727	497
Grant for Primary Health Care Access Program - Kimberley	1,439	1,404
Grant for Carelink	355	444
Grant for Dept Veterans Affairs - Home & Domiciliary Care	133	181
Grant for Aged Care Training Program	250	515
Grant for Medical Specialists Outreach Assistance Program	52	203
Grant for HIV Treatment	-	145
Grant for Aboriginal Health	608	114
Grant for Training Hotel Services Staff - Dept Education & Training	-	113
Office of Aboriginal and Torres Strait Islander Health - Wheatbelt	1,022	1,713
Customs	245	191
WA Alcohol and Drug Authority - Pilbara	(152)	95
Healthy for Life	1,074	434
Mobile Respite Program	112	89
Kimberley Paediatrics	152	-
Extended Specialist Training	100	-
Clever Networks	169	-
Respite for Young Carers and Carers of Young Disabled	30	24
Other grants	642	512
	15,912	15,396

Note 15 Grants and contributions (continued)	2008 $000	2007 $000
Other grants and contributions		
Disability Services Commission - Community Aids and Equipment Program	1,563	1,462
Disability Services Commission - Therapy Services	119	1,896
Grants for Medical Specialists Outreach Assistance Program	782	635
Western Australian Centre for Rural and Remote Medicine	80	276
Great Southern GP Network - For Ante Natal Program& Office relocation	108	219
Healthways	206	100
BHP Billiton	764	935
Great Southern Development Commission	-	754
Grant for Pilbara Development Commission - Wickham Hostel Upgrade	-	154
Dampier Peninsular Project	149	-
Bush Medivac - Dept of Industry	1,630	-
Regional Health Service Program	138	-
Pilbara Visiting Specialist Services Funding	480	-
Other grants	1,049	1,003
	7,068	7,434

Note 16 Donations revenue

General public contributions	735	505
Hospital Auxiliaries	98	57
Deceased estates	130	337
Abbotts Australia - Pumps	-	173
	963	1,072

Note 17 Other revenues

Recoveries	5,282	4,473
Use of hospital facilities	1,259	2,463
Rent from residential properties	294	287
Boarders' accommodation	3,702	3,270
Other	6,415	4,828
	16,952	15,321

Note 18 Service appropriations

Appropriation revenue received during the year:		
Service appropriations	679,068	660,595

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.

Note 19 Assets assumed / (transferred)

The following assets have been assumed from / (transferred to) other state government agencies during the financial year:

- Building for dental clinic	(3,316)	-
- Plant and equipment	(205)	20
Total assets assumed / (transferred)	(3,521)	20

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 under Treasurer's Instruction 955 and are taken directly to equity. Discretionary non-reciprocal transfer of assets between State Government agencies are reported as Assets assumed/ (transferred).

Note 20 Liabilities assumed by the Treasurer	2008 $000	2007 $000
The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	817	854

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 7 'Employee benefits expense').

Note 21 Cash and cash equivalents

Cash on hand	170	172
Cash at bank - general	18,642	15,520
Cash at bank - donations	2,414	2,129
Other short - term deposits	53	64
	21,279	17,885

Note 22 Restricted cash and cash equivalents

Cash assets held for specific purposes		
Cash at bank	560	442
	560	442

Restricted cash and cash equivalents are assets, the uses of which are restricted, by specific legal or other externally imposed requirements.

Note 23 Receivables

Current		
Patient fee debtors	4,772	3,759
Other receivables	4,371	4,554
Less: Allowance for impairment of receivables	(986)	(452)
Accrued revenue	2,647	3,127
	10,804	10,988
GST receivable	2,451	2,355
	13,255	13,343

Reconciliation of changes in the allowance for impairment of receivables:

Balance at start of year	452	429
Doubtful debts expense recognised in the income statement	736	381
Amounts written off during the year	(202)	(358)
Balance at end of year	986	452

Credit Risk

Ageing of receivables past due but not impaired based on the information provided to senior management, at the balance sheet date:

Not more than 1 year	4,046	3,402
More than 1 year	646	427
	4,692	3,829

Receivables individually determined as impaired at the balance sheet date:

Carrying amount, before deducting any impairment loss	1,594	315
Impairment loss	(815)	(315)
	779	0

The Health Service does not hold any collateral as security or other credit enhancements relating to receivables.

See also note 2(p) 'Receivables' and note 51 'Financial instruments'.

	2008 $000	2007 $000
Note 24 Amounts receivable for services		
Current	-	8,386
Non-current	135,285	87,945
	135,285	96,331

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(n) 'Amounts receivable for services'.

Note 25 Inventories		
Current		
Supply stores - at cost	1,666	1,686
Pharmaceutical stores - at cost	1,264	1,291
Engineering stores - at cost	588	604
	3,518	3,581

See note 2(o) 'Inventories'.

Note 26 Other current assets		
Prepayments	1,442	844
Other current assets	423	-
	1,865	844

Note 27 Property, plant and equipment		
Land		
At fair value (a)	109,918	71,659
	109,918	71,659
Buildings		
Clinical:		
At fair value	590,079	583,495
Accumulated depreciation	(2,421)	(19,311)
	587,658	564,184
Non-Clinical:		
At fair value	90,889	66,695
Accumulated depreciation	(544)	(420)
	90,345	66,275
Total land and buildings	787,921	702,118
Leasehold improvements		
At cost	945	830
Accumulated depreciation	(306)	(110)
	639	720
Computer equipment		
At cost	961	766
Accumulated depreciation	(446)	(250)
	515	516
Furniture and fittings		
At cost	1,874	1,414
Accumulated depreciation	(264)	(123)
	1,610	1,291
Motor vehicles		
At cost	1,915	1,638
Accumulated depreciation	(1,222)	(675)
	693	963
Medical equipment		
At cost	37,370	29,462
Accumulated depreciation	(10,906)	(5,901)
Accumulated impairment losses	(374)	(374)
	26,090	23,187

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Other plant and equipment		
At cost	12,029	11,789
Accumulated depreciation	(2,591)	(1,575)
	9,438	10,214
Works in progress		
Buildings under construction (at cost)	50,551	41,593
Other Work in Progress (at cost)	289	601
	50,840	42,194
Art Works		
At cost	72	66
Total of property, plant and equipment	877,818	781,269

(a) Land and buildings were revalued as at 1 July 2007 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2008 and recognised at 30 June 2008. In undertaking the revaluation, fair value was determined by reference to market values for land: $57,353,000 and buildings: $75,142,000. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See note 2(f) 'Property, Plant and Equipment'.

Valuation Services, the Office of the Auditor General and the Department of Treasury and Finance assessed the valuations globally to ensure that the valuations provided (as at 1 July 2007) were compliant with fair value at 30 June 2008.

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

Land		
Carrying amount at start of year	71,659	-
Assets transferred in on commencement	-	70,172
Additions	-	942
Transfers from Work in Progress	98	545
Disposals	(234)	-
Revaluation increments / (decrements)	38,395	-
Carrying amount at end of year	109,918	71,659
Buildings		
Carrying amount at start of year	630,459	-
Assets transferred in on commencement	-	591,540
Additions	853	5,004
Transfers from Work in Progress	51,642	51,721
Disposals	(510)	-
Transfer from/(to) other reporting entities	(237)	-
Revaluation increments / (decrements)	13,622	-
Depreciation	(19,506)	(17,956)
Transfer between asset classes	1,680	150
Carrying amount at end of year	678,003	630,459
Leasehold improvements		
Carrying amount at start of year	720	-
Assets transferred in on commencement	-	433
Transfers from work in progress	115	397
Depreciation	(196)	(110)
Carrying amount at end of year	639	720
Computer equipment		
Carrying amount at start of year	516	-
Assets transferred in on commencement	-	526
Additions	150	244
Transfers from Work in Progress	58	10
Disposals	(8)	-
Depreciation	(206)	(268)
Transfer between asset classes	5	4
Carrying amount at end of year	515	516

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Furniture and fittings		
Carrying amount at start of year	1,291	-
Assets transferred in on commencement	-	925
Additions	246	507
Transfers from Work in Progress	16	-
Transfer from/(to) other reporting entities	3	-
Depreciation	(144)	(126)
Transfer between asset classes	198	(15)
Carrying amount at end of year	1,610	1,291
Motor vehicles		
Carrying amount at start of year	963	-
Assets transferred in on commencement	-	1,284
Additions	230	354
Transfers from Work in Progress	85	-
Depreciation	(554)	(675)
Transfer between asset classes	(31)	-
Carrying amount at end of year	693	963
Medical equipment		
Carrying amount at start of year	23,187	-
Assets transferred in on commencement	-	20,739
Additions	5,735	8,490
Transfers from Work in Progress	1,033	76
Disposals	(256)	-
Transfer from/(to) other reporting entities	37	-
Impairment losses (a)	-	(374)
Depreciation	(5,216)	(5,911)
Transfer between asset classes	1,570	167
Carrying amount at end of year	26,090	23,187
Other plant and equipment		
Carrying amount at start of year	10,214	-
Assets transferred in on commencement	-	8,133
Additions	3,572	3,210
Transfers from Work in Progress	181	439
Disposals	(64)	-
Transfer from/(to) other reporting entities	233	20
Depreciation	(1,276)	(1,590)
Transfer between asset classes	(3,422)	2
Carrying amount at end of year	9,438	10,214
Works in progress		
Carrying amount at start of year	42,194	-
Assets transferred in on commencement	-	44,762
Additions	65,191	51,546
Write-down of assets	-	(617)
Transfers from Work in Progress	(53,229)	(53,188)
Transfer from/(to) other reporting entities	(3,316)	-
Transfer between asset classes	-	(309)
Carrying amount at end of year	50,840	42,194
Art Works		
Carrying amount at start of year	66	-
Assets transferred in on commencement	-	66
Additions	6	-
Carrying amount at end of year	72	66

Note 27 Property, plant and equipment (continued)	2008 $000	2007 $000
Total property, plant and equipment		
Carrying amount at start of year	781,269	-
Assets transferred in on commencement	-	738,580
Additions	75,982	70,297
Write-down of assets	-	(617)
Disposals	(1,072)	-
Transfer from/(to) other reporting entities	(3,280)	20
Revaluation increments / (decrements)	52,017	-
Impairment losses (a)	-	(374)
Depreciation	(27,098)	(26,637)
Carrying amount at end of year	877,818	781,269

(a) Impairment loss recognised in the Income Statement.

Note 28 Impairment of Assets

There were no indications of impairment to property, plant and equipment, and intangible assets at 30 June 2008.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period and at balance sheet date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2008 have either been classified as assets held for sale or written off.

Note 29 Intangible assets

Computer software		
At cost	126	126
Accumulated amortisation	(52)	(30)
	74	96

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	96	-
Assets transferred in on commencement	-	93
Additions	-	33
Amortisation expense	(22)	(30)
Carrying amount at end of year	74	96

(a) Impairment loss recognised in Income Statement.

Note 30 Other financial assets

Shares in Mount Barker Cooperative Ltd at cost	6	6

Note 31 Payables

Current		
Trade creditors	17,424	12,428
Accrued expenses	27,378	18,714
Accrued salaries	9,219	9,179
Accrued interest	206	219
	54,227	40,540

(See also note 2(q) 'Payables' and note 51 'Financial instruments')

Note 32 Borrowings	2008 $000	2007 $000
Current		
Western Australian Treasury Corporation loans (a)	564	551
Department of Treasury and Finance loans (b)	1,039	996
	1,603	1,547
Non-current		
Western Australian Treasury Corporation loans (a)	8,913	9,477
Department of Treasury and Finance loans (b)	16,021	17,060
	24,934	26,537
Total borrowings	26,537	28,084

(a) 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.

(b) 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 Government's debt servicing costs.

(c) Lease liabilities are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

Note 33 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	35,695	32,521
Time off in lieu leave (a)	11,858	10,574
Long service leave (b)	17,378	15,805
Deferred salary scheme	380	299
Gratuities	1,119	1,099
	66,430	60,298
Non-current		
Employee benefits provision		
Long service leave (b)	12,191	11,282
Deferred salary scheme	351	413
Gratuities	299	491
	12,841	12,186
Total Provisions	79,271	72,484

(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 balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	31,672	28,655
More than 12 months after balance sheet date	15,881	14,440
	47,553	43,095

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	6,437	6,482
More than 12 months after balance sheet date	23,132	20,605
	29,569	27,087

(c) The settlement of annual and long service leave liabilities give rise to the payment of employment on-costs including workers compensation insurance. 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 13 'Other expenses'.

Note 34 Other liabilities	2008 $000	2007 $000
Current		
Income received in advance	47	545
Refundable deposits	0	(114)
Other	92	54
	139	485

Note 35 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	781,023	-
Contributions by owners		
Capital contributions (a)	69,560	58,904
Transfer of net assets from other agencies (a) (b)	-	722,119
Total contributions by owners	69,560	781,023
Balance at end of year	850,583	781,023

(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 955 'Contribution by Owners Made to Wholly Owned Public Sector Entities' and are credited directly to equity.

(b) 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. Consequently, non-discretionary (non-reciprocal) transfers of net assets to other State government agencies are distribution to owners and are debited directly to equity.

Note 36 Reserves

Asset revaluation reserve (a)		
Balance at start of year	-	-
Net revaluation increments / (decrements) (b) (c) :		
Land	38,395	-
Buildings	13,622	-
Balance at end of year	52,017	-

(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.

(c) Any decrement is recognised as an expense in the Income Statement, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.

Note 37 Accumulated surplus/(deficit)

Balance at start of year	(8,819)	-
Result for the period	(295)	3,648
Change in accounting policy	-	(12,467)
Balance at end of year	(9,114)	(8,819)

Note 38 Notes to the Cash Flow Statement	2008 $000	2007 $000
a) **Reconciliation of cash**		
Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:		
Cash and cash equivalents (see note 21)	21,279	17,885
Restricted cash and cash equivalents (see note 22)	560	442
	21,838	18,327
b) **Reconciliation of net cash flows to net cost of services used in operating activities**		
Net cash used in operating activities (Cash Flow Statement)	(627,599)	(573,542)
Increase/(decrease) in assets:		
GST receivable	96	1,238
Other current receivables	830	2,333
Inventories	(63)	(411)
Prepayments	1,021	142
Decrease/(increase) in liabilities:		
Doubtful debts provision	(534)	(23)
Payables	(13,687)	(2,516)
Current provisions	(6,131)	(4,308)
Non-current provisions	(656)	844
Income received in advance	499	1,043
Other liabilities	(153)	59
Non-cash items:		
Depreciation and amortisation expense (note 10)	(27,120)	(26,667)
Net gain / (loss) from disposal of non-current assets (note 12)	(331)	-
Interest paid by Department of Health	(1,718)	(1,776)
Capital user charge paid by Department of Health (note 11)	-	(52,625)
Asset Impairment Losses	-	(374)
Superannuation liabilities assumed by the Treasurer (note 20)	(817)	(854)
Write down of property, plant and equipment (note 27)	-	(617)
Adjustment for other non-cash items	(296)	233
Net cost of services (Income Statement)	(676,659)	(657,821)
c) **Notional cash flows**		
Service appropriations as per Income Statement	679,068	660,595
Capital contributions credited directly to Contributed Equity (Refer Note 35)	69,560	58,904
Holding account drawdowns credited to Amounts Receivable for Services	1,569	11,929
	750,197	731,428
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	(640)	(651)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(551)	(539)
Interest paid to Department of Treasury & Finance	(1,078)	(1,125)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(996)	(950)
Capital user charge	-	(52,625)
Accrual appropriations	(40,524)	(32,375)
Capital works expenditure	(11,239)	(18,928)
Other non cash adjustments to service appropriations	-	14
	(55,028)	(107,179)
Cash Flows from State Government as per Cash Flow Statement	695,169	624,249

At the balance sheet date, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 39 Voluntary changes in accounting policy

Effective from 1 July 2007, the Health Service has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets (See note 5 'Voluntary changes in accounting policy'). Retrospective application of the change in accounting policy has resulted in an amount of $12,468,000 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006.The adjustments relating to the 2006-07 financial year are as follows:

Reconciliation of equity at the end of the last reporting period under previous asset capitalisation policy : 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Assets			
Current Assets	44,481	-	44,481
Non-Current Assets (a) (b)	881,287	(11,971)	869,316
Total Assets	925,768	(11,971)	913,797
Liabilities			
Current Liabilities	102,870	-	102,870
Non-Current Liabilities	38,723	-	38,723
Total Liabilities	141,593	-	141,593
Total Equity (c)	784,175	(11,971)	772,204
Accumulated surplus/(deficiency)			
Opening balance	-	(12,467)	(12,467)
Surplus/(Deficit) for the period	3,152	496	3,648
Closing balance	3,152	(11,971)	(8,819)
(a) Property, plant and equipment	793,233	(11,964)	781,269
(b) Intangible assets	103	(7)	96
(c) Accumulated surplus/(deficiency)	3,152	(11,971)	(8,819)

Reconciliation of income statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Expenses (a)	722,735	(451)	722,284
Total income other than income from State Government	64,418	45	64,463
Net cost of services	658,317	(496)	657,821
Income from State Government	661,469	-	661,469
Surplus/(Deficit) for the period	3,153	496	3,648
(a) Depreciation and amortisation expense	29,791	(3,124)	26,667
Loss on disposal of non-current assets	307	(307)	-
Repairs, maintenance and consumable equipment	18,777	2,980	21,757
	48,875	(451)	48,424

Note 39 Voluntary changes in accounting policy (continued)

Reconciliation of cash flow statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$000	$000	$000
Cash flows from State Government	624,249	-	624,249
Utilised as follows:			
Net cash (used in) / provided by -			
Operating activities (a)	(570,607)	(2,935)	(573,542)
Investing activities (b)	(54,115)	2,935	(51,180)
Net increase / (decrease) in cash and cash equivalents	(473)	-	(473)
Cash and cash equivalents at the beginning of period	18,800	-	18,800
Cash and cash equivalents at the end of period	18,327	-	18,327
(a) Payments for supplies and services	(215,255)	(2,980)	(218,235)
(a) Other receipts	14,065	45	14,110
(b) Payments for purchase of non-current physical assets	(54,160)	2,980	(51,180)
(b) Payments for purchase of non-current physical assets	45	(45)	-

Note 40 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off under the authority of the Accountable Authority.	329	324
b) Public and other property written off under the authority of the Accountable Authority.	22	106
c) Revenue and debts written off under the authority of the Minister.	-	-
d) Public and other property written off under the authority of the Minister.	-	146
e) Gifts of public property provided by the Health Service.	-	-

Note 41 Losses of public moneys and other property

Losses of public moneys and public or other property through theft or default	3	4
Less amount recovered	-	-
Net losses	3	4

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 remuneration of the Director General of Health is paid by the Department of Health.

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

	2008	2007
$170,001 - $180,000	1	-
$500,001 - $510,000	1	-
$610,000 - $620,000	-	1
Total	2	1

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:

	2008	2007
$50,001 - $60,000	2	-
$60,001 - $70,000	1	-
$70,001 - $80,000	1	1
$80,001 - $90,000	1	-
$90,001 - $100,000	1	-
$110,001 - $120,000	1	1
$120,001 - $130,000	-	2
$130,001 - $140,000	1	2
$140,001 - $150,000	1	2
$150,001 - $160,000	3	3
$160,001 - $170,000	1	1
$170,001 - $180,000	2	3
$300,001 - $310,000	-	1
$320,001 - $330,000	1	-
Total	16	16
	$000	**$000**
The total remuneration of senior officers is:	2,157	2,449

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.

Note 43 Remuneration of auditor

Remuneration payable to the Auditor General for the financial year is as follows:

Auditing the accounts, financial statements and performance indicators	620	570

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	117,401	58,008
Later than 1 year, and not later than 5 years	72,879	20,156
Later than 5 years	-	-
	190,280	78,164
The capital commitments include amounts for:		
- Buildings	189,626	77,776

The capital expenditure commitments are all inclusive of GST.

Note 44 Commitments (continued)	2008 $000	2007 $000

b) **Operating lease commitments:**

Commitments in relation to non-cancellable leases contracted for at the balance sheet date but not recognised in the financial statements, are payable as follows:

Within 1 year	8,219	4,095
Later than 1 year, and not later than 5 years	10,009	6,637
Later than 5 years	40	66
	18,268	10,798

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

The operating lease commitments are all inclusive of GST.

c) **Other expenditure commitments:**

Other expenditure commitments contracted for at the balance sheet date but not recognised as liabilities, are payable as follows:

Within 1 year	567	338
Later than 1 year, and not later than 5 years	166	-
Later than 5 years	-	-
	733	338

The other expenditure 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:

(a) Litigation in progress

Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service	9,700	1,100
Number of claims	3	3

Contaminated Sites

Under the Contaminated Sites Act 2003, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the Health Service may have a liability in respect of investigation or remediation expenses.

At the balance sheet date, the Health Service has eight reported contaminated sites. Two sites have been classified as "possibly contaminated - investigation required". The Health Service is unable to assess the likely outcome of the classification process, and accordingly, it is not practicable to estimate the potential financial effect or to identify the uncertainties relating to the amount or timing of any outflows. Whilst there is no possibility of reimbursement of any future expenses that may be incurred in the remediation of these sites, the Health Service may apply for funding from the Contaminated Sites Management Account to undertake further investigative work or to meet remediation costs that may be required.

Note 46 Events occurring after balance sheet date

There were no events occurring after the balance sheet date which had significant financial effects on these financial statements.

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 financial year.

	2008 $000	2007 $000

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 financial year.

Note 49 Administered trust accounts

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	690	722
Add Receipts		
- Patient Deposits	1,756	1,269
- Interest	5	5
	2,452	1,996
Less Payments		
- Patient Withdrawals	(1,644)	(1,306)
- Interest / Charges	(1)	-
Closing Balance	807	690

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	204	200
Add Receipts		
- Fees collected on behalf of medical practitioners	152	212
- Interest	2	2
	358	414
Less Payments		
- Payments to medical practitioners	(149)	(208)
- Charges	(6)	(2)
Closing Balance	203	204

c) Other trust accounts - not controlled by the Health Service

Accommodation Bonds Account	-	147
Staff Development and Diabetes Education Fund	4	4
	4	151
Opening Balance		
	4	151
Add Receipts		
- Interest	-	1
	4	152
Less Payments		
- Withdrawals	-	(148)
Closing Balance	4	4

Notes to the Financial Statements

For the year ended 30th June 2008

Note 50 Explanatory Statement

(A) Significant variances between actual results for 2007 and 2008

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.

	Note	2008 Actual $000	2007 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	475,152	418,275	56,877
Fees for visiting medical practitioners		47,190	44,087	3,103
Patient support costs	(b)	101,281	95,445	5,836
Finance costs		1,705	1,757	(52)
Depreciation and amortisation expense		27,120	26,667	453
Asset impairment losses		-	374	(374)
Capital user charge	(c)	-	52,625	(52,625)
Loss on disposal of non-current assets		331	-	331
Other expenses		70,143	61,297	8,846
Income				
Patient charges	(d)	28,628	25,111	3,517
Commonwealth grants and contributions		15,912	15,396	516
Other grants and contributions		7,068	7,434	(366)
Donations revenue		963	1,072	(109)
Interest revenue		143	129	14
Other revenues	(e)	16,952	15,321	1,631
Service appropriations		679,068	660,595	18,472
Assets assumed / (transferred)	(f)	(3,521)	20	(3,541)
Liabilities assumed by the Treasurer		817	854	(37)

(a) Employee benefits expense

The significant factors contributing to the growth in employee expenses were:

(i) Increased costs associated with industrial award increases for all employee categories, including the flow on effect on employee superannuation ($37m).

(ii) impact on employee benefit expenses resulting from FTE increases across WACHS during 2007/08 ($21m), including agency nursing and locum medical staff.

(b) Patient support costs

Patient support costs have increased due to the combined effect of significant increases in admitted and non admitted patient activity during 2007/08 and escalating costs for goods and services including food, drugs, patient supplies and patient transport.

(c) Capital user charge

Capital user charges were levies applied by Government for the use of its capital. The final charge was levied in 2006-07.

(d) Patient charges

Additional patient revenues have resulted from increases in fees and charges together with continued gains from targetted revenue initiatives and the flow on effects of new radiology contracting arrangements.

(e) Other revenues

Additional Other Revenues increased due to additional RiskCover performance adjustments ($1.2m) and various other miscellaneous revenues $0.4m.

(f) Assets assumed / (transferred)

Medical equipment supporting the Telehealth program and a dental clinic were transferred to the Metropolitan Health Service during 2007/08.

Note 50 Explanatory Statement (continued)

(B) Significant variations between estimates and actual results for 2008

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 the budget estimates.

	Note	2008 Actual $000	2008 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	475,152	409,253	65,899
Other goods and services		271,174	276,612	(5,438)
Total expenses		746,326	685,865	60,461
Less: Revenues	(b)	(69,666)	(58,252)	(11,414)
Net cost of services		676,660	627,613	49,047

(a) Employee benefits expense
The variance in employee benefits is attributable to cost of award increases ($15m) in excess of initial budget estimates and various continuing and new services ($53m) for which funding was not included in the initial budget but was the subject of subsequent budget adjustment.

(b) Revenues
(i) Various revenue sources not reflected in the initial budget allocation and for which budget adjustments were received during 2007/08, including RiskCover performance and investment returns ($4.4m), Commonwealth Programs ($2.7m);

(ii) Additional revenues received from targetted private patient initiatives ($1.6m) and specific purpose grants ($1.4m).

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments

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

Financial instruments held by the WA Country Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, 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
Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service. The Health Service measures credit risk on a fair value basis and monitors risk on a regular basis.

The maximum exposure to credit risk at balance sheet date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment as shown in the table at Note 51(c).

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, 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.

Provision for impairment of financial assets is calculated based on past experience, and current and expected changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 23 'Receivables'.

Liquidity risk
The Health Service is exposed to liquidity risk through its normal course of operations. Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due.

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.

Market risk
The Health Service does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations. The Health Service's borrowings are all obtained through the Western Australian Treasury Corporation (WATC) and the Department of Treasury and Finance (DTF) and are at fixed rates with varying maturities. The risk is managed by WATC through portfolio diversification and variation in maturity dates.

Other than as detailed in the Interest rate sensitivity analysis table at note 51(c), the Health Service is not exposed to interest rate risk because apart from restricted cash and minor amounts of cash and cash equivalents, all other cash and cash equivalents are non-interest bearing and its borrowings are limited to those with WATC and DTF.

b) **Categories of financial instruments**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows:

	2008 $000	2007 $000
Financial Assets		
Cash and cash equivalents	21,279	17,885
Restricted cash and cash equivalents	560	442
Other financial assets	6	6
Loans and receivables (a)	146,090	107,319
Financial Liabilities		
Financial liabilities measured at amortised cost	80,763	68,624

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 51 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk, liquidity risk and interest rate risk exposure

The following table details the exposure to liquidity risk and interest rate risk as at the balance sheet date. The Health Service's maximum exposure to credit risk at the balance sheet date is the carrying amount of the financial assets as shown on the following table. The table is based on information provided to senior management of the Health Service. The contractual maturity amounts in the table are representative of the undiscounted amounts at the balance sheet date. An adjustment for discounting has been made where material.

				Contractual maturity dates						
As at 30th June 2008	Weighted average effective interest rate %	Variable interest rate $000	Non-interest bearing $000	Within 1 year $000	1-2 years $000	2-3 years $000	3-4 years $000	4-5 years $000	More than 5 years $000	Total $000
Financial Assets										
Cash and cash equivalents	0.5%	1,951	19,232	96						21,279
Restricted cash and cash equivalents	6.8%	560	-							560
Other financial assets		6	-							6
Receivables (a)			10,804							10,804
Amounts receivable for services			135,286							135,286
		2,517	165,322	96	-	-	-	-	-	167,935
Financial Liabilities										
Payables			54,227							54,227
Borrowings										
- W A Treasury Corporation loans	6.4%			564	576	589	603	616	6,528	9,476
- Department of Treasury & Finance loans	6.1%			1,039	1,087	1,137	1,192	1,244	11,361	17,060
		-	54,227	1,603	1,663	1,726	1,795	1,860	17,888	80,763

WA Country Health Service

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For the year ended 30th June 2008

Note 51 Financial instruments (continued)

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2007	%	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets										
Cash and cash equivalents	0.4%	2,129	15,692	33	31					17,885
Restricted cash and cash equivalents	5.8%	442	-							442
Other financial assets		6	-							6
Receivables (a)			10,988							10,988
Amounts receivable for services			96,330							96,330
		2,577	123,010	33	31	-	-	-	-	125,651
Financial Liabilities										
Payables			40,540							40,540
Borrowings										
- W A Treasury Corporation loans	6.0%			551	564	576	589	603	7,145	10,028
- Department of Treasury & Finance loans	6.1%			996	1,045	1,090	1,137	1,193	12,595	18,056
		-	40,540	1,547	1,609	1,666	1,726	1,795	19,740	68,624

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

The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities.

Note 51 Financial instruments (continued)

Interest rate sensitivity analysis
The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the balance sheet date on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

		-1% change		+1% change	
As at 30th June 2008	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Assets					
Cash and cash equivalents	21,279	(20)	(20)	20	20
Restricted cash and cash equivalents	560	(6)	(6)	6	6
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	9,476	95	95	(95)	(95)
- Department of Treasury & Finance	17,060	171	171	(171)	(171)
Total Increase/(Decrease)		240	240	(240)	(240)

		-1% change		+1% change	
As at 30th June 2007	Carrying Amount $000	Profit $000	Equity $000	Profit $000	Equity $000
Financial Assets					
Cash and cash equivalents	17,885	(22)	(22)	22	22 22
Restricted cash and cash equivalents	442	(4)	(4)	4	4
Financial Liabilities					
Borrowings					
- W A Treasury Corporation loans	10,028	100	100	(100)	(100)
- Department of Treasury & Finance	18,056	181	181	(181)	(181)
Total Increase/(Decrease)		255	255	(255)	(255)

Fair values
All financial assets and liabilities recognised in the balance sheet, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 52 Schedule of Income and Expenses by Services

	Admitted Patient Services		Specialised Mental Health		Palliative Care		Non-Admitted Patient		Patient Transport		Prevention & Promotion	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES												
Expenses												
Employee benefits expense	223,707	196,318	6,713	5,007	1,053	995	97,178	85,160	11,017	9,697	50,889	44,714
Fees for visiting medical practitioners	30,256	29,230	65	28	5	21	14,355	12,910	68	83	210	230
Patient support costs	47,684	44,798	1,431	1,142	224	227	20,714	19,432	2,348	2,213	10,847	10,203
Finance costs	803	824	24	21	4	4	349	359	40	41	183	188
Depreciation and amortisation expense	12,767	12,516	383	319	60	63	5,547	5,429	629	618	2,905	2,851
Asset impairment losses	-	175	-	4	-	1	-	76	-	9	-	40
Capital user charge	-	24,700	-	630	-	125	-	10,714	-	1,220	-	5,626
Loss on disposal of non-current assets	156	-	5	-	1	-	68	-	8	-	34	-
Repairs, maintenance and consumable equipment	11,018	10,212	331	260	52	52	4,786	4,430	543	504	2,506	2,325
Other expenses	33,025	28,770	991	734	155	146	14,346	12,480	1,626	1,421	7,513	6,552
Total cost of services	359,416	347,543	9,943	8,145	1,554	1,634	157,343	150,990	16,279	15,806	75,087	72,729
INCOME												
Revenue												
Patient charges	14,196	12,886	95	96	47	-	8,665	7,612	145	-	355	209
Commonwealth grants and contributions	764	783	10	2	2	-	458	627	122	83	8,679	7,708
Other grants and contributions	903	1,245	7	1	53	38	1,240	1,583	24	7	2,528	2,102
Donations revenue	453	481	14	4	2	1	197	226	22	9	103	142
Interest revenue	68	58	2	-	-	-	29	27	3	1	15	17
Other revenues	7,981	6,869	239	56	38	21	3,467	3,235	393	124	1,816	2,027
Total income other than income from State Government	24,365	22,322	367	159	142	60	14,056	13,310	709	224	13,496	12,205
NET COST OF SERVICES	**335,051**	**325,221**	**9,576**	**7,986**	**1,412**	**1,574**	**143,287**	**137,680**	**15,570**	**15,582**	**61,591**	**60,524**
INCOME FROM STATE GOVERNMENT												
Service appropriations	336,289	326,579	9,606	8,020	1,415	1,580	143,824	138,258	15,620	15,646	61,783	60,790
Assets assumed / (transferred)	(1,744)	11	(50)	-	(7)	-	(746)	4	(81)	-	(320)	2
Liabilities assumed by the Treasurer	405	422	12	10	2	2	173	179	19	20	74	79
Total income from State Government	334,950	327,012	9,568	8,030	1,410	1,582	143,251	138,441	15,558	15,666	61,537	60,871
SURPLUS/(DEFICIT) FOR THE PERIOD	**(101)**	**1,791**	**(8)**	**44**	**(2)**	**8**	**(36)**	**761**	**(12)**	**84**	**(54)**	**347**

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2008

Note 52 Schedule of Income and Expenses by Services

	Home & Community Care		Aged Care Assessment		Community Mental Health		Residential Care		Total	
	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000	2008 $000	2007 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	11,715	9,629	2,432	2,242	21,273	19,121	49,175	45,392	475,152	418,275
Fees for visiting medical practitioners	117	68	86	107	850	477	1,178	933	47,190	44,087
Patient support costs	2,497	2,197	518	512	4,535	4,363	10,483	10,358	101,281	95,445
Finance costs	42	40	9	9	75	80	176	191	1,705	1,757
Depreciation and amortisation expense	669	614	139	143	1,214	1,219	2,807	2,895	27,120	26,667
Asset impairment losses	-	9	-	2	-	17	-	41	-	374
Capital user charge	-	1,212	-	282	-	2,406	-	5,710	-	52,625
Loss on disposal of non-current assets	8	-	2	-	15	-	34	-	331	-
Repairs, maintenance and consumable equipment	577	501	120	117	1,048	995	2,422	2,361	23,403	21,757
Other expenses	1,729	1,411	359	329	3,140	2,802	7,259	6,652	70,143	61,297
Total cost of services	17,354	15,681	3,665	3,743	32,150	31,480	73,534	74,533	746,325	722,284
INCOME										
Revenue										
Patient charges	40	34	1	-	216	-	4,868	4,274	28,628	25,111
Commonwealth grants and contributions	4,316	5,172	4	12	871	959	686	50	15,912	15,396
Other grants and contributions	20	21	14	10	242	121	2,037	2,306	7,068	7,434
Donations revenue	24	55	5	5	43	19	100	130	963	1,072
Interest revenue	4	6	1	2	6	2	15	16	143	129
Other revenues	418	783	86	78	760	272	1,754	1,856	16,952	15,321
Total income other than income from State Government	4,822	6,071	111	107	2,138	1,373	9,460	8,632	69,666	64,463
NET COST OF SERVICES	**12,532**	**9,610**	**3,554**	**3,636**	**30,012**	**30,107**	**64,074**	**65,901**	**676,659**	**657,821**
INCOME FROM STATE GOVERNMENT										
Service appropriations	12,571	9,656	3,566	3,651	30,112	30,233	64,282	66,182	679,068	660,595
Assets assumed / (transferred)	(65)	-	(18)	-	(156)	1	(334)	2	(3,521)	20
Liabilities assumed by the Treasurer	15	12	4	5	36	39	77	86	817	854
Total income from State Government	12,521	9,668	3,552	3,656	29,992	30,273	64,025	66,270	676,364	661,469
SURPLUS/(DEFICIT) FOR THE PERIOD	**(11)**	**58**	**(2)**	**20**	**(20)**	**166**	**(49)**	**369**	**(295)**	**3,648**

Appendices

Appendix 1: Abbreviations

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on HealthCare Standards
AMI	Acute Myocardial Infarction
ATSI	Aboriginal and Torres Strait Islander
ATSN	Apprenticeship and Traineeship Support Network
CALD	Culturally and Linguistically Diverse
CCC	Corruption and Crime Commission
COAG	Council of Australian Governments
CPI	Consumer Price Index
CPR	Cardiac Pulmonary Resuscitation
CRSU	Community Supported Residential Units
DAIP	Disability Access and Inclusion Plan
DHAC	District Health Advisory Council
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
EQUIP	Evaluation and Quality Improvement Program
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HCN	Health Corporate Network
HMDS	Hospital Morbidity Data System
HRIT	Health Reform Implementation Taskforce
LHAG	Local Health Advisory Group
MOU	Memorandum of Understanding
MPS	Multi-Purpose Service
NGO	Non Government Organisation
NICS	National Institute of Clinical Studies

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
PATS	Patient Assisted Travel Scheme
RFDS	Royal Flying Doctor Service
SOYF	Stay on Your Feet
SQuIRe	Safety and Quality Investment in Reform
TI	Treasury Instruction
UWA	University of WA
VMP	Visiting Medical Practitioner
WACHS	WA Country Health Service

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Produced by the
Information Management and Reporting Directorate
Department of Health

Government of Western Australia
Department of Health