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

2008-09 Annual Report

WA COUNTRY HEALTH SERVICE

HP11366 June'09 24004

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

WA Country Health Service

Annual Report 2008-09

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Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

HON DR GRAHAM JACOBS MLA
MINISTER FOR MENTAL HEALTH

In accordance with Section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Report of the WA Country Health Service for the year ended 30 June 2009.

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

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH
Accountable Authority

17 September 2009

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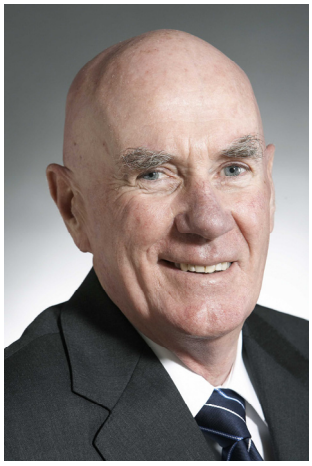
Illustrations

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

Overview of Agency

Executive Summary



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

Like health services around the world, WA Health faces serious challenges in meeting the health needs of our community today and building a sustainable health care system for the future. Growing demand for health care, competition for public resources, a shortage of health personnel, burgeoning technology costs and the growth of lifestyle diseases are just some of the problems we confront.

As part of WA Health, the WA Country Health Service, the largest country health system in Australia covering an area of 2.5 million square kilometres and one of the largest in the world, also faces service provision issues unique to rural and remote areas.

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

The WA Country Health Service provides a comprehensive and integrated health service to approximately half a million people, ten per cent of whom are Aboriginal Australians, and our hospitals handle as many emergency presentations as hospitals in the metropolitan area, and as many births as the State's major maternity hospital.

During the past 12 months the WA Country Health Service has made significant progress in strengthening health services in regional Western Australia and overcoming both the system wide challenges and those unique to rural and remote Western Australia.

Improving access to health services

The State Government approved an additional $26 million over four years to boost total funding for the Royal Flying Doctor Service (RFDS) to $68.5 million, with the WA Country Health Service completing negotiations for a new five year contract with the RFDS effective to June 2013. This extra funding allows the RFDS to replace five of its ageing aircraft and purchase three new planes (bringing the fleet to a total of 14 aircraft), as well as provide extra crews and medical staff. The funding significantly improves access to health services through better patient transport for country communities, and ensures that the RFDS is able to meet response times to required safety standards.

The Government increased support to country residents needing to travel away from their homes to access specialist medical services. An additional $30.8 million over three and half years from the Royalties for Regions scheme, including $4.2 million in January for 2008-09, was provided to overhaul and streamline the Patient Assisted Travel Scheme (PATS). Key changes to the PATS included increased fuel and accommodation subsidies and means country patients are no longer required to make any up-front payment towards their travel. All eligible country residents who have to travel more than 100 kilometres to access specialist medical treatment are entitled to receive the same subsidy regardless of their financial circumstances.

The WA Country Health Service successfully negotiated a contract with the Royal Darwin

Hospital whereby patients in the Kimberley will get faster emergency treatment and better access to acute care services closer to home. Under the contract, six beds per day are available at Royal Darwin Hospital for Kimberley patients who would otherwise need to be flown by RFDS to Perth for treatment. This innovative approach means more than 200 patients can be treated at the Royal Darwin Hospital each year.

In partnership with the St John Ambulance Association, the WA Country Health Service has been trialing a pilot Rural Paramedic Support project in the Kimberley and Pilbara to support rural volunteer ambulance centres.

Telehealth services have been boosted with the State and Commonwealth Governments each contributing $3 million under the Clever Networks initiative to improve broadband connections and telehealth infrastructure in regional WA. The funding enabled the expansion of bandwidth in 30 country sites. Telehealth services play a vital role in helping to overcome the barrier of distance, significantly improving access to health services for country communities.

Better hospitals and more equipment
Significant progress has been made on key projects including major regional hospital developments during 2008-09. These include the new Albany Health Campus and hospitals at Port Hedland and Kalgoorlie and the Broome Mental Health Centre. Work was also progressed on the Kalumburu Health Clinic and the Wyndham Multi-Purpose Centre development. The new Denmark Health Service was completed in December 2008 and Multi-purpose centres at Fitzroy Crossing and Morawa Perenjori were opened. A new and innovative accommodation facility – a Medi-Hotel was opened in Geraldton for patients requiring medical treatment but who do not need to stay in hospital.

More country patients now have easier access to radiology services following the installation of new equipment at hospitals throughout country WA. Teleradiology systems–computer workstations that allow images to be sent over broadband network lines – have been installed at Esperance, Merredin, Exmouth, Kununurra, Derby, Broome, Port Hedland, Tom Price, Newman, Karratha, Kalgoorlie, Narrogin and Albany. The new systems allow for quicker reporting by radiologists and review by metropolitan medical specialists if required, enabling faster diagnosis and treatment for patients and reducing the need for them to travel to Perth.

Improving hospital patient care
WA Country Health Service hospitals recorded a 7.8 percent increase in the number of cases admitted for surgery from 14,304 in 2007-08 to 15,423 in 2008-09. Significantly the number of over boundary cases on the waitlist for all categories has reduced from 291 on 30 June 2008 to 177 on 30 June 2009.

The WA Country Health Service has undertaken significant planning in order to commence the implementation of the WA Health Four Hour Rule Program in regional hospitals. The program will be commenced at Bunbury in October 2009, with other regional centres and Nickol Bay Hospital at Karratha from April 2010.

Improving primary health services
The WA Country Health Service has continued to pursue a range of initiatives to help communities stay healthier for longer and reduce the need for hospitalisation. These include promotion of the mental health campaign ‘Act Belong Commit’, the ‘Reducing the Risk of Falls’ program and the Alcohol and Tobacco Brief Intervention Policy. Screening programs which target indigenous health issues, such as the tracohoma and trichiasis screening have been implemented in the Pilbara, Kimberley and the Goldfields. The ‘Pit Stop’ men’s health program developed by the WA Country Health Service has proven so popular it has been adopted Australia-wide.

Improving indigenous health
Improving indigenous health is a priority for the WA Country Health Service. We continue to make important inroads in partnership with the Aboriginal community-controlled health sector to provide more culturally appropriate and effective health services. This partnership will help us to complement our services in communities for the benefit of Aboriginal people. In addition, we are strengthening our partnership with the Unity of First People of Australia (UFPA) to improve the health of indigenous communities in the Kimberley, with the signing in June 2009 of a Memorandum of Understanding cementing the partnership. State Government funding of $500,000 per year for four years, will enable the UFPA to expand the *Roadmap Towards*

Better Health Program to more indigenous people in the Kimberley.

Workforce innovations
The WA Country Health Service nurse Careers with Adventure – Rotational Nursing Programs continue to be successful in attracting and recruiting nursing staff. The programs offer nurses the opportunity to experience rural health care in a variety of settings over a 12-month rotation period. Thirty-eight nurse practitioners are in training across regional WA.

The Medical Association Industrial Agreement in September 2008 provided generous pay increases to medical practitioners, particularly those recruited to rural and remote WA, with doctors working in the north west of the state receiving the largest increase in the country health service.

A major effort will be directed towards employment of Aboriginal people within the WA Country Health Service with firm targets applied to each region.

Conclusion
These achievements, over the past twelve months, again highlight the tremendous effort, dedication and commitment of WA Country Health Service staff to improving health care for country communities throughout rural and remote Western Australia. I extend my thanks to you all.

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH

17 September 2009

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

Yamamoto House
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

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

WACHS – Midwest

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

WACHS – Wheatbelt

Shop 2, Northam Boulevard
Fitzgerald Street, NORTHAM WA 6401
Postal Address
PO Box 690, NORTHAM WA 6401
Phone: (08) 9621 0700
Fax: (08) 9621 0701
Email: whr@health.wa.gov.au

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
Phone: (08) 9781 2350
Fax: (08) 9781 2381

Our Purpose

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

Our Vision

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

Service Framework

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

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

The current Whole of Government goals are:

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

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

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

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

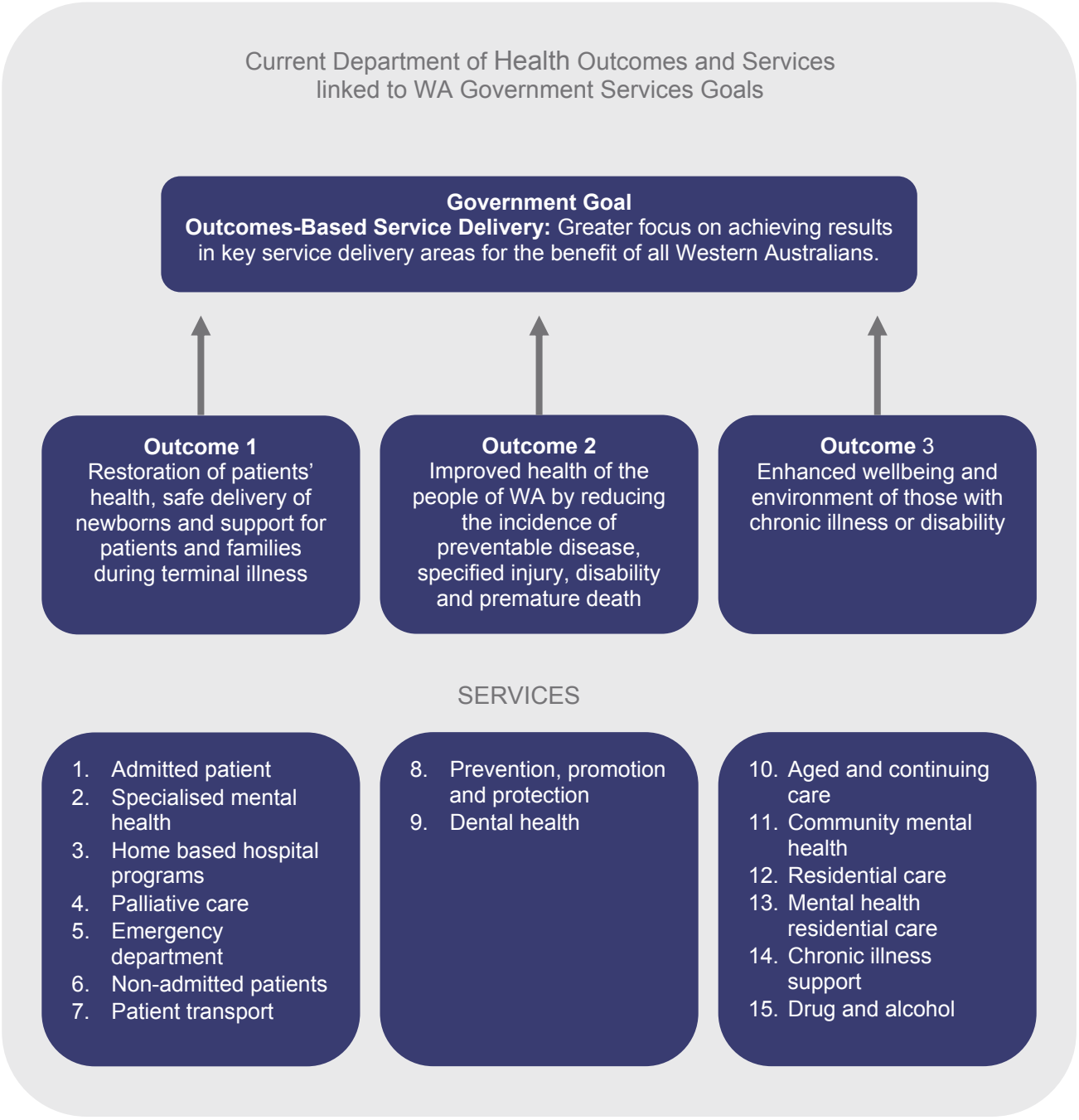
A range of Key Effectiveness Indicators measure progress achieved toward meeting these 'Outcomes'. Reporting of these is found in the Key Performance Indicators section of this annual report.

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

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

Service Framework (continued)

Figure 1: Department of Health outcome structure



Services Provided

Direct patient services

- accident and emergency medicine
- acute medical
- acute mental health
- acute surgical
- anaesthetics
- antenatal classes
- cardiology
- dermatology
- dental services
- ear, nose and throat
- endocrinology
- extended care
- gastroenterology
- general practice
- genetics
- gynaecology
- nephrology
- obstetrics
- occupational medicine
- oncology
- ophthalmology
- orthopaedics
- pain management
- pacemaker clinic
- paediatrics
- plastic surgery
- primary health care
- podiatry
- psychiatry and psychology
- renal dialysis
- residential aged care
- respite care
- rheumatology
- same day surgery
- urology

Medical support services

- ambulance and patient transport
- audiology
- dietetics
- medical imaging
- occupational therapy
- pathology
- pharmacy
- physiotherapy
- podiatry
- respiratory medicine
- social work
- speech pathology
- sexual health

Community and support services

- aged care
- child and maternal health
- community aged care packages
- community health
- community mental health
- health promotion
- health screening
- home and community care
- home based hospital programs
- immunisation
- meals on wheels
- public health
- palliative care
- residential care

Other services

- administration and corporate
- engineering / maintenance
- hotel and catering
- medical records

Compliance Reports

The Department of Health is established by the Governor under section 35 of the *Public Sector Management Act 1994*. The Director General of Health is responsible to the Ministers for Health and Mental Health for the efficient and effective management of the organisation. The Department of Health supports the Ministers in the administration of 42 Acts and 105 sets of subsidiary legislation.

Acts administered

- *Alcohol and Drug Authority Act 1974*
- *Anatomy Act 1930*
- *Animal Resources Authority Act 1981*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cannabis Control Act 2003*
- *Chiropractors Act 2005*
- *Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951*
- *Cremation Act 1929*
- *Dental Act 1939*
- *Dental Prosthetists Act 1985*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health Act 1911*
- *Health Legislation Administration Act 1984*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services (Conciliation and Review) Act 1995*
- *Health Services (Quality Improvement) Act 1994*
- *Hospital Fund Act 1930*
- *Hospitals and Health Services Act 1927*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medical Act 1894*
- *Medical Practitioners Act 2008*
- *Medical Radiation Technologists Act 2006*
- *Mental Health Act 1996*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Nurses and Midwives Act 2006*
- *Occupational Therapists Act 2005*
- *Optometrists Act 2005*
- *Osteopaths Act 2005*
- *Pharmacy Act 1964*
- *Physiotherapists Act 2005*
- *Podiatrists Act 2005*
- *Poisons Act 1964*
- *Prostitution Act 2000 (Act other than s.62 and Part 5)*
- *Psychologists Act 2005*
- *Queen Elizabeth II Medical Centre Act 1966*
- *Radiation Safety Act 1975*
- *Surrogacy Act 2008*
- *Tobacco Products Control Act 2006*
- *University Medical School Teaching Hospitals Act 1955*
- *White Phosphorous Matches Prohibition Act 1912*

Acts passed during 2008-09

- *Surrogacy Act 2008*

Bills in Parliament as at 30 June 2009

Royal Perth Hospital Protection Bill 2008

Amalgamation and establishment of Boards

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

Statement of Compliance with Public Sector Standards

As the accountable authority for the WA Country Health Service (WACHS), I am satisfied that WACHS has implemented procedures and processes to comply with the Public Sector Standards in Human Resource Management, the WA Public Sector Code of Ethics and the WA Health Code of Conduct. The following information details significant actions undertaken by WACHS in 2008-09 to prevent non-compliance and keep staff informed about the Standards and the Codes.

WACHS' Job Description documentation and employment processes emphasise compliance with the Public Sector Standards, the Codes and Equal Employment Opportunity legislation and policies.

In 2008-09 WACHS received seven claims for non-compliance with Public Sector Standards in Human Resource Management. Two are still pending within the agency while five were referred to the Office of the Public Sector Standards Commissioner (OPPSC) for investigation and appropriate action.

WACHS provides education and awareness training for its staff regarding the Public Sector Standards, Public Interest Disclosure (PID), the WA Health Code of Conduct and the Public Sector Code of Ethics. Training includes increasing workplace behaviour awareness, provides information about legislation changes, and ensures WACHS managerial staff have the required skills to manage and deal with issues pertaining to the Codes.

The Corporate Governance Directorate of the Department of Health presented information and awareness sessions across WACHS on PID and misconduct including the promotion of established pathways for the raising of matters that may constitute misconduct.

Mechanisms to monitor and assess the extent of compliance with the Codes implemented by WACHS included:

- employees participating in the WA Health employee satisfaction survey. This survey covered subjects including workplace behaviour, and sought feedback in relation to the compliance and management of these issues.
- WACHS staff participated in OPSSC surveys.
- Participating health service accreditation involves quality improvement activities.
- Maintaining and reviewing complaints and grievances statistics and records.
- Using external consultants to resolve potential conflicts of interest and provide written reports to management and human resource branches.
- Conducting internal and external compliance audits across WACHS.
- Performance Development Assessments which include staff knowledge and understanding of the Codes and the expected workplace behaviour.

Individual cases are investigated as appropriate and a specific outcome is reached on a case by case basis.

WACHS communicates information regarding the Codes to its employees via its intranet site, through staff development and induction training. Formal acceptance of the Codes is required from all staff. Substantiated non-compliance with the Codes is referred to internal or external agencies including the OPSSC for further investigation and action recommendations.

Table 1: Number of complaints alleging non-compliance with Codes

	Number
Number investigated internally in the agency	141
Number investigated by an external consultant	8
Total number lodged in 2008-2009	**149**

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH

17 September 2009

Pecuniary Interests

Senior officers of the WA Country Health Service have declared no pecuniary interests in 2008-09.

Accountable Authority

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

Senior Officers

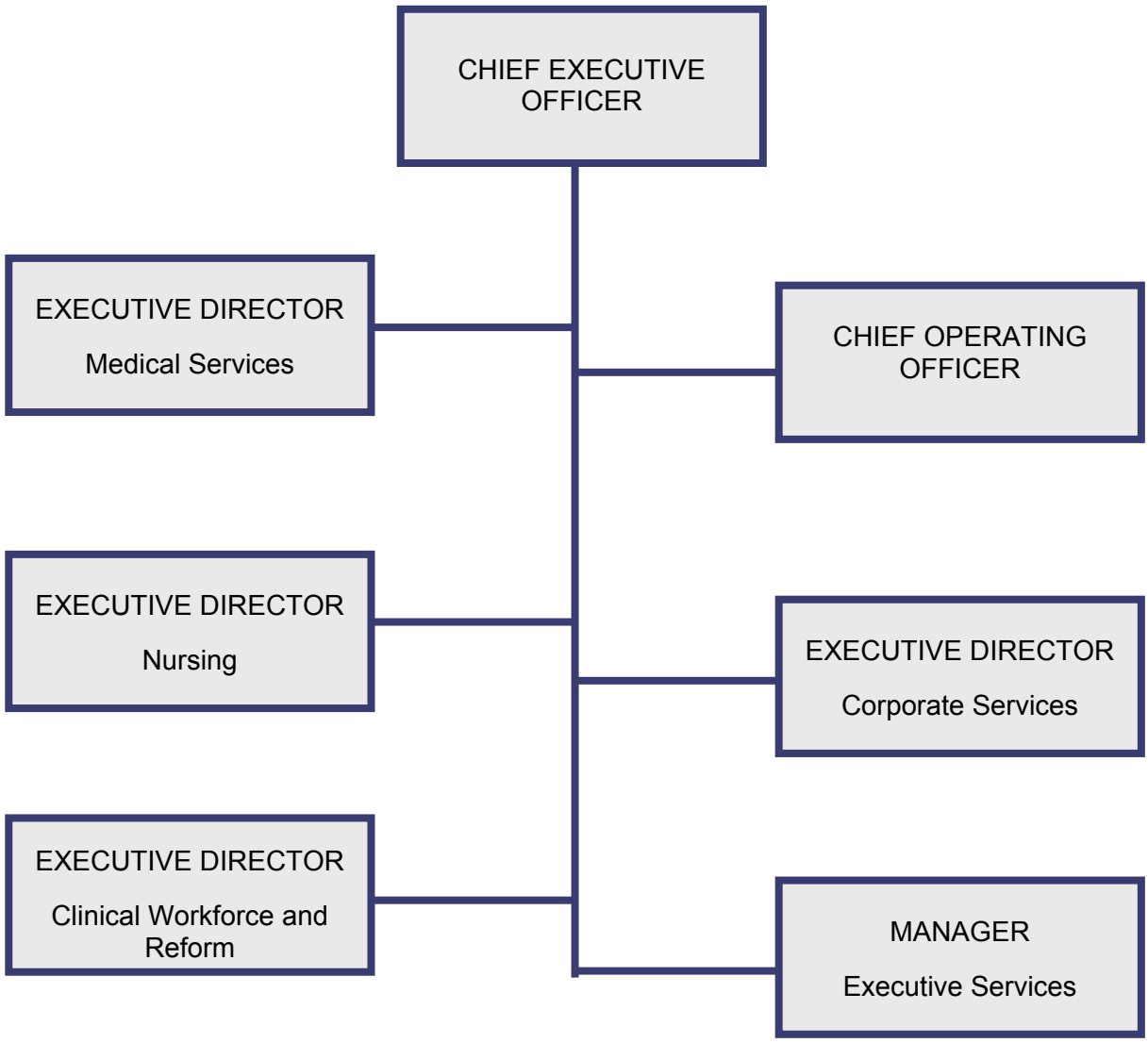
The senior officers as at 30 June 2009 for the WA Country Health Service (WACHS) and their areas of responsibility are listed below:

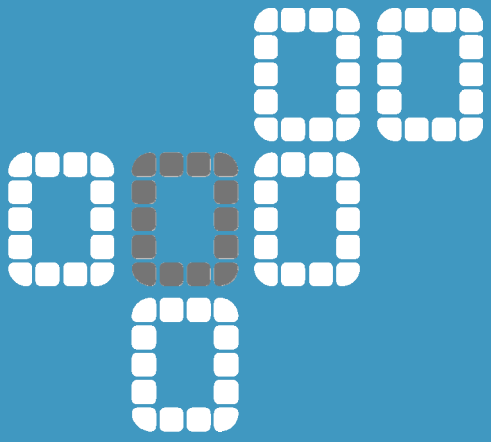
Table 2: WACHS Senior Officers as at 30 June 2009

Area of responsibility	Title	Name
WA Country Health Service	**Chief Executive Officer**	**Kim Snowball**
WACHS Area Operations	Chief Operating Officer	Jeff Moffet
WACHS Corporate Services	Acting Executive Director	Ken Mills
WACHS Executive Services	Manager	Gordon Stacey
WACHS Nursing	Executive Director	Karen Bradley
WACHS Medical Services	Executive Director	Dr Geoff Masters
WACHS Clinical Workforce and Reform	Executive Director	Dr Felicity Jeffries
Regional Operations	Regional Director Kimberley	Kerry Winsor
Regional Operations	Regional Director Pilbara	Tina Chinery
Regional Operations	Regional Director Mid West	Shane Matthews
Regional Operations	Regional Director Goldfields	Geraldine Ennis
Regional Operations	Regional Director Wheatbelt	Tim Free
Regional Operations	Regional Director Great Southern	Robert Pulsford
Regional Operations	Regional Director South West	Ian Smith

Management Structure

WA Country Health Service structure (June 2009)





Key Performance Indicators

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2009

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the WA Country Health Service and fairly represent the performance of the health service for the financial year ended 30 June 2009.

Dr Peter Flett
DIRECTOR GENERAL OF HEALTH
ACCOUNTABLE AUTHORITY

17 September 2009

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 2009

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 2009, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer www.audit.wa.gov.au/pubs/AuditPracStatement_Feb09.pdf.

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

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 2009

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 2009 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

(ii) the controls exercised by the 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 2009.

COLIN MURPHY
AUDITOR GENERAL
21 September 2009

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Introduction

The health of the Western 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 reported 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 patients' health, safe delivery of newborns and support for patients and families during terminal illness
Outcome 2: Improved health of the 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 the health service divisions and Area Health Services 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 the following annual reports must be read in conjunction:

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

Peel Health Service

For 2008-09 the Key Performance Indicators (KPIs) for the Peel Health Service are included in the Annual Report for the Metropolitan Health Service.

Table 3: Service activities in relation to the health outcomes

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

Comparative Results	Performance Targets
Where possible comparative results of prior years are provided.	Performance targets have been developed for the Effectiveness and Efficiency Key Performance Indicators wherever possible. Effectiveness indicator targets have been based on published national averages 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 2008-09 Government Budget Statements (GBS) for estimated expenditure in 2008-09.

Consumer Price Index (CPI) Deflator Series

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

Efficiency Indicators

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

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

The achievement of this outcome 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.

1-00: 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.

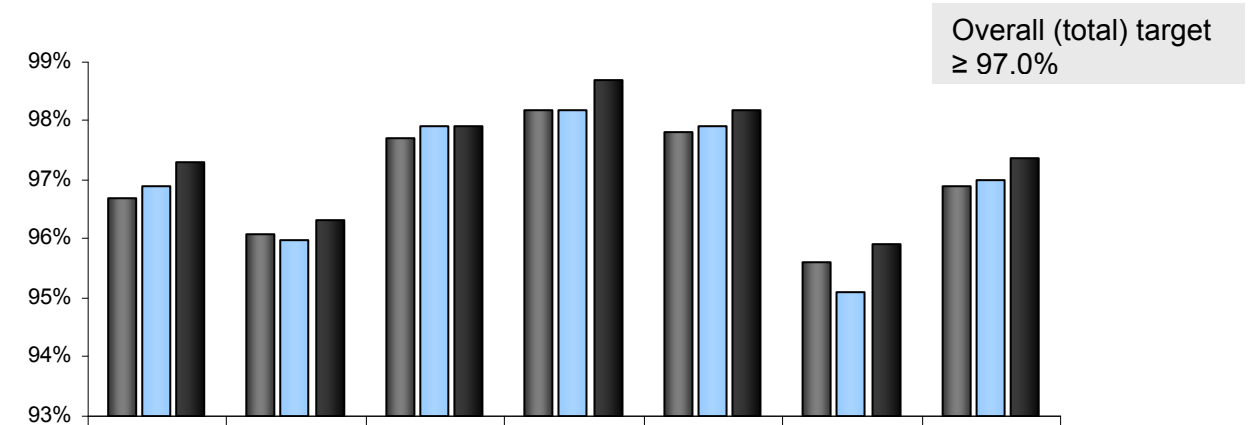
As the normal ageing process tends to decrease a patient's chances of returning home, the figures are presented in ten-year age groups. Data includes those patients separated after episodes of acute illness, rehabilitation, psycho-geriatric care and geriatric evaluation and management, but excludes other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

Results

The overall proportion for all ages of public patients discharged home from country hospitals was 97.4 per cent, above target and consistent with prior years.

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



	<40	40-49	50-59	60-69	70-79	80+	Total
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%
2008	97.3%	96.3%	97.9%	98.7%	98.2%	95.9%	97.4%

Data source
Hospital Morbidity Data System

1-01: Elective surgery waiting times

Rationale

In delivering services to achieve Outcome 1, the public health system provides elective surgery capacity in WACHS hospitals. Elective surgery is all non-emergency surgery for which admission to hospital can be delayed for at least 24 hours.

Timely access to the required surgical procedures is a measure of the public health system's capacity to perform elective surgery. 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 by clinical need into urgency categories based on the likelihood of the condition becoming an emergency if not seen within the recommended time frame, known as the boundary.

Performance targets

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

Results

Cases remaining

The tables presented below detail the number of cases remaining on the elective surgery waiting list at 30 June 2009 compared to the same time in the prior year. For the WA Country Health Service there are less over-boundary cases remaining. Reduced median waiting times are reported for all categories.

Elective surgery admissions during the year

In addition to the data presented in the tables, country public hospitals increased the number of cases admitted for surgery from 14,304 in 2007-08 to 15,423 in 2008-09, an increase of 7.8 per cent. The median waiting times for these admissions in each category remain within the boundaries, although slightly increased median times were recorded compared to 2007-08.

State and Commonwealth Government initiatives to support and enhance elective surgery capacity in WA have contributed to increased elective surgery activity and reduced median waiting times. A number of these initiatives will continue in 2009-10. In addition WACHS continues to improve its management of elective surgery waitlists to enable more people to receive surgical treatment in country locations.

Table 4: Cases remaining on the elective surgery waiting list – 30 June 2009

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Cases remaining within boundary	110	76	15	499	85	29	2122	98	83
Cases remaining over boundary	35	24		89	15		53	2	

Table 5: Cases 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
Cases remaining within boundary	82	59	25	424	73	39	2338	97	110
Cases remaining over boundary	56	41		156	27		79	3	

Data source: Patient Electronic Analysis Referral Liaison System

1-02: 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 the same hospital as an admitted patient for the same or a related condition as one for which the patient has previously 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 2.9 per cent. While this result exceeds the national target, the readmission rate is consistent with prior years for rural and remote locations. WACHS hospitals monitor their readmission rate 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 6: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2006	2007	2008	Target
Unplanned readmission rate	3.0%	2.8%	2.9%	<2.3%

Data sources
Hospital Morbidity Data System
Target - Report on Government Services 2009 National average

1-03: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

Rationale

An unplanned readmission is an unplanned return to the same hospital as an admitted patient for the same or a related mental health condition as one for which the patient has previously been discharged within 28 days.

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 rate for related unplanned mental health condition readmissions is 7.6 per cent and within the target set for this indicator.

The WACHS continues to provide a range of mental health programs and support networks delivering quality mental health services to country communities providing appropriate treatment and support when required, and preventing unplanned readmission to hospital.

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

	2006	2007	2008	Target
Unplanned readmission rate	5.2%	6.7%	7.6%	< 8.3%

Notes
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 is 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

Rationale

The survival rate of patients in hospitals can be affected by many factors. These include 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 likely to develop additional co-morbid conditions, and therefore better comparisons can be made if comparing particular age groups, rather than the whole population.

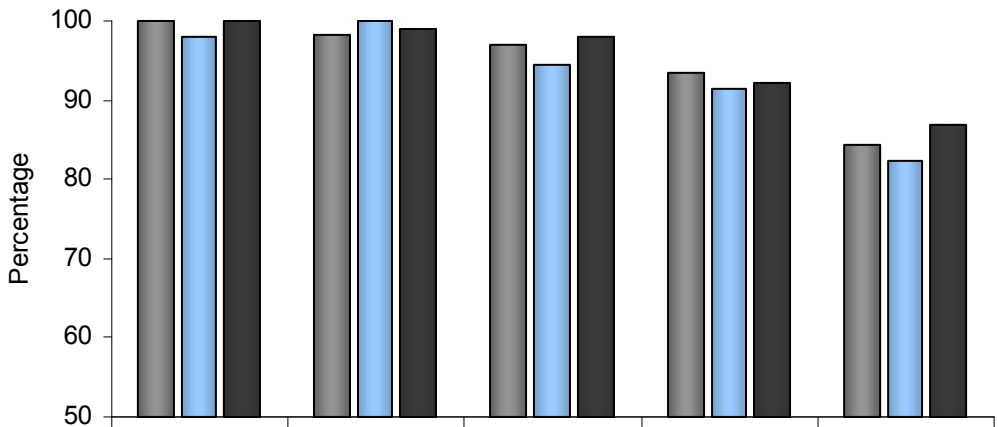
This indicator measures the hospitals' performance in relation to restoring the health of people who have had a stroke, myocardial infarction or fractured neck of femur by measuring those who survive the illness and are discharged. Following acute admission, some may be transferred to another hospital 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 70-79 years. Performance targets for stroke were met in age cohorts 0-49 and 70-79 yrs but not for other age groups. For FNOF the performance target was met in the 80+ yr age cohort. The performance recorded in this indicator, while not meeting the targets in some age groups, is generally comparable to or has improved when compared to prior years.

Performance Targets
0-49 years ≥ 99%
50-59 years ≥ 99%
60-69 years ≥97%
70-79 years ≥ 93 %
80+ years ≥ 81%

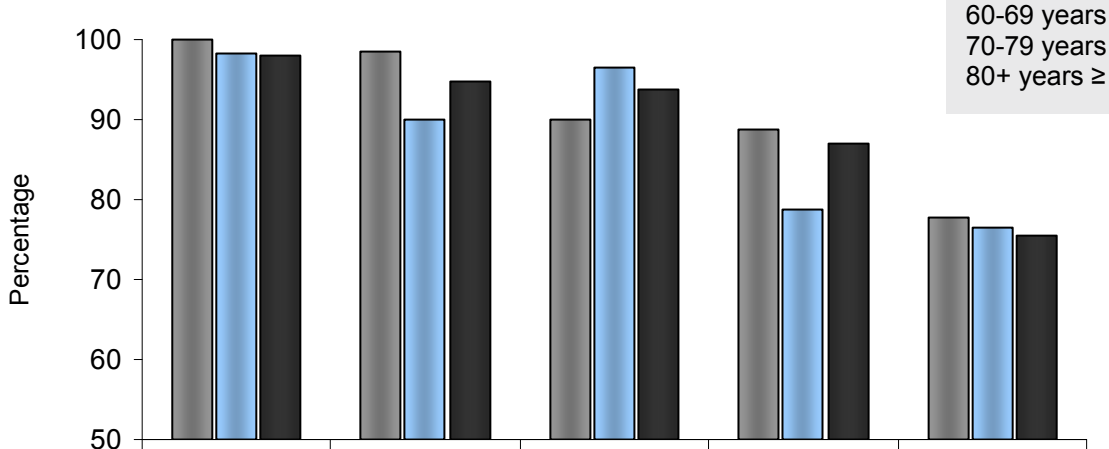
Figure 3: Survival rate for acute myocardial infarction (AMI)



	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
2008	100	99.1	98.0	92.1	86.9

Figure 4: Survival rate for stroke

Performance Targets
0-49 years ≥ 98%
50-59 years ≥ 97%
60-69 years ≥ 94%
70-79 years ≥ 87%
80+ years ≥ 77%

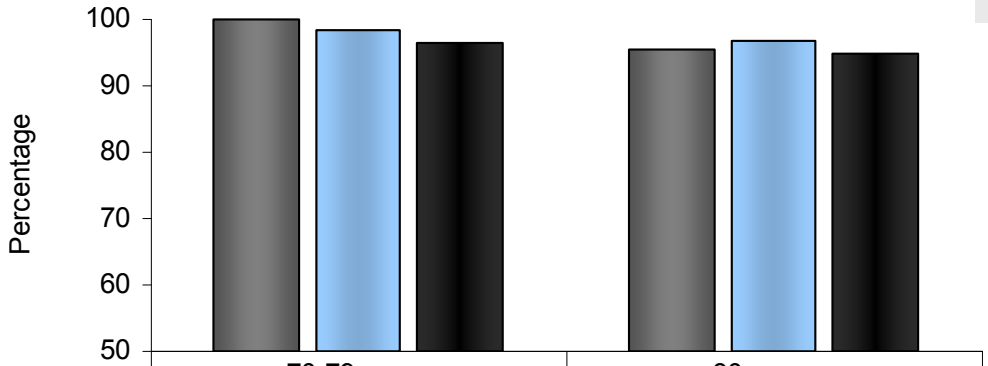


	0-49 yrs	50-59 yrs	60-69 yrs	70-79 yrs	80+ yrs
2006	100	98.5	90.0	88.7	77.8
2007	98.2	90.0	96.4	78.8	76.4
2008	98.1	94.7	93.7	87.1	75.5

Age Groups

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

Performance Targets
70-79 years ≥ 99%
80+ years ≥ 95%



	70-79 years	80+ years
2006	100	95.4
2007	98.5	96.9
2008	96.3	95.0

Age Groups

Note
For 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.

Data source
Hospital Morbidity Data System

1-06: Percentage of live births with an APGAR score of three or less five minutes post 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 9 babies born in WACHS facilities with an APGAR score of three or less five minutes post delivery with a total of 4,678 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 8: 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	2008	
0 – 1499	36.4	38.5	37.5	≤ 14.6
1500 – 1999	0.0	0.0	0.0	≤ 1.3
2000 – 2499	1.2	0.6	1.3	≤ 0.6
2500 and over	0.1	0.1	0.0	≤ 0.1

Data source
Midwives Notification System
Report on Government Services 2009

1-07: Proportion of emergency service patients seen within recommended times (major rural hospitals)

Rationale

When patients first enter an Emergency Department or Service, they are assessed by specially trained nursing staff who assess 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 or service when several people present at the same time, the process 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 patient attendances in each triage category whose treatment commenced within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) for each Triage category. This indicator reports for 21 WACHS Regional Resource Centres or Integrated Health District sites that provide emergency services and measures the time for medical treatment to commence by either a doctor or nurse.

Results

Emergency service attendances in all triage categories except Triage Category 1 were seen within the recommended thresholds.

There were 10 Triage Category 1 attendances across WACHS reporting sites with a recorded time outside the prescribed 'time to be seen'. While some of these are correct for the recorded time of treatment commencing, a small number of events may relate to data entry issues rather than access to clinical treatment. It should also be noted that in some cases treatment is delayed due to the aggressive or violent behaviour of the patient.

Table 9: Proportion of emergency department attendances seen within recommended times

	Target	2008-09
Triage category 1 (within 2 mins)	100%	98.7%
Triage category 2 (within 10 mins)	80%	92.4%
Triage category 3 (within 30 mins)	75%	88.2%
Triage category 4 (within 60 mins)	70%	90.0%
Triage category 5 (within 2 hours)	70%	95.5%

Note
Commencing in 2008-09, the number of sites reporting this KPI has been expanded to represent those WACHS sites that provide a significant volume of WACHS' emergency service activity and therefore prior year comparisons are not provided. Bunbury reports 'doctor seen'; all others sites report 'doctor or nurse seen' results.

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

Rationale

When patients attend hospitals they are initially received in the emergency service where assessment, treatment and a decision on whether to admit the patient 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 the outcome for the patient may be 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 clinical need.

Results

The percentage of Triage 4 and 5 emergency service attendances not admitted to WACHS hospitals was 92.3 per cent and 97.7 per cent respectively and is comparable to results reported in prior years.

Table 10: Rate of emergency presentation with a triage score of 4 and 5 not admitted

	2006-07	2007-08	2008-09
Triage 4 not admitted	90.1%	92.0%	92.3%
Triage 5 not admitted	97.0%	97.7%	97.7%

Data source
Emergency Department Data Collection, Information Collection and Management

S1-01: 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 complexity of the care 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 $5,006, exceeding the target. This is primarily the result of a realignment of hospital expenditure, including fixed costs, between indicators S1-01, S1-20 and S12-20.

Table 11: Average cost per casemix adjusted separation for non-teaching hospitals

	2006-07	2007-08	2008-09	Target
Actual cost	$4,240	$4,302	$5,006	$4,421
CPI adjusted cost	$3,910	$3,829	$5,006	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
This indicator does not include specialised mental health unit activity. (see KPI S2-00)
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

S1-20: Average cost per bed-day for admitted patients (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 $1,189, which is below target and is primarily a result of a realignment of hospital expenditure, including fixed costs, between indicators S1-01, S1-20 and S12-20.

Table 12: Average cost per bed day for admitted patients (selected small rural hospitals)

	2006-07	2007-08	2008-09	Target
Actual cost	$1,275	$1,297	$1,189	$1,301
CPI adjusted cost	$1,176	$1,155	$1,189	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
This indicator does not include specialised mental health unit activity. (see KPI S2-00)
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Data sources
HCARe activity data systems
WACHS Financial Systems

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

Rationale

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

Specialised mental health units are hospitals or hospital wards for the treatment and care of patients with mental or behavioural disorders.

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

Results

In 2008-09 the average cost per bedday in specialised mental health units in the WACHS was $1,125 exceeding the prescribed target.

Table 13: Average cost per bed day in an specialised mental health units

	2006-07	2007-08	2008-09	Target
Actual cost	$982	$1,113	$1,125	$1,081
CPI adjusted cost	$906	$991	$1,125	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
The WA Country Health Service has three authorised mental Health units situated in the Bunbury, Albany and Kalgoorlie Regional Resource Centres.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Data sources
Mental Health Information System
WACHS Financial Systems

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

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 smonitor the unit cost of this non-admitted component of hospital care in order to ensure overall quality and cost effectiveness.

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

Results

For 2008-09 WACHS recorded a cost per non-admitted hospital based occasion of service of $182.

Table 14: Average cost per non-admitted hospital based occasion of service for rural hospitals

	2006-07	2007-08	2008-09	Target
Actual cost	$174	$160	$182	$180
CPI adjusted cost	$160	$142	$182	

Note
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

S6-21: 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 overall quality and cost effectiveness.

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

Results

For 2008-09 WACHS recorded a cost per non-admitted occasion of service in a nursing post of $165, exceeding the target. There has been a small decrease in nursing post activity especially in those sites servicing small mining centres.

Nursing posts do not have the advantage of economies of scale. Minimum services may have to be rostered for very few patients.

Table 15: Average cost per non-admitted occasion of service in a nursing post

	2006-07	2007-08	2008-09	Target
Actual cost	$139	$147	$165	$133
CPI adjusted cost	$128	$131	$165	

Note
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

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

S7-20: Average cost per trip of Patient Assisted Travel Scheme

Rationale

The aim of the Patient Assisted Travel Scheme (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. 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 $394, exceeding the target. This result reflects additional State Government funding of $30 million over four years to improve PATS subsidies. Expenditure in 2008-09 includes $4 million of the approved funding increase.

Table 16: Average cost per trip of Patient Assisted Travel

	2006-07	2007-08	2008-09	Target
Actual cost	$327	$346	$394	$319
CPI adjusted cost	$302	$308	$394	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Data sources
PATS activity data systems
WACHS Financial Systems

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.

Notes
WACHS population health units deliver both illness prevention and health 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

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.

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

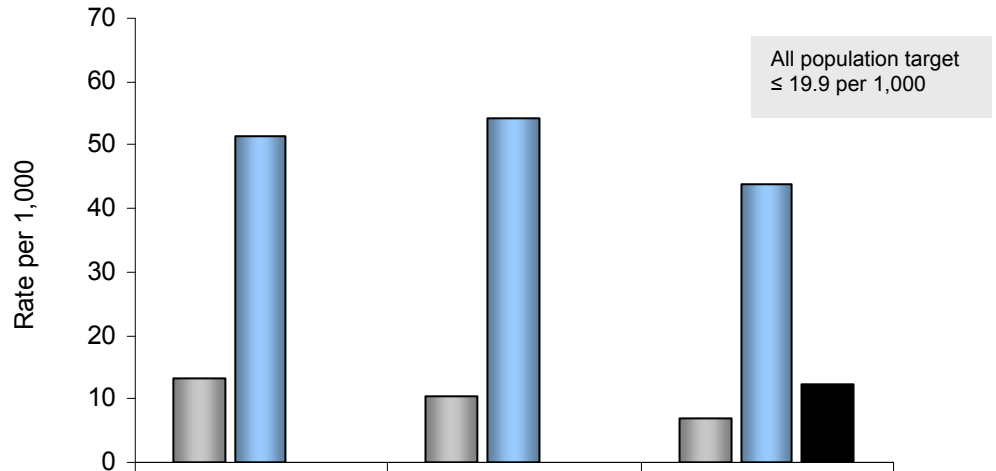
The Department of Health is also engaged in the surveillance of enteric diseases. Some forms of gastroenteritis, for example salmonellosis and shigellosis, are notifiable diseases and infection rates are monitored.

Results

In 2008 WACHS reported hospitalisation rates for gastroenteritis in non-Aboriginal children 0-4 years of 6.9 per 1,000, within target and continuing a decreasing trend. A rate of 43.8 per 1,000 was recorded in Aboriginal children 0-4 years, exceeding the target, but a lower rate than recorded in 2007.

WACHS has developed and implemented a number of environmental and community health programs which aim to prevent gastroenteritis and similar conditions in rural and remote locations, especially amongst Aboriginal populations.

Table 17: Rate of hospitalisation for gastroenteritis in children (0-4 years)



	2006	2007	2008
Non Aboriginal	13.3	10.5	6.9
Aboriginal	51.3	54.1	43.8
Total			12.4

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

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 2008 of hospitalisation for respiratory conditions in non-Aboriginal populations across WACHS met all population targets except for Croup.

The reported results in 2008 for WACHS Aboriginal populations did not meet the targets for the respiratory conditions reported.

Specific programs developed and implemented by WACHS target 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.

Performance targets

Condition	Age	Rate per 1,000 all population
Asthma	0-4 yrs	<10.4
	5-12 yrs	<3.4
	13-18 yrs	<1.5
	19-34 yrs	<1.5
	35 plus	<1.7
Bronchitis	0-4 yrs	<1.2
Bronchiolitis	0-4 yrs	<16.9
Croup	0-4 yrs	<5.5

Figure 6: Rate of hospitalisation per 1,000 for acute asthma (all ages)

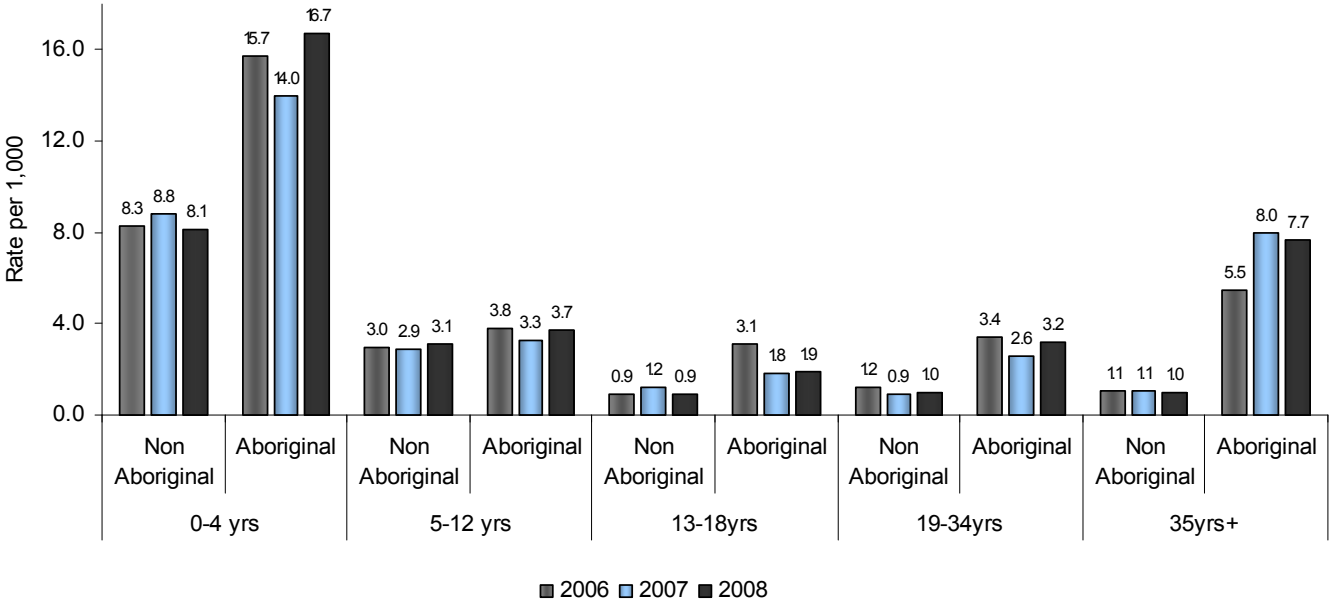


Figure 7: Rate of hospitalisation per 1,000 for acute bronchitis (0 to 4 yrs)

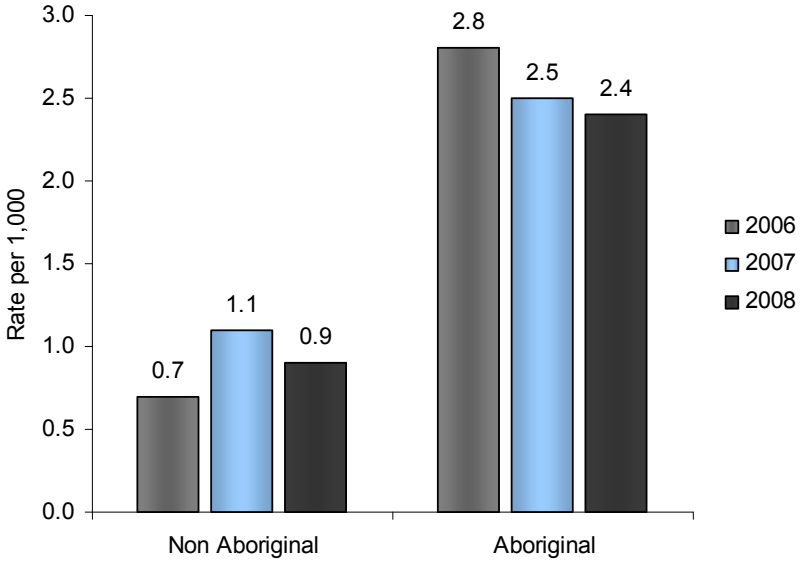


Figure 8: Rate of hospitalisation per 1,000 for bronchiolitis (0 to 4yrs)

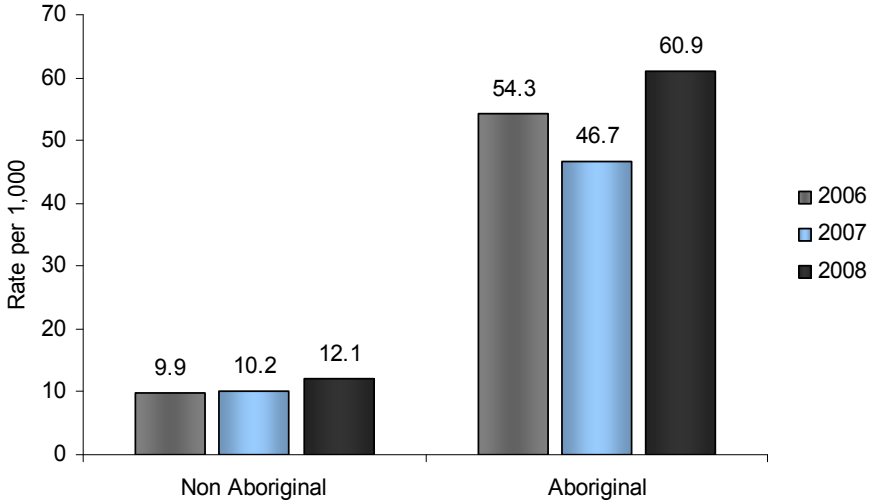
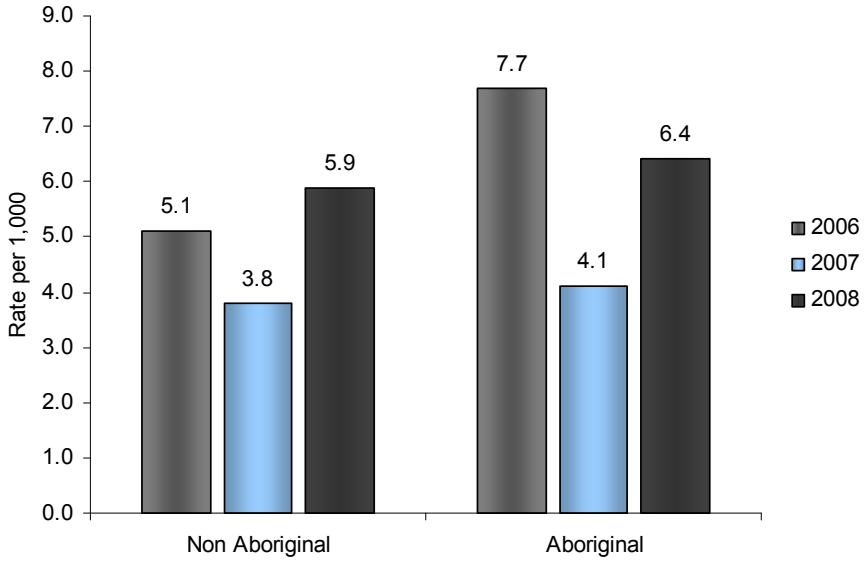


Figure 9: Rate of hospitalisation per 1,000 for croup (0 to 4yrs)



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.

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

2-10: Rate of hospitalisation for falls in older persons

Rationale

There are a number of illness prevention, and health promotion and protection initiatives delivered by Area Health Service Population Health Units supported by similar initiatives provided by Department of Health Divisions, aimed at community safety and well being and injury prevention.

Some of these, such as the "Stay on Your Feet" program, are designed to reduce the incidence and severity of fall-related injuries and hospitalisations of older persons. The number of older persons admitted to hospital per 1,000 population of a specific age group for treatment as a result of a fall in a domestic or community setting may be an indication of the impact of these strategies.

It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases.

Results

The hospitalisation rates in 2008 indicate the fall rate in Aboriginal populations is higher than for the non-Aboriginal population for 55-64 years and 65-79 years. However, the rate is higher in the 80+ years non-Aboriginal age cohort. This result is likely to be a function of the greater numbers of non-Aboriginal people in this age cohort experiencing mobility issues. As expected, the hospitalisation incidence increases with age.

The hospitalisations for falls by older persons demonstrates a relationship between falls events and an older person's possible diminished mobility. A fall in the home or in a community setting can affect an older person's quality of life. Targeting older persons with community and public health programs to prevent falls occurring can reduce injury and hospitalisation and support their ability to live safely at home.

The Falls Prevention Health Network is continuing to develop other performance measures and further consultation with the Network will facilitate additional Annual Report Key Performance Indicators.

Performance targets

Targets are being developed for this indicator.

Table 18: Rate of hospitalisation per 1,000 for falls in older persons for 2008

Age Cohorts	Aboriginal	Non-Aboriginal
55-64 years	32.4	4.3
65-79 years	45.3	16.5
80+ years	81.6	91.6

Notes
KPI 2-10 is a new indicator in 2008-09 and therefore prior comparisons are not provided.
This indicator measures hospitalisations 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. Individuals may experience repeat hospitalisations from the same cause.
Falls in hospitals and health facilities are not included in this KPI measurement, nor are falls occurring in settings not primarily targeted by the health promotion programs.

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

R2-51: Percentage of fully immunised children

Rationale

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore children 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, by delivering 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 per cent of children fully immunised at 12 months, 2 years and 5 years.

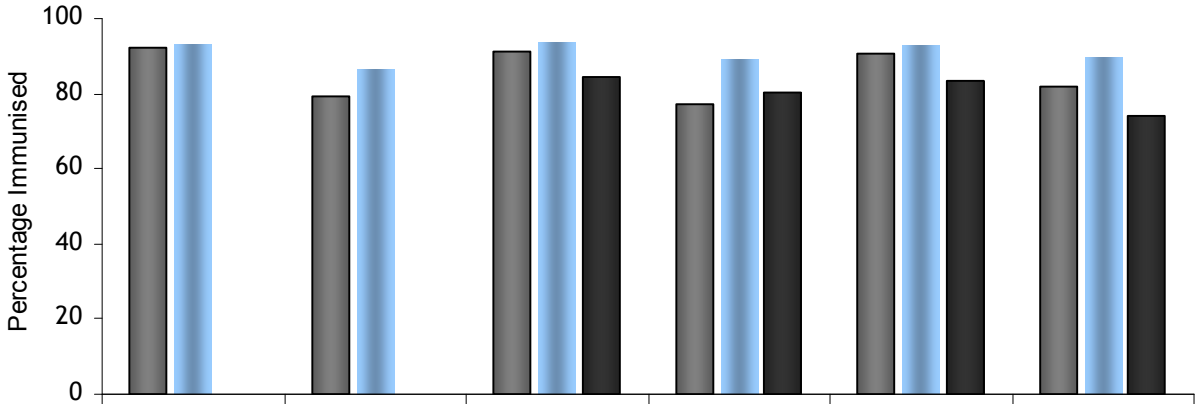
Rates of hospitalisation for infectious diseases or treatment for complications of these diseases are shown in R2-52. Without an immunisation program there is likely to be higher rates of hospitalisation or more disability and death resulting from the diseases.

Results

In 2008 the percentage of WACHS non-Aboriginal children fully immunised exceeded the national targets for the age cohorts except for 5 yrs, although the result remains consistent with the prior year. The 2008 immunisation percentages for Aboriginal children remain below the national benchmarks but are comparable to prior years.

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

Figure 10: Percentage of fully immunised children at 12 months, 2 years and 5 years



	2006 (Dec Quarter)		2007 (Dec Quarter)		2008 (Dec Quarter)	
	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal
12 months	92.0	79.1	91.1	77.3	90.5	82.1
2 years	93.5	86.3	93.7	89.1	93.0	89.4
5 years			84.7	80.4	83.6	73.9

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

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

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

Rationale

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

In 2008 this indicator has examined the hospitalisation rates for the infectious diseases measles, mumps, diphtheria, pertussis, poliomyelitis, rubella, hepatitis B and tetanus which are subjected to prevention immunisation programs provided to the community. Commencing in 2009 additional preventable diseases will be added to this indicator.

For 2008 hospitalisations were only recorded for pertussis 0-12 years and mumps 0-17 years. Cases are identified by the principal diagnosis recorded for a hospital admission.

Performance targets

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

Results

In 2008 WACHS recorded six hospitalisations for Aboriginal populations in the reported age cohorts for mumps and pertussis with rates of 16.0 and 21.5 per 100,000 respectively for each disease. WACHS also recorded one hospitalisation for mumps and three hospitalisations for pertussis for non-Aboriginal populations in the reported age cohorts with rates of 0.9 and 3.8 per 100,000 respectively.

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

WA Health is working with other states on implementing a national immunisation campaign to encourage adults, especially those caring for young children, to maintain their immunisations. WACHS population health units also monitor the occurrence of these diseases to inform any local refinement of immunisation programs.

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

	2006		2007		2008	
	Aboriginal	Non-aboriginal	Aboriginal	Non-aboriginal	Aboriginal	Non-aboriginal
Pertussis 0-12yrs	0.0	1.0	0.0	0.0	21.5	3.8
Mumps 0-17yrs	0.0	0.0	5.0	0.0	16.0	0.9

Note
The indicator was originally titled 'Rate of hospitalisation with an infectious disease for which there is an immunisation program'. The new title reflects a similar indicator under the new National Healthcare Agreement. In future reporting this indicator will include other 'selected' potentially preventable conditions. The hospitalisations reported will represent a range of conditions for which hospitalisation could be avoided because the disease or condition has been prevented from occurring or because affected individuals have had access to timely and effective primary care or health protection and illness prevention programmes.

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

S8-00: Cost per capita of 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 illness prevention and health 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
Immunisation
Promotion of a healthy lifestyle to prevent illness and disability
Support for self-management of chronic disease
Prevention and early detection of cancer

Results

For 2008-09 WACHS recorded a cost per capita for the Area Health Service's Population Health Units of $174.

Table 20: Cost per capita of population health units

	2006-07	2007-08	2008-09	Target
Actual cost	$161	$164	$174	$174
CPI adjusted cost	$148	$146	$174	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Data source
Australian Bureau of Statistics
WACHS Finance Systems

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

The achievement of this outcome of the health objective involves provision of services and programs that improve and enhance the wellbeing and the environment of people with chronic illness or disability. To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided to enable normal patterns of living.

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

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

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

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

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

Rationale

A large proportion of people with a mental illness 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 2008, 60.5 per cent of patients with a mental illness discharged from public mental health inpatient units had contact with a community-based public mental health non-admitted service within seven days of discharge. A further 12.3 per cent of clients were seen within eight to 14 days. These results are above the set targets and indicate an improvement from the previous year.

In addition to these clinical services clients have access to non-clinical support services reported under the Department of Health KPI R3-52.

Patients may also be seen by private sector clinicians (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) following discharge, for which data is not available.

Table 21: 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		2008		Target
	%	Cumulative %	%	Cumulative %	
0-7 days	52.9	52.9	60.5	60.5	60%
8-14 days	11.1	64.0	12.3	72.8	70%

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

S3-20: Aged care resident/carer satisfaction survey

Rationale

The provision of 24 hour non-acute long term 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.

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 appropriate, their nominated guardian or carer. Survey results are reported for both the specified residential aged care facility and other aged care residents.

Residential care services include high dependency, high dependency respite, low dependency and low dependency respite provided to nursing home type residents in hospitals, nursing home and hostel residents.

In 2008 the survey concentrated on Aboriginal residential care clients reporting general information regarding satisfaction with the residential care services provided.

In 2009 WACHS has conducted its survey for residential care clients in the South West and Wheatbelt. The information is similar in client target and survey methodology as adopted for the survey in 2007 and these results have been included for comparative analysis.

Client Survey

The existing survey tool previously developed with the Health Consumer's Council of WA, the Office of Aboriginal Health and with focus groups, was used. The survey was conducted by an external survey agency and the results collated and reviewed by the Department of Health's Epidemiology Branch.

Response rate	63.1 per cent
Population size	274 clients
Sample size	173 clients
Selection of population	WACHS Data Warehouse - Residential Care residents as at 1 May 2009 were used to select South West and Wheatbelt samples for this survey.

Sampling error rate ± 2.4% for the 95% confidence level.

Performance Target

Scale mean scores for each of the five domains are presented as scores out of 100. For normal admitted patients, a score of 80 is considered average, while a score of 90 or better is considered best practice standard.

Results

The results of the 2009 survey indicate that the overall level of satisfaction for residential patients is within the excellent range, similar to results recorded in 2007. Residential care services are delivering very high levels of satisfaction in the area of meeting personal as well as clinical needs, which residential care patients report as the most important area of service provision.

Residential aspects of the health care facility received the lowest level of satisfaction. However, the result still exceeds the average satisfaction levels. There also appears to have been some improvements made in this area as satisfaction has significantly increased from 2007.

Table 22: Aged care resident / care satisfaction

Scale	Mean Score	
	2007	2009
Time and attention paid to care	91.0	89.4
Meeting personal as well as clinical needs	94.8	94.4
The coordination and consistency of care	87.5	88.3
Information and communication between patients and carers	87.4	89.0
Residential aspects of the health care facility	85.2	87.8
Overall Indicator of Satisfaction	89.2	89.8

Note: In July 2008 the State Government Nursing Home in Derby was transferred to non-government management and administration and is no longer a WACHS funded or operated facility. It is therefore no longer included in WACHS residential care indicators.

Data sources: WACHS and the Epidemiology Branch, Department of Health

S11-00: Average cost per person receiving care from public community-based mental health services

Rationale

Services provided by public community-based mental health services include assessment, treatment and continuing care. This indicator gives a measure of the cost effectiveness of treatment for patients (non-admitted/ambulatory patients) receiving care from public community based mental health services

Results

The average cost per person receiving care from public community health WA Country Health Services was $3,613, exceeding the prescribed target. This result reflects an over estimation of the number of persons who would receive these services when calculating the target for the 2008-09 year.

Table 23: Average cost per person receiving care from public community based mental health services

	2006-07	2007-08	2008-09	Target
Actual cost	$3,321	$3,391	$3,613	$3,159
CPI adjusted cost	$3,063	$3,019	$3,613	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.

Data sources
Mental Health Information System
WACHS Financial Systems

S12-20: Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents

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 bedday for residents of the specified residential aged care facilities in the Kimberley at Kununurra, and in the Pilbara at Karlarra and for all other WACHS residential aged care services.

Results

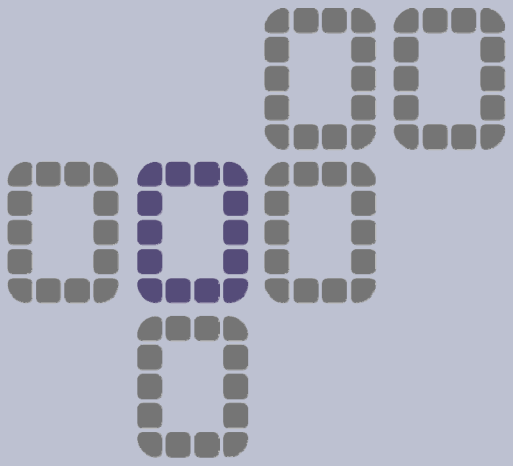
WACHS recorded a cost per residential care bedday of $389 exceeding the target. This is primarily the result of a realignment of hospital expenditure, including fixed costs, between indicators S1-01, S1-20 and S12-20.

Table 24: Average cost per bed day for specified residential care facilities, flexible care (hostels) and nursing home type residents

	2006-07	2007-08	2008-09	Target
Actual cost	$337	$366	$389	$369
CPI adjusted cost	$311	$326	$389	

Notes
Statewide corporate costs have been apportioned to this key performance indicator.
As 2008-09 commences the next five year CPI adjustment series, the actual cost reported for 2008-09 is not CPI adjusted.
In July 2008 the State Nursing Home in Derby was transferred to the management and administration of a non-government organisation and is no longer a facility funded or operated by the WA Country Health Service and therefore provides no expenditure or activity for this indicator.
Commencing 2008-09 the previous ACAT key performance indicator has been deleted and ACAT expenditure is now included in KPI S12-20.

Data sources
WACHS HCARe data warehouse
WACHS Financial Systems



Significant Issues and Trends

Overview

During 2008-09 the WA Country Health Service has continued the implementation of its strategic plan for the period 2007-2010 “Foundations for Country Health Services”.

Royal Flying Doctor Service

During 2008-09 the State Government approved a significant increase in funding to the Royal Flying Doctor Service (RFDS) with an additional $26 million over four years for increased and improved services for aero-medical inter-hospital patient transport, and additional and replacement aircraft. WACHS, on behalf of the Government, also completed the negotiations for a new five year contract effective to June 2013.

Patient Assisted Transport Scheme

In addition to extra funding for the RFDS, the State Government also increased funding for the Patient Assisted Transport Scheme (PATS) with $30 million over four years with $4.2 million in January 2009 for 2008-09. The additional funding has been provided to improve subsidies and simplify access to medical care for regional communities, increase escort travel, support patients having cancer treatment, and streamline scheme administration.

The administration of PATS has also been further improved with the establishment of dedicated and centralised PATS units in the Goldfields, Southwest, Wheatbelt and Pilbara.

Elective Surgery

During 2008-09 WACHS benefited from both State and Commonwealth Government elective surgery initiatives to increase activity and reduced median waiting times. WACHS received additional funding in 2008 for elective surgery under the Commonwealth Government Elective Surgery ‘Blitz’. A number of these initiatives will continue in 2009-10.

WACHS hospitals increased the number of cases admitted for surgery by 7.8 per cent from 14,304 in 2007-08 to 15,423 in 2008-09. The number of over-boundary cases on the waitlist for all categories has reduced from 291 on 30 June 2008 to 177 on 30 June 2009.

Managing unplanned care

In early 2009 WA Health commenced the implementation of the Four Hour Rule Program in Western Australian public hospitals. This is an initiative aimed at improving patient care and enhancing the patient journey from hospital arrival to departure, and stipulates a 98 per cent target for patients arriving at a hospital for emergency care to be seen, admitted, discharged or transferred within a four-hour timeframe. Whole-of-hospital long-term redesign and staff involvement will required to enable the target to be achieved.

The Four Hour Rule Program will improve patient care by remodelling hospital operations in order to reduce delays, improve coordination and streamline processes for unplanned care across an entire hospital. A statewide management and governance structure supporting project implementation has been established and performance measures adopted.

A staged implementation plan has been adopted commencing with the metropolitan teaching hospitals in April 2009, each implementation taking two years to achieve the target with 12 and 18 months benchmarks to be monitored.

For WACHS, the Regional Resource Centres will commence program implementation in 2009-10, with Bunbury commencing in October 2009, and the other five centres and Nickol Bay in April 2010. Commencement at Bunbury will provide the early opportunity for a WACHS region to engage in the service re-design elements of the program.

Aboriginal health

In 2008-09, the WACHS Area Director of Aboriginal Health, in conjunction with WA Health’s Office of Aboriginal Health, has taken the lead role in engaging with other government agencies and community organisations to implement the National Partnership Agreement (NPA) on Closing the

Overview (continued)

Gap in Indigenous Health and to progress numerous initiatives to meet this health challenge. The Indigenous Health NPA followed the agreement by the Council of Australian Governments (COAG) on partnerships between all levels of government to work with Aboriginal Communities to Close the Gap in Indigenous Disadvantage.

The WA Government has recognised that to achieve improvement in Aboriginal health, better and more relevant health services must be delivered, accompanied by improvements in housing, education, employment and economic development and has committed $117.4 million over four years to support initiatives to meet the health objectives.

The Indigenous Health NPA targets five areas:

- Preventive health;
- Primary health care;
- Hospital and hospital-related care;
- Patient experiences; and
- Sustainability.

In WA, the Aboriginal Health Partnership Group comprising the Aboriginal Health Council of WA, the Area Health Services, Aboriginal community organisations, government and the Divisions of General Practice will oversee plans to deliver the Indigenous Health NPA. Detailed regional plans and strategies will be developed, monitored and reviewed by nine Regional Aboriginal Health Planning Forums with seven in WA country regions.

Service provision

In 2008-09 WACHS hospitals experienced a 2.7 per cent increase in separations. However the volume of beddays, both acute and residential, remained consistent with 487,093 beddays in 2008-09 compared to 486,077 in the previous year.

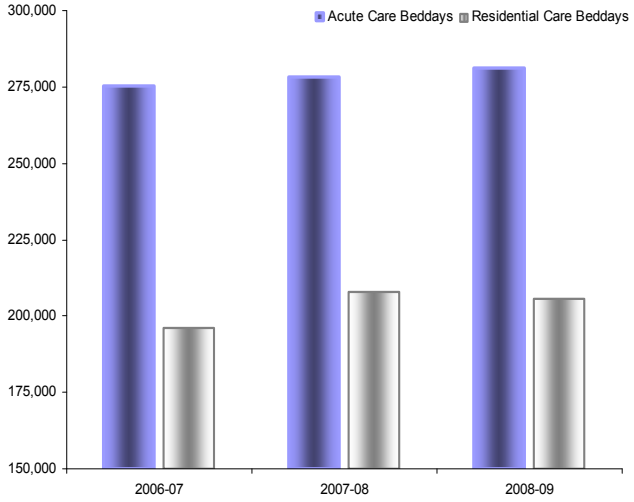
Attendances at WACHS emergency services increased by 0.8 per cent in 2008-09 following an 8.0 per cent increase in the previous year. Although a modest growth in total numbers, the number of emergency attendances with the more serious Triage categories of 1, 2 and 3 rose by 11 per cent and admissions by 8 per cent.

Non-admitted activity increased by 1.0 per cent in 2008-09 following a 12.8 per cent increase in 2007-08. PATS trips rose by 5.6 per cent in 2008-09. In 2008 mental health ambulatory service occasions increased 5.6 per cent and persons receiving community based mental health services by 2.6 per cent compared 2007. In 2008, 4678 babies were born in WACHS public hospitals.

Overview (continued)

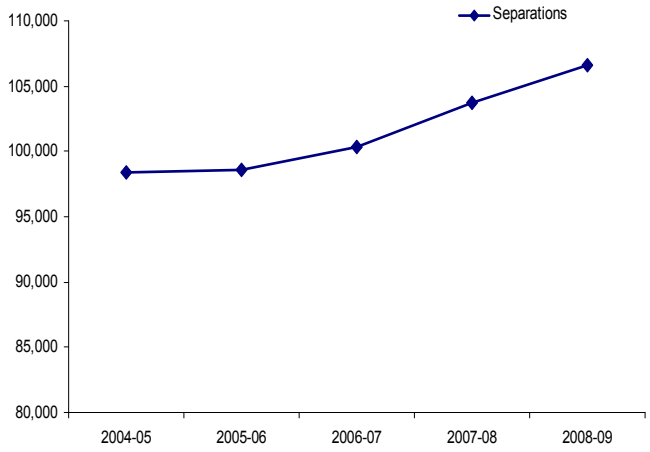
Activity

Figure 11: Residential and Acute Care beddays



Note: Bedday data for all WACHS hospitals excluding Boarders.

Figure 12: WACHS Total Separations



Note: Includes all WACHS hospitals and activity types except boarders.

Figure 13: Non-admitted occasions (hospital and nursing post)

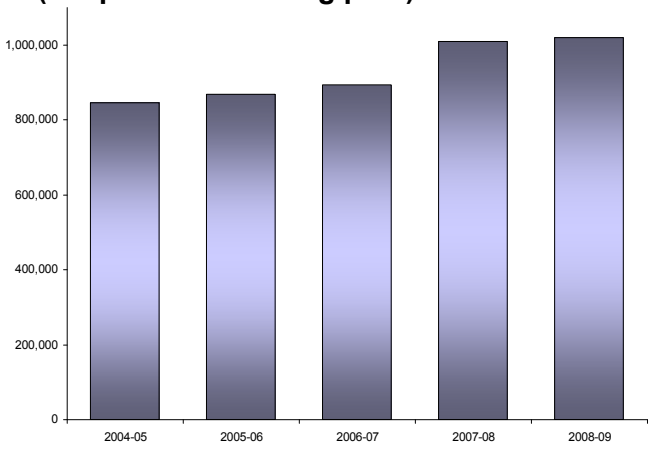


Figure 14: Total trips for the WACHS Patient Assisted Transport Scheme

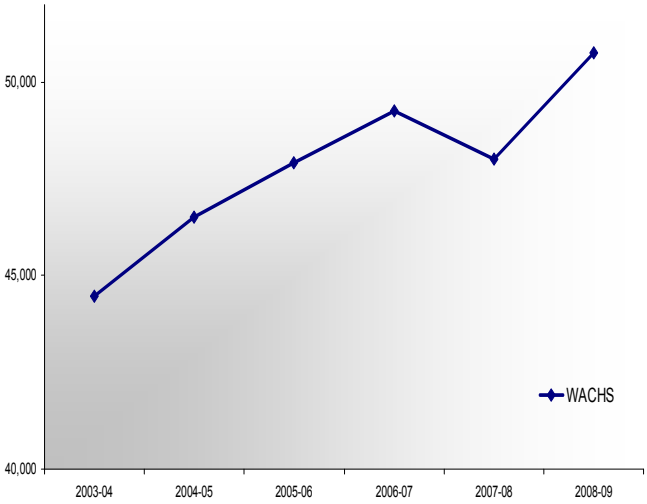


Figure 15: Elective Surgery Cases

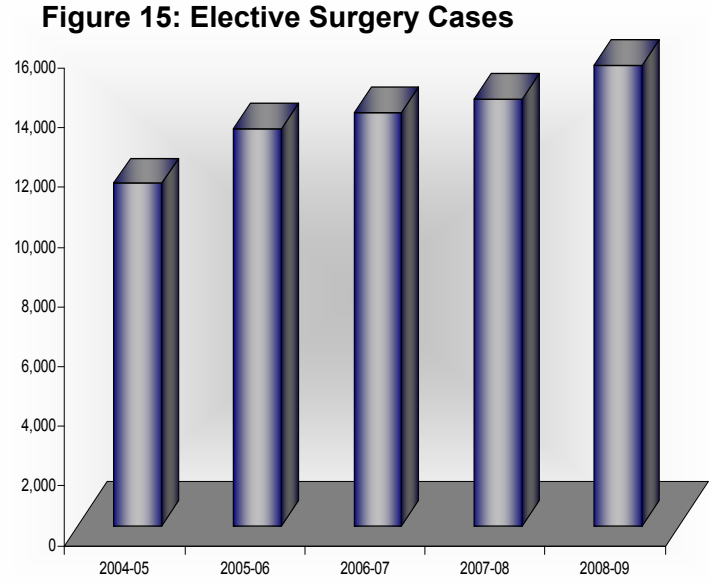
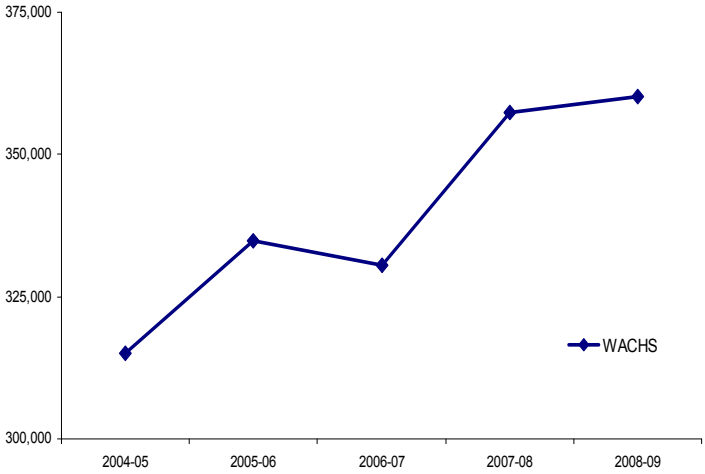


Figure 16: Emergency service attendances



Significant achievements and issues 2008-09

Innovation and leadership

The WA Country Health Service has implemented a number of initiatives and strategies to develop and deliver innovative health care, and to attract and retain its workforce and provide them with opportunities to develop their skills, knowledge and leadership potential.

In 2008-09 innovations such as the Four Hour Rule Program, initiatives to support elective surgery and patient transport, and workforce programs to address gaps in the workforce, skills shortages, and the attraction and retention of staff especially in clinical fields have featured in the activities of the WA Country Health Service (WACHS).

Aboriginal health

In early 2009, WACHS assumed responsibility for supporting the Regional Aboriginal Health Planning Forums in country areas. These forums are comprised of local Aboriginal health service providers including those from community controlled health organisations, public health providers, representatives from the local General Practitioner network and the Royal Flying Doctor Service, and local Aboriginal service providers, as well as representatives from the Aboriginal Health Council of WA, the Office of Aboriginal and Torres Strait Islander Health and WACHS.

A number of forums, whose purpose is for members to work in partnership to improve the health and well being outcomes of Aboriginal and Torres Strait Islander people in country Western Australia, have experienced varied levels of activity across the regions over the past few years. WACHS' aims to support a resurgence of the work of the forums. Individual forums met in three regions, Kimberley, Pilbara, Midwest with a combined forum for the Wheatbelt, Great Southern and South West. By the end of 2009, Regional Aboriginal Health Planning Forums will be operating in all WACHS regions.

Cancer nurse coordinators

A cancer nurse coordinator has been appointed at the WACHS Area Office to support the existing regional cancer nurse coordinators. Regional coordinators facilitate patient support, advocacy, assessment and referral.

Esperance Hospital is providing chemotherapy services two days per week and the WACHS South West cancer nurse coordinator is supported by a breast cancer specialist nurse.

Graduate nurses

WACHS Wheatbelt appointed their first graduate Nurse in Community Health and five Enrolled Nurses in Southern Wheatbelt have completed the conversion course to Registered Nurse.

WACHS South West Learning and Development Unit participated in the Edith Cowan University, Bunbury Campus Nursing Expo, highlighting the Graduate Program and the nursing opportunities in the region.

During 2008-09 four Enrolled Nurse (EN) graduates from the local EN program have been employed by WACHS Pilbara on a full year graduate nurse program. WACHS Pilbara has also accepted four Registered Nurse (RN) graduates in a program which will give them a diversity of experience only available in the rural and remote setting.

Nurse practitioners

WACHS has established four new Nurse Practitioner positions in emergency care and one in remote practice, bringing the total number of positions within WACHS to ten.

The Nurse Practitioner Workforce Plan has also been completed. Implementation of this plan will aim to establish further Nurse Practitioners across WACHS in 2009-10, including mental health and aged care services.

Innovation and leadership (continued)

Staff attraction and retention

During 2008-09 priority recruitment across the WACHS remained focused on the allied health, medical and nursing workforce. There was also an emphasis to recruit locally if possible, and to increase the level of employment of aboriginal employees.

All employment opportunities are advertised on the WA Health jobs website. This is supplemented by marketing of careers at a range of forums, including conferences and career expos. WACHS has also undertaken a number of centralised recruitment campaigns for nurses, doctors and allied health, on behalf of all regions. Nursing services have aligned marketing and promotion to the state wide campaign "nursing it can take you anywhere" This has helped increase exposure and decrease costs of advertising for WACHS.

The Clinical Workforce and Reform Unit continues to support the recruitment of medical practitioners, especially the employment of international medical graduates, as well as establishing standard fees for recruitment agencies.

Aboriginal employment continues to be a priority for a number of WACHS regions, with regions implementing specific strategies to increase the number of aboriginal staff. Incentive programs were trialled in specific areas of workforce shortage with good results. Increased staff accommodation is proposed and is in development across a number of sites.

In 2008-09 WACHS Wheatbelt increased the number of Aboriginal people employed in a variety of occupations including two Aboriginal Liaison Officer, eleven Aboriginal Health Workers, four Health Promotion Officers, a Registered Nurse, management and customer service officers and three clerical trainees.

A greater number of WACHS sites are now offering graduate nursing programs, in addition to including community nursing and midwives. These programs support the exposure of nurses to rural and remote medicine and facilitate local recruitment to permanent positions.

WACHS' rotational nurse programs continue to grow in subscription and exceeded 2008-09 operational targets. The programs have been successful in meeting short and longer term vacancies across WACHS and include a range of rotational options for varying experience levels. The program has been shortlisted for a Premier's Award.

Retention initiatives have aimed to increase incentives, improve orientation and induction, enhance career development opportunities, provide access to professional development, and facilitate greater support and networking opportunities.

The Institute for Healthy Leadership

During 2008-09 WACHS has continued to promote local and regional professional and personal development strategies implemented by the Area Health Service Coordinator and by regional management structures.

WACHS has also worked in collaboration with the Institute for Healthy Leadership to deliver leadership development training for WACHS Regional Medical Directors.

Currently, there are three WACHS participants in the 2009 Emerging Leaders Program, three on the 2009 Delivering the Future Leadership Program, and 12 places on the Leading for Improvement Program. There were 18 WACHS participants in the Emerging Leaders Program and 4 WACHS participants on the Delivering the Future Leadership Program in 2008. These programs are all administered by the Institute for Healthy Leadership.

Medical recruitment

In September 2008 the new WACHS Australian Medical Association Industrial Agreement was finalised, ensuring that employment conditions in country Western Australia remain attractive.

During 2008-09, WACHS Area Office undertook a review of arrangements for medical recruitment, and has developed and implemented a more standardised and streamlined process for engaging medical recruitment agencies.

Innovation and leadership (continued)

Paediatric nurse training

Princess Margaret Hospital (PMH) and the WA Country Health Service (WACHS) have implemented a joint venture to address a deficit in paediatric life support (PLS) education in country WA, developing a two-day PLS program including theory, skill and simulation. The training was a modified version of the nationally accredited PLS provided by medical and nursing staff. The collaborative effort delivered full-day, half-day and short training sessions

In 2008-09, the program was delivered in all seven regions in 14 different locations, facilitated by the Paediatric Nurse Educator from Princess Margaret Hospital for Children (PMH) in collaboration with the regional Learning and Development Educators.

Safety and Quality

WACHS' strong focus on safety and quality continues with the Safety and Quality Investment for Reform (SQuIRe) and Patient First programs. Clinical governance teams are in place across WACHS with eight SQuIRe Clinical Practice Improvements implemented. The 'human error and patent safety' and the 'Patient First' programs have also been implemented in all regions.

The enhanced culture of reporting, investigating and managing risk associated with clinical incidents and adverse events is evident with an increase in reporting across all regions.

Telehealth

During 2008-09 WACHS, with assistance from the Commonwealth Government, enhanced Telehealth through the expansion of bandwidth in approximately 30 rural sites to date. Local and Wide Area Networks have been reviewed and will be upgraded. Requirements for video conferencing equipment have been assessed and this information will inform Telehealth expansion in future years.

Building research and education capacity

WACHS Area Office and WACHS Kimberely have developed a significant collaboration with the University of Notre Dame, School of Nursing in Broome to establish specialist research training for registered nurses (RNs) working in the Kimberley. Five senior RNs have undertaken a unit on evidence-based teaching with the aim of providing them with skills to act as a research team leader in their own environment.

Hospitals and health services

WA Country Health Service provides an extensive range of hospital and health services across the largest country health system in Australia, and continues to develop and implement strategies and innovative methods of service delivery, and ensuring that these services are high quality, efficient, accessible and responsive to community needs.

Aged care

The COAG funded Older Patient Initiative (OPI) successfully risk-screened 25 per cent of all older people (non- Aboriginal over 65, Aboriginal and Torres Strait Islander over 45) presenting to the emergency departments at the Regional Resource Centres, providing further assessment and follow up to those patients identified 'at risk' and requiring complex aged care case management. The initiative has also been implemented at other sites such as Busselton, Esperance, Merredin, Narrogin and Northam hospitals.

Mental health

Planning has been completed by the Broome Mental Health Inpatient Unit Project Control Group for the construction of the Unit which will commence in mid- 2010. An extensive consultation program has been undertaken across a range of topics including cultural security, patient welfare and admission criteria. Further work is being undertaken on a comprehensive transfer plan to ensure smooth transition from point of referral into the unit.

Clinical practice improvement activities have been undertaken to support improved care for mental health patients in WACHS hospitals. This has resulted in the development of policy and guidelines for the assessment and management of mental health presentations to WACHS hospitals, including improved guidelines for the safe management of the sedated patient.

Home based hospital, ambulatory care and post acute programs

During 2008-09 WACHS trialed the introduction of ambulatory care services in six regional centres. These services aim to provide best practice treatment of ambulatory care sensitive conditions, and improve demand management, including earlier discharging of country patients from metropolitan hospitals. Following these trials, ambulatory care strategies including hospital in the home, hospital in the nursing home and post acute care have been consolidated at major regional centres including Albany, Bunbury, Geraldton and Port Hedland.

During the year, a Medi-hotel was established at Geraldton. The Medi-hotel provides alternative non-hospital accommodation for those patients who require a course of treatment or tests, people from isolated communities or those who have no suitable carer at home, and patients recovering post-surgery who do not require an acute hospital bed.

In addition, post acute services are being delivered from Bunbury, Busselton and Collie hospitals in WACHS South West.

Accreditation

Accreditation with the Australian Council on Health Care Standards (ACHS) EQuIP (Evaluating Quality Improvement Program) program is coordinated at regional level. Seventy of WACHS' 74 hospitals are currently accredited through ACHS. Four hospitals are not currently accredited, however two will be surveyed in September 2009 and the remaining two in April 2010.

Palliative care

WACHS has developed a project plan for the implementation of the Rural Palliative Care Program with the Palliative Care Network.

The South West Cancer Palliative Care Network has developed close links to the metropolitan network in preparing for the implementation of the Rural Palliative Care Model. In conjunction with the Network, WACHS South West has commenced planning to implement the End of Life Pathway.

WoundsWest

In partnership with WoundsWest, a telephone wounds advisory service ('1300 WOUNDS') is currently being piloted in six rural sites.

Hospitals and health services (continued)

Performance monitoring

WACHS launched its Public Hospital Activity website in January 2009 which includes detailed regional and site information about bed numbers in country hospitals.

Health information

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

Medical emergency response

During 2008-09 WACHS has developed a draft suite of medical emergency response (MER) policies and procedures customised for rural and remote settings, and these are currently being reviewed by all regions. They are consistent with the WA medical emergency policy and draw on work being undertaken nationally on 'managing the deteriorating patient' through the Australian Commission for Safety and Quality in Healthcare (ACSQHC).

WACHS South West has commenced a pilot project to implement MER at all sites. This project includes developing MER and medical emergency team systems and resources, and this work will inform further WACHS-wide use.

Access network

The WA Access Network project is part of the national community care reform agenda 'Access Point', aiming to streamline client entry to the community care system through the development of nationally consistent Access Points (Networks). The project also aims to reduce duplication of effort for service providers and clients in the sharing of information to support transition across the continuum of care.

The WA Access Network Model has demonstration sites at Broome/Derby (Remote), Esperance (Rural) and the City of Swan (Metro).

Jointly funded HACC / Access Project Officers have been appointed in WACHS Goldfields and Kimberley.

The primary functions of the Access Network Points (ANP) are to:

- provide an initial point of contact for people seeking information about community care services and other relevant support options;
- identify whether the person is within the eligible target population to receive community care services;
- provide an initial needs identification screening;
- facilitate referral to other appropriate services;
- refer individuals for face to face needs assessment and development of service response; and
- refer individuals to comprehensive assessment and other specialist areas for example, Aged Care Assessment Team (ACAT), continence advice, carer support.

Oracle rollout

During 2008-09 WACHS commenced implementation of the new Oracle financial system, with the WACHS Area Office and WACHS South West going live from 1 December 2009. The system is being progressively rolled out across WACHS with all sites to be implemented by mid-2010. Implementation will ensure that a standardised financial platform operates across the WA Health sector and will deliver improved efficiencies in WACHS' financial management and reporting processes.

Medical equipment

Audits of WACHS medical equipment have been updated. Submissions have been made for further funding including submissions under the 'Royalties for Regions' program.

WACHS has enhanced its medical imaging capabilities with the installation in December 2008 of 16-slice Computed Tomography scanners in Kalgoorlie and Geraldton.

During 2008-09 computed radiography was installed in Esperance, Merredin, Exmouth, Kununurra, Derby, Broome, Port Hedland, Tom Price, Newman, Nickol Bay (Karratha), Kalgoorlie, Narrogin and Albany. Sourcing of the equipment for the Kimberley is proceeding.

Hospitals and health services (continued)

Infrastructure and Capital

WACHS capital works projects completed during 2008-09 included:

- new Multi-Purpose centres at Denmark and at Fitzroy Crossing, where it is collocated with the new Nindilingarri Cultural Health Service;
- a new clinic was constructed at Kalumburu; and
- the roof of the Nickol Bay hospital was replaced.

A joint Commonwealth and State agreement was reached to build a new medical centre at Wiluna.

Projects progressed during the year included:

- developments at the Albany, Port Hedland and Kalgoorlie Regional Resource Centres;
- Busselton hospital development planning;
- Stages 3 and 4 of the staff accommodation program; and
- the Wyndham Multi-Purpose Centre development.

Also undertaken during the year were a number of projects for eHealth, administration and financial systems, equipment acquisition and replacement, and health facility minor works.

Under the Medical Equipment Replacement Program, equipment acquisitions for the WA Country Health Service in 2008-09 included:

- picture archiving and communication system equipment;
- computed radiography and CT scanners as described previously;
- scopes, theatre, sterilizing and monitoring / ECG equipment for a number of WACHS sites;
- a gas plasma sterilisation unit for the Bunbury Regional Resource Centre; and
- various equipment replacements including operating microscopes, hospital beds and washer upgrades.

Communities and partnerships

The WA Country Health Service (WACHS) has implemented many health promotion and illness prevention programs to improve the health of people living in country areas directed at both the individual and at the whole population.

Programs focus on providing information about prevention of illness and injury, about healthy lifestyles, and about the self management of chronic disease. For some of these programs WACHS works in partnership with other government and non-government agencies to address these health issues.

Health Promotion

The Health Promotion Strategic Framework 2007-11 is the platform for WACHS to implement health promotion projects across the regions. Projects include:

- the WA Healthy Schools project funded under the Australian Better Health Initiative for thirty WACHS schools and which aims to facilitate the implementation of best practice healthy eating and physical activity programs in schools;
- the WACHS Midwest Bicycle User Group in Geraldton and the Midwest Walking School Bus program;
- WACHS Wheatbelt developing and implementing an aboriginal child safety flip chart; and
- WACHS South West implementing a Physical Activity program - "Back to the Track Virtual Challenge" across the South West, a workplace program.

WA Health's Healthy Options Food and Nutrition Policy has been implemented across WACHS to ensure all country health services provide healthier food and drinks for staff, patients and their carers.

Mental Health

WACHS continued to support mental health promotion, including the dedication of 0.5 full-time equivalent staff to the 'Act Belong Commit' campaign in each region. These officers ensure mental health programs operate within the campaign philosophy, and work to create partnerships to develop and promote good mental health.

During 2008-09 the WACHS Wheatbelt facilitated an interagency meeting to review current activities and to develop a strategic plan in the area of mental health promotion and illness prevention in the Wheatbelt.

Older Adult Mental Health

During 2008-09 an older adult mental health training program for people working in aged care and in mental health was delivered to staff from both the public and private sector services across WACHS regions.

Falls prevention

The 'Reducing the Risks of Falls' program aims to target people who have been identified as having a falls risk and will be delivered by hospital staff to increase program sustainability.

Brief intervention

The comprehensive implementation of the WACHS Alcohol and Tobacco Brief Intervention Policy continued during 2008 – 09 across WACHS. Seventy four training sessions and a total of 636 health professionals were trained in brief intervention for alcohol and tobacco throughout WACHS.

During the year, WACHS, also worked with the Drug and Alcohol Office, National Drug Research Institute and Respiratory Health Network to develop an online brief intervention training package, to be launched in September 2009.

Bright start parenting program

The 'Bright Start' parenting program implemented in Geraldton underwent a 12-month review, and its recommendations and findings will inform further program development prior to implementation in other regions.

Retinal screening

An ongoing retinal screening program has been implemented in WACHS Goldfields.

Communities and partnerships (continued)

Community supported residential units

In partnership with the Mental Health Division and non-government agencies, including the Richmond Fellowship, Fusion Australia and Albany Halfway House Association, WACHS has supported the operations of community supported residential units situated in Bunbury, Albany, Busselton and Geraldton. All units are fully operational with service agreements in place.

Aboriginal mental health

The rate of suicides amongst Aboriginal people, particularly young people, is higher than that for the wider community evidenced by an alarming number of suicides in some Aboriginal communities. The reasons behind these suicides are complex, but reflect the disadvantage faced by many Aboriginal people in the country as well as particular social, economic and health issues.

During 2008-09, WACHS has been closely involved with local communities to develop models of care that are holistic and integrate services provided by mainstream and community controlled mental health services that address the cultural beliefs and attitudes of Aboriginal people to suicide and mental health.

Men's health promotion

The 'Pit Stop' Men's Health Program, developed by WACHS has proven to be popular Australia wide, with services across Australia requesting the package. During 2008 – 2009, 117 packages were distributed across Australia.

Aboriginal health

WACHS aims to deliver culturally appropriate planning and services although evidence indicates that Aboriginal peoples' experience of health service delivery often fails to deliver a culturally respectful service. To determine the level of satisfaction with services delivered, aboriginal patient surveys were conducted during 2008-09 in WACHS Great Southern and Pilbara. The results of the surveys are expected in late 2009.

During 2008-09 WACHS enhanced its screening programs targeting aboriginal health issues. A coordinated Trachoma and Trichiasis screening initiative has been implemented as core business in the endemic areas.

WACHS has sexually transmitted disease infection control teams in three regions, targeting populations at risk.

The AHS has established an ear health program in Goldfields aboriginal communities aimed at preventing middle ear infection.

WACHS Wheatbelt Aboriginal Health Service provides antenatal services, men's and women's health clinics, programs to improve access to mainstream primary care services, and camps and elders programs.

An Aboriginal Healthy Lifestyle Coordinator has been appointed in WACHS Goldfields to support the development and implementation of community plans to address chronic disease issues.

Diabetes services

WACHS and the Unity of First People of Australia (UFPA) have been working together to tackle aboriginal health issues in the Kimberley, particularly in relation to diabetes. During 2008–09, WACHS formalised its partnership with the UFPA, through the development of a memorandum of understanding. WACHS and the UFPA will work together to further develop the holistic model for health promotion developed by UFPA, to improve lifestyle choices for Aboriginal communities in the Kimberley, and decrease rates of chronic disease.

Merredin Noongar Clinic

Merredin Surgery and general practitioners (GPs) work closely with aboriginal health workers and nursing staff to provide a fortnightly Noongar medical and health clinic for the local community at the Merredin Progress Association. Where appropriate, the service extends beyond the fortnightly clinic with Wheatbelt aboriginal health staff and clients able to access GP bulk billing services at Merredin Surgery.

Communities and partnerships (continued)

Aged Care

During 2008-09 regular State, Commonwealth and WACHS Aged Care reference group meetings continued.

WACHS also continued its ongoing discussions with private providers for increased non-government involvement in the management of residential aged care in country areas. For example, 28 residents were transferred from Collie Hospital to a new residential aged care facility managed by Southern Cross Care. WACHS provides financial contributions to assist with the development of new residential care facilities in country areas and in 2008-09 three providers received funding for new facilities in Broome, Derby and Collie.

During the year WACHS developed its relationship with the private providers in the Great Southern, South West and Midwest, of 60 short term support packages for transitional care services for older people discharged home from hospital.

As part of the WA Sub-Acute Plan, COAG funding will be available to improve inpatient and outpatient sub-acute services in the country commencing with funding for increased Specialist Geriatrician visits and outpatient rehabilitation. Future plans include inpatient rehabilitation and older adult mental health services.

WACHS Midwest has implemented a trial to test the acceptability of technology for home monitoring of clients over 65.

Training in the Wellness Approach to Community Homecare which promotes an 'enabling' model rather than a 'maintenance' model, is being undertaken across WACHS regions to support HACC service providers implementing the 'Wellness Approach' model of care.

South West mental health

WACHS South West undertook a community needs assessment and review of current resources to consider treatment option planning for patients requiring detoxification services in the region. Consultation has occurred with the South West Community Drug Services Team, South West Aboriginal Medical Service, Drug and Alcohol Office, Peel SW and Greater Bunbury Divisions of General Practice, Bunbury Hospital, South West Mental Health Service, South West district hospitals, South West Population Health and other key stakeholders. A project report and recommendations is expected to be completed in October 09.

Dual Diagnosis: mental health and drug and alcohol disorders

WACHS continued to identify and support opportunities for innovative strategies to address co-existing mental health and drug and alcohol disorders for country regions. Memoranda of Understanding have been developed by WACHS and signed with local community drug services, and where relevant, aboriginal services, regarding to the case management of patients.

WACHS continues to participate in Headspace programs in the Kimberley and Great Southern regions, supporting integrated services for youth at risk of developing drug and alcohol and / or mental health problems.

The Wheatbelt community mental health service has developed a shared care model with a local NGO service to implement a memorandum of understanding and promote integrated service delivery. The model will be reviewed with recommendations made to inform similar programs across the region. Local alcohol accords remain in place in some high risk locations, as does training in responsible service of alcohol.

Boddington Medical Centre

WACHS Wheatbelt has entered into a partnership with the Shire of Boddington, to build a new Medical Centre next to the Boddington Hospital. The facility will provide a doctor's surgery, child and school health, a home and community care day centre, allied health consulting rooms, and a dental surgery.

Communities and partnerships (continued)

Royal Darwin Hospital

During 2008-09 WACHS negotiated a contract with the Royal Darwin Hospital facilitating the transfer of appropriately identified Kimberley patients to Darwin rather than to the Perth metropolitan area for treatment. The contract specifies the purchase of beddays and benefits patients with hospital care closer to home involving less travelling time for the patient, reduced costs for the Area Health Service, and provides care in a setting more conducive to Kimberley residents. Transfers commenced in February 2009.

Pathways Home Telepsychiatry Project

WACHS Telehealth services piloted a trial of home monitoring options for mental health patients in the Midwest and Wheatbelt. The project successfully demonstrated that this technology can be used for this purpose. Further work is required to implement it in a cost effective manner.

Royal Flying Doctor Service

In 2008-09 negotiations with the Royal Flying Doctors Service (RFDS) have been finalised and a 5-year contract has been signed effective until June 2013.

Health Networks

WACHS has established leadership representation on each of the WA Health Networks and is committed to implementing, in a timely manner, the models of care as they are developed. During 2008-09 WACHS has commenced the implementation of the Maternity and New-born, the Renal and the Rural Palliative Care models of care. In 2009-10 other models of care will be implemented as they are developed, commencing with chronic disease.

Ambulance services

During 2008-09 WACHS's partnership with the St John Ambulance Association (StJAA) continued with the Community Paramedic trial project in the Kimberley and the Pilbara. The project review in the Kimberley was completed and the Pilbara project evaluation is due to be concluded in 2009-10. The Community Paramedic recruits, trains and supports volunteers and is available to respond to calls alongside volunteers where necessary. The project's evaluation findings will be used in 2009-10 to inform WACHS and the StJAA regarding project implementation in other country regions.

Multi-purpose Service

An independent review of all 30 Multi-purpose Service (MPS) sites was conducted in June 2008 across five WACHS regions against a number of Aged Care Standards. The review highlighted three main areas for attention - restraint management, medication management, and leisure and lifestyle. Regional action plans were drawn up and actions are currently being implemented.

As part of these plans 136 staff training positions for Certificates in Aged Care have been negotiated under the Support for Aged Care Training Program, restraint management workshops are being run in October and a policy review is underway.

Wyndham Health Service is currently under consideration to operate as an MPS and development of a Service Delivery Plan has commenced.

District Health Advisory Councils

Twenty three 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, provide two-way communication and advocacy. Health service planning is made more relevant by their contributions. The Wheatbelt, Pilbara, parts of the Great Southern and some other towns have Local Health Advisory Councils, enabling them to inform the DHAC of local priorities.

The annual DHAC Chairpersons Forum prioritised improved access to dental and nurse practitioner services, and linkage with other agencies such as GP Networks for 2009-2011. DHAC chairs strongly supported WA Country Health priorities for 2009-2012 and the Values statements developed by staff and DHACs. Advocacy and Patient First Ambassador training is increasing DHACs involvement in safety and quality improvement. Health service open-days and health forums are proposed for the coming year.

Priorities for 2009-10

In 2009-10 the WA Country Health Service will take a new strategic direction. *Revitalising WA Country Health Service 2009-2012* follows on from the *Foundations for Country Health Service 2007-2010* Strategic Plan, and outlines the way forward for health service delivery in regional WA.

Revitalising WA Country Health Service 2009-2012 has been developed in consultation with staff and community members throughout rural and remote areas of the State with the clear purpose of *Working together for a healthier country WA*. It establishes the WA Country Health Service as an advocate for:

- **A fair share for country health**
  Securing a fair share of resources and being accountable for their use.
- **Service delivery according to need**
  Improving service access based on need and improving health outcomes.
- **Closing the gap to improve Aboriginal health**
  Improving the health of Aboriginal people
- **Workforce stability and excellence**

Building a skilled workforce and a supportive workplace.

It also seeks to embed five core values: *Community*; *Compassion*; *Quality*; *Integrity* and *Justice*; considered vital by staff and the community to epitomise the way the WA Country Health Service should carry out its work.

During 2009-2010 the WA Country Health Service will start to implement the following 13 key actions:

Strengthening and improving access to emergency department services

By better coordinating clinical services and improving support to country clinicians, emergency services will be strengthened and improved across the State.

Emergency department services will be coded so the type and level of the service is apparent to individuals, communities and clinicians, informing them of where and how to access the right care.

Work with communities so that health and hospital services match health needs

Over the years, the health needs and demographics of country communities have changed. Modern health care is not just about hospital services but also about preventing illness and disease, and caring for people in their homes.

The WA Country Health Service will clearly delineate and describe the types of services to be provided by hospitals and local health services so that communities know what service is provided, where it is located and how it can be accessed.

Link alcohol, drug and mental health services and strengthen prevention and mental health promotion

Alcohol, drug and mental health services will be better linked to improve services and health outcomes for those with dual diagnosis.

Working with communities and agencies, WA Country Health Service will seek to reduce alcohol and drug related harm and illness in local communities and support mental health promotion and suicide prevention across country WA.

Communities, District Health Advisory Councils and Regional Planning Forums will be regularly updated about the impact of alcohol and drugs on the health and wellbeing of individuals, families and communities. They will be invited to assist by increasing awareness about prevention approaches that reduce injury and illness and improve health.

Improve access of communities in rural and remote WA to primary health care services

Prevention, early detection and intervention are essential to improving health and quality of life for all. Too few general practitioners in regional and remote WA means we need to explore new and innovative ways of ensuring country communities continue to have access

Priorities for 2009-10 (continued)

to primary or community based health services.

The WA Country Health Service will work together with Commonwealth, State and local governments, general practitioners, Aboriginal community controlled health organizations, other non-government organisations and volunteers to make best use of all available resources.

Stabilise and skill the workforce and provide a safe and supportive workplace

The country health workforce faces challenges unique to rural and remote areas. The WACHS will develop appropriate skills training and support programs tailored to meet these challenges, that will attract, build and retain a strong, stable country health workforce and that develops a supportive culture and leaders who promote the WA Country Health Service values.

Improve services to aboriginal communities and boost aboriginal employment opportunities

The WA Country Health Service will work closely with Aboriginal communities to develop regional Aboriginal health plans to improve their health and ensure culturally appropriate health services.

The Area Health Service will increase the number of Aboriginal people working in country health services by setting employment targets, provide training, access to purposeful work, and create a workplace culture and environment that attracts and retains Aboriginal people.

Establish the WA Centre for Country Health Service Research and Education

An inter-disciplinary health service research and education program will be introduced during 2009-2011.

The WA Centre for Country Health Service Research and Education will be established by 2012 to provide professional development and further education and research opportunities for staff and to benefit regional communities.

Develop the WA Country Health Service Permanent Employee Housing Accommodation Strategy

A business plan will be developed with Government Regional Officers Housing (GROH) to improve WA Country Health Service accommodation for permanent employees.

The WA Country Health Service will continue to manage and resource improvements to short term and transient employee accommodation facilities.

Develop secure electronic clinical Information systems, telehealth and e-Health

The WA Country Health Service will improve access to health services in rural and remote WA by promoting the electronic exchange of clinical information and strengthening links to regional and metropolitan hospital and private providers through the use of telehealth and other e-Health services

Revitalise community and stakeholder partnerships and communication

The WA Country Health Service will include communities, service partners and funding providers in planning and improving health care services, by encouraging their participation in a range of advisory and consultative groups and forums, and ensuring a regular flow of information about health services.

Integral to this are the District Health Advisory Councils, the Country Health Forum and the Executive Aboriginal Reference Group as well as improved local communication.

Significant Issues and Trends

Priorities for 2009-10 (continued)

Develop a financial resource model to improve funding of country health services

The unique challenges encountered in providing health services in rural and remote Western Australia, attract an additional financial burden not faced in the metropolitan area. These include higher staffing,accommodation and communications costs, a higher cost of living, a greater cost for transferring patients between hospitals, as well as having to act as a provider of last resort with too few General Practitioners and a lack of private health service providers in many areas.

A Country Resource Allocation Model will be developed to ensure large country hospitals are funded appropriately to account for these additional costs and according to the level of demand for services.

Improve country aged care services

The changing demography and aged care needs of country communities requires focused attention to achieve access to the right mix of services in the right place.

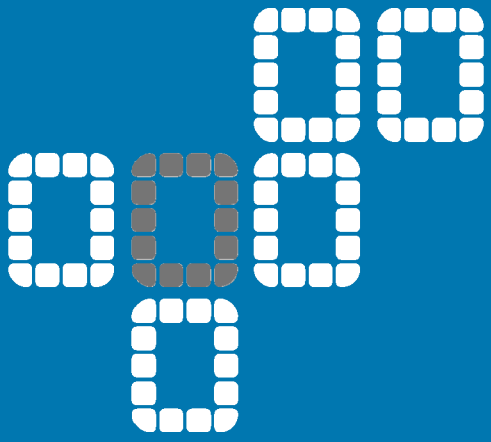
The WA Country Health Service, in close partnership with the Commonwealth, private and non-government organisations, service funders and providers, will work to improve the quality and accessibility of aged care community and residential services through a range of initiatives. These include the expansion of multi-purpose services and the creation of nurse practitioner positions.

Introduce new models of care that improve services and the health and well-being of country people

Models of care are being introduced throughout the state to improve delivery of clinical and health care for a range of significant health conditions including maternal and child health, chronic kidney disease, palliative care and stroke.

In rural and remote areas, the mix of service providers, types of services offered and needs of the community differ from those in the metropolitan area.

The WACHS sees models of care informing the way services are provided, based on the latest evidence about how to deliver care. WACHS is working with clinicians and a range of government, non government and private service providers to implement these models in ways that are best suited to each region.



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 2008-09 was $1,097,320.

Table 25: 2008-09 WACHS Advertising expenditure

Summary of Advertising	Amount ($)
Advertising Agencies	996,933
Market Research Organisations	Nil
Polling	Nil
Direct Mail Organisations	Nil
Media Advertising Organisations	100,387
Total Advertising Expenditure	**1,097,320**

Recipient / Organisation	Amount ($)
Advertising Agencies	
Adcorp Australia Ltd	526,554
ADEPTO Publications Pty Ltd	426
Albany Advertiser	2,232
Australasian College for Emergency Medicine	1,843
CBT Corp PL	264
Chandler MacLeod	16,895
Countrywide Media Pty Ltd	814
Market Creations	1,452
Market Force	31,972
Marketforce Advertising	255,548
Marketforce Express	54,361
Marketforce Productions	97,501
Muddy Waters	480
WA Country Health Service	6,591
Advertising Agencies Total	**996,933**
Market Research	
	Nil
Polling Organisations	
	Nil
Direct Mail Organisations	
	Nil
Media Advertising	
Adcorp Australia Ltd	16,935
Albany Advertiser	3,146
Alcohol and Other Drugs Council of Australia	150
APN Newspaper Pty Ltd	14,061
Aust Business Pages Directory	195
Avon Football Association	39
BK Signs	1,590

Recipient / Organisation	Amount ($)
Boddington Community Newsletter	45
Chittering Times	616
Community Newspaper Group	248
Countrywide Media Pty Ltd	1,672
Denmark Bulletin	28
Dongara Local Rag	21
Geraldton Newspapers Ltd	2,283
Great Southern Herald	1,696
Jerramungup Telecentre	33
Kalbarri Town Talk Association Inc	30
Kojonup Community Newspaper	25
Lake Grace Telecentre	10
Marketforce Advertising	28,024
Marketforce Productions	18,383
MINNIS Communication	220
Morawa Telecentre	500
Muka Matters Inc.	8
Northampton Community News	30
Nyabing News	13
Pindan Publishing	120
Pingelly Times	65
Pingrup Telecentre	10
Rebel Films	1,340
Rural Press	1,234
Rural Press Regional Media (WA) Pty Ltd	706
Sensis Pty Ltd	65
South West Printing & Publishing	133
Telecentre Network (Dalwallinu)	684
Telecentre Network (Jurien Bay)	60
Telecentre Network (Lake Grace)	20
Telecentre Network (York)	209
The Fence Post	68
The Kalgoorlie Miner	73
The Nursing Post	932
The Speech Pathology Assoc of Aust	220
The Underprivileged Childrens Group	424
The Windmill Newspaper	30
WA News	87
Watershed News	12
Weekender	3,548
Western Australian Association for Mental Health	167
Wongan Hills Telecentre	66
Wyalkatchem Weekly	8
York Telecentre	105
Media Advertising Total	**100,387**

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.

During 2008-09, the WA Country Health Service (WACHS), has implemented or continued numerous initiatives to reduce the risk of corruption and misconduct.

In addition to the actions implemented by the WACHS, the Corporate Governance Directorate (CGD), Department of Health provides independent and objective corporate governance services to assist area health services to achieve sound managerial control over all aspects of their operations. The CGD provides capacity building opportunities to area health services to enable them to meet their corporate governance responsibilities especially in the prevention of corruption and provides information and assessment reports on whether the area health services have adopted and / or implemented appropriate corporate governance mechanisms.

Specific achievements or action during the year include:

- Establishment of senior position of Manager Governance and Strategic Support with responsibility for misconduct management and investigation
- Development and delivery of staff training package in Governance and Accountability.
- Development and implementation of training for managers in the management of misconduct investigations.
- Provision of specific staff training in relation to Public Interest Disclosures.
- Misconduct Risk incorporated into Strategic Risk Register
- Review of risk associated with management of drugs and development of improved control strategies
- Regular reports to executive in relation to incidence of misconduct, with specific policy and practice recommendations made where need for improved risk management has been identified.

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 2008-09 a particular initiative to maintain the Area health Service's efforts in risk management and corruption prevention was the consolidation of a senior management position, Manager Governance and Strategic Support. This position oversees corruption control initiatives and manages the investigation of incidents of corruption and misconduct.

This manager is also responsible for the development and delivery of a staff training package in Governance and Accountability and the development and implementation of training for managers in the management of misconduct investigations.

During the year staff training in relation to PID was provided to those staff appointed as PID Officers, and a pilot program to promote awareness of the PID Act was delivered to staff in the Pilbara Region.

WACHS has identified and incorporated the risk factors contributing to misconduct into the Strategic Risk Register, and has specifically reviewed the risk associated with management of drugs and developed improved control strategies. The WACHS executive receive regular reports in relation to the incidence of misconduct, with specific policy and practice recommendations made where need for improved risk management has been identified.

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, with the authority delegation schedules, accounting standards, and the ACHS accreditation requirements.

Disability Access and Inclusion Plan

The *Disabilities Services Act 1993* requires public authorities to develop and implement a Disability Access and Inclusion Plan and undertake a continuous process of review to ensure the organisation meets the outcomes outlined in the Act.

During 2008-09, WACHS continued implementing the Area Health Service's 2006-09 Disability Access and Inclusion Plan (DAIP). Each WACHS region has developed a DAIP in accordance with the WACHS DAIP and the WA Health DAIP. The following is a selection of some of the actions undertaken by WACHS regions in relation to the six outcomes of the WA Health DAIP.

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:

- WACHS Great Southern DAIP was endorsed by the Regional Executive Team in August 2008. A regional Disability Access Reference Group was established to implement the recommendations of the region DAIP. The Reference Group holds quarterly meetings commencing in February 2009.
- WACHS Wheatbelt was a finalist in the Disability Services Commission 2008 "Count Us In" Awards. A regional DAIP brochure was created and distributed at Wheatbelt Induction days and published on the WA Health intranet. Local learning materials for the Wheatbelt have been developed, such as a Self Directed learning package, a DAIP DVD employee resource is on the intranet, and all sites within the region have access to a "Creating Accessible Events" document to assist employees to organize events.

Outcome 2

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

- DAIP is a standing agenda item for all WACHS capital works projects. For example, the plans for the new Regional Resource Centres being built at Port Hedland and Albany must be built in accordance with Australian Building Code design stipulations for disability access and inclusion.
- A public teletypewriter has been made available at the Carnarvon Hospital for all community members.
- WACHS Regional management teams continually audit and review their facilities to ensure that they comply with current disability access requirements and allocate resources to ensure standards are maintained or continuously improved.
- Projects in 2008-09 included:
  - installed seating and lighting at a number of health facilities;
  - Boyup Brook Hospital improved site access with re-bituminising sites;
  - adjusting client amenities to meet the required height standards;
  - the relocation of the Wheatbelt Regional Office enabled wheelchair access,
  - installing audible alarms to compliment visual alarms have been installed across all South West sites, car parks, reception areas; and
  - entrances for a number of WACHS sites have been reconfigured to ensure access for people with a disability especially the Aboriginal Health building in Albany, at Fitzroy Crossing and Broome, and at many sites in the Wheatbelt.

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:

- All public information provided by WACHS is in accordance with the DOH Communications Style Guide and available in alternative formats with resources marked accordingly promoting the option.
- WACHS provides information on the Rights and Responsibilities on a 'Patient.

Disability Access and Inclusion Plan
(continued)

First' DVD as well as version for the visually impaired who can listen to the information.

- Aboriginal Health Workers at all sites provide information in an appropriate manner including translation services to assist aboriginal people with a disability to access services

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:

- The Geraldton Hospital has purchased two air bladder devices for patients who are unable to access the call bell and require assistance from the staff.
- The regional online orientation induction training for corporate staff includes information regarding the WACHS DAIP.
- WACHS ensures that disability awareness training is mandatory in training days, employee induction sessions, self directed learning packages and in global communications.

Outcome 5

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

- WACHS regions provide all staff with education and training on the processes for dealing with complaints and enquiries from clients, patients and the public. Enquiries and complaints can be received in a number of different ways- in person, by telephone, by email or letter. Regions conduct regular reviews and audits on the complaints process and on the complaints received, to ensure relevance to people with a disability, including complaint documentation and the availability of alternative methods to progress a complaint.
- Complaints brochures especially designed for Aboriginal people are provided. During 2008-09 the Kimberley Population Health Unit – Remote Area Health redesigned its documentation to better reflect Aboriginal cultural values. The feedback question asks the consumer to "tell us your story" and the pictures used are more appropriate.
- Contact information for other agencies which can assist people with disabilities is also provided to patients and clients where they may be able to assist to progress and resolve a complaint or issue, for example the Disability Services Commission (DSC) Local Area Coordinators.
- Regions may also appoint Customer Liaison Officers to facilitate complaints. In July 2008 such a position was established at the Geraldton Regional Resource Centre.
- All sites provide information regarding Advocare and this agency provides regular visits to regional areas to advise people with disabilities about their advocacy service.

Outcome 6

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

- People with disabilities are encouraged and supported in participating on the District Health Advisory Councils. Information gained from their input is used to develop services appropriate to the needs of community members who have a disability.
- People with a disability are encouraged to participate in consultations facilitated by District Health Advisory Committees, particularly in relation to services to those with a disability. Where community consultation is used or required, a venue is chosen that enables people with disability to take part.

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 for 2008-09 by category.

Table 26: WACHS Total FTE by Category

Category	Definition	2007-08	2008-09
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers.	1,115	1,202
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services, medical.	28	34
Agency nursing	Includes nurses engaged on a "contract for service" basis.	115	131
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	0	1
Dental nursing	Includes dental clinic assistants.	n/a	n/a
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,264	1,269
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	181	216
Medical sessional	Includes sessional based medical occupations.	8	8
Medical support	Includes all Allied Health and scientific/technical related occupations.	583	601
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,372	2,445
Site services	Includes engineering, garden and security-based occupations.	175	187
Other categories	Includes Aboriginal and ethnic health worker related occupations.	85	83
Total		**5,926**	**6,176**

Note: 2007-08 reported data has been realigned to reflect 2008-09 FTE definitions.

Freedom of Information

For the year ending 30 June 2009, the WA Country Health Service considered 2,270 applications for access to information in accordance with the Freedom of Information Act 1992.

Table 27: Freedom of information applications 2008-09

Applications	Number
Carried over from 2007-08	42
Received in 2008-09	2,228
Total applications received in 2008-09	**2,270**
Granted full access	1,971
Granted partial or edited access	125
Withdrawn	44
Refused	33
In progress	70
Transferred and other	27

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 statistical 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; and
- 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.

WACHS 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.

WACHS experienced no significant industrial disputation during 2008-09.

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.

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

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

Table 28: Completed Audits

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

Note: WA Health – Audits for WA Health involved all Area Health Services including Dental Health Service and PathWest, and Department of Health Corporate Offices.

Major Capital Works

Please refer to the 2008-09 Department of Health Annual Report for financial details of capital works in the WA Country Health Service.

Table 29: Major Capital Works in WACHS

Capital works projects completed in the WACHS during 2008-09	Capital works projects in progress in the WACHS during 2008-09
Denmark Multi Purpose Centre (MPC)	Kalgoorlie Redevelopment Stage 1
Kalumburu Clinic	Albany Health Campus
Morawa & Perenjori MPC	Broome Regional Resource Centre Stage 1
Nickol Bay Hospital Roof replacement	Wyndham MPC
WACHS Staff Accommodation Stage 3 – Newman Housing	Port Hedland Regional Resource Centre Stage 2

Pricing Policy

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

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

The exception to this pricing policy are patients convalescing in a public hospital for more than 35 continuous days, who no longer require acute care and are deemed to be Nursing Home Type Patients, and may then be charged a patient contribution as determined by the Commonwealth Minister for Health and Ageing.

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

The one exception to this pricing policy for the above chargeable classes of patients, is that pharmaceutical items supplied to admitted private patients will be provided 'free of charge' and cannot be claimed under the Pharmaceutical Benefits Scheme.

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

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

Under the Australian Health Care Agreement, eligible patients who have entered into 'third party' arrangements with compensable insurers are known as compensable patients. This cohort of compensable patients may include among other groups, the Australian Defence Forces, the Insurance Commission of Western Australia covering motor vehicle accident patients and WorkCover for workers' compensation patients.

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

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

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

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

Recordkeeping

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

The WA Country Health Service ensures that all health service clinical and administrative records comply with the recordkeeping plans of the Area Health Service and the Department of Health, as well as complying with records management policies and procedures set down under State legislation.

WACHS' Regional Health Information Managers Group has regular meetings with the WACHS Area Office to discuss developments and current practices for recordkeeping and to exchange strategies and initiatives for the management of all health service records for subject areas. Such areas are policy, procedure and documentation development and standardisation, staff records responsibility training at staff development and orientation days, inter-regional relationships, improved communications and the identification of areas requiring attention.

During the year WACHS regions undertook Area Health Service and / or local initiatives including:

- regional audits of medical records to identify areas for improvement particularly in relation to improving support and training for frontline clerical staff;
- assessing that correct records management practices have been followed, for example record stamping and identification to prevent duplication;
- developing a clinical risk treatment plan for managing high risk in medical records management;
- reviewing of records storage requirements;
- conducting on site training of medical record personnel;
- establishing Area Health Service and regional shared drives, databases and intranet resources for training clerical staff in HCARe applications and records management practices and policies;
- identifying HCARe expert users across the regions for staff to use as 'help' contacts; and
- delivering presentations on record keeping plans to staff during staff meeting and orientation and induction programs.

A number of WACHS regions are scheduled to conduct recordkeeping audits in 2009-10.

Recruitment

The WA Country Health Service recruitment processes are undertaken in accordance with the "Public Sector Standards in Human Resource Management" policies and aim to recruit suitably skilled persons to positions promptly to ensure continuation of service.

During 2008-09 priority recruitment across the WA Country Health Service (WACHS) remained focused on the allied health, medical and nursing workforce. There was also an emphasis to recruit locally if possible, and to increase the level of employment of aboriginal people.

Recruitment campaigns conducted by WACHS included features in the "Weekend Australian" on rural health with information provided for all regions from a WA country health perspective.

Medical Recruitment

The Clinical Workforce and Reform Unit, established in August 2007, assists regions to recruit 'hard to fill' places, and provides a centralised unit for coordination of employment of international medical graduates. At 30 November 2008, 53.6 per cent of the rural and remote medical workforce in WA had obtained their basic medical qualifications overseas. The Unit is the liaison point for recruitment to permanent positions. Recruitment for locum positions is the responsibility of the individual regions. Medical Practitioners employed on Medical Services Agreements are also managed in the regions.

Regional vacancies are advertised on the WA Country Health Service website used by recruitment agencies and the website is a focal point for Medical Practitioners in considering a role within WACHS. A generic print media advertising campaign for medical practitioners for Australian based on-line journals in March 2009, resulted in a variety of applications. Regions are also encouraged to add their vacancies to the Health Corporate Network jobs vacancies site.

The Nationally Consistent Assessment Process for International Medical Graduates, an initiative of the Council of Australian Governments, has had significant impact on the recruitment processes for medical practitioners, reducing the number of applications being made. The need for international verification of initial qualifications, and demonstrating a certificate of advanced standing or successful completion of the Australian Medical Council Exams, has resulted in the reduced number of experienced applicants seeking work in Australia.

The Rural Generalist Pathway continues to develop with additional posts created for junior doctors in Broome, Albany and Geraldton. WACHS has worked closely with its partners Rural Health West, WA General Practice Education and Training (WAGPET) and the Postgraduate Medical Council of WA (PMCWA) to ensure appropriate education and support systems are developed at all rural hospitals providing training for junior doctors.

WACHS successfully negotiated with the PMCWA and the metropolitan Primary Allocation Centres (PACs) to include applications for training in rural hospitals through the Rural Generalist Pathway as part of the annual intern application process managed by PMCWA.

Graduate Nurse and Nurse Rotational Programs

All WACHS regions provide graduate nurse and rotational programs aiming to expose nurses to rural and remote health care and facilitate local recruitment to permanent positions. The nurse rotational programs exceeded the 2008-09 operational plan targets and interest in the programs continues to grow.

WACHS Pilbara has employed four Enrolled Nurse (EN) graduates from the local EN program on a full year EN graduate program. The region has also taken on four Registered Nurse (RN) graduates, providing them with a diversity of experience only available in the rural and remote setting.

Recruitment (continued)

The WACHS South West Learning and Development Unit has participated in the recent Edith Cowan University, Bunbury Campus Nursing Expo, highlighting the Graduate Program and working in the South West.

The GradNurse Connect recruitment and selection process for Registered and Enrolled Nurses will commence in July 2009 for 2010 intake, providing a central point for advertising for RN and EN graduate positions, and means that applicants only have to apply once for a number of different positions in the Midwest.

Aboriginal employees

The creation of an Aboriginal Health Coordinator position in the Pilbara will help facilitate and develop strategies to achieve the aim of increasing the number of aboriginal staff within WACHS Pilbara.

Aboriginal recruitment is also a priority for WACHS Kimberley and through the Foundations-funded project – 'Positive Employment Opportunities for Aboriginal People', research has been undertaken to determine barriers and needs in relation to Australian Torres Strait Islander recruitment and retention.

Recruitment initiatives

WACHS undertook a range of centralised recruitment campaigns for nurses, on behalf of all regions aligning WACHS activity with the State-wide multi-media campaign 'nursing it can take you anywhere'.

Health Corporate Network (HCN) have been visiting regions and offering short training sessions on HCN processes and the relevant forms for recruitment, selection and appointment. This has been made possible through the appointment of a new position, Client Liaison for WACHS / HCN.

WACHS proactively markets rural and remote careers to university students (nursing, medical and allied health) through a variety of strategies such as career expos, lectures and support for rural health student clubs.

WACHS Wheatbelt continued to advertise in local and national forums and via the internet until change to the WA government employee advertising policy was implemented in February 2009. The recruitment of international nurses has continued in the Wheatbelt and during the year a further 15 overseas nurses were sponsored to a total of 45 overseas nurses contributing to the provision of client services in Wheatbelt hospitals in 2008-09.

WACHS Kimberley provided a display at the Northwest Expo in 2009 focusing on health service careers and targeting high school students.

WACHS Pilbara conducted a trial of a midwives incentive scheme, achieving an increase in full-time midwives numbers at Port Hedland and Nickol Bay. Staff accommodation remains a major issue in the Pilbara and building additional staff housing at Newman and Port Hedland will assist in the recruitment and retention of staff. The region also conducted a trial of a recruitment nurse position at Port Hedland Hospital. This position supports nurse managers to fill positions and has resulted in a decrease in agency nurse usage and a reduction in vacant nursing positions. The process is now underway to embed the position within the recurrent establishment and expand the role to have a regional focus.

WACHS South West participated for the first time in placing registered nurse graduates in its district hospitals as well as increasing the graduate places from four to eight at the Bunbury Hospital. The region also offered all graduates a post graduate qualification on completion of the 12-month program. The region participated for the first time in the 'Ocean to Outback' program with a placement at Nannup Hospital, an area of need for nursing staff.

WACHS Midwest attended the recruitment expositions –'Combined Universities Centre for Rural Health' in May 2009 and a Careers Expo in Exmouth in July 2008, the WA Nurse Expo May 2009 and nominated officers to attend the 2009 School and Industry Leaders' Forum in May 2009.

Staff Development

During 2008-09 particular initiatives have been implemented across the WA Country Heath Service (WACHS) as part of its commitment to maintaining an environment that encourages personal and professional development of staff.

The following are some of the initiatives implemented in 2008-09 in WACHS as part of its commitment to developing its workforce.

WACHS has continued to promote local and regional professional and personal development strategies including:

- providing mannequins in all WACHS regions for neonate, child, adult and obstetrics simulation training;
- training 60 clinical staff in Advanced Life Support in Obstetrics;
- providing Paediatric Life Support training at 14 WACHS sites;
- providing local management workshops for 900 clinical leaders and corporate manages;
- providing conflict management training to 150 front line clerical and clinical staff and aggression de-escalation training to 2000 clerical and clinical staff;
- enhanced access to Perth based training events through the utilisation of videoconferencing;
- providing access to 55 training videos via intranet with 24/7 access for shift workers;
- providing on-site interactive workplace behaviour sessions for subjects such as the prevention of bullying, harassment, discrimination, the Codes of Conduct and Ethics, Public Interest Disclosure and the Equal Opportunity Legislation;
- Assessing and monitoring performance development across the Area Health Service; and
- focusing on e-learning as a way to minimise geographical inequities in regard to training opportunities. In many sites orientation and induction courses are provided via videoconference as well as workplace behaviour, prevention of bullying, cyclone and emergency response actions, local transfer of patients and the Needle and Syringe Program.

Specific regional programs included:

- the Wheatbelt Population Health Unit providing an annual Family Partnership Program enhancing the Wheatbelt's approach to a family-centred practice for community health and allied health staff; and providing 19 Wheatbelt staff with training in the Flinders model - Wheatbelt ongoing Wellness program;
- regionally provided clinical short courses in advanced life support and pediatric life support, plastering, trauma, Sexual Assault Resource Centre (SARC), dementia, brief intervention, CPR, defibrillation, manual handling, emergency response and fire training and infection control (hand hygiene);
- Local TAFE courses for Certificate 4 in Aged Care for Support Service workers; and
- professional development opportunities in all regions:
  - cultural awareness;
  - paediatric life support;
  - senior first aid;
  - disease control;
  - obstetric emergencies;
  - dementia care;
  - quality improvement;
  - Rostar;
  - basic life support;
  - communication and customer service;
  - neonatal resuscitation;
  - stress management;
  - videoconferencing;
  - triage;
  - remote area clinic nurses' professional development;
  - burns management;
  - pain management;
  - occupational safety and health;
  - wound care; and
  - diabetes management.

Workers' Compensation and Rehabilitation

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

In 2007 the WA Country Health Service developed its Safety Management System (SMS) using elements of the WorkSafe Plan. This system is currently under review to ensure that it meets the requirements of the WA Code of Practice for Occupational Safety and Health (OSH) in the Public Sector.

Occupational safety and health initiatives

During 2008-09 the SMS as been reviewed and is to be restructured to ensure that performance data can be collected and facilitates system effectiveness evaluation. Under the WACHS SMS:

- Management commitment – the Whole of Health OSH Policy 2007 has been adopted;
- Planning – addresses the collection of a range of performance data. A draft WACHS safety improvement action plan 2008-10 has been developed to address program initiatives and strategic risk;
- Hazard Management - all risk identification and control procedures. The WA Health risk management system is incorporated into injury prevention procedures to assist regions to identify and control safety risks using the hierarchy of control with corrective actions applied through risk analysis and control measures based on priority of risk. It is proposed to progressively collect performance data during 2010 to ensure all WACHS sites conduct regular site safety inspections. All procedures have been reviewed to provide clearer guidance and templates to regions;
- Consultation - Consultative mechanisms are described including a revised draft safety issue resolution procedure providing clear guidance to regions on how to escalate unresolved safety risks through the tiers of the organisation; and
- Training – a draft procedure identifies safety training needs for WACHS and a draft safety training matrix is attached to the draft WACHS safety improvement action plan 2008-2010.

It is envisaged that the revision of the SMS will be implemented during 2010.

In 2008 WACHS concluded a two year project which identified security and aggression risks across all regions, and provided each region with a risk-based plan to mitigate safety risks. In conjunction with this project, the WACHS Learning and Development Unit sponsored a trainer to deliver prevention of aggression training across the Area Health Service.

Based on risk assessment, regions received a funding allocation to improve aspects of physical security including:

- physical barriers;
- safe rooms;
- improved duress systems;
- improved closed circuit television; and
- improved communications in remote areas.

As a further outcome of this project, WACHS developed and implemented an annual workplace violence risk assessment process for each site.

Regions, subject to resource capacity, are currently undertaking a preliminary assessment of the implementation of the WACHS SMS using the WorkSafe Plan self-assessment tool, as required by the Public Sector Commission Circular 12/2009. The results, in concert with the Australian Council on Healthcare Standards EQuIP quality improvement program, will be used to further improve WACHS safety programs.

Employee rehabilitation

WACHS has a workers compensation and injury management system as required by the *Workers Compensation and Injury Management Act 1981*.

The system adopts a case management approach to ensure that 'return to work' outcomes are optimised for injured workers: Regional workers compensation staff ensure that injured employees receive their entitlements and refer injured workers for injury management intervention.
WACHS injury management coordinators, using a referral system, coordinate 'return to work' programs for injured employees in consultation with line managers for regional staff with workplace and non-work related injuries.

A survey of injured workers was conducted during 2008 and, as a result, the WACHS injury management system (IMS) was reviewed with the aim of simplifying the workers compensation claim lodgement process. A number of improvements made include:

- less forms and simpler claim lodgement process;
- increasing the rate of referral of injured workers with lost time injuries for injury management;
- ensuring all lost time claims are appropriately investigated and corrective action taken to mitigate any safety risks identified; and
- improving data collection in consultation with the insurer to improve performance monitoring.

Table 30: Workers' compensation claims

Employee category	Claims
Nursing Services/Dental Care Assistants	105
Administration and Clerical	20
Medical Support	18
Hotel Services	126
Maintenance	15
Medical (salaried)	5
Total	**289**

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

Substantive Equality

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

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

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

Occupational Safety & Health and Injury Management Performance

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

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

'All areas of WA Health will comply with or exceed OSH legal requirements, and continuously develop and implement safe systems and work practices that reflect its commitment to safety and health'.
(Source: WA Health OSH Policy 2007)

WA Country Health Service is committed to assisting injured workers to return to work as soon as medically appropriate and adheres to the requirements of the *Workers Compensation and Injury Management Act 198*1 in the event of a work related injury or illness.

All WACHS safety and injury management policies are available to staff on-line.

WACHS' regional Occupational Safety and Health Committees are a formal part of the consultative process with employees on OSH matters. Membership is stipulated in an agreed terms of reference and is consistent with the *OSH Act 1984*. Supporting policies and procedures further support the WACHS Safety Management System, including a formal OSH issue resolution procedure

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 the WACHS orientation days.

The WACHS IMS is implemented through:

- Workers compensation staff in each region who ensure that injured employees receive their entitlements and are referred for injury management intervention; and
- three 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.
(Source: WACHS Injury Management Policy and procedure, 2006)

WACHS regions are subject to an external review of their safety systems under the Safe Practice and Environment (SPE) standard of the Australian Council on Healthcare Standards (ACHS) EQuIP 4 quality improvement program.

Regions currently conduct annual self-assessments of their safety management system using the ACHS SPE criteria:

- safety management systems ensure safety and wellbeing for consumers/ patients, staff, visitors and contractors; and
- regions are required to submit a documented self-assessment of findings and improvement actions, and are subject to periodic review and formal audit by accredited ACHS surveyors within the accreditation cycle.

ACHS accreditation is attained only if performance for this indicator is rated at the mandatory level of performance of Moderate Achievement (MA). Accreditation, once

awarded, remains valid for up to four years, subject to annual performance improvement and a two yearly periodic review of mandatory criteria.

The newly development SMS has replaced regional systems and full implementation is scheduled for completion in 2010. Annual self-assessments are being integrated with existing EQuIP self-assessments to maximise improvement opportunities.

WACHS has identified 154 sites or business units across rural and remote Western Australia that requires an annual self-assessment, and has made excellent progress in supporting the existing EQuIP Safe Practice and Environment external assessments of its safety management system with site or business unit specific self assessments. To date 41 per cent of all sites or business units (63) are using the WorkSafe Plan with documented findings as outlined below:

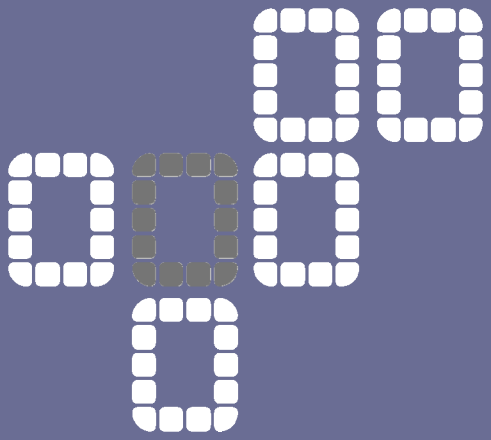
Table 31: Use and Assessment of Worksafe plan

Region	Number of regional sites or entities to be assessed using WorkSafe Plan	Number of documented WorkSafe Plan self-assessments completed
Goldfields	30	14
Great Southern	8	1
Kimberley	12	10
Midwest	12	10
Pilbara	17	17
South West	40	10
Wheatbelt	35	1
Total	**154**	**63**

Table 32: Occupational safety and health and injury management performance

Fatalities	Lost time injury/disease incidence rate	Lost time injury/disease incidence rate	Percentage of injured workers returned to work within 28 weeks	Percentage of managers trained in OSH and injury management responsibilities
0	2.71	19.08	84.1*	Not available

Note
*For the period 1 Jan 2008 to 31 December 2008



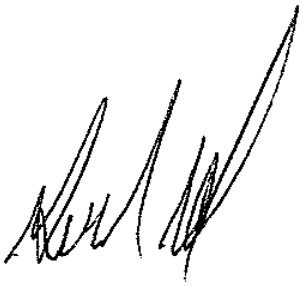
Financial Statements

Certification Statement

WA COUNTRY HEALTH SERVICE
CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2009

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 represent fairly the financial transactions for the financial year ending 30 June 2009 and financial position as at 30 June 2009.

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



Brett Roach
Acting Chief Finance Officer
Department of Health

Date: 17 September 2009

Dr Peter Flett
Accountable Authority
Department of Health

Date: 17 September 2009

Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2009

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

The financial statements comprise the Balance Sheet as at 30 June 2009, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

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

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer www.audit.wa.gov.au/pubs/AuditPracStatement_Feb09.pdf.

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

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 2009

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 2009 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

(ii) the controls exercised by the 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 2009.

COLIN MURPHY
AUDITOR GENERAL
21 September 2009

Financial Statements

WA Country Health Service

Income Statement

For the year ended 30 June 2009

	Note	2009 $000	2008 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	532,253	475,152
Fees for visiting medical practitioners		51,681	47,190
Patient support costs	8	127,903	101,281
Finance costs	9	1,766	1,705
Depreciation and amortisation expense	10	28,831	27,120
Loss on disposal of non-current assets	11	-	331
Repairs, maintenance and consumable equipment	12	24,080	23,404
Other expenses	13	72,841	70,142
Total cost of services		**839,355**	**746,325**
INCOME			
Revenue			
Patient charges	14	29,203	28,628
Commonwealth grants and contributions	15a	18,330	15,912
Other grants and contributions	15b	5,798	7,068
Donations revenue	16	1,007	963
Interest revenue		141	143
Other revenues	17	16,857	16,952
Total revenue		71,336	69,666
Gains			
Gain on disposal of non-current assets	11	12	-
Total income other than income from State Government		**71,348**	**69,666**
NET COST OF SERVICES		**768,007**	**676,659**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	746,637	679,068
Assets assumed / (transferred)	19	7,321	(3,521)
Liabilities assumed by the Treasurer	20	-	817
Royalties for Regions Fund	21	4,174	-
Total income from State Government		**758,132**	**676,364**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(9,875)**	**(295)**

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

WA Country Health Service

Balance Sheet

As at 30 June 2009

	Note	2009 $000	2008 $000
ASSETS			
Current Assets			
Cash and cash equivalents	22	16,064	21,279
Restricted cash and cash equivalents	23	3,065	560
Receivables	24	12,282	13,678
Inventories	26	3,701	3,518
Other current assets	27	1,804	1,442
Total Current Assets		36,916	40,477
Non-Current Assets			
Amounts receivable for services	25	174,023	135,285
Property, plant and equipment	28	1,275,382	877,818
Intangible assets	30	121	74
Other non-current assets	31	6	6
Total Non-Current Assets		1,449,532	1,013,183
TOTAL ASSETS		**1,486,448**	**1,053,660**
LIABILITIES			
Current Liabilities			
Payables	32	58,644	54,227
Borrowings	33	10,000	1,603
Provisions	34	78,668	66,430
Other current liabilities	35	860	139
Total Current Liabilities		148,172	122,399
Non-Current Liabilities			
Borrowings	33	14,934	24,934
Provisions	34	14,087	12,841
Total Non-Current Liabilities		29,021	37,775
Total Liabilities		**177,193**	**160,174**
NET ASSETS		**1,309,255**	**893,486**
EQUITY			
Contributed equity	36	941,437	850,583
Reserves	37	386,807	52,017
Accumulated surplus/(deficiency)	38	(18,989)	(9,114)
TOTAL EQUITY		**1,309,255**	**893,486**

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 30 June 2009

	Note	2009 $000	2008 $000
Balance of equity at start of period		893,486	772,204
CONTRIBUTED EQUITY	36		
Balance at start of period		850,583	781,023
Capital contribution		91,656	69,560
Distributions to owners		(802)	-
Balance at end of period		**941,437**	**850,583**
RESERVES	37		
Asset Revaluation Reserve			
Balance at start of period		52,017	-
Gains/(losses) from asset revaluation		334,790	52,017
Balance at end of period		**386,807**	**52,017**
ACCUMULATED SURPLUS / (DEFICIENCY)	38		
Balance at start of period		(9,114)	(8,819)
Surplus/(deficit) for the period		(9,875)	(295)
Balance at end of period		**(18,989)**	**(9,114)**
Balance of equity at end of period		**1,309,255**	**893,486**
Total income and expense for the period (a)		324,915	51,722

(a) The aggregate net amount attributable to each category of equity is:

2009: deficit $9,875,000 plus gains from asset revaluation $334,790,000.

2008: deficit $295,000 plus gains from asset revaluation $52,017,000.

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 30 June 2009

	Note	2009 $000	2008 $000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		706,134	636,826
Capital contributions		85,233	56,774
Holding account drawdowns		-	1,569
Royalties for Regions Fund		6,674	-
Net cash provided by State Government	39c	798,041	695,169
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(271,991)	(229,460)
Employee benefits		(518,705)	(467,508)
GST payments on purchases	2(p)	(12,901)	(28,493)
Other payments		-	935
Receipts			
Receipts from customers		29,753	28,148
Commonwealth grants and contributions		18,330	15,912
Other grants and subsidies		5,904	6,569
Donations received		1,007	963
Interest received		141	144
GST receipts on sales	2(p)	1,498	2,529
GST refunds from taxation authority	2(p)	13,884	24,933
Other receipts		15,244	17,730
Net cash (used in) / provided by operating activities	39b	(717,836)	(627,599)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current physical assets		(83,043)	(64,799)
Proceeds from sale of non-current physical assets	11	129	740
Net cash (used in) / provided by investing activities		(82,914)	(64,058)
Net increase / (decrease) in cash and cash equivalents		(2,709)	3,511
Cash and cash equivalents at the beginning of period		21,838	18,327
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	39a	19,129	21,838

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 2009 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the 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 2009.

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

AASB Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities' requires transfers, other than as a result of a restructure of administrative arrangements, in the nature of equity contributions to be designated by the Government (the owner) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions. Capital contributions (appropriations) have been designated as contributions by owners by Treasurer's Instruction 955 'Contributions by Owners made to Wholly Owned Public Sector Entities' and have been credited directly to contributed equity.

Transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.
(See note 36 '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 28 'Property, plant and equipment' for further information on revaluations.

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

Asset Revaluation Reserve
The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets as described in note 28 'Property, plant and equipment'.

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

(f) Property, Plant and Equipment (continued)

In order to apply this policy, the following methods are utilised :

* Land - not depreciated
* Buildings - diminishing value
* Plant and equipment - diminishing value with a straight line switch

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

The assets' useful lives are reviewed 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. Intangible assets having a limited useful life are systematically amortised over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

In order to apply this policy, the following methods are utilised :

* Computer software - diminishing value with a straight line switch method

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

The assets' useful lives are reviewed annually. Expected useful lives for each class of intangible asset are:

Computer Software	5 years

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

(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.

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 three categories of financial instrument:

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

These have been disaggregated into the following classes:

Financial Assets
* Cash and cash equivalents
* Restricted cash and cash equivalents
* Receivables
* Amounts receivable for services
* Other non-current assets

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 (see note 32 'Payables') 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 25 '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 26 ' 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 24 'Receivables')

(p) Receivables (continued)

Change to accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST were assigned on the 1st December 2008 to the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals. This change in accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative.

(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 32 '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 33 '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 34 'Provisions'.

(i) 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 an 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.

(s) Provisions (continued)

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.

(ii) 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 34 'Provisions'.)

(t) Superannuation Expense

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

(a) Defined benefit plans - For 2007-08, the change in the unfunded employer's liability (i.e. current service cost and, actuarial gains and losses) assumed by the Treasurer in respect of current employees who 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 - For 2007-08, the movements (i.e. current service cost and, actuarial gains and losses) in the liabilities in respect of the Pension Scheme and the GSS transfer benefits were recognised as expenses. As these liabilities were assumed by the Treasurer (refer note 2(s)(i)), a revenue titled 'Liabilities assumed by the Treasurer' equivalent to the expense was recognised under Income from State Government in the Income Statement. *See note 20 'Liabilities assumed by the Treasurer'*. Commencing in 2008-09, the reporting of annual movements in these notional liabilities has been discontinued and is no longer recognised in the Income Statement.

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

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 50).

Note 3 Judgements made by management in applying accounting policies

Judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Buildings

A number of buildings that are located on the land of local government agencies have been recognised in the financial statements. The Health Service believes that, based on past experience, its occupancy in these buildings will continue to the end of their useful lives.

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 14.6%. 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 2008 that impacted on the Health Service:

Review of AAS 27 'Financial Reporting by Local Governments', AAS 29 'Financial Reporting by Government Departments' and AAS 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:

AASB 1004 'Contributions';

AASB 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]; and

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

The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and revised topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 do not apply to Statutory Authorities. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance, otherwise there is no financial impact.

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:

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

AASB Standards and Interpretations	
1048	'Interpretation and Application of Standards' (issued September 2008)
1049	'Whole of Government and General Government Sector Financial Reporting' (revised - October 2007)
1050	'Administered Items'
1051	'Land Under Roads'
1052	'Disaggregated Disclosures';
2007-2	'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1- 8
2008-10	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets [AASB 7 & AASB 139]'
2008-12	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets – Effective Date and Transition [AASB 7, AASB 139 & AASB 2008-10]'
2009-3	'Amendments to Australian Accounting Standards – Embedded Derivatives [AASB 139 & Interpretation 9]'
Interpretation 4	'Determining whether an Arrangement contains a Lease' (revised – February 2007)
Interpretation 12	'Service Concession Arrangements'
Interpretation 13	'Customer Loyalty Programmes'
Interpretation 14	AASB 119 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'
Interpretation 129	'Service Concession Arrangements: Disclosures'

Future impact of Australian Accounting Standards not yet operative

The 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:

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

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 53. The key services of the Health Service are:

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

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

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

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

Patient Transport
Patient transport services are those services provided by the Patient Assisted Travel Scheme (PATS). These services assist people living in rural or remote locations to access specialist services.

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

Aged and Continuing Care
Aged and continuing care services include:

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

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

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

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

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

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

Note 7 Employee benefits expense

	2009 $000	2008 $000
Salaries and wages (a)	437,377	392,624
Superannuation - defined contribution plans (b)	38,333	34,256
Superannuation - defined benefit plans (c) (d)	-	817
Annual leave and time off in lieu leave (e)	46,863	40,574
Long service leave (e)	9,680	6,881
	532,253	475,152

(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 20 'Liabilities assumed by the Treasurer'). Commencing in 2008-09, the reporting of notional superannuation expense and equivalent notional income has been discontinued.

(e) Includes a superannuation contribution component.

Employment on-costs expense is included at note 13 'Other expenses'. The employment on-costs liability is included at note 34 'Provisions'.

Note 8 Patient support costs

Medical supplies and services	40,983	40,593
Domestic charges	6,359	5,923
Fuel, light and power	14,587	13,656
Food supplies	8,680	8,002
Patient transport costs	23,998	20,457
Purchase of external services	33,296	12,650
	127,903	101,281

Note 9 Finance costs

Interest paid	1,766	1,705

Note 10 Depreciation and amortisation

Depreciation		
Buildings	20,953	19,506
Leasehold improvements	228	196
Computer equipment	174	206
Furniture and fittings	166	144
Motor vehicles	545	554
Medical equipment	5,558	5,216
Other plant and equipment	1,176	1,276
	28,800	27,098
Amortisation		
Intangible assets	31	22
	28,831	27,120

Note 11 Net gain / (loss) on disposal of non-current assets

Cost of disposal of non-current assets		
Property, plant and equipment	(117)	(1,071)
Proceeds from disposal of non-current assets:		
Property, plant and equipment	129	740
Net gain/(loss)	12	(331)

See note 28 'Property, plant and equipment'.

Note 12 Repairs, maintenance and consumable equipment	2009 $000	2008 $000
Repairs and maintenance	16,505	15,400
Consumable equipment	7,575	8,003
	24,080	23,403

Note 13 Other expenses

Communications	5,099	5,431
Computer services	991	741
Employment on-costs (a)	21,549	18,257
Insurance	3,015	2,851
Legal expenses	97	35
Motor vehicle expenses	5,085	4,976
Operating lease expenses	8,682	7,962
Printing and stationery	3,013	2,962
Rental of property	15,115	9,624
Doubtful debts expense	675	736
Purchase of external services	1,607	6,242
Other	7,913	10,326
	72,841	70,143

(a) Includes workers' compensation insurance, fringe benefit tax and staff development costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 34 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 14 Patient charges

Inpatient charges	21,209	20,454
Outpatient charges	7,994	8,174
	29,203	28,628

Note 15 Grants and contributions

a) Commonwealth grants and contributions		
Nursing homes	2,433	3,701
Grant for National Respite Carers Program	1,145	928
Grant for Regional Health Services	3,746	4,325
Grant for Community Aged Care Program	756	727
Grant for Primary Health Care Access Program - Kimberley	1,368	1,439
Grant for Carelink	326	355
Grant for Dept Veterans Affairs - Home & Domiciliary Care	140	133
Grant for Aged Care Training Program	220	250
Grant for Medical Specialists Outreach Assistance Program	658	52
Grant for Aboriginal Health	-	608
Office of Aboriginal and Torres Strait Islander Health - Wheatbelt	1,645	1,022
Customs	243	245
WA Alcohol and Drug Authority - Pilbara	36	(152)
Healthy for Life	1,159	1,074
Mobile Respite Program	142	112
Kimberley Paediatrics	-	152
Extended Specialist Training	35	100
Clever Networks	1,113	169
Respite for Young Carers and Carers of Young Disabled	513	-
Rheumatic Heart Disease Register	380	-
Respite Carers Centre	152	30
New Directions Mothers & Babies	372	-
Communicable Disease Program	234	-
Other	1,514	642
	18,330	15,912

Note 15 Grants and contributions (continued)	2009 $000	2008 $000
b) Other grants and contributions		
Disability Services Commission - Community Aids and Equipment Program	1,770	1,682
Grants for Medical Specialists Outreach Assistance Program	723	782
Great Southern GP Network - For Ante Natal Program & Office relocation	175	108
HealthWays	251	206
BHP Billiton	397	764
Dampier Peninsular Project	93	149
Pilbara Visiting Specialist Services Funding	354	480
Mt Gibson Iron	125	-
Telethon Funding	175	-
Mumabulunjin Aboriginal Corp	135	-
St John Ambulance - Rural Support Paramedic Pilot Project	111	-
Western Australian Centre for Rural and Remote Medicine	-	80
Bush Medivac - Dept of Industry	-	1,630
Regional Health Service Program	-	138
Other	1,489	1,049
	5,798	7,068

Note 16 Donations revenue

General public contributions	620	735
Hospital auxiliaries	55	98
Deceased estates	332	130
	1,007	963

Note 17 Other revenues

Services to external organisations	4,898	5,265
Use of hospital facilities	1,282	1,259
Rent from residential properties	445	294
Boarders' accommodation	4,508	3,702
Other	5,724	6,432
	16,857	16,952

Note 18 Service appropriations

Appropriation revenue received during the year		
Service appropriations	746,637	679,068

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:

- Transfer of remote clinical buildings from the Department of Health	7,068	(3,316)
- Transfer of Pathways home funding for equipment	253	(205)
Total assets assumed / (transferred)	7,321	(3,521)

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

Note 20 Liabilities assumed by the Treasurer

The following liabilities have been assumed by the Treasurer during the financial year:		
- Superannuation	-	817

In 2007-08 the assumption of the superannuation liability by the Treasurer was a notional income to match the notional superannuation expense reported in respect of current employees who were members of the Pension Scheme and current employees who had a transfer benefit entitlement under the Gold State Superannuation Scheme (The notional superannuation expense for 2007-08 is disclosed at note 7 'Employee Benefits Expense'). Commencing in 2008-09, the reporting of the notional superannuation expense and equivalent notional income has been discontinued.

	2009 $000	2008 $000
Note 21 Royalties for Regions Fund		
Regional Community Services Account	4,174	-

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

Note 22 Cash and cash equivalents

Cash on hand	169	170
Cash at bank - general	13,010	18,642
Cash at bank - donations	2,885	2,414
Other short - term deposits	-	53
	16,064	21,279

Note 23 Restricted cash and cash equivalents

Cash assets held for specific purposes		
- Bequests	565	560
- Royalties for Regions Fund - Regional Infrastructure and Headworks Account(a)	2,500	-
	3,065	560

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

(a) These unspent funds are committed to a project in the Pilbara region

Note 24 Receivables

Current		
Patient fee debtors	4,540	4,772
Other receivables	5,842	4,794
Less: Allowance for impairment of receivables	(1,304)	(986)
Accrued revenue	3,235	2,647
	12,313	11,227
GST receivable	(31)	2,451
	12,282	13,678

Reconciliation of changes in the allowance for impairment of receivables:

Balance at start of year	986	452
Doubtful debts expense recognised in the income statement	675	736
Amounts written off during the year	(358)	(202)
Amount recovered during the year	1	-
Balance at end of year	1,304	986

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 52 'Financial instruments'.

Note 25 Amounts receivable for services

Non-current	174,023	135,285

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 26 Inventories

Current		
Supply stores - at cost	1,614	1,666
Pharmaceutical stores - at cost	1,454	1,264
Engineering stores - at cost	633	588
	3,701	3,518

See note 2(o) 'Inventories'.

	2009 $000	2008 $000
Note 27 Other current assets		
Prepayments	1,804	1,442
Note 28 Property, plant and equipment		
Land		
At fair value (a)	152,898	109,918
	152,898	109,918
Buildings		
Clinical:		
At fair value	885,412	590,079
Accumulated depreciation	(902)	(2,421)
	884,510	587,658
Non-Clinical:		
At fair value	98,219	90,889
Accumulated depreciation	(78)	(544)
	98,141	90,345
Total land and buildings	1,135,549	787,921
Leasehold improvements		
At cost	1,044	945
Accumulated depreciation	(534)	(306)
	510	639
Computer equipment		
At cost	1,175	961
Accumulated depreciation	(613)	(446)
	562	515
Furniture and fittings		
At cost	2,062	1,874
Accumulated depreciation	(430)	(264)
	1,632	1,610
Motor vehicles		
At cost	3,094	1,915
Accumulated depreciation	(1,698)	(1,222)
	1,396	693
Medical equipment		
At cost	48,001	37,370
Accumulated depreciation	(16,349)	(10,906)
Accumulated impairment losses	(374)	(374)
	31,278	26,090
Other plant and equipment		
At cost	11,688	12,029
Accumulated depreciation	(3,728)	(2,591)
	7,960	9,438
Works in progress		
Buildings under construction (at cost)	95,918	50,551
Other Work in Progress (at cost)	505	289
	96,423	50,840
Art Works		
At cost	72	72
Total of property, plant and equipment	1,275,382	877,818

Note 28 Property, plant and equipment (continued)	2009 $000	2008 $000

(a) Land and buildings were revalued as at 1 July 2008 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2009 and recognised at 30 June 2009. In undertaking the revaluation, fair value was determined by reference to market values for land: $77,328,614 and buildings: $98,141,408. 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'.

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	109,918	71,659
Transfers from Work in Progress	-	98
Disposals	(3)	(234)
Transfer from/(to) other reporting entities	(802)	-
Revaluation increments / (decrements)	43,785	38,395
Carrying amount at end of year	152,898	109,918
Buildings		
Carrying amount at start of year	678,003	630,459
Additions	505	853
Transfers from Work in Progress	27,115	51,642
Disposals	(60)	(510)
Transfer from/(to) other reporting entities	7,068	(237)
Revaluation increments / (decrements)	291,005	13,622
Depreciation	(20,953)	(19,506)
Transfer between asset classes	(32)	1,680
Carrying amount at end of year	982,651	678,003
Leasehold improvements		
Carrying amount at start of year	639	720
Additions	1	-
Transfers from work in progress	98	115
Depreciation	(228)	(196)
Carrying amount at end of year	510	639
Computer equipment		
Carrying amount at start of year	515	516
Additions	112	150
Transfers from Work in Progress	17	58
Disposals	(2)	(8)
Depreciation	(174)	(206)
Transfer between asset classes	94	5
Carrying amount at end of year	562	515
Furniture and fittings		
Carrying amount at start of year	1,610	1,291
Additions	188	246
Transfers from Work in Progress	11	16
Transfer from/(to) other reporting entities	-	3
Depreciation	(166)	(144)
Transfer between asset classes	(11)	198
Carrying amount at end of year	1,632	1,610
Motor vehicles		
Carrying amount at start of year	693	963
Additions	1,254	230
Transfers from Work in Progress	-	85
Disposals	(6)	-
Depreciation	(545)	(554)
Transfer between asset classes	-	(31)
Carrying amount at end of year	1,396	693

Note 28 Property, plant and equipment (continued)	2009 $000	2008 $000
Medical equipment		
Carrying amount at start of year	26,090	23,187
Additions	9,208	5,735
Transfers from Work in Progress	176	1,033
Disposals	(88)	(256)
Transfer from/(to) other reporting entities	-	37
Depreciation	(5,558)	(5,216)
Transfer between asset classes	1,450	1,570
Carrying amount at end of year	31,278	26,090
Other plant and equipment		
Carrying amount at start of year	9,438	10,214
Additions	1,350	3,572
Transfers from Work in Progress	(2)	181
Disposals	(71)	(64)
Transfer from/(to) other reporting entities	-	233
Depreciation	(1,176)	(1,276)
Reclassification to Intangible Asset	(78)	-
Transfer between asset classes	(1,501)	(3,422)
Carrying amount at end of year	7,960	9,438
Works in progress		
Carrying amount at start of year	50,839	42,194
Additions	73,002	65,190
Transfers from Work in Progress	(27,415)	(53,229)
Disposals	(3)	-
Transfer from/(to) other reporting entities	-	(3,316)
Carrying amount at end of year	96,423	50,839
Art Works		
Carrying amount at start of year	72	66
Additions	-	6
Carrying amount at end of year	72	72
Total property, plant and equipment		
Carrying amount at start of year	877,817	781,269
Additions	85,620	75,981
Disposals	(233)	(1,072)
Transfer from/(to) other reporting entities	6,266	(3,280)
Revaluation increments / (decrements)	334,790	52,017
Depreciation	(28,800)	(27,098)
Reclassification of Intangible Assets	(78)	-
Carrying amount at end of year	1,275,382	877,818

Note 29 Impairment of Assets

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

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

Note 30 Intangible assets

Computer software		
At cost	204	126
Accumulated amortisation	(83)	(52)
	121	74

Note 30 Intangible assets (continued)	2009 $000	2008 $000
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	74	96
Reclassification from Other Plant and Equipment	78	-
Amortisation expense	(31)	(22)
Carrying amount at end of year	121	74

Note 31 Other non-current assets

Shares in Mount Barker Cooperative Ltd at cost	6	6

(See also note 2(k) 'Financial Instruments')

Note 32 Payables

Current		
Trade creditors	29,290	17,424
Accrued expenses	19,865	27,378
Accrued salaries	9,283	9,219
Accrued interest	206	206
	58,644	54,227

(See also note 2(q) 'Payables' and note 52 'Financial instruments')

Note 33 Borrowings

Current		
Western Australian Treasury Corporation loans (a)	8,913	564
Department of Treasury and Finance loans (b)	1,087	1,039
	10,000	1,603
Non-current		
Western Australian Treasury Corporation loans (a)	-	8,913
Department of Treasury and Finance loans (b)	14,934	16,021
	14,934	24,934
Total borrowings	24,934	26,537

(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.

Note 34 Provisions

Current		
Employee benefits provision		
Annual leave (a)	41,847	35,695
Time off in lieu leave (a)	13,799	11,858
Long service leave (b)	21,224	17,378
Gratuities	1,593	1,119
Deferred salary scheme	205	380
	78,668	66,430
Non-current		
Employee benefits provision		
Long service leave (b)	12,917	12,191
Gratuities	345	299
Deferred salary scheme	825	351
	14,087	12,841
Total Provisions	92,755	79,271

Note 34 Provisions (continued)

	2009 $000	2008 $000
(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	39,926	31,672
More than 12 months after balance sheet date	15,720	15,881
	55,646	47,553
(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	7,276	6,437
More than 12 months after balance sheet date	26,865	23,132
	34,141	29,569

(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.

Note 35 Other liabilities

Current		
Income received in advance	152	47
Other	708	92
	860	139

Note 36 Contributed equity

Equity represents the residual interest in the net assets of the Health Service. The Government holds the equity interest in the Health Service on behalf of the community. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets (note 37).

Balance at start of the year	850,583	781,023
Contributions by owners		
Capital contributions (b)	89,156	69,560
Other contributions by owners:		
Royalties for Regions Fund – Regional Infrastructure and Headworks Accoun	2,500	-
Total contributions by owners	91,656	69,560
Distributions to owners		
Transfer of net assets to other agencies (a) (c)	(802)	-
Balance at end of year	941,437	850,583

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

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

(c) Under TI 955, non-discretionary (non-reciprocal) transfers of net assets between State government agencies have been designated as contributions by owners in accordance with AASB Interpretation 1038, where the transferee agency accounts for a non-discretionary (non-reciprocal) transfer of net assets as a contribution by owners and the transferor agency accounts for the transfer as a distribution to owners.

Note 37 Reserves

Asset revaluation reserve (a)		
Balance at start of year	52,017	-
Net revaluation increments / (decrements) (b) :		
Land	43,785	38,395
Buildings	291,005	13,622
Balance at end of year	386,807	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.

Note 38 Accumulated surplus/(deficiency)	2009 $000	2008 $000
Balance at start of year	(9,114)	(8,819)
Result for the period	(9,875)	(295)
Balance at end of year	(18,989)	(9,114)

Note 39 Notes to the Cash Flow Statement

a) **Reconciliation of cash**

Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:

Cash and cash equivalents (see note 22)	16,064	21,279
Restricted cash and cash equivalents (see note 23)	3,065	560
	19,129	21,838

b) **Reconciliation of net cost of services to net cash flows used in operating activities**

Net cash used in operating activities (Cash Flow Statement)	(717,836)	(627,599)
Increase/(decrease) in assets:		
GST receivable	(2,482)	96
Other current receivables	1,404	830
Inventories	183	(63)
Prepayments	363	1,021
Decrease/(increase) in liabilities:		
Doubtful debts provision	(318)	(534)
Payables	(4,417)	(13,687)
Current provisions	(12,238)	(6,131)
Non-current provisions	(1,246)	(656)
Income received in advance	(106)	499
Other liabilities	(615)	(153)
Non-cash items:		
Depreciation and amortisation expense (note 10)	(28,831)	(27,120)
Net gain / (loss) from disposal of non-current assets (note 11)	12	(331)
Interest paid by Department of Health	(1,766)	(1,718)
Superannuation liabilities assumed by the Treasurer (note 20)	-	(817)
Adjustment for other non-cash items	(114)	(296)
Net cost of services (Income Statement)	(768,007)	(676,659)

c) **Notional cash flows**

Service appropriations as per Income Statement	746,637	679,068
Royalties for Regions Fund	6,674	-
Capital contributions credited directly to Contributed Equity (Refer Note 36)	89,156	69,560
Holding account drawdowns credited to Amounts Receivable for Services (Refer Note 25)	-	1,569
	842,467	750,197
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	(629)	(640)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(564)	(551)
Interest paid to Department of Treasury & Finance	(1,137)	(1,078)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(1,039)	(996)
Accrual appropriations	(38,737)	(40,524)
Capital works expenditure	(2,320)	(11,239)
	(44,426)	(55,028)
Cash Flows from State Government as per Cash Flow Statement	798,041	695,169

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 40 Revenue, public and other property written off or presented as gifts	2009 $000	2008 $000
a) Revenue and debts written off under the authority of the Accountable Authority.	404	329
b) Public and other property written off under the authority of the Accountable Authority.	101	22
	505	351

Note 41 Losses of public moneys and other property

Losses of public moneys and public or other property through theft or default	-	3

Note 42 Resources provided free of charge

During the year there were no resources provided to other agencies free of charge for functions outside the normal operations of the Health Service.

Note 43 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:

	2009	2008
$170,001 - $180,000	-	1
$500,001 - $510,000	-	1
$610,000 - $620,000	1	-
Total	1	2

	$000	$000
The total remuneration of members of the Accountable Authority is:	619	683

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

The total remuneration includes the superannuation expense incurred by the Health Service in respect of the members of the Accountable Authority.

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:

$20,001 - $30,000	1	-
$30,001 - $40,000	1	-
$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
$100,001 - $110,000	2	-
$110,001 - $120,000	1	1
$130,001 - $140,000	1	1
$140,001 - $150,000	3	1
$150,001 - $160,000	-	3
$160,001 - $170,000	1	1
$170,001 - $180,000	1	2
$190,001 - $200,000	1	-
$310,001 - $320,000	1	-
$320,001 - $330,000	-	1
$340,001 - $360,000	2	-
Total	16	16

	$000	$000
The total remuneration of senior officers is:	2,587	2,157

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.

There are no senior officers presently employed who are members of the Pension Scheme.

	2009 $000	2008 $000
Note 44 Remuneration of auditor		
Remuneration payable to the Auditor General in respect to the audit for the current financial year is as follows:		
Auditing the accounts, financial statements and performance indicators	610	620

Note 45 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	75,836	117,401
Later than 1 year, and not later than 5 years	116,495	72,879
	192,331	190,280
The capital commitments include amounts for:		
- Buildings	191,928	189,626

The capital expenditure commitments are all inclusive of GST.

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	12,392	8,219
Later than 1 year, and not later than 5 years	13,622	10,009
Later than 5 years	82	40
	26,096	18,268

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	2,021	567
Later than 1 year, and not later than 5 years	2,833	166
	4,854	733

The other expenditure commitments are all inclusive of GST.

Note 46 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.	8,805	9,700
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.

During the year the Health Service reported 4 suspected contaminated site to DEC. These sites have yet to be classified. 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 Contingent liabilities and contingent assets (continued)

Contingent Assets

At the balance sheet date, the Health Service is not aware of any contingent assets.

Note 47 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 48 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.

Note 49 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 50 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.

	2009 $000	2008 $000
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	807	690
Add Receipts	1,721	1,761
	2,528	2,452
Less Payments	(1,829)	(1,645)
Closing Balance	699	807
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	203	204
Add Receipts	103	154
	306	358
Less Payments	(148)	(155)
Closing Balance	158	203
c) Other trust accounts - not controlled by the Health Service		
Staff Development and Diabetes Education Fund		
Opening Balance	4	4
Add Receipts	-	-
	4	4
Less Payments	-	-
Closing Balance	4	4

Notes to the Financial Statements
For the year ended 30 June 2009

Note 51 Explanatory Statement

(A) Significant variances between actual results for 2008 and 2009

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	2009 Actual $000	2008 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	532,253	475,152	57,101
Fees for visiting medical practitioners	(b)	51,681	47,190	4,491
Patient support costs	(c)	127,903	101,281	26,622
Finance costs		1,766	1,705	61
Depreciation and amortisation expense		28,831	27,120	1,711
Loss on disposal of non-current assets	(d)	-	331	(331)
Repairs, maintenance and consumable equipment		24,080	23,404	677
Other expenses		72,841	70,142	2,699
Income				
Patient charges		29,203	28,628	575
Commonwealth grants and contributions	(e)	18,330	15,912	2,418
Other grants and contributions	(f)	5,798	7,068	(1,270)
Donations revenue		1,007	963	44
Interest revenue		141	143	(2)
Other revenues		16,857	16,952	(95)
Gain on disposal of non-current assets	(r)	12	-	12
Service appropriations	(g)	746,637	679,068	67,569
Assets assumed / (transferred)	(h)	7,321	(3,521)	10,842
Liabilities assumed by the Treasurer	(i)	-	817	(817)
Royalties for Regions Fund		4,174	-	4,174

(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 ($36m);
(ii) the impact on employee benefits of expenses resulting from FTE increases across WACHS during 2008/09, including agency nursing and locum medical services ($24m).

(b) Fees for visiting medical practitioners
Fees for visiting medical practitioners have increased due to the combined effect of indexation of the fees schedule and significant increases in admitted and non admitted patient activity during 2008/09.

(c) Patient support costs
Patient support costs have increased significantly due to increases in patient activity across country Western Australia, together with escalating costs for goods and services including food, drugs, patient supplies and patient transport, particularly in regions experiencing high levels of economic activity.

(d) Loss on disposal of non-current assets
No significant losses or surpluses were incurred on asset disposals during the 2008/09 financial year.

(e) Commonwealth grants and contributions
Commonwealth Grants and Contributions are often received for specific and/or non recurrent programs and, consequently are variable from year to year. Changes in Commonwealth Grants and Contributions are detailed at Note 15(a).

(f) Other grants and contributions
Other Grants and Contributions are often received for specific and/or non recurrent programs and, consequently are variable from year to year. Changes in Other Grants and Contributions are detailed at Note 15(b).

(g) Service appropriations
The increase in Service Appropriations in 2008/09 supports increases in employment benefits and other operating costs resulting from increases in industrial awards and agreements, regional cost pressures, particularly in areas of high economic activity, and increases in activity.

(h) Assets assumed / (transferred)
Seven regional and remote community and Aboriginal health clinics were assumed by WA Country Health Service from the Department of Health during 2008/09 ($7.3m).

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2009

Note 51 Explanatory Statement (continued)

(i) Liabilities assumed by the Treasurer

In 2007/08 WA Country Health Service incurred a charge of $817,000 for the old pension scheme liability. Charges for pension superannuation liability are not recognised in WA Country Health Service accounts in 2008/09, consequently there is no notional subsidy for liabilities assumed by the Treasurer.

(B) Significant variations between estimates and actual results for 2009

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	2009 Actual $000	2009 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense	(a)	532,253	478,641	53,612
Other goods and services		307,102	281,106	25,996
Total expenses		839,355	759,747	79,608
Less: Revenues	(b)	(71,348)	(62,367)	(8,981)
Net cost of services		768,007	697,380	70,627

(a) Employee benefits expense

The variance in employee benefits is attributable to cost of award increases in excess of initial budget estimates ($12m) and various continuing and new services for which funding was not included in the initial budget but was the subject of subsequent budget adjustments ($40m).

(b) Revenues

The variance in revenues is largely due to the 2008/09 budget estimate not having fully factored in growth in revenues that had been achieved in 2007/08 and maintained into 2008/09.

Note 52 Financial instruments

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

Financial instruments held by the 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 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 52(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. At balance sheet date, there were no significant concentrations of credit risk.

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to Note 52(c) Financial Instruments Disclosures.

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

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
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instrument. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. 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 and are at fixed rates

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 52(c), the Health Service is not exposed to interest rate risk because apart from minor amounts of restricted cash, all other cash and cash equivalents and restricted cash are non-interest bearing and have no borrowings other than the borrowings from the Department of Treasury and Finance and WATC borrowings.

b) **Categories of Financial Instruments**

In addition to cash and bank overdraft, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows :

	2009 $000	2008 $000
Financial Assets		
Cash and cash equivalents	16,064	21,279
Restricted cash and cash equivalents	3,065	560
Other non-current assets	6	6
Loans and receivables (a)	186,336	146,513
Financial Liabilities		
Financial liabilities measured at amortised cost	83,578	80,763

(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 30 June 2009

c) **Financial Instrument disclosures**

Credit Risk and Interest Rate Risk Exposures

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

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

The Health Service does not hold any financial assets that had to have their terms renegotiated that would have otherwise resulted in them being past due or impaired.

Interest rate exposures and ageing analysis of financial assets

			Interest rate exposure			Past due but not impaired					
	Weighted average effective interest rate	Carrying amount	Variable interest rate	Fixed interest rate	Non-interest bearing	Up to 12 months	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Assets											
2009											
Cash and cash equivalents	0.5%	16,064	2,445	44	13,575						
Restricted cash and cash equivalents	9.1%	3,065	3,065			-					
Other non-current assets	0.0%	6			6						
Receivables (a)		12,313			12,313	5,237	907				
Amounts receivable for services		174,023			174,023						
		205,471	5,510	44	199,917	5,237	907	-	-	-	-
2008											
Cash and cash equivalents	0.5%	21,279	1,951	96	19,232						
Restricted cash and cash equivalents	6.8%	560	560								
Other non-current assets	0.0%	6			6						
Receivables (a)		11,227			11,227	4,046	646				
Amounts receivable for services		135,286			135,286						
		168,358	2,511	96	165,751	4,046	646	-	-	-	-

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

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

Liquidity Risk

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

Interest rate exposures and maturity analysis of financial liabilities

			Interest rate exposure		Maturity dates						
	Weighted average effective interest rate	Carrying amount	Variable interest rate	Non-interest bearing	Up to 3 months	3-12 months	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years
	%	$000	$000	$000	$000	$000	$000	$000	$000	$000	$000
Financial Liabilities											
2009											
Payables		58,644		58,644	58,644						
Borrowings											
- WA Treasury Corporation loans	5.3%	8,913	8,913		8,913		-	-	-	-	-
- Department of Treasury & Finance loans	6.9%	16,021	16,021		272	814	1,137	1,192	1,244	1,301	10,061
		83,578	24,934	58,644	67,829	814	1,137	1,192	1,244	1,301	10,061
2008											
Payables		54,227		54,227	54,227						
Borrowings											
- WA Treasury Corporation loans	6.4%	9,476	9,476		141	423	576	589	603	616	6,528
- Department of Treasury & Finance loans	6.1%	17,060	17,060		260	779	1,087	1,137	1,192	1,244	11,361
		80,763	26,536	54,227	54,628	1,202	1,663	1,726	1,795	1,860	17,889

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 30 June 2009

c) **Financial Instrument disclosures (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	
	Carrying Amount	Profit	Equity	Profit	Equity
2009	$000	$000	$000	$000	$000
Financial Assets					
Cash and cash equivalents	16,064	(25)	(25)	25	25
Restricted cash and cash equivalents	3,065	(31)	(31)	31	31
Financial Liabilities					
Borrowings					
- WA Treasury Corporation loans	8,913	89	89	(89)	(89)
- Department of Treasury & Finance	16,021	160	160	(160)	(160)
Total Increase/(Decrease)		193	193	(193)	(193)

		-1% change		+1% change	
	Carrying Amount	Profit	Equity	Profit	Equity
2008	$000	$000	$000	$000	$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					
- WA 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)

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 30 June 2009

Note 53 Schedule of Income and Expenses by Services

	Admitted Patient		Specialised Mental Health		Palliative Care		Non-Admitted Patients		Patient Transport	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	250,680	223,707	9,002	6,713	1,299	1,053	111,852	97,178	13,341	11,017
Fees for visiting medical practitioners	33,917	30,256	38	65	14	5	15,466	14,355	23	68
Patient support costs	60,240	47,684	2,163	1,431	312	224	26,879	20,714	3,206	2,348
Finance costs	832	803	30	24	4	4	371	349	44	40
Depreciation and amortisation expense	13,578	12,767	488	383	70	60	6,059	5,547	723	629
Loss on disposal of non-current assets	-	156	-	5	-	1	-	68	-	8
Repairs, maintenance and consumable equipment	11,341	11,019	407	331	59	52	5,060	4,786	604	543
Other expenses	34,307	33,025	1,232	991	178	155	15,307	14,346	1,826	1,626
Total cost of services	404,895	359,417	13,360	9,943	1,936	1,554	180,994	157,343	19,767	16,279
INCOME										
Revenue										
Patient charges	15,156	14,196	123	95	53	47	8,776	8,665	153	145
Commonwealth grants and contributions	1,167	764	2	10	1	2	779	458	811	122
Other grants and contributions	986	903	2	7	16	53	2,118	1,240	124	24
Donations revenue	458	453	6	14	1	2	245	197	6	22
Interest revenue	64	68	1	2	-	-	34	29	1	3
Other revenues	7,669	7,981	98	239	19	38	4,106	3,467	101	393
Gains										
Gain on disposal of non-current assets	6	-	-	-	-	-	3	-	-	-
Total income other than income from State Government	25,506	24,365	232	367	90	142	16,061	14,056	1,196	709
NET COST OF SERVICES	**379,389**	**335,052**	**13,128**	**9,576**	**1,846**	**1,412**	**164,933**	**143,287**	**18,571**	**15,570**
INCOME FROM STATE GOVERNMENT										
Service appropriations	374,125	336,289	12,941	9,606	1,820	1,415	162,702	143,824	14,218	15,620
Assets assumed / (transferred)	-	(1,744)	-	(50)	-	(7)	-	(746)	-	(81)
Liabilities assumed by the Treasurer	-	405	-	12	-	2	-	173	-	19
Royalties for Regions Fund	-	-	-	-	-	-	-	-	4,174	-
Total income from State Government	374,125	334,950	12,941	9,568	1,820	1,410	162,702	143,251	18,392	15,558
SURPLUS/(DEFICIT) FOR THE PERIOD	**(5,264)**	**(101)**	**(187)**	**(8)**	**(26)**	**(2)**	**(2,231)**	**(36)**	**(179)**	**(12)**

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

WA Country Health Service

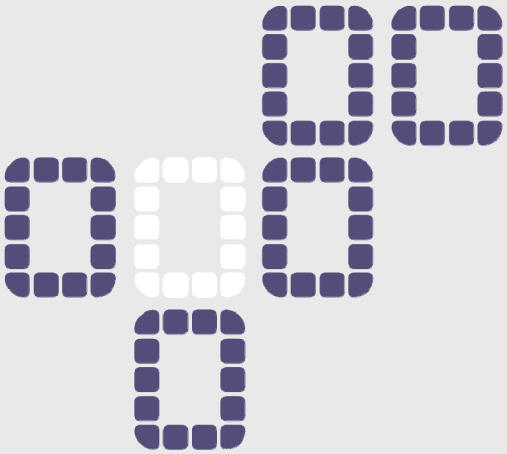
Notes to the Financial Statements

For the year ended 30 June 2009

Note 53 Schedule of Income and Expenses by Services (continued)

	Prevention, Promotion & Protection		Aged & Continuing Care		Community Mental Health		Residential Care		Total	
	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000	2009 $000	2008 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	55,105	50,889	15,250	14,147	23,210	21,273	52,514	49,175	532,253	475,152
Fees for visiting medical practitioners	203	210	89	203	672	850	1,259	1,178	51,681	47,190
Patient support costs	13,242	10,847	3,665	3,015	5,577	4,535	12,619	10,483	127,903	101,281
Finance costs	183	183	51	51	77	75	174	176	1,766	1,705
Depreciation and amortisation expense	2,985	2,905	826	808	1,257	1,214	2,845	2,807	28,831	27,120
Loss on disposal of non-current assets	-	34	-	10	-	15	-	34	-	331
Repairs, maintenance and consumable equipment	2,493	2,507	690	697	1,050	1,048	2,376	2,422	24,080	23,404
Other expenses	7,541	7,513	2,087	2,088	3,176	3,140	7,187	7,259	72,841	70,142
Total cost of services	81,752	75,088	22,658	21,019	35,019	32,150	78,974	73,534	839,355	746,325
INCOME										
Revenue										
Patient charges	110	355	2	41	-	216	4,830	4,868	29,203	28,628
Commonwealth grants and contributions	8,466	8,679	3,797	4,320	651	871	2,656	686	18,330	15,912
Other grants and contributions	1,943	2,528	184	34	332	242	93	2,037	5,798	7,068
Donations revenue	84	103	50	29	51	43	106	100	1,007	963
Interest revenue	12	15	7	5	7	6	15	15	141	143
Other revenues	1,413	1,816	843	504	854	760	1,754	1,754	16,857	16,952
Gains										
Gain on disposal of non-current assets	1	-	-	-	1	-	1	-	12	-
Total income other than income from State Government	12,029	13,496	4,883	4,933	1,896	2,138	9,455	9,460	71,348	69,666
NET COST OF SERVICES	**69,723**	**61,592**	**17,775**	**16,086**	**33,123**	**30,012**	**69,519**	**64,074**	**768,007**	**676,659**
INCOME FROM STATE GOVERNMENT										
Service appropriations	61,851	61,783	17,661	16,137	32,689	30,112	68,630	64,282	746,637	679,068
Assets assumed / (transferred)	7,321	(320)	-	(83)	-	(156)	-	(334)	7,321	(3,521)
Liabilities assumed by the Treasurer	-	74	-	19	-	36	-	77	-	817
Royalties for Regions Fund	-	-	-	-	-	-	-	-	4,174	-
Total income from State Government	69,172	61,537	17,661	16,073	32,689	29,992	68,630	64,025	758,132	676,364
SURPLUS/(DEFICIT) FOR THE PERIOD	**(551)**	**(55)**	**(114)**	**(13)**	**(434)**	**(20)**	**(889)**	**(49)**	**(9,875)**	**(295)**

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



Appendices

Appendix 1: Abbreviations

ACAT	Aged Care Assessment Team
ACHS	Australian Council on Health Care Standards
AHCA	Australian Healthcare Agreement
APGAR	Appearance Pulse Grimace Activity Respiration
AMI	Acute myocardial infarction
BI	Brief Intervention
BSWA	BreastScreen WA
CPI	Consumer Price Index
COAG	Council of Australian Governments
DAIP	Disability Access and Inclusion Plan
DG	Director General of Health
DHAC	District Health Advisory Councils
DOH	Department of Health
DSC	Disability Services Commission
ED	Emergency Department
ECG	Electrocardiogram
EN	Enrolled Nurse
FMA	*Financial Management Act 2006*
FNOF	Fractured Neck of Femur
FTE	Full Time Equivalent
GBS	Government Budget Statement
GP	General Practitioner
HACC	Home and Community Care
HCARe	Health Care And Related Information System
HCN	Health Corporate Network
HIN	Health Information Network
ICT	Information Communications Technology
IMS	Injury Management System
KPI	Key Performance Indicators
MER	Medical Emergency Response
MeRITS	Medical Record Information Tracking System
MHS	Metropolitan Health Service
MPC	Multi-purpose Centre
MPS	Multi-purpose Service

NPA	National Partnership Agreement
OAH	Office of Aboriginal Health
OPSSC	Office of the Public Sector Standards Commissioner
OSH	Occupational Safety and Health
PACS	Primary Allocation Centres
PATS	Patient Assisted Travel Scheme
PID	Public Interest
PLS	Paediatric Life Support
OPI	Older Patient Intiative
PMCWA	Post Graduate Medical Council of WA
PYLL	Person Years of Life Lost
RFDSWO	Royal Flying Doctors Service (Western Operations)
RN	Registered Nurse
RTO	Registered Training Organisation
SARC	Sexual Assault Resource Centre
SHRAC	State Health Research Advisory Committee
SMS	Safety Management System
SPE	Safe Practice and Environment
SQuIRe	Safety and Quality Investment in Reform
StJAA	St John Ambulance Association
STI	Sexually Transmitted Infection
TAFE	Technical and Further Education
TI	Treasurer's Instruction
UWA	University of Western Australia
WACHS	WA Country Health Service
WASPET	WA General Practice Education and Training

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Produced by the Information Management and Reporting Directorate

HP11366 June'09 24004