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

WA Country Health Service
Annual Report






2013–14

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

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Annual Report

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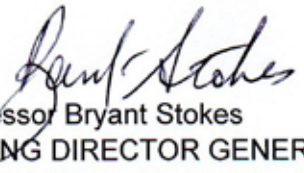
Statement of Compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the WA Country Health Service for the financial year ended 30 June 2014.

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



Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2014

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Overview of Agency

Vision statement

Our vision

Healthier, longer and better quality lives for all Western Australians.

Our mission

To improve, promote and protect the health of Western Australians by:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

Our 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 can be summarised as:

Executive summary

WA's public health system, WA Health, performed well for the community in 2013–14, despite strong demand for its services from a fast–growing population and the continuing challenge of delivering the Department of Health's biggest-ever infrastructure program.

The period was also my first full-year as Acting Director General after assuming the role in April 2013.

During 2013–14, an important committee – the Transition and Reconfiguration Committee – was formed to help facilitate the task of transferring services and resources to several new hospitals, including Fiona Stanley Hospital and Perth Children's Hospital, which are due to come on stream in the next few years.

The committee will also guide the future transformation of the Department of Health as it responds to changing demographic and economic conditions and, furthermore, to help devolve responsibility throughout the organisation.

The performance of WA Health in 2013–14 was underpinned by long–term planning, regular and ongoing monitoring and review, stronger governance guidelines, and innovative reform from a professional 43,000-strong workforce.

Delivering a healthy WA

Western Australians as a whole enjoy an excellent standard of health, reflected in life expectancy among the best in the world and infant mortality rates among the lowest in Australia.

The Australian Institute for Health and Welfare report, *The Australian Hospital Statistics 2012–13*, in early 2014 showed WA hospitals were treating more patients than ever before, while still meeting important national performance targets.

During 2013, the WA median wait time for elective surgery is the lowest for all urgency categories, compared to other States and Territories.

WA also continued to lead the country in the proportion of emergency department visits completed in four hours or less which, at 78 per cent, is higher than the national average of 71 per cent.

However, we recognise that sections of the community experience poorer health outcomes and we are resolute in our commitment to improve the health of those who are most in need.

The broad WA community benefits from effective public health programs, responsive health services and hospitals which, in the provision of patient care, meet high standards of safety and quality.

Work continued through the year on the $7 billion infrastructure overhaul that is expanding and transforming hospitals and health facilities across WA, including the construction of Fiona Stanley Hospital, the State's major new tertiary hospital, due to be opened in stages from October 2014.

Also announced in 2013–14 was the reconfiguration of South Metropolitan Health Service to ensure the workforce and resources were ready to operate Fiona Stanley Hospital when it opens.

Included in the reconfiguration was the transfer of the State Rehabilitation Centre from Shenton Park to Fiona Stanley Hospital, due in October 2014; the obstetrics, gynaecology and neonatal services at Kaleeya Hospital to Fiona Stanley Hospital by November 2014; and Fremantle Hospital's emergency department to Fiona Stanley Hospital in 2015.

Our challenge is to use this vast investment in infrastructure to boost productivity and efficiency in our health services. These services are costing more, but the State's revenue base is growing at a slower rate.

A particular focus has been information and communications technology governance and planning, and a professional and consistent approach to procurement.

With those priorities in mind, the Office of Deputy Director General and Office of Chief Procurement Officer were formed to support me in implementing key changes across the governance, performance and procurement processes in WA Health.

In 2013–14 WA Health also acted on the recommendations of the Corruption and Crime Commission's *Report on Fraud and Corruption in Procurement in WA Health: Dealing with the Risks.*

Since the report was tabled in June 2014, WA Health has conducted:

- a comprehensive risk assessment for fraud and corruption in procurement
- developed strategies to ensure compliance
- used risk assessment to inform internal audit and strategic planning and activity
- procurement staff training programs
- policy and procedure reviews to manage conflicts of interest, gifts and benefits, and outside employment.

Throughout these times of significant change, however, WA Health continues to improve its performance and align its efforts to the four key pillars of *WA Health Strategic Intent 2010–15*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

Caring for individuals and the community

WA continues to be at the forefront of tobacco control, with well supported initiatives such as Quitline, the Make Smoking History campaign and WA's own Smoke Free WA Health System Policy.

The Department of Health's tough stance on tobacco and related products was backed by a Supreme Court decision during 2013–14 that resulted in a fine for a retailer selling e–cigarettes.

Focus also continues on health conditions linked to excess body mass. A Department of Health report (*The Cost of Excess Body Mass to the Acute Hospital System in Western Australia 2011*) released during the year found more than $240 million a year, or 5.4 per cent of total hospital costs, was the cost attributed to excess body mass through health conditions such as osteoarthritis, type 2 diabetes, hypertensive disease and congestive heart failure. Initiatives continue to encourage people to "live lighter" to combat this problem.

There was also a free, statewide vaccination program offered to Year 8 students across WA, providing human papillomavirus vaccine, as well as booster doses of diphtheria, tetanus, pertussis and chicken pox vaccines.

Research, again, received strong support in 2013–14, with $8.71 million awarded from three State Government health research funds. Researchers will share $5.96 million of Medical and Health Research Infrastructure Fund grants; six projects will share $1.55 million in Targeted Research Fund grants; and six WA Health clinicians will share $1.2 million of Clinician Research Fellowship funding.

In addition, nearly $3 million was allocated for new initiatives to help Western Australian researchers access a greater share of national research funding and enhance the State's health and medical research capability.

Caring for those who need it most

WA Health renewed its commitment to closing the gap in life expectancy for Aboriginal people by announcing its new Footprints to Better Health Strategy.

More than 100 dedicated Aboriginal health services will be delivered under the strategy, which combines the former Closing the Gap program and the Indigenous Early Childhood Development programs.

The strategy is supported by the allocation of more than $32.2 million to build on the work already undertaken to close the gap in life expectancy and $2 million for the implementation of the Footprints to Better Health Strategy.

WA Health also contributed a team of professionals, including emergency department nurses, to the Typhoon Haiyan relief effort in the Philippines as part of the second Australian Medical Assistance Team (AusMAT) deployment to provide urgent medical assistance.

Sir Charles Gairdner Hospital became home to Australia's first CyberKnife – a $9 million, technologically advanced weapon in the fight against cancer – which uses high dose radiation to treat certain tumours.

BreastScreen WA launched an online booking system, which is expected to see more than 5,000 additional women screened for breast cancer each year.

There was record investment in school health, with the first of 155 new school health staff starting work in WA schools. There will be $38 million in funding over four years for additional school health staff across the State, most of whom will be based in regional teams servicing a number of schools in each area.

Making the best use of our funds and resources

This was the last year of Australian Government funding under the old system before the key national reform of Activity Based Funding takes hold from July 2014. This will benchmark our performance against other States and affect the amount of funding we receive from the Australian Government.

To be in the best position for this new funding regime, WA Health has focussed on improvements across the board, but especially in information and communication technology governance and planning, and adopting a professional and consistent approach to procurement.

As mentioned previously, more than $7 billion has been invested in 80 infrastructure projects, including the flagship Fiona Stanley Hospital and Perth Children's Hospital.

The metropolitan area also welcomed investment in a new $15 million 37–bed paediatric ward for the northern suburbs, based at Joondalup Health Campus.

In regional areas, major upgrades have been completed or are planned at 24 regional and remote facilities, including:

- construction of the $31.3 million redevelopment of the Esperance Health Campus
- expansion of the Albany Health Campus, which in its first year saw tens of thousands of people benefit from improved healthcare closer to home.
- the Emergency Telehealth System, which treated more than 4,500 people in regional WA in its first 18 months of operation. Further expansion of this initiative will help provide sustainable, efficient emergency services in regional WA.

Also the Southern Inland Health Initiative received an additional $1.9 million in grants to boost primary health services in the Wheatbelt and Central Great Southern.

Supporting our team

People are WA Health's greatest asset and attracting and retaining the best people into the workforce is vital to maintaining a quality health system.

The goal is to have the right doctors, nurses and allied health staff, in the right numbers, in the right places and at the right time to meet the challenging health needs of our State.

The WA Health workforce is facing significant challenges, including the transfer and reconfiguration of people and resources to new hospitals, most significantly Fiona Stanley Hospital and Perth Children's Hospital.

Several specialised transition management systems and databases were developed to help manage and streamline this staff transition process.

WA Health is also developing a 10–year strategic workforce plan, based on the *WA Health Clinical Services Framework 2010–2020*, which will ensure workforce planning is aligned with demand.

Staff retention is another important factor as it has a direct, costly and significant impact on the capacity of WA Health to deliver its quality services. Environmental factors such as the ageing population, the increase in competition in the labour market and the skills shortage in the health sector means that the need for WA Health to focus on improving retention levels is more critical than ever.

To advance greater Aboriginal employment and healthcare inclusion, the revitalised *WA Health Aboriginal Health Workforce Strategy 2014–2024* continues to fund and support leadership programs such as Aboriginal nursing cadetships, nurse mentors, and career and course transition pathways.

Significant workforce challenges are also being faced by the mental health sector. The current workforce is inadequate to meet the mental health needs of WA.

We also have to ensure the WA country community has adequate access to primary health care. WA Health has conducted a concerted and ongoing recruitment drive, resulting in 186 new permanent doctors who have commenced in WA Country Health Service hospitals since 2012.

Professor Bryant Stokes
Acting Director General
DEPARTMENT OF HEALTH

Country WA at a glance

In country WA a male is expected to live to **79.5** years of age and a female to **84.1** years of age

134,251 people were admitted to a country hospital in 2013

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

369 deaths in country WA are caused by coronary heart disease each year

2,635 people living in country WA are diagnosed with cancer each year

26% 16–24 year olds in WA experienced a mental health problem in 2013–14

54% of all potentially preventable hospitalisations in WA were due to chronic conditions

47.6% of children living in country WA do not undertake sufficient physical activity

33.6% of adults living in country WA are obese

91.8% of adults living in country WA do not eat two serves of fruit and five serves of vegetables daily

6,326 patients accessed the Royal Flying Doctor Service in 2013

9,663 patients accessed Telehealth services in 2013

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 2013–14 for administered legislation.

Accountable authority

The Acting Director General of Health, Professor Bryant Stokes, is the accountable authority for the WA Country Health Service.

Responsible Minister

The WA Country Health Service is responsible to the Minister for Health, the Hon. Dr Kim Hames.

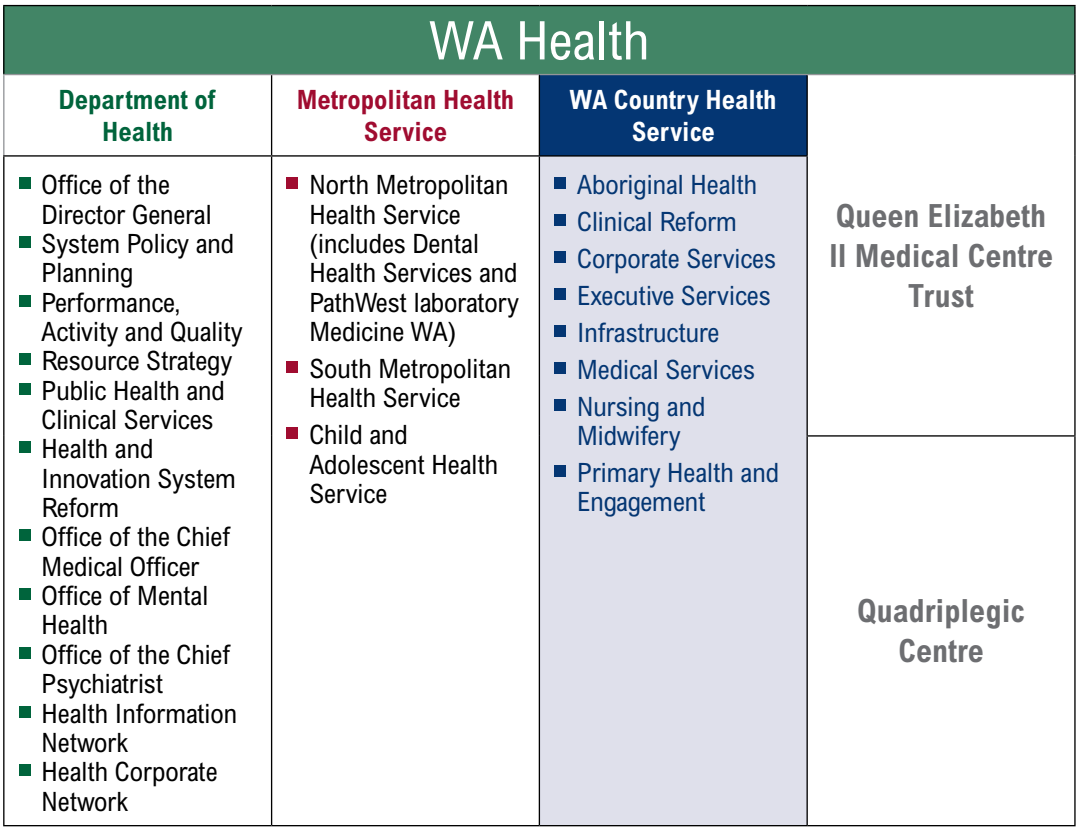
WA Health structure

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**



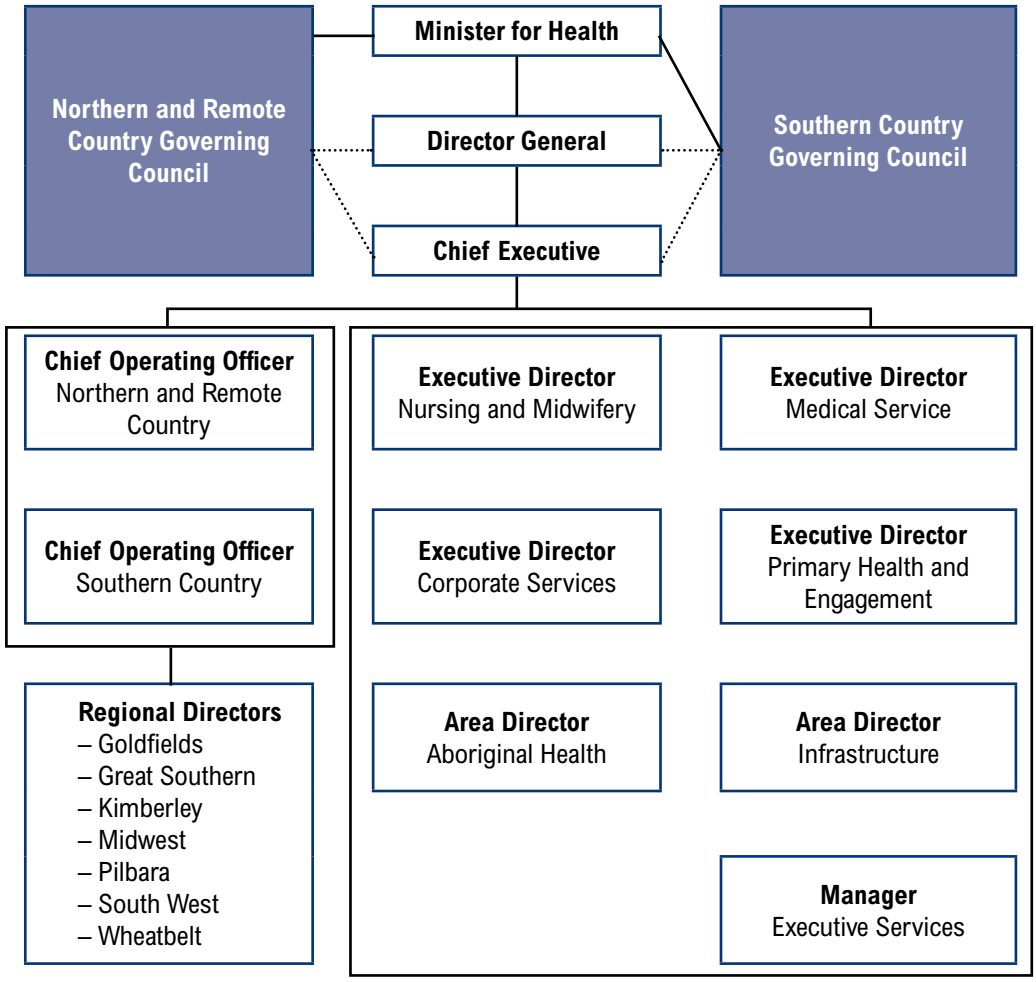
WA Country Health Service management structure

The WA Country Health Service has two governing councils (Northern and Remote Country, and Southern Country) and 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 the Wheatbelt. Each region is managed by a Regional Director who reports to the WA Country Health Service Chief Executive Officer through a Chief Operating Officer.

The WA Country Health Service Chief Executive is also on the State Health Executive Forum that advises the Director General. For information and the management structure of the State Health Executive Forum, please refer to the Department of Health Annual Report 2013–14.

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 2014 are listed in Table 1.

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

Area of responsibility	Title	Name	Basis of appointment
Area Operations	Chief Operating Officer – Northern and Remote Country Health Service	Shane Matthews	Acting
Area Operations	Chief Operating Officer – Southern Country Health Service	Tina Chinery	Acting
Corporate Services	Executive Director	Jordan Kelly	Acting
Medical Services	Executive Director	Dr Tony Robins	Substantive
Nursing and Midwifery	Executive Director	Marie Baxter	Substantive
Primary Health and Engagement	Executive Director	Melissa Vernon	Term contract
Regional Operations	Regional Director Goldfields	Geraldine Ennis	Substantive
Regional Operations	Regional Director Great Southern	Susan Kay	Term contract
Regional Operations	Regional Director Kimberley	Kerry Winsor	Substantive
Regional Operations	Regional Director Midwest	Margaret Denton	Acting
Regional Operations	Regional Director Pilbara	Ron Wynn	Term contract
Regional Operations	Regional Director South West	David Naughton	Acting
Regional Operations	Regional Director Wheatbelt	Caroline Langston	Term contract
WA Country Health Service	Chief Executive Officer	Jeffrey Moffet	Term contract

WA Country Health Service 2013–14

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 530,000 people (ABS ERP 2012), including over 48,000 Aboriginal people (ABS ERP 2011) 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 for a particularly 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 its 70 hospitals, the WA Country Health Service handles almost as many emergency presentations as hospitals in the metropolitan area combined, and almost as many births as the State's major maternity hospital. As well as the many country hospitals, there are also a number of smaller health centres and nursing posts spread across country WA.

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

The WA Country Health Service has established a network of District Health Advisory Councils across all regions, which are made up of 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.

Revitalising WA Country Health Services

The WA Country Health Service continues to work with regional communities to deliver a healthier country WA. Following the success of the *Revitalising Country Health Services Strategic Direction 2009–12*, new strategic priorities were introduced for the following three years in the *Towards Healthier Country Communities 2013–15* initiative.

These new strategic priorities build on past successes and lay out how the WA Country Health Service will continue to address key country health challenges to deliver high quality health services in regional WA over the next two years.

The purpose, values, vision and actions have evolved through consultation over several months with WA Country Health Service staff, governing councils and community members across all seven regions.

Our purpose	To improve, promote and protect the health of country Western Australians
What we stand for	**Quality health services for all** Our aim is to put the needs of our patients and their carers first in all that we do. Our staff will work closely with other health providers and our country communities to deliver high quality, accessible and safe services for everyone, closer to home where possible.
	Improving the health of Aboriginal people and those most in need We are working hard to close the gap in Aboriginal health and improve access to quality health care for those most in need in collaboration with our health partners and the public.
	A fair share for country health We understand the importance of maintaining a fair share for country WA and are committed to using the resources entrusted to us to provide WA taxpayers, including our country patients, families and carers, with optimum services and value for money.
	Supporting our team – workforce excellence and stability Our workforce is our success. We aim to create a workplace culture which attracts and retains staff who have the capability, skills, values and professionalism to deliver modern, high quality and safe health care.
Our values	**Community** Making a difference through teamwork, generosity and country hospitality.
	Compassion Listening and caring with empathy and dignity.
	Quality Creating a quality experience for every consumer.
	Integrity Accountability, honesty and professional ethical conduct in all that we do.
	Justice Valuing diversity with a fair share for all.

Performance management framework

To comply with its legislative obligation as a Western Australian 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 2013–14 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 3 and Figure 4).

The WA Health outcomes for achievement in 2013–14 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 Outcome 1 and 2 are cited below.

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. This activity is reported as part of the WA Country Health Service annual report under key performance indicator "average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents".

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

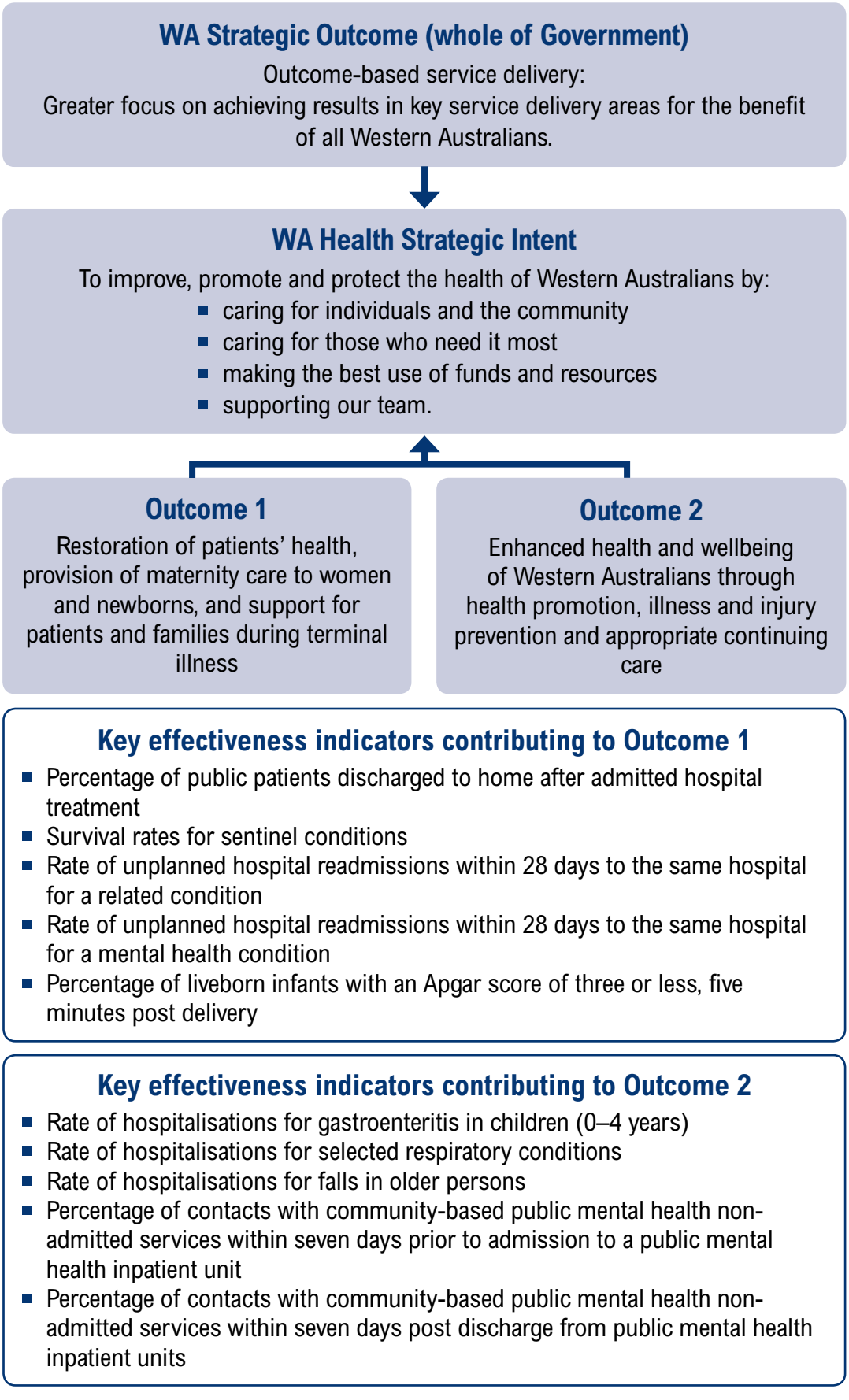


Figure 4: **Services delivered to achieve WA Health outcomes and key efficiency indicators for WA Country Health Service**

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 non-admitted hospital based occasion of service for rural hospitals
- 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 specified residential care facilities, flexible care (hostels) and nursing home type residents
- Average cost per bed-day in specialised mental health inpatient 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 2013–14 was $7.4 billion. Results for 2013–14 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 2013–14 are provided in the Financial statements.

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

Financial	2013–14 Target $'000	2013–14 Actual $'000	Variation $ +/–
Total cost of service	7,562,797	7,424,416	-138,381
Net cost of service	4,531,942	4,373,407	-158,535
Total equity	8,423,348	8,766,188	342,840
Net increase/decrease in cash held	(16,474)	110,780	127,254
Approved full time equivalent staff level	4,191,586	4,243,667	52,081

Note: 2013–14 targets are specified in the 2013–14 Budget Statements.
Data source/s: Budget Strategy Branch, Health Corporate Network.

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 2013–14 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	2013–14 Target	2013–14 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	≥97.4%	97.4%	0
Survival rates for sentinel conditions:			
Stroke, by age group:			
0–49 years	≥98.5%	100.0%	1.5
50–59 years	≥97.9%	96.6%	1.3
60–69 years	≥98.7%	92.2%	6.5
70–79 years	≥90.4%	95.3%	4.9
80+ years	≥79.3%	80.1%	0.8
Acute Myocardial Infarction (AMI), by age group:	≥100.0%	99.1%	0.9
0–49 years	≥99.1%	99.2%	0.1
50–59 years	≥99.2%	99.2%	0.0
60–69 years	≥98.7%	98.1%	0.6
70–79 years	≥92.1%	96.0%	3.9
80+ years			
Fractured neck of femur (FNOF), by age group:			
70–79 years	≥98.7%	98.5%	0.2
80+ years	≥97.8%	96.9%	0.9
Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition	≤2.2%	2.8%	0.6
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	≤4.8%	6.3%	1.5
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	4.2%	4.0%	0.2
2000–2499 grams	0.8%	0.7%	0.1
2500+ grams	0.1%	0.2%	0.1
Key efficiency indicators:			
Average cost per casemix adjusted separation for non-tertiary hospitals	$7,547	$5,879	$1,668
Average cost per day-bed for admitted patients (selected small rural hospitals)	$1,873	$1,365	$508
Average cost per emergency department/service attendance	$547	$696	$149
Average cost per non-admitted hospital based occasion of service for rural hospitals	$192	$124	$68
Average cost per non-admitted occasion of service provided in a rural nursing post	$265	$219	$46

Key performance indicators	2013–14 Target	2013–14 Actual	Variation
Average cost per trip of Patient Assisted Travel Scheme	$585	$489	$96
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	9.9	4.9
Rate of hospitalisation for selected respiratory conditions: Asthma, by age group: 0–4 years 5–12 years 13–18 years 19–34 years 35+ years Acute Bronchitis (0-4 years of age) Bronchiolitis (0-4 years of age) Croup (0-4 years of age)	 ≤5.1 ≤2.8 ≤0.9 ≤0.8 ≤0.8 ≤0.5 ≤9.7 ≤2.6	 5.6 3.6 1.0 1.0 1.1 1.1 18.7 3.5	 0.5 0.8 0.1 0.2 0.3 0.6 9.0 0.9
Rate of hospitalisation for falls in older persons	0.5% reduction per annum	24.5	+9.0
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%	43.0%	27.0
Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	55.8%	19.2
Key efficiency indicators:			
Average cost per capita of Population Health Units	$310	$320	$10
Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents	$526	$605	$79
Average cost per bed-day in specialised mental health inpatient units	$1,159	$1,859	$700
Average cost per three month period of care for community mental health	$1,995	$2,555	$560

Note: Actual results to target for the following key performance indicators are reported as per total population in the summary table above. Aboriginal and non-Aboriginal population results are provided in the Disclosure and Compliance section of this report.

1. Rate of hospitalisations for gastroenteritis in children (0–4 years)
2. Rate of hospitalisation for selected respiratory conditions
3. Rate of hospitalisation for falls in older persons.

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 is to drive major improvements in public hospital service delivery and better health outcomes for Australians. It includes the National Elective Surgery Target (NEST) and the National Emergency Access Target (NEAT).

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 focuses on two areas. Under NEST Part 1 of the national agreement, WA has a target to increase the percentage of elective surgery admissions 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 are:

- 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 is required to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

From 2010 to 2013, for categories 1, 2 and 3, the number of patients treated within clinically recommended times has gradually increased by approximately 9.7 per cent, 12.9 per cent and 0.5 per cent respectively (see Table 4).

From 1 January to 31 December 2013, 95.9 per cent of urgency category 1 patients were admitted within 30 days, just below the set target of 100 per cent, and 97.7 per cent of urgency category 3 patients were admitted within the recommended 365 days, also just below the set target of 98.0 per cent. For urgency category 2 patients, 89.4 per cent were admitted within the recommended 90 days, which is above the set target of 88.0 per cent (see Table 4).

WA Health is performing above baseline for all urgency categories, and above the 2013 target for urgency category 2.

Table 4: **Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2013**

		2010 (%) (baseline)	2011 (%)	2012 (%)	2013 (%)
Category 1	Performance	87.4	86.6	86.3	**95.9**
	Target	–	87.4	94.0	**100.0**
Category 2	Performance	79.2	83.5	82.0	**89.4**
	Target	–	79.2	84.0	**88.0**
Category 3	Performance	97.2	96.3	96.4	**97.7**
	Target	–	97.2	98.0	**98.0**

Note: Data extraction occurred on the 3 June 2014.
Data source/s: 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 2013 shows that WA's overall performance did not meet the 2013 targets for each urgency category. However, WA's performance has exceeded the baseline for all categories (see Table 5).

Table 5: **Average overdue wait time (in days) for WA patients who have waited beyond clinically recommend times, by category, 2010–2013**

		31 Dec 2010 (baseline)	31 Dec 2011	31 Dec 2012	31 Dec 2013
Category 1	Performance	27	27.3	12.1	**12.9**
	Target	–	27	0	**0**
Category 2	Performance	90	77.4	54.2	**55.0**
	Target	–	90	68	**45.0**
Category 3	Performance	87	69.3	66.9	**75.8**
	Target	–	87	65	**44.0**

Notes:
1. Data extraction occurred on the 3 June 2014.
2. As part of the National agreement, this measure is assessed at the 31 December as a point in time measure.

Data source/s: Wait List Data Collection, Inpatient Data Collections.

WA Health aims to ensure that patients who had waited beyond the clinically recommended time (long waits) will have received surgery, or have appropriate alternative treatment options identified. As at June 2013 for all categories, long wait overdue patients were found to have either had surgery or received appropriate alternative treatment within the first quarter of 2013 (see Table 6).

Table 6: **The number of overdue long wait patients as at 31 December 2012 remaining on elective surgery wait lists at 31 December 2013**

Period	Category 1	Category 2	Category 3
31 Dec 12	7	49	27
31 Mar 13	0	6	9
30 Jun 13	0	0	0
30 Sep 13	0	0	0
31 Dec 13	**0**	**0**	**0**

Data source/s: Wait List Data Collection, Inpatient Data Collections.

National Emergency Access Target (NEAT)

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

Between 2012 and 2015 all State and Territories are striving to meet progressive annual interim targets with the aim of ensuring that patients presenting to a public hospital emergency department will be admitted, transferred or discharged within four hours. By 2015 WA Health aims to ensure that 90 per cent of patients presenting to a public hospital emergency department will be admitted, transferred or discharged within four hours.

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

Results for WA Country Health Service compared to the State result and National targets are presented in Table 7. In 2013, 85.5 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 2013 State average and National target of 77.6 per cent and 81 per cent respectively.

Table 7: **Percentage of emergency department presentations at WA Country Health Service hospitals with a length of stay of 4 hours or less, 2010–2013**

Year	WACHS (%)	State (%)	Target (%)
2010	87.6	74.0	n/a
2011	87.1	79.3	71.3 (baseline)
2012	86.8	78.3	76.0
2013	**85.5**	**77.6**	**81.0**

Data source/s: 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 code between 1 (most severe) and 5 (least severe) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 8).

Table 8: **Triage category, treatment acuity and WA performance targets**

Triage category	Description	Treatment acuity	Performance indicator threshold
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%

Note: Treatment commences when a medical officer on duty (or, if no medical officer is on duty, a treating nurse) provides treatment or diagnostic service.

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 2013–14, the proportion of WA country patients in emergency departments who were seen within the recommended time was above the minimum benchmarks for all triage categories except triage 1 (see Table 9). For triage 1 patients, the result of 98.2 per cent is in line with the 2012–13 performance and an improvement on 2009–10 to 2011–12 performance.

Table 9: **Percentage of emergency department patients seen within recommended times, by triage category, 2009–10 to 2013–14**

Triage category	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)	Performance indicator threshold
1	96.3	93.4	95.8	98.6	**98.2**	**100%**
2	88.9	86.1	89.7	93.3	**91.0**	**≥80%**
3	86.1	84.0	86.8	87.1	**83.6**	**≥75%**
4	88.1	85.0	90.5	90.3	**87.6**	**≥70%**
5	98.1	94.0	97.7	97.2	**96.9**	**≥70%**

Data source/s: Emergency Department Data Collection.

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

Many patients who are scored as triage 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 2013–14, the rates of emergency department attendances triaged 4 and 5 not admitted, remained steady at 92.7 per cent and 98.1 per cent respectively (see Table 10).

Table 10: **Rate of emergency attendances with a triage score of 4 and 5 not admitted, 2009–10 to 2013–14**

Triage category	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013–14 (%)
4	93.1	92.9	93.2	93.3	**92.7**
5	97.8	97.9	98.3	98.2	**98.1**

Data source/s: Emergency Department Data Collection.

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Significant Issues

WA Health continually strives to improve its performance and align its efforts to the four key pillars of the *WA Health Strategic Intent 2010–15*:

- caring for individuals and the community
- caring for those who need it most
- making the best use of funds and resources
- supporting our team.

In alliance with these key pillars, WA Health has continued to deliver health system reform through a broad range of mechanisms in a rapidly changing environment. This has occurred while managing the challenges of current and emerging issues affecting WA Health's operations. The population growth and its geographical dispersion across WA presents a challenge in ensuring the health needs and expectations of the public are met. With the changing demography and disease patterns, a diverse range of programs and initiatives are required. In turn, this impacts upon health service planning decisions for the future while managing reform and costs efficiently.

The WA Country Health Service's *Towards Healthier Country Communities 2013–15* articulates strategy and the health care priorities of the WA Country Health Service over the next two years.

Demand and activity

The WA Country Health Service aims to provide excellent health care that assists country Western Australians to lead healthy and fulfilling lives. The WA Country Health Service is building links with primary care (e.g. general practitioners), and child health and development services as well as building capacity in critical care and rehabilitation services. A $1.5 billion capital works program, and the reform of country health services is bringing world class health care closer to home for more people living in regional and remote WA.

Examples include: the completion of the Albany Health Campus, which opened in 2013, emergency department upgrades being undertaken at Kalgoorlie and Bunbury Health Campuses, completion of the Broome Mental Health Unit, and construction of a new hospital in Busselton, due for completion later this year.

Individuals often carry an increased burden of disease in areas where primary care services are lacking. This in turn can increase the demands placed on local hospitals. Key strategies in combating this issue include the rapid expansion of telehealth into regional WA. Regional consumers can access specialist services remotely through the telehealth service without the need to leave their town and travel to Perth. Similarly, the Emergency Telehealth service is now available in more than 40 sites in the Wheatbelt, Midwest and Goldfields, enabling local general practitioners and hospital staff to be supported by high quality emergency advice around the clock from a qualified emergency medicine specialist. Progress with furthering telehealth uptake is faced with the issue of technology moving faster than policy development. There is also significant interest shown from the not-for-profit organisations and private sector to fund their telehealth-based applications and solutions. To achieve the full potential for telehealth to assist resolution of service access issues, particularly general practitioners and primary care services, further investment is required to resource general practitioners and specialist services and accommodate private and not-for-profit organisation providers. Consumers and clinicians have praised the work of the WA Country Health Telehealth and Emergency Telehealth services, particularly for the ability to support local clinicians to improve health outcomes as

well as guarantee the community access to safe quality services with robust governance and educational capacity.

The WA Country Health Service continues to focus on emergency care and building on the achievements already made in reducing waiting times in hospital emergency departments. WA Country Health Service performance in 2013–14 towards the National Emergency Access Target was consistent with previous year's performance and above the 81 per cent State target. In addition, WA Country Health Service is working towards reducing hospitalisation and length of stay through better care coordination and links with primary care.

Ensuring the needs of patients and carers are placed first in all health care services requires staff to work closely with other health care providers to deliver high quality, accessible and safe services, closer to home wherever possible. This is achieved through the Safety and Quality Investment for Reform, National Safety and Quality Standards, staff development and induction programs as well as contracted services.

Workforce challenges

A key objective of WA Country Health Service is to maintain and develop a stable workforce using innovative attraction, education and retention strategies. Some challenges in attracting and retaining a skilled workforce in country WA include:

- remoteness
- an ageing workforce
- competition with other health providers for medical, nursing and allied health staff
- a competitive global skills market for general practitioners
- providing suitable accommodation for staff
- peer support and educational opportunities
- accessing and retaining a suitably skilled Aboriginal workforce.

The Southern Inland Health Initiative also introduced a range of financial incentives to attract and retain general practitioners, and recruit emergency department nurse practitioners and support staff. Since it began in mid-2011, 42 additional doctors have signed up under the Southern Inland Health Initiative to enable regional and district hospitals to provide 24 hour, seven days a week coverage on emergency department rosters. WA Country Health Service also re-introduced rotational nursing and midwifery programs to attract, recruit and retain nurses and midwives.

WA Country Health Service views the development of a skilled and professional Aboriginal health workforce as an essential prerequisite for ensuring improvements in Aboriginal health. An Aboriginal health workforce assists in bridging the cultural differences that may exist between Aboriginal consumers and mainstream health service providers. Following on from the *WA Country Health Service Aboriginal Employment Strategy 2010–14*, the *2014–18 Aboriginal Employment Strategy* was launched in May 2014 by the Minister for Health. The strategy describes how WA Country Health Service will continue to address key health challenges in its regions, including improving the health of Aboriginal people by supporting workforce excellence and stability.

The WA Country Health Service Aboriginal workforce has grown to 367, representing an approximate 22 per cent increase over two years. WA County Health Service also has service contracts with Aboriginal organisations which substantially contribute to Aboriginal employment.

Managing funding reform and cost efficiencies

Royalties for Regions continue to contribute to WA regional health services. The Southern Inland Health Initiative is a $565 million State Government initiative to benefit people in the southern inland of WA and is dramatically improving the medical resources and 24 hour emergency coverage in the catchment area. This includes the Minister's announcement of $108.8 million in district health service upgrades, and in small hospital works in the Wheatbelt and Central Great Southern. The recently announced North-West Health Initiative will see the redevelopment of hospitals and health services in the north west of WA over the coming years.

In 2012, the two country Governing Councils (Southern Country, and Northern and Remote Country), commenced operation and introduced a new dynamic to planning and priority setting. The Governing Councils' regional engagement visits with community representatives, health stakeholders, and staff and clinicians have been valuable in identifying the health services and issues that are important to communities. The Governing Councils and WA Country Health Service health services work closely with the District Health Advisory Councils. The District Health Advisory Councils were established to give country residents a say in how their health services are delivered. This year, the District Health Advisory Councils celebrated their 10 year anniversary. They have been recognised as significantly improving the WA Country Health Service's links with consumers.

Implementing funding reform and cost efficiencies across country WA is significantly affected by the higher costs of service delivery in distant and remote areas. Higher costs are associated with accommodation, transport, staff turnover and recruitment, and reduced service time that is lost to travel. The WA Country Health Service continues to strive to meet all performance requirements despite such challenges. For example, WA Country Health Service implemented significant service reform and improved service access, quality and safety through the introduction of the Emergency Telehealth service. Currently this service covers over 44 sites located in the Wheatbelt, Midwest, Goldfields, Kimberley, Great Southern and the South West.

Small hospital reform is being undertaken through the Primary Health Care Demonstration Sites as part of the Southern Inland Health Initiative. Primary care has been demonstrated as one of the most effective ways to deliver health services to tackle chronic disease. A comprehensive system of primary health care encompasses health promotion and illness prevention as well as treatment and rehabilitation. Communities in rural areas face challenges to maintain modern and appropriate health services. An ageing population, along with fewer people moving into communities can mean the health network no longer meets the needs of the local community.

Primary Health Care Demonstration Sites will be fit-for-purpose health care facilities that will enable communities to focus on the promotion of good health, the prevention and early detection of illness, and the management of chronic disease on the one site. The mix of health services available at each site will reflect the community's population, location, health needs and current service provision. Communities can 'opt in' to host a Primary Health Care Demonstration Site, and during 2013–14, Pingelly and Cunderdin were selected as inaugural sites and development is under way.

The 2013–14 WA State Government election commitments included increased investment in school health to increase the number of school health services and nurses. These election commitments included improving ear, eye and oral health services to Aboriginal children living in rural and remote communities and the continuation of 2012–13 Child Health Investment and 2010–11 Child Development Service Investment.

Health inequalities

Caring for the most vulnerable people in WA's rural communities remains a priority for the WA Country Health Service. Due to the geographical vastness and remoteness there are significant challenges particularly related to limited access to primary care, aged care, and medical and allied health services. The WA Country Health Service continues to work with local communities and other service providers on the best ways to deliver services to improve the health of country people, including culturally appropriate services for Aboriginal people. The WA Country Health Service constantly reviews and improves the targeted services and programs to address the health impact of socio-economic disadvantage among some country WA consumers.

In the area of Aboriginal health, the WA governance structure developed in the planning and design phase of the National Partnership Agreements for Closing the Gap and Indigenous Early Childhood Development continued to be a key success in creating a united vision, identifying opportunities and overcoming challenges. The Closing the Gap initiative entered its fifth and final year of implementation in 2013–14. The WA Country Health Service secured $32.3 million of State funding to support the implementation of the *WA Footprints to Better Health Strategy in 2014–15*. This continues major elements of the National Partnership Agreements for Closing the Gap and Indigenous Early Childhood Development.

Immunisation coverage is a significant component in minimising the incidence of major vaccine preventable diseases. While immunisation coverage in WA is generally lower than that of other jurisdictions in Australia, country WA as a whole performs better than the State average. The WA Country Health Service is the largest provider of childhood vaccines in country WA and works collaboratively with other not-for-profit organisations and private providers to improve immunisation rates, particularly where it is not the sole provider. WA country immunisation coverage varies from region to region, with the Wheatbelt and Kimberley proportionally being the biggest providers, performing the best with equal to or better than the Australian average.

The WA Country Health Service is working with the Mental Health Commission, the Office of Mental Health and the Office of the Chief Psychiatrist to comprehensively implement the service improvements recommended in the *Stokes Review (2012)*[1]. One of these service improvements is the roll out of Statewide Standardised Clinical Documentation, which will align mental health records across WA country and metropolitan areas.

A key mental health service enhancement in country WA is the continued funding of the highly successful Statewide Specialist Aboriginal Mental Health Service. This service has brought significant organisational change, improving cultural safety and accessibility of mental health services for Aboriginal people and enhancing the WA Country Health Service Aboriginal workforce. The expanded 16-bed inpatient mental health unit at the new Albany Health Campus has also provided people living in the Great Southern region better access to care in their own community, and reduced the need to travel to the metropolitan area for treatment.

[1] Stokes B. (2012). Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia.

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Disclosure and Compliance

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 2014, 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.

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
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.

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 2014 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.

Report on Controls
I have audited the controls exercised by the WA Country Health Service during the year ended 30 June 2014.

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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.

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
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.

Opinion
In my opinion, 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 2014.

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 2014.

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

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
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.

Opinion

In my opinion, 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 2014.

Matters of Significance

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 time indicators has not been finalised for the year ended 30 June 2014. Consequently, the "Elective Surgery Waiting Times" KPI has not been included in the audited KPIs for the year ended 30 June 2014.

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 2014. Consequently, the two KPIs have not been included in the audited KPIs for the year ended 30 June 2014. My opinion is not modified in respect of these matters.

Independence

In conducting this audit, 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 2014 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
22 September 2014

Certification Statement

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2014

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 2014 and financial position as at 30 June 2014.

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.

Graeme Jones
CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 16 September 2014

Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

Date: 16 September 2014

Financial Statements

WA Country Health Service

Statement of Comprehensive Income

For the year ended 30 June 2014

	Note	2014 $000	2013 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	8	840,187	797,260
Fees for visiting medical practitioners		81,179	75,285
Patient support costs	9	300,206	270,734
Finance costs	10	438	552
Depreciation and amortisation expense	11	66,187	58,997
Loss on disposal of non-current assets	12	528	716
Repairs, maintenance and consumable equipment	13	32,982	38,054
Other expenses	14	138,820	146,749
Total cost of services		**1,460,527**	**1,388,347**
INCOME			
Revenue			
Patient charges	15	50,304	48,110
Commonwealth grants and contributions	16(i)	340,306	321,961
Other grants and contributions	16(ii)	78,039	62,387
Donation revenue	17	885	679
Other revenue	18	22,405	22,759
Total revenue		491,939	455,896
Total income other than income from State Government		**491,939**	**455,896**
NET COST OF SERVICES		**968,588**	**932,451**
INCOME FROM STATE GOVERNMENT			
Service appropriations	19	902,737	840,624
Assets transferred	20	188	1,429
Services received free of charge	21	75	25
Royalties for Regions Fund	22	74,690	39,653
Total income from State Government		**977,690**	**881,731**
SURPLUS/(DEFICIT) FOR THE PERIOD		**9,102**	**(50,720)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	37	83,110	68,092
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**92,212**	**17,372**

Refer also to note 53 '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 2014

	Note	2014 $000	2013 $000	
ASSETS				
Current Assets				
Cash and cash equivalents		8,428	4,512	
Restricted cash and cash equivalents	23	23,678	27,670	
Receivables	24	21,468	20,187	(a)
Amounts receivable for services	25	-	6,600	
Inventories	26	5,271	5,114	
Other current assets	27	5,130	3,999	
Total Current Assets		63,975	68,082	
Non-Current Assets				
Amounts receivable for services	25	429,154	360,610	
Property, plant and equipment	28	1,755,148	1,634,628	
Intangible assets	30	180	98	
Total Non-Current Assets		2,184,482	1,995,336	
Total Assets		**2,248,457**	**2,063,418**	
LIABILITIES				
Current Liabilities				
Payables	32	98,124	105,618	(a)
Borrowings	33	1,303	1,436	
Provisions	34	115,953	112,629	
Other current liabilities	35	392	41	
Total Current Liabilities		215,772	219,724	
Non-Current Liabilities				
Borrowings	33	8,529	9,780	
Provisions	34	23,577	22,048	
Total Non-Current Liabilities		32,106	31,828	
Total Liabilities		**247,878**	**251,552**	
NET ASSETS		**2,000,579**	**1,811,866**	
EQUITY				
Contributed equity	36	1,483,046	1,386,545	
Reserves	37	505,520	422,410	
Accumulated surplus	38	12,013	2,911	
TOTAL EQUITY		**2,000,579**	**1,811,866**	

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

(a) Restated amounts for 2013 (see note 6 'Prior year restatement').

WA Country Health Service

Statement of Changes in Equity

For the year ended 30 June 2014

	Note	2014 $000	2013 $000
CONTRIBUTED EQUITY	36		
Balance at start of period		1,386,545	1,283,605
Transactions with owners in their capacity as owners:			
Capital appropriations		51,664	54,746
Royalties for Regions Fund		45,137	48,702
Distributions to owners		(300)	(508)
Balance at end of period		1,483,046	1,386,545
RESERVES	37		
Asset Revaluation Reserve			
Balance at start of period		422,410	354,318
Comprehensive income for the period		83,110	68,092
Balance at end of period		505,520	422,410
ACCUMULATED SURPLUS	38		
Balance at start of period		2,911	53,631
Surplus/(deficit) for the period		9,102	(50,720)
Balance at end of period		12,013	2,911
TOTAL EQUITY			
Balance at start of period		1,811,866	1,691,554
Total comprehensive income for the period		92,212	17,372
Transactions with owners in their capacity as owners		96,501	102,940
Balance at end of period		**2,000,579**	**1,811,866**

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 2014

	Note	2014 $000 Inflows (Outflows)	2013 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		836,210	776,824
Capital appropriations		50,280	53,425
Holding account drawdown		4,141	-
Royalties for Regions Fund		119,826	88,355
Net cash provided by State Government	39	**1,010,457**	**918,604**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(831,816)	(780,183)
Supplies and services		(544,517)	(490,927)
Receipts			
Receipts from customers		49,962	46,973
Commonwealth grants and contributions		340,306	321,961
Other grants and contributions		78,370	62,387
Donations received		868	584
Other receipts		20,723	23,882
Net cash used in operating activities	39	**(886,104)**	**(815,323)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(124,490)	(126,207)
Receipts			
Proceeds from sale of non-current physical assets	12	61	94
Net cash provided used in investing activities		**(124,429)**	**(126,113)**
Net decrease in cash and cash equivalents		(76)	(22,832)
Cash and cash equivalents at the beginning of the period		32,182	55,014
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	39	**32,106**	**32,182**

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2014 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'*. 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 2014.

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 and buildings which have been measured at fair value .

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest thousand dollars ($'000).

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'.

(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 on delivery of the service to the customer.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(d) Income (continued)

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 19 '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

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 and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Where market-based evidence is available, the fair value of land and buildings (non-clinical sites) is determined on the basis of current market values determined by reference to recent market transactions.

In the absence of market-based evidence, fair value of land and buildings (clinical sites) is determined on the basis of existing use. This normally applies where buildings are specialised or where land use is restricted. Fair value for existing use buildings 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 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.

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' 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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(f) Property, Plant and Equipment (continued)

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

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

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

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

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

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

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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(h) Impairment of Assets (continued)

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of 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 24 '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

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

See also note 19 'Service appropriations' and note 25 'Amounts receivable for services'.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(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 26 ' 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 24 '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, Peel Health Service, WA Country Health Service, WA Alcohol and Drug Authority, 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'.

(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 not expected to be settled wholly within 12 months after the end of the reporting period 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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

When assessing expected future payments, consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions, 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.

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 superannation 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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

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 14 'Other expenses' and note 34 'Provisions'.

(t) Superannuation Expense

The 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.

(w) Comparative Figures

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

(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 50).

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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 4 Key sources of estimation uncertainty (continued)

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 11.1%. 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 2013 that impacted on the Health Service.

Title	
AASB 13	*Fair Value Measurement* This Standard defines fair value, sets out a framework for measuring fair value and requires additional disclosures for assets and liabilities measured at fair value. There is no financial Impact.
AASB 119	*Employee Benefits* This Standard supersedes AASB 119 (October 2010), making changes to the recognition, presentation and disclosure requirements. The Health Service assessed employee leave patterns to determine whether annual leave is a short-term or other long-term employee benefit. The resultant discounting of annual leave liabilities that were previously measured at the undiscounted amounts is not material.
AASB 1048	*Interpretation of Standards* This Standard supersedes AASB 1048 (June 2012), enabling references to the Interpretations in all other Standards to be updated by reissuing the service Standard. There is no financial impact.
AASB 2011-8	*Amendments to Australian Accounting Standards* arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Int 2, 4, 12, 13, 14, 17, 19, 131 & 132] This Standard replaces the existing definition and fair value guidance in other Australian Accounting Standards and Interpretations as the result of issuing AASB 13 in September 2011. There is no financial impact.
AASB 2011-10	*Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, 8, 101, 124, 134, 1049 & 2011-8 and Int 14]* This Standard makes amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 119 in September 2011. The resultant discounting of annual leave liabilities that were previously measured at the undiscounted amounts is not material.
AASB 2012-5	*Amendments to Australian Accounting Standards arising from Annual Improvements 2009-11 Cycle [AASB 1, 101, 116, 132 & 134 and Int 2]* This Standard makes amendments to the Australian Accounting Standards and Interpretations as a consequence of the annual improvements process. There is no financial impact.
AASB 2012-6	*Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transition Disclosures [AASB 9, 2009-11, 2010-7, 2011-7 & 2011-8]* This Standard amends the mandatory effective date of AASB 9 Financial Instruments to 1 January 2015 (instead of 1 January 2013). Further amendments are also made to numerous consequential amendments arising from AASB 9 that will now apply from 1 January 2015. There is no financial impact.
AASB 2012-10	*Amendments to Australian Accounting Standards - Transition Guidance and Other Amendments [AASB 1, 5, 7, 8, 10, 11, 12, 13, 101, 102, 108, 112, 118, 119, 127, 128, 132, 133, 134, 137, 1023, 1038, 1039, 1049 & 2011-7 and Int 12]* This Standard introduces a number of editorial alterations and amends the mandatory application date of Standards for not-for-profit entities accounting for interests in other entities. There is no financial impact.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

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

Initial application of an Australian Accounting Standard (continued)

Title	
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part A of this omnibus Standard makes amendments to other Standards arising from revisions to the Australian Accounting Conceptual Framework for periods ending on or after 20 December 2013. Other Parts of this Standard become operative in later periods. There is no financial impact for Part A of the Standard.

Future impact of Australian Accounting Standards not yet operative

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*'. Consequently, the Health Service has not applied early any of the following Australian Accounting Standards that have been issued that may impact the Health Service. Where applicable, the Health Service plans to apply these 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 was amended to 1 January 2017. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2017
AASB 1031	*Materiality* This Standard supersedes AASB 1031 (February 2010), removing Australian guidance on materiality that is not available in IFRSs and refers to other Australian pronouncements that contain guidance on materiality. There is no financial impact.	1 Jan 2014
AASB 1055	*Budgetary Reporting* This Standard requires specific budgetary disclosures in the financial statements of not-for-profit entities within the General Government Sector. The Health Service will be required to disclose additional budgetary information and explanations of major variances between actual and budgeted amounts, though there is no financial impact.	1 Jul 2014
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 Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 2013-3	*Amendments to AASB 136 - Recoverable Amount Disclosures for Non-Financial Assets* This Standard introduces editorial and disclosure changes. There is no financial impact.	1 Jan 2014
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments* The omnibus Standard makes amendments to other Standards arising from the deletion of references to AASB 1031 in other Standards for periods beginning on or after 1 January 2014 (Part B), and, defers the application of AASB 9 to 1 January 2017 (Part C). The Health Service has not yet determined the application or the potential impact of AASB 9, otherwise there is no financial impact for Part B.	1 Jan 2014 1 Jan 2017

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

Note 6 Prior year restatement

The prior year's amounts for Receivables and Payables have been adjusted to include the GST amounting to $4.181m on accrued expenses.

Information on the accounting procedure for Goods and Services Tax is provided at note 2(p).

	Note	2013 (Previously stated) $000	Increase / (Decrease) $000	2013 (Restated) $000
Statement of Financial Position (Extract)				
Current Assets				
Receivables				
GST receivables	24	-	4,181	4,181
Total receivables		16,006	4,181	20,187
Current Liabilities				
Payables				
Accrued expenses	32	52,297	4,181	56,478
Total payables		101,437	4,181	105,618

Note 7 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 53. The key services of the Health Service are:

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. 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 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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 7 Services of the Health Service (continued)

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 confidence 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 a non-hospital environment to complete their restorative process, optimise their functional capacity and assists them and their family to access longer term care arrangements;

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

• residential care in rural areas provided for people assessed as no longer being able to live at home and includes 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
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.

	2014 $000	2013 $000
Note 8 Employee benefits expense		
Salaries and wages (a)	775,983	734,351
Superannuation - defined contribution plans (b)	64,204	62,909
	840,187	797,260

(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 $ 0.840 million ($ 0.261 million in 2012/13).

(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 14 'Other expenses'.

Note 9 Patient support costs		
Medical supplies and services	73,628	62,143
Domestic charges	8,546	8,207
Fuel, light and power	25,923	25,137
Food supplies	9,826	9,745
Patient transport costs	81,976	76,059
Aboriginal health services	33,533	45,924
Pathology services	14,378	13,701
Purchase of health care services	10,249	3,854
Purchase of outsourced medical services	26,124	17,740
Purchase of other outsourced services	3,472	3,240
Grants payments	12,551	4,984
	300,206	270,734
Note 10 Finance costs		
Interest expense	438	552

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 11 Depreciation and amortisation expense		
Depreciation		
Buildings	52,689	45,046
Leasehold improvements	230	200
Computer equipment	352	246
Furniture and fittings	225	170
Motor vehicles	955	1,097
Medical equipment	10,276	10,848
Other plant and equipment	1,421	1,357
	66,148	58,964
Amortisation		
Computer software	39	33
	66,187	58,997
Note 12 Loss on disposal of non-current assets		
Cost of disposal of non-current assets:		
Property, plant and equipment	589	810
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(61)	(94)
Net loss	528	716
Note 13 Repairs, maintenance and consumable equipment		
Repairs and maintenance	22,730	24,547
Consumable equipment	10,252	13,507
	32,982	38,054
Note 14 Other expenses		
Communications	4,185	4,421
Computer services	2,812	1,706
Workers compensation insurance (a)	12,886	10,644
Other employee related expenses	20,857	22,408
Insurance	4,194	3,896
Legal expenses	159	53
Motor vehicle expenses	5,405	5,468
Operating lease expenses	47,459	46,401
Printing and stationery	3,919	3,974
Doubtful debts expense	1,805	1,118
Purchase of outsourced services	15,801	17,012
Write-down of assets	4,789	710
Donations to non government organisations (b)	3,949	15,021
Act of Grace payment	-	250
Other	10,600	13,667
	138,820	146,749

(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) The 2014 amount predominantly represents the construction costs of a Home and Community Care Centre for the Kalumburu Aboriginal Corporation. The funding for this was received through the East Kimberley Development Package. As part of the National Partnership Agreement (NPA) between the Commonwealth and the State of Western Australia signed in July 2009, WA Country Heath Service was responsible for the project management and construction of some of the heath infrastructure projects on behalf of the relevant Aboriginal Corporation.

Note 15 Patient charges		
Inpatient bed charges	25,040	24,460
Inpatient other charges	269	145
Outpatient charges	24,995	23,505
	50,304	48,110

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 16 Grants and contributions		
(i) Commonwealth grants and contributions		
Recurrent		
Nursing homes	3,009	3,316
Aboriginal Health and Cadetship Program	-	194
Bringing Them Home	111	109
Carelink	219	464
Community Aged Care Program	875	829
Customs	159	159
Ear Health	-	645
Extended Aged Care in the Home	622	570
FaHCSIA Respite for Young Carer, RSCYP and Mental Health	209	207
Healthy for Life	1,197	1,177
Indigenous Traineeship	95	357
Job Creation Packages	738	635
Mobile Respite Program	698	378
National Respite Carers Program	1,284	1,527
National Health Reform Agreement (a)	299,148	282,747
New Directions Mothers & Babies	1,098	790
New Directions OATSIH OVAHS	100	158
Office of Aboriginal and Torres Strait Islander Health	3,452	2,955
Primary Health Care Access Program - Kimberley	1,627	1,600
Rural Primary Health Services	-	4,097
Substance Abuse	544	516
Trachoma & Healthy Kids Check	-	739
Other	521	1,370
Capital		
Albany Heath Campus	-	4,200
Bromme High Dependency Unit	-	200
Busselton Health Campus	1,000	1,051
COAG ED 4-HR Rule Solutions(FHRS) Stage 3	441	1,699
East Kimberley Environmental Health	-	30
Kalgoorlie Day Therapy Unit	3,525	-
Kalumburu Remote Aged Care Redevelopment	1,544	3,000
Kimberley Renal - Kununurra capital grant	1,100	2,100
Kimberley Renal - Derby capital grant	1,100	-
Kununurra Hospital expansion capital grant	-	2,500
Kununurra Service providers housing	-	2,300
Kununurra Short Stay Patient Accomodation	-	3,100
Narrogin General Health Clinic	2,300	-
NPA Kununurra CT Scanner	1,555	-
NPA Bunbury Sub Acute Inpatient Beds	2,642	-
NPA Bunbury RP Day Therapy Unit	656	-
NPA Bunbury Wireless LAN	103	-
Projects funded under National Partnership Agreement (b)	-	(6,854)
Renal Dialysis and Support Services	2,000	-
Redevelopment of Bunbury, Narrogin and Collie Hospitals	3,500	-
Simulated Learning Environment Program	-	346
Strengthening Regional Cancer Services	3,100	-
Warmun Remote Clinic Redevelopment	-	2,750
Other	34	-
	340,306	321,961

(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 new 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 net refund of $6.854 million was made in the 2012-13 financial year, as the funds received in 2011-12 were in excess of the requirements of the NPA projects.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000
Note 16 Grants and contributions (continued)		
(ii) Other grants and contributions		
Australian College of Emergency Medicine - EMET Funding	844	725
Australian College of Emergency Medicine - STP	430	-
Centre Care - 1 Life Suicide	104	160
Disability Services Commission - Community Aids & Equipment Program	2,150	2,057
WA Alcohol and Drug Authority - Community Drug Service Team & other programs	4,114	4,065
Great Southern GP Network	-	119
Kimberley Paediatric Outreach Program	109	-
McGrath Foundation - Breast Care Nurse Funding	286	399
Medical Specialists Outreach Assistance Program	1,871	1,595
Medicare Local - For Ante Natal Program	190	158
Medicare Local - Rural Primary Health Services	3,711	-
Mental Health Commission (service delivery agreement)	50,299	43,483
Mental Health Commission (SSAMHS)	4,436	4,863
National Partnership Payments - improving public hospital Services	1,646	-
Mental Health Commission Recovery Centre	250	250
Mental Health Commission Independent Community Living Strategy	400	-
Nindilingarri Cultural Health	136	136
Novartis Pharmaceuticals - Grant for Opthalmic Equipment	-	105
Paediatric Outreach Services for Indigenous & Chronic Disease	313	-
Personally Controlled Electronic Health Records	908	611
Prevocational General Practice Placements	934	339
Royal Australian & New Zealand College of Anesthetists	210	634
Royal Australian & New Zealand College of Obestricicians & Gynaecologists	409	120
Royal Australian & New Zealand College of Ophthalmologists	-	50
Royal Australian & New Zealand College of Psychiatrists	-	205
Royal Australian College of Physicians Specialist Training Program	620	797
Royal Australian College of Physicians - STP Progress Report & Rural Support Loading	450	318
Royal Australian College of Surgeons	406	-
St John of God Private Hospital - Bunbury Mental Health STP	-	80
St John of God Private Hospital - Bunbury STP Orthopaedic & General Surgical	160	-
Telethon Funding	368	428
Other	2,285	690
	78,039	62,387

Note 17 Donation revenue

General public contributions	340	460
Hospital auxiliaries	174	137
Community fund-raising (a)	(82)	82
Deceased estates	453	-
	885	679

(a) A refund has been made to the donor in the current financial year, as the Health Service could not fulfill the specific purpose for which the funds were donated in the previous financial year.

Note 18 Other revenue

Services to external organisations	7,270	9,778
Use of hospital facilities	1,014	1,525
Rent from commercial properties	476	208
Rent from residential properties	464	225
Boarders' accommodation	9,109	7,917
Home and Community Care client fees	1,660	1,709
RiskCover insurance premium rebate	902	379
Other	1,510	1,018
	22,405	22,759

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000
Note 19 Service appropriations		
Appropriation revenue received during the period:		
Service appropriations (via the Department of Health)	902,737	840,624

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.

Note 20 Assets transferred		
Assets transferred from/(to) other State government agencies during the period:		
Land from Metropolitan Health Services	182	340
Land from Department of Health	-	4
Building from Metropolitan Health Services	-	131
Medical equipment from Metropolitan Health Services	-	26
Medical equipment from Department of Health	6	-
Patient entertainment system from Metropolitan Health Services	-	1,028
Building to Metropolitan Health Service	-	(101)
Mammogram equipment from Metropolitan Health Services	-	1
	188	1,429

Discretionary transfers of net assets (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 21 Services received free of charge		
Services received free of charge from other State government agencies during the period:		
State Solicitor's Office - legal advisory services	33	-
Department of Finance - government accommodation	42	25
	75	25

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 22 Royalties for Regions Fund		
Regional Community Services Account:		
Busselton Health Campus - ICT	1,305	-
District Allowances	19,399	12,937
Patient Assisted Travel Scheme	9,741	-
Pilbara Cardiovascular Screen Program	91	596
Pilbara Health Partnership (Asset Investment)	2,500	2,829
Renal Dialysis Service Expansion	210	-
Royal Flying Doctor Service	4,077	5,063
Royal Flying Doctor Service Replacement Aircraft	8,048	-
Rural Generalists Pathways	1,800	1,203
Rural in Reach - Women Support	364	500
Southern Inland Health Initiative		
- District Medical Workforce Investment Program (Stream 1)	20,516	11,432
- Redevelopment Integrated District HS (Stream 2)	2,947	2,416
- Telehealth Investment Program (Stream 5)	1,661	1,338
St John Ambulance Services	2,031	1,339
	74,690	39,653

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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 23 Restricted cash and cash equivalents (a)		
Current		
Royalties for Regions Fund	2,848	2,183
Capital grant from the Commonwealth Government (b)	16,017	21,605
Patient receipts under section 19 (2) of the Health Insurance Act 1973	3,216	2,525
Bequests	722	499
Statewide specialist Aboriginal Mental health Service Project	352	594
Other	523	264
	23,678	27,670

(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 24 Receivables		
Current		
Patient fee debtors	12,346	10,202
Other receivables	7,384	6,625
Less: Allowance for impairment of receivables	(6,303)	(4,501)
Accrued revenue	4,601	3,680
GST receivable	3,440	4,181 (a)
	21,468	20,187
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	4,502	4,333
Doubtful debts expense	1,805	1,118
Amounts written off during the period	(4)	(937)
Amount recovered during the year	-	(12)
Balance at end of period	6,303	4,502

The Health Service does not hold any collateral or other credit enhancements as security for receivables.
See also note 2(p) 'Receivables' and note 52 'Financial instruments'.

(a) See note 6 'Prior year restatements'.

Note 25 Amounts receivable for services (Holding Account)		
Current	-	6,600
Non-current	429,154	360,610
	429,154	367,210

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 26 Inventories		
Current		
Supply stores - at cost	1,975	1,874
Pharmaceutical stores - at cost	2,267	2,419
Other inventories - at cost	1,029	821
	5,271	5,114

See note 2(o) 'Inventories'.

Note 27 Other current assets		
Prepayments	5,130	3,999

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 28 Property, plant and equipment		
Land		
At fair value (a)	192,198	202,760
Buildings		
At fair value (a)	1,358,372	1,276,025
Accumulated depreciation	-	-
	1,358,372	1,276,025
Total land and buildings	1,550,570	1,478,785
Leasehold improvements		
At cost	2,441	1,926
Accumulated depreciation	(1,198)	(968)
	1,243	958
Computer equipment		
At cost	3,173	2,649
Accumulated depreciation	(1,477)	(1,252)
	1,696	1,397
Furniture and fittings		
At cost	3,343	2,919
Accumulated depreciation	(1,141)	(972)
	2,202	1,947
Motor vehicles		
At cost	7,894	7,090
Accumulated depreciation	(5,740)	(4,871)
	2,154	2,219
Medical equipment		
At cost	97,742	90,230
Accumulated depreciation	(51,806)	(43,296)
	45,936	46,934
Other plant and equipment		
At cost	15,932	14,512
Accumulated depreciation	(8,915)	(7,611)
	7,017	6,901
Works in progress		
Buildings under construction (at cost)	140,827	90,000
Other Work in Progress (at cost)	3,433	5,417
	144,260	95,417
Artworks		
At cost	70	70
Total property, plant and equipment	1,755,148	1,634,628

(a) Land and buildings were revalued as at 1 July 2013 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2014 and recognised at 30 June 2014. In undertaking the revaluation, fair value was determined by reference to the market value for land: $93.462 million and buildings: $109.242 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'.

Information on fair value measurements is provided in Note 29.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 28 Property, plant and equipment (continued)		
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	202,760	178,876
Additions	122	898
Transfer from/(to) other reporting entities	(4)	(164)
Disposals	(219)	(84)
Revaluation increments / (decrements)	(10,238)	23,544
Donations to non government organisations	(223)	(310)
Carrying amount at end of period	192,198	202,760
Buildings		
Carrying amount at start of period	1,276,025	1,060,246
Additions	931	1,924
Transfers from Work in Progress	41,094	214,637
Transfer from/(to) other reporting entities	(114)	30
Disposals	(150)	(290)
Revaluation increments / (decrements)	93,348	44,548
Depreciation	(52,689)	(45,046)
Write-down of assets	(9)	(24)
Donations to non government organisations	(64)	-
Carrying amount at end of period	1,358,372	1,276,025
Leasehold improvements		
Carrying amount at start of period	958	913
Additions	515	245
Depreciation	(230)	(200)
Carrying amount at end of period	1,243	958
Computer equipment		
Carrying amount at start of period	1,397	560
Additions	650	161
Transfers from Work in Progress	43	-
Transfer from/(to) other reporting entities	-	1,028
Disposals	(2)	(21)
Depreciation	(352)	(246)
Transfer between asset classes	-	(19)
Write-down of assets	(40)	(66)
Carrying amount at end of period	1,696	1,397
Furniture and fittings		
Carrying amount at start of period	1,947	1,715
Additions	665	501
Transfers from Work in Progress	-	17
Disposals	(51)	(30)
Depreciation	(225)	(170)
Transfer between asset classes	-	(28)
Write-down of assets	(134)	(58)
Carrying amount at end of period	2,202	1,947
Motor vehicles		
Carrying amount at start of period	2,219	1,739
Additions	893	970
Transfers from Work in Progress	-	641
Disposals	-	(3)
Depreciation	(955)	(1,097)
Transfer between asset classes	-	(31)
Write-down of assets	(3)	-
Carrying amount at end of period	2,154	2,219

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 28 Property, plant and equipment (continued)		
Medical equipment		
Carrying amount at start of period	46,934	48,089
Additions	8,962	7,830
Transfers from Work in Progress	740	742
Transfer from/(to) other reporting entities	6	26
Disposals	(167)	(651)
Depreciation	(10,276)	(10,848)
Transfer between asset classes	-	1,888
Write-down of assets	(255)	(142)
Donations to non government organisations	(8)	-
Carrying amount at end of period	45,936	46,934
Other plant and equipment		
Carrying amount at start of period	6,901	9,562
Additions	942	528
Transfers from Work in Progress	740	139
Disposals	(60)	(148)
Depreciation	(1,421)	(1,357)
Transfer between asset classes	-	(1,811)
Write-down of assets	(85)	(12)
Carrying amount at end of period	7,017	6,901
Works in progress		
Carrying amount at start of period	95,417	213,501
Additions	99,376	113,212
Capitalised to asset classes	(42,616)	(216,177)
Write-down of assets	(4,263)	(408)
Donations to non government organisations	(3,654)	(14,711)
Carrying amount at end of period	144,260	95,417
Artworks		
Carrying amount at start of period	70	70
Carrying amount at end of period	70	70
Total property, plant and equipment		
Carrying amount at start of period	1,634,628	1,515,271
Additions	113,057	126,268
Disposals	(649)	(1,227)
Transfer from/(to) other reporting entities	(112)	920
Revaluation increments / (decrements)	83,110	68,092
Depreciation	(66,148)	(58,963)
Write-down of assets	(4,789)	(710)
Donations to non government organisations	(3,949)	(15,021)
Carrying amount at end of period	1,755,148	1,634,628

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

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).

The following table represents the Health Service's assets measured and recognised at fair value at 30 June 2014.

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Land				
Vacant land	-	8,223	-	8,223
Residential	-	85,239	-	85,239
Specialised	-	-	98,736	98,736
Buildings				
Residential	-	109,242	-	109,242
Specialised	-	-	1,249,130	1,249,130
	-	202,704	1,347,866	1,550,570

(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) annually. 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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 29 Fair value measurements (continued)

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

Cost Approach (continued)

The Health Service's hospitals and medical centres are specialised buildings 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, 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 annual 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.

The maximum effective age used in the valuation of specialised buildings is 50 years. The effective age of a building is initially calculated from the commissioning date, and is reviewed after the building has 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 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 annual 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 2014:

2014	Land $000	Buildings $000
Fair value at start of period	100,843	1,157,878
Additions	-	40,539
Disposals	(223)	(2,011)
Revaluation increments/(decrements)	(2,205)	99,892
Transfers from/(to) Level 2 (a)	321	-
Depreciation	-	(47,168)
Fair value at end of period	98,736	1,249,130
Total gains or losses for the period included in profit or loss, under 'Other Gains'	-	-
Change in unrealised gains or losses for the period included in profit or loss for assets held at the end of the reporting period	-	-

(a) Residential land amalgamated into a hospital site during the 2013/14 financial year.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

Note 29 Fair value measurements (continued)

(d) Information about significant unobservable inputs (Level 3) in fair value measurements

Description	Fair value at 30 June 2014 $000	Unobservable inputs	Range of inputs (probability - weighted average	Relationship of unobservable inputs to fair value
Specialised land	$98,736	Difference between hypothetical alternate land use value and current use land value	0% - 99.0% (22.06%) of hypothetical alternate land use value	The higher the difference, the lower the fair value
Specialised buildings	$1,249,130	Residual value of 25% of current replacement cost	$69,588 - $18,481,750 per building	A change of residual value percentage by +/- 5% (i.e. 20% or 30%) results in a change in fair value of $45,316,581

Residual values used in the calculation of depreciated replacement costs is an unobservable input for specialised buildings, as the valuation processes do not involve physical inspection on site to determine the actual conditions of the assets.

(e) Valuation processes

The Financial Services Branch at the Health Corporate Network (HCN) 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. Discussions of valuation processes and results are held between the HCN and the chief finance officer at least once every year.

Landgate Valuation Service determines the fair values of the Health Service's land and buildings annually. A quantity surveyor is engaged by the Department of Health to provide an annual update of the current replacement costs for specialised buildings. The Landgate Valuation Services endorses the current replacement costs calculated by the quantity surveyor and calculates the depreciated replacement costs.

	2014 $000	2013 $000
Note 30 Intangible assets		
Computer software		
At cost	291	252
Accumulated amortisation	(227)	(189)
	64	63
Works in progress		
Computer software under development (at cost)	116	35
Total intangible assets	180	98
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	63	99
Additions	40	-
Disposals	-	(3)
Amortisation expense	(39)	(33)
Carrying amount at end of period	64	63
Works in progress		
Carrying amount at start of year	35	29
Additions	81	6
Carrying amount at end of year	116	35

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000

Note 31 Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets as at 30 June 2014.

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.

All surplus assets at 30 June 2014 have either been classified as assets held for sale or written off.

Note 32 Payables

Current		
Trade creditors	20,274	21,335
Accrued expenses	46,532	56,478 (a)
Accrued salaries	31,279	27,762
Accrued interest	39	43
	98,124	105,618

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

(a) See note 6 'Prior year restatements'.

Note 33 Borrowings

Current		
Department of Treasury loans (a)	1,303	1,436
Non-current		
Department of Treasury loans (a)	8,529	9,780
	9,832	11,216

(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.

Note 34 Provisions

Current		
Employee benefits provision		
Annual leave (a)	56,126	55,513
Time off in lieu leave (a)	21,164	20,674
Long service leave (b)	35,490	33,091
Gratuities	1,237	1,095
Deferred salary scheme (c)	1,936	2,256
	115,953	112,629
Non-current		
Employee benefits provision		
Long service leave (b)	23,281	21,856
Gratuities	296	192
	23,577	22,048
	139,530	134,677

(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	60,437	60,403
More than 12 months after the end of the reporting period	16,853	15,784
	77,290	76,187

(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	9,204	9,401
More than 12 months after the end of the reporting period	49,567	45,546
	58,771	54,947

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2014

	2014 $000	2013 $000
Note 34 Provisions (continued)		
(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	1,171	1,073
More than 12 months after end of the reporting period	765	1,183
	1,936	2,256
Note 35 Other liabilities		
Current		
Income received in advance	331	-
Refundable deposits	-	1
Other	61	40
	392	41
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).		
Balance at start of period	1,386,545	1,283,605
Contributions by owners		
Capital appropriation (a)	51,664	54,746
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	45,137	48,702
	96,801	103,448
Distributions to owners		
Transfer of net assets to other agencies (b) (c)	(300)	(508)
Balance at end of period	1,483,046	1,386,545

(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.

Note 37 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	422,410	354,318
Net revaluation increments / (decrements) (b) :		
Land	(10,238)	23,544
Buildings	93,348	44,548
Balance at end of period	505,520	422,410

(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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000
Note 38 Accumulated surplus/(deficit)		
Balance at start of period	2,911	53,631
Result for the period	9,102	(50,720)
Balance at end of period	12,013	2,911
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	8,428	4,512
Restricted cash and cash equivalents	23,678	27,670
	32,106	32,182
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(886,104)	(815,323)
Increase/(decrease) in assets:		
GST receivable	(741)	-
Receivables	3,824	195
Inventories	157	140
Prepayments and other current assets	1,131	(45)
Decrease/(increase) in liabilities:		
Payables	(3,897)	(28,528)
Current provisions	(3,324)	(8,871)
Non-current provisions	(1,529)	(3,470)
Income received in advance	(331)	-
Other current liabilities	(20)	(10)
Non-cash items:		
Doubtful debts expense (note 14)	(1,805)	(1,118)
Depreciation and amortisation expense (note 11)	(66,187)	(58,997)
Loss from disposal of non-current assets (note 12)	(528)	(716)
Interest paid by Department of Health	(442)	(565)
Donation of non-current assets	17	95
Services received free of charge (note 21)	(75)	(25)
Write off of Receivables (note 24)	4	937
Write down of property, plant and equipment (note 28)	(4,789)	(710)
Donations of property, plant and equipment (note 28)	(3,949)	(15,021)
Adjustment for other non-cash items	-	(419)
Net cost of services (Statement of Comprehensive Income)	(968,588)	(932,451)
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	902,737	840,624
Royalties for Regions Fund as per Statement of Comprehensive Income	74,690	39,653
Royalties for Regions Fund credited directly to Contributed Equity (Refer Note 36)	45,137	48,702
Capital contributions credited directly to Contributed Equity (Refer Note 36)	51,664	54,746
Holding account drawdowns credited to Amounts Receivable for Services	4,141	-
	1,078,369	983,725
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	(442)	(565)
Repayment of interest-bearing liabilities to Department of Treasury	(1,385)	(1,321)
Accrual appropriations	(66,085)	(63,235)
	(67,912)	(65,121)
Cash Flows from State Government as per Statement of Cash Flows	1,010,457	918,604

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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000
Note 40 Revenue, public and other property written off		
a) Revenue and debts written off under the authority of the Accountable Authority.	-	894
b) Public and other property written off under the authority of the Accountable Authority.	-	92
	-	986
Note 41 Gifts of public property		
Gifts of public property provided by the Health Service	295	310
Note 42 Services provided free of charge		
Mental Health Commission - contracted mental health services	-	2,620

Note 43 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority

The Director General of Health is the Accountable Authority for WA Country Health Service. The remuneration of the Director General of Health is paid by the Department of Health.

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

	2014	2013
$110,001 - $120,000	-	1
$400,001 - $410,000	-	1
$650,001 - $660,000	1	-
Total	1	2

	$000	$000
Base remuneration and superannuation	592	627
Annual leave and long service leave accruals	67	(100)
Other benefits	-	-
The total remuneration of members of the Accountable Authority	659	527

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

Remuneration of senior officers

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

$90,001 - $100,000	2	-
$100,001 - $110,000	1	-
$140,001 - $150,000	-	1
$150,001 - $160,000	1	-
$170,001 - $180,000	1	1
$180,001 - $190,000	1	4
$190,001 - $200,000	3	1
$200,001 - $210,000	1	2
$210,001 - $220,000	1	1
$220,001 - $230,000	2	1
$230,001 - $240,000	2	-
$240,001 - $250,000	1	-
$250,001 - $260,000	-	1
$390,001 - $400,000	-	-
$410,001 - $420,000	-	2
$420,001 - $430,000	1	-
$430,001 - $440,000	-	1
Total	17	15

	$000	$000
Base remuneration and superannuation	3,288	3,450
Annual leave and long service leave accruals	22	60
Other benefits	94	115
The total remuneration of senior officers	3,404	3,625

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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

	2014 $000	2013 $000
Note 44 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	618
Note 45 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	158,721	150,366
Later than 1 year, and not later than 5 years	219,339	289,552
	378,060	439,918
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	16,296	20,522
Later than 1 year, and not later than 5 years	9,033	14,198
Later than 5 years	924	1,629
	26,253	36,349
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.		
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	123,537	45,519
Later than 1 year, and not later than 5 years	77,288	41,026
Later than 5 years	12,294	5,828
	213,119	92,373
Note 46 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.	20,187	16,379
Number of claims	10	6
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Environment and Conservation (DEC)	608	268
Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Conservation (DEC). In accordance with the Act, DEC classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.		
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 30th June 2014

	2014 $000	2013 $000

Note 47 Events occurring after the end of the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

Note 48 Related bodies

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

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

Note 49 Affiliated bodies

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

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

Note 50 Administered trust accounts

Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.

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	981	1,240
Add Receipts	1,712	2,141
	2,693	3,381
Less Payments	(1,740)	(2,400)
Balance at the end of period	953	981

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

Note 51 Explanatory Statement

Significant variances between actual results for 2013 and 2014

Significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

	Note	2014 Actual $000	2013 Actual $000	Variance $000
Expenses				
Employee benefits expense		840,187	797,260	42,927
Fees for visiting medical practitioners		81,179	75,285	5,894
Patient support costs	(a)	300,206	270,734	29,472
Finance costs		438	552	(114)
Depreciation and amortisation expense	(b)	66,187	58,997	7,190
Loss on disposal of non-current assets		528	716	(188)
Repairs, maintenance and consumable equipment	(c)	32,982	38,054	(5,072)
Other expenses		138,820	146,749	(7,929)
Income				
Patient charges		50,304	48,110	2,194
Commonwealth grants and contributions		340,306	321,961	18,345
Other grants and contributions	(d)	78,039	62,387	15,652
Donation revenue		885	679	206
Other revenue		22,405	22,759	(354)
Service appropriations	(e)	902,737	840,624	62,113
Assets transferred	(f)	188	1,429	(1,241)
Services received free of charge		75	25	50
Royalties for Regions Fund	(g)	74,690	39,653	35,037

(a) Patient support costs
The increase in patient support costs is primarily attributable to the transfer of functions from the Department of Health, including the management of and payments in relation to various contracts with non Government organisations ($8.5m), a Royalties for Regions contribution to the cost of replacement aircraft for the Royal Flying Doctor Service ($8.0m) and the commencement of new Cardiothoracic Services at St John of God Bunbury Hospital ($1.5m). The balance of the increase relates to normal activity and cost growth on patient support services.

(b) Depreciation and amortisation expense
Depreciation on buildings has increased due to accelerated depreciation of the Busselton and Nickol Bay Hospitals which are to be decommissioned when redevelopments are completed, and the write down of the residual value of the old Albany hospital.

(c) Repairs, maintenance and consumable equipment
2012/13 expenditures included one-off non-capital equipment purchases for new facilities including Albany Health Campus, the Kalgoorlie Hospital expansion and the Kununurra Ochre Health Centre which have not been repeated in 2013/14. Accordingly 2013/14 expenditure has normalised and is comparable with the Repairs, maintenance and consumable equipment expenditure of $33m in 2011/12.

(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. Changes in Other grants and contributions are detailed in Note 16(ii).

(e) Service appropriations
Increases in Services Appropriations represent increased funding to support industrial Award and other cost increases and for various new and expanded services in 2013/14.

(f) Assets transferred
Assets transferred in 2012/13 included one-off capital expenditures by Health Information Network for systems and information technology infrastructure at the new Albany Health Campus which were transferred to WA Country Health Service on commissioning of the hospital.

(g) Royalties for Regions Fund
Revenues for Royalties for Regions projects vary according to the cashflow requirements of new and continuing projects. Changes in contributions from the Royalties for Regions Fund between 2012/13 and 2013/14 are detailed in Note 22.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2014

Note 51 Explanatory Statement (continued)

Significant variances between estimated and actual results for 2014

Significant variations between the estimates and actual results for 2014 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2014 Actual $000	2014 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense		840,187	767,732	72,455
Other goods and services		620,340	575,057	45,283
Total expenses		1,460,527	1,342,789	117,738
Less: Revenues	(a)	(491,939)	(180,728)	(311,211)
Net cost of services		968,588	1,162,061	(193,473)

(a) Revenues

Under the National Health Reform Agreement, activity based funding and block grant funding have been received from the Commonwealth Government for health services and for teaching, training and research provided by local hospital networks. Under these arrangements $283.1m which was initially budgeted as Services Appropriation was received from the State Pool Account and recognised as Revenue.

Funding for Mental Health Services funded by the Mental Health Commission increased by $4.2m due primarily to a mid year budget adjustment received for the Statewide Specialised Aboriginal Mental Health Service.

Commonwealth Capital grants totaling $24.6m not included in the initial budget were received for various projects as set out in Note 16.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2014

Note 52 Financial instruments

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

Financial instruments held by the Health Service are cash and cash equivalents, restricted cash and cash equivalents, borrowings, receivables and payables. The Health Service has limited exposure to financial risks. The Health Service's overall risk management program focuses on managing the risks identified below.

Credit risk

Credit risk arises when there is the possibility of the Health Service's receivables defaulting on their contractual obligations resulting in financial loss to the Health Service.

The maximum exposure to credit risk at 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 52(c) 'Financial Instrument disclosures' and note 24 'Receivables'.

Credit risk associated with the Health Service's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than government, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. At 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 52(c) 'Financial Instruments disclosures'.

Liquidity risk

Liquidity risk arises when the Health Service is unable to meet its financial obligations as they fall due. The Health Service is exposed to liquidity risk through its 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 2014

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 :

	2014 $000	2013 $000
Financial Assets		
Cash and cash equivalents	8,428	4,512
Restricted cash and cash equivalents	23,678	27,670
Loans and receivables	447,182	383,216
Financial Liabilities		
Financial liabilities measured at amortised cost	107,956	116,834

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2014

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
2014							
Cash and cash equivalents	8,428	8,428	-	-	-	-	-
Restricted cash and cash equivalents	23,678	23,678	-	-	-	-	-
Receivables	18,028	11,538	2,221	2,397	1,742	130	-
Amounts receivable for services	429,154	429,154	-	-	-	-	-
	479,288	472,798	2,221	2,397	1,742	130	-
2013							
Cash and cash equivalents	4,512	4,512	-	-	-	-	-
Restricted cash and cash equivalents	27,670	27,670	-	-	-	-	-
Receivables	16,006	9,803	2,454	2,048	1,701	-	-
Amounts receivable for services	367,210	367,210	-	-	-	-	-
	415,398	409,195	2,454	2,048	1,701	-	-

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

Notes to the Financial Statements
For the year ended 30 June 2014

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
2014										
Financial Assets										
Cash and cash equivalents	-	8,428	-	-	8,428	8,428	8,428	-	-	-
Restricted cash and cash equivalents	-	23,678	-	-	23,678	23,678	23,678	-	-	-
Receivables	-	18,028	-	-	18,028	18,028	18,028	-	-	-
Amounts receivable for services	-	429,154	-	-	429,154	429,154	-	-	-	429,154
		479,288	-	-	479,288	479,288	50,134	-	-	429,154
Financial Liabilities										
Payables	-	98,124	-	-	98,124	98,124	98,124	-	-	-
Department of Treasury Loans	4.10%	9,832	-	9,832	-	11,110	458	1,191	6,594	2,867
		107,956	-	9,832	98,124	109,234	98,582	1,191	6,594	2,867

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2014

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
2013										
Financial Assets										
Cash and cash equivalents	-	4,512	-	-	4,512	4,512	4,512	-	-	-
Restricted cash and cash equivalents	-	27,670	-	-	27,670	27,670	27,670	-	-	-
Receivables	-	16,006	-	-	16,006	16,006	16,006	-	-	-
Amounts receivable for services	-	367,210	-	-	367,210	367,210	-	6,600	-	360,610
		415,398	-	-	415,398	415,398	48,188	6,600	-	360,610
Financial Liabilities										
Payables	-	105,618	-	-	105,618	105,618	105,618	-	-	-
Department of Treasury Loans	4.65%	11,216	-	11,216	-	13,436	353	1,605	7,821	3,657
		116,834	-	11,216	105,618	119,054	105,971	1,605	7,821	3,657

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

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		+100 basis points	
		Surplus $000	Equity $000	Surplus $000	Equity $000
2014					
Financial Liabilities					
Department of Treasury Loans	9,832	98	98	(98)	(98)
Total Increase/(Decrease)		98	98	(98)	(98)
2013					
Financial Liabilities					
Department of Treasury Loans	11,216	112	112	(112)	(112)
Total Increase/(Decrease)		112	112	(112)	(112)

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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2014

Note 53 Schedule of income and expenses by service

	Public Hospital Admitted Patients		Palliative Care		Emergency Department		Public Hospital Non-Admitted Patients		Patient Transport	
	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	414,971	410,844	3,361	3,189	115,371	96,813	69,983	69,535	3,499	2,359
Fees for visiting medical practitioners	64,322	39,013	325	301	9,197	9,142	4,242	6,566	-	5
Patient support costs	166,381	115,750	1,058	954	37,056	28,961	19,205	20,801	41,365	40,096
Finance costs	395	284	2	2	13	67	8	48	-	2
Depreciation and amortisation expense	52,279	29,932	265	236	1,831	7,164	68	5,146	-	644
Loss on disposal of non-current assets	528	370	-	3	-	87	-	62	-	1
Repairs, maintenance and consumable equipment	20,208	19,688	132	152	2,786	4,621	1,200	3,319	11	35
Other expenses	23,088	75,180	555	587	6,332	17,820	17,890	12,799	232	877
Total cost of services	742,172	691,061	5,698	5,424	172,586	164,675	112,596	118,276	45,107	44,019
Income										
Patient charges	29,396	28,114	201	192	6,109	5,842	4,387	4,196	-	-
Commonwealth grants and contributions	180,988	170,511	1,361	1,288	41,324	39,096	29,681	28,081	-	-
Other grants and contributions	19,286	12,860	-	(60)	500	400	372	298	-	(385)
Donation revenue	518	397	4	3	107	82	77	59	-	-
Other revenue	13,092	13,299	90	91	2,721	2,764	1,954	1,985	-	-
Total income other than income from State Government	243,280	225,181	1,656	1,514	50,761	48,184	36,471	34,619	-	(385)
NET COST OF SERVICES	**498,892**	**465,880**	**4,042**	**3,910**	**121,825**	**116,491**	**76,125**	**83,657**	**45,107**	**44,404**
INCOME FROM STATE GOVERNMENT										
Service appropriations	476,345	443,571	3,611	3,362	109,622	102,079	78,735	73,317	29,739	27,693
Assets transferred	103	788	1	6	23	173	16	125	6	47
Services received free of charge	42	14	-	-	9	3	7	2	2	1
Royalties for Regions Fund	17,785	9,442	7,110	3,775	18,142	9,632	3,555	1,887	10,673	5,666
Total income from State Government	494,275	453,815	10,722	7,143	127,796	111,887	82,313	75,331	40,420	33,407
SURPLUS/(DEFICIT) FOR THE PERIOD	**(4,617)**	**(12,065)**	**6,680**	**3,233**	**5,971**	**(4,604)**	**6,188**	**(8,326)**	**(4,687)**	**(10,997)**

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

Notes to the Financial Statements

For the year ended 30 June 2014

Note 53 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Continuing Care		Mental Health (a)		Total	
	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000	2014 $000	2013 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	96,108	95,936	57,402	65,900	79,492	52,684	840,187	797,260
Fees for visiting medical practitioners	732	9,059	147	6,223	2,214	4,976	81,179	75,285
Patient support costs	13,413	28,699	15,057	19,713	6,671	15,760	300,206	270,734
Finance costs	1	66	19	46	-	37	438	552
Depreciation and amortisation expense	2,987	7,099	8,670	4,877	87	3,899	66,187	58,997
Loss on disposal of non-current assets	-	86	-	59	-	48	528	716
Repairs, maintenance and consumable equipment	3,628	4,579	2,202	3,145	2,815	2,515	32,982	38,054
Other expenses	50,653	17,659	28,909	12,130	11,161	9,697	138,820	146,749
Total cost of services	167,522	163,183	112,406	112,093	102,440	89,616	1,460,527	1,388,347
Income								
Patient charges	6,053	5,789	4,158	3,977	-	-	50,304	48,110
Commonwealth grants and contributions	40,950	38,742	28,129	26,613	17,873	17,630	340,306	321,961
Other grants and contributions	503	402	346	276	57,032	48,596	78,039	62,387
Donation revenue	106	82	73	56	-	-	885	679
Other revenue	2,696	2,739	1,852	1,881	-	-	22,405	22,759
Total income other than income from State Government	50,308	47,754	34,558	32,803	74,905	66,226	491,939	455,896
NET COST OF SERVICES	**117,214**	**115,429**	**77,848**	**79,290**	**27,535**	**23,390**	**968,588**	**932,451**
INCOME FROM STATE GOVERNMENT								
Service appropriations	108,628	101,154	74,618	69,484	21,439	19,964	902,737	840,624
Assets transferred	23	172	16	118	-	-	188	1,429
Services received free of charge	9	3	6	2	-	-	75	25
Royalties for Regions Fund	10,315	5,476	7,110	3,775	-	-	74,690	39,653
Total income from State Government	118,975	106,805	81,750	73,379	21,439	19,964	977,690	881,731
SURPLUS/(DEFICIT) FOR THE PERIOD	**1,761**	**(8,624)**	**3,902**	**(5,911)**	**(6,096)**	**(3,426)**	**9,102**	**(50,720)**

(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.

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Certification Statement

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2014

I hereby certify the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the WA Country Health Service and fairly represent the performance of the Health Service for the financial year ended 30 June 2014.

Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2014

Key performance indicator index

Outcome 1

Percentage of public patients discharged to home after admitted hospital treatment

Survival rates for sentinel conditions

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

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

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

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 non-admitted hospital based occasion of service for rural hospitals

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

Average cost per trip of Patient Assisted Travel Scheme

Outcome 2

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

Rate of hospitalisation for selected respiratory conditions

Rate of hospitalisation for falls in older persons

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

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

Average cost per capita of Population Health Units

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

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

Average cost per three month period of community care provided by a public community mental health service

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 2013 target is ≥97.4 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 2013, a total of 97.4 per cent of public patients in country WA, across all ages, were discharged to home after receiving admitted hospital treatment (see Table 11). This result met the target and was consistent with previous years.

Table 11: **Percentage of public patients discharged to home after admitted hospital treatment, by age group, 2009–2013**

Age group (years)	Calendar years				
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
0–39	97.2	97.1	96.7	96.9	**97.0**
40–49	96.0	96.0	95.8	96.2	**96.1**
50–59	97.8	97.7	97.6	97.9	**97.9**
60–69	98.2	98.4	98.7	98.7	**98.7**
70–79	98.1	98.3	98.4	98.4	**98.6**
80+	96.1	96.6	96.6	96.9	**97.1**
All ages	97.2	97.3	97.1	97.3	**97.4**
Target (>)	97.0	97.4	97.4	97.4	**97.4**

Data source/s: 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 2013 target for each condition by age group:

Age group (years)	Sentinel condition		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥98.5	100.0	
50–59	≥97.9	≥99.1	
60–69	≥98.7	≥99.2	
70–79	≥90.4	≥98.7	≥98.7
80+	≥79.3	≥92.1	≥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

The performance of WA Country Health Service hospitals varied by sentinel condition.

In 2013, the survival rate for stroke was above the target for country WA patients aged 0–49, 70–79 and aged 80 years and over (see Table 12). For patients aged 50–59 and 60–69 performance was below target.

Table 12: **Survival rate for stroke, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2013 Target (%)
0–49	94.9	97.6	98.5	93.5	**100.0**	**≥98.5**
50–59	95.9	94.4	97.9	95.8	**96.6**	**≥97.9**
60–69	95.7	93.0	96.8	98.7	**92.2**	**≥98.7**
70–79	88.6	86.9	88.4	90.4	**95.3**	**≥90.4**
80+	72.8	79.3	72.4	76.6	**80.1**	**≥79.3**

Note: Due to the low number of cases within some age categories, care should be taken when considering fluctuations in results.
Data source/s: Hospital Morbidity Data System.

In 2013, the survival rate for people who had an acute myocardial infarction was below the target for people aged 0–49 and 70–79 years in country WA. Survival rates for all other age groups met or exceeded the target (see Table 13).

Table 13: **Survival rate for acute myocardial infarction, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2013 Target (%)
0–49	100.0	100.0	100.0	100.0	**99.1**	**100.0**
50–59	98.4	99.0	100.0	98.2	**99.2**	**≥99.1**
60–69	96.8	97.2	99.2	98.7	**99.2**	**≥99.2**
70–79	95.9	98.7	95.0	96.6	**98.1**	**≥98.7**
80+	84.7	90.5	89.9	92.1	**96.0**	**≥92.1**

Data source/s: Hospital Morbidity Data System.

The survival rate for country WA patients who had a fractured neck of femur was below the target for all age groups (see Table 14).

Table 14: **Survival rate for fractured neck of femur, by age group, 2009–2013**

Age group (years)	Calendar years					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2013 Target (%)
70–79	96.8	96.6	98.7	95.0	**98.5**	**≥98.7**
80+	95.5	96.1	97.8	96.3	**96.9**	**≥97.8**

Data source/s: Hospital Morbidity Data System.

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

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 health care system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. There are some conditions that may require numerous admissions to enable the best level of care to be given. However, in most of these cases hospital readmission is planned.

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 using 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.

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 2013 target is ≤2.2 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 2013, the percentage of unplanned readmissions within 28 days to a country hospital for a related condition was 2.8 per cent (see Table 15). This result was above the target of 2.2 per cent, but consistent with prior years.

Table 15: **Percentage of unplanned readmissions within 28 days to the same hospital for a related condition, 2009–2013**

	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
Unplanned readmissions	2.2	2.8	2.9	2.3	**2.8**
Target	≤2.3	≤2.2	≤2.2	≤2.2	**≤2.2**

Notes:
1. This indicator is based on a 3 month period each year. For 2013 data is reported from 1 September – 30 November.
2. Fluctuations in performance are a result of relatively small population numbers, which can result in small changes in activity having a disproportionate influence on overall performance.

Data source/s: 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 2013 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 2013, the percentage of unplanned readmissions within 28 days to a country hospital by patients with a mental health condition was 6.3 per cent (see Table 16). This was above the target of 4.8 per cent but consistent with prior years.

Table 16: **Percentage of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2009–2013**

	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)
Unplanned readmissions	5.9	4.8	6.1	6.1	**6.3**
Target	≤6.5	≤5.2	≤4.8	≤4.8	**≤4.8**

Notes:
1. This indicator is based on a 3 month period each year. For 2013 data is reported from 1 September – 30 November.
2. Fluctuations in performance are a result of relatively small population numbers, which can result in small changes in activity having a disproportionate influence on overall performance.

Data source/s: 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 2013 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	4.2
2000–2499	0.8
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 2013, the percentage of liveborn infants with a birth weight of 0–1499 grams or over 2500 grams, and an Apgar score of 3 or less, was 30.0 per cent and 0.2 per cent respectively (see Table 17). For infants with a birth weight between 1500–2499 grams, performance was below the targets.

Table 17: **Percentage of liveborn infants with an Apgar score of three or less, five minutes post-delivery, by birth weight, 2009–2013**

Birth weight (grams)	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
0–1499	42.9	40.0	40.0	14.3	**30.0**	**14.3**
1500–1999	4.3	6.7	0.0	4.2	**4.0**	**4.2**
2000–2499	0.0	0.0	0.8	1.4	**0.7**	**0.8**
2500+	0.1	0.1	0.2	0.2	**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 variation between reporting years.
Data source/s: 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

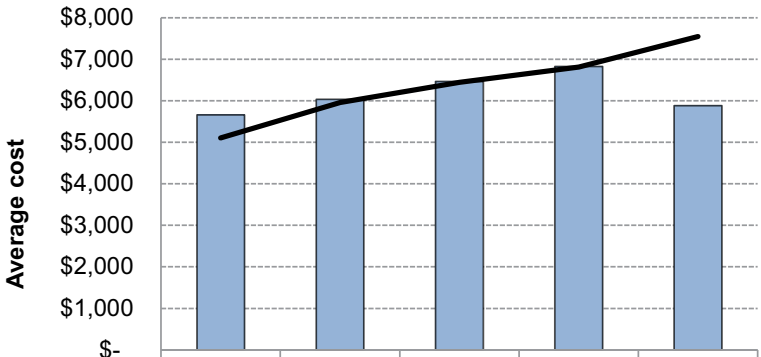
The target for 2013–14 is $7,547 per casemix weighted separation from a non-tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix weighted separation for country WA non-tertiary hospitals for 2013–14 was $5,879 (see Figure 5). This was below the target of $7,547 and is attributed to an increase in activity associated with changes in the counting, classification and cost allocation methodology in relation to public hospital admitted patients to align with national reporting.

Figure 5: **Average cost per casemix weighted separation for non-tertiary hospitals, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$5,657	$6,032	$6,465	$6,822	$5,879
Target	$5,102	$5,960	$6,446	$6,813	$7,547

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.
Data source/s: 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

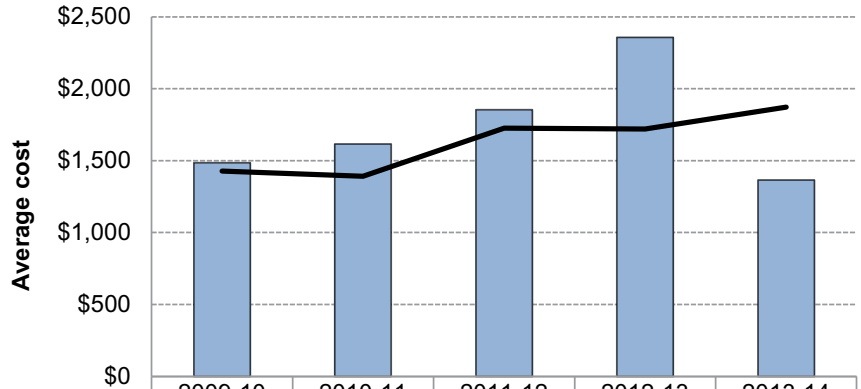
The target for 2013–14 is $1,873 per bed-day for admitted patients (selected small rural hospitals).

A result below the target is desirable.

Results

The average cost per bed-day for admitted patients for selected small rural hospitals for 2013–14 was $1,365 (see Figure 6) and below the target. This lower expenditure is attributable to changes in the counting, classification and cost allocation methodology in relation to small rural hospitals to align with national reporting.

Figure 6: **Average cost per bed-day for admitted patients (selected small rural hospitals), 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$1,486	$1,616	$1,855	$2,357	$1,365
Target	$1,428	$1,392	$1,727	$1,721	$1,873

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.
Data source/s: 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

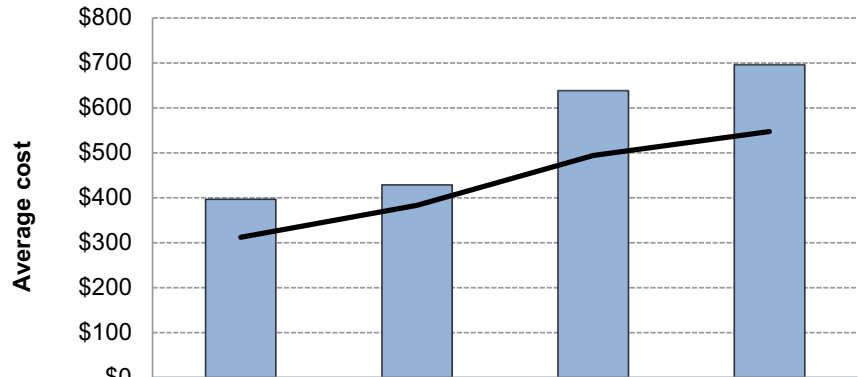
The target for 2013–14 is $547 per emergency department attendance.

A result below the target is desirable.

Results

For 2013–14, the average cost per emergency department attendances for WA country hospitals was $696 (see Figure 7). This result was less than a 10 per cent increase from the 2012–13 performance but was still above the target. The increase in expenditure is attributed to an increase in activity associated with changes in the counting, classification and cost allocation methodology in relation to country hospitals to align with national reporting.

Figure 7: **Average cost per emergency department attendances, 2010–11 to 2013–14**



	2010-11	2011-12	2012-13	2013-14
Ave cost	$396	$429	$638	$696
Target	$312	$383	$494	$547

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework. This process has resulted in an increase in the number of WA country hospital sites included in the calculation.
Data source/s: Emergency Department Data Collection, Health Service financial systems.

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

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.

A non-admitted occasion of service is essentially the provision of medical or surgical services that does not require an admission to hospital, and is typically provided in an outpatient setting. The provision of non-admitted health care services, by health service providers other than doctors, aims to ensure patients have access to the care they need in the most appropriate setting to address the patient's clinical needs.

Target

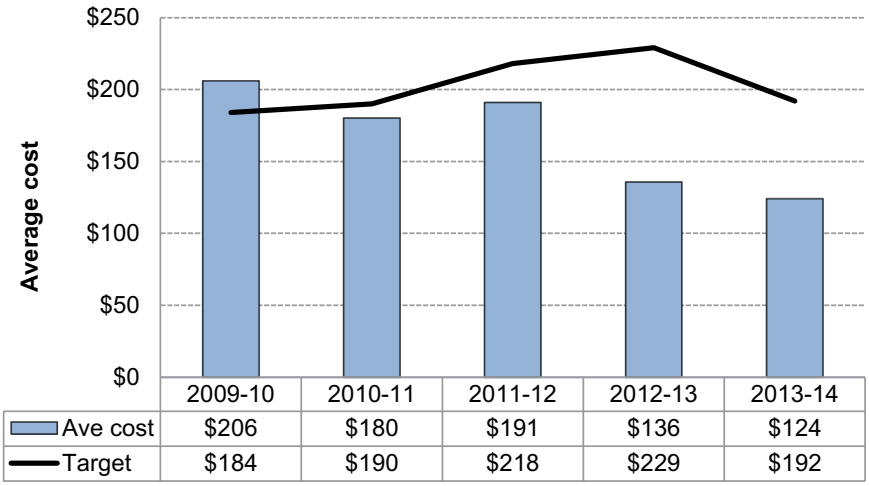
The target for 2013–14 is $192 per non–admitted occasion of service (rural hospitals).

A result below the target is desirable.

Results

The average cost per non-admitted occasion of service for WA country hospitals in 2013–14 was $124 (see Figure 8). This result was below the target but in line with 2012–13 performance.

Figure 8: **Average cost per non-admitted hospital based occasion of service for rural hospitals, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$206	$180	$191	$136	$124
Target	$184	$190	$218	$229	$192

Note: Changes in the counting, classification and costing of public hospital admitted patients, is occurring as part of the implementation of the national Activity Based Funding framework.
Data source/s: Non Admitted Patient Activity and Wait List Data Collection, Hospital site's non-admitted activity data systems, Emergency Department Data Collection, 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

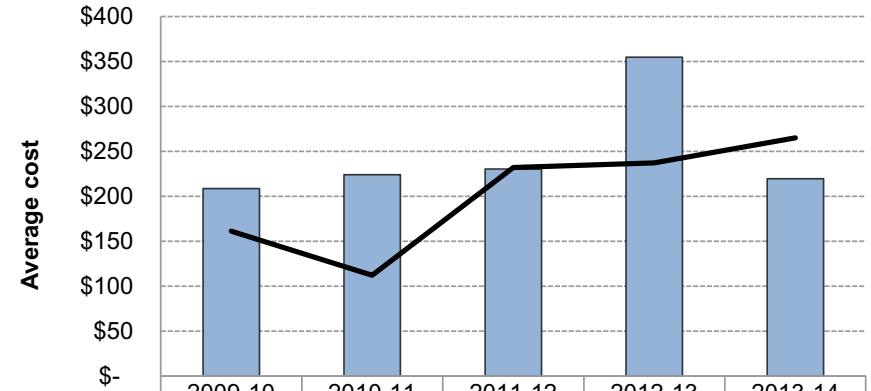
The target for 2013–14 is $265 per non–admitted occasion of service (rural nursing post).

A result below the target is desirable.

Results

In 2013–14, the average cost per non-admitted occasion of service for country WA nursing posts was $219 (see Figure 9), and below the target. The decrease in expenditure to target was a result of activity levels returning to those comparable with 2011–2012. The projected target for 2013–14 was influenced by the higher than average cost for 2012–13.

Figure 9: **Average cost per non-admitted occasion of service in a rural nursing post, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$209	$224	$230	$355	$219
Target	$161	$112	$232	$237	$265

Data source/s: 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

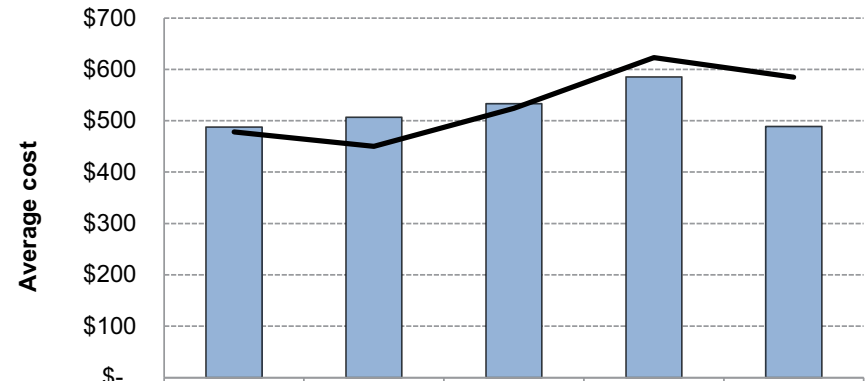
The target for 2013–14 is $585 per trip of Patient Assisted Travel Scheme trip.

A result below the target is desirable.

Results

In 2013–14, the average cost per Patient Assisted Travel Scheme trip was $489, and below the target (see Figure 10). The lower expenditure is attributed to ongoing efficiency measures applied in 2012–13, while maintaining access to service. A new Patient Assisted Travel Scheme online system was introduced in December 2012. The implementation of the system has included new work practices and business rules which have resulted in an increase in the number of Patient Assisted Travel Scheme trip related data captured.

Figure 10: **Average cost per trip, Patient Assisted Travel Scheme, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave Cost	$488	$507	$533	$586	$489
Target	$478	$450	$524	$623	$585

Data source/s: 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 2013 is ≤5.0 hospitalisations per 1,000 children less than 5 years of age.

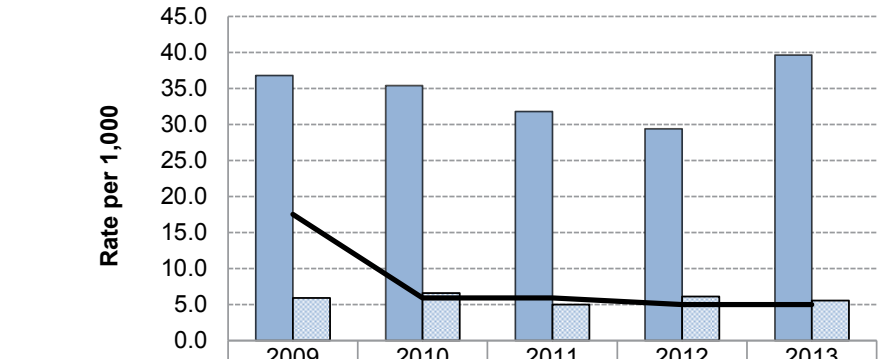
The target is based on the best result achieved within the previous five years for either Aboriginal or non-Aboriginal population groups.

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

Results

In 2013, the rate of non-Aboriginal children aged 0–4 years hospitalised for gastroenteritis in country WA was 5.5 per 1,000 children (see Figure 11). The rate for Aboriginal children was consistent with prior years. The rate of hospital admissions due to gastroenteritis for both non-Aboriginal and Aboriginal children exceeded the target of 5.0 per 1,000 children.

Figure 11: **Rate of hospitalisations for gastroenteritis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	36.8	35.4	31.8	29.4	39.6
Non-Aboriginal	5.9	6.6	5.0	6.1	5.5
Target (≤)	17.5	5.9	5.9	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 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: 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 2013 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.

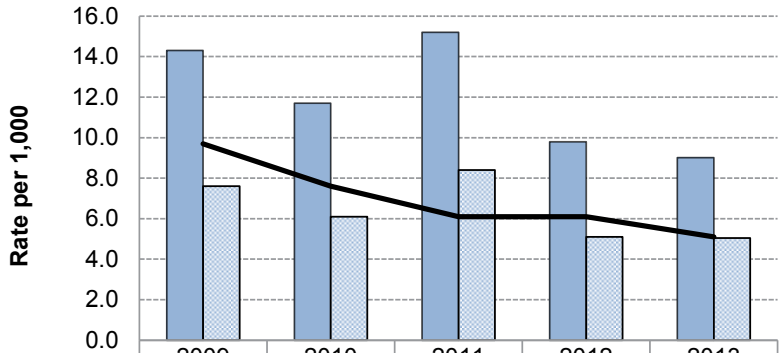
Respiratory condition	Age group (years)	Target
Asthma	0–4	≤ 5.1
	5–12	≤ 2.8
	13–18	≤ 0.9
	19–34	≤ 0.8
	35+	≤ 0.8
Acute Bronchitis	0–4	≤ 0.5
Bronchiolitis	0–4	≤ 9.7
Croup	0–4	≤ 2.6

Results

Acute asthma

In 2013, country WA non-Aboriginal people aged 0–4 (5.0 per 1,000), 19–34 (0.8 per 1,000) and or 35 years and over (0.7 per 1,000) met the target rate for hospitalisation due to acute asthma (see Figure 12, Figure 13, Figure 14, Figure 15, Figure 16). For all Aboriginal children the age group target was not met. The rate of Aboriginal children hospitalised for acute asthma in country WA declined for children aged 0–4 years compared to previous years.

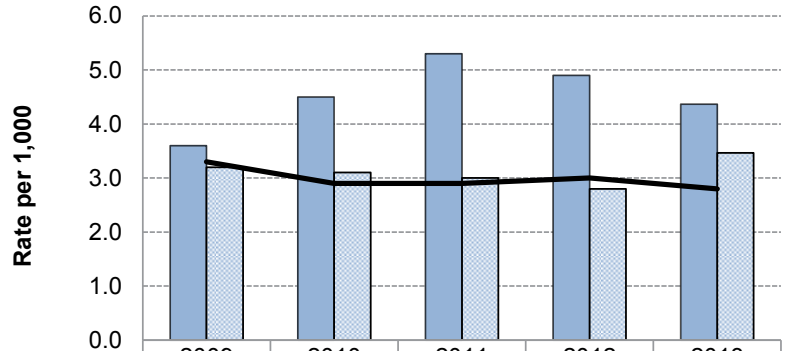
Figure 12: **Rate of hospitalisation for acute asthma per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	14.3	11.7	15.2	9.8	9.0
Non-Aboriginal	7.6	6.1	8.4	5.1	5.0
Target (≤)	9.7	7.6	6.1	6.1	5.1

Data source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

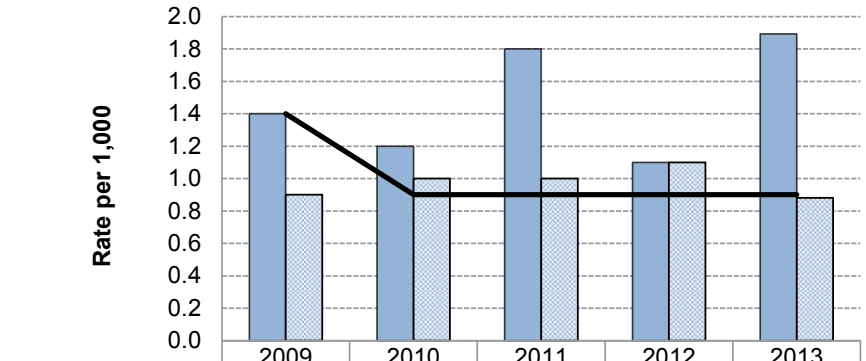
Figure 13: **Rate of hospitalisation for acute asthma per 1,000 children aged 5–12 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	3.6	4.5	5.3	4.9	4.4
Non-Aboriginal	3.2	3.1	3.0	2.8	3.5
Target (≤)	3.3	2.9	2.9	3.0	2.8

Data source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

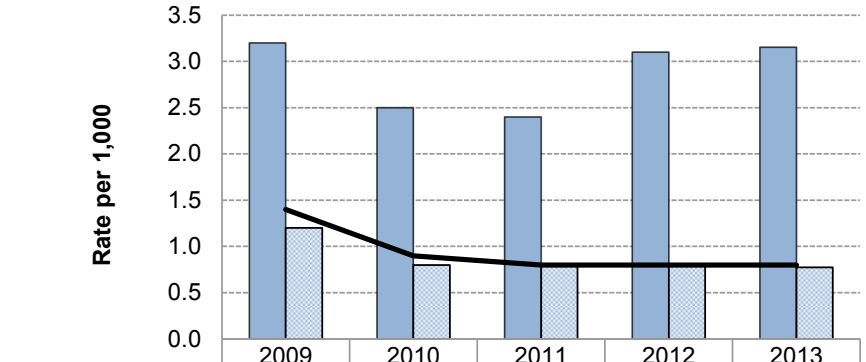
Figure 14: **Rate of hospitalisation for acute asthma per 1,000 children aged 13–18 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	1.4	1.2	1.8	1.1	1.9
Non-Aboriginal	0.9	1.0	1.0	1.1	0.9
Target (≤)	1.4	0.9	0.9	0.9	0.9

Data source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

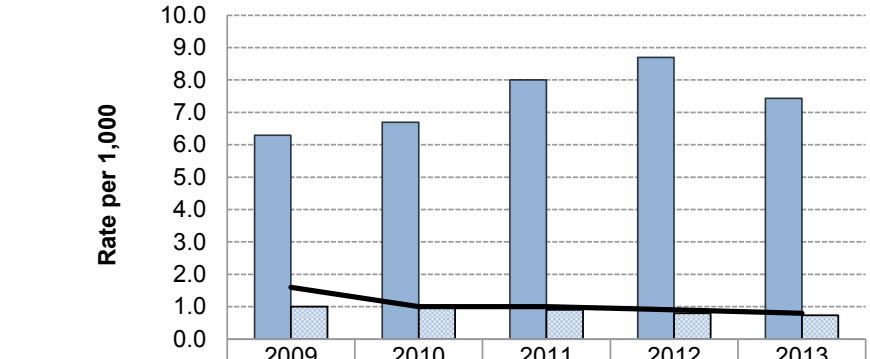
Figure 15: **Rate of hospitalisation for acute asthma per 1,000 persons aged 19–34 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	3.2	2.5	2.4	3.1	3.2
Non-Aboriginal	1.2	0.8	0.8	0.8	0.8
Target (≤)	1.4	0.9	0.8	0.8	0.8

Data source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Figure 16: **Rate of hospitalisation for acute asthma per 1,000 persons aged 35 years and older, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	6.3	6.7	8.0	8.7	7.4
Non-Aboriginal	1.0	1.0	0.9	0.8	0.7
Target (≤)	1.6	1.0	1.0	0.9	0.8

Notes:

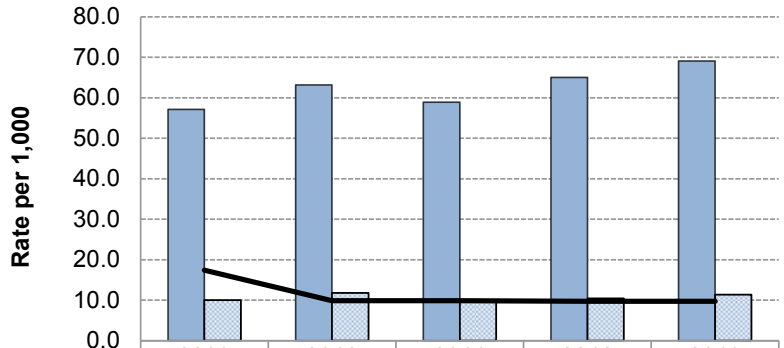
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Bronchiolitis

In 2013, the rate of hospitalisation for bronchiolitis was 69.1 per 1,000 for Aboriginal children and 11.4 per 1,000 for non-Aboriginal children (see Figure 17) in country WA. From 2009, Aboriginal children were more likely to be hospitalised for bronchiolitis. Both Aboriginal and non-Aboriginal hospitalisation rates were higher than the target.

Figure 17: **Rate of hospitalisation for bronchiolitis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	57.1	63.2	58.9	65.0	69.1
Non-Aboriginal	10.0	11.8	9.7	10.4	11.4
Target (≤)	17.4	9.9	9.9	9.7	9.7

Notes:

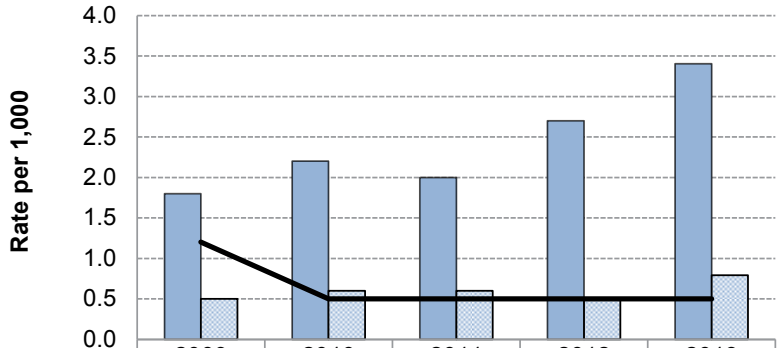
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Acute bronchitis

In 2013, the rate of non-Aboriginal children in country WA hospitalised for acute bronchitis was 0.8 for every 1,000 children (see Figure 18). The rate of Aboriginal children hospitalised for acute bronchitis was 3.4 for every 1,000 children. This was consistent with prior years with Aboriginal children more likely to be hospitalised for acute bronchitis. Both Aboriginal and non-Aboriginal hospitalisation rates for acute bronchitis were higher than the target.

Figure 18: **Rate of hospitalisation for acute bronchitis per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	1.8	2.2	2.0	2.7	3.4
Non-Aboriginal	0.5	0.6	0.6	0.5	0.8
Target (≤)	1.2	0.5	0.5	0.5	0.5

Notes:

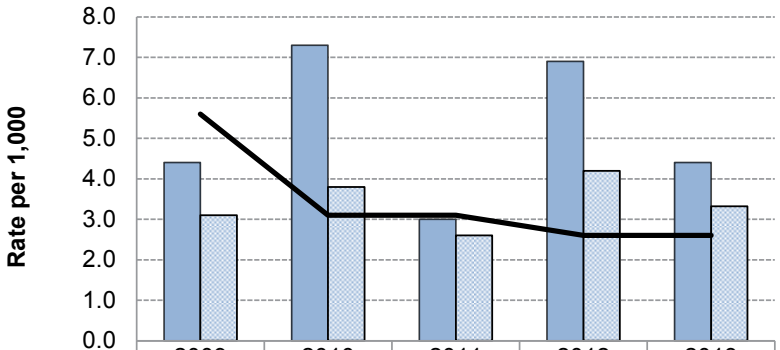
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

Croup

In 2013, the rate of Aboriginal and non-Aboriginal children in country WA hospitalised for croup was 4.4 and 3.3 for every 1,000 children respectively (see Figure 19). The results were above the target.

Figure 19: **Rate of hospitalisation for croup per 1,000 children aged 0–4 years, 2009–2013**



	2009	2010	2011	2012	2013
Aboriginal	4.4	7.3	3.0	6.9	4.4
Non-Aboriginal	3.1	3.8	2.6	4.2	3.3
Target (≤)	5.6	3.1	3.1	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 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
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 source/s: 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 populations, by 2020.

Results

In 2013, the rate of hospitalisations for falls in both Aboriginal and non-Aboriginal country WA populations increased across all age groups (see Table 18). The rate of hospitalisation was higher for Aboriginal people compared to non-Aboriginal people, regardless of age. For all age categories there was an increase in the rate of hospitalisation for falls compared to 2012 performance.

[2] http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Falls_Model_of_Care.pdf

Table 18: **Rate of hospitalisations for falls per 1,000 by age group, 2009–2013**

Age Group (years)		Years					Target
		2009	2010	2011	2012	2013	
55-64	Aboriginal	22.0	29.1	40.1	28.1	**42.6**	**0.5 per cent per annum reduction for a sustained period for both subgroup populations by 2020**
	Non-Aboriginal	5.3	4.6	5.9	5.7	**5.9**	
65-79	Aboriginal	34.8	44.1	51.0	40.8	**43.1**	
	Non-Aboriginal	17.5	16.7	18.7	18.7	**21.0**	
80+	Aboriginal	115.3	70.2	58.8	91.5	**119.7**	
	Non-Aboriginal	85.5	83.7	97.3	101.7	**109.3**	

Notes:
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
2. Caution needs to be taken in the interpretation of the rate of hospitalisation for falls (per 1,000 population) among the Aboriginal population. Small population numbers have resulted in significant variations across the years and comparison is not recommended.

Data source/s: Hospital Morbidity Data System, Australian Bureau of Statistics.

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. 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. 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 well-being of Western Australians with mental illness and ensure sustainability of the public health system.

Target

The target for 2013 was 70 per cent.

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

Results

In 2013, 43.0 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 public mental health non-admitted service in the previous seven days (see Table 19). This result was below the aspirational target of 70 per cent but consistent with previous years.

Table 19: **Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission, 2009–2013**

	Year					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	Target (%)
Pre-admission community-based contacts	41.4	41.4	44.6	41.2	**43.0**	**70.0**

Notes:

1. The target is considered to be aspirational based on a national definition and jurisdictional results can be sourced at National Mental Health Key Performance Indicator performance results
2. In 2013, to improve data quality and to align with state and national reporting requirements the denominator data source and reporting period for this KPI were modified. Data for all previously published years (2009–10 to 2012–13) has been restated for comparability purposes. Previously reported results, no longer considered appropriate, are as follows:

	2009–10	2010–11	2011–12	2012–13
Results (%)	49.4	51.1	53.6	51.7
Target (%)	65	70	70	70

Data source/s: 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 helps to ensure the best health outcomes for individuals and also reduce 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 2013 the target was 75 per cent.

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

Results

In 2013, 55.8 per cent of country WA people who were admitted to a public mental health inpatient unit had been in contact with a community-based public mental health non-admitted service within seven days following their discharge (see Table 20). This result was higher than the 2012 result and trending in the right direction. The target is considered aspirational, as the indicator includes follow-up by public community mental health services only.

Table 20: **Percentage of contacts with a community-based mental health non-admitted service seven days post discharge, 2009–2013**

	Year					
	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2013 %	Target (%)
Post-admission community-based contacts	51.9	48.6	45.2	51.0	**55.8**	**75.0**

Notes:
1. The target is considered to be aspirational based on the national definition.
2. In 2013, to improve data quality and to align with state and national reporting requirements the denominator data source for this KPI was modified. Data for all previously published years (2008 to 2012) has been restated for comparability purposes. Previously reported results, no longer considered appropriate, are as follows:

	2008	2009	2010	2011	2012
Results (%)	60.5	61.0	64.4	65.9	70.5
Target (%)	60	60	70	70	75

Data source/s: Mental Health Information System, Hospital Morbidity Data System.

Average cost per capita of Population Health Units

Outcome 2
Efficiency KPI
Service 7: Prevention, promotion and 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

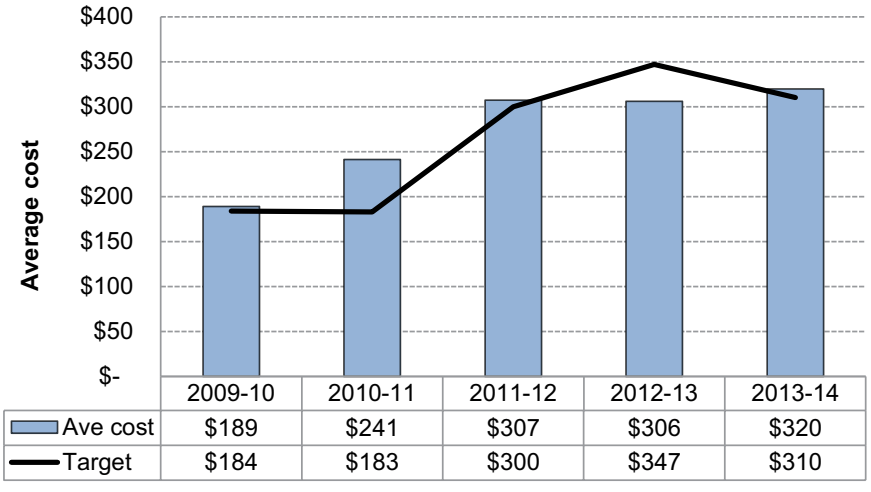
The target for 2013–14 is $310 per capita of population health units.

A result below the target is desirable.

Results

In 2013–14, the average cost per capita of country WA Population Health Units was $320 (see Figure 20).

Figure 20: **Average cost per capita of Population Health Units, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$189	$241	$307	$306	$320
Target	$184	$183	$300	$347	$310

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2011 for areas defined by the Australian Standard Geographical Classification. The Australian Bureau of Statistics has changed its geographical boundaries and WA Health is currently updating their processes for estimating and projecting populations based on the reclassification of Australian Bureau of Statistics geographical boundaries.
Data source/s: 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

Western Australia'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

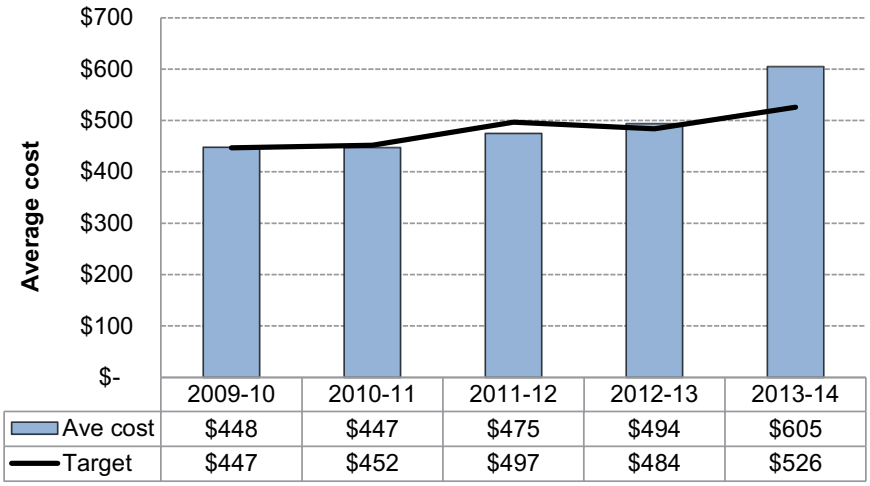
The target for 2013–14 is $526 per bed-day in a specified residential care facility flexible care (hostels) and nursing home type residents.

A result below the target is desirable.

Results

In 2013–14, the average cost per bed-day for specified residential care facilities, flexible care and nursing home type residents in country WA was $605 (see Figure 21), and above the target. The higher expenditure to target is predominantly due to lower activity coupled with a high proportion of fixed costs.

Figure 21: **Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$448	$447	$475	$494	$605
Target	$447	$452	$497	$484	$526

Data source/s: 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

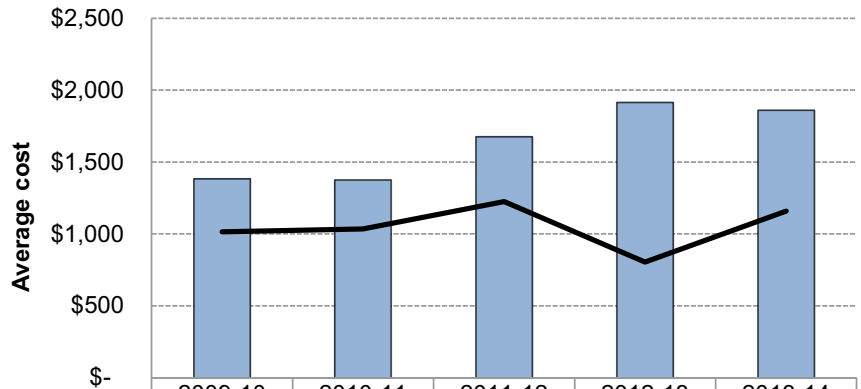
The target for 2013–14 is $1,159 per bed-day in a specialised mental health unit.

A result below the target is desirable.

Results

In 2013–14, the average cost per bed-day in a specialised mental health inpatient unit in country WA was $1,859 (see Figure 22). This result was an improvement on 2012–13 performance however it was still above the target. The higher expenditure to target is largely attributable to statewide corporate overheads born by WA Country Health Service that were not included in the target methodology or the Mental Health Commission service provision agreement.

Figure 22: **Average cost per bed-day in specialised mental health inpatient units, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$1,383	$1,375	$1,676	$1,914	$1,859
Target	$1,015	$1,034	$1,225	$804	$1,159

Note: In 2013–14, changes and improvements continue to be implemented in the counting and classification methodology under the national Activity Based Funding framework.
Data source/s: Health Care and Related Information System Client Management System, BedState, TOPAS, Health Service financial system.

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

Average cost per three month period of community care provided by a public community mental health service

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

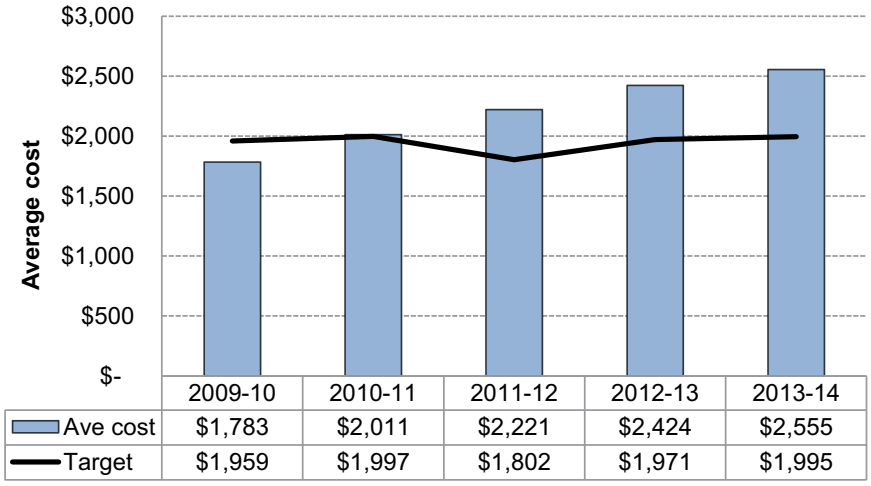
The target for 2013–14 is $1,995 per three month period of care for a person receiving public community mental health services.

A result below the target is desirable.

Results

In 2013–14, the average cost per three month period of care for a person receiving public community mental health services in country WA was $2,555. While this result was higher than the target, it was only 5 per cent higher than the 2012–13 performance (see Figure 23). The higher expenditure to target is largely attributable to statewide corporate overheads born by WA Country Health Service that were not included in the target methodology or the Mental Health Commission service provision agreement.

Figure 23: **Average cost per three month period of care for a person receiving public mental health services, 2009–10 to 2013–14**



	2009-10	2010-11	2011-12	2012-13	2013-14
Ave cost	$1,783	$2,011	$2,221	$2,424	$2,555
Target	$1,959	$1,997	$1,802	$1,971	$1,995

Note: In 2013–14, changes and improvements continue to be implemented in the counting and classification methodology under the national Activity Based Funding framework.
Data source/s: Mental Health Information System, Health Service financial system.

Ministerial directives

Treasurer's Instruction 902 (12) requires disclosing information on any 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 that are relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities, and financing activities.

Summary of board and committee remuneration

The total annual remuneration for each board or committee is listed below (see Table 21). For details of individual board or committee members please refer to Appendix 2.

Table 21: **Summary of State Government boards and committees within the WA Country Health Service, 2013–14**

Board/Committee name	Total remuneration ($)
Albany Hospital Medical Advisory Committee	0
Blackwood District Health Advisory Council	670
Blackwood Hospital Medical Advisory Committee	330
Bunbury District Health Advisory Council	2,340
Bunbury Hospital Medical Advisory Committee	3,113
Busselton Hospital Medical Advisory Committee	560
Broome and Surrounding Communities District Health Advisory Council	0
Central Great Southern District Health Advisory Council	2,575
Central Great Southern Medical Advisory Committee	2,557
Denmark Hospital Medical Advisory Committee	0
Donnybrook Hospital Medical Advisory Committee	0
East Kimberley District Health Advisory Council (formerly Kununurra/ Wyndham and Surrounding Communities)	1,438
Eastern Wheatbelt District Health Advisory Council	750
Eastern Wheatbelt Medical Advisory Committee	2,528
Gascoyne District Health Advisory Committee	420
Geraldton Hospital Medical Advisory Committee	0
Goldfields District Health Advisory Council	263
Leschenault District Health Advisory Council	1,110
Lower Great Southern District Health Advisory Council	2,437
Margaret River Hospital Medical Advisory Committee	0
Mid West District Health Advisory Council	1,440
Naturaliste Leeuwin District Health Advisory Council	60
Northern and Remote Country Health Service Governing Council	137,043

Board/Committee name	Total remuneration ($)
Plantagenent Cranbrook Health Service Medical Advisory Committee	917
Port Hedland Medical Advisory Committee	0
South East District Health Advisory Council	0
Southern Country Health Service Governing Council	182,349
Southern Wheatbelt District Health Advisory Council	0
Southern Wheatbelt Medical Advisory Committee	2,392
Warren District Health Advisory Council	100
Warren District Hospital Medical Advisory Committee	818
Western District Health Advisory Council	2,520
Western Wheatbelt Medical Advisory Committee	0
WA Country Health Service (WACHS) 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, if an eligible person receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital, they are treated 'free of charge'.

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*. These hospital fees are reviewed annually on 1 July.

Please refer to the Department of Health's Annual Report 2013–14 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's Annual Report 2013–14 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, in comparison with the preceding financial year. Table 22 shows the year-to-date (June 2014) number of WA Country Health Service full time equivalent employees for 2012–13 and 2013–14.

Table 22: **WA Country Health Service total full time employees by category**

Category	Definition	2012–13	2013–14
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1493	1,528
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.	93	85
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	94	92
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	44	51
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations.	1,268	1,271
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	318	356
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	13	14
Medical support	Includes all Allied Health and scientific/ technical related occupations.	793	796
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,807	2,877
Site services	Includes engineering, garden and security-based occupations.	175	177
Other categories	Includes Aboriginal and ethnic health worker related occupations.	140	137
	TOTAL	**7,237**	**7,384**

Notes:
1. The number of full time equivalent employees was calculated as the monthly average full time equivalent employees 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, workers' compensation.
2. Full time equivalent employee figures provided are based on Actual (Paid) month to date full time equivalent employees.
3. Data was extracted on 11 July 2014.
4. Totals may not add due to rounding.

Data source/s: Human Resource Data Warehouse.

Staff development

The WA Country Health Service maintains an extensive staff development program to ensure the development and maintenance of skills and competencies required to deliver safe and quality health care.

A Learning Management System implemented within WA Country Health Service during 2014 delivered greater standardisation and efficiency in the documentation, administration, management and hosting of learning programs for WA Country Health Service. The system introduced a learner-centred focus for staff, with the system interface providing views that show visual progress against learning requirements. The system supports fully integrated online records management to provide evidence of training completion for accreditation and other requirements.

Due to the geographical distribution of the WA Country Health Service workforce, there is a strong emphasis on the use of technology to support learning with extensive e-learning and video-conferencing, self-directed learning, and 'train the trainer' approaches deployed. For example, video-conferencing with external education providers (such as non-government organisations, peak bodies, professional associations, metropolitan health services, clinical interest groups and universities) is used to facilitate local access to clinical learning and development. Likewise the utilisation of Telehealth has provided the opportunity to establish real time mentoring partnerships between metropolitan-based health practitioners and country hospital general practitioners and nurses.

Clinical skills development is a major component of WA Country Health Service staff development programs. A number of programs aligned specifically to the development needs of health professionals, including medical, nursing and allied health professionals. In particular, targeted training has occurred to ensure staff competency in the areas covered by the National Safety and Quality Health Service Standards. The National Safety and Quality Health Service Standards include partnering with consumers, preventing and controlling health care associated infections, medication safety, patient identification, clinical handover, management of blood products, pressure injury prevention and management, clinical deterioration and falls prevention.

Training and support is also provided for the development of non-clinical skills including safety, targeted job-related learning programs, leadership, management, emergency management, administration and technology. WA Country Health Service is committed to developing the leadership skills of its staff, and supports its staff to participate in programs offered through the Institute for Health Leadership and the Public Sector Commission.

In 2013–14 a number of learning projects commenced or progressed, including the Nursing Competency project, Post-Graduate Medical Education Unit programs, the Allied Health Senior Leadership Development program, the On-Track – Towards sustainable supervision of students program, the Child and Adolescent Mental Health program, adaptation of the Trauma Informed Care program for videoconference delivery, and the Aboriginal Mentorship program.

Industrial relations

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

Key activities for 2013–14 included negotiating new industrial agreements for hospital support workers, oral health workers and medical practitioners. Progress was also made in negotiations for new industrial agreements for the nursing workforce, health professionals, and administrative, clerical and technical staff.

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 & Rehabilitation Act 1981*.

The WA Country Health Service is committed to the providing its staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services. In 2013–14 a total of 363 workers' compensation claims were made (see Table 23).

Table 23: **Number of WA Country Health Service workers' compensation claims in 2013–14**

Employee category	Number
Nursing services/dental care assistants	151
Administration and clerical	31
Medical support	23
Hotel services	137
Maintenance	19
Medical (salaried)	2
TOTAL	**363**

Note: For the purposes 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.

For further details of the WA Country Health Service's occupational injury and illness prevention and rehabilitation programs and services please see the Occupational safety, health and injury section of this report.

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.

No senior officers of the WA Country Health Service declared a pecuniary interest in 2013–14.

Other legal disclosures

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, the WA Country Health Service incurred in 2013–14 a total advertising expenditure of $125,924 (see Table 24). There was no expenditure in relation to market research, polling, or direct mail organisations.

Table 24: **Summary of WA Country Health Service advertising for 2013–14**

Summary of advertising	Amount ($)
Advertising agencies	47,623
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	78,301
Total advertising expenditure	**125,924**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 25.

Table 25: **WA Country Health Service advertising, by class of expenditure, 2013–14**

Recipient/organisations	Amount ($)
Advertising agencies	
Beilby Corporation Pty Ltd	10,869
Boddington Community Newsletter	50
Bruce Rock Telecentre Incorporated	58
Dalwallinu Telecentre Incorporated	127
Directorylistings.com.au Pty Ltd	995
Dowerin Community Resource Centre Incorporated	27
Endeavour Community Newspaper Incorporated	25
Health Service Directory	886
Katanning Regional Business Association	682
Koorda Telecentre Incorporated	868
Market Force	4,350
McGuigan	300
Nq Exhibitions	1,027
Other	1,043
Pingrup Telecentre and Resource Library	18
Royal Australasian College of Medical Administrators	2,200
Rural Doctors Association	750
Sensis Pty Ltd	179

Recipient/organisations	Amount ($)
Shire of Wongan-Ballidu	96
The Australasian College for Emergency Medicine	1,240
Tremain Media	12,375
West Australian Newspapers	137
Whistling Moose Graphics	9,095
York Telecentre Incorporated	226
Total	**47,623**
Market research organisations	
Total	**0**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Adcorp	28,982
Albany Advertiser	721
Albany Chamber of Commerce & Industry Incorporated	463
Australian Telephone Directory	5,495
Big Pages	2,985
BK Signs	80
Business Indigenous & Government Pages	995
Dean Proudman	356
Denmark Bulletin	40
Directories of Australia Pty Ltd	975
Directorylistings.com.au	1,095
Dongara Denison Local Rag	27
Health Promotion	27
Hedland Community Radio	1,000
Imatec Digital	10,500
Jasmine Phillips	309
Lilee T Baker	140
Local newspapers & media	13,163
Marietta Deegan	502
Minnis Journals Pty Ltd	825
My South West	45
Optimum Media Decisions (WA) Ltd	563

Recipient/organisations	Amount ($)
Pingelly Times	45
Rural Press Regional Media (WA) Pty Ltd	283
Sensis Melbourne	57
Shire of Broome	173
Southern Cross Austereo	754
The Australasian College for Emergency Medicine	1,364
The Royal Australasian College of Physicians	385
The West Australian	3,006
The Williams Community Newspaper	78
West Australian Newspapers	2,815
Watershed News Incorporated	53
Total	**78,301**

Disability access and inclusion plan

The *Disability Services Act 1993* was introduced to ensure that people with disability have the same opportunities as other Western Australians. In 2004, the national *Disability Access and Inclusion Plan 2010–15* was implemented by WA Health to ensure that people with disability, their family and carers are able to fully access the range of health services, facilities and information available in the public health system, and to have the opportunity to provide feedback on the quality of services received, and participate in public consultation concerning WA Health services. WA Health implemented the *Disability Access and Inclusion Plan 2010–15* which incorporates these principles. At 11 June 2014 all public authorities are now required to ensure that people with disabilities have equal opportunities to employment. WA Health is commencing implementation of this principle.

The following information details the current initiatives and programs being implemented by the WA Country Health Services in-line with the WA Health Disability Access and Inclusion policy.

Access to service

Throughout 2013–14, the WA Country Health Service has progressed implementation of the Area Health Service Disability Access and Inclusion Plans at both a regional and network level. This has included actions such as ensuring staff are made aware of the Act and the Department of Health's Disability Access and Inclusion policy during the recruitment and orientation process, and during their performance development. Staff are reminded of their roles and responsibilities via the intranet Disability Access and Inclusion Plan page, regular global emails, and Department of Health Circulars and Bulletins. To ensure that WA Country Health Service contractors are aware of their responsibilities, in all contract documentation templates a statement is now included about the responsibilities of agents and contractors in relation to the relevant requirements of the Act. Information on patient rights and responsibilities is displayed at WA Country Health Service sites, and it is specified that such information can be made available in alternative formats.

Access to buildings

The WA Country Health Service continues to review its operations to ensure that the requirements of the Disability Access and Inclusion plan are met. Regional health services undertake regular audits of existing WA Country Health Service facilities and buildings, in conjunction with their local District Health Advisory Councils, consumers with disabilities, and Disability Services Commission representatives. Issues that arise from these audits are progressively addressed through existing minor works and capital works approval processes. Upgrades have included parking lot improvements to assist access for all. Adequate ACROD parking has been provided for both the staff and public, with these parking sites located close to the main entrances. In addition, ward areas have non-slip surfaces for those persons requiring walking aids. During 2013–14 extensive new capital works were undertaken and disability and inclusion access was reviewed and incorporated as per the Australian Building Code. These considerations are evident at the Albany Health Campus, with the incorporation of easy wheelchair access, and wide corridors and doorways.

Access to information

In 2013–14, the WA Country Health Service further enhanced access through the provision of information in a variety of formats. Stipulations under the Department of Health's *Style Guide for Corporate Visual Identity* have been adopted in the preparation of all information developed for public distribution, and all information is available in alternative formats, including the health service's 'Rights and Responsibilities' information provided on a Patient First DVD enabling visually impaired clients to listen to the information. All information supplied and issued by WA Country Health Service includes the wording *"this information is available in alternative formats"*. WA Country Health Service displays its own information posters as well as those provided by the Disability Services Commission promoting Disability Access and Inclusion. The Albany Health Campus redevelopment has enabled a number of system improvements to be put in place to improve disability access to information. The WA Country Health Service has also developed a self-directed learning package for staff.

To improve access to information for people who speak limited English, or have difficulty speaking, hearing, seeing and/or reading, WA Country Health Service facilitates the use of interpreters. WA Country Health service has also installed 12 Sound Shuttle Hearing Loop Systems throughout the South West region.

Quality of service by staff

To ensure all staff can deliver consistent services and health care to people with a disability, disability awareness is included in mandatory training days, induction sessions and self-directed learning packages. To assist staff in achieving competencies at certificate level, in appropriate training courses, the WA Country Health Service facilitates regular education sessions using e-learning packages and the Disability Services Commission's training packages and DVDs. Staff also receive training and information on the *National Charter of Health Care Rights*.

WA Country Health Service regions also actively promote the patient centred Patient First program at all levels. For example, WA Country Health Service Wheatbelt undertook an evaluation of motor vehicles used to transport clients with disabilities, and the most appropriate vehicle for use was determined and is now in use with the Fleet Coordinator.

Opportunity to provide feedback

The WA Country Health Service conducts regular regional and area-wide audits of its complaints processes, especially in relation to ensuring that people with disability have the same opportunities as others in the community. Regions review complaint forms and lodgment processes to ensure these provide the appropriate platform for initiating a complaint. To assist an individual to register a complaint, WA Country Health Service regions have patient and customer liaison officers. Information on the complaint process can also be facilitated by providing access to translating and interpreting services. The WA Country Health Service Compliments and Complaints policy and regional grievance mechanisms and procedures can be made available in alternative formats upon request.

Information on how to access Advocare support services is available across the WA Country Health Service, enabling community members, including those with a disability, to state their concerns to an external body if required. Many WA Country Health Service areas have routine annual visits by Advocare to alert the community to the services relating to advocacy, especially people with a disability.

Participation in public consultation

Public consultations undertaken by WA Country Health Service actively seek to include the voice of consumers with disabilities. People with disabilities are encouraged to participate in, and have been appointed to, WA Country Health Service District Health Advisory Councils. Information and advice from the District Health Advisory Councils informs the Area Health Service as to the appropriate health care services to meet the needs of all community members, including those with a disability. The District Health Advisory Councils also have input into stakeholder advisory groups associated with the redevelopment of facilities, and actively seek input from those with disabilities.

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's Annual Report 2013–14.

Recordkeeping plans

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

WA Country Health Service finalised its agency specific recordkeeping plan and supporting framework, which was approved by the State Records Commission on 3 August 2013 for the full 5 year period. The WA Country Health Service Recordkeeping Plan and framework addresses the geographic rural and remote challenges faced in country WA through the creation of a central support model. The model covers capture and creation activities through user training and support in the TRIM electronic document and records management system, as well as the implementation of a full suite of on-line tools to overcome issues associated with the vast distances between the WA Country Health Service's facilities.

A number of significant information management projects have been completed during 2013–14 to ensure the capture of valuable information assets within the TRIM electronic document and records management system. These have included:

1. Identification and registration of the full range of WA Country Health Service Infrastructure building plans for assets within the WA regional areas.
2. Identification and capture of historical senior executive email and significant electronic documents within the Central Office.
3. Governance controls of intranet resources by creating direct hyperlink functionality to TRIM to view the latest version of a document.
4. TRIM implementation to the South West Regional Executive Office that has developed the strategic direction for regional roll-outs.
5. Commencement of centrally coordinated Human Resources Misconduct Folder system using TRIM to ensure effective management of the process.

The success of the WA Country Health Service Recordkeeping Plan and the abovementioned projects during this period have contributed to a 94 per cent increase of information captured in TRIM from the previous year.

As part of implementing the WA Country Health Service Recordkeeping framework, significant progress has been made during 2013–14 in raising recordkeeping awareness through communication strategies and provision of resources. To this end, an effective and measurable training program for new and existing staff was developed. The program is available on-line and aims to ensure staff are aware of their recordkeeping obligations and have the skills to manage corporate records effectively. Training is supported by a comprehensive array of resources available on the WA Country Health Service intranet, which include compliance and policy documents, forms, and TRIM help guides and user manuals. Helpdesk assistance and support from the Records and TRIM Services is also available. Further awareness raising programs are planned and will include targeted training sessions, refresher training for staff having difficulties using the electronic document and records management system, and optional software training packages to increase the adoption of the system.

Regular reporting on the success of the recordkeeping and training programs is provided to senior management. These reports include training assessments, follow-up training, number of electronic document and records management system users, statistics on records created, data integrity evaluation and ‘help-desk’ support requests. These mechanisms help drive the message of compliance with the recordkeeping plan throughout the business areas in WA Country Health Service. As a measure of the success of the WA Country Health Service compliance programs, the TRIM electronic document and records management system user base increased by 38 per cent within this reporting period.

Substantive equality

WA Health contributes towards achieving substantive equality for all Western Australians by continuing to concentrate on the *Policy Framework for Substantive Equality* and adopting policies and implementing initiatives that address the diverse needs and sensitivities of the communities in which it operates.

The WA Country Health Service has developed policies and implemented initiatives distinctive to their unique environment and that are appropriate and sensitive to cultural needs, are patient focussed, innovative, accessible and safe.

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 programs. Examples of such programs include: the Council of Australian Governments' Closing the Gap program, the Footprints To Better Health program, and the *WA Country Health Service Aboriginal Employment Strategy 2014–2018*.

Occupational safety, health and injury

All areas of the WA Country Health Service are committed to continuously improving their occupational safety, health and injury management systems in line with the *Occupational Safety and Health Act 1984* and the injury management requirements of the *Workers' Compensation and Injury Management Act 1981*.

Commitment to occupational safety and health injury management

The WA Country Health Service management is committed to occupational safety and health injury management through:

- promoting a culture that integrates safety as a core value into all aspects of work
- developing and implementing an effective occupational safety and health management systems
- taking all practical measures to identify hazards, assess risks and to control risks
- thoroughly investigating all incidents/accidents to prevent recurrences
- ensuring that management and supervisory staff accept responsibility to provide and maintain safe systems of work where employees are not exposed to hazards
- informing all employees of their duty of care and empowering them to take responsibility for the safety and health of themselves and others
- communicating, consulting and cooperating with employees and occupational safety and health representatives to ensure that all practical measures are undertaken to improve occupational safety and health performance
- establishing an occupational safety and health plan with measurable objectives and targets to ensure continuous improvement in safety and health performance
- providing training, time, resources and financial support to enable implementation of this commitment
- continuously reviewing the occupational safety and health statement of commitment and formally reviewing the document every two years.

Compliance with occupational safety and health injury management

The WA Country Health Service is committed to providing a safe workplace to achieve high standards in safety and health for its employees, contractors and visitors. The WA Country Health Service safety management system is aligned with the requirements of the *Occupational Safety and Health Act 1984,* and is based on the management commitment, planning, consultation and reporting, hazard management, and training and supervision elements of the WorkSafe Plan. Practical guidelines to assist managers, supervisors and employees to incorporate safety in their daily practice and resolve issues on a local level where applicable are available on-line.

Employee consultation

WA Country Health Service has established occupational safety and health committees in each region as part of a formal consultative process. The membership is stipulated in agreed terms of reference and is consistent with the *Occupational Safety and Health Act 1984*. Supporting policies and procedures exist to further support the WA Country Health Service safety management system, including a formal occupational safety and health issue resolution procedure.

WA Country Health Service has also established a Work Health and Safety Reference Group, which provides advice to the WA Country Health Service corporate leaders on the:

- coordination and integration of work health and safety and injury management policies across WA Country Health Service
- development and implementation of WA Country Health Service work health and safety and injury management programs and strategies
- identification of WA Country Health Service-wide work health and safety risks and implementation of uniform risk control measure
- development of relevant WA Country Health Service policy and program evaluation
- other relevant WA Country Health Service work health and safety issues and injury management, policies and strategies.

Employee rehabilitation

In the event of a work related injury or illness, the WA Country Health Service is committed to assisting injured workers to return to work as soon as medically appropriate. WA Country Health Service has a documented Injury Management System in place which meets the requirements of the *Worker's Compensation and Injury Management Act 1981*. The system adopts a case management approach to ensure that return to work outcomes of injured workers are optimised. To this end, there are workers compensation staff located in each region that ensure injured employees receive their entitlements and are referred for injury management intervention. There are also three injury management coordinators who coordinate the return to work programs and prepare and monitor, in consultation with the case management team, written return to work plans for those employees with workplace and non-work related injuries.

The supporting policies and procedures are available to all employees on-line or from their line manager, and details are provided to employees during the WA Country Health Service orientation training, upon lodgement of a worker's compensation claim and when referred for injury management. Relevant documents provided to injured workers include the code of practice on injury management and an overview of the WA Country Health Service injury management system and process.

Occupational safety and health assessment and performance indicators

An assessment of the WA Country Health Service Safety Management System was conducted by an external consultant in 2012. The report of its findings was presented to the WA Country Health Service Chief Executive Officer and Executive in early 2013 and identified a number of improvement opportunities.

An action plan was endorsed by the WA Country Health Service Executive in August 2013 to address the improvement opportunities, with four recommendations completed to date.

The WA Country Health Service's performance in relation to occupational safety, health and injury for 2013–14 is summarised in Table 26.

Table 26: **WA Country Health Service's occupational safety, health and injury performance for 2013–14**

	2013–14
Fatalities	0
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	3.30
Lost time injury severity rate (rate per 100)	25.82
Percentage of injured workers returned to work within 26 weeks	67.8%
Percentage of managers trained in occupational safety, health and injury management responsibilities	38.0%

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Appendices

Appendix 1: WA Country Health Service addresses and locations

WA Country Health Service (WACHS)

Street address:
189 Wellington Street, EAST PERTH WA 6892

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) 9174 1600
Fax: (08) 9172 4167
Email: wachspb_execservices@health.wa.gov.au

WACHS – Midwest

Street address:
Ground floor, 45 Cathedral Avenue
GERALDTON WA 6530

Postal address:
PO Box 22, GERALDTON WA 6531

Phone: (08) 9956 2209
Fax: (08) 9956 2421
Email: Margaret.Denton@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: whr@health.wa.gov.au

WACHS – Goldfields

Street address:
The Palms, 68 Piccadilly Street
KALGOORLIE WA 6430

Postal address:
PO Box 716, KALGOORLIE WA 6433

Phone: (08) 9080 5710
Fax: (08) 9080 5724
Email: Geraldine.ennis@health.wa.gov.au

WACHS – Great Southern

Street address:
Albany Health Campus
Corner Warden Avenue and Hardie Road
ALBANY WA 6331

Postal address:
PO Box 165, ALBANY WA 6331

Phone: (08) 9892 2672
Fax: (08) 9842 1095
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 2309
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 Frans Cronje	Per meeting	12 months	$0
Secretary	Latrice Porter	Not eligible	Not applicable	$0
Member	Dr Clark Wasiun	Not eligible	Not applicable	$0
Member	Dr Alice Poon	Not eligible	Not applicable	$0
Member	Dr Michelle Middlemost	Not eligible	Not applicable	$0
Member	Dr Alasdair Millar	Not eligible	Not applicable	$0
Member	Dr Paul Salmon	Not eligible	Not applicable	$0
Member	Dr David Tadj	Not eligible	Not applicable	$0
Member	Dr David Ingram	Not eligible	Not applicable	$0
Member	Dr Justin Yeung	Not eligible	Not applicable	$0
Member	Dr Brian Cunningham	Not eligible	Not applicable	$0
Ex-officio Member	Dr Helen Van Gessel	Not eligible	Not applicable	$0
Ex-officio Member	Barbara Marquand	Not eligible	Not applicable	$0
Ex-officio Member	Kylie Oliver	Not eligible	Not applicable	$0
			Total:	**$0**
Blackwood District Health Advisory Council				
Chair	Max Barrington	Per meeting	12 months	$0
Member	Philippe Kaltenrieder	Per meeting	12 months	$280
Member	Abbie Fetter	Per meeting	12 months	$0
Member	Patricia Twiss	Per meeting	12 months	$220
Member	Michael Wood	Per meeting	12 months	$170
Member	Terry Linz	Per meeting	12 months	$0
			Total:	**$670**
Blackwood Hospital Medical Advisory Committee				
Chair	Dr Michael Hoar	Per meeting	12 months	$330
Deputy Chair	Dr Mick Dewing	Not eligible	Not applicable	$0
Secretary	Susan Kelly	Not eligible	Not applicable	$0
Member	Dr Nigel Jones	Not eligible	Not applicable	$0
Member	Dr Neil Wells	Not eligible	Not applicable	$0
			Total:	**$330**
Bunbury District Health Advisory Council				
Chair	John Gardyne	Per meeting	12 months	$1,680
Member	June Foulds	Per meeting	12 months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Bunbury District Health Advisory Council (cont.)				
Member	Margaret Smith	Per meeting	12 months	$240
Member	Lera Bennell	Per meeting	12 months	$0
Member	Joan Birkett	Per meeting	12 months	$300
Member	Lynne King	Per meeting	12 months	$120
Member	Margaret Leatherborrow	Per meeting	12 months	$0
			Total:	**$2,340**
Bunbury Hospital Medical Advisory Committee				
Member	Dr Stephen Hinton	Per meeting	12 months	$3,113
Member	Kim King	Not eligible	Not applicable	$0
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 Gordon De Cean	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 Ivan Jansz	Not eligible	Not applicable	$0
Member	Dr Neill Kling	Not eligible	Not applicable	$0
Member	Naomi Lilywhite	Not eligible	Not applicable	$0
Member	Dr Vijaya Mohan	Not eligible	Not applicable	$0
Member	Dr Diane Mohen	Not eligible	Not applicable	$0
Member	Dr Koula Pratsis	Not eligible	Not applicable	$0
Member	Dr Jon Purday	Not eligible	Not applicable	$0
Member	Dr Parthasarathy Ramesh	Not eligible	Not applicable	$0
Member	Marianne Slattery	Not eligible	Not applicable	$0
Member	Dr Lila Stephens	Not eligible	Not applicable	$0
			Total:	**$3,113**
Busselton Hospital Medical Advisory Committee				
Chair	Dr Gavin Riches	Per meeting	12 months	$560
Secretary	Leanne Howlett	Not eligible	Not applicable	$0
Member	Antony Beeley	Not eligible	Not applicable	$0
Member	Dr Michael Massey	Not eligible	Not applicable	$0
Member	Dr Sarah Moore	Not eligible	Not applicable	$0
Member	Dr John Robinson	Not eligible	Not applicable	$0
Member	Dr Trent Healy	Not eligible	Not applicable	$0
Member	Dr Phil Chapman	Not eligible	Not applicable	$0
Member	Carolyn VanBuren	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Busselton Hospital Medical Advisory Committee (cont.)				
Member	Jeremy Higgins	Not eligible	Not applicable	$0
Member	Nik Booker	Not eligible	Not applicable	$0
Member	Dr Gordon De Cean	Not eligible	Not applicable	$0
			Total:	**$560**
Broome and Surrounding Communities District Health Advisory Council				
Secretary	Lani Wilson	Not eligible	Not applicable	$0
Member	Adam Vincent	Not eligible	Not applicable	$0
Member	Alex Ramirez	Not eligible	Not applicable	$0
Member	Harpreet Singh	Not eligible	Not applicable	$0
Member	Chris Mitchell	Not eligible	Not applicable	$0
Member	Doug Josif	Not eligible	Not applicable	$0
Member	Sandra Flannigan	Not eligible	Not applicable	$0
Member	Jean Woods	Per meeting	12 months	$0
Member	Jen Bullen	Not eligible	Not applicable	$0
Member	June Walley	Not eligible	Not applicable	$0
Member	Kaz Fitzpatrick	Not eligible	Not applicable	$0
Member	Margie Ware	Per meeting	12 months	$0
Member	Marie Shinn	Per meeting	12 months	$0
Member	Margaret Moore	Not eligible	Not applicable	$0
Member	Allan McMullen	Not eligible	Not applicable	$0
Member	Mark Malone	Not eligible	Not applicable	$0
Member	Tracey Chamberlain	Not eligible	Not applicable	$0
Member	Maggie Nolan	Not eligible	Not applicable	$0
Member	Gwenda Jones	Not eligible	Not applicable	$0
Member	Arthur Hartmann	Not eligible	Not applicable	$0
			Total:	**$0**
Central Great Southern District Health Advisory Council				
Chair	Gladys Wells	Per meeting	12 months	$918
Member	Pauline Roosendaal	Per meeting	12 months	$0
Member	Hilary Harris	Per meeting	12 months	$720
Member	Norma Hersey	Per meeting	12 months	$937
Member	Isobel Bradbury	Per meeting	12 months	$0
Member	Dianne Callaghan	Per meeting	12 months	$0
Member	Jonathon Palmer	Per meeting	12 months	$0
			Total:	**$2,575**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Central Great Southern Medical Advisory Committee				
Chair	Dr Nicholas du Preez	Per meeting	12 months	$2,557
Secretary	Jessica Wood	Not eligible	Not applicable	$0
Member	Dr Bilal Ahmad	Not eligible	Not applicable	$0
Member	Dr Ashik Varghese	Not eligible	Not applicable	$0
Member	Dr Arcadie Moscaliov	Not eligible	Not applicable	$0
Member	Dr Samantha Weaver	Not eligible	Not applicable	$0
Member	Dr Ayman Mitri	Not eligible	Not applicable	$0
Member	Dr Petrus Lotter	Not eligible	Not applicable	$0
Member	Dr Anthony King	Not eligible	Not applicable	$0
Member	Dr Oluwole Oluyede	Not eligible	Not applicable	$0
Ex-officio Member	Hazel MacKenzie	Not eligible	Not applicable	$0
Ex-officio Member	Dr Helen van Gessel	Not eligible	Not applicable	$0
			Total:	**$2,557**
Denmark Medical Advisory Committee				
Chair	Dr Hector Faulkner	Per meeting	Not applicable	$0
Secretary	Nicola Cogan	Not eligible	Not applicable	$0
Member	Dr Tine Adams	Not eligible	Not applicable	$0
Member	Dr Jane James	Not eligible	Not applicable	$0
Member	Dr Amirthalingan Prathalingam	Not eligible	Not applicable	$0
Member	Sam Barron	Not eligible	Not applicable	$0
Member	Robyn Millar	Not eligible	Not applicable	$0
			Total:	**$0**
Donnybrook Hospital Medical Advisory Committee				
Chair	Dr Amba Roy-Choudhury	Per meeting	12 months	$0
Member	Dr Peter Rae	Not eligible	Not applicable	$0
Member	Dr Wietske van der Velden Schuijling	Not eligible	Not applicable	$0
			Total:	**$0**
East Kimberley District Health Advisory Council (formerly Kununurra/Wyndham and Surrounding Communities)				
Chair	Maxine Middap	Per meeting	12 months	$1,438
Deputy Chair	Di Ausburn	Not eligible	Not applicable	$0
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Jane Drew	Not eligible	Not applicable	$0
Member	Jane Parker	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
East Kimberley District Health Advisory Council (cont.)				
Member	Chris Loessl	Not eligible	Not applicable	$0
Member	Di Tucker	Not eligible	Not applicable	$0
Member	Angela Dwyer	Not eligible	Not applicable	$0
Member	Lorraine May	Not eligible	Not applicable	$0
Member	Margaret Williams	Not eligible	Not applicable	$0
Member	Peter Frewen	Not eligible	Not applicable	$0
Member	Robyn Long	Not eligible	Not applicable	$0
Member	Virginia O'Neill	Not eligible	Not applicable	$0
			Total:	**$1,438**
Eastern Wheatbelt District Health Advisory Council				
Chair	Onida Truran	Per meeting	12 months	$0
Member	Allison Wilkinson	Not eligible	Not applicable	$0
Member	Ian Nugent	Not eligible	Not applicable	$0
Member	Wendy Jardine	Not eligible	Not applicable	$0
Member	Jill Hatch	Per meeting	12 months	$0
Member	Alan McAndrew	Per meeting	12 months	$0
Member	Marilyn Reidy	Per meeting	12 months	$0
Member	Robyn Richards	Per meeting	12 months	$0
Member	Adrian Wesley	Per meeting	12 months	$0
Member	Darren Mollenoyuz	Per meeting	12 months	$0
Member	Mary Cowan	Per meeting	12 months	$25
Member	Lynne White	Per meeting	12 months	$250
Member	Sandra Waters	Per meeting	12 months	$475
			Total:	**$750**
Eastern Wheatbelt Medical Advisory Committee				
Chair	Dr Peter Lines	Per meeting	Not applicable	$2,528
Secretary	Sarah Wardell	Not eligible	Not applicable	$0
Member	Dr Adenola Adeleye	Not eligible	Not applicable	$0
Member	Dr Brian Walker	Not eligible	Not applicable	$0
Member	Dr Caleb Chow	Not eligible	Not applicable	$0
Member	Dr Sarat Tata	Not eligible	Not applicable	$0
Member	Dr Modupe Olanrewaju	Not eligible	Not applicable	$0
Member	Dr Jonathan Ruiz	Not eligible	Not applicable	$0
Member	Dr Mirielsa Ruiz	Not eligible	Not applicable	$0
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Ian Nugent	Not eligible	Not applicable	$0
Member	Allison Wilkinson	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Eastern Wheatbelt Medical Advisory Committee (cont.)				
Member	Dr Andrew Van Ballegooyen	Not eligible	Not applicable	$0
Member	Dr Patrick Bushe	Not eligible	Not applicable	$0
Member	Dr Gabrielle Adeniyi	Not eligible	Not applicable	$0
Member	Karen DeBonde	Not eligible	Not applicable	$0
Member	Wendy Jardine	Not eligible	Not applicable	$0
			Total:	**$2,528**
Gascoyne District Health Advisory Council				
Chair	Greg Rose	Not eligible	Not applicable	$0
Member	Karla Tittums	Not eligible	Not applicable	$0
Member	Sandy Bell	Not eligible	Not applicable	$0
Member	Gino Gianatsis	Per meeting	12 months	$90
Member	Leanne Norman	Per meeting	10 months	$0
Member	Cathy Gianatsis	Per meeting	12 months	$90
Member	Jennifer Raymond	Per meeting	12 months	$90
Member	John Newton	Per meeting	12 months	$150
			Total:	**$420**
Geraldton Medical Advisory Committee				
Chair	Dr Ian Taylor	Per meeting	12 months	$0
Member	Dr Andrew Jamieson	Not eligible	Not applicable	$0
Member	Dr Roy Varghese	Not eligible	Not applicable	$0
Member	Marianne Van Der Veen	Not eligible	Not applicable	$0
Member	Dr Helko Schenk	Not eligible	Not applicable	$0
Member	Marie Norris	Not eligible	Not applicable	$0
Member	Dr Jaques Perry	Not eligible	Not applicable	$0
			Total:	**$0**
Goldfields District Health Advisory Council				
Chair	Nola Wolski	Per meeting	12 months	$75
Member	Williamina Ingham	Per meeting	12 months	$138
Member	Diane Paddon	Per meeting	12 months	$0
Member	Geraldine Ennis	Per meeting	12 months	$50
Member	David Bowdidge	Per meeting	12 months	$0
Member	Donnie Martin	Per meeting	12 months	$0
Member	Lisa Barnett	Per meeting	12 months	$0
			Total:	**$263**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Leschenault District Health Advisory Council				
Chair	Amanda Lovitt	Per meeting	12 months	$1,110
Member	Lee Westwood	Per meeting	12 months	$0
Member	Michelle Smith	Per meeting	12 months	$0
Member	Jennifer Borchardt	Per meeting	12 months	$0
Member	Jenny French	Per meeting	12 months	$0
Member	Natalie Green	Per meeting	12 months	$0
Member	William Adams	Per meeting	12 months	$0
Member	Diane Canale	Per meeting	12 months	$0
Member	Claire Roach	Per meeting	12 months	$0
Member	Dr Val Lishman	Per meeting	12 months	$0
Member	Robert Bertolini	Per meeting	12 months	$0
Member	Colin Beauchamp	Per meeting	12 months	$0
Member	Vince Cosentino	Per meeting	12 months	$0
Member	Diana Lofthouse	Per meeting	12 months	$0
			Total:	**$1,110**
Lower Great Southern District Health Advisory Council				
Chair	Irene Montefiore	Per meeting	12 months	$0
Member	Dot Price	Per meeting	12 months	$0
Member	Sara Lembo	Per meeting	12 months	$0
Member	Ivan Edwards	Per meeting	12 months	$2,437
Member	Pamela Smyth	Per meeting	12 months	$0
Member	Graham Carthew	Per meeting	12 months	$0
Member	Dr Ceinwen Gearon	Per meeting	12 months	$0
Member	Ruth McLean	Per meeting	12 months	$0
Member	Kerry Arundel	Per meeting	12 months	$0
Member	Eliza Woods	Per meeting	12 months	$0
			Total:	**$2,437**
Margaret River Medical Advisory Committee				
Chair	Dr Verelle Roocke	Per meeting	12 months	$0
Member	Jeremy Higgins	Not eligible	Not applicable	$0
Member	Mary Allen	Not eligible	Not applicable	$0
Member	Alison Abbey	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

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Margaret River Medical Advisory Committee (cont.)				
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 Tagen Robertson	Not eligible	Not applicable	$0
Member	Dr Kirsty MacGregor	Not eligible	Not applicable	$0
Member	Dr Fraser Wood	Not eligible	Not applicable	$0
Member	Dr Shannon Tucker	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 Sharon Bennier	Not eligible	Not applicable	$0
Member	Dr Peter Carroll	Not eligible	Not applicable	$0
Member	Dr Dana Luscher	Not eligible	Not applicable	$0
Member	Dr Kate Collister	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 Alan Walley	Not eligible	Not applicable	$0
Member	Dr Tony Yates	Not eligible	Not applicable	$0
Member	Dr Gareth Mann	Not eligible	Not applicable	$0
Member	Dr Katina Koukourou	Not eligible	Not applicable	$0
			Total:	**$0**
Midwest District Health Advisory Council				
Chair	Barbara Thomas	Per meeting	12 months	$180
Member	Anne Browning	Per meeting	12 months	$120
Member	Betty Pearson	Per meeting	12 months	$60
Member	Brain McTaggart	Per meeting	12 months	$60
Member	Graeme Bedford	Per meeting	12 months	$180
Member	Iris Annear	Per meeting	12 months	$240
Member	Jennifer Teakle	Per meeting	12 months	$240
Member	Lynette Fabling	Per meeting	12 months	$60
Member	Merle Isbister	Per meeting	12 months	$120
Member	Stephanie Blight-Lee	Per meeting	12 months	$180
			Total:	**$1,440**
Naturaliste District Health Advisory Council				
Chair	Elizabeth Jones	Per meeting	12 months	$0
Deputy Chair	Max Kewish	Per meeting	12 months	$60
Secretary	Leanne Howlett	Per meeting	12 months	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Naturaliste District Health Advisory Council (cont.)				
Member	Lorrae Loud	Per meeting	12 months	$0
Member	Creena Holly	Per meeting	12 months	$0
Member	Tanya Gillett	Per meeting	12 months	$0
Member	David McDonald	Per meeting	12 months	$0
Member	Amanda Poller	Per meeting	12 months	$0
Member	Jeremy Higgins	Per meeting	12 months	$0
Member	Nik Booker	Per meeting	12 months	$0
			Total:	**$60**
Northern and Remote Country Health Service Governing Council				
Chair	Nola Wolski	Annual	12 months	$58,317
Deputy Chair	Marani Hutton	Not eligible	Not applicable	$0
Member	Dr Roger Goucke	Not eligible	Not applicable	$0
Member	Dr Jay-Mien Phang	Not eligible	Not applicable	$0
Member	Dr Philip Montgomery	Not eligible	Not applicable	$0
Member	Sandy Davies	Not eligible	Not applicable	$0
Member	Maureen Carter	Annual	12 months	$26,242
Member	Mark Casserly	Annual	12 months	$26,242
Member	Brian Wall	Annual	12 months	$26,242
			Total:	**$137,043**
Plantagenent Cranbrook Health Service Medical Advisory Committee				
Chair	Dr Victor Seah	Per meeting	12 months	$917
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
Member	Dr Joseph Ogunleye	Not eligible	Not applicable	$0
Member	Dr Vino Kariyakarawana	Not eligible	Not applicable	$0
			Total:	**$917**
Port Hedland Medical Advisory Committee				
Chair	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
Member	Dr Christoper Buck	Not eligible	Not applicable	$0
Member	Dr Bruce Campbell	Not eligible	Not applicable	$0
Member	Dr Cystal Claite	Not eligible	Not applicable	$0
Member	Dr Hans Dahl	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Port Hedland Medical Advisory Committee (cont.)				
Member	Dr Bruce Dixon	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 Mangwagna	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 Herath Padmasiri	Not eligible	Not applicable	$0
Member	Dr Daniel Saplontai	Not eligible	Not applicable	$0
Member	Dr Smirti 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
Member	Dr Sat Bhatia	Not eligible	Not applicable	$0
Member	Dr Felicity Breen	Not eligible	Not applicable	$0
Member	Dr Malcolm Clark	Not eligible	Not applicable	$0
Member	Dr Michael Haines	Not eligible	Not applicable	$0
Member	Dr Patrick Lang	Not eligible	Not applicable	$0
Member	Dr Tao-Kwang Lee	Not eligible	Not applicable	$0
Member	Dr David Porter	Not eligible	Not applicable	$0
Member	Dr Prabhath Wagaarachchi	Not eligible	Not applicable	$0
Member	Dr Ina Brown	Not eligible	Not applicable	$0
			Total:	**$0**
South East District Health Advisory Council				
Chair	Ibrahim Thuriyya	Per meeting	12 months	$0
Member	Pamela Kerr	Per meeting	12 months	$0
Member	Patrick Hogan	Per meeting	12 months	$0
Member	Harold Graham	Per meeting	12 months	$0
Member	Gabrielle Lilley	Per meeting	12 months	$0
Member	Meredith Waters	Per meeting	12 months	$0
Member	Ellen Saltmarsh	Per meeting	12 months	$0
Member	Peter Tredinnick	Per meeting	12 months	$0
Member	Geraldine Ennis	Per meeting	12 months	$0
Member	Dulcie Pahew	Per meeting	12 months	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Southern Wheatbelt District Health Advisory Council				
Chair	Stan Sherry	Per meeting	12 months	$0
Member	Mel Crosby	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	Amanda Milton	Per meeting	12 months	$0
Member	Debrah Clarke	Per meeting	12 months	$0
Member	Julie Christensen	Per meeting	12 months	$0
			Total:	**$0**
Southern Country Health Service Governing Council				
Chair	Prof. Geoffrey Dobb	Not eligible	Not applicable	$0
Deputy Chair	Kathy Finlayson	Annual	12 months	$34,990
Member	Adjunct Prof. Bernard Laurence	Annual	12 months	$26,242
Member	Dr Michiel Mel	Not eligible	Not applicable	$0
Member	Dr Ian Lishman	Annual	12 months	$16,149
Member	Jennifer Grieve	Annual	12 months	$26,242
Member	Irene Mills	Annual	12 months	$26,242
Member	Joydeep Choudhurry	Annual	12 months	$26,242
Member	David Barton	Annual	12 months	$26,242
			Total:	**$182,349**
Southern Wheatbelt Medical Advisory Committee				
Chair	Dr Peter Maguire	Per meeting	Not applicable	$2,392
Secretary	Amy Stone	Not eligible	Not applicable	$0
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Alan Kerrigan	Not eligible	Not applicable	$0
Member	Dr Safi Ansari	Not eligible	Not applicable	$0
Member	Dr Nigel Chikolwa	Not eligible	Not applicable	$0
Member	Dr Katherine Comparti	Not eligible	Not applicable	$0
Member	Dr Ilario DaSilva	Not eligible	Not applicable	$0
Member	Dr Reinier DeVilliers	Not eligible	Not applicable	$0
Member	Dr Coert Erasmus	Not eligible	Not applicable	$0
Member	Dr Fancois Jacobs	Not eligible	Not applicable	$0
Member	Dr JP Lalonde	Not eligible	Not applicable	$0
Member	Dr Beom Koh	Not eligible	Not applicable	$0
Member	Dr Stephen Lai	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Southern Wheatbelt Medical Advisory Committee (cont.)				
Member	Dr Nnaji Nwoko	Not eligible	Not applicable	$0
Member	Dr Peter Beaton	Not eligible	Not applicable	$0
Member	Dr Peter Smith	Not eligible	Not applicable	$0
Member	Dr Peter Van Maarseveen	Not eligible	Not applicable	$0
Member	Kerry Fisher	Not eligible	Not applicable	$0
Member	Jenny Menasse	Not eligible	Not applicable	$0
			Total:	**$2,392**
Warren District Health Advisory Council				
Chair	Ray Curo	Per meeting	12 months	$100
Member	Neroli Logan	Per meeting	12 months	$0
Member	Denise Jenkins	Per meeting	12 months	$0
Member	Sue Priddis	Per meeting	12 months	$0
Member	Amanda Poller	Per meeting	12 months	$0
Member	Anne Trent	Per meeting	12 months	$0
			Total:	**$100**
Warren District Hospital Medical Advisory Committee				
Chair	Dr John Davies	Per meeting	12 months	$818
Member	Dr Alison Turner	Not eligible	Not applicable	$0
Member	Dr James Bowie	Not eligible	Not applicable	$0
Member	Dr Kushdev Singh	Not eligible	Not applicable	$0
			Total:	**$818**
Western Wheatbelt District Health Advisory Council				
Member	Patricia Walters	Per meeting	12 months	$400
Member	Liz Christmas	Per meeting	12 months	$325
Member	Lydia Mills	Per meeting	12 months	$420
Member	Kerri Roberts	Per meeting	12 months	$475
Member	Cynthia McMorran	Per meeting	12 months	$500
Member	Georgina Mackintosh	Per meeting	12 months	$300
Member	Diane Kelly	Per meeting	12 months	$100
			Total:	**$2,520**
Western Wheatbelt Medical Advisory Council				
Chair	Dr Peter Barratt	Per meeting	12 months	$0
Secretary	Jenny Kowald	Not eligible	Not applicable	$0
Member	Dr Amir Kosarnia	Not eligible	Not applicable	$0
Member	Dr Bernard Chapman	Not eligible	Not applicable	$0
Member	Dr Colin Smyth	Not eligible	Not applicable	$0
Member	Dr Kevin Christianson	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Western Wheatbelt Medical Advisory Council (cont.)				
Member	Dr Duncan Steed	Not eligible	Not applicable	$0
Member	Dr Herma Inverarity	Not eligible	Not applicable	$0
Member	Dr Liviu Vasiniuc	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 Nina McLellan	Not eligible	Not applicable	$0
Member	Dr Ola Jinadu	Not eligible	Not applicable	$0
Member	Dr Richard Spencer	Not eligible	Not applicable	$0
Member	Dr Hendrik Smit	Not eligible	Not applicable	$0
Member	Dr Stephanie Spencer	Not eligible	Not applicable	$0
Member	Dr Michele Genevieve	Not eligible	Not applicable	$0
Member	Beverley Hamerton	Not eligible	Not applicable	$0
Member	Dr Tony Mylius	Not eligible	Not applicable	$0
Member	Dr Rifat Qamar	Not eligible	Not applicable	$0
			Total:	**$0**
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	Tony Robins	Not eligible	Not applicable	$0
Member	Grace Ley	Not eligible	Not applicable	$0
Member	Angela Berragan	Not eligible	Not applicable	$0
Member	Lisa McGinnis	Not eligible	Not applicable	$0
Member	Belinda West	Not eligible	Not applicable	$0
Member	Steve Jensen	Not eligible	Not applicable	$0
Member	David Naughton	Not eligible	Not applicable	$0
Member	Shane Wilson	Not eligible	Not applicable	$0
Member	Meredith Arcus	Not eligible	Not applicable	$0
Member	Andrew Jamieson	Not eligible	Not applicable	$0
Member	Ken Mills	Not eligible	Not applicable	$0
Member	Damian Jolley	Not eligible	Not applicable	$0
Member	Kerry Winsor	Not eligible	Not applicable	$0
			Total:	**$0**

Notes:

1. 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.
2. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
3. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2013–14 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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Produced by Resourcing and Performance Division