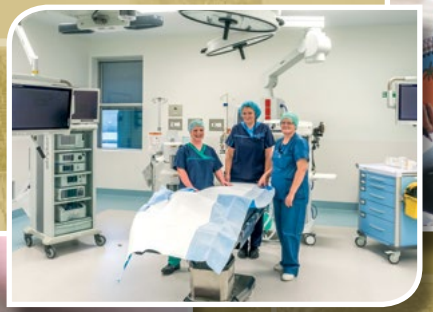
Government of **Western Australia**
WA Country Health Service

WA Country Health Service
Annual Report 2015–16



better health • better care • better value

WA Country Health Service
Annual Report 2015–16

WA Country Health Service

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Statement of compliance

HON MR JOHN DAY BSc BDSc MLA
MINISTER FOR HEALTH

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the final Annual Report of the WA Country Health Service for the financial year ended 30 June 2016.

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

As on 1 July 2016, the WA Country Health Service as it was previously constituted under the *Hospital and Health Services Act 1927* section 15 was abolished and the Minister for Health ceased to have management and control of any hospital in the WA Country Health Service. This report is submitted, signed by the Reporting Officer, Dr David Russell-Weisz, Director General of the Department of Health, as appointed by the Treasurer under section 68(1) of the *Financial Management Act 2006*.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

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Overview of agency

Vision statement

Vision

To deliver a safe, high quality, sustainable health system for all Western Australians.

Values

WA Health's Code of Conduct identifies the values that we hold as fundamental in our work and describes how these values translate into action.

Our values are:

Priorities

Our strategic priorities are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.

Ensuring people in Western Australia receive safe, high quality and accessible health services underpins our strategic priorities. This includes delivering health services that are patient centred, based on evidence and within a culture of continuous improvement:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services.

WACHS executive summary

The WA Country Health Service (WACHS) is the largest country health service in Australia and one of the biggest in the world. It delivers a range of comprehensive health services across a 2.5 million square kilometre area to more than 547,000 people, including an estimated 55,522 Aboriginal people.

The breadth and scope of WACHS is vast, with services being planned and delivered for a diverse and sprawling population with widely varying health needs. A highly transient population of tourists and fly-in-fly-out workers also exists in many of its regions.

Across the 71 hospitals and 27 nursing posts that reported emergency activity in the past year, WACHS managed around 40 per cent of the State's emergency presentations despite having only 21 per cent of WA's population. In addition, WACHS supported 80 per cent as many births as the State's major maternity hospital, King Edward Memorial Hospital. As well as the many country hospitals, there are also a number of smaller health centres and 27 nursing and remote nursing posts providing health and nurse-led emergency services spread across country WA.

The range of health services provided by WACHS includes emergency and hospital services, population, public and primary health care, mental health, drug and alcohol services, Aboriginal health, child and community health, and residential and community aged care services.

The *WACHS Strategic Directions 2015–2018: Healthier Country Communities through Partnerships and Innovation* was launched early in the financial year and builds on the achievements of the past decade. It aligns to the *WA Health Strategic Intent 2015–2020* and *WA Health Reform Program 2015–2020: Better Health, Better Care, Better Value*. Priorities for WACHS continue to be Aboriginal health, maternal and child health, health promotion, disease control, mental health, drug and alcohol issues, acute and sub-acute care, hospital infrastructure development and community and residential aged care. Timely access to services and improving the quality and safety of health care delivery also remain priorities.

Infrastructure

In the most ambitious health infrastructure building program ever undertaken in country WA, more than 80 projects totalling more than $1.5 billion in capital works projects are underway or have been completed recently in regional Western Australia. These are transforming the way health care is delivered to local communities.

In regional cities and large towns, emergency, inpatient and outpatient services are being brought together with other important health services in modern, functional buildings to create health care hubs. In smaller towns and districts, emergency, hospitals and health centres are being modernised with upgraded facilities and telehealth services providing access to top emergency medical specialists when required.

Some of the key infrastructure projects during the year included the opening of new developments for Esperance and Carnarvon, completion of the Exmouth Health Service, extensive upgrades to the emergency department at Broome Health Campus and the finalisation of all clinical works at Kalgoorlie Health Campus.

As part of the half-a-billion dollar Southern Inland Health Initiative (SIHI) program, funded by the Royalties for Regions program, upgrades transforming sites in the Wheatbelt, Great Southern, South West and Midwest into contemporary, integrated health services have been completed. Works have commenced on the Collie Health Service Redevelopment, with constructed works expected to start on the Katanning Health Service and Warren Health Service redevelopments in August and September 2016, respectively. Other district hospital projects including Merredin and Narrogin are out to tender, as is the Primary Health Care Demonstration site at Pingelly.

Construction works have been completed at the small hospital/nursing post sites of Gnowangerup, Kojonup, Tambellup and Wagin, with tenders out to market for Moora, Jurien Bay, Southern Cross, Beverley, Dalwallinu, York and Wongan Hills.

The $13 million redevelopment of Harvey Health Service is progressing. When completed in 2017, the extended range of services will include a new emergency department and treatment room, improved facilities for community-based health services and improved outpatient facilities.

The $207.15 million Karratha Health Campus is the biggest investment in a public hospital in regional WA. It will have an expanded emergency department, a brand new surgical centre, state-of-the-art CT scanner, new delivery suites and maternity wing, world-class telehealth services and expanded outpatients and essential services. The design phase is now underway, with construction expected to commence in the second half of 2016, and completion due in 2018.

Southern Inland Health Initiative

The Southern Inland Health Initiative (SIHI), which commenced on 1 July 2011, comprises a capital works program and a health workforce and health services improvement program. It represents the State's biggest investment in regional health care in WA history.

Since the SIHI program began, more doctors have been attracted and retained in the SIHI catchment area to provide medical services, both in the community and the local emergency departments. Also, the introduction of the Premier's Award-winning Emergency Telehealth Service complements the existing 24-hour, seven-day-a-week nurse-led emergency care to achieve robust, safe emergency care coverage for more than 50 hospitals, health centres and nursing posts across the SIHI catchment. The SIHI investment has transformed emergency medical care in southern regional WA into a new innovative model which uses modern technology, including video conferencing, and has vastly improved rostering, access to specialists and support for the country medical and emergency workforce. This new approach is proving to be effective in providing communities with equitable access to safe, quality emergency care aligned to meet the described level of emergency services in the *WA Clinical Services Framework 2014–2024*.

SIHI has significantly increased the range of local health services that bring care closer to home and help people to avoid hospital. In partnership with non-government and community organisations, SIHI is building a more sustainable rural health system. New primary health initiatives have been established to better support people in this region, such as the Community Midwifery Service and primary health nurse practitioners. Telehealth services are used to improve access to specialist outpatient appointments and antenatal classes, and aid in monitoring chronic conditions, diabetes and other health issues in people's homes, at their local hospital or health centres. These services are providing people with more equitable access to health support and new options of care in more convenient locations.

The SIHI capital program is investing in upgrades to 37 hospital and health service facilities across the Wheatbelt, South West, Midwest and Great Southern. Upgrades will ensure these facilities continue to be equipped to deliver contemporary models of care now and in the future.

An evaluation of SIHI outlined in *SIHI Evaluation: Preliminary Key Findings Report* (March, 2016) indicates that this investment strategy has transformed the delivery of health care and emergency services in the southern inland area. SIHI is not complete and the program continues to be implemented and evaluated.

Health services

WACHS continued to work with all levels of government, regional communities and service providers to address key country health challenges and deliver high quality health services in regional WA.

Services that assist people to understand and manage chronic conditions such as heart disease, respiratory disease and diabetes have been implemented in partnership with consumers and a range of services providers such as Silver Chain, Diabetes WA and Asthma WA. The focus has been to provide integrated and more accessible services to reduce episodes of acute illness and improve patient outcomes in the three priority conditions outlined in the *Chronic Conditions Prevention and Management Strategy 2015–2020:* diabetes, chronic respiratory disease and chronic heart disease.

WACHS has developed a partnership with the WA Primary Health Alliance (WAPHA) to improve access to chronic conditions care coordination and management services for rural consumers by sharing resources, data analysis, and co-funding effective, evidence-based programs.

Together with WAPHA, Rural Health West and the Aboriginal Health Council of WA, WACHS has undertaken joint service planning to ensure service gaps and duplication are reduced.

Work has continued during the year on the Bringing Dialysis Services Closer to Home Project, which provides an additional 17 dialysis chairs (located at Kalgoorlie, Fitzroy Crossing, Esperance and Roebourne) to the existing 77 chairs; and a total of 92 renal hostel beds (located at Broome, Derby, Kununurra, Fitzroy Crossing, Kalgoorlie and Carnarvon) due for completion in 2017–18.

The Improving Ear, Eye and Oral Health Initiative, funded through the Royalties for Regions Program, continued with Aboriginal Health Workers (AHWs) to screen for ear, eye and oral conditions. AHWs are supported in their role with video otoscopes and tablets promoting the use of Telehealth for timely ear health intervention and referral. The program also provides training for AHWs to apply of fluoride varnish to prevent tooth decay.

During the year, WACHS published the *WACHS Public and Primary Health Directions Strategy (2015–2018)* which identifies three priority action areas to improve health outcomes and health equity and decrease hospital demand: child health and development; chronic conditions prevention and management; and public health and communicable disease control. Two supporting documents, *The Healthy Country Kids Strategy* and the *Chronic Conditions Prevention and Management Strategy* were also published during 2015–16.

As part of the 2013–14 Budget the State Government committed $6 million over four years for the Improving Ear, Eye and Oral Health of Children Living in Rural and Remote Aboriginal Communities. Since services commenced in late April 2015, a total of 2,955 screenings have been conducted across 462 clinics in 38 communities and referral pathways from the communities to specialist services strengthened.

The WA Trachoma Program, managed by WACHS, has successfully reduced the rates of trachoma, a bacterial eye infection, in rural and remote Aboriginal communities from 24 per cent in 2006 to 2.6 per cent in 2015. Transmitted through person-to-person contact or by flies, repeated infections with trachoma during childhood can lead to preventable blindness. Australia is the only developed country where trachoma still occurs and it is found almost exclusively in remote Aboriginal communities, including northern and remote WA.

WACHS has worked with the Lions Eye Institute's Lions Outback Vision Van to provide eye services to local people in regional and remote areas. Funded by WA Health, the Lions Eye Institute and the Australian Government, with additional support from LotteryWest, the van has three consulting rooms equipped with sophisticated diagnostic equipment, performing tests that are usually not available outside the metropolitan area.

Three WACHS regions – Kimberley, Midwest and the Great Southern – trialled Patient Opinion during the year. Patient Opinion is an independently moderated online feedback website where health consumers can share their stories for the purpose of service improvement. The service enhances the existing consumer feedback and complaints system and will be reviewed in the next financial year to assess its usefulness to WACHS and health consumers.

In May 2016, WACHS introduced 'WACHS Link', a planned inter-hospital patient transfer process that is patient focused and allows for metropolitan hospital inpatients to be transferred to their appropriate country hospital. 'WACHS Link' assists metropolitan hospitals in the initial stage of securing a bed in a WACHS hospital and assists with patient discharge planning. Planning is underway to expand this service to unplanned adult patient transfers in the second half of 2016.

The WACHS Emergency Care Capability Framework (ECCF) was produced during the year to develop minimum requirements and guidelines for sites providing emergency care within WACHS. The framework includes an emergency care role delineation capability matrix that determines the service to be delivered for each WACHS site and outlines the minimum requirements to support that service. It also outlines a basic set of guidelines to support and facilitate the delineation process.

Mental Health

In Mental Health services, WACHS participated in reviewing the Mental Health Assertive Patient Flow and Bed Management for the Adult Services policy, implemented TeleMental Health projects to enhance mental health services, and provided ongoing education and training for non-mental health service providers in order to build local and regional mental health understanding and capacity.

The Statewide Specialist Aboriginal Mental Health Program has consolidated its approach, achieving increased access to culturally secure services for Aboriginal people in country WA.

WACHS hosted the biannual Rural and Remote Mental Health Conference in Bunbury during October 2015. The conference theme was 'Shining the Light on Rural Mental Health' and included a mental health carer and consumer engagement workshop. It was opened by the Minister for Mental Health and was attended by more than 200 people.

WACHS successfully implemented the *Mental Health Act 2014*, which required widespread awareness raising and communication across the entire mental health system, including specific training for all WACHS clinical staff involved in any aspect of mental health care.

Planning and implementation commenced for the new $1.8 million Youth Mental Health program. This program is designed to enhance and improve young people's (16 to 24 years) access to mental health services, promoting early intervention and a 'wrap around' model of care to support existing staff to develop improved holistic approaches to the care of this vulnerable group and their families.

WACHS also initiated a functional review of its Central Office mental health functions and appointed an Area Director of Clinical Services Adult and Older Adult Mental Health. This senior Consultant Psychiatrist role has a responsibility for overseeing clinical governance, standards and practice across WACHS mental health, plus supporting and driving clinical reform. The role of Executive Director of Mental Health was introduced and has membership on the WACHS Executive, reinforcing the importance of mental health across all areas of day-to-day operations, planning and strategic development in WACHS.

Aboriginal Health

Aboriginal health continues to be a key priority for WACHS, which delivers health services to an estimated 55,522 Aboriginal people or 10 per cent of the total WACHS population.

During the year, WACHS transitioned all Aboriginal Health funded programs for comprehensive Primary Health Care (PHC) and WA Footprints to Better Health (WAFBH) under the Delivering Community Services in Partnership policy, in line with the Holman Review recommendation.

The WAFBH program focuses on the delivery of health promotion, education and self-management programs targeting the early years, healthy lifestyles, healthy transition to adulthood, chronic disease self-management and the social determinants of health. The WAFBH program also focuses on the prevention and management of chronic illness which is attributed to approximately 80 per cent of the life expectancy gap between the Aboriginal and non-Aboriginal population. The procurement strategy for the WAFBH program is aligned with the principles and strategic direction of the *WA Aboriginal Health and Wellbeing Framework 2015–2030*.

The PHC program focuses on increasing access to comprehensive early intervention and primary health care treatment and clinical services, with a specific focus on improving antenatal, postnatal and early childhood outcomes such as child health checks and immunisations. It also consists of educational health promotion programs addressing healthy lifestyles choices and risk factors such as heart health, as well as the prevention of, and early intervention in, chronic illness.

The WACHS Aboriginal Health Improvement Unit (AHIU) delivered information sessions and workshops to support the transitioning of preferred providers from output funding to outcomes-based service provision. WACHS and the Department of Finance undertook seven, non-mandatory pre-tender briefings across WA.

WACHS continues to work with and support Aboriginal communities and the Aboriginal Health Planning Forums to review and update Regional Aboriginal Health Plans to improve health and service access.

The WACHS CEO chairs the Aboriginal Health Executive Group (AHEG) on behalf of WA Health which aims to ensure Aboriginal people in Western Australia have access to culturally secure, high-quality health care and services to improve health and wellbeing.

Workforce

Maintaining a skilled and stable workforce is a key priority for WACHS. Work has continued to address workforce shortages in rural areas. Some recent initiatives included the development of innovative medical staffing models to address regional requirements, and improve the reporting and auditing of the contracted medical workforce.

WACHS consolidated the Community Residency Program to support the development of general practitioners, and developed the Nursing and Midwifery Strategic Plan to address key workforce issues. It also progressed the Agency Reduction Strategy to reduce reliance on agency staff.

Allied health graduates were supported through the introduction of the Transition to Practice Program, and allied health staff new to senior clinical roles had opportunities to participate in the Transition to Leadership Program.

In addition, a new Management Development Program supporting management career pathways for WACHS staff was developed during the year.

Increasing the number of Aboriginal people employed in the public sector is a goal for the State Government. WACHS has developed a number of strategies to meet the Public Sector Commission (PSC) target of 3.2 per cent, and has exceeded this target by employing 354 Aboriginal people, or 3.9 per cent of the WACHS workforce.

WACHS committed $156,000 in recurrent funding to an Aboriginal Entry Level Employment Program that will enable WACHS regions to employ trainees, cadets, apprentices and/or employees in entry-level positions that require on-the-job training.

It also hosted six Aboriginal school-based traineeships across the Goldfields, Kimberley and Great Southern and supported the PSC Aboriginal Traineeship Program, which resulted in the allocation of seven PSC Aboriginal trainee scholarships for 2016–17.

In addition, WACHS offered nine Aboriginal employees a traineeship in allied health therapy assistance, and all participants successfully completed a Certificate III.

WACHS endorsed the establishment of senior level Regional Aboriginal Health Consultant (RAHC) roles that will form part of the Regional Executive Teams and will be responsible for leading and coordinating the development, implementation and evaluation of Aboriginal health projects, programs and services to close the gap in Indigenous health disadvantage.

WACHS concluded the year preparing for the new governance arrangements commencing on 1 July 2016 as a result of the passing of the *Health Services Act 2016*. WACHS enters the new financial year eager to build on the achievements of 2015–16 and to work diligently to respond to the new Board and the transition to a new governance system focused on delivering better health, better care and better value to local communities.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

Country WA at a glance

In country WA a male is expected to live to **80.0** years of age and females to **84.2** years of age

116,883
discharges from a country public hospital in 2015

818
people on any day will present to a major country emergency department

366
deaths in country WA are caused by coronary heart disease

2,703
people in country WA were diagnosed with cancer in 2014

15,742
people were treated by a country WA specialised public mental health service in 2015

44.4%
of all potentially preventable hospitalisations in country WA were due to chronic conditions

58.7%
of children living in county WA do not undertake sufficient physical activity

34.5%
of adults living in country WA are obese

92.6%
of adults living in country WA do not eat 2 serves of fruit and 5 serves of vegetables daily

6,672
patients accessed the Royal Flying Doctor Service in 2015

25,813
Telehealth occasions of service were accessed by patients in 2015

Operational structure

Enabling legislation

The WA Country Health Service is established by the Governor under sections 15 and 16 of the *Hospitals and Health Services Act 1927*. The Minister for Health is incorporated as the WA Country Health Service under section 7 of the *Hospitals and Health Services Act 1927*, and has delegated all of the powers and duties as such to the Director General of Health.

Administered legislation

Please refer to the *Department of Health's Annual Report 2015–16* for administered legislation.

Accountable authority

The Director General of Health, Dr David Russell-Weisz, is the reportable officer for the WA Country Health Service in 2015–16.

Responsible Minister

The WA Country Health Service is responsible to the Minister for Health, the Hon. John Day.

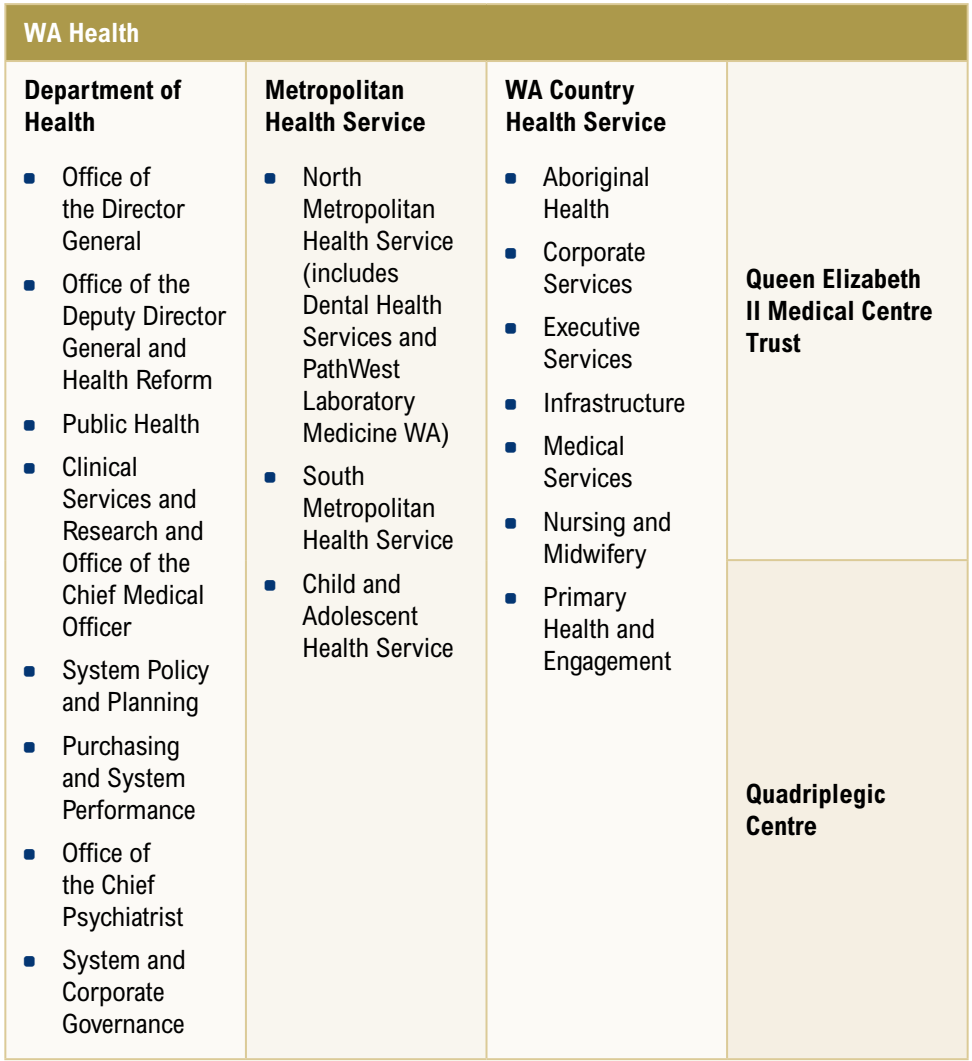
WA Health structure

WA Health encompasses five health service areas:

1. Department of Health
2. Metropolitan Health Service
3. WA Country Health Service
4. Quadriplegic Centre
5. Queen Elizabeth II Medical Centre Trust (see Figure 1).

Each service area is composed of health service providers and/or support service providers. The Quadriplegic Centre and the Queen Elizabeth II Medical Centre Trust are responsible for submitting their own annual reports.

Figure 1: **WA Health structure**



WA Country Health Service management structure

The WA Country Health Service has seven administrative regions supported by a central office in Perth (see Figure 2).

The seven administrative regions are the Goldfields, Great Southern, Kimberley, Midwest, Pilbara, South West and Wheatbelt. More information about the WA Country Health Service locations can be found in Appendix 1. Each region is managed by a Regional Director who reports to the WA Country Health Service Chief Executive Officer through the Chief Operating Officer – Operations.

The WA Country Health Service Chief Executive is also on the State Health Executive Forum that advises the Director General. For information on the management structure of the State Health Executive Forum, please refer to the *Department of Health Annual Report 2015–16*.

Figure 2: **WA Country Health Service management structure**

Senior officers

Senior officers and their area of responsibility for the WA Country Health Service as at 30 June 2016 are listed in Table 1.

Table 1: **WA Country Health Service senior officers**

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive Officer	Jeffrey Moffet	Term Contract
Corporate Services	Executive Director	Jordan Kelly	Acting
Medical Services	Executive Director	Dr Tony Robins	Term Contract
Nursing and Midwifery	Executive Director	Marie Baxter	Term Contract
Workforce	Executive Director	Marshall Warner	Term Contract
Operations	Chief Operating Officer	Shane Matthews	Acting
Strategy and Reform	Chief Operating Officer	Melissa Vernon	Acting
Finance	Director	John Arkell	Substantive
Mental Health	Executive Director	David Naughton	Term Contract
Regional Operations	Regional Director Kimberley	Bec Smith	Term Contract
Regional Operations	Regional Director Midwest	Margaret Denton	Acting
Regional Operations	Regional Director Great Southern	Susan Kay	Term Contract
Regional Operations	Regional Director Pilbara	Ronald Wynn	Term Contract
Regional Operations	Regional Director Southwest	Kerry Winsor	Substantive
Regional Operations	Regional Director Wheatbelt	Sean Conlan	Acting
Regional Operations	Regional Director Goldfields	Geraldine Ennis	Substantive

WA Country Health Service 2015–16

The WA Country Health Service is the largest country health service in Australia and one of the biggest in the world, delivering a range of comprehensive health services to more than 547,000 people – 21 per cent of WA's population (ABS ERP 2014). This includes an estimated 55,522 (10 per cent) Aboriginal people (ABS ERP 2012 Aboriginal proportions applied to ERP 2014) across a 2.5 million square kilometre area.

The breadth and scope of the WA Country Health Service is vast, with services being planned and delivered across a geographically dispersed population with diverse health needs. A highly transient population of tourists and fly-in-fly-out workers also exists in many of its regions.

Across its 71 hospitals (Clinical Services Framework 2014–2024) and 27 nursing posts (WACHS Emergency Care Capability Framework, 2016), the WA Country Health Service manages approximately 40 per cent of the State's emergency presentations – an estimated 394,120 ED occasions of service in 2015–16 – despite comprising only 21 per cent of WA's population. It also manages around 80 per cent as many births as the State's major maternity hospital, King Edward Memorial Hospital, with an estimated 4,700 births in 2015–16. As well as the many country hospitals, there is also a number of smaller health centres and 27 nursing and remote nursing posts providing health and nurse-led emergency services spread across country WA.

The range of health services provided by the WA Country Health Service includes emergency and hospital services, population health, public and primary health care, mental health, drug and alcohol services, Aboriginal health, child and community health, and residential and community aged care services.

The WA Country Health Service has established a network of District Health Advisory Councils across all regions, which comprise a wide range of community representatives and other consumers. The Councils engage, consult and interact with the WA Country Health Service to provide valuable input and feedback to improve health services for local communities.

WA Country Health Service strategic directions and priorities

The WA Country Health Service continues to work with regional communities to deliver a healthier country WA. The current *WA Country Health Service Strategic Directions 2015–18* focuses on key priorities, strengthening governance, and improving performance and sustainability. Key strategies focus on embedding a culture of safety and quality, improving emergency and hospital services and infrastructure, further improving access to primary health care, emergency care, ambulatory care programs, metropolitan and regional specialist services. A key enabler of care closer to home is the availability of more clinical services via telehealth video conferencing and other e-health services.

Priorities for the WA Country Health Service are Aboriginal health, maternal and child health, health promotion, disease control, mental health, drug and alcohol issues, acute and sub-acute care, hospital infrastructure development and community and residential aged care, timely access to services and improving the quality and safety of health care delivery. The purpose and values of the WA Country Health Service is summarised in Figure 3.

Figure 3: **Purpose, guiding principles and values of the WA Country Health Service**

Our Purpose	WACHS improves the health and wellbeing of country Western Australians through access to quality services and by supporting people to look after their own health.
Our Guiding Principles	• Consumers first in all we do. • Safe, high quality services and information at all times. • Care closer to home where safe and viable. • Evidence-based services. • Partnerships and collaboration.
Our Values	**Community** Making a difference through teamwork, cooperation, a 'can do' attitude, generosity and country hospitality.
	Compassion Listening and caring with empathy, respect, courtesy and kindness.
	Quality Creating a quality health care experience for every consumer, continual improvement, innovation and learning.
	Integrity Accountability, honesty and professional, ethical conduct in all that we do.
	Justice Valuing diversity, achieving health equality, cultural respect and a fair share for all.

Performance management framework

To comply with its legislative obligation as a WA government agency, WA Health operates under the Outcome Based Management performance management framework. This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards achieving the relevant overarching whole-of-government goal. WA Health's key performance indicators measure the effectiveness and efficiency of the health services provided by WA Health in achieving the stated desired health outcomes.

All WA Health reporting entities contribute to the achievement of the outcomes through health services delivered either directly by the entities or indirectly through contracts with non-government organisations.

WA Health's outcomes and key performance indicators for 2015–16 are aligned to the State Government goal of 'greater focus on achieving results in key service delivery areas for the benefit of all Western Australians' (see Figure 4).

The WA Health outcomes for achievement in 2015–16 are as follows:

Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

The health service activities that are aligned to Outcomes 1 and 2 are cited below (Figures 4 and 5).

Activities related to Outcome 1 aim to:

1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
2. Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
3. Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
4. Provide appropriate care and support for patients and their families during terminal illness.

Activities related to Outcome 2 aim to:

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:
   - immunisation programs
   - safety programs.
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 (e.g. breast and cervical cancer screening; screening of newborns) with appropriate referrals
   - programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education)
   - monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
4. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability, enabling people with chronic illness or disability to maintain as much independence in their everyday life as their illness or disability permits, supporting people in their homes for as long as possible and providing extra care when long-term residential care is required. Services and programs are delivered to:
   - 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
   - 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.

Performance against these activities and outcomes are summarised in the Agency Performance section and described in detail under Key Performance Indicators in the Disclosure and Compliance section of this report.

Figure 4: **Outcomes and key effectiveness indicators for the WA Country Health Service aligned to the State Government goal**

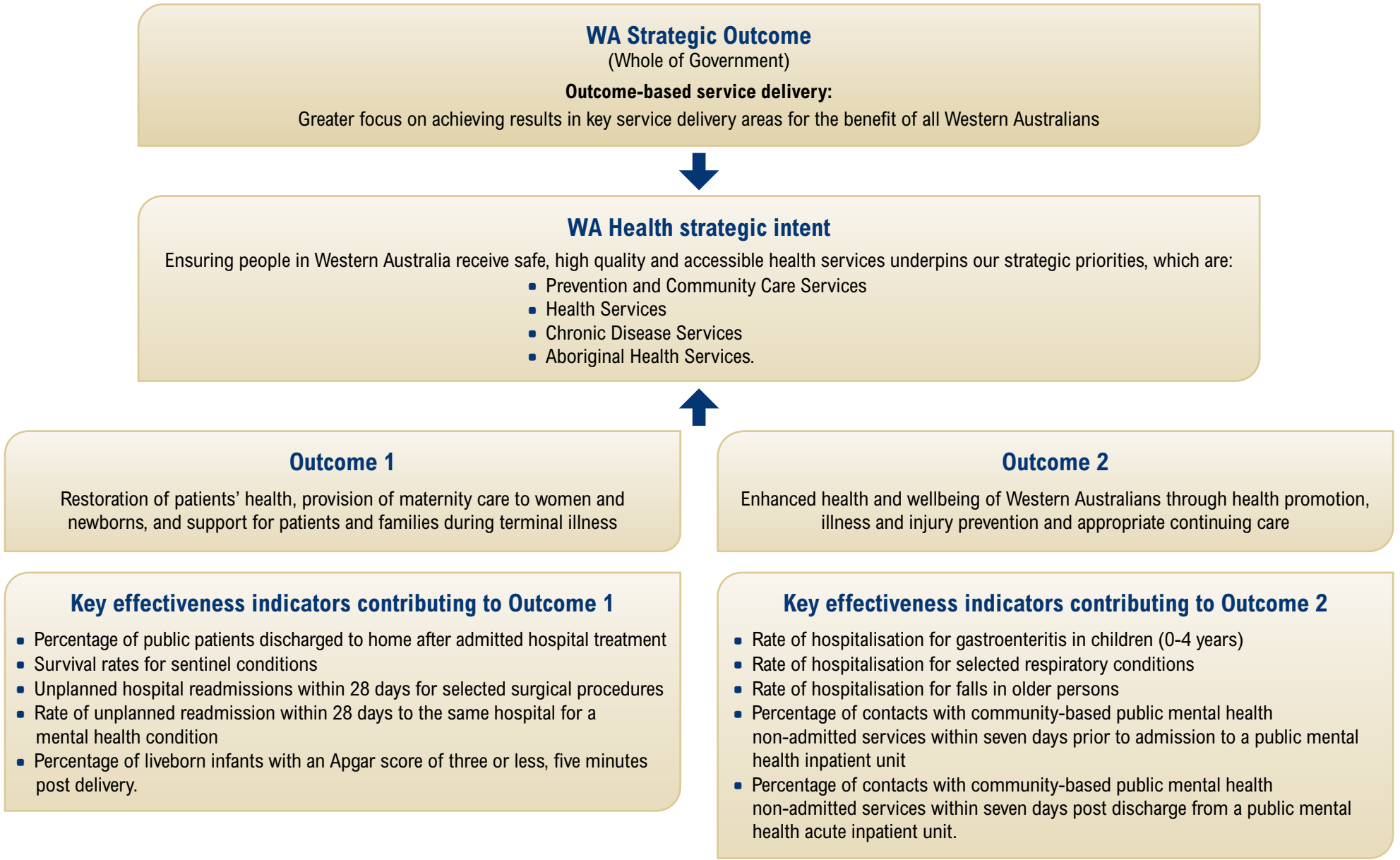


Figure 5: **Services delivered to achieve WA Health outcomes and key efficiency indicators for the WA Country Health Service**

Outcome 1

Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness

Outcome 2

Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care

Services delivered to achieve Outcome 1

1. Public hospital admitted patients
2. Home-based hospital programs
3. Palliative care
4. Emergency department
5. Public hospital non-admitted patients
6. Patient transport.

Services delivered to achieve Outcome 2

7. Prevention, promotion and protection
8. Dental health
9. Continuing care
10. Contracted mental health.

Key efficiency indicators for services within Outcome 1

- Average cost per casemix adjusted separation for non-tertiary hospitals
- Average cost per bed-day for admitted patients (selected small rural hospitals)
- Average cost per emergency department/service attendance
- Average cost per public patient non-admitted activity
- Average cost per non-admitted occasion of service provided in a rural nursing post
- Average cost per trip of Patient Assisted Travel Scheme.

Key efficiency indicators for services within Outcome 2

- Average cost per capita of population health units
- Average cost per bed-day for specific residential care facilities, flexible care (hostels) and nursing home type residents
- Average cost per bed-day in specialised mental health inpatients units
- Average cost per three-month period of care for community mental health.

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Agency performance

Financial

The total cost of providing health services to WA in 2015–16 was $8.4 billion. Results for 2015–16 against agreed financial targets (based on Budget statements) are presented in Table 2.

Full details of the WA Country Health Service's financial performance during 2015–16 are provided in the Financial statements.

Table 2: **Actual results versus budget targets for WA Health**

Financial	2015–16 Target $'000	2015–16 Actual $'000	Variation $ +/–
Total cost of service	8,149,524	8,420,946	271,422
Net cost of service	4,799,867	4,933,295	133,428
Total equity	10,119,720	9,576,838	-542,882
Net increase/decrease in cash held	(107,948,)	(325,300)	(217,352)
Approved full time equivalent staff level (salary associated with FTE)	4,686,045	4,703,263	17,218

Note: 2015–16 targets are specified in the 2015–16 Budget Statements.

Data source/s: Budget Strategy Branch, Health Service Support.

Summary of key performance indicators

Key performance indicators assist the WA Country Health Service to assess and monitor the extent to which Government outcomes are being achieved. Effectiveness indicators provide information that aid with assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service. Key performance indicators also provide a means to communicate to the community how the WA Country Health Service is performing.

A summary of the WA Country Health Service key performance indicators and variation from the 2015–16 targets is given in Table 3.

Note: Table 3 should be read in conjunction with detailed information on each key performance indicator found in the Disclosure and Compliance section of this report.

Table 3: **Actual results versus KPI targets**

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Key effectiveness indicators:			
Percentage of public patients discharged to home after admitted hospital treatment	≥97.5%	97.6%	0.1%
Survival rates for sentinel conditions:			
Stroke, by age group:			
0–49 years	≥98.5%	96.7%	-1.8%
50–59 years	≥97.9%	98.2%	0.3%
60–69 years	≥98.7%	92.7%	-6.0%
70–79 years	≥95.3%	96.1%	0.8%
80+ years	≥80.1%	81.9%	1.8%

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Acute Myocardial Infarction (AMI), by age group:			
0–49 years	≥99.1%	100.0%	0.9%
50–59 years	≥99.2%	99.0%	-0.2%
60–69 years	≥99.2%	100.0%	0.8%
70–79 years	≥98.7%	98.4%	-0.3%
80+ years	≥96.0%	92.4%	-3.6%
Fractured neck of femur (FNOF), by age group:			
70–79 years	≥98.7%	98.1%	-0.6%
80+ years	≥97.8%	94.2%	-3.6%
Unplanned hospital readmissions within 28 days for selected surgical procedures:			
appendicectomy	N/A	3.7	
cataract surgery	N/A	0.1	
prostatectomy	N/A	2.2	
hysterectomy	N/A	2.8	N/A
tonsillectomy and adenoidectomy	N/A	2.9	
hip replacement	N/A	2.7	
knee replacement	N/A	6.4	
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	≤4.8	8.1	3.3
Percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery, by birth weight:			
0–1499 grams	≤14.3%	30.0%	15.7%
1500–1999 grams	≤4.0%	0.0%	-4.0%
2000–2499 grams	≤0.6%	0.6%	0.0%
2500+ grams	≤0.1%	0.2%	0.1%

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Key efficiency indicators:			
Average cost per casemix adjusted separation for non-tertiary hospitals	$10,384	$6,740	-$3,644
Average cost per bed-day for admitted patients (selected small rural hospitals)	$1,389	$3,235	$1,846
Average cost per emergency department/ service attendance	$661	$853	$192
Average cost per public patient non-admitted activity	N/A*	$426	N/A
Average cost per non-admitted occasion of service provided in a rural nursing post	$376	$407	$31
Average cost per trip of Patient Assisted Travel Scheme	$546	$488	-$58
Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Key effectiveness indicators:			
Rate of hospitalisations for gastroenteritis in children (0-4 years)	≤5.0	9.5	4.5
Rate of hospitalisation for selected respiratory conditions:			
Acute asthma, by age group:			
0–4 years	≤4.3	5.5	1.2
5–12 years	≤2.3	3.5	1.2
13–18 years	≤0.5	0.8	0.3
19–34 years	≤0.6	0.8	0.2
35+ years	≤0.6	1.0	0.4
Acute Bronchitis (0-4 years of age)	≤0.4	0.7	0.3
Bronchiolitis (0-4 years of age)	≤9.7	18.7	9.0
Croup (0-4 years of age)	≤2.6	2.9	0.3

Key performance indicators	2015–16 Target	2015–16 Actual	Variation
Rate of hospitalisation for falls in older persons	0.5% reduction per annum	23.1%	-1.0%
Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	70%	44.9%	-25.1%
Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	71.8%	-3.2%
Key efficiency indicators:			
Average cost per capita of Population Health Units	$317	$362	$45
Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents	$598	$408	-$190
Average cost per bed-day in specialised mental health inpatient units	$2,315	$2,072	-$243
Average cost per three-month period of care for community mental health	$2,500	$2,815	$315

Performance towards the National Health Partnership Agreement targets

WA signed the National Partnership Agreement on Improving Public Hospital Services in 2011. The objective of the agreement was to drive major improvements in public hospital service delivery and better health outcomes for Australians. It included the National Elective Surgery Target (NEST) and the National Emergency Access Target (NEAT).

Following expiry of the National Partnership Agreement during 2015, WA Health introduced a new WA Elective Services Target (WEST) and WA Emergency Access Target (WEAT). As these were not implemented until 2016, for the purposes of this report, NEST and NEAT are reported up to the end of the 2015 calendar year.

National Elective Surgery Target (NEST)

Elective surgery is a term used to describe surgery that is medically necessary, but can be delayed for at least 24 hours. The NEST commenced on 1 January 2012 and focused on two areas. Under NEST Part 1 of the national agreement, WA had a target to increase the percentage of elective surgery cases admitted within the clinically recommended time for all urgency categories. Under NEST Part 2 of the national agreement, WA has a target to reduce the average overdue days waited beyond the clinically desirable times for each urgency category.

The urgency categories and clinically desirable times were:

- category 1 – admitted within 30 days
- category 2 – admitted within 90 days
- category 3 – admitted within 365 days.

Part 1: Treating patients within the clinically recommended time

WA Health was required to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

From 2010 to 2015, the number of patients treated within clinically recommended times improved from the baseline by approximately 6.18 per cent for category 1, by approximately 11.5 per cent for category 2 and approximately 0.8 per cent for category 3 (see Table 4).

From 1 January to 31 December 2015, 92.8 per cent of urgency category 1 patients were admitted within 30 days, lower than the set target of 100 per cent. For urgency category 2 patients, 88.3 per cent were admitted within the recommended 90 days, which is below the set target of 100 per cent and 98.0 per cent of urgency category 3 patients were admitted within the recommended 365 days, which is marginally below the set target of 100 per cent.

Table 4: **Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2015**

		2010 Baseline (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
Category 1	Performance	87.4	86.6	86.3	95.9	98.1	**92.8**
	Target	-	87.4	94.0	100.0	100.0	**100.0**
Category 2	Performance	79.2	83.5	82.0	89.4	91.6	**88.3**
	Target	-	79.2	84.0	88.0	95.0	**100.0**
Category 3	Performance	97.2	96.3	96.4	97.7	98.5	**98.0**
	Target	-	97.2	98.0	98.0	98.5	**100.0**

Data sources: Wait List Data Collection, Inpatient Data Collections.

Part 2: Reducing the average waiting time for overdue patients

Performance against the elective surgery targets from 1 January to 31 December 2015 shows that WA did not meet the 2015 targets for each urgency category (see Table 5); however, the average overdue waiting time for category 1 and 2 patients had improved significantly compared to the 2010 baseline.

Table 5: **Average overdue wait time (in days) for WA patients who have waited beyond clinically recommend times, by category, 2010–2015**

		31 Dec 2010 (baseline)	31 Dec 2011	31 Dec 2012	31 Dec 2013	31 Dec 2014	31 Dec 2015
Category 1	Performance	27.0	27.3	12.1	12.9	36.3	**14.7**
	Target	-	27	0	0	0	**0**
Category 2	Performance	90.0	77.4	54.2	55.0	48.7	**71.3**
	Target	-	90	68	45	23	**0**
Category 3	Performance	87.0	69.3	66.9	75.8	62.9	**89.4**
	Target	-	87	65	44	22	**0**

Notes: As part of the National agreement, this measure is assessed at the 31 December as a point in time measure.

Data sources: Wait List Data Collection, Inpatient Data Collections.

National Emergency Access Target (NEAT)

The National Emergency Access Target (NEAT) aim was to drive improvements in access to emergency care for patients.

Between 2012 and 2015 all States and Territories have been striving to meet progressive annual interim targets with the aim of ensuring that where clinically appropriate, patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours. By 2015 WA Health's aim was to ensure that 90 per cent of patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours, where clinically appropriate.

NEAT performance is calculated as an average of all participating hospitals over the calendar year. In the WA Country Health Service, the participating hospitals included Bunbury Hospital, Albany Health Campus, Broome Hospital, Geraldton Hospital, Hedland Health Campus, Kalgoorlie Health Campus and Nickol Bay Hospital.

Results for WA Country Health Service compared to the State result and National targets are presented in Table 6. In 2015, 88.8 per cent of patients presenting to a WA Country Health Service emergency department were admitted, transferred or discharged within four hours. This is above the 2015 State average of 80.3 and slightly below National target of 90 per cent.

Table 6: **Percentage of emergency department presentations at WA Country Health Service hospitals with a length of stay of 4 hours or less, 2011–2015**

Year	WACHS (%)	State (%)	Target (%)
2011	87.1	79.3	71.3 (baseline)
2012	86.8	78.3	76.0
2013	85.5	77.6	81.0
2014	85.8	79.7	85.0
2015	**88.8**	**80.3**	**90.0**

Data source: Emergency Department Data Collection.

Improvements towards emergency department access

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for their first few hours in hospital. With the ever-increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe high-quality care.

Percentage of emergency department patients seen within recommended times (major rural hospitals)

When patients first enter an emergency department they are assessed by specially trained nursing staff on 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.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and is recommended for prioritising those who present to an emergency department. A patient is allocated a triage category between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 7).

Table 7: **Triage category, treatment acuity and WA performance targets**

Triage category	Description	Treatment acuity	Target
1	Immediate life-threatening	Immediate (≤2 minutes)	100%
2	Imminently life-threatening	≤10 minutes	≥80%
3	Potentially life-threatening or important time-critical treatment or severe pain	≤30 minutes	≥75%
4	Potentially life-serious or situational urgency or significant complexity	≤60 minutes	≥70%
5	Less urgent	≤120 minutes	≥70%

By measuring this indicator, changes over time can be monitored that assist in managing the demand on emergency department services and the effectiveness of service provision. This in turn can enable the development of improved management strategies that ensure optimal restoration to health for patients.

In 2015–16, the proportion of WA patients in major rural hospital emergency departments who were seen within the recommended time was above the minimum benchmarks for all triage categories except triage 1 (see Table 8). For triage 1 patients, the result of 99 per cent is an increase from the 2014–15 performance.

Table 8: **Percentage of major rural hospital emergency department patients seen within recommended times, by triage category, 2011–12 to 2015–16**

Triage category	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)	Target
1	95.8	98.6	98.2	98.5	**99.0**	**100%**
2	89.7	93.3	91.0	87.0	**88.8**	**≥80%**
3	86.8	87.1	83.6	81.7	**84.4**	**≥75%**
4	90.5	90.3	87.6	85.2	**87.4**	**≥70%**
5	97.7	97.2	96.9	96.6	**97.1**	**≥70%**

Data source: Emergency Department Data Collection.

Percentage of emergency attendances with a triage score of 4 and 5 not admitted

Many patients who are assessed as triage category 4 and 5 when presenting to an emergency department are treated in the emergency department but not subsequently admitted to hospital. For a large number of country hospitals, information regarding non-admission for emergency attendance triaged 4 and 5 may also indicate the availability of primary care services and out-of-hours general practice options in that community. In such instances, community members must attend a rural hospital emergency department or service, as access to primary care services is not available.

The outcome of a patient attending a rural emergency department or service is based on clinical need and therefore a target for this measure has not been determined.

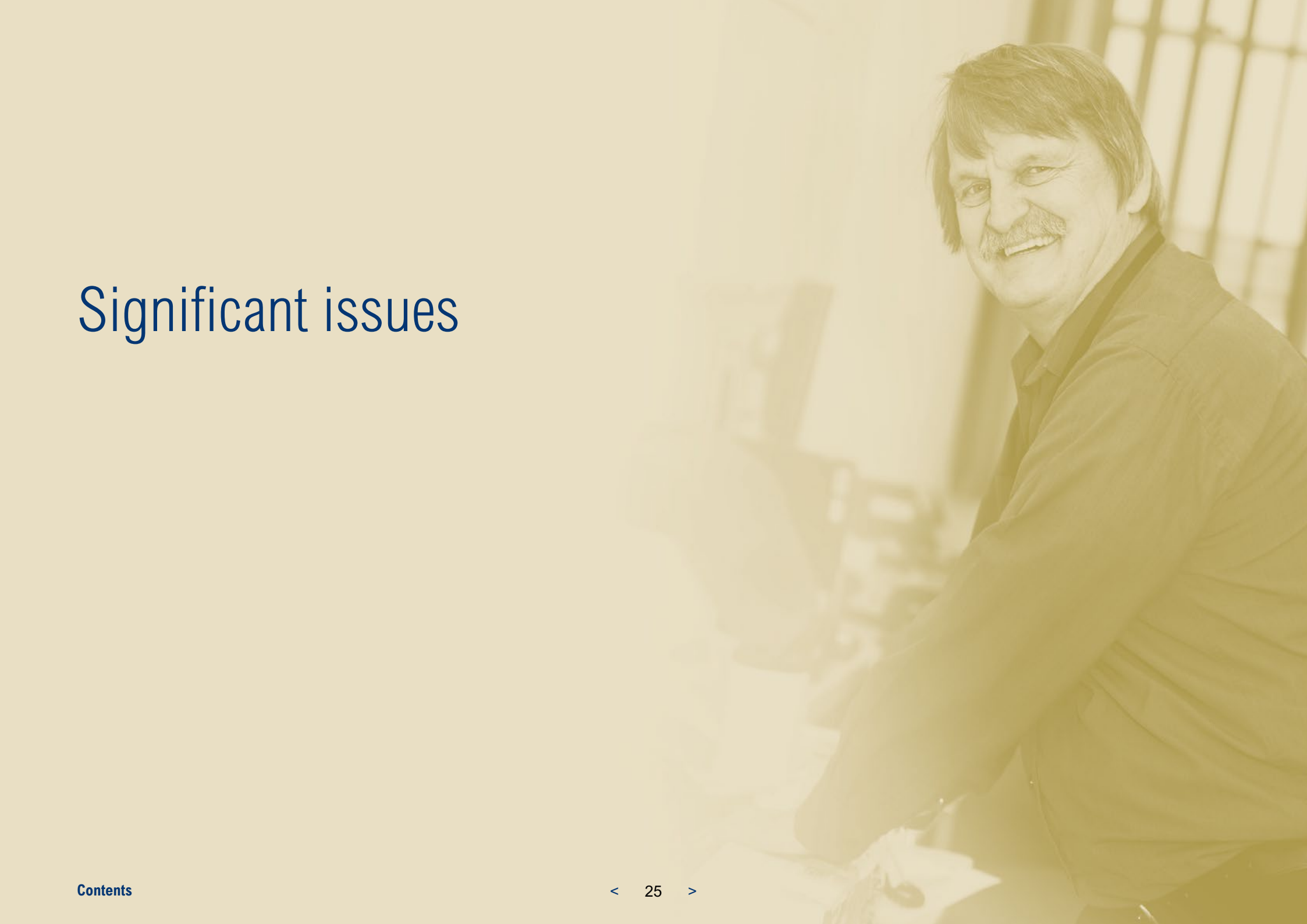
In 2015–16, the percentage of emergency department attendances triaged as category 4 and 5 and not admitted, decreased from 2014–15 to 92.4 per cent and 98.0 per cent respectively (see Table 9).

Table 9: **Percentage of major rural hospital emergency attendances with a triage score of 4 and 5 not admitted, 2011–12 to 2015–16**

Triage category	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014-15 (%)	2015-16 (%)
4	93.2	93.3	92.7	93.9	**92.4**
5	98.3	98.2	98.1	98.3	**98.0**

Data source: Emergency Department Data Collection.

Significant issues



The *WA Health Strategic Intent 2015–2020* underpins the requirement for people in Western Australia to receive safe, high quality and accessible health services. The Strategic Intent outlines the key direction that the health system will undertake. It aims to support operational planning that will take into account necessary health service demand management, sustainability and improvement, with a key focus on:

1. Prevention and Community Care Services
2. Health Services
3. Chronic Disease Services
4. Aboriginal Health Services.

The *WA Health Reform Program 2015–2020* is an integrated program of work aligned to the Strategic Intent. It comprises a series of projects across four key areas of reform:

1. Governance
2. Performance
3. Support Services
4. Procurement.

The reform will enable decision-making and health service delivery that supports local community needs. It will also allow policy and standards to be aligned to national and international best practice. This will ensure the quality and safety of health services are maintained.

Demand and activity

Significant factors driving demand in regional WA include changes in population and population demographics, increased availability in the scope of local services and higher than average burden of disease in Aboriginal and rural populations. In 2015–16, there was a 3.4 per cent increase in weighted activity within the WA Country Health Service, primarily driven by increased inpatient and outpatient services.

There is an increasing emphasis on care closer to home, impacting on service requirements. This is particularly evident in mental health, renal medicine and specialist care, where increased demand placed pressure on waiting times for acute or specialist services. Demographic factors also continue to be a driver, with the ageing regional population affecting residential and community aged care places. Limitations to service capability and capacity leads to some consumers not being able to stay in their home towns, especially as their care needs increase or become more specialised.

Country populations carry a high burden of disease in areas where General Practitioners and other primary health care is insufficient. Initiatives aimed at improving access to these services have been implemented and are expected to improve detection of chronic and other health conditions. Long term, this will increase the requirement for hospital and specialist intervention and health expenditure.

The WA Country Health Service is undergoing considerable reforms and service expansion, particularly in areas of child health and development, chronic disease prevention, coordination and management, and acute mental health. There is a focus on expanding chronic disease programs and delivering cancer and renal services closer to home. Ongoing capital investment is aimed at facilitating higher levels of self-sufficiency within regions. In 2015–16, capital investment projects that directly meet objectives include:

- Southern Inland Health Initiative, involving infrastructure upgrades, and improved access and quality of emergency and primary care
- Esperance Health Campus Redevelopment, improving inpatient service
- design and development of Karratha Health Campus
- investment in renal dialysis infrastructure, allowing more patients to access care closer to home.

Several factors impeding progress towards addressing demand and activity issues, include:

- the Activity Based Funding model (based on the Independent Hospital Pricing Authority model) does not adequately incorporate costs specific to providing care in regional WA such as:
  - location based costs – staff accommodation, transport, allowances and turnover
  - costs of scale – related to providing services below the break-even activity threshold, such as where the minimum safe staffing level for a service has spare capacity
- longer term patient retention in acute settings rather than in alternative accommodation such as aged care placements, sub-acute services, or mental health step-down facilities. This increases the requirement for acute services resources
- the requirement to fill in service ‘gaps’ where there is a shortage of alternate service providers and/or continuity in service provision by other service providers.

Progress towards meeting patient requirements in 2015–16 included:

- commencement of the Karratha Hospital construction
- redevelopment of Emergency Departments at Broome, Carnarvon and Esperance
- redevelopment of the Wagin and Exmouth health services
- increased access to the Emergency Telehealth Service, providing patients and staff with state-of-the-art access to high quality emergency medical care.

Workforce challenges

Attraction and retention of clinical staff in the many WA Country Health Service sites continues to be a challenge. In 2015–16, key shortages existed in specific clinical roles, such as midwifery. Shortages are compounded by geographical isolation and difficulty attracting prospective staff to some regional and remote locations. The provision of housing and additional conditions to remotely located staff increases financial staff costs, impacting on cost effectiveness.

In regional WA, the requirement to provide round-the-clock care can present challenges to the supply of health professionals, especially at smaller sites. Where clinical staff cannot be engaged, regional patients may need to wait for treatment, be transported to larger facilities, or access other services outside of the WA Country Health Service. The shortfall of General Practitioners increases emergency care presentations, with more than half being non-urgent. Services may not be culturally appropriate or meet consumer needs if the workforce is not representative of the community. Alternative models of care need to be explored if staff supply cannot support service delivery.

During 2015–16, the WA Country Health Service developed innovative staffing models to address regional staff requirements, including:

- Improvements made to reporting and auditing of contracted medical staff.
- Community Residency Program consolidated to support development of General Practitioners.
- TeleMental Health projects implemented to enhance mental health services, with education and training for non-mental health service providers.
- A Nursing and Midwifery Strategic Plan developed to address key issues relating to nursing staff.
- An agency reduction strategy developed to reduce reliance on agency staff.
- New Allied Health graduates and those new to senior clinical roles supported through the Transition to Practice and Transition to Leadership Programs, respectively.
- Aboriginal Health Consultant roles and workforce reform initiatives developed.
- An Aboriginal Mentorship Program, with 25 Aboriginal staff currently involved, developed.
- Aboriginal Entry Level Employment Framework developed to support engagement of trainees, cadets and apprentices with on-the-job training.

Improving retention rates in certain regional locations continues to be the key to many initiatives in 2015–16. Many WA Country Health Service sites require staff with broad generalist skills and experience, adding to the difficulty in employing appropriate staff. Workforce supply models do not adequately account for willingness of staff to work in some regional and remote locations. Generic recruitment approaches and templates do not allow for attraction strategies that promote the unique WA Country Health Service environment to prospective candidates.

Attainment of Primary Employing Health Service status by the WA Country Health Service has supported recruitment and training of junior doctors. Junior doctor rotations have commenced in the Midwest region by partnering with private health providers. WA Country Health Service Mental Health has achieved statewide targets relating to education and training of operational staff required for successful implementation of the *Mental Health Act 2014*. Development of Nursing and Midwifery and Allied Health practice frameworks has standardised competency assessment and scope of practice for individual health professions. It has also created a targeted approach to learning and development. Aboriginal Health Consultant positions have been endorsed for some regions. An in-house Management Development Program has been provided for new and aspiring managers.

Managing funding reform and cost efficiencies

Higher costs associated with staff accommodation, goods and services, and transport affect the implementation strategies within the WA Country Health Service. These are significantly impacted by other market sectors such as mining, and the small scale of operation in some sites.

Strategies to improve the revenue and cost profile of services have been developed. These include business process strategies that increase efficiency through improved business management, and cost savings and procurement/contract strategies that reduce expenditure. Considerable work is being undertaken to fully understand the costs of delivering services in a rural and remote environment and the key cost drivers. This will support negotiations and discussions with funding authorities around future budget requirements. The inability of the Activity Based Funding model to recognise location and scale based costs of care in regional WA make achievement of initiatives more difficult.

In 2015–16, the new Patient Administration and Billing system was implemented in the Pilbara and Wheatbelt regions. Implementation commenced in the Goldfields and Midwest, with the Kimberley region to follow in 2016–17. The systems were implemented in the Great Southern and South West prior to 2015–16. Business Intelligence tools have been operationalised through the WA Country Health Service Business Intelligence Portal, providing service managers with ready access to relevant and timely information on activity and financial performance. The Enabling Performance Improvement Project was completed at four larger hospitals, focusing on:

- articulation of the types of services provided in operating hospitals and health services in rural and remote locations
- identification and correct allocation of costs to specific services
- identification and quantification of uniquely rural and remote costs of delivering health services
- reviewing the quality, completeness and timeliness of activity data.

Health inequalities

Individuals who reside in country areas often experience poorer health and an increased burden of disease compared to people in the Metropolitan area. This is more pronounced in areas where primary care services are lacking and communities experience socio-economic disadvantage. Environment, housing, education, employment, workforce challenges and access to healthy lifestyles also contribute to health outcomes. The significant and persistent disparity between the health status of Aboriginal and non-Aboriginal people adds to inequalities.

The health outcomes for country WA includes reduced life expectancies – about two years less than the metropolitan population. For Aboriginal people, this is significantly greater – around 10.5 years less than non-Aboriginal people. More than one-third of the country population is obese, compared with one quarter of the metropolitan population. This places the country population at greater risk of major health issues. Mortality rates are higher, particularly for heart disease, diabetes, some cancers, long-term respiratory diseases and transport accidents. The number of mental health admissions per capita is also greater.

Potentially preventable health conditions such as vaccine preventable infections and lifestyle related conditions cost at least $93 million per year in country hospital admissions. Aboriginal children in country WA are two to three times more likely to die before 12 months of age, be born prematurely and have a low birth weight. Aboriginal children are nearly 30 times more likely to suffer nutritional anaemia and malnutrition in the first four years of life and suffer infectious and parasitic diseases, compared with non-Aboriginal children.

Strategies aimed at reducing health inequalities include:

- Royalties for Regions Program, which continues to fund a range of health services such as the Southern Inland Health Initiative. This includes:
  - a capital investment program to upgrade hospital and health service infrastructure
  - Emergency Telehealth Service
  - Improving Ear, Eye and Oral Health Initiative, which screens for ear, eye and oral conditions in children in rural and remote Aboriginal communities
- extensive capital works program
- Dialysis Services Closer to Home project.

Implementation of some of these strategies has already begun, and benefits realised. Examples include:

- Emergency Telehealth Service which has
  - delivered more than 33,000 consults to 75 sites since it began in 2012
  - provided opportunities for improved clinical governance, best practice and clinical leadership
  - facilitated real-time education specific to emergency medicine, normally only achieved in metropolitan tertiary hospitals.
- continued implementation of the Southern Inland Health Initiative, delivering
  - a 50 per cent increase in General Practitioners in funded towns since 2011. This provides medical services in both the community and local emergency department
  - better outcomes in aged care and dementia services provided in small regional communities.
- development of planning and service models for the Youth Mental Health Program
- improved access to culturally secure services for Aboriginal people in country WA through the Statewide Specialist Aboriginal Mental Health Program.

Disclosure and compliance

Audit Opinion

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE

Report on the Financial Statements

I have audited the accounts and financial statements of the WA Country Health Service.

The financial statements comprise the Statement of Financial Position as at 30 June 2016, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the WA Country Health Service at 30 June 2016 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

Director General's Responsibility for the Financial Statements
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 and the Treasurer's Instructions, and for such internal control as the Director General determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility for the Audit of the Financial Statements
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements based on my audit. The audit was conducted in accordance with Australian Auditing Standards. Those Standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Health Service's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Director General, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

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Report on Controls

I have audited the controls exercised by the WA Country Health Service during the year ended 30 June 2016.

Controls exercised by the WA Country Health Service are those policies and procedures established by the Director General to ensure 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.

Opinion
In my opinion, in all material respects, the controls exercised by the WA Country Health Service are sufficiently adequate to 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 during the year ended 30 June 2016.

Director General's Responsibility for Controls
The Director General is responsible for maintaining an adequate system of internal control to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of public and other property, and the incurring of liabilities are in accordance with the Financial Management Act 2006 and the Treasurer's Instructions, and other relevant written law.

Auditor's Responsibility for the Audit of Controls
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the controls exercised by the WA Country Health Service based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the adequacy of controls to ensure that the Health Service complies with the legislative provisions. The procedures selected depend on the auditor's judgement and include an evaluation of the design and implementation of relevant controls.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Report on the Key Performance Indicators

I have audited the key performance indicators of the WA Country Health Service for the year ended 30 June 2016.

The key performance indicators are the key effectiveness indicators and the key efficiency indicators that provide information on outcome achievement and service provision.

Opinion
In my opinion, in all material respects, the key performance indicators of the WA Country Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2016.

Matters of Significance

Emergency Department Waiting Times

The WA Country Health Service received approval from the Acting Under Treasurer to remove the following indicators as audited key performance indicators (KPIs) from 1 July 2013:

- Percentage of Emergency Department patients seen within recommended times (major rural hospitals)
- Rate of emergency attendances with a triage score of four and five not admitted

The approval was conditional on their inclusion as unaudited performance indicators in the agency's 2013-14 Annual Report and that they be reinstated as audited KPIs following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2016. Consequently, the two KPIs have not been included in the audited KPIs for the year ended 30 June 2016. My opinion is not modified in respect of this matter.

Elective Surgery Waiting Times

The WA Country Health Service received approval from the Under Treasurer to remove the 'Elective Surgery Waiting Times' Key Performance Indicator (KPI) from the audited KPIs for the year ended 30 June 2012. The approval was conditional on the inclusion of unaudited performance indicators measuring elective surgery waiting times in the agency's 2011-12 Annual Report and that elective surgery waiting times be reinstated as an audited KPI following the successful definition of national elective surgery waiting time indicators. The definition of national elective surgery waiting times has been developed. Implementation is planned from 1 July 2016 in line with the national implementation date. Consequently, the 'Elective Surgery Waiting Times' KPI has not been included in the audited KPIs for the year ended 30 June 2016. My opinion is not modified in respect of this matter.

Director General's Responsibility for the Key Performance Indicators

The Director General is responsible for the preparation and fair presentation of the key performance indicators in accordance with the Financial Management Act 2006 and the Treasurer's Instructions and for such controls as the Director General determines necessary to ensure that the key performance indicators fairly represent indicated performance.

Auditor's Responsibility for the Audit of Key Performance Indicators

As required by the Auditor General Act 2006, my responsibility is to express an opinion on the key performance indicators based on my audit conducted in accordance with Australian Auditing and Assurance Standards.

An audit involves performing procedures to obtain audit evidence about the key performance indicators. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments the auditor considers internal control relevant to the Director General's preparation and fair presentation of the key performance indicators in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the relevance and appropriateness of the key performance indicators for measuring the extent of outcome achievement and service provision.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence
In conducting the above audits, I have complied with the independence requirements of the Auditor General Act 2006 and Australian Auditing and Assurance Standards, and other relevant ethical requirements.

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators
This auditor's report relates to the financial statements and key performance indicators of the WA Country Health Service for the year ended 30 June 2016 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
21 September 2016

Certification of financial statements

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

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 2016 and financial position as at 30 June 2016.

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.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

Financial statements

WA Country Health Service

Statement of Comprehensive Income

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	934,279	901,814
Fees for visiting medical practitioners		85,015	78,727
Patient support costs	8	338,308	319,061
Finance costs	9	272	369
Depreciation and amortisation expense	10	68,458	63,757
Loss on disposal of non-current assets	11	149	4,956
Repairs, maintenance and consumable equipment	12	33,766	35,666
Other expenses	13	132,736	153,893
Total cost of services		**1,592,983**	**1,558,243**
INCOME			
Revenue			
Patient charges	14	55,053	51,783
Commonwealth grants and contributions	15(i)	412,832	368,328
Other grants and contributions	15(ii)	102,897	83,026
Donation revenue	16	950	829
Other revenue	17	23,799	23,966
Total revenue		595,531	527,932
Total income other than income from State Government		**595,531**	**527,932**
NET COST OF SERVICES		**997,452**	**1,030,311**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	959,817	966,870
Assets assumed	19	762	-
Services received free of charge	20	161	74
Royalties for Regions Fund	21	86,853	83,456
Total income from State Government		**1,047,593**	**1,050,400**
SURPLUS FOR THE PERIOD		**50,141**	**20,089**
OTHER COMPREHENSIVE INCOME/(LOSS)			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	37	(54,622)	(7,341)
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE PERIOD		**(4,481)**	**12,748**

Refer also to note 55 'Schedule of Income and Expenses by Service'.

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Financial Position

As at 30 June 2016

	Note	2016 $000	2015 $000
ASSETS			
Current Assets			
Cash and cash equivalents		18,227	17,094
Restricted cash and cash equivalents	22	47,998	36,319
Receivables	23	22,424	24,994
Inventories	25	5,554	5,554
Other current assets	26	3,132	4,521
Non-current assets classified as held for sale	27	-	65
Total Current Assets		97,335	88,547
Non-Current Assets			
Amounts receivable for services	24	586,669	509,870
Property, plant and equipment	28	1,760,135	1,787,004
Intangible assets	30	9,859	235
Total Non-Current Assets		2,356,663	2,297,109
Total Assets		**2,453,998**	**2,385,656**
LIABILITIES			
Current Liabilities			
Payables	32	98,439	116,300
Borrowings	33	1,600	1,518
Provisions	34	126,981	123,965
Other current liabilities	35	14	104
Total Current Liabilities		227,034	241,887
Non-Current Liabilities			
Borrowings	33	5,267	6,865
Provisions	34	25,200	25,377
Total Non-Current Liabilities		30,467	32,242
Total Liabilities		**257,501**	**274,129**
NET ASSETS		**2,196,497**	**2,111,527**
EQUITY			
Contributed equity	36	1,670,697	1,581,246
Reserves	37	443,557	498,179
Accumulated surplus	38	82,243	32,102
TOTAL EQUITY		**2,196,497**	**2,111,527**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Changes in Equity

For the year ended 30 June 2016

	Note	2016 $000	2015 $000
CONTRIBUTED EQUITY	36		
Balance at start of period		1,581,246	1,483,046
Transactions with owners in their capacity as owners:			
Capital appropriations		29,491	52,489
Royalties for Regions Fund		60,866	36,720
Other contributions by owners		-	8,991
Distributions to owners		(906)	-
Balance at end of period		1,670,697	1,581,246
RESERVES	37		
Asset Revaluation Reserve			
Balance at start of period		498,179	505,520
Comprehensive income/(loss) for the period		(54,622)	(7,341)
Balance at end of period		443,557	498,179
ACCUMULATED SURPLUS	38		
Balance at start of period		32,102	12,013
Surplus for the period		50,141	20,089
Balance at end of period		82,243	32,102
TOTAL EQUITY			
Balance at start of period		2,111,527	2,000,579
Total comprehensive income/(loss) for the period		(4,481)	12,748
Transactions with owners in their capacity as owners		89,451	98,200
Balance at end of period		**2,196,497**	**2,111,527**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

WA Country Health Service

Statement of Cash Flows

For the year ended 30 June 2016

	Note	2016 $000 Inflows (Outflows)	2015 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		882,738	885,774
Capital appropriations		27,974	51,041
Royalties for Regions Fund		147,719	120,174
Net cash provided by State Government	39	**1,058,431**	**1,056,989**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(958,343)	(887,555)
Supplies and services		(577,428)	(566,555)
Receipts			
Receipts from customers		54,757	50,036
Commonwealth grants and contributions		412,832	368,328
Other grants and contributions		102,897	82,694
Donations received		950	829
Other receipts		26,457	22,787
Net cash used in operating activities	39	**(937,878)**	**(929,436)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(107,776)	(106,248)
Receipts			
Proceeds from sale of non-current physical assets	11	35	2
Net cash used in investing activities		**(107,741)**	**(106,246)**
Net increase / (decrease) in cash and cash equivalents		12,812	21,307
Cash and cash equivalents at the beginning of the period		53,413	32,106
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	39	**66,225**	**53,413**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2016 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

The Health Service has adopted any applicable new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 '*Application of Australian Accounting Standards and Other Pronouncements*'. Partial exemption permitting early adoption of AASB 2015-7 '*Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities*' has been granted. Aside from AASB 2015-7, there has been no early adoption of Australian Accounting Standards that have been issued or amended (but not operative) by the Health Service for the annual reporting period ended 30 June 2016.

Note 2 Summary of significant accounting policies

(a) General Statement

The Health Service is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with 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 2006* and the Treasurer's instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had 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, except for land, buildings and site infrastructure 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).

Note 3 'Judgements made by management in applying accounting policies' discloses judgements that have been made in the process of applying the Health Service's accounting policies resulting in the most significant effect on amounts recognised in the financial statements.

Note 4 'Key sources of estimation uncertainty' discloses key assumptions made concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

(c) Contributed Equity

AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*' requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, 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 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.

The 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 also note 36 'Contributed equity'.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(d) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. The following specific recognition criteria must also be met before 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 are transferred to the purchaser and can be measured reliably.

Provision of services
Revenue is recognised by reference to the stage of completion of the transaction.

Service Appropriations
Service Appropriations are recognised as revenues at fair 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 'Amounts receivable for services' (holding account) held at Treasury.
See also note 18 'Service appropriations' for further information.

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.

Royalties for Regions funds are recognised as revenue at fair value in the period in which the Health Service obtains control over the funds. The Health Service obtains control of the funds at the time the funds are deposited into the Health Service's bank account.

Gains
Realised and unrealised gains 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 expensed in the period in which they are incurred.

(f) Property, Plant and Equipment

Site infrastructure
In current financial year, reclassification has been made to separate site infrastructure from buildings. Site infrastructure include roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

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 Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
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 the fair value at the date of acquisition.

Subsequent measurement
Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land, buildings and site infrastructure and historical cost for all other property, plant and equipment. Land, buildings and site infrastructure are carried at fair value less accumulated depreciation (buildings and site infrastructure) 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 values determined by reference to recent market transactions.

Note 2 Summary of significant accounting policies (continued)

(f) Property, Plant and Equipment (continued)

Subsequent measurement (continued)
In the absence of market-based evidence, fair value of land, buildings and site infrastructure (clinical sites) is determined on the basis of existing use. This normally applies where buildings and site infrastructure are specialised or where land use is restricted. Fair value for existing use buildings and site infrastructure is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost. Fair value for restricted use land is determined by comparison with market evidence for land with similar approximate utility (high restricted use land) or market value of comparable unrestricted land (low restricted use land).

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

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Valuation Services) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period. Site infrastructure were last revalued as at 1 July 2013.

The most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic 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.

See also note 28 'Property, plant and equipment' and note 29 'Fair value measurements' for further information on revaluation.

Derecognition
Upon disposal or derecognition of an item of property, plant and equipment, any revaluation surplus 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 on a class of assets basis.

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

In order to apply this policy, the following methods are utilised :
* Land - not depreciated
* Buildings - diminishing value
* Site infrastructure - diminishing value
* Plant and equipment - straight line

The assets' useful lives are reviewed annually. Estimated useful lives for each class of depreciable asset are:

Buildings	50 years
Site infrastructure	50 years
Leasehold improvements	Term of the lease
Computer equipment	4 to 10 years
Furniture and fittings	10 to 20 years
Motor vehicles	2 to 10 years
Medical equipment	3 to 20 years
Other plant and equipment	4 to 30 years

Artworks controlled by the Health Service are classified as property, plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently 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 Statement of Comprehensive Income.

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

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

Amortisation for intangible assets with finite useful lives is calculated for the period of the expected benefit (estimated useful life which is reviewed annually) on the straight line basis. All intangible assets controlled by the Health Service have a finite useful life and zero residual value.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(g) Intangible Assets (continued)

Estimated useful lives for each class of intangible asset are:

Computer software	5 - 10 years

Computer software

Software that is an integral part of the related hardware is recognised as property, plant and equipment. Software that is not an integral part of the related hardware is recognised 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 the end of each reporting period. 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. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised as expense in the Statement of Comprehensive Income. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised 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 the asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

Intangible assets not yet available for use are tested for impairment at the end of each reporting period 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 the end of each reporting period.

See also note 31 'Impairment of assets' for the outcome of impairment reviews and testing.

Refer also to note 2(p) 'Receivables' and note 23 'Receivables' for impairment of receivables.

(i) Non-current assets (or disposal groups) classified as held for sale

Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are disclosed separately from other assets in the Statement of Financial Position. 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. The Health Service does not have any 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 two categories of financial instrument:
- Loans and receivables; and
- Financial liabilities measured at amortised cost.

Financial instruments have been disaggregated into the following classes:

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

Note 2 Summary of significant accounting policies (continued)

(k) Financial Instruments (continued)

Financial liabilities:
* Payables
* 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 Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand, cash at bank 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 fair value.

(n) Amounts Receivable for Services (holding account)

The Health Service receives service appropriation funding from the State Government partly in cash and partly as an asset (holding account receivable). The holding account receivable balance is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.

See also note 18 'Service appropriations' and note 24 'Amounts receivable for services'.

(o) Inventories

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

Inventories not held for resale are measured at cost unless they are no longer required, in which case they are measured at net realisable value. See note 25 ' Inventories'.

(p) Receivables

Receivables are recognised at original invoice amounts 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 against the allowance account. 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.

See also note 2(k) 'Financial Instruments' and note 23 'Receivables'.

Change to accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the 'Department of Health'. This accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services) was the NGR in previous financial years. The Health entities in the GST group include the Department of Health, Mental Health Commission, Metropolitan Health Service, WA Country Health Service, QE II Medical Centre Trust, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health.

(q) Payables

Payables are recognised 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 also note 2(k) 'Financial instruments' and note 32 'Payables'.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(r) Borrowings

All loans payable are initially recognised at fair value, being the net proceeds received. Subsequent measurement is at amortised cost using the effective interest rate method.

See also 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 the end of each reporting period.

See also note 34 'Provisions'.

Provisions - employee benefits

All annual leave, time off in lieu leave and long service leave provisions are in respect of employees' services up to the end of the reporting period.

Annual Leave and Time Off in Lieu Leave

Annual leave and time off in lieu leave are not expected to be settled wholly within 12 months after the end of the reporting period and are therefore considered to be 'other long-term employee benefits'. The annual leave and time off in lieu leave liability are recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

The provision for annual leave and time off in lieu leave are classified as a current liability as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period.

Long service leave

Long service leave is not expected to be settled wholly within 12 months after the end of the reporting period. The long service leave liability is recognised and measured at the present value of amounts expected to be paid when the liabilities are settled using the remuneration rate expected to apply at the time of settlement.

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, as well as the experience of employee departures and periods of service. The expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

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 end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

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 Statement of Comprehensive Income for this leave as it is taken.

Deferred Salary Scheme

The provision for the deferred salary scheme relates to Health Service's employees who have entered into an agreement to self-fund an additional twelve months leave to be taken in the fifth year of the agreement. The provision recognises the value of salary set aside for employees to be used in the fifth year. This liability is measured on the same basis as annual leave. It is reported as a current provision as employees can leave the scheme at their discretion at any time.

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

Superannuation

The Government Employees Superannuation Board (GESB) and other fund providers administer public sector superannuation arrangements in Western Australia in accordance with legislative requirements. Eligibility criteria for membership in particular schemes for public sector employees vary according to commencement and implementation dates.

Eligible employees contribute to the Pension Scheme, a defined benefit pension scheme closed to new members since 1987, or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme closed to new members since 1995.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension Scheme or the GSS 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). From 30 March 2012, existing members of the WSS or GESBS and new employees have been able to choose their preferred superannuation fund provider. The Health Service makes contributions to GESB or other fund providers on behalf of employees in compliance with the *Commonwealth Government's Superannuation Guarantee (Administration) Act 1992.* Contributions to these accumulation schemes extinguish the Health Service's liability for superannuation charges in respect of employees who are not members of the Pension Scheme or GSS.

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

The Health Service has no liabilities under the Pension Scheme or the GSS. The liabilities for the unfunded Pension Scheme and the unfunded GSS transfer benefits attributable to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS obligations are funded by concurrent contributions made by the Health Service to the GESB.

The GESB makes all benefit payments in respect of the Pension Scheme and GSS transfer benefits, and recoups the employer's share from the Treasurer.

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

Gratuities

The Health Service is obliged to make gratuity payments to medical practitioners and nurses under their respective industrial agreements. These groups of employees are entitled to a gratuity payment for each year of continuous service in specified regions in Western Australia.

The liability for gratuity payments is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future salary levels, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

Employment on-costs

Employment on-costs (workers' compensation insurance) are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of 'Other expenses' and are not included as part of the Health Service's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'.

See also note 13 'Other expenses' and note 34 'Provisions'.

(t) Superannuation Expense

Superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBS or other superannuation funds.

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

Services received free of charge or for nominal cost, that the Health Service would otherwise purchase if not donated, are recognised as income at the fair value of the services where they can be reliably measured. A corresponding expense is recognised for services received.

Services received from other State Government agencies are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(v) Assets Transferred between Government Agencies

Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are measured at the fair value of those net assets that the Health Service would otherwise pay for, and are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions*' in respect of the net assets transferred.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

Note 2 Summary of significant accounting policies (continued)

(w) Comparative Figures

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

(x) 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 52).

Note 3 Judgements made by management in applying accounting policies

The preparation of financial statements requires management to make judgements about the application of accounting policies that have a significant effect on the amounts recognised in the financial statements. The Health Service evaluates these judgements regularly.

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

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

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 11.2%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year 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.

Other estimations and assumptions used in calculating the Health Service's long service leave provision include expected future salary rates, discount rates, employee retention rates and expected future payments. Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision.

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 effective for annual reporting periods beginning on or after 1 July 2015 that impacted on the Health Service.

Title	
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part C of this Standard defers the application of AASB 9 to 1 January 2017. The application date of AASB 9 was subsequently deferred to 1 January 2018 by AASB 2014-1. The Health Service has not yet determined the application or the potential impact of AASB 9.
AASB 2014-8	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]* This Standard makes amendments to AASB 9 *Financial Instruments* (December 2009) and AASB 9 *Financial Instruments* (December 2010), arising from the issuance of AASB 9 *Financial Instruments* in December 2014. The Health Service has not yet determined the application or the potential impact of AASB 9.

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

Initial application of an Australian Accounting Standard (continued)

Title	
AASB 2015-3	*Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality* This Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing that Standard to effectively be withdrawn. There is no financial impact.

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 1101 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 1101. By virtue of a limited exemption, the Health Service has early adopted AASB 2015-7 *Amendements to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities*. Where applicable, the Health Service plans to apply the following Australian Accounting Standards from their application date.

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainity of revenue and cash flows arising from a contract with a customer. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 16	Leases This Standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2019
AASB 1057	Application of Australian Accounting Standards This Standard lists the application paragraphs for each other Standard (and Interpretation), grouped where they are the same. There is no financial impact.	1 Jan 2016
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Health Service to determine the application or potential impact of the Standard	1 Jan 2018
AASB 2014-4	*Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]* The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.	1 Jan 2016

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

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

Future impact of Australian Accounting Standards not yet operative (continued)

Title		Operative for reporting periods beginning on/after
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2014-7	Amendments to *Australian Accounting Standards arising* from AASB 9 (December 2014) This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2015-1	*Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140)* These amendments arise from the issuance of International Financial Reporting Standard *Annual Improvements to IFRSs* 2012-2014 Cycle in September 2014, and editorial corrections. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2016
AASB 2015-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 (AASB 7, 101, 134 & 1049)* This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.	1 Jan 2016
AASB 2015-6	*Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049)* The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.	1 Jul 2016
AASB 2015-8	*Amendments to Australian Accounting Standards – Effective Date of AASB 15* This Standard amends the mandatory effective date (application date) of AASB 15 *Revenue from Contracts with Customers* so that AASB 15 is required to be applied for annual reporting periods beginning on or after 1 January 2018 instead of 1 January 2017. The Health Service has not yet determined the application or the potential impact of AASB 15.	1 Jan 2017
AASB 2016-2	*Amendments to Australian Accounting Standards – Disclosure Initative: Amendments to AASB 107* This Standard amends AASB 107 *Statement of Cash Flows* (August 2015) to require disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. There is no financial impact.	1 Jan 2017
AASB 2016-3	*Amendments to Australian Accounting Standards – Clarifications to AASB 15* This Standard clarifies identifying performance obligations, principal versus agent considerations, timing of recognising revenue from granting a licence, and, provides further transitional provisions to AASB 15. The Health Service has not yet determined the application or the potential impact.	1 Jan 2018
AASB 2016-4	*Amendments to Australian Accounting Standards – Recoverable Amount of Non-Cash-Generating Specialised Assets of Not-for-Profit Entities* This Standard clarifies that the recoverable amount of primarily non-cash-generating assets of not-for-profit entities, which are typically specialised in nature and held for continuing use of their service capacity, is expected to be materially the same as fair value determined under AASB 13 *Fair Value Measurement*. The Health Service has not yet determined the application or the potential impact.	1 Jan 2017

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 55. The key services of the Health Service are:

Public Hospital Admitted Patients
Public hospital admitted patient services describe the care services 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. An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, renal dialysis, oncology services, and obstetric care.

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

Emergency Department
Emergency department services describe the treatment provided in major rural hospitals to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either not available from their general practitioner, or for which their general practitioner has referred them for treatment. An emergency department can provide a range of services and may result in an admission to hospital or in-treatment without admission. Not all public hospitals provide emergency care services. Privately provided contracted emergency services are included.

Public Hospital Non-admitted Patients
Medical officers, nurses and allied health staff provide non-admitted (out-patient) care services and include clinics for pre and post surgical care, allied health care and medical care, as well as emergency services provided in the remainder of rural hospitals not included under the Emergency Department service.

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

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

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, food and meal services, transport and home maintenance. These services aim to support people to stay at home where their capacity for independent living is at risk of premature admission to long-term residential care;

The Transition Care Program aims to help older people's independence and confidnece at the end of a hospital stay by assisting them to maintain or improve their functional ability. This program provides the person with more time and support in anon-hospital environment to complete their restorative process, optimise their functional capacity and assists them and their family to access longer term care arrangements;

Non-government continuing care programs that offer residential care type services for frail aged or youger 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;

Residential care in rural areas provided for peoplee assessed as no longer being able to live at home and include nursing home care provided by the State, nursing home type care provided in public hospitals and hostel care; and

Chronic illness support services providing people with a chronic condition with treatment and preventive care to enable them to remain healthy at home. Services include chronic disease support initiatives which aim to improve the life of those with chronic conditions, reduce avoidable hospital admissions and inpatient length-of-stay, emergency department attendance, and not-for-profit sector contracts that provide community members with services and support for a range of chronic conditions and illnesses.

Mental Health
Contracted mental health services describe inpatient care in an authorised ward and community mental health services provided by Health Services under agreement with the Mental Health Commission for specialised admitted and community mental health.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 7 Employee benefits expense		
Salaries and wages (a)	860,214	833,434
Superannuation - defined contribution plans (b)	74,065	68,380
	934,279	901,814

(a) Includes the value of the fringe benefits to employees plus the fringe benefits tax component, the value of superannuation contribution component of leave entitlements and redundancy payments of $1.766 million ($1.736 million in 2014/15).

(b) Defined contribution plans include West State, Gold State and GESB Super and other eligible funds.

Employment on-costs expenses (workers' compensation insurance) are included at note 13 'Other expenses'.

Note 8 Patient support costs		
Medical supplies and services	91,587	84,840
Domestic charges	9,473	9,196
Fuel, light and power	29,691	28,608
Food supplies	10,817	10,247
Patient transport costs	96,815	80,193
Aboriginal health services	37,758	44,136
Pathology services	16,030	15,191
Purchase of health care services	12,547	12,647
Purchase of outsourced medical services	23,549	23,259
Purchase of other outsourced services	3,607	3,504
Grants payments	6,434	7,240
	338,308	319,061
Note 9 Finance costs		
Interest expense	272	369
Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	47,175	44,329
Site infrastructure	7,264	6,903
Leasehold improvements	414	809
Computer equipment	522	321
Furniture and fittings	238	195
Motor vehicles	685	896
Medical equipment	10,164	9,015
Other plant and equipment	1,336	1,249
	67,798	63,717
Amortisation		
Computer software	660	40
	68,458	63,757
Note 11 Loss on disposal of non-current assets		
Carrying amount of non-current assets disposed:		
Property, plant and equipment	184	4,958
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(35)	(2)
Net loss	149	4,956

	2016 $000	2015 $000
Note 12 Repairs, maintenance and consumable equipment		
Repairs and maintenance	23,430	22,134
Consumable equipment	10,336	13,532
	33,766	35,666
Note 13 Other expenses		
Communications	3,879	4,544
Computer services	2,874	2,165
Workers compensation insurance (a)	18,333	14,454
Other employee related expenses	24,474	23,804
Insurance	4,832	4,606
Legal expenses (b)	87	11,852
Motor vehicle expenses	4,870	5,329
Operating lease expenses	35,571	43,781
Printing and stationery	4,134	4,052
Doubtful debts expense	1,032	1,521
Purchase of outsourced services	16,119	19,033
Write-down of assets	1,944	4,542
Other	14,587	14,210
	132,736	153,893

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

(b) $11.656 million was paid in 2014/15 as settlement on a litigation claim, for which $10.000 million was included in contingent liabilities for 2013/14.

Note 14 Patient charges		
Inpatient bed charges	25,915	25,020
Inpatient other charges	-	258
Outpatient charges	29,138	26,505
	55,053	51,783
Note 15 Grants and contributions		
(i) Commonwealth grants and contributions		
Recurrent		
Nursing homes	4,857	5,477
Aged Care Training Program	-	35
Assistance with Care and Housing for the Aged	104	-
Bringing Them Home	105	105
Community Aged Care Program	885	956
Customs	-	179
Dept of Veteran Affairs - Home & Domiciliary Care	62	156
Extended Aged Care in the Home	701	618
FaHCSIA Respite for Young Carer, RSCYP and Mental Health	493	209
Healthy for Life	1,269	1,250
Job Creation Packages	891	751
Mobile Respite Program	542	572
National Respite Carers Program	1,579	1,548
National Health Reform Agreement via the Department of Health (a)	359,203	308,242
National Health Reform Agreement via the Mental Health Commission (a)	21,837	23,168
New Directions Mothers & Babies	1,276	1,147
New Directions OATSIH OVAHS	-	1,034
Office of Aboriginal and Torres Strait Islander Health	2,636	1,902
Primary Health Care Access Program - Kimberley	1,726	1,701
Substance Abuse	276	473
Sexual health	98	-
Other	30	189

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 15 Grants and contributions (continued)		
(i) Commonwealth grants and contributions (continued)		
Capital		
Busselton Health Campus	-	500
HHF – Redevelopment of Bunbury, Narrogin, and Collie Hospitals (Regional Priority Round)	1,000	20
Kalgoorlie Regional Resource Centre	-	300
Kimberley Renal - Support Services (b)	-	(1,290)
NPA Broome ED Redevelopment	2,339	4,225
NPA Kununurra CT Scanner	82	-
NPA Bunbury Day Therapy Unit	21	121
NPA Bunbury Rehab Beds	459	3,997
Renal Dialysis and Support Services	8,000	10,000
Simulated Learning Environment Program (b)	-	(11)
Strengthening Regional Cancer Services	2,361	750
Other	-	4
	412,832	368,328

(a) As from 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement for services, health teaching, training and research provided by local hospital networks (Health Services). The funding arrangement established under the Agreement requires the Commonwealth Government to make funding payments to the State Pool Account from which distributions to the local hospital networks (Health Services) are made by the Department of Health and Mental Health Commission. In previous financial years, the equivalent Commonwealth funding was received in the form of Service Appropriations from the State Treasurer, via the Department of Health.

(b) A refund was made in 2014/15 for both the Kimberley Renal Support Services and the Stimulated Learning Environment Program, as the funds provided in prior years were in excess of program requirements.

(ii) Other grants and contributions		
Australian College of Emergency Medicine - EMET Funding	716	599
Australian College of Emergency Medicine - STP	790	600
Closing the Gap	119	119
Disability Services Commission - Community Aids & Equipment Program	2,982	2,757
Disability Services Commission - NDIS My Way	951	-
Community Drug Service Team & other programs	4,760	4,681
Ear Health Funding	91	48
Global Diagnostics Bunbury StP - Radiology Registrar	-	110
Home Care Nursing OVAHS	110	159
McGrath Foundation - Breast Care Nurse Funding	420	393
Medical Specialists Outreach Assistance Program	492	1,666
Medicare Local - For Ante Natal Program	143	161
Medicare Local - Rural Primary Health Services	846	2,395
Mental Health Commission - Independent Community Living Strategy	400	400
Mental Health Commission - Perinatal Program	75	124
Mental Health Commission - service delivery agreement	64,115	57,669
Mental Health Commission - SSAMHS	5,580	4,710
New Directions OVAHS	221	221
Nindilingarri Cultural Health	-	136
Paediatric Outreach Services for Indigenous & Chronic Disease	-	387
Practise Incentive Payments	91	118
Prevocational General Practice Placements	646	901
Royal Australian & New Zealand College of Anesthetists	226	360
Royal Australian & New Zealand College of General Medicine & Geriatrics	-	243

	2016 $000	2015 $000
Note 15 Grants and contributions (continued)		
(ii) Other grants and contributions (continued)		
Royal Australian & New Zealand College of Obestricicians & Gynaecologists	360	366
Royal Australian & New Zealand College of Ophthalmologists	125	110
Royal Australian & New Zealand College of Psychiatrists - Specialist Training Program	240	120
Royal Australian College of Physicians Specialist Training Program	612	708
Royal Australian College of Physicians - STP Progress Report & Rural Support Loading	786	180
Royal Australian College of Surgeons	236	360
Rural Health West - Hedland Health Campus outpatients visiting specialists	390	291
Rural Health West - Visiting Specialists	916	-
Rural Health West - GP Anaesthetic Mentoring	13	-
Rural Health West - Outreach in the Outback (MH)	462	-
Rural Health West - Paediatric Outreach	674	-
Rural Health West - Health Ears - Better Hearing, Better Listening Program	227	-
Dry July Foundation	100	-
Telethon Funding	-	402
WAPHA Rural Primary Health Services	1,346	-
Other	587	1,032
Capital		
Enhancing Pilbara Health	-	500
Onslow Health Service Redevelopment	12,049	-
	102,897	83,026
Note 16 Donation revenue		
General public contributions	308	268
Hospital auxiliaries	190	134
Community fund-raising	370	-
Deceased estates	82	427
	950	829
Note 17 Other revenue		
Services to external organisations	9,659	7,337
Use of hospital facilities	1,128	1,018
Rent from commercial properties	523	396
Rent from residential properties	516	499
Staff and boarders' accommodation	8,842	8,996
Home and Community Care client fees	1,718	1,670
RiskCover insurance premium rebate	345	424
Act of grace and ex-gratia payments received for patients (note 23)	-	2,476
Other	1,068	1,150
	23,799	23,966
Note 18 Service appropriations		
Appropriation revenue received during the period:		
Service appropriations (via the Department of Health)	959,817	966,870

Service appropriations fund the net cost of services delivered. Appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the budgeted depreciation expense for the year and any agreed increase in leave liability during the year.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 19 Assets assumed		
Assets assumed from other State government agencies during the period:		
Medical equipment from Metropolitan Health Services	762	-
	762	-

Discretionary transfers of assets and liabilities between State Government agencies free of charge, are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions* in respect of the net assets transferred.

Note 20 Services received free of charge		
Services received free of charge from other State government agencies during the period:		
Department of Finance - government accommodation	56	74
Metropolitan Health Services - inventory	105	-
	161	74

Services received free of charge or for nominal cost, are recognised as revenues at the fair value of those services that can be reliably measured and which would have been purchased if they were not donated.

Note 21 Royalties for Regions Fund		
Regional Community Services Account:		
District Allowances	8,941	12,582
Ear Health	1,500	1,500
Fitzroy Kids Health	150	200
Patient Assisted Travel Scheme	10,480	10,080
Pilbara Cardiovascular Screen Program	-	123
Regional Palliative Care	1,250	1,000
Regional Kalgoorlie Telehealth	1,800	-
Royal Flying Doctor Service	4,000	4,000
Royal Flying Doctor Service - WA expansion of capacity	12,476	-
Rural Generalists Pathways	82	2,400
Rural in Reach - Women Support	-	250
St John Ambulance Services	1,503	2,844
Regional Infrastructure Headworks Account:		
Busselton Health Campus - ICT	-	7,973
Pilbara Health Partnership (Asset Investment)	1,773	5,182
Renal Dialysis Service Expansion	163	463
Southern Inland Health Initiative		
- District Medical Workforce Investment Program (Stream 1)	32,625	26,499
- District Hospital Investment Program (Stream 2)	5,310	4,869
- Residential Aged and Dementia Care Investment Program (Stream 6)	839	153
- Telehealth Investment Program (Stream 5)	3,961	3,338
	86,853	83,456

This is a sub-fund within the over-arching 'Royalties for Regions Fund' established under the Royalties for Regions Act 2009. The recurrent funds are committed to projects and programs in WA regional areas.

	2016 $000	2015 $000
Note 22 Restricted cash and cash equivalents (a)		
Current		
Royalties for Regions Fund	3,704	7,423
Capital grant from the Commonwealth Government (b)	28,091	23,828
Patient receipts under section 19 (2) of the Health Insurance Act 1973	3,413	3,362
Bequests	971	1,010
Capital funding from external sources	10,787	500
Mental Health Commission Funding (note 51)	1,014	196
Other	18	-
	47,998	36,319

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

(b) Unspent funds from the Commonwealth Government are committed to projects and programs in WA regional areas.

Note 23 Receivables		
Current		
Patient fee debtors (a)	14,031	12,679
Other receivables	6,497	5,802
Less: Allowance for impairment of receivables	(5,946)	(4,889)
Accrued revenue	4,013	7,363
GST receivable	3,829	4,039
	22,424	24,994
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	4,889	6,303
Doubtful debts expense	1,032	1,521
Amounts written off during the period	-	(459)
Amounts recovered during the period (a)	25	(2,476)
Balance at end of period	5,946	4,889

(a) The 2014/15 amount of $2.476 million were act of grace payments received for patient fee debts which were impaired in previous years. Under the Private Patient Scheme approved by the State Government, the Department of Health has commenced the ex-gratia payments towards patient fee debts in July 2015. The total amount of ex-gratia payments received is $2.455 million for 2015/16.

(b) The Health Service does not hold any collateral or other credit enhancements as security for receivables.

See also note 2(p) 'Receivables' and note 54 'Financial instruments'.

Note 24 Amounts receivable for services (Holding Account)		
Current	-	-
Non-current	586,669	509,870
	586,669	509,870

Represents the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability. See note 2(n) 'Amounts receivable for services'.

Note 25 Inventories		
Current		
Supply stores - at cost	2,075	1,985
Pharmaceutical stores - at cost	2,472	2,479
Other inventories - at cost	1,007	1,090
	5,554	5,554

See note 2(o) 'Inventories'.

WA Country Health Service

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	2016 $000	2015 $000
Note 26 Other current assets		
Prepayments	3,132	4,521
Note 27 Non-current assets classified as held for sale		
Opening balance	65	-
Land reclassified as held for sale	-	37
Buildings reclassified as held for sale	-	28
Less assets sold	(65)	-
Closing balance	-	65

Information on fair value measurements is provided in Note 29.

Note 28 Property, plant and equipment		
Land		
At fair value (a)	123,830	169,984
Buildings		
At fair value (a)	1,309,648	1,283,942
Accumulated depreciation	-	-
	1,309,648	1,283,942
Site infrastructure		
At fair value (b)	186,329	189,572
Accumulated depreciation	-	-
	186,329	189,572
Leasehold improvements		
At cost	3,598	3,598
Accumulated depreciation	(2,423)	(2,008)
	1,175	1,590
Computer equipment		
At cost	4,101	3,257
Accumulated depreciation	(2,133)	(1,745)
	1,968	1,512
Furniture and fittings		
At cost	4,265	4,230
Accumulated depreciation	(1,428)	(1,192)
	2,837	3,038
Motor vehicles		
At cost	7,613	7,884
Accumulated depreciation	(6,894)	(6,600)
	719	1,284
Medical equipment		
At cost	105,968	100,486
Accumulated depreciation	(67,166)	(58,051)
	38,802	42,435
Other plant and equipment		
At cost	16,414	15,281
Accumulated depreciation	(10,900)	(9,701)
	5,514	5,580
Works in progress		
Buildings under construction (at cost)	81,306	76,245
Other Work in Progress (at cost)	7,826	11,557
	89,132	87,802
Artworks		
At cost	181	265
Total property, plant and equipment	1,760,135	1,787,004

Note 28 Property, plant and equipment (continued)

(a) Land and buildings were revalued as at 1 July 2015 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2016 and recognised at 30 June 2016. In undertaking the revaluation, fair value was determined by reference to the market value for land: $55.682 million and buildings: $77.800 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 2(f) 'Property, plant and equipment'.

(b) Site infrastructure were revalued as at 1 July 2013 by the Western Australian Land Information Authority (Valuation Services). The valuation was performed during the year ended 30 June 2014 and recognised at 30 June 2014. A revaluation of site infrastructure has not been undertaken in the 2014/15 and 2015/16 financial years, as no external events have occurred since the last date of valuation, such as changes in market conditions, that would indicate that the fair value of site infrastructure recorded have materially changed. In undertaking the revaluation, fair values of site infrastructure were determined on the basis of depreciated replacement cost. See note 2(f) 'Property, plant and equipment'.

Site infrastructure include roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

(c) Information on fair value measurements is provided in Note 29.

	2016 $000	2015 $000
Reconciliations		
Reconciliations of the carrying amount of property, plant and equipment at the beginning and end of the reporting period are set out below.		
Land		
Carrying amount at start of period	169,984	192,198
Transfer from/(to) other reporting entities	(561)	-
Disposals	-	(32)
Classified as held for sale	-	(37)
Revaluation increments / (decrements)	(45,647)	(22,145)
Transfer between asset classes	54	-
Carrying amount at end of period	123,830	169,984
Buildings		
Carrying amount at start of period	1,283,942	1,160,687
Additions	836	4,237
Transfers from Work in Progress	81,253	142,163
Transfer from/(to) other reporting entities	(345)	8,991
Disposals	-	(3,285)
Classified as held for sale	-	(28)
Revaluation increments / (decrements)	(8,975)	14,804
Depreciation	(47,175)	(44,329)
Transfer between asset classes	160	800
Write-down of assets	(48)	(98)
Carrying amount at end of period	1,309,648	1,283,942
Site infrastructure		
Carrying amount at start of period	189,572	197,685
Transfers from Work in Progress	4,021	-
Disposals	-	(1,211)
Depreciation	(7,264)	(6,903)
Carrying amount at end of period	186,329	189,572
Leasehold improvements		
Carrying amount at start of period	1,590	1,243
Depreciation	(415)	(809)
Transfer between asset classes	-	1,156
Carrying amount at end of period	1,175	1,590

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	2016 $000	2015 $000
Note 28 Property, plant and equipment (continued)		
Computer equipment		
Carrying amount at start of period	1,512	1,696
Additions	961	1,108
Transfers from Work in Progress	197	12
Disposals	(13)	(4)
Depreciation	(522)	(321)
Transfer between asset classes	(30)	(957)
Write-down of assets	(137)	(22)
Carrying amount at end of period	1,968	1,512
Furniture and fittings		
Carrying amount at start of period	3,038	2,202
Additions	477	1,133
Transfers from Work in Progress	52	256
Disposals	-	(11)
Depreciation	(238)	(195)
Transfer between asset classes	(121)	(79)
Write-down of assets	(371)	(268)
Carrying amount at end of period	2,837	3,038
Motor vehicles		
Carrying amount at start of period	1,284	2,154
Additions	135	29
Disposals	(6)	-
Depreciation	(685)	(896)
Write-down of assets	(9)	(3)
Carrying amount at end of period	719	1,284
Medical equipment		
Carrying amount at start of period	42,435	45,936
Additions	5,548	6,597
Transfers from Work in Progress	819	206
Transfer from/(to) other reporting entities	762	-
Disposals	(93)	(305)
Depreciation	(10,164)	(9,015)
Transfer between asset classes	(25)	(165)
Write-down of assets	(480)	(819)
Carrying amount at end of period	38,802	42,435
Other plant and equipment		
Carrying amount at start of period	5,580	7,017
Additions	971	631
Transfers from Work in Progress	291	111
Disposals	(7)	(111)
Depreciation	(1,335)	(1,249)
Transfer between asset classes	45	(755)
Write-down of assets	(31)	(64)
Carrying amount at end of period	5,514	5,580
Works in progress		
Carrying amount at start of period	87,802	144,260
Additions	91,860	89,753
Transfers between asset classes	(3,029)	-
Capitalised to asset classes	(86,633)	(142,943)
Write-down of assets	(868)	(3,268)
Carrying amount at end of period	89,132	87,802

	2016 $000	2015 $000
Note 28 Property, plant and equipment (continued)		
Artworks		
Carrying amount at start of period	265	70
Transfers from Work in Progress	-	195
Transfer between asset classes	(84)	-
Carrying amount at end of period	181	265
Total property, plant and equipment		
Carrying amount at start of period	1,787,004	1,755,148
Additions	100,789	103,488
Disposals	(119)	(4,958)
Transfer from/(to) other reporting entities	(144)	8,991
Classified as held for sale	-	(65)
Revaluation increments / (decrements)	(54,622)	(7,341)
Depreciation	(67,798)	(63,717)
Reclassification of Intangible assets	(3,030)	-
Write-down of assets	(1,944)	(4,542)
Carrying amount at end of period	1,760,135	1,787,004

Note 29 Fair value measurements

(a) Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:

1) quoted prices (unadjusted) in active markets for identical assets (level 1).
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) Inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Asset measured at fair value 2016				
Land				
Vacant land	-	5,085	-	5,085
Residential	-	50,597	-	50,597
Specialised	-	-	68,148	68,148
Buildings				
Residential	-	77,800	-	77,800
Specialised	-	-	1,231,848	1,231,848
Site infrastructure	-	-	186,329	186,329
	-	133,482	1,486,325	1,619,807

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Asset measured at fair value 2015				
Land				
Non-current assets classified as held for sale (Note 27)	-	37	-	37
Vacant land	-	7,105	-	7,105
Residential	-	70,001	-	70,001
Specialised	-	-	92,878	92,878
Buildings				
Non-current assets classified as held for sale (Note 27)	-	28	-	28
Residential	-	101,741	-	101,741
Specialised	-	-	1,182,200	1,182,200
Site infrastructure	-	-	189,572	189,572
	-	178,912	1,464,650	1,643,562

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Note 29 Fair value measurements (continued)

(b) Valuation techniques used to derive level 2 and level 3 fair values

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services). Prior to 1 July 2014, the Health Service also obtained independent valuations of site infrastructure from the Landgate Valuation Services. Two principal valuation techniques are applied to the measurement of fair values:

Market Approach (Comparable Sales)
The Health Service's residential properties and vacant land are valued under the market approach. This approach provides an indication of value by comparing the asset with identical or similar properties for which price information is available. Analysis of comparable sales information and market data provides the basis for fair value measurement.

The best evidence of fair value is current prices in an active market for similar properties. Where such information is not available, Landgate Valuation Services considers current prices in an active market for properties of different nature or recent prices of similar properties in less active markets, and adjusts the valuation for differences in property characteristics and market conditions.

For properties with buildings and other improvements, the land value is measured by comparison and analysis of open market transactions on the assumption that the land is in a vacant and marketable condition. The amount determined is deducted from the total property value and the residual amount represents the building value.

Cost Approach
Properties of a specialised nature that are rarely sold in an active market or are held to deliver public services are referred to as non-market or current use type assets. These properties do not normally have a feasible alternative use due to restrictions or limitations on their use and disposal. The existing use is their highest and best use.

For current use land assets, fair value is measured firstly by establishing the opportunity cost of public purpose land, which is termed the hypothetical alternate land use value. This approach assumes unencumbered land use based upon potential highest and best alternative use as represented by surrounding land uses and market analysis.

Fair value of the land is then determined on the assumption that the site is rehabilitated to a vacant marketable condition. This requires costs associated with rehabilitation to be deducted from the hypothetical alternate land use value of the land. Costs may include building demolition, clearing, planning approvals and time allowances associated with realising that potential.

In some instances the legal, physical, economic and socio political restrictions on a land results in a minimal or negative current use land value. In this situation the land value adopted is the higher of the calculated rehabilitation amount or the amount determined on the basis of comparison to market corroborated evidence of land with low level utility. Land of low level utility is considered to be grazing land on the urban fringe of the metropolitan area with no economic farming potential or foreseeable development or redevelopment potential at the measurement date.

The Health Service's hospitals and medical centres are specialised buildings and site infrastructure valued under the cost approach. Staff accommodation on hospital grounds is also considered as specialised buildings for valuation purpose. This approach uses the depreciated replacement cost method which estimates the current cost of reproduction or replacement of the buildings and site infrastructure, on its current site, less deduction for physical deterioration and relevant forms of obsolescence. Depreciated replacement cost is the current replacement cost of an asset less, where applicable, accumulated depreciation calculated on the basis of such cost to reflect the already consumed or expired future economic benefits of the asset.

The valuation under cost approach commences in the fourth year subsequent to the building commissioning, as the actual construction cost, with adjustment of the movement in building cost index, is an approximation of current replacement cost in the first three years. The building cost index is published by the Department of Finance's Building Management and Works.

The techniques involved in the determination of the current replacement costs include:

a) Review and updating of the 'as-constructed' drawing documentation;
b) Categorisation of the drawings using the Building Utilisation Categories (BUC's) which designate the functional areas typically provided by the following types of clinical facilities. Each BUC has different cost rates which are calculated from the historical construction costs of similar clinical facilities and are adjusted for the year-to-year change in building costs using building cost index.
   - Nursing Posts and Medical Centres
   - District Hospitals
   - Major District Hospitals
   - Regional Hospitals
c) Measurement of the general floor areas;
d) Application of the BUC cost rates per square meter of general floor areas;
e) Application of the applicable regional cost indices, which are used throughout the construction industry to estimate the additional costs associated with building construction in locations outside of the Perth area.

Note 29 Fair value measurements (continued)

The maximum effective age used in the valuation of specialised buildings and site infrastructure is 50 years. The effective age of buildings and site infrastructure is initially calculated from the commissioning date, and is reviewed after the buildings and site infrastructure have undergone substantial renewal, upgrade or expansion.

The straight line method of depreciation is applied to derive the depreciated replacement cost, assuming a uniform pattern of consumption over the initial 37 years of asset life (up to 75% of current replacement costs). All specialised buildings and site infrastructure are assumed to have a residual value of 25% of their current replacement costs.

The valuations are prepared on a going concern basis until the year in which the current use is discontinued.

Buildings with definite demolition plan are not subject to revaluation. The depreciated replacement costs at the last valuation dates for these buildings are written down to the income statement as depreciation expenses over their remaining useful life.

(c) Fair value measurements using significant unobservable inputs (Level 3)

The following table represents the changes in level 3 items for the period ended 30 June 2016:

2016	Site Infrastructure $000	Land $000	Buildings $000
Fair value at start of period	189,572	92,878	1,182,200
Additions	4,021	-	80,535
Disposals	-	(170)	-
Revaluation increments/(decrements)	-	(24,560)	12,247
Transfers between asset classes	-	-	70
Depreciation	(7,264)	-	(43,204)
Fair value at end of period	186,329	68,148	1,231,848

The following table represents the changes in level 3 items for the period ended 30 June 2015:

2015	Site Infrastructure $000	Land $000	Buildings $000
Fair value at start of period	197,686	98,736	1,051,444
Additions	-	-	151,424
Disposals	-	(32)	25,331
Revaluation increments/(decrements)	(1,211)	(6,236)	(3,285)
Transfers from/(to) Level 2 (a)	-	410	-
Depreciation	(6,903)	-	(42,714)
Fair value at end of period	189,572	92,878	1,182,200

(a) Residential land amalgamated into a hospital site.

(d) Valuation processes

The Department of Health manages the valuation processes for the Health Service. These include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports. Valuation processes and results are discussed with the chief finance officer at least once every year.

Landgate Valuation Service determines the fair values of the Health Service's land and buildings, and prior to 1 July 2014, also determined the fair values of site infrastructure. A quantity surveyor is engaged by the Department of Health to provide an update of the current replacement costs for specialised buildings and site infrastructure. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor and calculates the depreciated replacement costs.

	2016 $000	2015 $000
Note 30 Intangible assets		
Computer software		
At cost	8,487	331
Accumulated amortisation	(838)	(266)
	7,649	65
Works in progress		
Computer software under development (at cost)	2,210	170
Total intangible assets	9,859	235

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Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 30 Intangible assets (continued)		
Reconciliation:		
Reconciliation of the carrying amount of intangible assets at the beginning and end of the period is set out below.		
Computer software		
Carrying amount at start of period	65	64
Additions	6	40
Transfers from Work in Progress	5,209	-
Disposals	(1)	-
Amortisation expense	(660)	(40)
Transfer between asset classes	3,030	-
Carrying amount at end of period	7,649	65
Works in progress		
Carrying amount at start of year	170	116
Additions	7,249	54
Capitalised to asset classes	(5,209)	-
Carrying amount at end of year	2,210	170

Note 31 Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets as at 30 June 2016.

The Health Service held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period, there were no intangible assets not yet available for use.

Note 32 Payables

Current		
Trade creditors	28,822	24,129
Accrued expenses	60,774	56,416
Accrued salaries	8,823	35,727
Accrued interest	20	28
	98,439	116,300

See also note 2(q) 'Payables' and note 54 'Financial instruments'.

Note 33 Borrowings

Current		
Department of Treasury loans (a)	1,600	1,518
Non-current		
Department of Treasury loans (a)	5,267	6,865
	6,867	8,383

(a) 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 by the Department of Health on behalf of the Health Service. Interest rates are linked to the State Government's debt servicing costs.

	2016 $000	2015 $000
Note 34 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	60,416	59,876
Time off in lieu leave (a)	23,487	22,110
Long service leave (b)	39,678	38,679
Gratuities	1,393	1,361
Deferred salary scheme (c)	2,007	1,939
	126,981	123,965
Non-current		
Employee benefits provision		
Long service leave (b)	24,994	25,101
Gratuities	206	276
	25,200	25,377
	152,181	149,342

(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 the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	65,424	63,766
More than 12 months after the end of the reporting period	18,479	18,220
	83,903	81,986

(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 the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	10,167	9,811
More than 12 months after the end of the reporting period	54,505	53,969
	64,672	63,780

(c) Deferred salary scheme liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	935	1,076
More than 12 months after end of the reporting period	1,072	863
	2,007	1,939

Note 35 Other current liabilities		
Current		
Refundable deposits	2	-
Other	12	104
	14	104

Note 36 Contributed equity

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

WA Country Health Service

Notes to the Financial Statements
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Note 36 Contributed equity (continued)	2016 $000	2015 $000
Balance at start of period	1,581,246	1,483,046
Contributions by owners		
Capital appropriation (a)	29,491	52,489
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	60,866	36,720
Transfer of net assets from other agencies (b) (c) (d)	-	8,991
	90,357	98,200
Distributions to owners		
Transfer of net assets to other agencies (b) (c) (d):		
Land in Morawa and Northampton transferred to the Department of Land	(170)	-
Land and Buildings transferred to Department of Housing	(736)	-
Balance at end of period	1,670,697	1,581,246

(a) Treasurer's Instruction (TI) 955 *'Contributions by Owners Made to Wholly Owned Public Sector Entities'* designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 *'Contributions by Owners Made to Wholly-Owned Public Sector Entities'*.

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

Under TI 955 non-discretionary and non-reciprocal transfers of net assets between state government agencies as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non-discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

(c) TI 955 requires non-reciprocal transfers of net assets to Government to be accounted for as distribution to owners in accordance with AASB Interpretation 1038.

(d) In 2014/15, 24 apartments in the Pelago East Development in Karratha were transferred from the Department of Housing to provide rental accommodation to the Health Service's employees.

Note 37 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	498,179	505,520
Net revaluation increments / (decrements) (b) :		
Land	(45,647)	(22,145)
Buildings	(8,975)	14,804
Balance at end of period	443,557	498,179

(a) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets.

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

Note 38 Accumulated surplus/(deficit)		
Balance at start of period	32,102	12,013
Result for the period	50,141	20,089
Balance at end of period	82,243	32,102

Note 39 Notes to the Statement of Cash Flows

Reconciliation of cash

Cash assets at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash and cash equivalents	18,227	17,094
Restricted cash and cash equivalents	47,998	36,319
	66,225	53,413

	2016 $000	2015 $000
Note 39 Notes to the Statement of Cash Flows (continued)		
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(937,878)	(929,436)
Increase/(decrease) in assets:		
GST receivable	(210)	599
Receivables	(1,328)	3,989
Inventories	1	283
Prepayments and other current assets	(1,387)	(608)
Decrease/(increase) in liabilities:		
Payables	18,125	(20,843)
Current provisions	(3,016)	(8,012)
Non-current provisions	176	(1,800)
Income received in advance	-	331
Other current liabilities	90	(43)
Non-cash items:		
Doubtful debts expense (note 13)	(1,032)	(1,521)
Depreciation and amortisation expense (note 10)	(68,458)	(63,757)
Loss from disposal of non-current assets (note 11)	(149)	(4,956)
Interest paid by Department of Health	(280)	(380)
Services received free of charge (note 20)	(161)	(74)
Write off of Receivables (note 23)	-	459
Write down of property, plant and equipment (note 13 and note 28)	(1,944)	(4,542)
Adjustment for other non-cash items	(1)	-
Net cost of services (Statement of Comprehensive Income)	(997,452)	(1,030,311)
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	959,817	966,870
Royalties for Regions Fund as per Statement of Comprehensive Income	86,853	83,456
Royalties for Regions Fund credited directly to Contributed Equity (Refer Note 36)	60,866	36,720
Capital contributions credited directly to Contributed Equity (Refer Note 36)	29,491	52,489
	1,137,027	1,139,535
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to Department of Treasury	(280)	(380)
Repayment of interest-bearing liabilities to Department of Treasury	(1,516)	(1,450)
Accrual appropriations	(76,800)	(80,716)
	(78,596)	(82,546)
Cash Flows from State Government as per Statement of Cash Flows	1,058,431	1,056,989

At the end of the reporting period, 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**		
a)	Revenue and debts written off under the authority of the Accountable Authority.	-	459
b)	Public and other property written off under the authority of the Accountable Authority.	-	275
		-	734

Note 41 Losses of public moneys and other property		
Losses of public moneys and public or other property through theft or default	3	-
Less amount recovered	-	-
Net losses (a)	3	-

(a) Items pending settlement of claim through insurance.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000
Note 42 Gifts of public property		
Gifts of public property provided by the Health Service	-	19
Note 43 Services provided free of charge		
Mental Health Commission - contracted mental health services (a)	1,056	523

(a) The costs of mental health services provided under the Service Delivery Agreement is $1.056 million above the level of funding received from the Mental Health Commission.

Note 44 Remuneration of 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.

Remuneration of senior officers
The number of senior officers other than senior officers reported as members of the Accountable Authority, whose total fees, salaries, superannuation, non-monetary benefits and other benefits for the financial year, fall within the following bands are:

$40,001 - $50,000	1	-
$60,001 - $70,000	1	-
$70,001 - $80,000	1	1
$110,001 - $120,000	1	-
$140,001 - $150,000	-	1
$150,001 - $160,000	-	1
$180,001 - $190,000	1	-
$200,001 - $210,000	1	3
$210,001 - $220,000	2	-
$220,001 - $230,000	1	2
$230,001 - $240,000	1	2
$240,001 - $250,000	2	1
$250,001 - $260,000	1	-
$280,001 - $290,000	-	1
$300,001 - $310,000	1	-
$310,001 - $320,000	1	-
$380,001 - $390,000	-	1
$410,001 - $420,000	1	-
$440,001 - $450,000	-	1
$450,001 - $460,000	1	-
$460,001 - $470,000	-	1
Total	17	15

	$000	$000
Base remuneration and superannuation	3,691	3,679
Annual leave and long service leave accruals	(81)	(14)
Other benefits	212	67
The total remuneration of senior officers	3,822	3,732

The total remuneration includes the superannuation expense incurred by the Health Service in respect of senior officers other than senior officers reported as members of the Accountable Authority.

Note 45 Remuneration of auditor

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

Auditing the accounts, financial statements and key performance indicators	595	589

	2016 $000	2015 $000

Note 46 Commitments

The commitments below are inclusive of GST where relevant.

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	185,106	109,153
Later than 1 year, and not later than 5 years	120,376	318,827
	305,482	427,980

Operating lease commitments:
Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	9,997	13,424
Later than 1 year, and not later than 5 years	6,166	6,928
Later than 5 years	113	313
	16,276	20,665

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.

Private sector contracts for the provision of health services:
Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	45,211	102,041
Later than 1 year, and not later than 5 years	66,172	24,820
	111,383	126,861

Other expenditure commitments:
Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:

Within 1 year	53,907	40,191
Later than 1 year, and not later than 5 years	69,596	73,474
Later than 5 years	10,058	20,889
	133,561	134,554

Note 47 Contingent liabilities and contingent assets

Contingent liabilities
In addition to the liabilities included in the financial statements, the Health Service has the following contingent liabilities:

Litigation in progress		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	10,115	10,175
Number of claims	6	6
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Environment and Regulation (DER)	300	-

Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Regulation (DER). In accordance with the Act, DER 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.

Contingent assets

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

WA Country Health Service

Notes to the Financial Statements
For the year ended 30 June 2016

	2016 $000	2015 $000

Note 48 Events occurring after the end of the reporting period

The Health Services Act 2016 has been enacted to replace the Hospitals and Health Services Act 1927 as from 1 July 2016. Under the new Act, the Health Service will become one of the health service providers that are separate board-governed statutory authorities.

This is the final financial year in which the Health Service operates as a statutory authority under the Hospitals and Health Services Act.

Note 49 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 50 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service but is not subject to operational control by the Health Service.

The Health Service had no affiliated bodies during the financial year.

Note 51 Special purpose accounts

Mental Health Commission Fund (WA Country Health Service) Account

The purpose of the special purpose account is to receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the WA Country Health Service, in accordance with the annual Service Agreement and subsequent agreements.

The special purpose account has been established under section 16(1)(d) of the Financial Management Act.

Balance at the start of period	196	-
Add Receipts:		
Service delivery agreement		
State contributions (note 15(ii))	64,115	57,669
Commonwealth contributions (note 15(i))	21,837	23,168
Other (note 15(ii))	6,055	5,233
	92,006	86,070
Less Payments	(91,188)	(85,874)
Balance at the end of period	1,014	196

Note 52 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.

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:

Balance at the start of period	1,067	953
Add Receipts	1,442	1,588
	2,509	2,541
Less Payments	(1,304)	(1,474)
Balance at the end of period	1,205	1,067

Note 53 Explanatory Statement

Significant variances between actual results for 2015 and 2016

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. Variations greater than 10% but less than $ 1 million have not been considered material for explanatory purposes.

	Note	2016 Actual $000	2015 Actual $000	Variance $000
Expenses				
Employee benefits expense		934,279	901,814	32,465
Fees for visiting medical practitioners		85,015	78,727	6,288
Patient support costs		338,308	319,061	19,247
Finance costs		272	369	(97)
Depreciation and amortisation expense		68,458	63,757	4,701
Loss on disposal of non-current assets	(a)	149	4,956	(4,808)
Repairs, maintenance and consumable equipment		33,766	35,666	(1,900)
Other expenses	(b)	132,736	153,893	(21,157)
Income				
Patient charges		55,053	51,783	3,270
Commonwealth grants and contributions	(c)	412,832	368,328	44,504
Other grants and contributions	(d)	102,897	83,026	19,871
Donation revenue		950	829	121
Other revenue		23,799	23,966	(168)
Service appropriations		959,817	966,870	(7,053)
Assets assumed		762	-	762
Services received free of charge		161	74	87
Royalties for Regions Fund		86,853	83,456	3,397

(a) Loss on disposal of non-current assets
The decrease in losses on disposal is attributable to the de-recognition of clinics in Warmun and Wickham that were not expected to generate any future economic benefits, and the closure of the Coonanna clinic that was not able to be relocated and reused due to its asbestos construction, in 2014/15.

(b) Other expenses
The decrease in Other Expenses is attributable to a one off pre Riskcover legal settlement that occurred in 2014/15 and reductions in operating lease costs, primarily associated with staff accommodation in the North of the State.

(c) Commonwealth grants and contributions
Grants and Contributions are received for specific and/or non recurrent programs and, consequently, are variable from year to year. The most significant change was a $46.6 million increase in hospital activity payments received from the Commonwealth under the National Health Reform Agreement. Other changes in Commonwealth grants and contributions are detailed in Note 15(i).

(d) Other grants and contributions
Grants and Contributions are received for specific and/or non recurrent programs and, consequently, are variable from year to year. The receipt of a $12 million contribution in 2015/16, from Chevron Australia towards the cost of the Onslow Hospital redevelopment was the most significant. Changes in Other grants and contributions are detailed in Note 15(ii).

Significant variances between estimated and actual results for 2016

Significant variations between the estimates and actual results for 2016 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	2016 Actual $000	2016 Estimates $000	Variance $000
Operating expenses			
Employee benefits expense	934,279	939,813	(5,534)
Other goods and services	658,704	617,365	41,339
Total expenses	1,592,983	1,557,178	35,805
Less: Revenues	(595,531)	(556,592)	(38,939)
Net cost of services	997,452	1,000,586	(3,134)

No explanations have been provided, as variations between estimated and actual results are not considered to be significant.

Note 54 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 the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at note 54 c) 'Financial Instrument disclosures' and note 23 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 23). 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 the end of the reporting period, there were no significant concentrations of credit risk.

All debts are individually reviewed, on a timely basis at 30, 60, 90 and 120 days. In circumstances where a third party is responsible for payment, or there are legal considerations, payment of accounts can be delayed considerably. Unpaid debts are referred to an external debt collection service within six months of the account being raised.

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 54 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 normal operations.

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.

Notes to the Financial Statements
For the year ended 30 June 2016

Note 54 Financial Instruments (continued)

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

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 instruments. 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 with the Department of Treasury and are at variable interest rates with varying maturities. The risk is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

b) **Categories of financial instruments**

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are :

	2016 $000	2015 $000
Financial Assets		
Cash and cash equivalents	18,227	17,094
Restricted cash and cash equivalents	47,998	36,319
Loans and receivables	605,265	530,825
Financial Liabilities		
Financial liabilities measured at amortised cost	105,306	124,683

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

Note 54 Financial Instruments (continued)

c) **Financial Instrument disclosures**

Credit Risk

The following table discloses the Health Service's maximum exposure to credit risk and the ageing analysis of financial assets. The Health Service's maximum exposure to credit risk at the end of the reporting period 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.

Aged analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired Financial assets
			1 - 3 months	3 - 12 months	1 - 5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2016							
Cash and cash equivalents	18,227	18,227	-	-	-	-	-
Restricted cash and cash equivalents	47,998	47,998	-	-	-	-	-
Receivables	18,595	9,442	4,612	2,479	2,040	21	-
Amounts receivable for services	586,669	586,669	-	-	-	-	-
	671,489	662,336	4,612	2,479	2,040	21	-
2015							
Cash and cash equivalents	17,094	17,094	-	-	-	-	-
Restricted cash and cash equivalents	36,319	36,319	-	-	-	-	-
Receivables	20,955	12,515	2,364	3,156	2,705	215	-
Amounts receivable for services	509,870	509,870	-	-	-	-	-
	584,238	575,798	2,364	3,156	2,705	215	-

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

Note 54 Financial Instruments (continued)

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

Liquidity risk and interest rate exposure

The following table details the Health Service's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2016										
Financial Assets										
Cash and cash equivalents	-	18,227	-	-	18,227	18,227	18,227	-	-	-
Restricted cash and cash equivalents	-	47,998	-	-	47,998	47,998	47,998	-	-	-
Receivables	-	18,595	-	-	18,595	18,595	18,595	-	-	-
Amounts receivable for services	-	586,669	-	-	586,669	586,669	-	-	-	586,669
		671,489	-	-	671,489	671,489	84,820	-	-	586,669
Financial Liabilities										
Payables	-	98,439	-	-	98,439	98,439	98,439	-	-	-
Department of Treasury Loans	3.26%	6,867	-	6,867	-	7,235	443	1,328	5,465	
		105,306	-	6,867	98,439	105,675	98,882	1,328	5,465	-

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

Note 54 Financial Instruments (continued)

c) Financial instrument disclosures (continued)

Liquidity risk and interest rate exposure (continued)

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2015										
Financial Assets										
Cash and cash equivalents	-	17,094	-	-	17,094	17,094	17,094	-	-	-
Restricted cash and cash equivalents	-	36,319	-	-	36,319	36,319	36,319	-	-	-
Receivables	-	20,955	-	-	20,955	20,955	20,955	-	-	-
Amounts receivable for services	-	509,870	-	-	509,870	509,870	-	-	-	509,870
		584,238	-	-	584,238	584,238	74,368	-	-	509,870
Financial Liabilities										
Payables	-	116,300	-	-	116,300	116,300	116,300	-	-	-
Department of Treasury Loans	4.11%	8,383	-	8,383	-	9,200	452	1,357	7,301	90
		124,683	-	8,383	116,300	125,500	116,752	1,357	7,301	90

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

Note 54 Financial Instruments (continued)

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 end of the reporting period 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.

	Amount Exposed to Interest Rate Risk $000	-100 basis points Surplus $000	-100 basis points Equity $000	+100 basis points Surplus $000	+100 basis points Equity $000
2016					
Financial Liabilities					
Department of Treasury Loans	6,867	69	69	(69)	(69)
Total Increase/(Decrease)		69	69	(69)	(69)
2015					
Financial Liabilities					
Department of Treasury Loans	8,383	84	84	(84)	(84)
Total Increase/(Decrease)		84	84	(84)	(84)

Fair values

All financial assets and liabilities recognised in the Statement of Financial Position, 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.

Note 55 Schedule of income and expenses by service

	Public Hospital Admitted Patients		Palliative Care		Emergency Department		Public Hospital Non-Admitted Patients		Patient Transport	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	394,440	380,748	2,024	1,954	160,415	154,847	123,279	119,000	7,014	6,771
Fees for visiting medical practitioners	65,408	60,081	-	-	9,987	9,497	6,230	5,925	7	7
Patient support costs	141,914	133,840	511	482	45,307	42,729	39,266	37,032	36,603	34,521
Finance costs	230	312	1	2	3	4	38	51	-	-
Depreciation and amortisation expense	36,017	33,544	-	-	12,067	11,238	9,616	8,956	725	675
Loss on disposal of non-current assets	78	2,608	-	-	36	1,199	11	370	2	52
Repairs, maintenance and consumable equipment	14,468	15,282	5	5	5,430	5,736	4,269	4,509	174	184
Other expenses	14,792	35,764	1,147	1,197	7,936	11,443	2,367	5,053	53,062	41,372
Total cost of services	667,347	662,179	3,688	3,640	241,181	236,693	185,076	180,896	97,587	83,582
Income										
Patient charges	17,996	17,103	-	-	2,207	227	23,410	23,030	-	-
Commonwealth grants and contributions	241,778	203,703	-	-	67,654	83,161	64,033	41,284	-	-
Other grants and contributions	7,879	18,292	-	-	7,160	532	3,992	396	-	-
Donation revenue	458	485	3	3	166	101	127	72	-	-
Other revenue	13,908	14,005	95	96	2,889	2,910	2,076	2,090	-	-
Total income other than income from State Government	282,019	253,588	98	99	80,076	86,931	93,638	66,872	-	-
NET COST OF SERVICES	**385,328**	**408,591**	**3,590**	**3,541**	**161,105**	**149,762**	**91,438**	**114,024**	**97,587**	**83,582**
INCOME FROM STATE GOVERNMENT										
Service appropriations	404,021	409,273	2,371	2,518	138,883	123,752	88,985	107,505	72,061	66,659
Assets assumed	554	-	-	-	123	-	85	-	-	-
Services received free of charge	68	42	-	-	24	9	19	6	10	2
Royalties for Regions Fund	8,865	15,150	1,269	1,027	33,313	30,590	6,219	6,931	27,023	17,023
Total income from State Government	413,508	424,465	3,640	3,545	172,343	154,351	95,308	114,442	99,094	83,684
SURPLUS FOR THE PERIOD	**28,180**	**15,874**	**50**	**4**	**11,238**	**4,589**	**3,870**	**418**	**1,507**	**102**

(a) Includes services in addition to those provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

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

Note 55 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Continuing Care		Mental Health (a)		Total	
	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000	2016 $000	2015 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	103,720	100,085	64,617	62,374	78,770	76,035	934,279	901,814
Fees for visiting medical practitioners	1,209	1,150	113	107	2,061	1,960	85,015	78,727
Patient support costs	29,930	28,227	18,756	17,689	26,021	24,541	338,308	319,061
Finance costs	-	-	-	-	-	-	272	369
Depreciation and amortisation expense	6,477	6,032	2,220	2,068	1,336	1,244	68,458	63,757
Loss on disposal of non-current assets	14	469	5	161	3	97	149	4,956
Repairs, maintenance and consumable equipment	4,845	5,118	1,535	1,621	3,040	3,211	33,766	35,666
Other expenses	50,751	53,376	1,878	3,221	803	2,467	132,736	153,893
Total cost of services	196,946	194,457	89,124	87,241	112,034	109,555	1,592,983	1,558,243
Income								
Patient charges	54	-	11,224	11,423	162	-	55,053	51,783
Commonwealth grants and contributions	7,141	6,217	10,114	10,322	22,112	23,640	412,832	368,328
Other grants and contributions	4,192	535	4,043	368	75,631	62,903	102,897	83,026
Donation revenue	135	100	61	68	-	-	950	829
Other revenue	2,864	2,884	1,967	1,981	-	-	23,799	23,966
Total income other than income from State Government	14,386	9,736	27,409	24,162	97,905	86,543	595,531	527,932
NET COST OF SERVICES	**182,560**	**184,721**	**61,715**	**63,079**	**14,129**	**23,012**	**997,452**	**1,030,311**
INCOME FROM STATE GOVERNMENT								
Service appropriations	178,314	172,557	61,534	61,559	13,648	23,047	959,817	966,870
Assets assumed	-	-	-	-	-	-	762	-
Services received free of charge	20	9	9	6	11	-	161	74
Royalties for Regions Fund	7,952	11,127	1,458	1,608	754	-	86,853	83,456
Total income from State Government	186,286	183,693	63,001	63,173	14,413	23,047	1,047,593	1,050,400
SURPLUS FOR THE PERIOD	**3,726**	**(1,028)**	**1,286**	**94**	**284**	**35**	**50,141**	**20,089**

(a) Includes services in addition to those provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

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

Certification of key performance indicators

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2016

I hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the WA Country Health Service's performance and fairly represent the performance of the Health Service for the financial year ended 30 June 2016.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
REPORTING OFFICER

15 September 2016

Key performance indicators

Outcome 1

Outcome 2

Percentage of public patients discharged to home after admitted hospital treatment

Outcome 1
Effectiveness KPI

Rationale

The main goals of health care provision are to ensure that people receive appropriate evidence-based health care without experiencing preventable harm and that effective partnerships are forged between consumers, health care providers and organisations. Through achieving improvements in the specific priority areas that these goals describe, hospitals can deliver safer and higher-quality care, better outcomes for patients and provide a more effective and efficient health system.

Measuring the number of patients discharged to home after hospital care allows for the monitoring of changes over time that can enable the identification of the priority areas for improvement. This in turn enables the determination of targeted interventions and health promotion strategies, aimed at ensuring optimal restoration of patients' health. This will ensure the WA health system is effective and efficient, delivers safe high-quality care, and provides the best outcomes for patients.

Target

The 2015 target is ≥97.5% per cent.

The target is based on the best result achieved within the previous five years.

Improved or maintained performance is demonstrated by a result exceeding or equal to the target.

Results

During 2015, a total of 97.6 per cent of public patients in country WA, across all ages, were discharded to home after receiving admitted hospital treatment (see Table 10). This result is above the target of 97.5 per cent.

Table 10: **Percentage of public patients discharged to home after admitted hospital treatment, by age group, 2011–2015**

Age group (years)	Calendar years				
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
0–39	96.7	96.9	97.0	97.2	**97.4**
40–49	95.8	96.2	96.1	96.0	**96.4**
50–59	97.6	97.9	97.9	97.9	**97.8**
60–69	98.7	98.7	98.7	98.7	**98.6**
70–79	98.4	98.4	98.6	98.7	**98.7**
80+	96.6	96.9	97.1	97.2	**96.5**
All ages	97.1	97.3	97.4	97.5	**97.6**
Target (>)	97.4	97.4	97.4	97.4	**97.5**

Data source: Hospital Morbidity Data System.

Survival rates for sentinel conditions

Outcome 1
Effectiveness KPI

Rationale

Hospital survival indicators should be used as screening tools, rather than being assumed to be definitively diagnostic of poor quality and/or safety.

This indicator measures a hospital's performance in relation to restoring the health of people who have suffered a sentinel condition, specifically a stroke, acute myocardial infarction (AMI), or fractured neck of femur (FNOF). For these conditions, a good recovery is more likely when there is early intervention and appropriate care on presentation to an emergency department and on admission to hospital.

These three conditions have been chosen as they are particularly significant for the health care of the community and are leading causes of death and hospitalisation in Australia.

Patient survival after being admitted for one of these three sentinel conditions can be affected by many factors which include the diagnosis, the treatment given or procedure performed, age, co-morbidities at the time of the admission and complications which may have developed while in hospital.

Target

The 2015 target for each condition by age group:

Age group (years)	Sentinel condition		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥98.5	≥99.1	Not reported
50–59	≥97.9	≥99.2	Not reported
60–69	≥98.7	≥99.2	Not reported
70–79	≥95.3	≥98.7	≥98.7
80+	≥80.1	≥96.0	≥97.8

The target is based on the best result achieved within the previous five years. If a result of 100 per cent is obtained the next best result is adopted to address the issue of small numbers.

Improved or maintained performance is demonstrated by a result exceeding or equal to the target.

Results

During 2015, the survival rate for stroke was above the target for country WA patients aged 50–59, 70–79 and 80 years and over. For country WA patients aged 0–49 and 60–69 years the results were under target (see Table 11). Low numbers of cases lead to significant fluctuation in the results. The result in the 0–49 age group is derived from 59 of 61 cases surviving stroke, in the 60-69 age group 89 of 96 survived.

Table 11: **Survival rate for stroke, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–49	98.5	93.5	100.0	98.1	**96.7**	**≥98.5**
50–59	97.9	95.8	96.6	92.2	**98.2**	**≥97.9**
60–69	96.8	98.7	92.2	94.9	**92.7**	**≥98.7**
70–79	88.4	90.4	95.3	92.2	**96.1**	**≥95.3**
80+	72.4	76.6	80.1	78.4	**81.9**	**≥80.1**

Data source: Hospital Morbidity Data System.

In 2015, the survival rate for people who had an acute myocardial infarction for the 0–49 and 60–69 year age group reported 100 per cent survival rate, which was above the target of 99.1 and 99.2 per cent respectively. Survival rates for the 50–59, 70–79 and 80 years and over age groups was below the target (see Table 12). Low numbers of cases lead to significant fluctuation in the results. The results in the 50–59 age range are 100 cases of 101 survived; for 70–79, 122 of 124 cases survived and for 80+ 159 of 172 survived.

Table 12: **Survival rate for acute myocardial infarction, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–49	100.0	100.0	99.1	100.0	**100.0**	**≥99.1**
50–59	100.0	98.2	99.2	99.0	**99.0**	**≥99.2**
60–69	99.2	98.7	99.2	98.5	**100.0**	**≥99.2**
70–79	95.0	96.6	98.1	97.6	**98.4**	**≥98.7**
80+	89.9	92.1	96.0	90.7	**92.4**	**≥96.0**

Data source: Hospital Morbidity Data System.

The survival rate for country WA patients who had a fracture of the femur reported for the 70–79 and 80 years and over was below the target of 98.7 and 97.8 per cent respectively (see Table 13). Low numbers of cases lead to significant fluctuation in the results. The results in the 70–79 range represent 51 of 52 cases surviving, in the 80+ range 130 of 138 cases survived.

Table 13: **Survival rate for fractured neck of femur, by age group, 2011–2015**

Age group (years)	Calendar years					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
70–79	98.7	95.0	98.5	100.0	**98.1**	**≥98.7**
80+	97.8	96.3	96.9	93.9	**94.2**	**≥97.8**

Data source: Hospital Morbidity Data System.

Unplanned hospital readmissions within 28 days for selected surgical procedures

Outcome 1
Effectiveness KPI

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions can be assessed in order to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can help to ensure effective restoration to health and improve the quality of life of Western Australians.

Target

As a new indicator for 2015–16, no target is available. From 2016–17, targets will be set using the best audited result recorded within the previous five years.

Results

In 2015, the percentage of unplanned readmissions within 28 days to a country hospital for selected surgical procedures are presented in Table 14.

Table 14: **Percentage of unplanned readmissions within 28 days for selected surgical procedures 2015**

Unplanned readmissions	
Surgical Procedure	**2015 (%)**
Appendicectomy	3.7
Cataract Surgery	0.1
Hip Replacement	2.2
Hysterectomy	2.8
Knee Replacement	2.9
Prostatectomy	2.7
Tonsillectomy	6.4

Data source: Hospital Morbidity Data System.

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

Outcome 1
Effectiveness KPI

Rationale

Readmission rate is considered a global performance measure because it potentially points to deficiencies in the functioning of the overall health care system. Admissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. These readmissions necessitate patients spending additional time in hospital and use additional hospital resources.

Good intervention and appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation.

By measuring and monitoring this indicator, the level of potentially avoidable hospital readmissions for mental health patients can be assessed to identify key areas for improvement. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can aim to improve mental health and the quality of life of Western Australians.

For this indicator a sample period of three months is used, and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise.

Target

The 2015 target is ≤4.8 per cent.

The target is based on the best result achieved within the previous five years, where the result is greater than zero.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2015, the percentage of unplanned readmissions within 28 day to a country hospital by patients with a mental health condition was 8.1 per cent (see Table 15). This was above the target of 4.8 per cent. The variation to target results from the combination of the absence of supported care facilities in WACHS communities and the continuing expansion of inpatient mental health facilities as part of WACHS comitment to care closer to home. Where metropolitan facilities often discharge to supported care, WACHS discharges to home. If issues arise post discharge, readmission may represent the option that provides the best patient outcome.

Table 15: **Percentage of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2011–2015**

	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)
Unplanned readmissions	6.1	6.1	6.3	9.6	**8.1**
Target	≤4.8	≤4.8	≤4.8	≤4.8	**≤4.8**

Notes:

1. This indicator is based on a 3 month period each year. For 2015 data is reported from 1 September – 30 November.

Data source: Hospital Morbidity Data System.

Percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery

Outcome 1
Effectiveness KPI

Rationale

The Apgar score is an assessment of an infant's health at birth based on breathing, heart rate, colour, muscle tone and reflex irritability. An Apgar score is applied at one, five and possibly at ten minutes after delivery to determine how well the infant is adapting outside the mother's womb. The higher the Apgar score the better the health of the newborn infant.

An Apgar score of three or less is considered to be critically low, and can indicate complications and compromise for the infant.

This indicator provides a means of monitoring the effectiveness of maternity care during pregnancy and birth by identifying the potential incidence of sub-optimal outcomes. This can lead to the development and delivery of improved care pathways and interventions to improve the health outcomes of Western Australian infants.

Target

The 2015 target for liveborn infants with an Apgar score of three or less, by birth weight:

Birth weight (grams)	Percentage
0–1499	14.3
1500–1999	4.0
2000–2499	0.6
2500+	0.1

The target is based on the best result achieved within the previous five years, where the result is greater than zero.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2015, the percentage of liveborn infants with a birth weight of 0–1499 grams with an Apgar score of 3 or less was 30.0 per cent which was above the target of 14.3 per cent. There are very low numbers of cases in this indicator, small variations in the numbers result in significant fluctuation in percentage terms. This was an improvement on the 2014 result. For infants with a birth weight above 2500 grams the result was above the target of 0.1, the result represents 10 cases of 4646. Infants with a birth weight between 1500–2499 grams achieved a result equal to or below target (see Table 16).

Table 16: **Percentage of liveborn infants with an Apgar score of three or less, five minutes post-delivery, by birth weight, 2011–2015**

Birth weight (grams)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
0–1499	40.0	14.3	30.0	37.5	**30.0**	**14.3**
1500–1999	0.0	4.2	4.0	0.0	**0.0**	**4.0**
2000–2499	0.8	1.4	0.7	0.6	**0.6**	**0.6**
2500+	0.2	0.2	0.2	0.3	**0.2**	**0.1**

Note: Caution should be taken in the interpretation of the results as liveborn infant numbers used in the calculation of this measure are small and can result in significant variations between reporting years.

Data source: Midwives Notification System.

Average cost per casemix adjusted separation for non-tertiary hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Non-tertiary hospitals provide crucial health care for Western Australians. Similar to tertiary hospitals, while the role of non-tertiary hospitals is constantly evolving to meet the changing needs and characteristics of the population, they still provide comprehensive specialist health care services.

Through measuring the cost of a hospital stay by the range and type of patients (the casemix) treated in non-tertiary hospitals, this indicator can facilitate improved efficiency in these hospitals by providing a transparent understanding of the cost of care.

Target

The target for 2015–16 is $10,384 per casemix weighted separation from a non-tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix weighted separation for country WA non-tertiary hospitals for 2015–16 was $6,740 (see Table 17). This was below the target of $10,384. The result is in line with previous actuals. There was a miscalculation in the development of the 2015–16 budget figure, this was subsequently corrected. The consequence is a high variance of average cost to target.

Table 17: **Average cost per casemix weighted separation for non-tertiary hospitals, 2013–14 to 2015–16**

	2013–14 (%)	2014–15 (%)	2015–16 (%)
Average cost	$6,995	$6,830	**$6,740**
Target	$7,547	$7,248	**$10,384**

Note: A new methodology for calculating the weighted separations for non-tertiary hospitals has been developed and applied. The new methodology more accurately calculates the weighted average due to improvements in data reporting processes introduced in 2013–14. Previously reported results, no longer considered appropriate, are as follows:

	2011–12	2012–13	2013–14
Average cost	$6,465	$6,822	$5,879
Target	$6,446	$6,813	$7,547

Data sources: Hospital Morbidity Data System, Inpatient Data Collections, Health Service financial systems

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

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Small rural hospitals provide essential health care and treatment to small rural communities in WA.

Through measuring the cost of a hospital stay by the range and type of patients (the casemix) treated in non-tertiary hospitals, this indicator can facilitate improved efficiency in these hospitals by providing a transparent understanding of the cost of care.

Target

The target for 2015–16 is $1,389 per bed-day for admitted patients (selected small rural hospitals).

A result below the target is desirable.

Results

The average cost per bed-day for admitted patients for selected small rural hospitals for 2015–16 was $3,235 (see Table 18) which was above target. The introduction of a new Patient Administration System webPAS in 2015–16 has allowed improved recording and analysis of data. Additionally, there has been an ongoing reduced demand in this indicator which has contributed to the rise in average cost.

Table 18: **Average cost per bed-day for admitted patients (selected small rural hospitals), 2013–14 to 2015–16**

	2013–14 (%)	2014–15 (%)	2015–16 (%)
Average cost	$2,406	$2,102	**$3,235**
Target	$1,873	$1,736	**$1,389**

Note:

1. The introduction of webPAS has allowed improved recording and analysis of data resulting in reduced activity.
2. Changes and improvements in the counting and classification methodology under the National Activity Based funding framework has resulted in results from 13–14 onward no longer considered appropriate. Previously reported results are as follows:

	2011–12	2012–13	2013–14
Average cost	$1,855	$,2357	$1,365
Target	$1,727	$1,721	$1,873

Data sources: Occupied Bed Day Data Warehouse, Health Service financial systems.

Average cost per emergency department/service attendance

Outcome 1
Efficiency KPI
Service 4: Emergency department

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for the first few hours in hospital. With the ever increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe, high-quality care.

Target

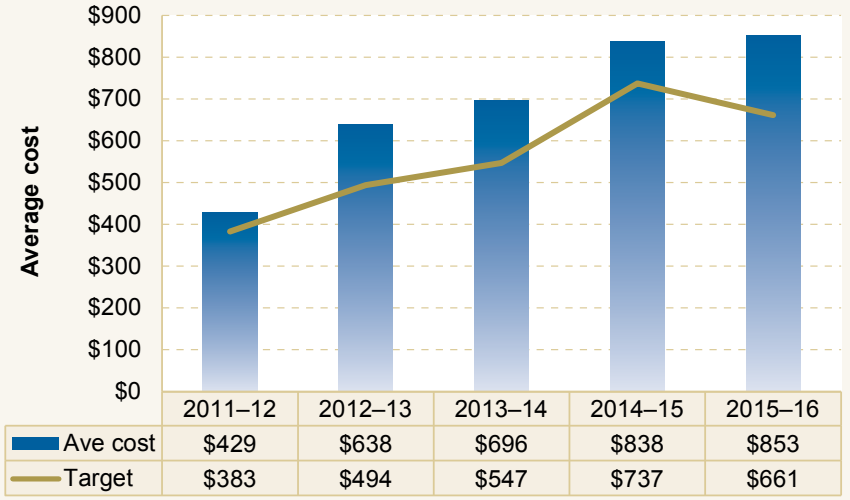
The target for 2015–16 is $661 per emergency department attendance.

A result below the target is desirable.

Results

For 2015–16, the average cost per emergency department attendances for WA country hospitals was $853 (see Figure 6). The high variance of average cost to target is a result of the introduction of costing tools from 2014–15 which have facilitated a more accurate mapping of cost distributions. The costing tools demonstrated that the proportion of costs related to emergency department is higher than previously indicated. There has been a corresponding reduction in other indicators primarily costs attributed to residential and nursing home type patient care.

Figure 6: **Average cost per emergency department attendances, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$429	$638	$696	$838	$853
Target	$383	$494	$547	$737	$661

Note: In 2014–15, a new costing model was introduced after the calculation of the 2015–16 targets.
Data sources: Emergency Department Data Collection, Health Service financial systems

Average cost per public patient non-admitted activity

Outcome 1
Efficiency KPI
Service 5: Public hospital non-admitted patients

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. These services provide consultations with a clinician or specialist to determine the most appropriate treatment of a patient's condition.

Target

As a new indicator for 2015–16, no target is available. From 2016–17, the target will be set in the annual budget setting process.

Results

For 2015–16, the average cost per public patient non-admitted activity was $426 (see Table 19).

Table 19: **Average cost per public patient non-admitted activity, 2015–16**

	2015–16 ($)
Average cost	426

Data sources: Non Admitted Patient Activity and Wait List Data Collection, Hospital site's non-admitted activity data systems, Health Service financial systems.

Average cost per non-admitted occasion of service provided in a rural nursing post

Outcome 1
Efficiency KPI
Service 5: Public hospital non-admitted patients

Rationale

This indicator measures the average cost per non-admitted occasion of service provided in WA Country Health Service nursing posts.

In addition to non-admitted occasions of service provided in hospitals, in some rural locations these services are also provided by nurses and allied health staff in rural nursing posts. Nursing posts and nursing centres offer basic health care and treatment. Qualified nurses staff these centres and doctors visit on a routine basis. These include clinics for postsurgical care, allied health and medical care as well as small volumes of emergency care services.

It is important to monitor the unit cost of this type of non-admitted activity provided at these small specialised service units, which often provide the only health care service in a rural or remote locality. Nursing posts do not have the advantage of economies of scale, where minimum service capacity and access must be provided at times for very few patients.

Target

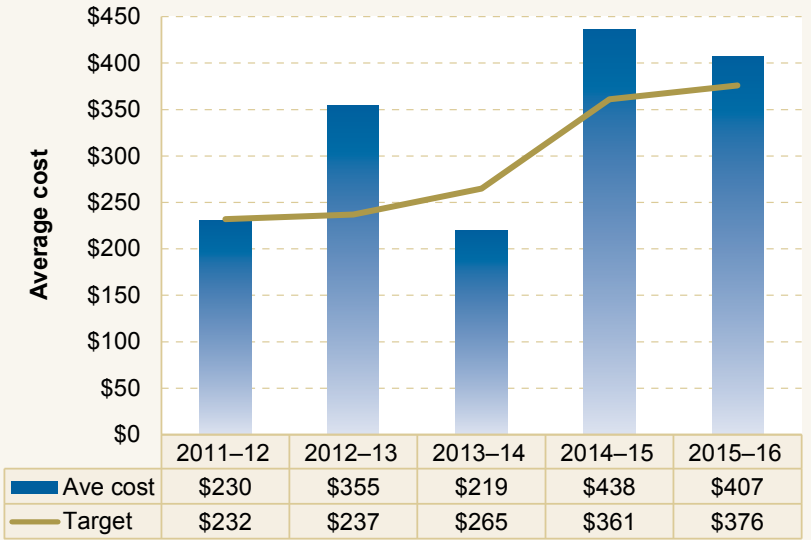
The target for 2015–16 is $376 per non–admitted occasion of service (rural nursing post).

A result below the target is desirable.

Results

In 2015–16, the average cost per non-admitted occasion of service for country WA nursing posts was $407, (see Figure 7) above the target of $376.

Figure 7: **Average cost per non-admitted occasion of service in a rural nursing post, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$230	$355	$219	$438	$407
Target	$232	$237	$265	$361	$376

Note:

1. In 2014–15, the reported average cost of per non-admitted occasion of service in a rural nursing post was reported as $368. This amount was incorrect due to a calculation error. The correct average cost per non-admitted occasion of service in a rural nursing post is $438 as reflected above.
2. Nursing Posts have a relatively fixed cost profile which can lead to variability in the actual average cost per unit of activity when compared to prior reporting periods.

Data sources: Nursing post's non-admitted activity data system, Health Service financial systems.

Average cost per trip of Patient Assisted Travel Scheme

Outcome 1
Efficiency KPI
Service 6: Patient transport

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

The Patient Assisted Travel Scheme provides a subsidy towards the cost of travel and accommodation for eligible patients travelling long distances to seek certain categories of specialist medical services. The aim of the Patient Assisted Travel Scheme is to help ensure that all Western Australians can access safe, high-quality health care when needed.

Target

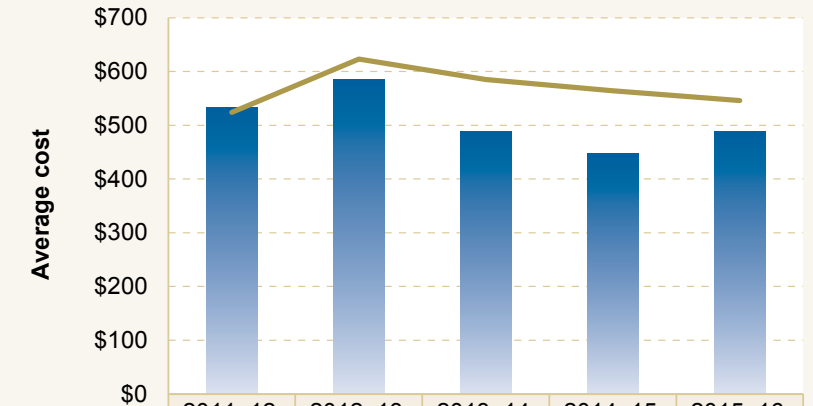
The target for 2015–16 is $546 per trip of Patient Assisted Travel Scheme trip.

A result below the target is desirable.

Results

In 2015–16, the average cost per Patient Assisted Travel Scheme trip was $488, below the target of $546 (see Figure 8). The variation to target results from actual travel costs being lower than assumed in the modelling of the target, for example air travel costs were lower than modelled.

Figure 8: **Average cost per trip, Patient Assisted Travel Scheme, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave Cost	$533	$586	$489	$447	$488
Target	$524	$623	$585	$564	$546

Data sources: Patient Assisted Travel Scheme Online system, Health Service financial systems.

Rate of hospitalisation for gastroenteritis in children (0–4 years)

Outcome 2
Effectiveness KPI

Rationale

Gastroenteritis is a common illness in infants and children. It is usually caused by viruses that infect the bowel and tends to be most common during winter months. Rotavirus gastroenteritis is the leading cause of severe gastroenteritis in children aged less than five years, but it is a vaccine-preventable disease.

The rotavirus vaccination program was added to the Australian publicly funded schedule in July 2007. Before the rotavirus vaccination program was introduced, this virus was responsible for more than 10,000 annual hospitalisations of children aged less than five years, placing significant burden on paediatric hospitals.

Surveillance of the hospitalisation of children with gastroenteritis can support the further development and delivery of targeted intervention and prevention programs to further reduce the impact of this disease on individuals and the community, ensuring enhanced health and well-being of Western Australian children and sustainability of the public health system.

Target

The target for 2015 is ≤5.0 hospitalisations per 1,000 children less than 5 years of age.

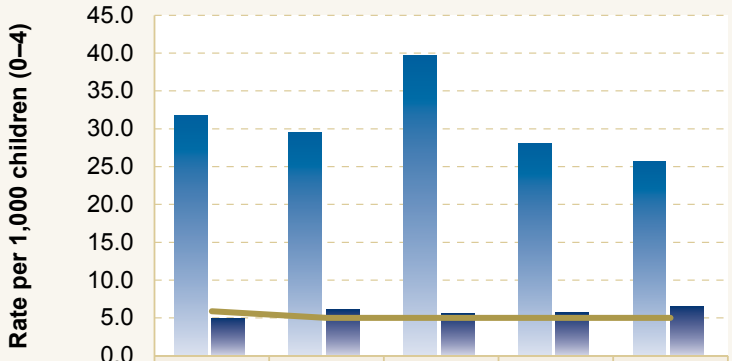
The target is based on the best result achieved within the previous five years for either Aboriginal or non-Aboriginal population groups.

Improved or maintained performance will be demonstrated by a result lower than or equal to the target.

Results

In 2015, the rate of non-Aboriginal children aged 0–4 years hospitalised for gastroenteritis in country WA was 6.5 per 1,000 children (see Figure 9). The rate of Aboriginal children is slightly below prior years.

Figure 9: **Rate of hospitalisations for gastroenteritis per 1,000 children aged 0–4 years, 2011-2015**



	2011	2012	2013	2014	2015
Aboriginal	31.8	29.4	39.6	28.1	25.7
Non-Aboriginal	5.0	6.1	5.5	5.7	6.5
Target (≤)	5.9	5.0	5.0	5.0	5.0

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for gastroenteritis due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Rate of hospitalisation for selected respiratory conditions

Outcome 2
Effectiveness KPI

Rationale

Respiratory disease refers to a number of conditions that affect the lungs or their components. Each of these conditions is characterised by some level of impairment of the lungs in performing the essential functions of gas exchange.

Respiratory disease is associated with a number of contributing factors, including poor environmental conditions, socio-economic disadvantage, smoking, alcohol use, substance use and previous medical conditions. Children under the age of five years are particularly susceptible to developing respiratory conditions due to low levels of childhood immunisation, parental smoking, poor nutrition, and poor environmental conditions.

While there are many respiratory conditions that cause hospitalisation, some of the more common conditions that have a substantial impact on the community include acute asthma, acute bronchitis, acute bronchiolitis and croup.

The implementation of initiatives that help prevent and better manage these respiratory conditions, such as the WA Health Asthma Model of Care, go a long way to reducing the impacts on individuals and the community, of these conditions.

Surveillance of hospitalisations for these common respiratory conditions can ensure that changes over time are identified to drive improvements in the quality of care and facilitate the development and delivery of effective targeted intervention and prevention programs, thus enhancing the overall health and well-being of Western Australians.

Target

The 2015 targets, by respiratory condition, are outlined in the table below. The targets are based on the best result recorded within the previous five years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

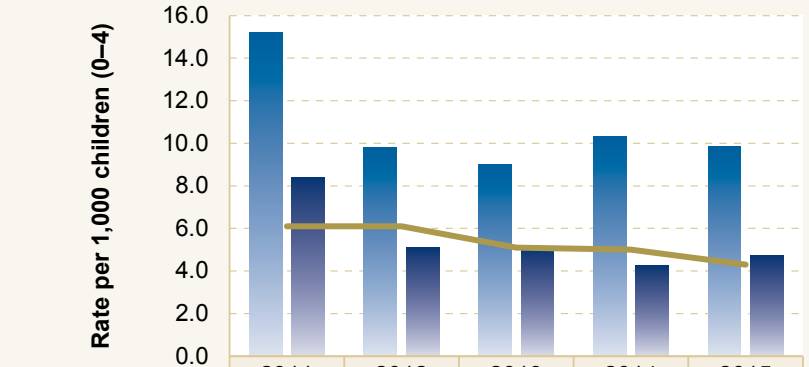
Respiratory condition	Age group (years)	Target
Acute Asthma	0–4	≤ 4.3
	5–12	≤ 2.3
	13–18	≤ 0.5
	19–34	≤ 0.6
	35+	≤ 0.6
Acute Bronchitis	0–4	≤ 0.4
Bronchiolitis	0–4	≤ 9.7
Croup	0–4	≤ 2.6

Results

Acute asthma

In 2015, country WA non-Aboriginal people in age group 19–34 achieved a result of 0.5, lower than the target of 0.6. In age groups 0–4, 5–12, 13–18, and 35 years and over, the results were higher than the target rate for hospitalisation for acute asthma (see Figure 10 to 14). For all Aboriginal people the age group target was not met. The rate of Aboriginal persons hospitalised for acute asthma in country WA declined in all age groups except 5–12 and 19–34 years. The number of cases is small. The variation in the rate of Aboriginal hospitalisations in children 5–12 years (3.3 to 4.2) is an increase of 9 cases in over 10,000 separations. Similarly the increase in the rate for 13–18 non-Aboriginal children (0.5 to 0.8) is an increase of 9 cases in over 32,000 separations.

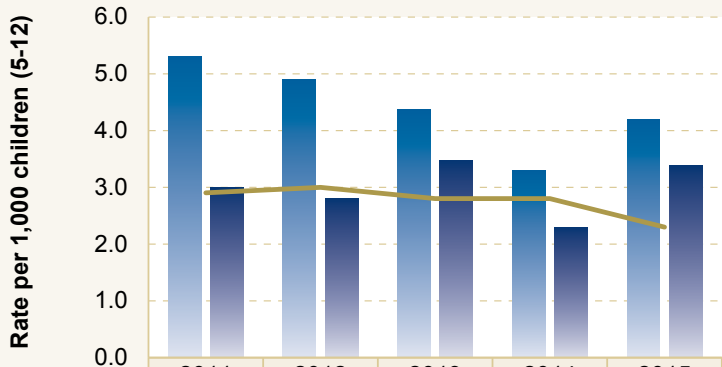
Figure 10: **Rate of hospitalisation for acute asthma per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	15.2	9.8	9.0	10.3	9.8
Non-Aboriginal	8.4	5.1	5.0	4.3	4.7
Target (≤)	6.1	6.1	5.1	5.0	4.3

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

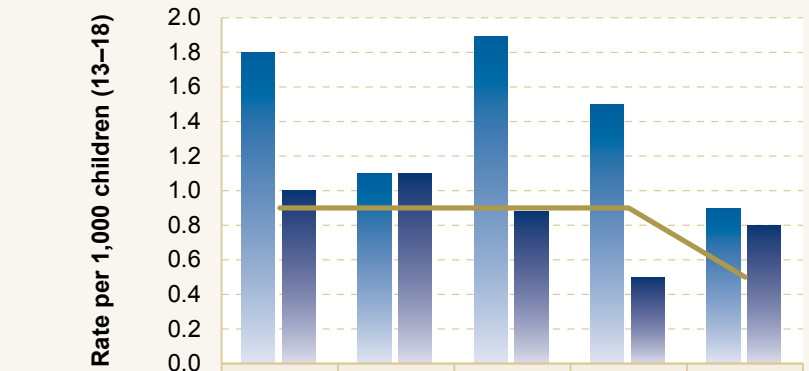
Figure 11: **Rate of hospitalisation for acute asthma per 1,000 children aged 5–12 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	5.3	4.9	4.4	3.3	4.2
Non-Aboriginal	3.0	2.8	3.5	2.3	3.4
Target (≤)	2.9	3.0	2.8	2.8	2.3

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

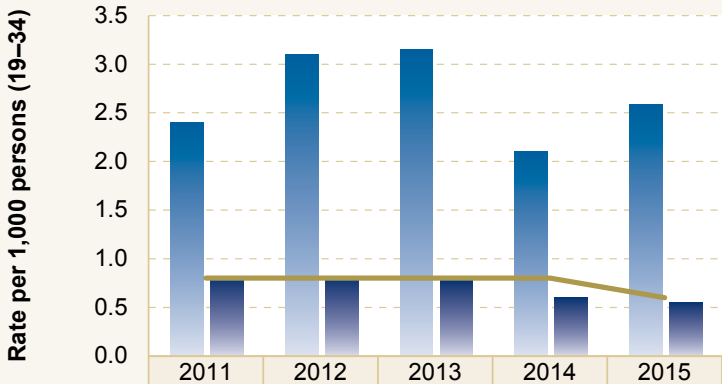
Figure 12: **Rate of hospitalisation for acute asthma per 1,000 children aged 13–18 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	1.8	1.1	1.9	1.5	0.9
Non-Aboriginal	1.0	1.1	0.9	0.5	0.8
Target (≤)	0.9	0.9	0.9	0.9	0.5

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

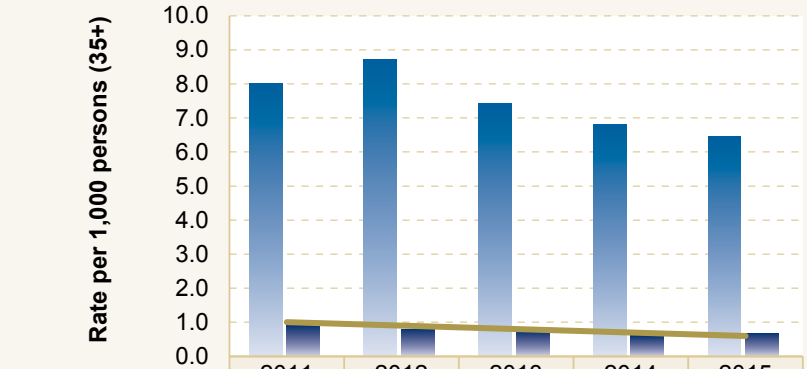
Figure 13: **Rate of hospitalisation for acute asthma per 1,000 persons aged 19–34 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	2.4	3.1	3.2	2.1	2.6
Non-Aboriginal	0.8	0.8	0.8	0.6	0.5
Target (≤)	0.8	0.8	0.8	0.8	0.6

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Figure 14: **Rate of hospitalisation for acute asthma per 1,000 persons aged 35 years and older, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	8.0	8.7	7.4	6.8	6.5
Non-Aboriginal	0.9	0.8	0.7	0.6	0.7
Target (≤)	1.0	0.9	0.8	0.7	0.6

Notes:

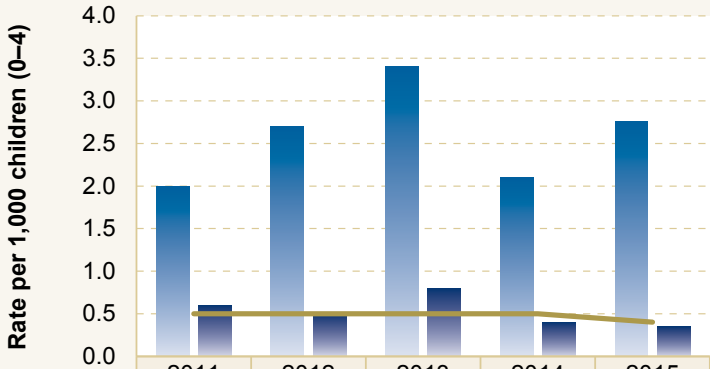
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. For acute asthma, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Acute bronchitis

During 2015, the rate of non-Aboriginal children in country WA hospitalised for acute bronchitis was 0.3 for every 1,000 children (see Figure 15). This was below the target of 0.4 per 1,000 children. The rate of Aboriginal children hospitalised for acute bronchitis was 2.8 for every 1,000 children. There are a low number of separations in the indicator – the rise from 2.1 to 2.8 in the Aboriginal rate represents 4 additional separations.

Figure 15: **Rate of hospitalisation for acute bronchitis per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	2.0	2.7	3.4	2.1	2.8
Non-Aboriginal	0.6	0.5	0.8	0.4	0.3
Target (≤)	0.5	0.5	0.5	0.5	0.4

Notes:

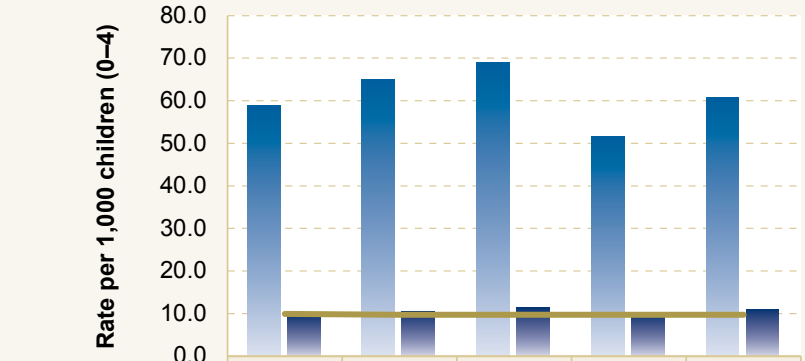
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. For acute bronchitis, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Bronchiolitis

In 2015, the rate of hospitalisation for bronchiolitis was 60.8 per 1,000 for Aboriginal children and 11.0 per 1,000 for non-Aboriginal children in country WA (see Figure 16). There are a low number of separations in the indicator – the rise from 51.6 to 60.8 in the Aboriginal rate represents 56 additional separations.

Figure 16: **Rate of hospitalisation for bronchiolitis per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	58.9	65.0	69.1	51.6	60.8
Non-Aboriginal	9.7	10.4	11.4	9.9	11.0
Target (≤)	9.9	9.7	9.7	9.7	9.7

Notes:

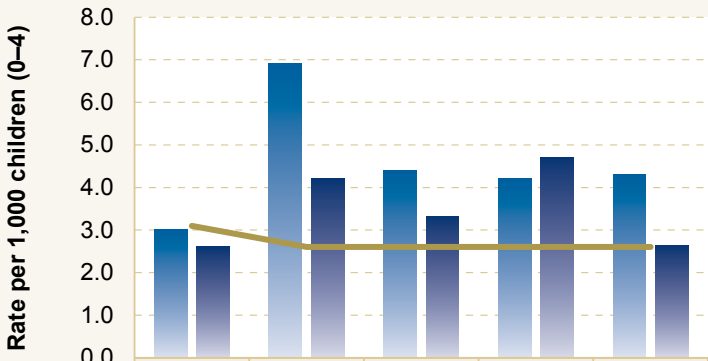
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. For bronchiolitis, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Croup

In 2015, the rate of non-Aboriginal children in country WA hospitalised for croup was 2.6 equal to the target. The rate of Aboriginal children was above target (see Figure 17). There are a low number of separations in the indicator, the non-Aboriginal variance is a reduction of 65 separations from 2014 to 2015 (of a total of approximately 32,000 separations).

Figure 17: **Rate of hospitalisation for croup per 1,000 children aged 0–4 years, 2011–2015**



	2011	2012	2013	2014	2015
Aboriginal	3.0	6.9	4.4	4.2	4.3
Non-Aboriginal	2.6	4.2	3.3	4.7	2.6
Target (≤)	3.1	2.6	2.6	2.6	2.6

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. For croup, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

Rate of hospitalisation for falls in older persons

Outcome 2
Effectiveness KPI

Rationale

Falls occur at all ages but the frequency and severity of falls-related injury increases with age. The increase in falls as people age is associated with decreased muscle tone, strength and fitness as a result of physical inactivity. Certain medications, previous falls and predisposing medical conditions such as stroke, dementia, incontinence and visual problems can contribute to an increased risk of falls.

Fall-related injury among older people is a major public health issue that can result in emergency department attendances and hospitalisation and can lead to substantial loss of independence. With the growth of the ageing population, fall-related injuries threaten to significantly increase demand on the public hospital system.

By assessing the impact of falls on the public hospital system and by measuring the rate of hospitalisation for falls in older persons, effective intervention and prevention programs can be delivered. Successful interventions and prevention programs, such as the Falls Prevention Model of Care for the Older Person in Western Australia[1], can reduce the number and severity of falls in older persons thus, enhancing their overall health and well-being, enabling them to remain independent and productive members of their community.

Target

Target of a 0.5 per cent per annum reduction in the rate of hospitalisations for falls for a sustained period for both Aboriginal and non-Aboriginal people, by 2020.

Results

In 2015, the rate of hospitalisations for falls in non-Aboriginal people in country WA populations decreased in all age groups. The rate for Aboriginal people increased in all age groups (see Table 20). There are low numbers of falls in most age groups which contributes to some volatility in the reported rates. For example the rise in 55–64 year Aboriginal falls represents an increase of 9 falls. The increase in 80+ Aboriginal falls is an increase of 27 falls.

Table 20: **Rate of hospitalisations for falls per 1,000 by age group, 2011–2015**

Age group (years)		Years					Target
		2011	2012	2013	2014	2015	
55–64	Aboriginal	40.1	28.1	42.6	26.0	**27.6**	0.5 per cent per annum reduction for a sustained period for both subgroup people by 2020
	Non-Aboriginal	5.9	5.7	5.9	6.1	**5.6**	
65–79	Aboriginal	51.0	40.8	43.1	45.4	**46.8**	
	Non-Aboriginal	18.7	18.7	21.0	21.1	**19.0**	
80+	Aboriginal	58.8	91.5	119.7	111.7	**200.7**	
	Non-Aboriginal	97.3	101.7	109.3	104.3	**100.9**	

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.
2. Caution needs to be taken in the interpretation of the rate of hospitalisation for falls (per 1,000 population) among Aboriginal people. Small population numbers have resulted in significant variations across the years.

Data sources: Hospital Morbidity Data System, Australian Bureau of Statistics.

1 http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Falls_Model_of_Care.pdf

Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit

Outcome 2
Effectiveness KPI

Rationale

The impact of mental illness within the Australian population has become increasingly apparent with mental illness being one of the leading causes of non-fatal burden of disease in Australia. The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians aged between 16 and 85 years had a mental disorder. That's why it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community care setting.

A large proportion of mental illness treatment is carried out in the community care setting through ambulatory mental health services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care, alleviating the need for, or assisting with, improving the management of, admissions to hospital-based inpatient care for mental illness.

Monitoring the level of accessibility to community mental health services pre-admission to hospital can be gauged in order to assist in the development of effective programs and interventions. This in turn can help to improve the health and wellbeing of Western Australians with mental illness and ensure sustainability of the public health system.

Target

The target for 2015 was 70 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

Results

In 2015, 44.9 per cent of country WA people who were admitted to a WA country public mental health inpatient unit had been in contact with a community-based mental health non-admitted service in the previous seven days (see Table 21). This result was below the target of 70 per cent. WACHS delivers services to a large number of small centres and communities and as a consequence has a service delivery model that is necessarily reliant on visiting services which presents difficulties in achieving the target.

Table 21: **Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission, 2011–2015**

	Year					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Pre-admission community-based contacts	44.6	41.2	43.0	48.5	44.9	70

Data sources: Mental Health Information System, Hospital Morbidity Data System.

Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from a public mental health acute inpatient units

Outcome 2
Effectiveness KPI

Rationale

The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians aged between 16 and 85 years had a mental disorder. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community care setting.

A large proportion of mental illness treatment is carried out in the community care setting through ambulatory mental health services post-discharge from hospital.

Post-discharge community mental health services are critical to maintaining clinical and functional stability of patients and to reducing vulnerability in individuals with mental illness by providing support and care. This support and care can go a long way to ensuring the best health outcomes for individuals and to reducing the need for hospital readmission.

Monitoring the level of accessibility to community mental health services post-admission to hospital can help assist in the development of effective programs and interventions. This in turn can help improve the health and wellbeing of Western Australians with mental illness and ensure sustainability of the public health system.

Target

In 2015, the target was 75 per cent.

This target was endorsed by the Australian Health Ministers' Advisory Council Mental Health Standing Committee in May 2011.

The target is considered aspirational, as the indicator includes follow-up community mental heatlh services only.

Results

In 2015, 71.8 per cent of people who were admitted to a WA country public mental heatlh inpatient unit, had been in contact with a community-based public mental health non-admitted service within seven days following their discharge (see Table 22). This result was slightly below the target of 75 per cent.

Table 22: **Percentage of contacts with a community-based mental health non-admitted service seven days post discharge, 2011–2015**

	Year					
	2011 (%)	2012 (%)	2013 (%)	2014 (%)	2015 (%)	Target (%)
Post-admission community-based contacts	45.2	51.0	55.9	66.6	**71.8**	**75**

Note: In 2016, a new calculation method was introduced. The results from 2011 to 2014 have been reinstated for comparability purposes.

Previously reported results as follows are no longer considered applicable. The target remains unchanged:

	Year			
	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Post-admission community based contacts	45.2	51.0	55.8	62.5

Data sources: Mental Health Information System, Hospital Morbidity Data System

Average cost per capita of Population Health Units

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion & protection

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

Population health units support individuals, families and communities to increase control over and improve their 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 by utilising the *WA Health Promotion Strategic Framework 2012–2016*. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

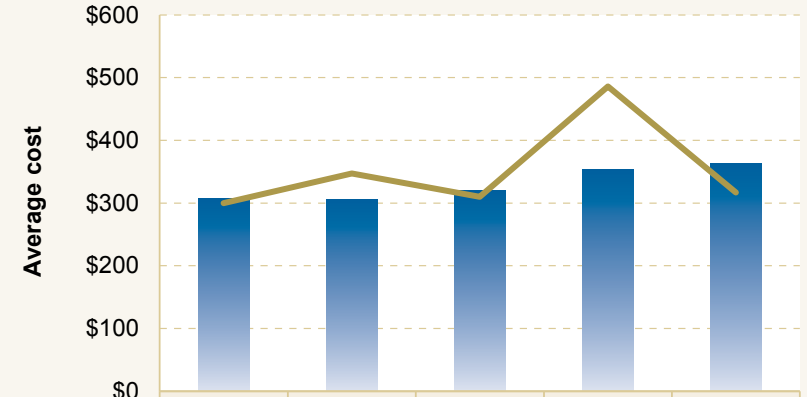
The target for 2015–16 is $317 per capita of population health units.

A result below the target is desirable.

Results

In 2015–16, the average cost per capita of country WA Population Health Units was $362, (see Figure 18) this is above the target of $317 but consistent with previous years' average costs.

Figure 18: **Average cost per capita of Population Health Units, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$307	$306	$320	$353	$362
Target	$300	$347	$310	$486	$317

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2014 for areas defined by the Australian Standard Geographical Classification.

Data sources: Australian Bureau of Statistics, Health Service financial systems.

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

Outcome 2
Efficiency KPI
Service 9:
Continuing care

Rationale

WA's public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The WA Country Health Service provides long-term care facilities for rural patients requiring 24 hour nursing care. This health care service is delivered to high and low dependency residents in nursing homes, hospitals, hostels and flexible care facilities, and constitutes a significant proportion of the activity within the WA Country Health Service jurisdictions where access to non-government alternatives is limited.

Target

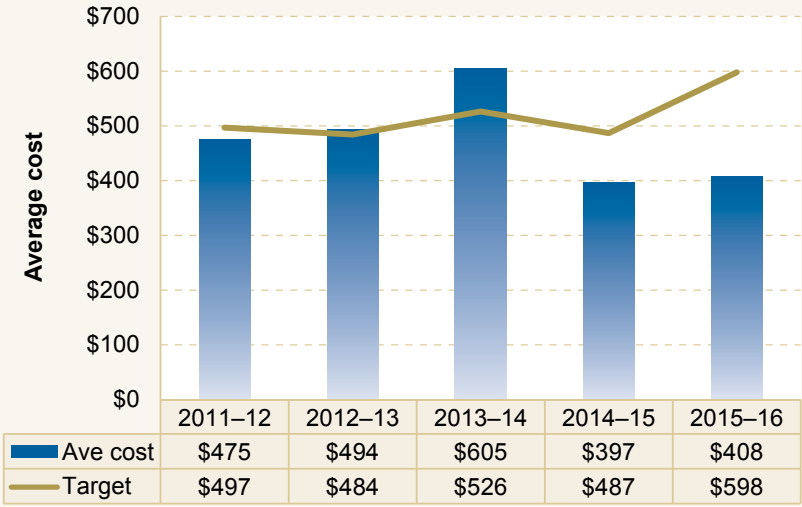
The target for 2015–16 is $598 per bed-day in a specified residential care facility flexible care (hostels) and nursing home type residents.

A result below the target is desirable.

Results

In 2015–16, the average cost per bed-day for specified residential care facilities, flexible care and nursing home type residents in country WA was $408 (see Figure 19), which was below the target. The high variance of average cost to target is as a result of the introduction of costing tools from 2014–15 which have facilitated a more accurate mapping of cost distributions. The costing tools demonstrated that the proportion of costs related to residential care, flexible care and nursing home style patients was lower than previously indicated. There has been a corresponding increase in costs attributed to other indicators such as emergency services.

Figure 19: **Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$475	$494	$605	$397	$408
Target	$497	$484	$526	$487	$598

Data sources: Occupied Bed Day Data Warehouse, Health Service financial system.

Average cost per bed-day in specialised mental health inpatient units

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

WA Health aims to provide safe, high-quality health care to ensure healthier, longer, and better quality lives for all Western Australians.

The *2007 National Survey of Mental Health and Wellbeing*[2] found that an estimated 3.2 million Australians, aged between 16 and 85 years, had a mental disorder in the 12 months prior to the survey. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients in the community, as well as through specialised mental health inpatient units.

Target

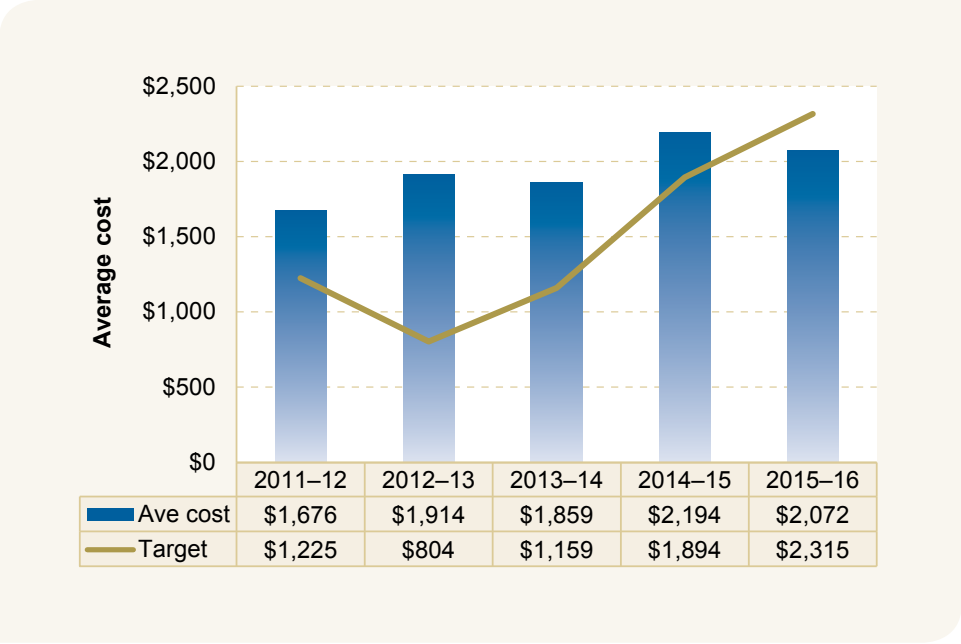
The target for 2015–16 is $2,315 per bed-day in a specialised mental health unit.

A result below the target is desirable.

Results

In 2015–16, the average cost per bed-day in a specialised mental health inpatient unit in country WA was $2,072 (see Figure 20).

Figure 20: **Average cost per bed-day in specialised mental health inpatient units, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$1,676	$1,914	$1,859	$2,194	$2,072
Target	$1,225	$804	$1,159	$1,894	$2,315

Data sources: Health Care and Related Information System Client Management System, BedState, TOPAS, Health Service financial system, WebPas and HCare.

2 https://www.aihw.gov.au/mental-health/

Average cost per three month period of care for community mental health

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

Mental illness is having an increasing impact on the Australian population and is one of the leading causes of disability burden in Australia. The *2007 National Survey of Mental Health and Wellbeing* found that an estimated 3.2 million Australians, aged between 16 and 85 years, had a mental disorder in the 12 months prior to the survey. Therefore, it is important to ensure effective and appropriate care is provided to mental health clients not only in a hospital setting but also in the community care setting through the provision of community mental health services.

Community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, and residential services. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.

Target

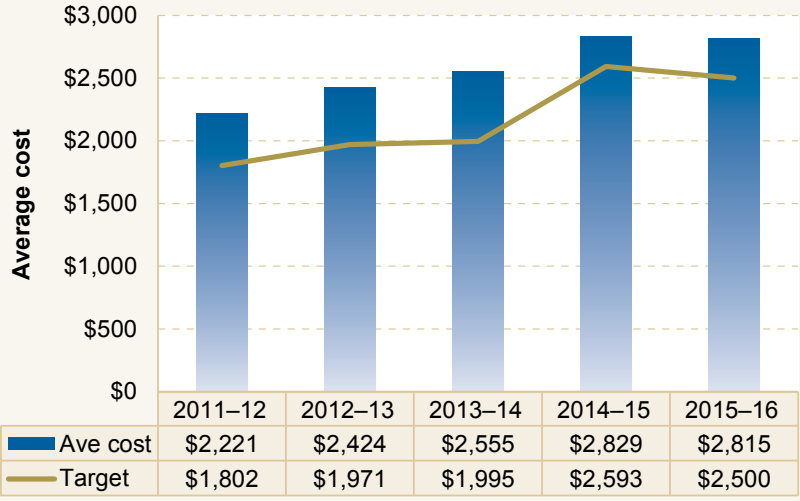
The target for 2015–16 is $2,500 per three month period of care for a person receiving public community mental health services.

A result below the target is desirable.

Results

In 2015–16, the average cost per three month period of care for a person receiving public community mental health services in country WA was $2,815 (see Figure 21). The higher expenditure to target is partially attributable to additional costs borne by WA Country Health Service that were not included in the target methodology or the Mental Health Commission service provisions agreement.

Figure 21: **Average cost per three month period of care for a person receiving public mental health services, 2011–12 to 2015–16**



	2011–12	2012–13	2013–14	2014–15	2015–16
Ave cost	$2,221	$2,424	$2,555	$2,829	$2,815
Target	$1,802	$1,971	$1,995	$2,593	$2,500

Data sources: Mental Health Information System, Health Service financial system.

Ministerial directives

Treasurer's Instructions 902 (12) requires disclosing information about Ministerial directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financing activities.

WA Health has received no Ministerial directives related to this requirement.

Summary of board and committee remuneration

The total annual remuneration for each board or committee is listed below (see Table 23). For details of individual board or committee members please refer to Appendix 2.

Table 23: **Summary of State Government boards and committees within the WA Country Health Service, 2015–16**

Board/Committee name	Total remuneration ($)
Albany Medical Advisory Committee	$2,715
Blackwood District Health Advisory Council	$1,200
Blackwood Hospital Medical Advisory Council	$300
Bunbury District Health Advisory Council	$480
Bunbury Hospital Medical Advisory Council	$1,700
Busselton Medical Advisory Council	$0
Broome and Surrounding Communities District Health Advisory Council	$0
Central Great Southern District Health Advisory Council	$3,770
Central Great Southern Medical Advisory Committee	$1,980
Denmark Medical Advisory Committee	$1,517
Donnybrook Hospital Medical Advisory Council	$0
Derby and Surrounding Communities District Health Advisory Council	$0
Eastern District Health Advisory Council (Wheatbelt)	$5,447
Eastern Medical Advisory Council (Wheatbelt)	$3,867
Gascoyne District Health Advisory Council	$120
Geraldton District Health Advisory Council	$0
Geraldton Medical Advisory Council (name changed to Midwest Medical Advisory Committee)	$0
Goldfields District Health Advisory Council	$3,420
Kununurra/Wyndham and Surrounding Communities District Health Advisory Council (name changed to East Kimberley District Health Advisory Council)	$0
Leschenault District Health Advisory Council	$270
Lower Great Southern District Health Advisory Council	$1,275
Margaret River Medical Advisory Council	$2,195
Midwest District Health Advisory Council	$1,560
Naturaliste District Health Advisory Council	$225
Plantagenent Cranbrook Health Service Medical Advisory Committee	$856
Port Hedland Medical Advisory Council (name changed to East Pilbara-Hedland Health Campus Medical Advisory Committee)	$0
South East District Health Advisory Council	$0
Southern District Health Advisory Council (Wheatbelt)	$1,855
Southern District Medical Advisory Council (Wheatbelt)	$2,353
Warren District Health Advisory Council	$240
Warren District Hospital Medical Advisory Council	$1,277
Western District Health Advisory Council (Wheatbelt)	$6,065
Western Medical Advisory Council (Wheatbelt)	$0
WA Country Health Service Audit Liaison Committee	$0

Other financial disclosures

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles, which are embedded in the *Hospitals and Health Services Act 1927 (WA)*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Hospitals (Services Charges) Regulations 1984* and the *Hospitals (Services Charges for Compensable Patients) Determination 2005* and are reviewed annually.

Please refer to the *Department of Health Annual Report 2015–16* for further information on the pricing policy.

Capital works

WA Health has a substantial asset investment program that facilitates remodelling and development of health infrastructure. Program initiatives include the continuation of major projects to reconfigure metropolitan general and tertiary hospitals, and significant investment in regional hospital infrastructure.

Please refer to the *Department of Health Annual Report 2015–16* for financial details of the full WA Country Health Service capital works program.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, compared with the preceding financial year. Table 24 shows the year-to-date (June 2016) number of WA Country Health Service full-time equivalent employees for 2014–15 and 2015–16.

Table 24: **WA Country Health Service total full-time employees by category**

Category	Definition	2014–15	2015–16
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1,596	1,617
Agency	Includes full-time equivalent employees associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	118	120
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	116	132
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	56	67
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply, laundry and transport occupations.	1,267	1,266
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	378	395
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	13	12

Category	Definition	2014–15	2015–16
Medical support	Includes all allied health and scientific/ technical related occupations.	803	796
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,913	2,933
Site services	Includes engineering, garden and security-based occupations.	171	173
Other categories	Includes Aboriginal and ethnic health worker related occupations.	132	131
	Total	**7,563**	**7,642**

Notes:

1. Data Source: HR Data Warehouse.
2. FTE is calculated as the monthly average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, Time Off in Lieu and Workers Compensation.
3. FTE figures provided are based on Actual (Paid) month to date FTE.

Staff development

WA Country Health Service collaborates with other Health Services and the Department of Health to enhance existing policies on recruitment, selection and appointment, and to improve and streamline recruitment practices. This is to ensure timely recruitment of skilled candidates for vacancies in regional areas.

WA Country Health Service has developed support materials to encourage metropolitan-based applicants to consider a health career in the country. Various occupation-specific attraction and retention programs have been implemented, including programs to increase the employment of Aboriginal people. WA Country Health Service continues to utilise entry-level employment pathways including traineeships to encourage careers within WA Health.

WA Country Health Service aims to provide a learning and development framework that supports the delivery of safe, high quality, consumer-centred care and services. This is achieved through supporting and facilitating learning programs that provide for the development and maintenance of professional skills through contemporary workforce education and learning.

Ensuring ongoing skills development and continuous learning assists in attraction and retention of a workforce whose skills and capability grow in line with service needs. WA Country Health Service's commitment to staff development is articulated in the WA Country Health Service Workforce Learning and Development Policy.

Professional development for all staff is provided via a range of learning modules including (but not limited to) eLearning, face-to-face, videoconference, essential skills days and workplace-based education. WA Country Health Service encourages participation in mentoring and coaching to enhance professional development.

Strategies implemented during 2015–16 include a review of mandatory training requirements to ensure programs are targeted based on need and risk. Wherever possible, learning and development approaches across WA Country Health Services are standardised. This ensures the cost effective delivery of training and consistent standards for learning are delivered across and within regions. The use of a single learning management system enables a WA Country Health Service-wide governance approach to the management, publication and reporting of training and development. Targeted programs have been developed for specific occupational groups, including a Nursing and Midwifery Practice Framework, Allied Health Transition to Practice and Transition to Leadership programs, and Post-graduate Medical Education. An in-house Management Development Program has also been developed for new and aspiring WA Country Health Service managers.

WA Country Health Service has continued to expand its use of the innovative Statewide Telehealth network and Emergency Telehealth Services to provide staff in regional and remote locations with direct access to metropolitan-based specialists delivering training to support clinical skills development.

Industrial relations

The WA Health Industrial Relations Service provides advisory, representation and consultancy support in industrial relations. Additionally, the service supports significant workforce management issues for the metropolitan, country and other health services comprising WA Health.

For further details, please refer to the *Department of Health Annual Report 2015–16*.

Workers' compensation

The WA Workers' Compensation system is a scheme set up by the State Government and exists under the statute of the *Workers' Compensation & Injury Management Act 1981*.

WA Country Health Service is committed to providing staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services. In 2015–16 a total of 320 workers' compensation claims were made (see Table 25).

Table 25: **Number of WA Country Health Service workers' compensation claims in 2015–16**

Employee category	Number
Nursing Services/Dental Care Assistants	116
Administration and Clerical	38
Medical Support	16
Hotel Services	124
Maintenance	20
Medical (salaried)	6
Total	**320**

Note: For the purpose of the annual report, employee categories are defined as:

- 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.

Unauthorised use of credit cards

WA Health uses Purchasing Cards for purchasing goods and services to achieve savings through improved administrative efficiency and more effective cash management. The Purchasing Card is a personalised credit card that provides a clear audit trail for management.

WA Health credit cards are provided to employees who require it as part of their role. Credit cards are not for personal use by the cardholder. Should a cardholder use a credit card for a personal purpose, they must give written notice to the accountable authority within five working days and refund the total amount of expenditure.

There were 10 transactions in the period where credit cards were inadvertently used for personal purposes. The full amount ($654.77) was refunded before the end of the reporting period.

Table 26: **Personal use expenditure by WA Country Health Service cardholders, January to June 2016**

Credit card personal use expenditure	January to June 2016
Aggregate amount of personal use expenditure for the reporting period	$654.77
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	$26.00
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	$628.77
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	$0.00

Government Building Contracts

The Government Building Training Policy applies to State Government building, construction and maintenance contracts that have a labour component of $2 million and over. All tenders issued from 1 October 2015 are in scope of this policy.

The WA Country Health Service supports the Government Building Training Policy and is committed to developing a strong training culture and sustained commitment to training through employment of apprentices and trainees within the building and construction industry.

As at 30 June 2016, no contracts subject to the Government Building Training Policy were awarded.

Governance requirements

Pecuniary interests

Senior officers of government are required to declare any interest in an existing or proposed contract that has, or could result in, the member receiving financial benefits.

In 2015–16, no senior officers of the WA Country Health Service declared a pecuniary interest.

Other legal disclosures

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, WA Country Health Service incurred a total advertising expenditure of $72,794 in 2015–16 (see Table 27). There was no expenditure in relation to advertising agencies, market research, polling, or direct mail organisations.

Table 27: **Summary of WA Country Health Service advertising for 2015–16**

Summary of advertising	Amount ($)
Advertising agencies	0
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	$72,794
Total advertising expenditure	**$72,794**

The organisations that provided advertising services and the amount paid to each are detailed in Table 28.

Table 28: **WA Country Health Service advertising, by class of expenditure, 2015–16**

Recipient /organisations	Amount ($)
Advertising agencies	
Total	**0**
Market research organisations	
Total	**0**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Optimum Media Decisions	28,474
Adcorp Australia Limited	13,638
Bandicoot Express	27
Dalwallinu Telecentre	465
York Telecentre	259
Koorda Telecentre	199
Boddington Community Newsletter	40
Radiowest Broadcasters Pty Ltd	2,660

Rural Press Regional Media Pty Ltd	197
Sensis Pty Ltd	67
Directorylistings.com.au	1,094
Muddy Waters newspaper	330
Australian Business Directory	195
Mitchell Communications	6,067
Northwest Telegraph	203
Carat Australian Media Services Pty Ltd	2,314
Newman Chamber of Commerce and Industry	196
West Australian Newspapers Limited	220
Northampton Community News	100
Perenjori Community News	20
Gnowangerup Community Resource Centre	15
The Countryman Newspaper	385
Market Creations	2,000
Royal Australian College of Psychiatrists	1,485
Royal Australasian College of Medical Administrators	2,420
Australian College of Rural and Remote Medicine	7,920
Australian and New Zealand College of Anaesthetists	1,100
Royal Australian College of General Practitioners	374
CRIT-IQ newsletter	330
Total	**72,794**

Disability access and inclusion plan

The *Disability Services Act 1993* was introduced to ensure that people with disability have the same opportunities to fully access the range of health services, facilities and information available in the public health system, and to participate in public consultation regarding WA Health services.

Amendments to the *Disability Services Act 1993* resulted in a key change for WA public authorities in June 2014. Public authorities are now required to ensure that people with disability have equal employment opportunities.

Access to service

WA Country Health Service is committed to ensuring that people with disability, their families and carers can fully access the range of health services, facilities and information available in the public health system.

This has been achieved through the progressive implementation of the *WA Country Health Service Disability Action and Inclusion Plan 2015–2020*. Regional Disability Access and Inclusion Plan Committees meet in each of the seven WA Country Health Service regions, and the WA Country Health Service-wide Disability Access and Inclusion Coordinators Group meet quarterly to progress and coordinate strategies.

WA Country Health Service strategies have included actions such as ensuring staff are made aware of the *Disability Services Act 1993* and *WA Country Health Service Disability Access and Inclusion Plan 2015–2020* through recruitment and orientation processes and during their performance development.

WA Country Health Service staff also have access to Disability Access and Inclusion information and resources such as the Disability Services Commission Accessible Events checklist via the WA Country Health Service Disability Access and Inclusion intranet page. In December 2015, several WA Country Health Service regional sites undertook Disability Awareness Week events and activities to raise awareness with staff.

To ensure that the WA Country Health Service agents and contractors are aware of their responsibilities under the *Disability Services Act*, a statement is included in all contract documentation templates in relation to the relevant requirements of the Act.

Access to buildings

There are extensive improvements and infrastructure redevelopments planned and underway across a number of WA Country Health Service sites. All infrastructure projects are undertaken with a view to universal access and compliance with the minimum access, exit and amenity levels set out in the Building Code of Australia.

WA Country Health Service continues to review its operations to ensure it meets the requirements of the *WA Country Health Service Disability Action and Inclusion Plan 2015–2020*. Regional health services undertake regular audits of facilities and buildings in conjunction with representatives from their local District Health Advisory Councils, consumers with disability and Disability Service Commission representatives.

Access to information

The *Department of Health Communications Style Guide* has been adopted for all information developed for public distribution. All information is available in alternative formats upon request. WA Country Health Service facilitates the use of interpreters for people who have difficulty speaking, hearing, seeing and/or reading or who speak limited English, consistent with the *Western Australian Language Services Policy 2014*.

Where possible, all WA Country Health Service information or publications intended for use by consumers are developed in partnership, or with input from, consumers and display the WA Country Health Service 'Consumer Approved' logo.

The WA Country Health Service promotes disability access and inclusion through its own information posters as well as those provided by the Disability Services Commission. Information about patient rights and responsibilities is displayed at WA Country Health Service sites.

Quality of service by staff

WA Country Health Service aims to provide people with disability with the same quality of service, opportunities, rights and responsibilities as enjoyed by other people in the community.

WA Country Health Service works continuously to improve disability awareness so that all staff deliver consistent quality services and healthcare to people with disability. Regular education and training about the service needs of people with disability are provided through mandatory training days, induction sessions, and self-directed learning packages.

Opportunity to provide feedback

WA Country Health Service conducts regular regional and area-wide audits of its complaints processes, with special focus on ensuring people with disability have the same opportunities as others in the community.

Individuals can register a complaint with the assistance of the regional Patient and Customer Liaison Officer. Regions review complaint forms and lodgement processes to ensure the appropriate platform is provided for initiating a complaint. WA Country Health Service provides information about the complaints process for the people with hearing impairment and can facilitate access to translating and interpreting services upon request.

Information about accessing the Advocare and the Health and Disability Service Complaints Office support services is available across the WA Country Health Service. This service provides community members, including those with disability, with an opportunity to share their concerns with an external body if required.

WA Country Health Service Compliments and Complaints Policy and regional grievance mechanisms and procedures can be made available in alternative formats.

The WA Country Health Service is currently undertaking a pilot project to implement the online consumer feedback website 'Patient Opinion Australia' in three of its regions. This will provide alternative and accessible avenues for consumers to express their compliments and complaints.

Participation in public consultation

Public consultations undertaken by WA Country Health Service actively seek to include consumers with disability. People with disability are encouraged to participate in, and have been appointed to, WA Country Health Service District Health Advisory Councils. Information and advice from District Health Advisory Councils and regional Disability Access Inclusion Plan Committees informs the health services on the healthcare and service needs of community members, including those with disability.

The *WA Country Health Service Disability Access and Inclusion Plan 2015–2020* was developed in public consultation with consumers and disability service agencies. The Plan is made available on the WA Country Health Service internet and in alternative formats upon request.

Opportunities to obtain and maintain employment

The WA Country Health Service is committed to ensuring consistent application of the *Equal Employment Opportunity Act (1984)*. All workforce advertising and recruitment processes are managed through WA Country Health Service Central Human Resources (HR) in conjunction with Regional HR and Health Corporate Network.

WA Country Health Service Human Resource Managers conduct regular promotion of the *WA Health Equity and Diversity Plan 2010–2015* to staff at management level.

Work environments within the WA Country Health Service are adapted to meet the needs of staff with disability as required.

Compliance with public sector standards

Details of the WA Health compliance with the *WA Public Sector Code of Ethics, Public Sector Standards in Human Resource Management and the WA Health Code of Conduct* can be found in the *Department of Health Annual Report 2015–16*.

Recordkeeping plans

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

WA Country Health Service's *Recordkeeping Plan* and supporting framework were designed to address the rural and remote challenges in country WA. The *Recordkeeping Plan* was approved by the State Records Commission on 3 August 2013 for a five-year period.

To support the challenges faced due to the vast distances between WA Country Health Service facilities, a full suite of online tools have been implemented. The WA Country Health Service Records and the Electronic Document and Records Management System team progresses the central support model through training and support services.

A Recordkeeping Compliance Officer was appointed in August 2015 to assist in reviewing compliance requirements. The recordkeeping compliance officer is also responsible for the evaluation of training programs and reporting recordkeeping activities on a monthly basis.

As a result, an effective and measurable training program has been developed that informs employees of their recordkeeping obligations and the skills to manage corporate records effectively. This training program addresses recordkeeping awareness and Electronic Document and Records Management System training for new and existing employees.

During 2015–16, a number of significant information management projects have been completed to ensure the capture of valuable information assets within the TRIM system.

These include:

- implementation of the TRIM electronic document system in the Great Southern and Midwest Regions
- capture and preservation of historic information and correct disposal of inactive hard copy records located in regional areas
- establishment of Regional Electronic Document and Records Management System user groups to monitor projects timelines and ensure framework compliance hard copy records
- development of information governance strategies to organise electronic records stored within shared drives.

The success of the information management program and the abovementioned projects have contributed to an increase of users by over 21 per cent compared to the same period last year. WA Country Health Service TRIM users contributed to the corporate memory with over 318,000 records saved during 2015–16.

Substantive equality

WA Health continues to contribute towards substantive equality for all Western Australians through the implementation of the Policy Framework for Substantive Equality. The Framework provides a clear direction for all persons employed in WA Health by addressing the diverse needs and sensitivities of the communities in which it operates.

The WA Country Health Service is committed to improving the health outcomes of Aboriginal people through a coordinated approach to the planning, funding and delivery of Aboriginal health programs. This includes the development of a workplace environment that values the employment and retention of Aboriginal employees, which in turn supports a more culturally appropriate, competent and responsive health care service.

The implementation of the *WA Country Health Service Aboriginal Employment Strategy 2014–18* supports this approach via a number of strategies:

- Aboriginal cultural awareness training for all staff
- acknowledgment and promotion of Aboriginal employees' cultural knowledge and the benefits of bridging the cultural gap
- mentoring of Aboriginal employees through the Aboriginal Mentorship Program
- establishment and implementation of Aboriginal employment programs and traineeships.

The WA Country Health Service supports effective communication between health service providers and those who need language assistance. This includes Aboriginal people, people from culturally and linguistically diverse backgrounds and people who are deaf or hearing impaired. A recent audit was conducted on the provision of language services by WA Country Health Services to non-English speaking and hearing impaired consumers. The findings have informed improvements in service delivery and policy.

Occupational safety, health and injury management

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. WACHS aims to comply with, or exceed, the requirements of the *Occupational Safety and Health Act 1984* and the injury management requirements within the *Workers' Compensation and Injury Management Act 1981*.

Commitment to occupational safety, health and injury management

The WA Country Health Service takes a proactive approach to occupational safety, health and injury management through the establishment of clear goals and the implementation of strategies that support:

- achievement of high standards of health and safety performance through effective safety management
- establishment and maintenance of an integrated safety and health system that supports continuous improvement of safety and health performance across all operational activities
- effective mechanisms for consultation and reporting of safety and health matters
- effective systems for identifying hazards and controlling risks associated with WA Country Health Service activities, processes and services
- evaluation of staff training and supervision to ensure reductions in work-related injuries.

Compliance with occupational safety, health and injury management

The WA Country Health Service promotes the election of safety and health representatives and the formation of safety and health committees. Committees, comprised of management and safety and health representatives, meet regularly to facilitate consultation and collaboration in initiating, developing and implementing measures designed to ensure compliance with all occupation safety and health injury management requirements.

Employee consultation

The WA Country Health Service promotes safety and health activities and regularly provides information about safety and health to ensure that all staff have access to current and relevant information, particularly when it applies to their roles and the healthcare environment. The WA Country Health Service also adopts a consultative approach to the resolution of safety risks in order to ensure that hazards are addressed and incidents are investigated, thereby promoting a positive safety culture.

Employee rehabilitation

The WA Country Health Service is committed to providing timely and effective management of employee injury and illness, to facilitate an early return to work where medically appropriate. The WA Country Health Service has an Injury Management System that supports employees and meets legal and other obligations, including but not limited to the *Workers' Compensation and Injury Management Act 1981*. Dedicated Injury Management Coordinators are available to assist with the management of workers' compensation claims and the establishment of return-to-work programs.

Occupational safety, health assessment and performance indicators

The annual performance reported for the WA Country Health Service in relation to occupational safety, health and injury for 2015–16 is summarised in Table 29.

Table 29: **Occupational safety, health and injury performance, 2013–14 to 2015–16**

Measure	Actual Results		Results against Target	
	2013–14	2015–16	Target	Comments
Fatalities (number of deaths)	0	**0**	0	**Target achieved**
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	3.30	**2.41**	0 or 10% reduction	27% reduction **Target achieved**
Lost time injury severity rate (rate per 100)	25.82	**45.11**	0 or 10% reduction	75% increase **Target not achieved**
Percentage of injured workers returned to work within 13 weeks	N/A	**57.1%**	N/A	N/A
Percentage of injured workers returned to work within 26 weeks	67.8%	**68.4%**	Greater than or equal to 80%	**Target not achieved**
Percentage of managers trained in occupational safety, health and injury management responsibilities	38.0%	**33.1%**	Greater than or equal to 80%	**Target not achieved**

Note: Performance is based on a three-year trend and so the comparison base year is two years prior to the current reporting year.

Government of **Western Australia**
Department of **Treasury**

Your ref : FAA27944 Mental Health Commission SPAs
Our ref : 00349043
Enquiries : Christine Crasto-Carvalho
Telephone : 6551 2580

Dr D J Russell-Weisz
Director General
Department of Health
PO Box 817
PERTH BUSINESS CENTRE WA 6849

Dear Dr Russell-Weisz

MENTAL HEALTH COMMISSION SPECIAL PURPOSE ACCOUNTS

Further to your letters of 16 March and 28 May 2016, I am pleased to advise that acting under delegated authority from the Treasurer, I have:

- determined and approved, pursuant to section 16(1)(d) of the Financial Management Act 2006 (the Act), the Mental Health Commission Fund (East Metropolitan Health Service) Account as an agency special purpose account (SPA) for the purposes set out in the associated special purpose statement;. It is noted that your letter does not seek approval to the SPA but this has since been confirmed by Mr Graeme Jones, Chief Finance Officer of the Department of Health.
- approved under section 17 of the Act, the special purpose statement for the Mental Health Commission Fund (East Metropolitan Health Service) Account as attached; and
- approved, under section 17(3) and (4) of the Act, the amended special purpose statements for the:
  - Mental Health Commission Fund (North Metropolitan Health Service) Account;
  - Mental Health Commission Fund (South Metropolitan Health Service) Account;
  - Mental Health Commission Fund (Children and Adolescent Health Service) Account;
  - Mental Health Commission Fund (WA Country Health Service) Account and
- approved closure of the Mental Health Commission Fund (Fiona Stanley Hospital) Account under section 21(1) of the Act.

The original statements are enclosed for your records. A copy of the approved special purpose statements is required to be sent to the Auditor General under section 17(4) of the Act.

The approved statements are required to be published in the Metropolitan Health Service (MHS) and WA Country Health Service (WACHS) 2015–16 annual reports under Treasurer's instruction (TI) 950 'Publication of special purpose statements and trust statements'.

It is noted that despite an error in the previously approved statements, the MHS and WACHS have properly disclosed the SPAs in notes to their annual financial statements as required by TI 1103(15)(ii) 'Statements of Financial Position'.

I am aware that the WACHS and four health service areas within MHS will become health service providers (HSPs) under the *Health Services Act 2016* when it is proclaimed on 1 July 2016. It is understood that the SPAs and associated statements will continue under transitional provisions (section 237 transfer orders) as an interim arrangement until the HSPs are ready to sign the special purpose statements in their own right. It would be appreciated if this could be actioned as soon as practicable.

Yours sincerely

Michael Barnes
UNDER TREASURER
20 JUN 2016
Enc.

Gordon Stephenson House, 140 William Street, Perth, Western Australia 6000
Locked Bag 11, Cloisters Square, Western Australia 6850
Telephone (08) 6551 2777
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Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Special Purpose Statement for s16(1)(d) FMA Special Purpose Accounts

MENTAL HEALTH COMMISSION FUND (WA COUNTRY HEALTH SERVICE) ACCOUNT

Title and Responsibility: A special purpose account, entitled the Mental Health Commission Fund (WA Country Health Service) Account (the "Account") is to be established pursuant to s16(1)(d) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the WA Country Health Service under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To receive funds from the Mental Health Commission, to fund the provision of mental health services as jointly endorsed by the Department of Health and the Mental Health Commission, in the WA Country Health Service, in accordance with the annual Service Agreement and subsequent agreements.

Commencement Date: 1 June 2016

Receipts: There shall be credited to the Account such moneys payable by the Mental Health Commission in respect of the stated purpose of the Account.

Payments: Moneys standing to the credit of the Account are to be expended for the purposes detailed:

- in the Service Agreement between the Mental Health Commission and the Department of Health
- in subsequent agreements between the Mental Health Commission and the WA Country Health Service, or the Department of Health and the Mental Health Commission on behalf of the WA Country Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the WA Country Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's *Financial Management Manual*, and any other legal requirements and agreements.

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall be disposed via agreement between the Director General of the Department of Health and the Mental Health Commissioner.

I have examined and agree to the provisions of this Special Purpose Statement.

Dr D J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 28 May 2016

I approve the establishment of a s16(1)(d) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 20/6/16

Department of Health

GOVERNMENT OF WESTERN AUSTRALIA

Trust Statement
for s16(1)(c) FMA Special Purpose Accounts

WA COUNTRY HEALTH SERVICE
PATIENTS' PRIVATE MONEY TRUST ACCOUNT

Title and Responsibility: A special purpose account, entitled the WA Country Health Service Patients' Private Money Trust Account (the "Account") is to be established pursuant to s16(1)(c) of the *Financial Management Act 2006*, and maintained by the Minister for Health incorporated as the board of the Hospitals formerly comprised in the WA Country Health Service under s7 *Hospitals and Health Services Act 1927*, who has delegated all the powers and duties as such to the Director General of the Department of Health.

Purpose: To hold funds in trust on behalf of patients at public hospitals in the WA Country Health Service, which can only be spent in accordance with their instructions and/or returned to them upon discharge.

Commencement Date: 1 July 2016

Receipts: There shall be credited to the Account moneys held in trust on behalf of patients at public hospitals in the WA Country Health Service.

Payments: Moneys standing to the credit of the Account are to be:

- expended in accordance with patients' instructions; and/or
- returned to the patients upon their discharge from a public hospital in the WA Country Health Service.

Administration, Accounting and Reporting:

Money in the Account is to be administered, accounted for and reported on by the Accountable Authority of the WA Country Health Service, in accordance with the *Financial Management Act 2006, Financial Management Regulations 2007, Treasurer's Instructions*, the agency's Financial Management Manual, and any other legal requirements and agreements (including the relevant provisions in the *Health Services Act 2016*).

Disposal of Funds on Cessation:

Any balance standing to the credit of the Account upon cessation of operations for which the Account was created shall returned to the relevant patients, or dealt with in accordance with the *Unclaimed Money Act 1990* or any other relevant written law.

I have examined and agree to the provisions of this Trust Statement.

Dr David J Russell-Weisz
Director General

Department of Health
(as delegate of the Minister for Health)

Date: 23/6/16

I approve the establishment of a s16(1)(c) Special Purpose Account for the purposes specified in this Statement.

Michael Barnes
Under Treasurer

Department of Treasury
(as delegate of the Treasurer)

Date: 28/6/16

Appendices

Appendix 1: WA Country Health Service contact details

WA Country Health Service (WACHS)

Street address:
189 Wellington Street, Perth WA 6000
Postal address:
PO Box 6680, East Perth Business Centre WA 6892
Phone: (08) 9223 8500
Fax: (08) 9223 8599
Email: centralofficereception.WACHS@health.wa.gov.au
Web: www.wacountry.health.wa.gov.au

WACHS – Kimberley

Street address:
Yamamoto House, Unit 4, 9 Napier Terrace
Broome WA 6725
Postal address:
Locked Bag 4011, Broome WA 6725
Phone: (08) 9194 1600
Fax: (08) 9194 1666
Email:
KHS.ExecSecretary@health.wa.gov.au

WACHS – Pilbara

Street address:
Level 2, State Government Building
Corner Brand and Tonkin Street
South Hedland WA 6722
Postal address:
PMB 12, South Hedland WA 6722
Phone: (08) 9173 1600
Fax: (08) 9173 3893
Email:
wachspb_execservices@health.wa.gov.au

WACHS – Midwest

Street address:
45 Cathedral Avenue
Geraldton WA 6530
Postal address:
PO Box 22, Geraldton WA 6531
Phone: (08) 9956 2209
Fax: (08) 9956 2421
Email:
CES.WACHS-Midwest@health.wa.gov.au

WACHS – Wheatbelt

Street address:
Shop 4, 78 Wellington Street
Northam WA 6401
Postal address:
PO Box 690, Northam WA 6401
Phone: (08) 9621 0700
Fax: (08) 9621 0701
Email: wheatbeltreception@health.wa.gov.au

WACHS – Goldfields

Street address:
The Palms, 68 Piccadilly Street
Kalgoorlie WA 6430
Postal address:
PO Box 716, Kalgoorlie WA 6430
Phone: (08) 9080 5710
Fax: (08) 9080 5724
Email:
WACHS-GoldfieldsExec@health.wa.gov.au

WACHS – Great Southern

Street address:
84 Collie Street, Albany WA 6330
Postal address:
PO Box 165, Albany WA 6331
Phone: (08) 9892 2672
Fax: (08) 9847 4101
Email: gs.ces@health.wa.gov.au

WACHS – South West

Street and postal address:
4th floor, Bunbury Tower, 61 Victoria Street
Bunbury WA 6230
Phone: (08) 9781 2350
Fax: (08) 9781 2385
Email:
execservices.wachssw@health.wa.gov.au

Appendix 2: Boards and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Albany Medical Advisory Committee				
Chair	Dr David Tadj	Per meeting	12 months	$2,715
Member	Dr Frans Cronje	Not eligible	Not applicable	$0
Member	Dr Clark Wasiun	Not eligible	Not applicable	$0
Member	Dr Justin Yeung	Not eligible	Not applicable	$0
Member	Dr Paul Salmon	Not eligible	Not applicable	$0
Member	Dr Alasdair Millar	Not eligible	Not applicable	$0
Member	Dr Peter Kendall	Not eligible	Not applicable	$0
Member	Dr Pui Poon	Not eligible	Not applicable	$0
Member	Dr Guruparan Sritharan	Not eligible	Not applicable	$0
Member	Dr Thomas Schaefer	Not eligible	Not applicable	$0
Member	Dr Alexander Fergie	Not eligible	Not applicable	$0
Member	Dr Mahesh Reddy	Not eligible	Not applicable	$0
Member	Dr Thomas Bowles	Not eligible	Not applicable	$0
Member	Barbara Marquand	Not eligible	Not applicable	$0
Ex-officio Member	Susan Kay	Not eligible	Not applicable	$0
Ex-officio Member	Kylie Oliver	Not eligible	Not applicable	$0
			Total:	**$2,715**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Blackwood District Health Advisory Council				
Chair	Philippe Kaltenrieder	Per meeting	12 months	$840
Deputy Chair	Max Barrington	Per meeting	12 months	$180
Member	Patricia Twiss	Per meeting	12 months	$120
Member	Terry Linz	Per meeting	12 months	$60
Member	Anne-Maree Martino	Per meeting	12 months	$0
Member	Cate Stevenson	Per meeting	12 months	$0
Member	Heather Dixon	Not eligible	Not applicable	$0
			Total:	**$1,200**
Blackwood Hospital Medical Advisory Council				
Chair	Dr Michael Hoar	Per meeting	12 months	$300
Member	Dr Nigel Jones	Not eligible	Not applicable	$0
Member	Dr Neil Wells	Not eligible	Not applicable	$0
Member	Dr Keith Erath	Not eligible	Not applicable	$0
Member	Dr Michiel Mel	Not eligible	Not applicable	$0
Member	Dr William Dewing	Not eligible	Not applicable	$0
			Total:	**$300**
Bunbury District Health Advisory Council				
Chair	John Gardyne	Per meeting	12 months	$60
Deputy Chair	Margaret Smith	Per meeting	12 months	$60
Member	Lera Bennell	Per meeting	12 months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Joan Birkett	Per meeting	12 months	$180
Member	Lynne King	Per meeting	12 months	$180
Member	Margaret Leatherborrow	Per meeting	12 months	$0
Member	Maria Fitzgerald	Per meeting	12 months	$0
Member	Robyn Jones	Per meeting	12 months	$0
Member	Mark Lawther	Per meeting	12 months	$0
			Total:	**$480**
Bunbury Hospital Medical Advisory Council				
Chair	Dr Stephen Hinton	Per meeting	12 months	$1,700
Member	Yvonne Bagwell	Not eligible	Not applicable	$0
Member	Dr Adam Coulson	Not eligible	Not applicable	$0
Member	Dr Emma Crampin	Not eligible	Not applicable	$0
Member	Dr Iain Gilmore	Not eligible	Not applicable	$0
Member	Dr Samir Heble	Not eligible	Not applicable	$0
Member	Andrea Hickert	Not eligible	Not applicable	$0
Member	Dr Neil Kling	Not eligible	Not applicable	$0
Member	Dr Vijaya Mohan	Not eligible	Not applicable	$0
Member	Dr Dianne Mohen	Not eligible	Not applicable	$0
Member	Dr Koula Pratsis	Not eligible	Not applicable	$0
Member	Dr Ramesh Parthasarathy	Not eligible	Not applicable	$0
Member	Marianne Slattery	Not eligible	Not applicable	$0
Member	Dr Anupam Chauham	Not eligible	Not applicable	$0
Member	Dr Lila Stephens	Not eligible	Not applicable	$0
Member	Dr Winston McKean	Not eligible	Not applicable	$0
Member	Dr Winton Barnes	Not eligible	Not applicable	$0
Member	Dr Ben Cunningham	Not eligible	Not applicable	$0
Member	Kerry Winsor	Not eligible	Not applicable	$0
Member	Dr Naru Pal	Not eligible	Not applicable	$0
Member	Naomi Lillywhite	Not eligible	Not applicable	$0
			Total:	**$1,700**
Busselton Medical Advisory Council				
Chair	Dr John Pollard	Not eligible	Not applicable	$0
Member	Dr Russell Hartley	Not eligible	Not applicable	$0
Member	Dr Phillip Chapman	Not eligible	Not applicable	$0
Member	Dr Vinod Pushpalingham	Not eligible	Not applicable	$0
Member	Dr Sarah Moore	Not eligible	Not applicable	$0
Member	Dr Sven Geldermann	Not eligible	Not applicable	$0
Member	Daniel Anderson	Not eligible	Not applicable	$0
Member	Rory Stemp	Not eligible	Not applicable	$0
Member	Chris Love	Not eligible	Not applicable	$0
Member	Dr Peter English	Not eligible	Not applicable	$0
Ex-officio Member	Kerry Winsor	Not eligible	Not applicable	$0
Ex-officio Member	Dr Winston McKean	Not eligible	Not applicable	$0
Ex-officio Member	Dr Winton Barnes	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Broome and Surrounding Communities District Health Advisory Council				
Member	Karen Fitpatrick	Per meeting	12 months	$0
Member	Margaret Moore	Per meeting	12 months	$0
Member	Chris Mitchell	Per meeting	12 months	$0
Member	Andrew Waters	Not eligible	Not applicable	$0
Member	Laura Hanscombe	Per meeting	12 months	$0
Member	Marie Shinn	Per meeting	12 months	$0
Member	Mala Croft	Per meeting	12 months	$0
Member	Adam Vincent	Not eligible	Not applicable	$0
Member	Tracey Chamberlain	Per meeting	12 months	$0
			Total:	**$0**
Central Great Southern District Health Advisory Council				
Chair	Hilary Harris	Per meeting	12 months	$1,620
Member	Gladys Wells	Per meeting	12 months	$700
Member	Norma Hersey	Per meeting	12 months	$745
Member	Pauline Roosendaal	Per meeting	12 months	$420
Member	Bronwyn Bradley	Per meeting	12 months	$285
			Total:	**$3,770**
Central Great Southern Medical Advisory Committee				
Chair	Dr Nicholas du Preez	Per meeting	12 months	$1,980
Member	Dr Bilal Ahmad	Not eligible	Not applicable	$0
Member	Dr Ayman Mitri	Not eligible	Not applicable	$0
Member	Dr Oluwole Oluyede	Not eligible	Not applicable	$0
Member	Dr Samantha Weaver	Not eligible	Not applicable	$0
Member	Dr Amir Ishak	Not eligible	Not applicable	$0
Member	Dr Saleem Hafees	Not eligible	Not applicable	$0
Member	Dr Grantes Murphy	Not eligible	Not applicable	$0
Member	Dr Deepak Panneersalvam	Not eligible	Not applicable	$0
Member	Dr Herbert Lau	Not eligible	Not applicable	$0
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
Ex-officio Member	Robyn Millar	Not eligible	Not applicable	$0
			Total:	**$1,980**
Denmark Medical Advisory Committee				
Chair	Dr Hector Faulkner	Per meeting	12 months	$1,517
Member	Dr Virginia Longley	Not eligible	Not applicable	$0
Member	Dr Jane James	Not eligible	Not applicable	$0
Member	Dr Amirthalingan Prathalingam	Not eligible	Not applicable	$0
Member	Dr Brett Lamb	Not eligible	Not applicable	$0
Member	Dr Pieter Austin	Not eligible	Not applicable	$0
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
Ex-officio Member	Sam Barron	Not eligible	Not applicable	$0
			Total:	**$1,517**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Donnybrook Hospital Medical Advisory Council				
Chair	Dr Peter Rae	Not eligible	Not applicable	$0
Member	Dr Wietske van der Velden Schuijling	Not eligible	Not applicable	$0
Member	Dr Loren Geyer	Not eligible	Not applicable	$0
Member	Dr Winton Barnes	Not eligible	Not applicable	$0
Memberv	Dr Winston McKean	Not eligible	Not applicable	$0
Ex-officio Member	Kerry Winsor	Not eligible	Not applicable	$0
Ex-officio Member	Robyn Phillips	Not eligible	Not applicable	$0
Ex-officio Member	Glen Matters	Not eligible	Not applicable	$0
Ex-officio Member	Leanne Northrop	Not eligible	Not applicable	$0
			Total:	**$0**
Derby and Surrounding Communities District Health Advisory Council				
Chair	Susan Murphy	Per meeting	12 months	$0
Member	Elsia Archer	Per meeting	12 months	$0
Member	Lyn Henderson Yates	Per meeting	12 months	$0
Member	Jeannie Roberts	Per meeting	12 months	$0
Member	Dave Dench	Per meeting	12 months	$0
Member	Ruth Southern	Per meeting	12 months	$0
Member	Jayde Fuller	Per meeting	12 months	$0
Member	Paul Bridge	Per meeting	9 months	$0
Member	Adam Vincent	Per meeting	5 months	$0
Member	Margi Faulkner	Per meeting	12 months	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Eastern District Health Advisory Council (Wheatbelt)				
Chair	Onida Truran	Per meeting	12 months	$0
Deputy Chair	Sandra Waters	Per meeting	12 months	$2,256
Member	Jill Hatch	Per meeting	12 months	$0
Member	Alan McAndrew	Per meeting	12 months	$1,498
Member	Robyn Richards	Per meeting	12 months	$0
Member	Lyn White	Per meeting	12 months	$1,693
Member	Adrian Wesley	Per meeting	12 months	$0
Member	Mary Cowan	Per meeting	12 months	$0
Member	Marie Royce	Per meeting	12 months	$0
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Sharon Hearns	Not eligible	Not applicable	$0
Member	Wendey Jardine	Not eligible	Not applicable	$0
			Total:	**$5,447**
Eastern Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Lines	Per meeting	12 months	$3,867
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Jonathan Ruiz	Not eligible	Not applicable	$0
Member	Dr Mirielsa Nufable-Ruiz	Not eligible	Not applicable	$0
Member	Dr Caleb Chow	Not eligible	Not applicable	$0
Member	Dr Thyagaraj Ramakrishna	Not eligible	Not applicable	$0
Member	Dr Andrew Van Ballegooyen	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Adenola Adeleye	Not eligible	Not applicable	$0
Member	Dr Mark Byrne	Not eligible	Not applicable	$0
Member	Dr Modupe Olanrewaju	Not eligible	Not applicable	$0
Member	Dr Gabriel Adeniyi	Not eligible	Not applicable	$0
Member	Dr Tony Mylius	Not eligible	Not applicable	$0
Member	Dr Herma Inverarity	Not eligible	Not applicable	$0
Member	Dr Olga Ward	Not eligible	Not applicable	$0
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Sharon Hearns	Not eligible	Not applicable	$0
Member	Wendy Jardine	Not eligible	Not applicable	$0
			Total:	**$3,867**
Gascoyne District Health Advisory Council				
Chair	Greg Rose	Per meeting	10 months	$0
Member	Gino Gianatsis	Per meeting	12 months	$60
Member	Leanne Norman	Per meeting	12 months	$0
Member	Cathy Gianatsis	Per meeting	12 months	$0
Member	Jennifer Raymond	Per meeting	12 months	$60
Member	Jackie Cameron	Per meeting	10 months	$0
Member	Elizabeth Burnett	Per meeting	12 months	$0
			Total:	**$120**
Geraldton District Health Advisory Council				
Chair	Don Rolston	Per meeting	12 months	$0
Member	Glenn Jones	Per meeting	12 months	$0
Member	Sheena Bryne	Per meeting	12 months	$0
Member	Margaret Pike	Per meeting	6 months	$0
Member	Jodie Green	Not eligible	Not applicable	$0
Member	Kym Coulthard	Per meeting	11 months	$0
Member	Pam Syme	Not eligible	Not applicable	$0
			Total:	**$0**
Geraldton Medical Advisory Council (Name changed to Midwest Medical Advisory Committee)				
Chair	Dr Ian Taylor	Not eligible	Not applicable	$0
Member	Dr Andrew Jamieson	Not eligible	Not applicable	$0
Member	Dr Roy Varghese	Not eligible	Not applicable	$0
Member	Dr Helko Schenk	Not eligible	Not applicable	$0
Member	Marie Norris	Not eligible	Not applicable	$0
Ex-officio Member	Dr Jaques Perry	Not eligible	Not applicable	$0
Member	Dr Sara Armitage	Not eligible	Not applicable	$0
Member	Dr Ken Whiting	Not eligible	Not applicable	$0
Member	Dr Apaks Dede	Not eligible	Not applicable	$0
Member	Dr Katherine Templeman	Not eligible	Not applicable	$0
Member	Dr Yoland Chikari	Not eligible	Not applicable	$0
Member	Dr William Beresford	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Goldfields District Health Advisory Council				
Chair	Graham Thomson	Per meeting	12 months	$90
Deputy Chair	Kirsty McCluskey	Per meeting	12 months	$450
Member	Margaret Ann Christie	Per meeting	12 months	$270
Member	Debbie Van Luxemborg	Per meeting	12 months	$450
Member	Williamina Ingham	Per meeting	12 months	$270
Member	Keith Cowan	Per meeting	9 months	$450
Member	Diane Paddon	Per meeting	12 months	$540
Member	Natasha Edgecombe	Per meeting	9 months	$360
Member	Greg Baxter	Per meeting	12 months	$540
			Total:	**$3,420**
Kununurra/Wyndham and Surrounding Communities District Health Advisory Council (Name changed to East Kimberley District Health Advisory Council)				
Chair	Maxine Middap	Per meeting	12 months	$0
Member	Terry Howe	Not eligible	Not applicable	$0
Member	Donna Hindmarsh	Not eligible	Not applicable	$0
Member	Jane Drew	Not eligible	Not applicable	$0
Member	Sister Marcella Hegarty	Per meeting	12 months	$0
Member	Peter Frewen	Per meeting	12 months	$0
Member	Robyn Long	Not eligible	Not applicable	$0
Member	Virginia O'Neill	Not eligible	Not applicable	$0
Member	Dr James Harris	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Leschenault District Health Advisory Council				
Chair	Amanda Lovitt	Per meeting	12 months	$0
Deputy Chair	William Adams	Per meeting	12 months	$270
Member	Diane Canale	Per meeting	12 months	$0
Member	Colin Beauchamp	Per meeting	12 months	$0
Member	Vincent Cosentino	Per meeting	12 months	$0
			Total:	**$270**
Lower Great Southern District Health Advisory Council				
Chair	Irene Montefiore	Per meeting	12 months	$0
Member	Debbie Blanchette	Per meeting	7 months	$0
Member	Sara Lembo	Per meeting	12 months	$0
Member	Ivan Edwards	Per meeting	12 months	$1,275
Member	Pamela Smyth	Per meeting	7 months	$0
Member	Graham Carthew	Per meeting	12 months	$0
Member	Dr Ceinwen Gearon	Not eligible	Not applicable	$0
Member	Ruth McLean	Per meeting	12 months	$0
Member	Denise Kay	Per meeting	12 months	$0
Member	Eliza Woods	Per meeting	12 months	$0
Member	Dot Price	Per meeting	12 months	$0
Member	Merindo Logie	Per meeting	12 months	$0
Member	Brenda Tillbrook	Per meeting	12 months	$0
			Total:	**$1,275**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Margaret River Medical Advisory Council				
Chair	Dr Verelle Roocke	Per meeting	12 months	$2,195
Member	John Pollard	Not eligible	Not applicable	$0
Member	Marie Tweedie	Not eligible	Not applicable	$0
Member	Dr Peter Durey	Not eligible	Not applicable	$0
Member	Dr Ray Clarke	Not eligible	Not applicable	$0
Member	Dr Cathy Milligan	Not eligible	Not applicable	$0
Member	Dr Adam Bancroft	Not eligible	Not applicable	$0
Member	Dr Bob Bucat	Not eligible	Not applicable	$0
Member	Dr John Collis	Not eligible	Not applicable	$0
Member	Dr Marigold Jones	Not eligible	Not applicable	$0
Member	Dr Kirsty MacGregor	Not eligible	Not applicable	$0
Member	Dr Graham Velterop	Not eligible	Not applicable	$0
Member	Dr Shaun O'Rourke	Not eligible	Not applicable	$0
Member	Dr Sharyn Bennier	Not eligible	Not applicable	$0
Member	Dr Peter Carroll	Not eligible	Not applicable	$0
Member	Dr Richard Roddy	Not eligible	Not applicable	$0
Member	Dr Martin Ibach	Not eligible	Not applicable	$0
Member	Dr Nathalie Maron	Not eligible	Not applicable	$0
Member	Dr Louise Marsh	Not eligible	Not applicable	$0
Member	Dr Allan Walley	Not eligible	Not applicable	$0
Member	Dr Karen Wickham	Not eligible	Not applicable	$0
Member	Dr Gareth Mann	Not eligible	Not applicable	$0
Member	Dr Katina Koukourou	Not eligible	Not applicable	$0
Member	Rachel Jenkin	Not eligible	Not applicable	$0
Member	Lisa Sims	Not eligible	Not applicable	$0
Member	Dr Gary Wilson	Not eligible	Not applicable	$0
Member	Dr Kamal Ali	Not eligible	Not applicable	$0
Member	Dr Gerhard Erasmus	Not eligible	Not applicable	$0
Ex-officio Member	Rory Stemp	Not eligible	Not applicable	$0
Ex-officio Member	Dr Winston Barnes	Not eligible	Not applicable	$0
			Total:	**$2,195**
Midwest District Health Advisory Council				
Chair	Merle Isbister	Per meeting	12 months	$240
Deputy Chair	Graeme Bedford	Per meeting	12 months	$180
Member	Anne Browning	Per meeting	12 months	$300
Member	Steph Bligh-Lee	Per meeting	12 months	$240
Member	Iris Annear	Per meeting	12 months	$240
Member	Jennifer Teakle	Per meeting	5 months	$180
Member	Lynette Fabling	Per meeting	12 months	$180
			Total:	**$1,560**
Naturaliste District Health Advisory Council				
Chair	Elizabeth Jones	Per meeting	12 months	$225
Deputy Chair	Max Kewish	Per meeting	12 months	$0
Secretary	Leanne Howlett	Not eligible	Not applicable	$0
Member	Lorrae Loud	Not eligible	Not applicable	$0
Member	Creena Holly	Per meeting	12 months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Tanya Gillett	Not eligible	Not applicable	$0
Member	David McDonald	Per meeting	12 months	$0
Member	Naomi Grimshaw	Per meeting	12 months	$0
Member	Rory Stemp	Not eligible	Not applicable	$0
Member	Gaye Hargreaves	Per meeting	10 months	$0
			Total:	**$225**
Plantagenet Cranbrook Health Service Medical Advisory Committee				
Chair	Dr Victor Seah	Per meeting	12 months	$856
Member	Dr Carol Fitzpatrick	Not eligible	Not applicable	$0
Member	Dr Ligia Galvez	Not eligible	Not applicable	$0
Member	Dr Amanda Villis	Not eligible	Not applicable	$0
Member	Dr Elaine Sabin	Not eligible	Not applicable	$0
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
Ex-officio Member	Ruth Godden	Not eligible	Not applicable	$0
			Total:	**$856**
Port Hedland Medical Advisory Council (Name changed to East Pilbara-Hedland Health Campus Medical Advisory Committee)				
Chair	Dr Ganesan Sakarapani	Not eligible	Not applicable	$0
Member	Dr Philip Montgomery	Not eligible	Not applicable	$0
Member	Dr Farhan Aizaz	Not eligible	Not applicable	$0
Member	Dr Anita Banks	Not eligible	Not applicable	$0
Member	Dr Stephanie Breen	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Christoper Buck	Not eligible	Not applicable	$0
Member	Dr Bruce Campbell	Not eligible	Not applicable	$0
Member	Dr Crystal Claite	Not eligible	Not applicable	$0
Member	Dr Hans Dahl	Not eligible	Not applicable	$0
Member	Dr John Van Bocksmeer	Not eligible	Not applicable	$0
Member	Dr Annie Lang	Not eligible	Not applicable	$0
Member	Dr Cynthia Leeuwin	Not eligible	Not applicable	$0
Member	Dr Sing Lok	Not eligible	Not applicable	$0
Member	Dr Heather Lyttle	Not eligible	Not applicable	$0
Member	Dr Tadzoka Mangwana	Not eligible	Not applicable	$0
Member	Dr Sarah McEwan	Not eligible	Not applicable	$0
Member	Dr Vafa Naderi	Not eligible	Not applicable	$0
Member	Dr Anura Padmasiri	Not eligible	Not applicable	$0
Member	Dr Daniel Saplontai	Not eligible	Not applicable	$0
Member	Dr Smriti Shah	Not eligible	Not applicable	$0
Member	Dr Servaas Terblanche	Not eligible	Not applicable	$0
Member	Dr John Walker	Not eligible	Not applicable	$0
Member	Dr Justin Withnall	Not eligible	Not applicable	$0
Ex-officio Members	Jamie Gunn	Not eligible	Not applicable	$0
Ex-officio Members	Brian Wilson	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
South East District Health Advisory Council				
Chair	Meredith Waters	Per meeting	12 months	$0
Member	Thuriyya Ibrahim	Per meeting	12 months	$0
Member	Gabrielle Lilley	Per meeting	12 months	$0
Member	Pamela Kerr	Per meeting	12 months	$0
Member	Ellen Saltmarsh	Per meeting	12 months	$0
Member	Sue Meyer	Per meeting	6 months	$0
Member	Pam Gardner	Per meeting	6 months	$0
Member	Kathleen Fowler	Per meeting	6 months	$0
			Total:	**$0**
Southern District Health Advisory Council (Wheatbelt)				
Chair	Stan Sherry	Per meeting	12 months	$1,615
Member	Mel Crosby	Per meeting	12 months	$240
Member	Amanda Milton	Per meeting	12 months	$0
Member	Geoff Hodgson	Per meeting	12 months	$0
Member	Moya Carne	Per meeting	12 months	$0
Member	Bronwen O'Sullivan	Per meeting	12 months	$0
Member	Frank Heffernan	Per meeting	12 months	$0
Member	Debrah Clarke	Per meeting	12 months	$0
			Total:	**$1,855**
Southern District Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Maguire	Per meeting	12 months	$2,353
Deputy Chair	Dr Peter Smith	Per meeting	12 months	$0
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Alan Kerrigan	Not eligible	Not applicable	$0
Member	Dr Ilario DaSilva	Not eligible	Not applicable	$0
Member	Dr Reinier De Villiers	Not eligible	Not applicable	$0
Member	Dr Coert Erasmus	Not eligible	Not applicable	$0
Member	Dr Megan Hardie	Not eligible	Not applicable	$0
Member	Dr JP Lalonde	Not eligible	Not applicable	$0
Member	Dr Stephen Lai	Not eligible	Not applicable	$0
Member	Dr Nnaji Nwoko	Not eligible	Not applicable	$0
Member	Dr Peter Beaton	Not eligible	Not applicable	$0
Member	Dr Peter Van Maarseveen	Not eligible	Not applicable	$0
Member	Dr Jean Foster	Not eligible	Not applicable	$0
Member	Dr Wynand Breytenbach	Not eligible	Not applicable	$0
Member	Dr Gina Sherry	Not eligible	Not applicable	$0
Member	Dr Katherine Comparti	Not eligible	Not applicable	$0
Member	Dr Hermanus Lochner	Not eligible	Not applicable	$0
Member	Dr Abiola Olowu	Not eligible	Not applicable	$0
Member	Kerry Fisher	Not eligible	Not applicable	$0
Member	Jenny Menasse	Not eligible	Not applicable	$0
			Total:	**$2,353**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Warren District Health Advisory Council				
Chair	Ray Curo	Per meeting	12 months	$240
Deputy Chair	Neroli Logan	Not eligible	Not applicable	$0
Member	Carla Logan	Not eligible	Not applicable	$0
Member	Sue Priddis	Not eligible	Not applicable	$0
Member	Amanda Poller	Not eligible	Not applicable	$0
Member	Anne Trent/Polley	Not eligible	Not applicable	$0
Member	Sydney Brunelli	Not eligible	Not applicable	$0
Member	Lesley Polley	Not eligible	Not applicable	$0
Member	Gordon Smith	Not eligible	Not applicable	$0
			Total:	**$240**
Warren District Hospital Medical Advisory Council				
Chair	Dr John Davies	Per meeting	12 months	$1,227
Member	Dr Alison Turner	Not eligible	Not applicable	$0
Member	Dr James Bowie	Not eligible	Not applicable	$0
Member	Dr Lucas Vesely	Not eligible	Not applicable	$0
Member	Dr Mildred Chiwara	Not eligible	Not applicable	$0
Member	Dr Paul Griffiths	Not eligible	Not applicable	$0
Member	Dr Peter Wutchak	Not eligible	Not applicable	$0
Member	Dr Jan Van Vollenstee	Not eligible	Not applicable	$0
			Total:	**$1,277**
Western District Health Advisory Council (Wheatbelt)				
Chair	Irene Mills	Per meeting	12 months	$830
Deputy Chair	Jan Court	Per meeting	12 months	$0
Member	Michelle Thompson	Per meeting	12 months	$600
Member	Kerrie Roberts	Per meeting	12 months	$390
Member	Sandra Randall	Per meeting	12 months	$0
Member	Georgina Mackintosh	Per meeting	12 months	$1,260
Member	Diane Kelly	Per meeting	12 months	$90
Member	Patricia Walters	Per meeting	12 months	$0
Member	Keith Murray	Per meeting	12 months	$885
Member	Cynthia McMorran	Per meeting	12 months	$615
Member	Michelle Cockman	Per meeting	12 months	$690
Member	Dianne Hooper	Per meeting	12 months	$705
			Total:	**$6,065**
Western District Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Gavin Osgarby	Not eligible	Not applicable	$0
Member	Dr Marie Fox	Not eligible	Not applicable	$0
Member	Dr Mark Daykin	Not eligible	Not applicable	$0
Member	Dr Matt Archer	Not eligible	Not applicable	$0
Member	Dr Stephanie Spencer	Not eligible	Not applicable	$0
Member	Dr Michele Genevieve	Not eligible	Not applicable	$0
Member	Dr Tony Mylius	Not eligible	Not applicable	$0
Member	Dr Vish Madikeri Ramaraju	Not eligible	Not applicable	$0
Member	Jenny Lee	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
WA Country Health Service Audit Liaison Committee				
Chair	Joydeep Choudhury	Not eligible	Not applicable	$0
Member	Jeffrey Moffet	Not eligible	Not applicable	$0
Member	Jordan Kelly	Not eligible	Not applicable	$0
Member	Shane Matthews	Not eligible	Not applicable	$0
Member	Dr Tony Robins	Not eligible	Not applicable	$0
Member	Steve Jensen	Not eligible	Not applicable	$0
Member	Allison Wilkinson	Not eligible	Not applicable	$0
Member	Kerry Winsor	Not eligible	Not applicable	$0
Member	Angela Berragan	Not eligible	Not applicable	$0
Member	Barry O'Connor	Not eligible	Not applicable	$0
			Total:	**$0**

Notes:

1. The above list of Boards is as per the State Government Boards and Committees Register.
2. Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2015–16 financial year. If a member was ineligible to receive remuneration, their period of membership is immaterial to the remuneration amount and has been defined as 'Not applicable'.

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