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

WA Country Health Service

Annual Report 2012–13

Delivering a **Healthy WA**

WA Country Health Service

Annual Report 2012–13

WA Country Health Service
189 Wellington Street
EAST PERTH WA 6004

Telephone: (08) 9223 8500
Fax: (08) 9223 8599

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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 2013.

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

18 September 2013

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Contents

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 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:

Care – Respect – Excellence
Integrity – Teamwork – Leadership

Executive summary

WA Health is a leading public health system that in 2012–13 performed well for the Western Australian community despite high demand for its services from the State's burgeoning population.

It also came amid change at the helm of the organisation with the departure of Kim Snowball in March 2013, after almost three years in the Director General's role.

This performance was underpinned by long-term planning, regular and ongoing monitoring and review, innovative reform and a professional strong workforce.

Delivering a healthy WA

While recognising that sections of the community experience poorer health outcomes than the rest, 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.

Despite a significant decline in Aboriginal mortality rates over the past decade, the rate of Aboriginal mortality for children and adults is still twice the rate of the non-Aboriginal rate. WA Health is committed to narrowing this gap.

The community benefits from WA Health's high standards of patient care, safety and quality, evident in its public health programs, responsive health services and hospitals.

WA Health continually works to improve its performance and aligns 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.

On 1 July 2012, Western Australia officially launched five new health service governing councils made up of community members and clinicians selected by the Minister for Health. These high-level governing councils have an important role to play in planning, monitoring and reporting on our public health services, and engaging with clinical and community stakeholders.

Their establishment has made the State's public health system even more responsive and accountable to the community. The WA Country Health Service is served by two governing councils – the Northern and Remote Country Governing Council and Southern Country Governing Council, each with its own set of unique health service delivery challenges and needs.

The newly formed Northern and Remote Country and Southern Country governing councils play an important role in planning, monitoring and reporting on their respective public health services, and engaging with clinical and community stakeholders.

The WA Country Health Service is a key part of Western Australia's broader public health system and is the biggest country health service in Australia, covering an area of nearly 2.5 million square kilometres and delivering comprehensive health services to around half a million people – approximately 10 per cent of whom are Aboriginal.

The WA Country Health Service employs approximately 9000 staff in its range of acute and community health services. Across its 70 rural and remote hospitals, the WA Country Health Service handles almost as many emergencies as the metropolitan hospitals combined and almost as many births as the State's major maternity hospital.

Caring for individuals and the community

In 2012–13, WA Country Health Service hospitals consistently treated patients within clinically recommended timeframes – surpassing key targets set under National Health Reform initiatives for emergency care and elective surgery.

Consistently over the year, there were no over-boundary cases for elective surgery cases in the higher urgency categories.

Likewise in calendar year 2012, WA Country Health Service hospitals admitted, referred on or discharged 86.8 per cent of patients within four hours of their presentation to an emergency department, exceeding the 76 per cent target set under the National Emergency Access Target. This was against a backdrop of continued growth in emergency department attendances of about four per cent per annum.

WA Country Health Service National Emergency Access Target sites, including health campuses at Nickol Bay Hospital, Kalgoorlie and Broome, benefitted from a range of initiatives such as emergency department upgrades and expansions and implementation of new systems to improve patient flow and administration.

Dialysis services for patients in the Kimberley were enhanced with implementation of Stage One of the WA Country Health Service's Renal Dialysis Plan. The commencement of dialysis services at Fitzroy Crossing and Kununurra and expansion of dialysis services at Derby has improved access to dialysis close to where people live.

The $565 million Southern Inland Health Initiative, funded under the Royalties for Regions program, continued to transform healthcare services throughout the State's Wheatbelt. The range of primary health services available to small communities was enhanced through a number of agreements with non-government organisations and a chronic condition coordination service commenced.

Extensive stakeholder engagement was also undertaken in two Wheatbelt communities, with a view to developing a new model of primary healthcare service delivery and new primary healthcare centres to replace the historically under utilised small town hospital model. These centres will bring together local emergency services, primary health and community-based healthcare services under the one roof, providing a central hub within the community and creating better efficiencies for the service providers. Planning for the primary healthcare centres will continue into the new financial year.

Rural patients also benefitted from new and improved cancer services including the opening of a new chemotherapy cancer centre at Albany Health Campus.

Caring for those who need it most

Caring for the most vulnerable people in Western Australia's rural communities remains a priority for the WA Country Health Service.

During 2012–13, the WA Country Health Service consolidated programs and initiatives established under the Coalition of Australian Governments' commitment to improve the lives of Aboriginal people by ending disparity between Aboriginal and non-Aboriginal Australians.

The year 2012–13 was the fourth year of the *Closing the Gap* program which delivered 98 Aboriginal-specific health programs across Western Australia and created 317 positions, 69 per cent of which were filled by Aboriginal people. WA Health's Aboriginal Health Improvement Unit has secured $31.4 million in State Government funding to continue developing *Closing the Gap* initiatives.

The Specialist Aboriginal Mental Health Service, part of the WA Country Health Service, has 31 employee positions of which 80 per cent are held by Aboriginal people. The program has led to more Aboriginal people in rural and remote areas accessing mental health services.

Making the best use of funds and resources

The WA Country Health Service worked hard at directing funds and resources to areas capable of providing maximum long-term benefit to regional Western Australians. It invested in new and improved health facilities and embraced cutting-edge technologies.

A $7 billion infrastructure overhaul, the biggest in the State's history, continued to expand and transform hospitals and health facilities across Western Australia, including rural and remote parts of the State.

Completion of the $170.4 million Albany Health Campus was a key achievement of 2012–13, ushering in a new era of health care for the Great Southern region. Having already attracted doctors and medical specialists to the area, the state-of-the art hospital is paving the way in enhanced patient services, with the introduction of cutting-edge information technology and was the first hospital in the State to introduce the new emergency department patient information system (webPAS ED) and patient entertainment system.

Construction has commenced on the $120.4 million Busselton Health Campus. This project is currently on time and on budget, scheduled to be completed at the end of 2014.

Meanwhile, Goldfields residents are benefiting from a new emergency department, medical imaging department and high-dependency unit following completion of the first phase of Kalgoorlie Health Campus' $55.8 million redevelopment.

Residents in the Pilbara and Kimberley can also expect enhanced emergency care following improvements to the emergency departments at Nickol Bay and Broome hospitals.

The $325 milllion Southern Inland Health Initiative will also provide capital works programs to upgrade rural health services in the region, with the commencement of planning for six integrated district health services in Northam, Narrogin, Merredin, Katanning, Manjimup and Collie.

The Emergency Telehealth Service was established as a pilot program to overcome some of the challenges in delivering safe, sustainable and equitable emergency health services in the country.

The service uses high-quality videoconferencing technology to enable emergency physicians, based in Perth, to examine, manage and treat patients in country hospitals. The service facilitates effective emergency care through quick diagnosis, immediate on-site treatment, and where required, arranging timely patient transfers to tertiary hospitals.

In its first 12 months of operation, the service provided approximately 3,282 consultations to patients across 24 regional locations. Beyond service provision, the emergency telehealth service provides real-time training and clinical governance and supports the retention of staff in small communities.

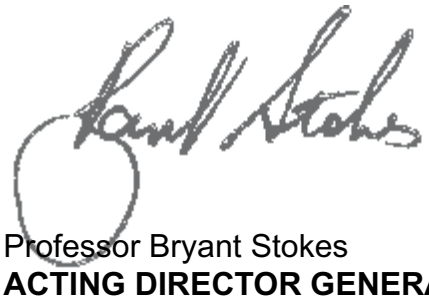
Supporting our team

People are the WA Country Health Service's greatest asset and attracting and retaining the best people into its workforce is vital to maintaining a quality health system for regional Western Australians.

The attraction of 13 new general practitioners to the State's southern inland region during 2012–13 was a coup for the service. Twenty-six new doctors have commenced work in the catchment since the Southern Inland Health Initiative commenced in 2011, highlighting the success of the program.

In 2012–13, emergency medicine continued to be a focus with 24/7 emergency department rosters continuing to run at select hospitals, three emergency department nurse practitioners recruited and standardised nursing orientation introduced throughout regional Western Australia.

The WA Country Health Service enters the new financial year keen to consolidate and build on the achievements of 2012–13, positive about the challenges that lie ahead and determined to continue serving the community with excellent health care that helps country Western Australians lead healthy and fulfilling lives.



Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH

Chief Executive summary

The WA Country Health Service (WACHS) continues to work together with regional communities to deliver a healthier country WA. Following on from the successes of our *Revitalising Country Health Services Strategic Direction 2009–12*, we have introduced our new strategic priorities for the next three years – *Towards Healthier Country Communities 2013–15*.

These new strategic priorities build on our 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. The result is the recognition that we are heading in the right direction.

Western Australia's five health service governing councils were established in July 2012 to increase the level of community and clinician input into the planning and monitoring of public health service in WA and to align with health reforms taking place across Australia.

The WA Country Health Service is served by two governing councils, each with its own set of unique health service delivery challenges and needs. The Southern Country Governing Council provides input into health services for communities in the Great Southern, South West and the Wheatbelt. The Northern and Remote Country Governing Council has input on the health services delivered to communities in the Goldfields, Midwest, Pilbara and Kimberley.

In their first year of operation alternate meetings of the governing councils were held at different health service sites in their respective regions, where they engaged with local stakeholders to gain a clear view and understanding of the issues, challenges and opportunities facing the health services across the WA Country Health Service.

These regional engagement visits, along with discussions with the WA Country Health Service senior management and specific service specialists, were key to validating and refining the WA Country Health Service future strategic priorities.

The other core responsibility of the governing councils relates to monitoring the WA Country Health Service performance. Business performance meetings were held every second month where the councils reviewed and discussed key performance measures and specific priority areas. These meetings provided additional focus for the WA Country Health Service Executive team in working towards achieving and maintaining key targets.

One of our significant achievements during this financial year has been the completion and seamless transition into the new $170.4 million Albany Health Campus. This state-of-the-art facility was opened in May 2013 by the Premier, Minister for Health and Minister for Regional Development, marking the completion of the largest public country hospital development ever undertaken in Western Australia.

The construction of the Albany Health Campus was part of the continuing $1.5 billion country health capital works program with new hospital works and redevelopments under way in all seven WA Country Health Service regions. This significant capital works program will bring world class health care closer to home for people living in regional and remote Western Australia.

Capital milestones achieved during the past financial year include construction commencing in September 2012 on the new $120.4 million Busselton Health Campus; completion of Stage 2 of the $55.8 million Kalgoorlie Health Campus redevelopment in November 2012 and work on Stage 3 of the redevelopment getting underway in May 2013 with the awarding of the construction tender for new outpatients and specialists clinics.

Stage 1 of the Broome Health Campus redevelopment saw the completion of the Emergency Department in July 2012 and the new $20.5 million Ochre Health Centre in Kununurra was officially opened in November 2012.

Planning is underway for the redevelopment of the Exmouth Multipurpose Service and the Carnarvon Health Campus and the project definition plan phases have also been completed on the $31.3 million Esperance Health Campus redevelopment.

The $565 million Royalties for Regions funded Southern Inland Health Initiative continues to improve access to medical and emergency care for people living in the southern inland region. An important innovation that is revolutionising the delivery of healthcare in the region is the introduction of the Emergency Telehealth Service (ETS). ETS utilises the technology of telehealth combined with an effective, quality medical workforce to diagnose, treat and manage patients locally, reducing the need for people living in regional WA to travel away from their homes to access medical care.

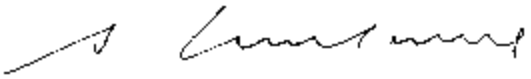
The $325 million Southern Inland Health Initiative capital works program is under way with planning commenced for the six integrated district health services in Northam, Narrogin, Merredin, Katanning, Manjimup and Collie. Thirty hospitals will benefit from the infrastructure enhancement due for completion by mid 2013–14. In addition, facility planning for refurbishments of small hospitals and nursing posts has been carried out across the Wheatbelt and Great Southern regions.

The WA Country Health Service has made a significant contribution to improving the health of Aboriginal people under the *Closing the Gap National Partnership Agreement*, which entered its fourth and final year of implementation in 2012–13.

Significantly, during this period the *Closing the Gap* program has resulted in the delivery of 98 Aboriginal specific programs across five priority areas and supported by 317 positions (69 per cent Aboriginal employees) across the State. This is an excellent outcome and work is continuing to reduce Aboriginal disadvantage across the WA Country Health Service.

The Aboriginal Health Improvement Unit, through the development of a business case, has been successful in securing a further $31.4 million of State funding to support future development and sustainability of the Closing the Gap initiatives for 2013–14.

The past financial year has been full of challenges for the WA Country Health Service, and I am pleased to report that our staff continue to meet these challenges head on with enthusiasm and dedication to improve, promote and protect the health of country Western Australians.



Shane Matthews
ACTING CHIEF EXECUTIVE
WA COUNTRY HEALTH SERVICE

Address and location

WA Country Health Service
Central Office

Street address:
189 Wellington Street
EAST PERTH WA 6004

Postal address:
PO Box 6680
EAST PERTH BUSINESS CENTRE
WA 6892

Phone: (08) 9223 8500
Fax: (08) 9223 8599
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 1615
Fax: (08) 9194 1666

WACHS – Pilbara

Street address:
Colebatch Way, SOUTH HEDLAND WA 6722

Postal address:
PMB12, SOUTH HEDLAND WA 6722

Phone: (08) 9174 1600
Fax: (08) 9173 3893

WACHS – Midwest

Street address:
Shenton Street, GERALDTON WA 6530

Postal address:
PO Box 22, GERALDTON WA 6531

Phone: (08) 9956 2209
Fax: (08) 9956 2421

WACHS – Wheatbelt

Street address:
Shop 4, 78 Wellington Street
178 Fitzgerald Street, NORTHAM WA 6401

Postal address:
PO Box 690, NORTHAM WA 6401
Phone: (08) 9621 0700
Fax: (08) 9621 0701

WACHS – Goldfields

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

Postal address:
PO Box 716, KALGOORLIE WA 6430

Phone: (08) 9080 5710
Fax: (08) 9080 5724

WACHS – Great Southern

Street address:
Callistemon House
Warden Avenue, ALBANY WA 6331

Postal address:
PO Box 165, ALBANY WA 6331

Phone: (08) 9892 2222
Fax: (08) 9842 1095

WACHS – South West

Street and postal address:
4th floor, Bunbury Tower
61 Victoria Street, BUNBURY WA 6230

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

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 our *Revitalising Country Health Services Strategic Direction 2009–12*, new strategic priorities have been introduced for the next 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. The result is the recognition that the WA Country Health Service is heading in the right direction.

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 purpose	To improve, promote and protect the health of country Western Australians
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.

Services provided

The WA Country Health Service provides services across a range of sites and through varied mechanisms, for example face to face appointments or Telehealth.

Direct patient services

- accident and emergency medicine
- acute medical
- acute mental health
- acute surgical
- anaesthetics
- antenatal classes
- cardiology
- dermatology
- dental services
- ear, nose and throat
- endocrinology
- gastroenterology
- general surgery
- genetics
- gynaecology and obstetrics
- hospital in the home
- nephrology
- occupational medicine
- oncology
- ophthalmology

- orthopaedics
- pain management
- pacemaker clinic
- paediatrics
- plastic surgery
- primary health care/general practice
- podiatry
- psychiatry and psychology
- radiation oncology
- renal dialysis
- rheumatology
- same day surgery
- urology
- diabetes education and care coordination
- respiratory education and care coordination
- cancer – care coordination
- hospital admission risk prevention – care coordination
- home oxygen – care coordination
- palliative care – care coordination.

Medical support services

- Aboriginal health services
- ambulance and patient transport
- audiology
- dietetics
- general physician
- medical imaging
- occupational therapy
- pathology
- pharmacy
- physiotherapy
- podiatry
- rehabilitation
- respiratory medicine
- social work
- speech pathology
- sexual health
- sub-acute care.

Community and support services

- aged and residential care
- alcohol and drug treatment
- child and maternal health
- community health
- community mental health
- community midwifery
- diabetes management and education
- disaster preparedness
- disease control
- health promotion
- health screening
- home and community care
- immunisation
- meals on wheels
- medi hotel services
- palliative care
- respite.

Other services

- administration and corporate
- engineering/supply/maintenance
- hotel and catering
- medical records
- telehealth.

Pecuniary interests

In 2012–13, WA Country Health Service Acting Executive Director for Primary Health and Engagement, Ms Melissa Vernon, declared that she was a Board Member of Amity Health (a small non government organisation based in Albany). She resigned from this position when supply of primary health care services was being discussed for the eastern Wheatbelt. Although the funding of the services was being directed through her office, Ms Melissa Vernon declared that she did not participate in these negotiations and there was no gain to her from these grants being awarded to Amity Health.

Accountable authority

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

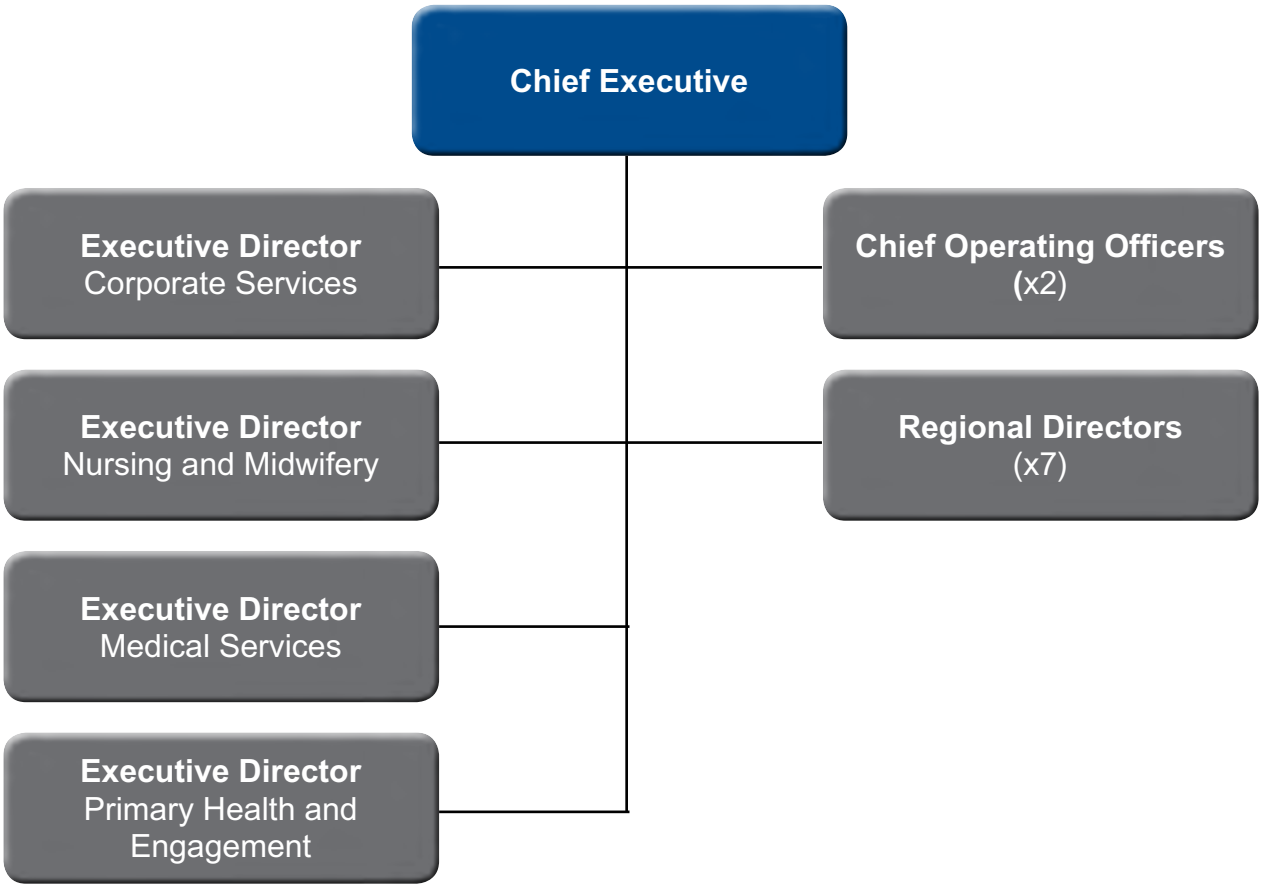
Senior officers

The senior officers and their area of responsibility for WA Country Health Service, as at 30 June 2013, are listed below:

Table 1: **WA Country Health Service senior officers as at 30 June 2013**

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive Officer	Shane Mathews	Acting
Area Operations	Chief Operating Officer Northern and Remote Country Health Service	Kerry Winsor	Acting
Area Operations	Chief Operating Officer Southern Country Health Service	Tina Chinery	Acting
Corporate Services	Executive Director	Jordon Kelly	Acting
Nursing and Midwifery	Executive Director	Marie Baxter	Substantive
Medical Services	Executive Director	Dr Meredith Arcus	Acting
Primary Health and Engagement	Executive Director	Melissa Vernon	Acting
Regional Operations	Regional Director Goldfields	Geraldine Ennis	Substantive
Regional Operations	Regional Director Great Southern	Susan Kay	Substantive
Regional Operations	Regional Director Kimberley	Kim Darby	Acting
Regional Operations	Regional Director Midwest	Margaret Denton	Acting
Regional Operations	Regional Director Pilbara	Ron Wynn	Substantive
Regional Operations	Regional Director South West	Grace Ley	Substantive
Regional Operations	Regional Director Wheatbelt	Caroline Langston	Acting

WA Country Health Service management structure



WA Country Health Service 2012–13

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 541,000 people (*WA Tomorrow Population Report*, Department of Planning 2012), including over 47,000 Aboriginal people (ABS projections 2011), over a vast 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 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 regional hospitals, there are also a number of smaller health centres and nursing posts spread across country WA.

The range of health services purchased includes primary health care, emergency and hospital services, population health, mental health, Aboriginal health, and community and aged care.

The WA Country Health Service is committed to "Working together for a healthier country WA". Our dedicated and committed staff work hard to deliver safe, high quality and accessible health care to regional and remote Western Australia.

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.

On July 1, 2012, five new governing councils, made up of members of the community and clinicians, were selected by the WA Minister for Health. The WA Country Health Service has two governing councils – the Northern and Remote Country Governing Council and the Southern Country Governing Council.

Governing councils have an important role to play in planning, monitoring and reporting on our public health services, and engaging with clinical and community stakeholders. Their establishment ensures the public health system is even more responsive and accountable to the community.

WA Country Health Service regions

The WA Country Health Service consists of seven administrative regions supported by the central office in Perth. They are the Kimberley, Pilbara, Midwest, Wheatbelt, Goldfields, South West and the Great Southern. Each region is managed by a regional director who reports to the WA Country Health Service Chief Executive Officer through a Chief Operating Officer.

Each of the seven WA Country Health Service regions provides an extensive range of health services, including hospital, mental health, aged care, public health, community health, primary health, Aboriginal health, child health, pharmacy and health transport services. Other essential providers of health care within the regions include private general practitioners, private and visiting medical specialists and allied health professionals, non-government and community-based organisations, Aboriginal community controlled health organisations, and other government agencies.

Kimberley

Covering an area of around 424,517 square kilometres, WA Country Health Service Kimberley has main hospitals situated at Broome, Derby and Kununurra with smaller hospitals located in Fitzroy Crossing, Halls Creek and Wyndham. There are also remote area nursing posts in some of the remote Aboriginal communities. The Kimberley population has steadily grown over the last decade and is estimated at over 38,105 (*WA Tomorrow*, 2012). Generally, Kimberley residents are young, with 80 per cent being younger than 45 years of age, and highly mobile. Aboriginal people comprise 43 per cent of the population (ABS 2011 population data). Population density is very low (0.08 people per square kilometre) creating a challenge for health service delivery and accessibility.

Pilbara

The WA Country Health Service Pilbara covers an area of around 508,000 square kilometres. The main hospitals are situated at South Hedland (Hedland Health Campus), Karratha (Nickol Bay Hospital), Newman, Tom Price, Onslow, Roebourne and small hospitals. There are also a number of remote area nursing posts in some of the smaller towns and in Aboriginal communities. The Pilbara resources boom has resulted in the region's rapid population growth to the current number of more than 61,190 people (*WA Tomorrow*, 2012). About half the residents are 'fly in – fly out' workers. Of the residents approximately 12 per cent are Aboriginal people (ABS 2011 population data). Consequently, the necessity to expand and improve the health services within the Pilbara is fundamental to the continued success of the region.

Midwest

The WA Country Health Service Midwest covers an area of around 592,141 square kilometres, with its main hospitals situated at Geraldton, Carnarvon and Meekatharra. There are also a number of health centres and nursing posts across the region. About 70 per cent of the population of the Midwest, over 66,000 people (*WA Tomorrow*, 2012), reside in the City of Greater Geraldton and the vast majority of the region's population lives on the coast. The area has an Aboriginal population of around 12 per cent (ABS 2011 population data) and an increasing proportion of aged people.

Wheatbelt

The WA Country Health Service Wheatbelt covers an area of around 155,300 square kilometres. The main hospitals are situated at Northam, Narrogin, Merredin and Moora and there are also a number of other hospitals, nursing posts in the smaller communities. The population of the Wheatbelt is estimated to be more than 78,000 people with a progressing median age (*WA Tomorrow*, 2012). About five per cent of the population are Aboriginal people (ABS 2011 population data). One of the noted idiosyncrasies of the Wheatbelt is its scattered population dispersion which has made attracting and retaining health practitioners difficult in some parts of the region.

Goldfields

Covering an area of approximately 770,500 square kilometres, the WA Country Health Service Goldfields main hospitals are situated at Kalgoorlie and Esperance. There are also a number of health centres and nursing posts across the region. The permanent population of the Goldfields is estimated at around 58,000 people (*WA Tomorrow*, 2012) boosted by a significant number of workers who fly in and fly out from Perth to work on remote mining sites. It is estimated that Aboriginal people make up about 10 per cent of the region's population (ABS 2011 population data).

South West

The WA Country Health Service South West covers an area of about 24,000 square kilometres with a permanent population of around 174,000 people (*WA Tomorrow*, 2012) as well as attracting a high number of tourists every year. Around two per cent of the permanent population are Aboriginal people (ABS 2011 population data). The main hospitals are located at Bunbury (South West Health Campus), Busselton, Bridgetown, Collie and Margaret River.

Great Southern

The total land area covered by the WA Country Health Service Great Southern is approximately 39,000 square kilometres. The area has a population of around 61,000 people (*WA Tomorrow*, 2012), of which three per cent are Aboriginal people (ABS 2011 population data). A high proportion of older people live in the main centres. The main hospitals are located at Albany, Denmark, Katanning and Mt Baker.

Performance against national elective surgery and emergency access targets

National Elective Surgery Target

WA signed the National Health Reform Agreement on Improving Public Health Services in 2011. The agreement includes the National Elective Surgery Target. This program progressively increases and measures the numbers of elective surgeries and reduces long waits for patients.

The objective of the National Elective Surgery Target is to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

The National Elective Surgery Target commenced on 1 January 2012 and focuses on two areas:

- **part 1:** a stepped improvement in the number of patients treated within the clinically recommended time.
- **part 2:** a progressive reduction in the number of patients who are overdue for surgery, particulary patients who have waited the longest beyond the clinically recommended time.

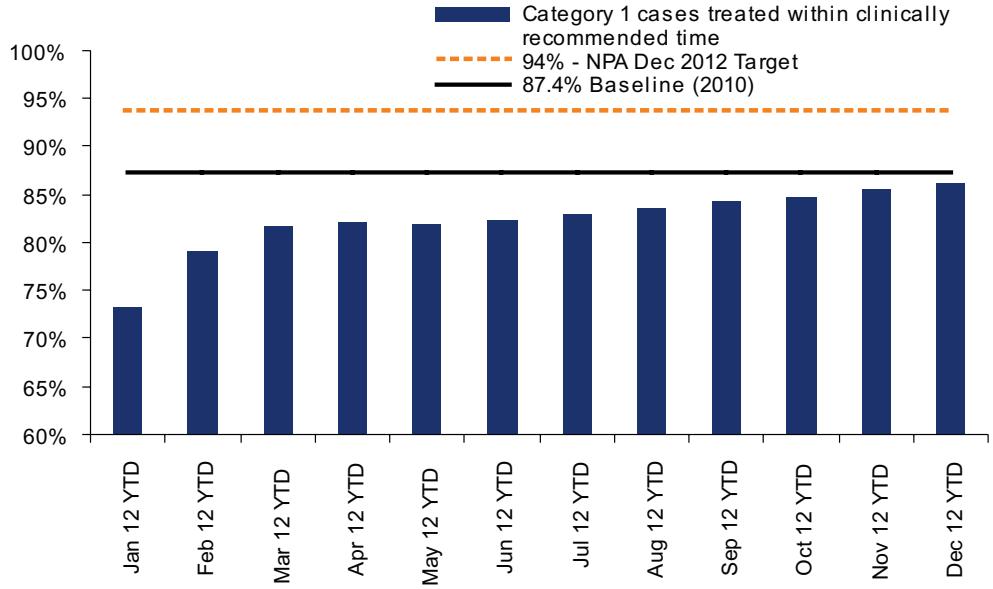
WA Health performance for National Elective Surgery Target part 1

For WA Health Table 2 shows the 2012 monthly trend for all elective surgery cases treated within the clinically recommended time.

Table 2: **National Partnership Agreement target, proportion (percentage) of cases treated within the clinically recommended time, by category, January 2012 – December 2012**

	Category 1 (%)	Category 2 (%)	Category 3 (%)
2012			
January	73.2	79.5	96.9
February	79.1	78.7	97.0
March	81.6	79.3	96.9
April	82.2	80.4	96.9
May	82.0	80.8	96.8
June	82.4	80.6	96.6
July	83.0	80.8	96.5
August	83.6	80.8	96.5
September	84.2	81.1	96.5
October	84.8	81.4	96.4
November	85.6	81.6	96.4
December	86.3	82.0	96.4
NPA NEST 2012 Target	**94.0**	**84.0**	**98.0**

Figure 1: **Proportion of category 1 cases treated within the clinically recommended time**



As shown in Figure 1, the proportion of category 1 cases treated within boundary increased from 73.2 per cent at the end of January 2012 to 86.3 per cent at the end of December 2012, however this result did not meet the National Partnership Agreement target of 94 per cent.

Figure 2: **Proportion of category 2 cases treated within the clinically recommended time**

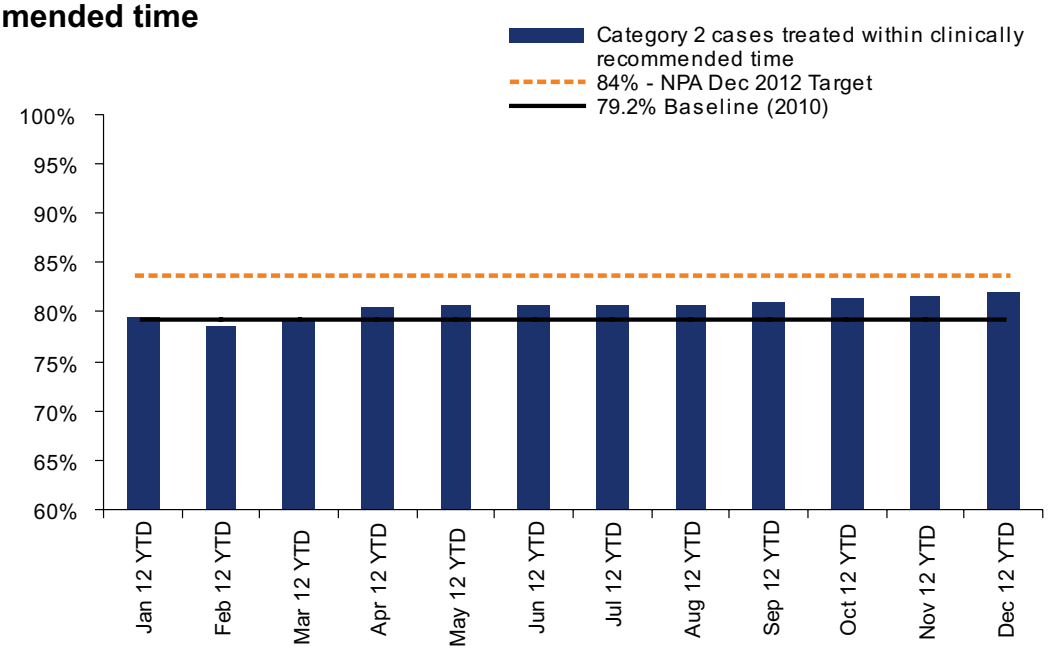


Figure 2 shows that the proportion of category 2 cases within the clinically recommended timeframe increased from 79.5 per cent at the end of January 2012 to 82 per cent at the end of December 2012.This result is slightly under the National Partnership Agreement target of 84 per cent.

Figure 3: **Proportion of category 3 cases treated within the clinically recommended time**

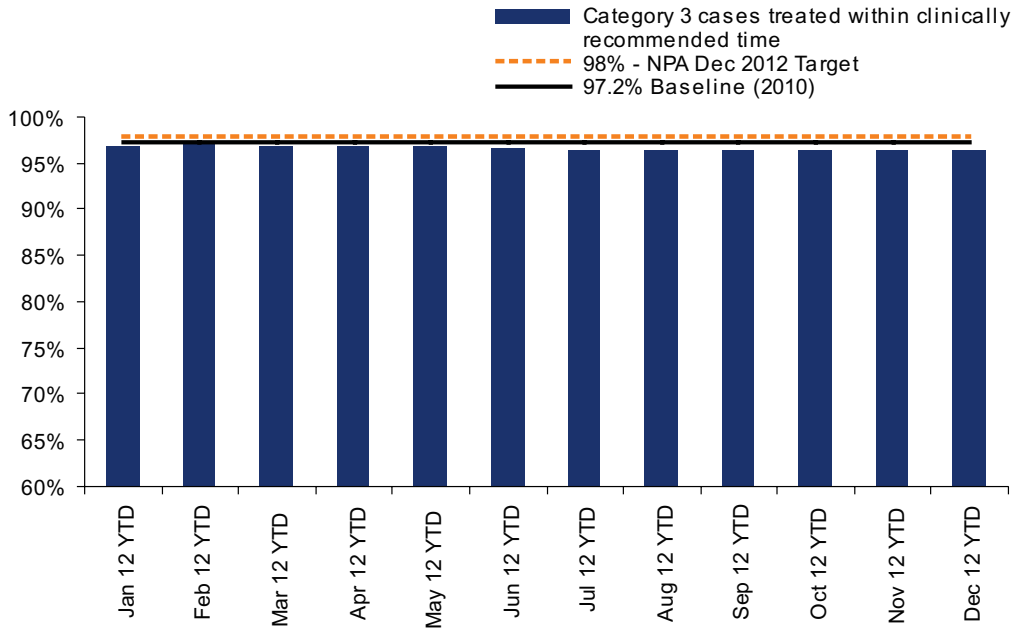


Figure 3 presents the 2012 monthly trend for category 3 cases treated within the clinically recommended time. The proportion of category 3 cases within boundary marginally declined from 96.9 per cent at the end of January 2012 to 96.4 per cent at the end of December 2012. This result did not meet the National Partnership Agreement target of 98 per cent.

WA Health performance for National Elective Surgery Target part 2

Reducing the average waiting time for those patients who have waited the longest beyond the clinically recommended time is the second objective under the National Partnership Agreement for all jurisdictions to achieve, including WA.

Table 3: **National Partnership Agreement target, average overdue wait time (in days) for cases that have waited beyond the clinically recommended time, by category, January 2012 – December 2012**

	Category 1 (%)	Category 2 (%)	Category 3 (%)
2012			
January	31.1	76.3	83.1
February	33.4	70.4	78.8
March	22.9	81.5	78.7
April	17.9	87.7	86.4
May	22.8	86.7	79.3
June	17.0	89.5	80.8
July	18.7	90.0	82.5
August	22.4	76.7	77.5
September	17.9	78.4	77.5
October	20.4	76.4	79.3
November	22.1	69.8	65.1
December	12.1	54.2	66.9
NPA NEST 2012 Target	**0**	**68**	**65**

Table 3 shows the 2012 monthly trend data for average overdue wait time (in days) for cases that have waited beyond the clinically recommended time by triage category.

Figure 4: **Average overdue wait time (in days) for category 1 patients that have waited beyond the clinically recommended time**

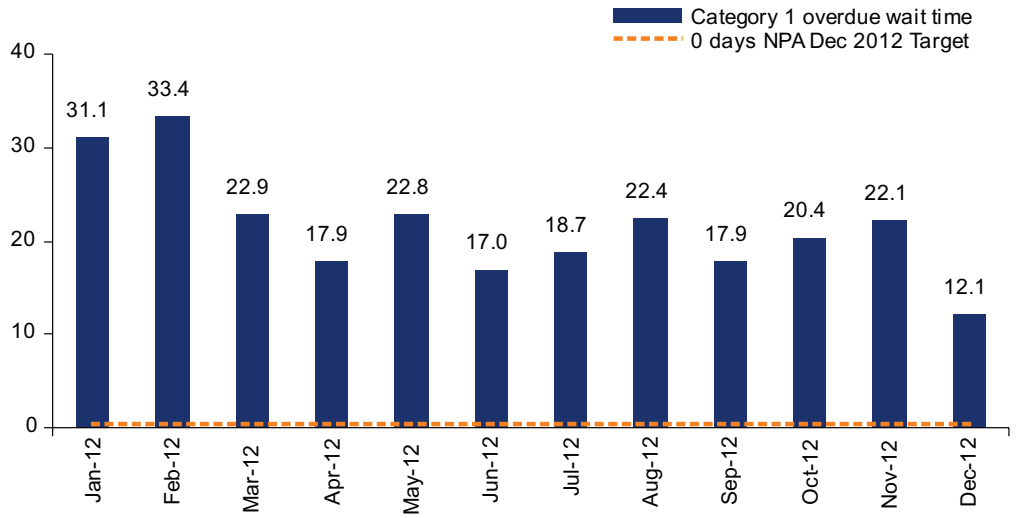


Figure 4 shows for category 1 the average overdue wait time dropped from 31.1 days at the end of January 2012 to 12.1 days at the end of December 2012. This result did not meet the National Partnership Agreement target of zero days.

Figure 5: **Average overdue wait time (in days) for category 2 patients that have waited beyond the clinically recommended time**

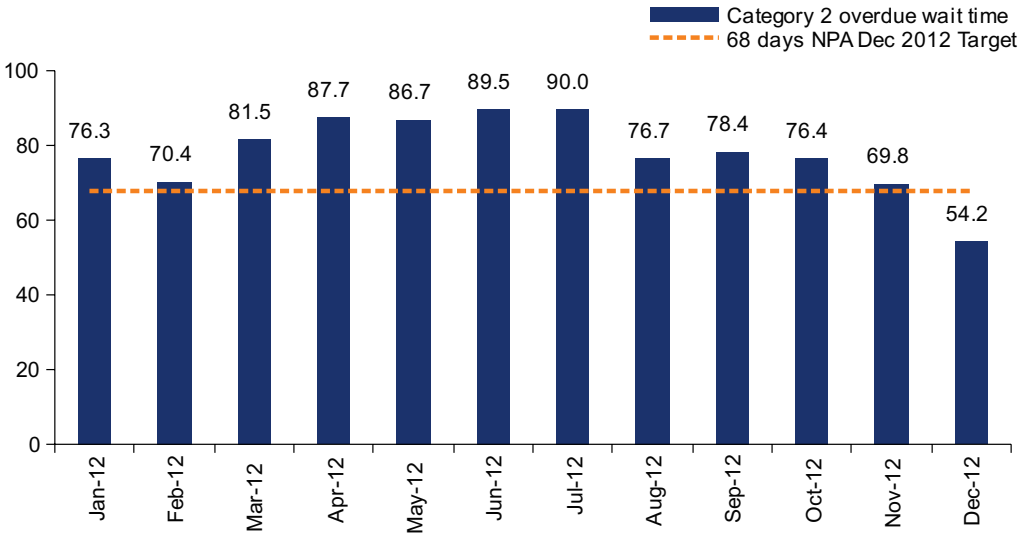


Figure 5 shows for category 2, the average overdue wait time dropped from 76.3 days at the end of January 2012 to 54.2 days at the end of December 2012. This result is better than the National Partnership Agreement target of 68 days.

Figure 6: **Average overdue wait time (in days) for category 3 patients that have waited beyond the clinically recommended time**

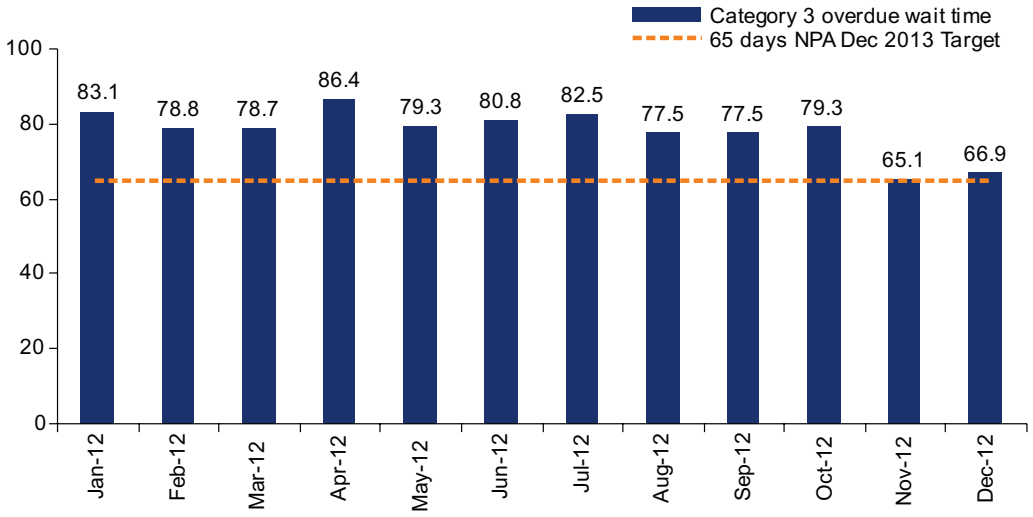


Figure 6 shows for category 3, the average overdue wait time dropped from 83.1 days at the end of January 2012 to 66.9 days at the end of December 2012. This result is marginally above the National Partnership Agreement target of 65 days.

National Emergency Access Target

In 2011, WA signed the National Partnership Agreement on Improving Public Hospital Services. The agreement includes the National Emergency Access Target, which aims to drive improvements in access to emergency care for patients.

The National Emergency Access Target requires that by 2015, 90 per cent of all patients presenting to a public hospital emergency department will be admitted, transferred or discharged within four hours. Between now and 2015 each state is required to meet annual interim targets which increase progressively until 2015.

National Emergency Access Target 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.

The National Emergency Access Target performance benchmark for WA for period 1 (1 January – 31 December 2012) was 76 per cent. In 2012, the WA Country Health Service National Emergency Access Target hospitals achieved a result of 86.8 per cent, above the National Partnership Agreement target.

Health snapshot of population

Each year WA Health commissions a general health and wellbeing survey. The survey is conducted independently across the State and collects self-reported health information from randomly selected respondents aged 16 years and over.

The following is a summary of the findings in the national health priority areas for WA country residents in 2012:

- **Overweight or obese**
  In country WA, 69.7 per cent of respondents reported to be overweight or obese. More men than women were found to be overweight or obese (75.5 per cent compared to 63.1 per cent).
- **Smoking**
  Nearly one in five respondents (16.5 per cent) smoked on a daily or occasional basis. Fewer women smoked than men (13.3 per cent compared to 19.4 per cent).
- **Respiratory conditions**
  In 2012, 1.9 per cent of respondents had experienced a respiratory condition, other than asthma, that lasted for six months or more. A similar proportion of men and women were affected (2.1 per cent compared to 1.6 per cent).
- **Health Service utilisation**
  In the past 12 months, the most commonly used health service reported by respondents in country WA was primary health services. In 2012, on average, each respondent visited a primary health service on four occasions.
- **Chronic conditions**
  Arthritis was the most common chronic condition self reported by respondents. Approximately one in five (20.5 per cent) respondents reported that they had been diagnosed with arthritis.
- **Mental health**
  In 2012, 13.3 per cent of respondents reported that they had been diagnosed by a doctor with a mental health problem in the last 12 months. Stress (8.1 per cent) was the most common doctor diagnosed mental health condition. More women than men reported a doctor diagnosed mental health condition.

Significant Issues Impacting the Agency

Significant issues

Highlights 2012–2013

- Southern Inland Health Initiatives:
  - more doctors and nurse practitioners to meet rural health workforce demand
  - eight grant agreements with non-government organisations to improve primary health care services.
- Young regional health practitioner named WA 2012 Nurse of the Year.
- The WA Country Health Service launched the Northern and Remote Country Governing Council and the Southern Country Governing Council.
- Milestone for Broome Hospital with completion of emergency department upgrade.
- Construction started on Busselton Health Campus.
- Opening of new emergency department and medical imaging and high-dependency unit at Kalgoorlie Health Campus.
- Completion of Nickol Bay Hospital emergency department.
- Bunbury opens a $10 million coronary care unit; early works revealed for Collie Hospital upgrade with more rural hospital upgrades to commence.
- Opening of the new $170 million Albany Health Campus.
- Aboriginal health:
  - majority of *Closing the Gap* programs fully operational for a period of 18 months
  - 98 Aboriginal specific programs delivered across five priority areas and supported by 317 positions (69 per cent Aboriginal employees) across Western Australia.

Caring for individuals and the community

Improving public hospital services in rural areas

Elective surgery

As part of the National Health Reform Agreement, a National Elective Surgery Target was established and requires jurisdictions to:

- **part 1:** a stepped improvement in the number of patients treated within the clinically recommended time.
- **part 2:** a progressive reduction in the number of patients who are overdue for surgery, particulary patients who have waited the longest beyond the clinically recommended time.

The National Elective Surgery Target program commenced on 1 January 2012 and sets progressive performance targets for Western Australia to meet over a four-year period. To achieve the National Elective Surgery Target, the WA Country Health Service continues to own and direct the management of its elective surgery waitlists. This ensures the delivery of services within the required performance parameters are based on the ‘first on-first off’ principle for similar cases.

Emergency department

Western Australia signed up to the National Partnership Agreement on Improving Public Hospital Services in 2011. As a signatory, WA is committed to work towards national targets around access to emergency and elective services. The National Emergency Access Target is a national four-hour target where, by the end of 2015, 90 per cent of all patients presenting to a public hospital emergency department should within four hours of presentation, leave the emergency department for admission to hospital, be referred to another hospital for treatment or be discharged.

Service improvement activity that commenced under the Four Hour Rule Program is continuing as part of ongoing emergency care reform and the National Emergency Access Target, as is the public reporting of performance and safety and quality indicators. The National Emergency Access Target serves to promote the best quality of care that is safe, effective, personal and timely.

The Four Hour Rule program utilised a rigorous clinical service redesign methodology tailored to suit the needs of WA Health. The program aimed to improve the quality of patient care and reduce pressure on staff and services by streamlining processes from admission through to discharge. The program has been implemented across seven nominated hospitals which include Bunbury, Albany, Broome, Geraldton, Kalgoorlie, Port Hedland and Nickol Bay. The program is now being integrated as part of normal practice through National Emergency Access Target action plans.

Action plans for all WA Country Health Service National Emergency Access Target sites were also completed in May 2013, including:

- Albany Health Campus – webPas (the new patient administration system) emergency department module was implemented
- Broome Hospital – emergency department redevelopment was completed in August 2012
- South West Health Campus – stage one emergency department expansion opened in May 2013
- Kalgoorlie Health Campus – emergency department redevelopment was completed and opened in October 2012
- Nickol Bay Hospital – emergency department redevelopment was completed and opened in October 2012
- Hedland Health Campus – implemented all clinical service redesign solutions to improve patient flow and efficiency.

Service planning

Under the Southern Inland Health Initiative Stream 2 (District Hospital and Health Services Investment Program), service planning was completed for central Great Southern (Katanning), Wellington (Collie) and the coastal Wheatbelt. Service plans informed the development of the Eastern, Southern and Western Wheatbelt Implementation Plan, concept and functional briefs.

The Warren Blackwood (Manjimup-Bridgetown) service plan development and Midwest district service plan development is also progressing and will be finalised in 2013–14. Murchison district service plan development will commence in 2013–14.

Eight grant agreements have been established with non-government organisations to improve primary health care services and improve access and reliability of service provision for patients in small communities, in relation to evidence and need. These include:

- diabetes education capacity-building in Wheatbelt and central Great Southern region (Silver Chain WA and Amity Health)
- oral language program in central Great Southern region (YMCA)
- chronic conditions coordination in Wheatbelt and central Great Southern region (Silver Chain WA)
- Kids Health Link in eastern Wheatbelt region (Amity Health)
- occupational therapy aged care residential in eastern Wheatbelt region (Amity Health)
- asthma/chronic lung program in eastern Wheatbelt region (Amity Health)
- mental health recovery project in Wheatbelt region
- aged care clinician project in Wheatbelt region.

A key aim is to work in partnership with non-government organisations, Medicare Locals and general practitioners to achieve coordinated care and implement sustainable models of service delivery. This allows care closer to home and improved health outcomes for patients.

Primary health nurse practitioners have been contracted to the western, eastern, southern Wheatbelt and central Great Southern districts through a contract with Silver Chain Western Australia.

For the Southern Inland Health Initiative Stream 3 (Primary Health Care Demonstration Program), the selection process for Primary Health Care Demonstration Sites was finalised and formal commitments were given by the shires of Cunderdin and Pingelly to become Primary Health Care Demonstration Sites. These sites will provide enhanced primary health and community-based care and emergency services under one roof. Development of the modified clinical service redesign methodology was undertaken in 2012–13 with 14 community meetings held in Pingelly and 16 community meetings held in Cunderdin over a four-month period.

In 2013–14, the Clinical Service Redesign phase 2 is expected to be completed with the development of a new model of care at each site to enhance primary health services and meet the communities' needs. Facility planning and design will commence for new primary health care centres at Pingelly and Cunderdin in consultation with the shires, service providers and respective communities. A third Wheatbelt Primary Health Care Demonstration Site will be identified and commencement of that site's modified clinical service redesign process will follow.

Renal dialysis plan

The WA Country Health Service *Renal Dialysis Plan* was completed in 2010. Implementation of phase one is underway with $6.72 million from the State Government's Royalties for Regions Program, together with $9.82 million from the State and $46.41 million from the Australian Government, enabling the WA Country Health Service to implement the first stage of a $63.51 million *Renal Dialysis Plan.*

- The first stage will increase the number of dialysis chairs and provide patient accommodation in the regions and additional staff. This will enable more people to receive dialysis in regional or remote locations.
- Fitzroy Crossing's interim haemodialysis unit has been established, enabling eight patients to be dialysed closer to home. Satellite renal dialysis services commenced with the opening of facilities in Kununurra and Derby, enabling at least 23 patients to return to the Kimberley from Perth.
- Planning has commenced for the construction of hostel accommodation for renal patients in Derby, Kununurra and Fitzroy Crossing. The WA Country Health Service has also commenced planning for accommodation for renal support staff in Port Hedland, Geraldton and Kalgoorlie.
- The renal services expansion will provide seven additional dialysis chairs in Kalgoorlie and the establishment of renal support teams in the Midwest, Goldfields and Pilbara.
- The enhanced services will be supported by specialist nephrologists with telehealth services being expanded to the Pilbara and Kimberley.

Rural cancer services

- The Chemotherapy Cancer Centre opened at the new Albany Health Campus and has six chemotherapy chairs. New and upgraded equipment provided at the state-of-the-art facility is now providing advanced imaging services.
- Geraldton Hospital has a new unit including four chemotherapy chairs and one chemotherapy bed, with two additional chemotherapy chairs at St John of God Hospital in Geraldton.
- Guidelines for the establishment of further chemotherapy unit requirements have been developed in collaboration with the WA Cancer and Palliative Care network.
- Kalgoorlie Chemotherapy Cancer Centre is currently under construction and will include four chemotherapy chairs and one chemotherapy bed.
- As a priority for 2013–14, Narrogin and Northam Hospital chemotherapy units will be developed within the Southern Inland Health Initiative development program.

Caring for those who need it most

Community care

Southern Inland Health Initiative Stream 6, Residential Aged Care and Dementia Investment Program ($20 million), will provide incentive for private providers to expand options for residential aged care and dementia care across the Southern Inland area. The WA Country Health Service will commence implementation of activities under this stream to develop new models for the provision of residential aged care.

Closing the Gap

- *Closing the Gap* entered into its fourth year of implementation in 2012–13. Following an extended recruitment period, the majority of programs have now been fully operational for a period of 18 months.
- Throughout the four-year period, Closing the Gap has resulted in the delivery of 98 Aboriginal specific programs across five priority areas supported by 317 positions (69 per cent Aboriginal employees) across WA.

- Development of a business case by the Aboriginal Health Improvement Unit, has been successful in securing a further $31.4 million of State funding to support future development and sustainability of the Closing the Gap initiatives for 2013–14. Strategic collaboration with industry partners has provided a shared step towards reducing Aboriginal disadvantage by identifying priority areas.
- Work will commence on implementing an outcome-focussed model of monitoring and reporting all *Closing the Gap* programs in 2013–14. This will allow the Aboriginal Health Improvement Unit to better track improvements in service provision, access, health and workforce, in line with the Delivering Community Services in Partnership policy.

Making best use of our funds and resources

Community given greater input into public health system

Two governing councils for the WA Country Health Service came into effect in the first week of the 2012–13 year. The councils will help WA Country Health Service fulfil its commitment to increase community and clinician input into, and control of, its public health system.

Servicing country Western Australia, the Northern and Remote Country Governing Council and Southern Country Governing Council will aim to make the public health system more responsive and accountable to the community with their clinical, corporate, government and community representatives. Council members were chosen in an expression-of-interest process.

Achievements in capital works and infrastructure

A number of capital works and infrastructure projects were completed during 2012–13. Construction also commenced on other projects which, when complete, will ensure regional Western Australia has access to a greater range of facilities and services.

Highlights included:

- Completion of the first stage of an emergency department redevelopment at Broome Hospital. Doctors and nurses are already working in the improved space which includes a newly constructed staff base.
- The turning of the first sod for the new Busselton Health Campus which, on completion, will have 64 overnight and 20 same-day beds, a renal unit, procedure room, two theatres, and an expanded emergency department. The campus is expected to be completed by 2014.
- Completion of the first and most extensive phase of the $55.8 million Kalgoorlie Health Campus redevelopment which included a new emergency department, medical imaging unit and high dependency unit. The improved facilities will benefit more than 56,000 people living in the Goldfields region.
- The awarding of a $17 million tender to create new outpatient and specialist clinics for the Kalgoorlie Health Campus by refurbishing the campus' former medical imaging and emergency department building.
- Completion of a $714,592 upgrade to the emergency department of Nickol Bay Hospital at Karratha.

- The opening of a $10 million coronary care unit in Bunbury. The first such unit for a regional area, it will enable South West residents to access specialist cardiac care closer to home. On the day of its opening, details of a $693,330 upgrade for Collie Hospital were announced.
- The opening of the new $170.4 million Albany Health Campus, the biggest country hospital capital project in Western Australia's history. The state-of-the-art, integrated health facility will transform the way health services are delivered to residents of the Great Southern.
- Completion of other major capital works including $10 million renal clinics in Derby and Kununurra and a $20 million integrated primary health care centre in Kununurra.

Information technologies

The Emergency Telehealth Service commenced on 31 August 2012 – a significant achievement under the Southern Inland Health Initiative (telehealth investment stream). In its first 11 months of operation, the service delivered approximately 3000 emergency medicine consultations. An emergency medicine consultant is rostered to deliver dedicated emergency medicine advice and support to 24 geographically dispersed areas.

By providing a timely, dedicated and accessible specialist emergency medicine service, the Emergency Telehealth Service is providing country patients with greater equity in accessing specialist services. The service has demonstrated its ability to use telehealth modality and an effective medical workforce to diagnose, treat and manage patients in situ, reducing the need for patients to travel for medical attention. In 2013–14, the Emergency Telehealth Service will be expanded to the wider WA Country Health Service regions.

Supporting our team

Improving our workforce

Achievements in this area included:

- the recruitment of 26 doctors to Southern Inland Health Initiative sites, accomplished under the Southern Inland Health Initiative Stream 1 (District Medical Workforce Investment Program)
- the implementation in Northam, Merredin, Narrogin and Esperance Hospitals of 24/7 emergency department rosters, with three emergency department nurse practitioners recruited and now working in Collie, Manjimup and Esperance. Recruitment will continue in the new reporting year for Merredin, Northam and Narrogin
- endorsement of the Nursing and Midwifery Strategic Plan which was published on the intranet in February 2013
- endorsement of the Framework for Midwifery Professional Development
- introduction of Patient Safety Action Teams with reporting against national safety standards to begin in the new reporting year
- a review of nursing orientation programs which led to the introduction of a standardised program for the WA Country Health Service.

Achievements and successes

Coral Bay's sole health practitioner, Kristy Cooper was named Western Australia's 2012 Nurse of the Year on 22 September 2012. Ms Cooper also won the Rural and Remote Registered Nurse category and was honoured for her professionalism and strong commitment to remote practice.

A $38.2 million, Pilbara Health initiative is a five-year joint health partnership, which has introduced a raft of improvements in the Pilbara and was honoured in this year's Premier's Awards. The WA Country Health Service and the Department of Regional Development and Lands won the category of 'Revitalising the Regions'. The award was received for Joint Partnership Initiative of the Pilbara Industry's Community Council and the WA Country Health Service.

The partnership is between the State Government's Royalties for Regions program administered by the Department of Regional Development and Lands, Pilbara Development Commission and the WA Chamber of Minerals and Energy's Pilbara Industry's Community Council Health initiative members (BHP Billiton Iron Ore, Chevron Australia Pty Ltd, North West Shelf Joint Venture, Rio Tinto and Woodside Energy). The initiative aims to boost health services in the region.

The Joint Health Partnership included:

- improving the region's emergency response capacities through the employment and training of more emergency staff
- the employment of the first Aboriginal liaison officers in emergency departments
- increasing medical specialist services across the West Pilbara
- the installation of a CT scanner in Karratha has improved diagnostic capability and since it was installed in November 2009 more than 5,000 scans have been completed
- an Aboriginal employment program which was developed and implemented to increase Aboriginal employment in the Pilbara and to improve their health outcomes."

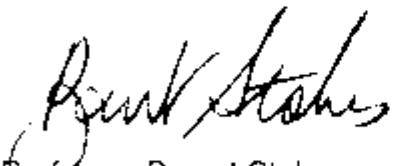
Key Performance Indicators

Certification Statement

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2013

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 2013.



Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

18 September 2013

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 2013, 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 2013 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 2013.

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.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

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 2013.

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 2013.

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 qualified audit opinion.

Basis for Qualified Opinion
Controls over the initial recording of waiting time data used for the effectiveness indicator "Percentage of emergency service patients seen within recommended times (major rural hospitals)" were inadequate. Audit tests of a sample of attendance and treatment times identified a significant number of differences between source records and the database. Consequently, I was unable to determine whether this effectiveness indicator was fairly presented.

Qualified Opinion
In my opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, 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 2013.

Emphasis of Matter
As reported by the Health Service in the key performance indicators, the effectiveness indicators for "Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition" and "Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition" are based on the sample period 1 September to 30 November 2012. My opinion is not modified in respect of this matter.

Matter of Significance
WA Country Health Service has 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 2013. Consequently, the "Elective Surgery Waiting Times" KPI has not been included in the audited KPIs for the year ended 30 June 2013. My opinion is not modified in respect of this matter.

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 2013 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
20 September 2013

WA Health annual reporting requirements for 2012–13

WA Health comprises of five legal entities that must prepare annual reports[1], as a means of disseminating performance information, to the Minister for Health, the State Government, Parliament, and the public. The legal entities are:

- Department of Health
- Metropolitan Health Service
- WA Country Health Service
- Queen Elizabeth II Medical Centre Trust
- Quadriplegic Centre.

The Department of Health, Metropolitan Health Service and WA Country Health Service annual reports[2] are produced by the Performance, Activity and Quality Division of the Department of Health, in collaboration with all relevant entity budget holders. The Queen Elizabeth II Medical Centre Trust and the Quadriplegic Centre are responsible for meeting their respective annual reporting requirements.

Under section 61 of the *Financial Management Act 2006* and Treasurer's Instruction 904, WA Health the entities are required to present annual indicators of performance to Parliament and public through the annual reports. This performance information includes key performance indicators. The key performance indicators are reported to enable stakeholders to assess WA Health's performance in achieving government desired outcomes and the delivery of services.

WA Health outcomes and services

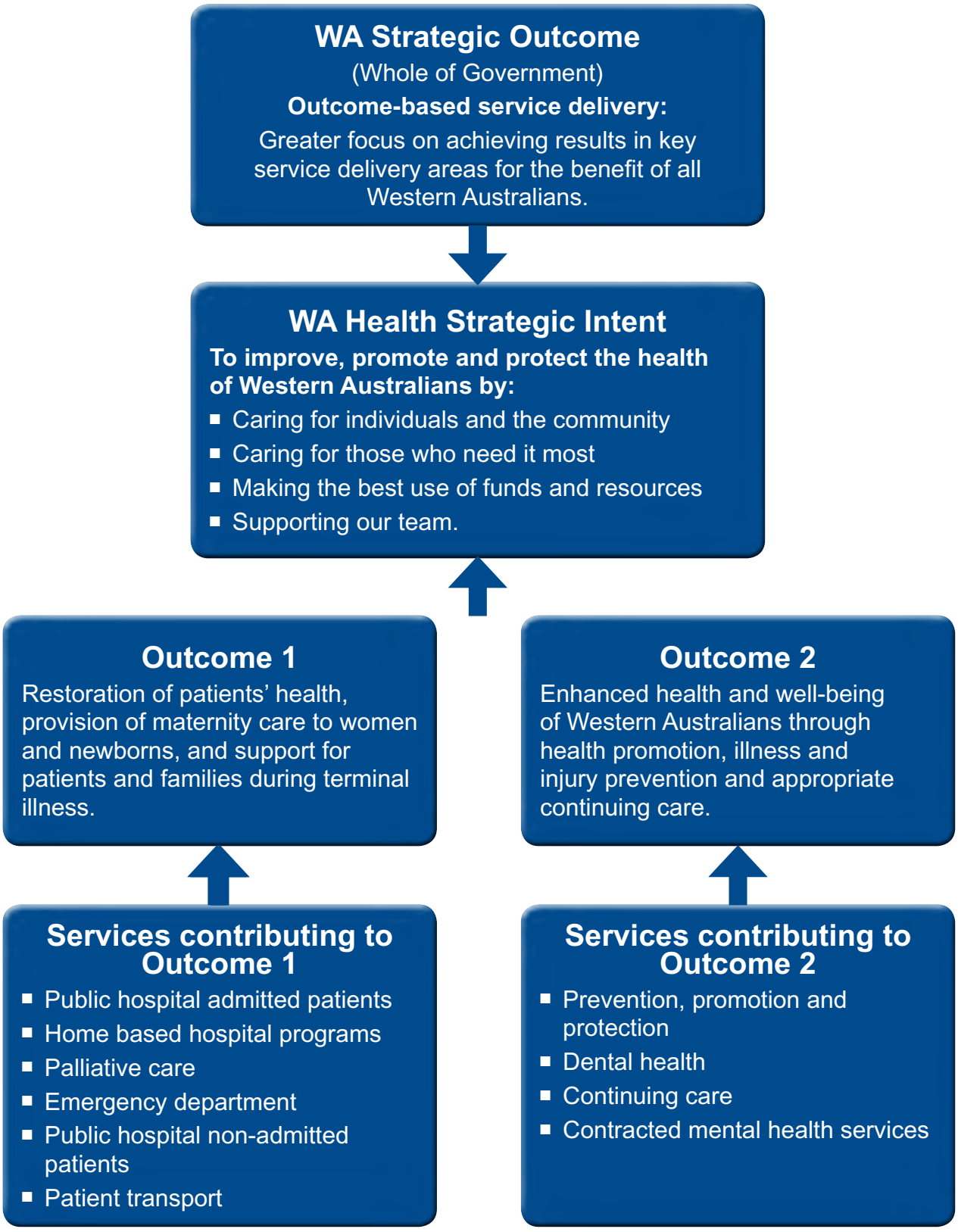
To comply with its legislative obligation as a Western Australian government agency, WA Health operates under the "Outcome Based Management" performance management framework[3]. This framework describes how outcomes, services and key performance indicators are used to measure agency performance towards 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 2012–13 annual report key performance indicators are aligned to the State Government goal (see Figure 7).

1 http://www.treasury.wa.gov.au/cms/uploadedFiles/_Treasury/Legislation/fab_update.pdf
2 http://www.health.wa.gov.au/publications/annual_reports.cfm
3 http://www.treasury.wa.gov.au/cms/uploadedFiles/_Treasury/Publications/Outcome_Based_Management.pdf

Figure 7: **WA Health Outcomes and Services aligned to the State Government goal**



The WA Health Outcomes for achievement in 2012–13 were 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 well-being of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.*

All health entities contribute to the achievement of these outcomes, with different health service divisions taking responsibility for specific areas. As such, the overall performance of WA Health should be determined by reading, in conjunction, the annual reports for the Department of Health, Metropolitan Health Service and WA Country Health Service.

WA Health activities that are aligned to Outcome 1 and 2 are cited below.

Activities related to **Outcome 1** aim to:

- ensure that people have appropriate and timely access to acute care services when they are in need of them so that intervention occurs as early as possible
- provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury
- provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible
- provide appropriate obstetric care during pregnancy and the birth episode to both mother and child
- provide appropriate care and support for patients and their families during terminal illness.

Activities related to **Outcome 2** aim to:

- 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 such as diet and exercise.
- reduce the likelihood of onset of disease or injury by:
  - immunisation programs and safety programs.
- 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, for example breast and cervical cancer screening, and screening of newborns, with appropriate referrals
  - programs that support self-management by people with diagnosed conditions and disease such as diabetic education.
- monitor the incidence of disease in the population to determine the effectiveness of primary health measures.
- providing continuing care services and programs that improve and enhance the wellbeing and the environment for people with chronic illness or disability.

Key performance indicators

The suite of 2012–13 WA Health key performance indicators consists of key effectiveness indicators and key efficiency indicators that aim to cover each outcome and each service respectively. Combined, these key performance indicators report the extent to which the strategies and activities of WA Health contribute to achieving the agency's outcomes.

Each key performance indicator within the approved suite of indicators has been defined to:

- ensure accuracy and consistency in data collection, collation and analysis
- support the interpretation of a key performance indicator in terms of what is being measured
- allow for comparisons across WA Health services
- support the audit process conducted by the Office of Auditor General.

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

Key performance indicator reporting requirements

- WA Health is required under an Act of Parliament, as well as the Treasurer's Instructions, to present key performance indicators to Parliament.
- The Office of the Auditor General will perform an interim audit of information systems, followed by a final audit of key performance indicators.
- For those key performance indicators related to Outcome 2 the findings may be presented by Aboriginality if the data is available and meaningful.
- Comparative results across time are provided wherever possible and as appropriate.
- All efficiency indicators are reported as both actual and Consumer Price Index adjusted figures.
- The health service population is based on Australian Bureau of Statistics data used in the Epidemiology Branch Rates Calculator estimated 2012 resident population figures.

Table 4: **Service activities in relation to components of the outcome**

Outcome 1	
Service 1*	Public hospital admitted patients
Service 2	Home-based hospital programs
Service 3	Palliative care
Service 4*	Emergency department
Service 5*	Public hospital non-admitted patients
Service 6*	Patient transport
Outcome 2	
Service 7*	Prevention, promotion and protection
Service 8	Dental health
Service 9*	Continuing care
Service 10*	Contracted mental health

* Denotes services reported within the WA Country Health Service Annual Report.

Comparative results

Where possible, comparative results for prior years are provided.

Performance targets

- Effectiveness indicator targets have been based on published national averages for performance indicators where available, or from the analysis of previous performance results.
- Efficiency indicator targets are derived from the 2012–13 Government Budget Statements and may get revised in the 2013–14 Government Budget Statements.
- Targets have also been developed by Performance, Activity and Quality Division within the Department of Health and/or key stakeholders where national targets are not available.

Consumer price index deflator series

All efficiency indicators are reported as both actual and Consumer Price Index adjusted figures. The index figures are derived from the Consumer Price Index all groups, weighted average of the eight capital cities index numbers. For the financial year series, the index is the average of the December and March quarters and is rebased to reflect a mid year point of the five year series that appears in the annual reports. The average of the December and March quarters is used, because the full year index series is not available in time for the annual reporting cycle.

Efficiency indicators

The efficient use of resources can help minimise the overall costs of providing health care. While it is important to monitor the unit cost of the various components of hospital care and health care services in order to ensure overall quality and cost effectiveness, it should be noted that variations in patient characteristics and clinic service types between sites and across time, can result in differences in service delivery costs.

Mental health

The Mental Health Commission of Western Australia has assumed the policy control and management for the provision of mental health services in Western Australia. The mental health efficiency indicators reported in the WA Country Health Service report represent services provided under agreement with the Mental Health Commission.

Service descriptions

1. Public hospital admitted patients

Public hospital admitted patient services describe services provided to patients admitted into public hospitals, or admitted as public patients into privately managed hospitals that are under contract to the Department of Health (excluding specialised mental health wards). 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.

2. Home-based hospital programs

The home-based hospital service can be provided for patients who can be safely cared for without constant monitoring, and for conditions traditionally requiring hospital admission and inpatient treatment. This service is provided by the Health services and non-government providers and involves daily home visits by nurses, with medical governance usually by a hospital-based doctor. This Service is delivered through programs such as Hospital in the Home, Rehabilitation in the Home and Mental Health in the Home, which provide short-term acute care in the patient's home, and the Friend in Need Emergency program, which delivers care interventions for older and chronically ill patients with a range of short term clinical care requirements.

3. 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 health care professionals, particularly those in rural areas.

4. Emergency department

Emergency department services describe the treatment provided to people with the sudden onset of illness or injury requiring urgent medical attention. An emergency department can provide a range of services, and patients attending an emergency department may be admitted to hospital or be treated without admission. The Service includes privately managed contracted emergency services; however, not all public hospitals provide emergency department services.

5. Public hospital non-admitted patients

Medical officers, nurses and allied health staff provide non-admitted (outpatient) care services which include clinics for pre and post-surgical care, allied health care and medical care, as well as emergency services provided in small rural hospitals that are not included under the emergency department service.

6. Patient transport

Patient transport services assist patients in reaching appropriate and timely access to medical treatment. The Service includes St John Ambulance Western Australia and the Royal Flying Doctor Service (Western Operations), which assist patients in need of urgent medical treatment. Also included is the Patient Assisted Travel Scheme, which provides a subsidy towards the cost of travel and accommodation for eligible permanent country residents, and their approved escorts, who are required to travel a long distance to access certain categories of specialist medical services.

7. Prevention, promotion and protection

Prevention, promotion and protection services aim to achieve optimal health and wellbeing of the Western Australian population. The Service implements strategies that encourage healthy lifestyles, aim to reduce the risk and onset of disease and disability, provide facility for early detection of health issues, and monitor the incidence of disease in the population. Some areas covered by this service include communicable disease control, environmental health, disaster planning and management, child and community health, and health promotion activities.

8. Dental health

Dental health services are aimed at preventing oral and dental health issues as well as facilitating access to oral health care for target populations. This service includes the:

- School Dental Program, which provides dental health assessment and treatment for school children
- Adult dental service, which ensures equity of access to financially and/or geographically disadvantaged Western Australians
- Specialist and general oral health services provided by the Oral Health Centre of Western Australia to financially disadvantaged Western Australians.

Dental health services are provided through government funded dental clinics, mobile services and private dental practitioners participating in the metropolitan and country patient dental subsidy schemes.

9. Continuing care

Continuing care services are those services that are provided to Western Australians in need of long term assistance to maintain their health and lead independent lives. This Service is delivered to the Western Australian community through programs such as:

- the Home and Community Care program, which provides services such as nursing care and domestic assistance
- the Transition Care Program, which aims to help older people's independence after a hospital stay
- non-government continuing care programs, which offer residential care type services for aged or disabled persons
- residential care and nursing home care provided by the State
- chronic illness support services, which provide people with a chronic condition with treatment and preventive care to enable them to remain healthy at home.

10. Contracted mental health

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

Outcome 1:

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

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

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

Outcome 1: Effectiveness KPI

Percentage of patients discharged to home after admitted hospital treatment

Rationale

The performance indicator shows the percentage of all separations for patients admitted to WA Country Health Service public hospitals (excluding inter-hospital transfers) that are discharged home after hospital treatment. It is an indicator of the WA Country Health Service's performance towards achieving its objective of restoring people to health through provision of high quality and safe public admitted patient services.

The Australian Safety and Quality Goals for Health Care, set by the Australian Commission on Safety and Quality in Health Care, include the following two goals:

- safety of care: that people receive health care without experiencing preventable harm
- appropriateness of care: that people receive appropriate evidenced-based care.

This key performance indicator, the percentage of people discharged home, provides an indication of how effective the public hospital admitted patient services are in restoring people to health after an acute illness that required hospitalisation. Following effective and appropriate treatment, patients are normally discharged home or to their usual residence when they are well enough.

Data includes those patients separated after episodes of acute illness, rehabilitation, psycho-geriatric care and geriatric evaluation and management.

Targets

The 2012 target is 97.4 per cent.

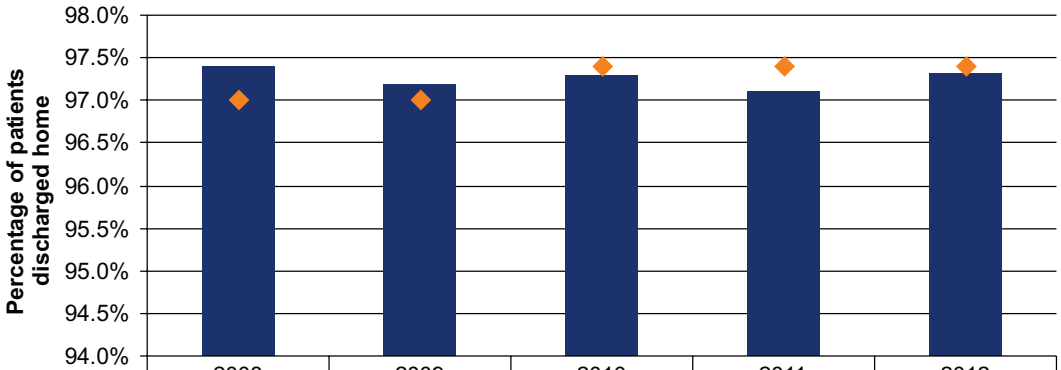
The target is based on the best result achieved over the past four years.

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

Results

For 2012, out of a total of over 86,000 separations from WA Country Health Service public hospitals, 97.3 per cent of them had the patients discharged to their usual residence after their admission. This is a result that almost met the target and was slightly better than the prior year.

Figure 8: **Percentage of patients discharged to home after admitted hospital treatment**



	2008	2009	2010	2011	2012
All ages	97.4%	97.2%	97.3%	97.1%	97.3%
Target	97.0%	97.0%	97.4%	97.4%	97.4%

Data source: Hospital Morbidity Data System.

Outcome 1: Effectiveness KPI

Survival rates for sentinel conditions

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 the hospitals' performance in relation to restoring the health of people who were admitted for selected sentinel conditions.

The sentinel conditions reported in this key performance indicator are stroke, heart attack (also known as acute myocardial infarction or AMI) and fractured hip (also known as fractured neck of femur or FNOF). Stroke, acute myocardial infarction and fractured neck of femur are leading causes of deaths and disability in the population and patients' outcome can be affected by the diagnosis, the treatment given and procedures performed in hospitals.

The WA Country Health Service, as part of the Western Australian public health system, aims to deliver high quality, accessible and safe services for country Western Australians. As safety and quality is central to achieving the WA Country Health Service objective of restoring people to health through provision of public admitted patient services, ongoing assessment and review through this key performance indicator is important.

It is also important to note that patients' outcome can also be affected by factors including the age, sex and co-morbidities of each individual patient at the time of admission or complications developed while in hospital. Hence crude in-hospital survival indicators such as this one should be used as screening tools, rather than being assumed to be definitively diagnostic of poor quality and/or safety.

Target

The 2012 target for each condition by age group:

Age group (years)	Sentinel condition		
	Stroke (%)	AMI (%)	FNOF (%)
0–49	≥98.1	≥99.3	–
50–59	≥97.9	≥99.1	–
60–69	≥96.8	≥99.2	–
70–79	≥88.6	≥98.7	≥98.7
80+	≥79.3	≥90.5	≥97.8

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

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

Results

In 2012, the survival rate for stroke for patients aged 60–69 years (98.7 per cent) and 70–79 years (90.4 per cent) was above the target of 96.8 per cent and 88.6 per cent respectively. For all other age groups performance was below target.

Table 5: **WA Country Health Service survival rate for stroke, by age group**

Age group (years)	Year					
	2008 (%)	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2012 Target (%)
0–49	98.1	94.9	97.6	98.5	93.5	≥98.1
50–59	94.7	95.9	94.4	97.9	95.8	≥97.9
60–69	93.7	95.7	93.0	96.8	98.7	≥96.8
70–79	87.1	88.6	86.9	88.4	90.4	≥88.6
80+	75.5	72.8	79.3	72.4	76.6	≥79.3

For patients with an acute myocardial infarction, the survival rate was below the target with the exception of patients aged 0–49 years (100 per cent compared to 99.3 per cent) and those aged 80 years and over (92.1 per cent compared to 90.5 per cent). In 2012 the survival rate for patients aged 80 years and over was above that reported in the past four years.

Table 6: **WA Country Health Service survival rate for AMI, by age group**

Age group (years)	Year					
	2008 (%)	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2012 Target (%)
0–49	100.0	100.0	100.0	100.0	100.0	≥99.3
50–59	99.1	98.4	99.0	100.0	98.2	≥99.1
60–69	98.0	96.8	97.2	99.2	98.7	≥99.2
70–79	92.1	95.9	98.7	95.0	96.6	≥98.7
80+	86.9	84.7	90.5	89.9	92.1	≥90.5

In 2012 survival rates of patients with a fractured neck of femur did not meet the target for either age group.

Table 7: **WA Country Health Service survival rate for fractured neck of femur, by age group**

Age group (years)	Year					
	2008 (%)	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2012 Targets (%)
70–79	96.3	96.8	96.6	98.7	95.0	≥98.7
80+	95.0	95.5	96.1	97.8	96.3	≥97.8

Note: Caution needs to be taken when interpreting the results as patient numbers for these conditions are generally low, and therefore any variations in patient outcomes for these conditions can cause large variations to the annual crude survival rates.
Data source: Hospital Morbidity Data System.

Outcome 1: Effectiveness KPI

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

Rationale

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

Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources. Good medical and/or surgical intervention 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.

For this indicator a representative period (September to November 2012) is used and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise. The representative period selected endeavours to reflect the busiest period in a year for hospitals. For 2010 and prior years, July to September and April to June were used.

Target

The 2012 target was less than or equal to 2.2 per cent.

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

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

Results

The reported unplanned readmission rate for WA Country Health Service for 2012 was 2.3 per cent, slightly above the target achieved in 2009. The 2012 result is however, lower than the prior two years.

Table 8: **Unplanned readmission rate for the same or related condition**

	2008	2009	2010	2011	2012
Target (%)	**< 2.3**	**< 2.3**	**< 2.2**	**< 2.2**	**< 2.2**
WACHS unplanned readmission rate (%)	2.9	2.2	2.8	2.9	2.3

Note: Results represent data for a three month period of each calendar year.
Data source: Hospital Morbidity Data System.

Outcome 1: Effectiveness KPI

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

Rationale

An unplanned readmission is an unplanned return to the same hospital as an admitted patient for a mental health condition for which the patient has previously been discharged within 28 days. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Appropriate medical intervention together with good discharge planning should decrease the likelihood of unplanned hospital readmissions for a mental health condition. Therefore a low unplanned readmission rate suggests that good clinical practice is in operation.

For this indicator a representative period (September to November 2012) is used and relevant data is subjected to clinical review to ensure the accuracy of the readmission status – unplanned or otherwise. The representative period selected endeavours to reflect the busiest period in a year for hospitals. For 2010 and prior years, July to September and April to June were used.

Target

The 2012 target was less than or equal to 4.8 per cent.

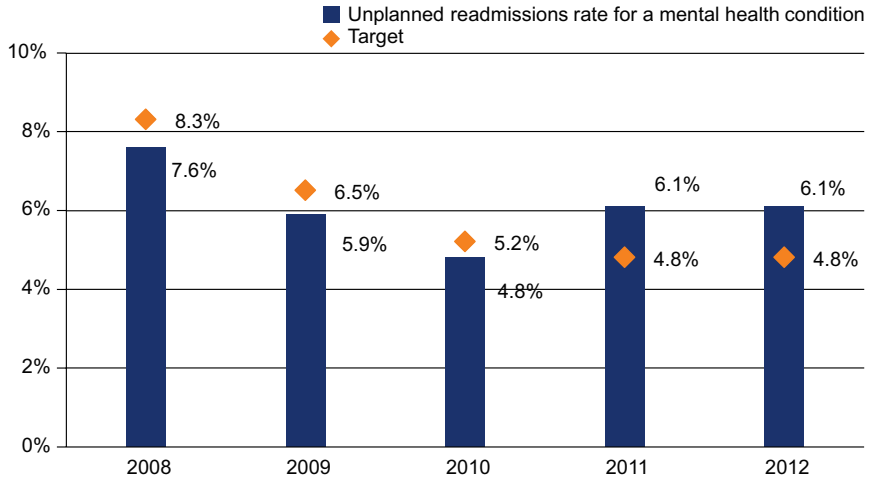
The target was based on the best result achieved within the previous four years, where the result was greater than zero.

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

Results

In 2012, the WA Country Health Service readmission rate for mental health patients was 6.1 per cent, no change from prior year, however higher than the target.

Figure 9: **Unplanned readmissions for a mental health condition**



Note: Results represent data for a three month period of each calendar year.
Data source: Hospital Morbidity Data System.

Outcome 1: Effectiveness KPI

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

Rationale

This indicator reports on the percentage of live births in WA Country Health Service hospitals with an APGAR score of three or less, at five minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories.

A numerical scoring system known as APGAR is often used to assess a newborn's condition shortly after birth, including his/her heart rate, respiratory effort, muscle tone, reflex irritability and colour. The higher the APGAR score the better the health of the newborn. An APGAR score of three or less is considered to be critically low, and can indicate complications and compromise for the baby.

Research has found that low APGAR scores are strongly associated with babies' birthweights being low. Although the management of labour in hospitals does not usually affect birthweights, it can affect the prevalence of low APGAR scores for babies with similar birthweights. Factors other than hospital maternity services can also influence APGAR scores, for example maternal risk factors, multiple births and socio-economic factors.

Target

The 2012 target for babies with an APGAR score of three or less, by birthweight:

Birth weight (grams)	Percentage
<1500	37.5
1500–1999	4.3
2000–2499	0.8
≥2500	0.1

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

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

Results

Overall in 2012, 0.3 per cent live born babies in WA Country Health Service hospitals had an APGAR score of three or less at five minutes post delivery. For the under 2000 grams groups, the targets were met. For the other two groups, the results were higher than the desirable target level.

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

Birth weight (grams)	2008 (%)	2009 (%)	2010 (%)	2011 (%)	2012 (%)	2012 Target (%)
0–1499	37.5	42.9	40.0	40.0	14.3	≤37.5
1500–1999	0.0	4.3	6.7	0.0	4.2	≤4.3
2000–2499	1.3	0.0	0.0	0.8	1.4	≤0.8
2500+	0.0	0.1	0.1	0.2	0.2	≤0.1

Note: Caution needs to be taken in the interpretation of the percentage of live births with an APGAR score of three or less for babies born under 2,500 grams. Small population numbers have resulted in significant variations across the years and comparison is not recommended.
Data source: Midwives Notification System.

Outcome 1: Effectiveness KPI

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

Rationale

This indicator measures the proportion of emergency department attendances in each triage category with treatment that commenced within the recommended timeframe.

When patients first enter an emergency department or service, they are assessed by specially trained nursing staff to determine how urgently treatment should be provided. The aim of the process, known as triage, is to ensure treatment is given in the appropriate timeframe for prevention of adverse conditions arising from deterioration in the patient's condition.

The triage process and scores are recognised by the Australian College for Emergency Medicine and recommended for prioritising those who present to an emergency department. In a busy emergency department or service when several people present at the same time, the process aims for the best outcome for all.

A patient can be allocated a triage code between 1 (most urgent) and 5 (least urgent). Treatment within recommended times should assist in the restoration to health, either during the emergency visit or the admission to hospital which may follow emergency department care.

This indicator reports performance of major WA Country Health Service regional hospital emergency departments, measuring the time for medical treatment to commence by either a doctor or nurse. 'Waiting to be seen time' is the earlier of date/time seen by doctor or date/time seen by nurse (treatment commences) less the date/time of presentation (which is the earlier of arrival date/time and triage date/time).

Target

The 2012–13 target by triage category:

Triage category	Percentage
Category 1 (resuscitation)	100
Category 2 (emergency)	≥80
Category 3 (urgent)	≥75
Category 4 (semi–urgent)	≥70
Category 5 (non–urgent)	≥70

The target was set in accordance with the recommendations of the Australasian College for Emergency Medicine.

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

Results

In 2012–13, the proportion of WA country patients in emergency departments seen within the recommended time was above the minimum benchmarks for all triage categories except triage 1. For triage 1 patients, the result of 98.6 per cent was an improvement from prior years.

Table 10: **Proportion of emergency department attendances seen within recommended time by triage category**

	2008–09 (%)	2009–10 (%)	2010–11 (%)	2011–12 (%)	2012–13 (%)	Target (%)
Triage 1 (seen within 2 minutes)	98.7	96.3	93.4	95.8	98.6	100.0
Triage 2 (seen within 10 minutes)	92.4	88.9	86.1	89.7	93.3	80.0
Triage 3 (seen within 30 minutes)	88.2	86.1	84.0	86.8	87.1	75.0
Triage 4 (seen within 60 minutes)	90.0	88.1	85.0	90.5	90.3	70.0
Triage 5 (seen within 2 hours)	95.5	98.1	94.0	97.7	97.2	70.0

Note: WA Country Health Service selected sites that contribute to this KPI are those that provide a significant volume of WA Country Health Service emergency service activity and high level complex care and report casemix adjusted separations. Bunbury and Kalgoorlie report 'doctor seen'; other sites report 'doctor or nurse seen' results.
Data source: Emergency Department Data Collection.

Outcome 1: Effectiveness KPI

Rate of emergency attendances with a triage score of four and five not admitted

Rationale

This indicator reports the number of triage 4 and 5 emergency attendances at a WA Country Health Service hospital where the patient is not subsequently admitted.

The hospital emergency department or service assess a patient, initiate treatment and decide whether to admit the patient for further care. As described in the previous indicator, the triaging of patients attending an emergency service ensures patients are treated in order of their clinical urgency and that patients receive timely care. While urgency refers principally to time-critical intervention and is not synonymous with severity; more patients who are triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5.

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.

Target

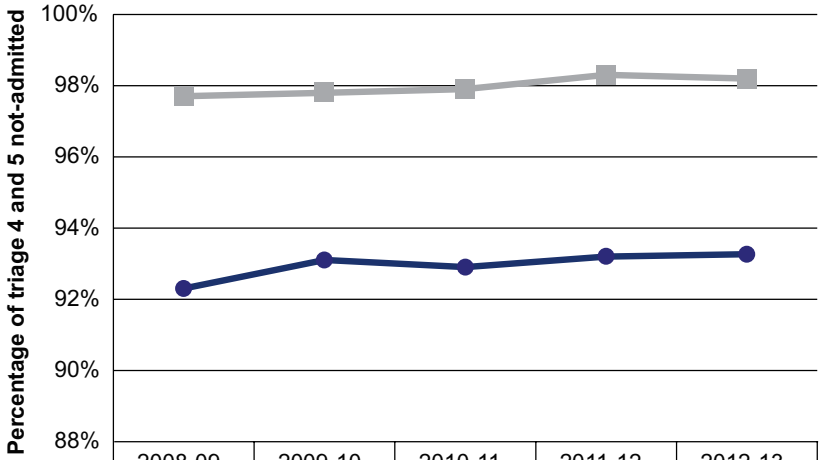
A target was not determined for this key performance measure.

The outcome of a patient attending a rural emergency department or service is based on clinical need.

Results

Rates of emergency department attendances triaged 4 and 5 not admitted remained steady in 2012–13, being 93.3 per cent and 98.2 per cent respectively.

Figure 10: **WA Country Health Service triage 4 and 5 non-admitted**



	2008-09	2009-10	2010-11	2011-12	2012-13
Triage 4 Not-admitted	92.3%	93.1%	92.9%	93.2%	93.3%
Triage 5 Not-admitted	97.7%	97.8%	97.9%	98.3%	98.2%

Data source: Emergency Department Data Collection.

Service 1: Public hospital admitted patients Efficiency KPI

Average cost per casemix adjusted separation for non-tertiary hospitals

Rationale

This indicator measures the average cost of a casemix-adjusted separation in WA Country Health Service non-tertiary hospitals. 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.

Casemix refers to the range and types of patients treated by a hospital or health service. Treating patients with more complex conditions is likely to more costly than treating patients with less complex conditions. Hence, separations in a hospital need to be adjusted from the actual raw number by a casemix index to reflect the complexity of the care provided in the efficiency measure of costs associated with admitted patient services.

The use of casemix for reporting hospital activity is a recognised methodology for adjusting actual activity data to reflect the complexity of health care provided against the resources allocated. WA public hospitals utilise the Australian Refined National Diagnostic Related Groups (to which cost weights are allocated) to adjust for the average complexity of patients treated in each hospital.

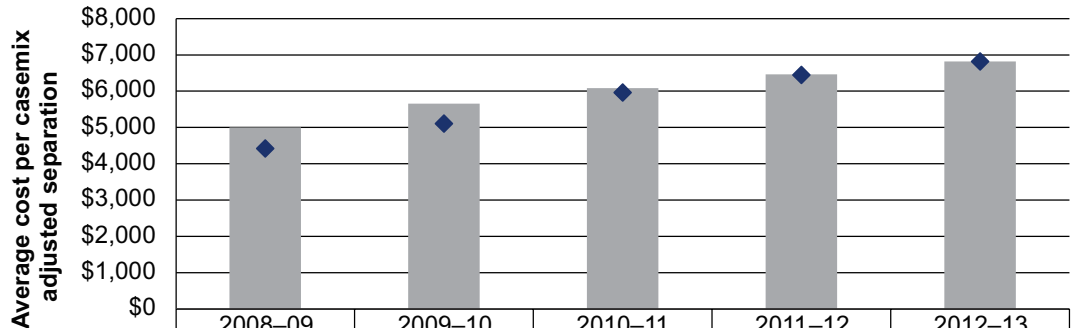
Target

The target for 2012–13 was $6,813 per weighted separation as set in the State Government Budget Statements published in May 2012. A result below the target was desirable.

Results

For 2012–13, WA Country Health Service recorded a cost per casemix adjusted separation of $6,822, marginally above the target.

Figure 11: **Average cost per casemix adjusted separation for non-tertiary hospitals**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$5,006	$5,657	$6,086	$6,465	$6,822
Target	$4,421	$5,102	$5,960	$6,446	$6,813
CPI adjusted	$5,006	$5,519	$5,765	$5,984	$6,240

Data source: WA inpatient data system and WA Country Health Service financial system

Service 1: Public hospital admitted patients Efficiency KPI

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

Rationale

This indicator measures the cost per bed-day for admitted patients in WA small rural hospitals.

The use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical procedures delivered to patients. it is not the appropriate method of costing admitted activity in small rural hospitals. This is due to small country hospitals not having the advantage of economies of scale. Accordingly these hospitals report patient costs by bed-days.

Target

The target for 2012–13 was $1,721 per bed-day as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

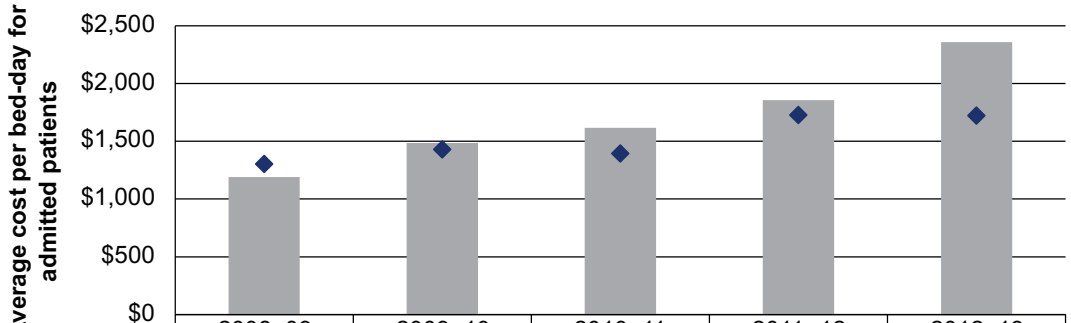
Results

For 2012–13, the cost per small hospital bed-day was $2,357, significantly above the target.

The significant variance from the target to 2012–13 cost was the result of a combination of lower activity volume actually realised and higher service costs than projected for the year.

The variance from 2011–12 to 2012–13 was 12.8 per cent higher for expenditure and 12.6 per cent lower for the reported activity. This increase was largely due to improved expenditure allocation changes across key performance indicators.

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



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$1,189	$1,486	$1,616	$1,855	$2,357
Target	$1,301	$1,428	$1,392	$1,727	$1,721
CPI adjusted	$1,189	$1,450	$1,531	$1,717	$2,132

Note: WA Country Health Service sites reporting bed-days rather than weighted separations do so based on a historically lower level of separation activity and complexity compared to a larger casemix separation site.
Data source: WA Country Health Service occupied bed-day data warehouse and WA Country Health Service financial systems.

Service 4: Emergency departments Efficiency KPI

Average cost per emergency department attendance

Rationale

This indicator, commenced in 2010–11, measures the average cost per attendance at WA major regional hospital emergency departments.

Emergency departments provide treatment in a hospital to those people with sudden onset of illness or injury of such severity and urgency that they need immediate medical attention and treatment. Emergency departments provide a range of services, from immediate resuscitation to urgent medical advice. An emergency department attendance may result in an admission to hospital or in treatment without admission.

Providing emergency department services to meet the needs of these patients requires a significant allocation of hospital resources to deliver the necessary health care. With the ever increasing demand on emergency departments and health services, the efficient use of these resources can improve the patient's health outcome and their journey through the public hospital system, especially as this part of the acute health service is often the first point of contact with hospitals for residents in a community.

Target

The target for 2012–13 was $494 per emergency department attendance as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

For 2012–13, the WA Country Health Service reported an average cost per emergency department attendance of $638 and above the target. This year saw further improved key performance indicator expenditure modelling involving WA Country Health Service's new standardised cost centre structure. The resulted in some expenditure previously reported under the public hospital non-admitted key performance indicator being included in this key performance indicator. Consequently, this change contributed to the significant variance between the actual result and target, as well as the difference in unit cost between this year and the prior year.

Table 11: **Average cost per emergency department attendance**

	2010–11	2011–12	2012–13
Target	$312	$383	$494
Actual cost	$396	$429	$638
CPI adjusted	$375	$397	$578

Note: This indicator reports for the 13 sites reporting under the emergency department triage effectiveness indicator.
Data source: Emergency Department Data Collection and WA Country Health Service financial systems.

Service 5: Public patients non-admitted Efficiency KPI

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

Rationale

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

An occasion of service is defined as any examination, consultation, treatment or other service provided to a patient, or a group of patients, in each functional unit of a health service facility or hospital on each occasion that such a service is provided.

The provision of non-admitted health care services aims to ensure patients have access to the care they need in the most appropriate setting.

Non-admitted patient occasions of service in scope include emergency services (excluding those reported in the WA Country Health Service emergency department efficiency key performance indicator), medical, surgical, allied health and nursing, pharmacy, pathology, radiology, domiciliary care and other services provided in an outpatient setting. In rural hospitals, medical officers, nurses and allied health staff provide non-admitted (outpatient) patient services.

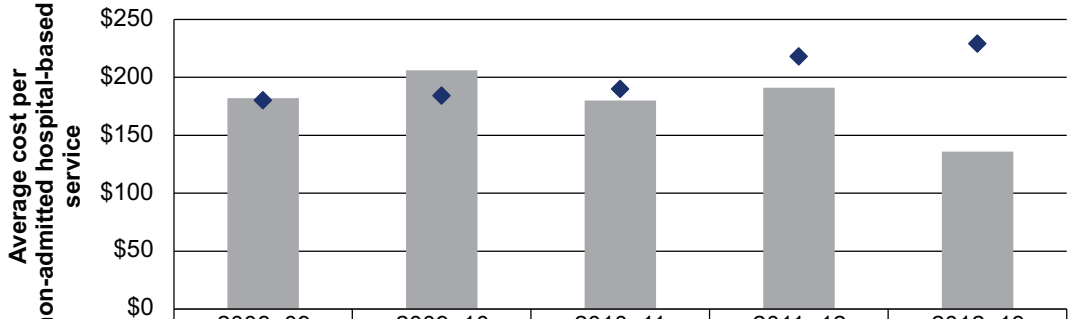
Target

The target for 2012–13 was $229 per non-admitted occasion as set in the State Government Budget Statements published in May 2012. A result below the target was desirable.

Results

In 2012–13 the WA Country Health Service recorded a cost per non-admitted hospital based occasion of service of $136 and well below the target. This year saw further improved key performance indicator expenditure modelling involving the WA Country Health Service's new standardised cost centre structure. This resulted in some expenditure previously reported in this key performance indicator being included in the emergency department efficiency key performance indicator. Consequently, this change contributed to the significant variance between the actual result and target, as well as the difference in unit cost between this year and prior year.

Figure 13: **Average cost per non-admitted hospital based occasion of service for rural hospitals**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$182	$206	$180	$191	$136
Target	$180	$184	$190	$218	$229
CPI adjusted	$182	$201	$171	$177	$123

Data source: WA Health and site non-admitted activity data systems and WA Country Health Service financial systems.

Service 5: Public patients non-admitted Efficiency KPI

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

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 post-surgical 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

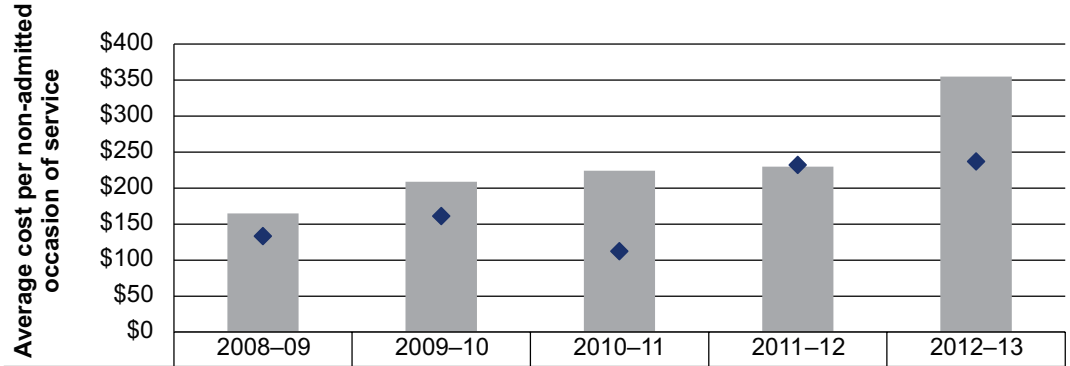
The target for 2012–13 was $237 per non-admitted occasion in a nursing post as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

For 2012–13 cost per non-admitted occasion of service provided at nursing posts was $355 and above the target. This was due to the significantly lower activity volume than projected for the budget.

Figure 14: **Average cost per non-admitted occasion of service in a nursing post**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$165	$209	$224	$230	$355
Target	$133	$161	$112	$232	$237
CPI adjusted	$165	$204	$212	$213	$321

Data source: HCARe and site non-admitted activity data systems and WA Country Health Service financial systems.

Service 6: Public patient transport Efficiency KPI

Average cost per trip of Patient Assisted Travel Scheme

Rationale

This indicator measures the cost of providing Patient Assisted Travel Scheme to eligible WA Country Health Service country residents.

The Patient Assisted Travel Scheme provides a subsidy towards the cost of travel and where applicable accommodation for eligible permanent country residents of a WA Country Health Service region, and their approved escorts, who are required to travel a minimum distance to access the nearest eligible medical specialist services (including a telehealth enabled service). Without travel assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Target

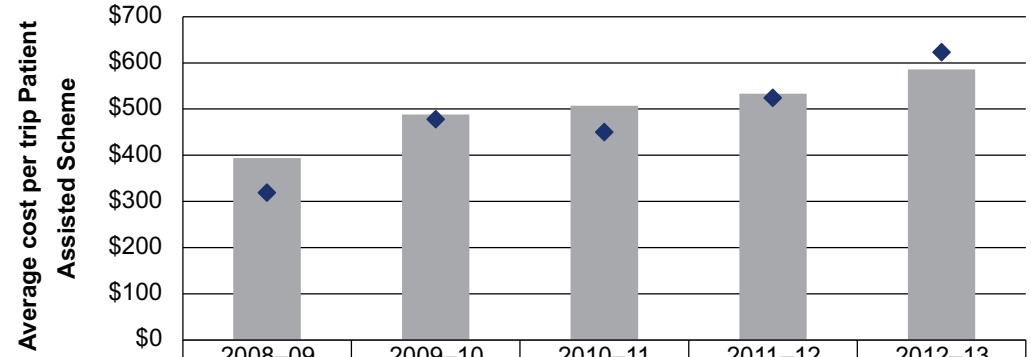
The target for 2012–13 was $623 per Patient Assisted Travel Scheme trip as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

The average cost per Patient Assisted Travel Scheme trip in 2012–13 was $586 and under target.

Figure 15: **Average cost per trip of Patient Assisted Travel**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$394	$488	$507	$533	$586
Target	$319	$478	$450	$524	$623
CPI adjusted cost	$394	$476	$480	$493	$530

Data source: Patient Assisted Travel Scheme activity web based data system and WA Country Health Service financial systems.

Outcome 2

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

The achievement of this health objective involves activities which:

1. Increase the likelihood of optimal health and wellbeing by:
   - providing programs which support the optimal physical, social and emotional development of infants and children
   - encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury by:
   - immunisation program
   - safety programs
   - encouraging healthy lifestyles through factors (e.g. diet and exercise).
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - programs for early detection of developmental issues in children and appropriate referral for intervention
   - early identification and intervention of disease and disabling conditions (breast and cervical cancer screening, screening of newborns) with appropriate referrals
   - programs which support self-management by people with diagnosed conditions and disease (diabetic education)
   - monitoring 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 the 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 permits. This support allows people to stay in their homes for as long as possible and provides extra care when long term residential care is required. Services:
   - 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.

Outcome 2: Effectiveness KPI

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

Rationale

Gastroenteritis is an infection of the digestive system and a very common illness in infants and children. It would be expected that hospital admissions for this condition would decrease as the performance and quality of service in many different health areas improves.

Reduction in the number of children who are admitted to hospital per 1,000 (children) for treatment of gastroenteritis may be an indication of improved primary care or community health strategies – for example, health education. It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

Health promotion and illness prevention programs are delivered to ensure there is an understanding of hygiene within homes and in the community to promote the prevention of gastroenteritis.

The WA Country Health Service provides support to environmental health workers in Aboriginal communities and those working with Aboriginal Medical Services. The Department of Health is also engaged in the surveillance of enteric diseases. Some forms of gastroenteritis, for example salmonellosis and shigellosis, are notifiable diseases and infection rates are monitored.

Target

The target for 2012–13 was less than or equal to 5.0 hospitalisations per 1,000 children less than five years of age.

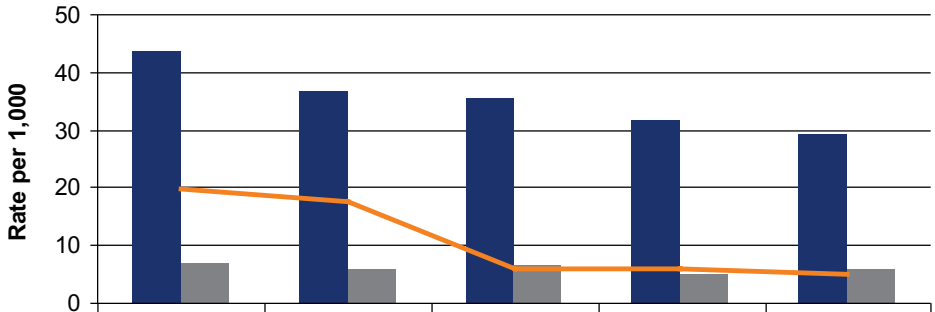
The target was based on the best result achieved within the previous four years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

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

Results

As shown in Figure 11, Aboriginal children had a higher hospitalisation rate 29.4 per 1,000 target population than the non-Aboriginal children, who reported only 6.1 per 1,000 target population for 2012. However, the trend is declining for the Aboriginal target group from 43.8 per 1,000 in 2008 to 29.4 per 1,000 in 2012.

Figure 16: **Rate of hospitalisation for gastroenteritis in children (0–4 years)**



	2008	2009	2010	2011	2012
Aboriginal	43.8	36.8	35.4	31.8	29.4
Non-Aboriginal	6.9	5.9	6.6	5	6.1
Target	19.9	17.5	5.9	5.9	5.0

Note: This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another health service area. This indicator is not necessarily a measure of the performance of the health service providing the hospitalisation.
Data source: Hospital Morbidity Data System and Australian Bureau of Statistics.

Outcome 2: Effectiveness KPI

Rate of hospitalisation for selected respiratory conditions

Rationale

Respiratory disease refers to a number of conditions that affect the lungs or their components. 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 rate of admission to hospital per 1000 population for treatment of respiratory conditions may be an indication of improved primary care or community health strategies – for example, health education, disease prevention and disease management.

The implementation of initiatives such as the WA Health Asthma Model of Care aims to prevent and better manage these respiratory conditions and reduce the impact on individuals and the health system.

Asthma is a chronic inflammatory condition of the airways with attacks occurring at varying levels of severity. In Australia, it is the most widespread chronic health problem and is also one of the National Health Priority Areas. Asthma is generally not preventable; however, with effective disease management, hospitalisation for acute asthma attacks should be reduced.

Croup is a respiratory condition that is usually triggered by an acute viral infection of the upper airway. Immunisation against influenza is recommended as this may actually prevent croup caused by the influenza virus (influenza-induced croup).

Bronchiolitis is the inflammation of the bronchioles, often caused by viruses. Although impossible to prevent the conditions entirely, the risk of a child developing the conditions can be reduced by taking preventative steps.

In particular, it is important to prevent children from being exposed to tobacco smoke because children who inhale smoke passively are more at risk of developing severe bronchiolitis or acute bronchitis.

Specific programs developed and implemented by the WA Country Health Service in conjunction with primary care providers and representative organisations (e.g. Asthma Foundation), target the prevention, management and treatment of respiratory conditions especially in Aboriginal populations. Programs target individuals, families, groups and communities and focus on the determinants of poor health.

For these conditions the number of hospitalisations would be expected to decrease as the impact of prevention, education and management programs increases.

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

Target

The 2012–13 targets, by respiratory condition, are outlined in the table below. The targets have been based on the best result recorded within the previous four years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

Respiratory condition	Age group (years)	Target
Asthma	0–4	≤ 6.1
	5–12	≤ 3.0
	13–18	≤ 0.9
	19–34	≤ 0.8
	35+	≤ 0.9
Acute bronchitis	0–4	≤ 0.5
Bronchiolitis	0–4	≤ 9.7
Croup	0–4	≤ 2.6

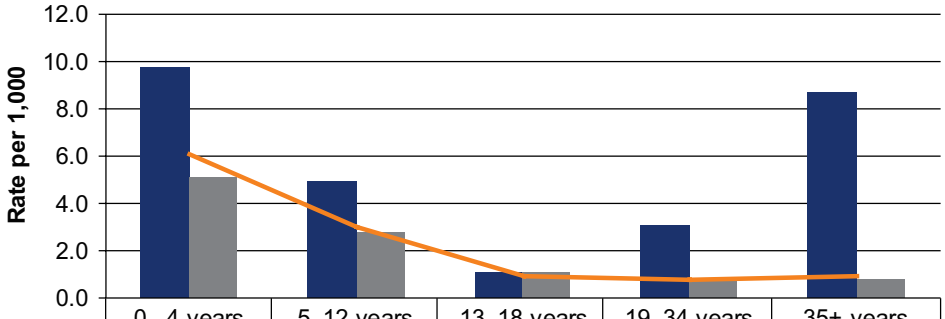
Improved or maintained performance was demonstrated by a result lower than or equal to the target.

Results

Acute asthma

For the Aboriginal population, the 2012 hospitalisation rate for younger people (under and including 18 years) improved from that of prior year, in particular, dropping to 9.8 per 1000 for 0–4 year olds from 15.2 in 2011. For 19–34 and 35+ age groups, the rates (3.1 and 8.7 respectively) increased slightly, though not significantly. As shown in Figure 12, the Aboriginal population's hospitalisation rates for asthma are still above the targets and generally higher than the non-Aboriginal population.

Figure 17: **Rate of hospitalisation per 1000 population for acute asthma**



	0– 4 years	5–12 years	13–18 years	19–34 years	35+ years
Aboriginal	9.8	4.9	1.1	3.1	8.7
Non-Aboriginal	5.1	2.8	1.1	0.8	0.8
Target	6.1	3	0.9	0.8	0.9

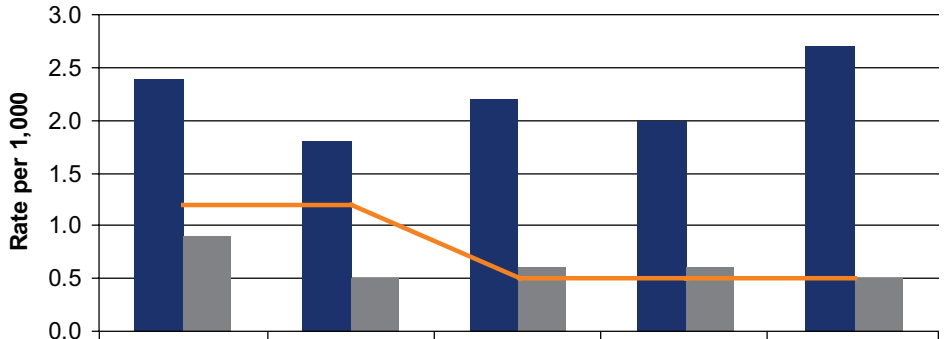
Table 12: **Hospitalisation rates for acute asthma**

Aboriginal					
Year	Age group (years)				
	0–4	5–12	13–18	19–34	35+
2008	16.7	3.7	1.9	3.2	7.7
2009	14.3	3.6	1.4	3.2	6.3
2010	11.7	4.5	1.2	2.5	6.7
2011	15.2	5.3	1.8	2.4	8.0
2012	9.8	4.9	1.1	3.1	8.7
Non-Aboriginal					
Year	Age group (years)				
	0–4	5–12	13–18	19–34	35+
2008	8.1	3.1	0.9	1.0	1.0
2009	7.6	3.2	0.9	1.2	1.0
2010	6.1	3.1	1.0	0.8	1.0
2011	8.4	3.0	1.0	0.8	0.9
2012	5.1	2.8	1.1	0.8	0.8

Data source: Hospital Morbidity Data System and Australian Bureau of Statistics.

Other respiratory conditions (acute bronchitis, croup and bronchiolitis)
For the 0–4 years non-Aboriginal age group, the hospitalisation rate for acute bronchitis has remained relatively unchanged since 2009, with the 2012 result meeting the target (0.5 hospitalisations per 1,000 children). The Aboriginal cohort reported 2.7 hospitalisations per 1,000 in 2012, the highest rate since 2008.

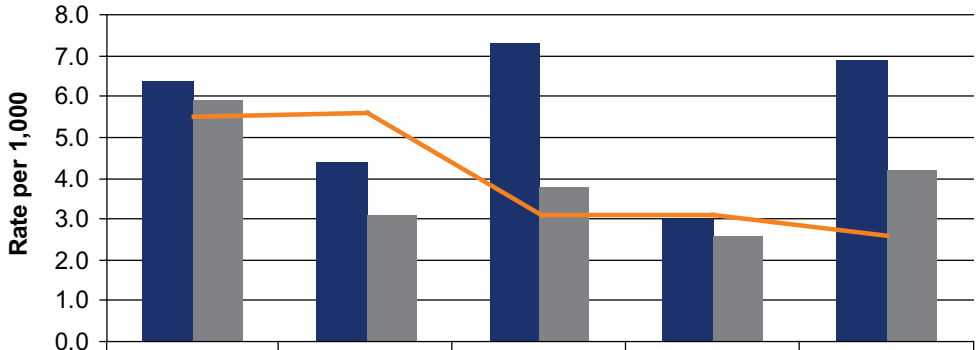
Figure 18: **Rate of hospitalisation per 1,000 children for acute bronchitis**



	2008	2009	2010	2011	2012
Aboriginal	2.4	1.8	2.2	2.0	2.7
Non-Aboriginal	0.9	0.5	0.6	0.6	0.5
Target	1.2	1.2	0.5	0.5	0.5

Admissions due to croup in 2012 for both the Aboriginal and non-Aboriginal cohort, 6.9 and 4.2 per 1,000 respectively compared with last year, these were above the target set 3.0 hospitalisations per 1,000 children aged 0–4 years.

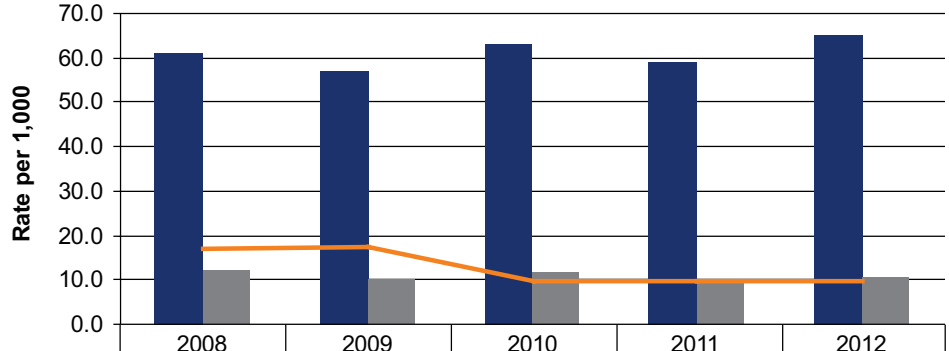
Figure 19: **Rate of hospitalisation per 1,000 children for croup**



	2008	2009	2010	2011	2012
Aboriginal	6.4	4.4	7.3	3.0	6.9
Non-Aboriginal	5.9	3.1	3.8	2.6	4.2
Target	5.5	5.6	3.1	3.1	2.6

Hospitalisations for bronchiolitis among young children were higher than acute bronchitis and croup. The Aboriginal cohort reported 65 hospitalisations per 1,000 in 2012, highest rate since 2008. For the non-Aboriginal group, 10.4 per 1,000 was recorded in 2012, which has remained stable over the prior years. Target of 9.7 hospitalisations per 1,000 children aged 0–4 years was not achieved in 2012.

Figure 20: **Rate of hospitalisation per 1,000 children for bronchiolitis**



	2008	2009	2010	2011	2012
Aboriginal	60.9	57.1	63.2	58.9	65.0
Non-Aboriginal	12.1	10.0	11.8	9.7	10.4
Target	16.9	17.4	9.9	9.9	9.7

Outcome 2: Effectiveness KPI

Rate of hospitalisation for falls in older persons

Rationale

Fall-related injury among older people is a major public health issue that can result in emergency department attendances and hospitalisation and lead to substantial loss of independence.

There are a number of falls prevention, health promotion and protection initiatives delivered by WA Country Health Service Population Health Units. This is also supported by similar initiatives provided by Department of Health divisions – aimed at community safety and well-being and injury prevention.

Some of these, such as the *Stay on Your Feet*® program and Falls Prevention Model of Care for the Older Person in Western Australia, are designed to prevent and reduce the incidence and severity of fall-related injuries and hospitalisations of older persons. Through assessing the impact of falls on the public hospital system by measuring the rate of hospitalisation for falls in older persons, effective intervention and prevention programs can be delivered.

The number of older persons admitted to hospital, per 1,000 population of a specific age group, for treatment as a result of a fall in a domestic or community setting may be an indication of the impact of these strategies.

Falls in hospitals and health facilities are not included in this KPI measurement, nor are falls occurring in settings not primarily targeted by health promotion programs.

Target

The target was for a 0.5 per cent per annum reduction for a sustained period for both Aboriginal and non-Aboriginal people by 2020.

Results

Compared with last year, for the younger age groups (55–64 and 65–79 years), hospitalisation rates due to falls either decreased in 2012 for both age groups or remained the same. As expected, hospitalisation rates for a fall increases with age. For the 80+ age group, 2012 rates were higher, and did not achieve the target of 0.5 per cent reduction.

Table 13: **Rate of hospitalisation per 1,000 for falls in older persons**

	2008		2009		2010		2011		2012	
Age group (years)	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
55–64	32.4	4.3	22	5.3	29.1	4.6	40.1	5.9	28.1	5.7
65–79	45.3	16.5	34.8	17.5	44.1	16.7	51.0	18.7	40.8	18.7
80+	81.6	91.6	115.3	85.5	70.2	83.7	58.8	97.3	91.5	101.7

Note: This indicator measures hospitalisations of individuals living in a given location who may attend a hospital in their own or another health service. The performance of the health service providing the hospitalisation is not being measured. Individuals may experience repeat hospitalisations from the same cause.

Falls in hospitals and health facilities are not included in this KPI measurement, nor are falls occurring in settings not primarily targeted by health promotion programs.

Data source: Hospital Morbidity Data System and Australian Bureau of Statistics.

Outcome 2: Effectiveness KPI

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

Rationale

This indicator reports the proportion of admissions to WA Country Health Service specialised inpatient mental health units, for which a community ambulatory service contact was recorded in the seven days immediately preceding that admission.

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in function that can lead to challenges in living an independent life. As a result, hospitalisation may be required on more than one occasion each year with the need for ongoing community-based support.

Access to community-based mental health services may assist with improving the management of, or alleviate the need for admissions to, inpatient care. Many consumers admitted to public sector mental health acute inpatient units are known to public sector community mental health services and it is reasonable to expect that community services should be involved in pre-admission care.

The time period of seven days was recommended nationally as an indicative measure for contact with public community-based non-admitted services prior to admission to public mental health inpatient units.

Target

In 2012–13 the target was 70 per cent.

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

Results

In 2012–13, 51.7 per cent of the people who were to be admitted to a country public mental health inpatient unit were in contact with a community-based public mental health non-admitted service within seven days prior to their admission. This is a lower result when compared with last year and was well below the target. The mental health community services in country WA have not achieved the national benchmark. This is due to the challenges in meeting mental health service delivery issues in rural and remote areas.

Table 14: **Community mental health contact prior to admission**

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

Data source: Mental Health Information Systems.

Outcome 2: Effectiveness KPI

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

Rationale

This indicator measures the proportion of separations from WA Country Health Service specialised inpatient mental health units for which a community ambulatory service contact, in which the patient participated, was recorded in the seven days immediately following that separation.

A large proportion of people with a mental health problem may have a chronic or recurrent illness that results in only partial recovery between acute episodes and deterioration in function that can lead to challenges in living an independent life. As a result, hospitalisation may be required on more than one occasion each year, with the need for ongoing community-based support.

The time period of seven days was recommended nationally as transition in care from hospital to the community as a critical time in the treatment continuum. Evidence suggests the time following discharge is the period of increased vulnerability, and timely follow-up mitigates the risk of relapse. A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.

Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community-based services and support, are less likely to need readmission. These community services provide ongoing clinical treatment and access to a range of programs that maximise an individual's independent functioning and quality of life.

Target

In 2012 the target was 75 per cent.

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

Results

In 2012, 70.5 per cent of patients with a mental illness discharged from public mental health inpatient units had contact with a community-based public mental health non-admitted service within seven days of discharge. This result continues the improving trend of prior years and was below the national target.

Figure 15: **Community mental health contact post discharge**

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

Data source: Mental Health Information Systems.

Service 7: Promotion, protection and prevention Efficiency KPI

Cost per capita of population health units

Rationale

This indicator reports the cost of, on a per capita basis, delivering population health services. Population health considers the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of health.

The WA Country Health Service population health programs support individuals, families and communities to increase control over and improve their health. In rural locations population health units provide health promotion and health protection services and other programs including:

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

Target

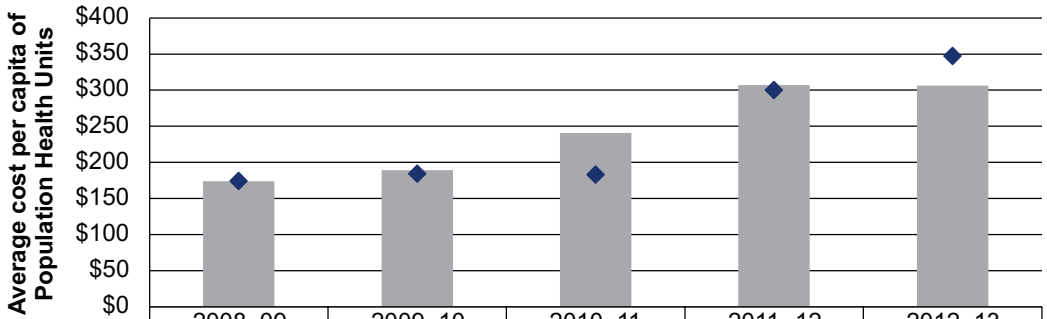
The target for 2012–13 was $347 per capita as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

The cost per capita for population health was $306 and under the target with no significant movement from prior year.

Figure 21: **Cost per capita of population health units**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$174	$189	$241	$307	$306
Target	$174	$184	$183	$300	$347
CPI adjusted	$174	$184	$228	$284	$277

Data source: Department of Planning and Infrastructure and WA Country Health Service financial system.

Service 9: Continuing care Efficiency KPI

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

Rationale

This indicator reports the cost per residential aged care bed-day for residents of the specified residential aged care facilities in the Kimberley at Kununurra, and in the Pilbara at Karlarra in Port Hedland, and for all other WA Country Health Service residential aged care services.

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

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

WA Country Health Service residential care services include:

- high dependency care – permanent and respite
- low dependency care – permanent and respite
- nursing home type care in hospital
- hostel care
- flexible care.

Target

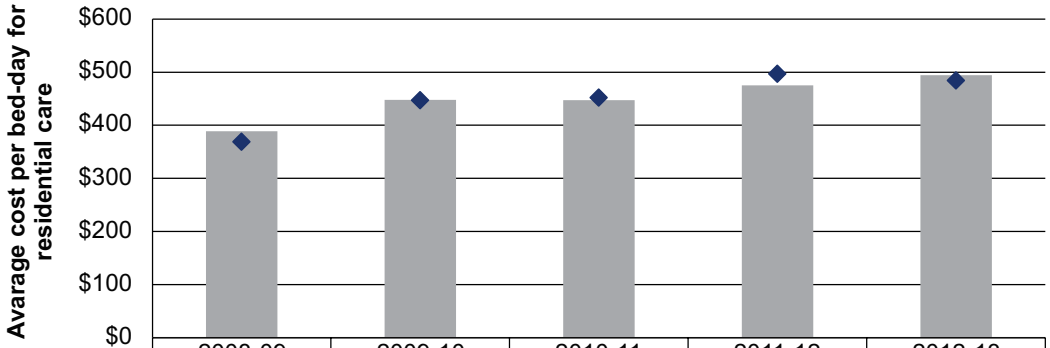
The target for 2012–13 was $484 per residential care bed-day as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

For 2012–13, the average cost per residential care bedday was $494 and above the target by two per cent. This is no significant variance from prior years.

Figure 22: **Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents**



	2008-09	2009-10	2010-11	2011-12	2012-13
Actual cost	$389	$448	$447	$475	$494
Target	$369	$447	$452	$497	$484
CPI adjusted	$389	$437	$423	$440	$447

Data source: WA Country Health Service HCARe data warehouse and WA Country Health Service financial system.

Service 10: Contracted mental health Efficiency KPI

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

Rationale

This indicator gives a measure of the cost effectiveness of treatment for patients (non-admitted/ambulatory patients) receiving care from public community based mental health services.

According to the *WA Health and Wellbeing Survey 2012* data, the prevalence of having a doctor diagnosed mental health condition (stress related, depression, anxiety or other) in the 12 months prior to the survey was 14 per cent amongst people aged 16 years and over. Given the prevalence of mental illness in the community, it is crucial to ensure effective and appropriate care is provided in the community for Western Australians in need.

Public community mental health services provided include assessment, treatment and continuing care. The aim is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.

Efficient use of public community-based resources can help minimise the overall costs of providing mental health care. It is important to monitor the unit cost of community-based patient care in specialised public mental health community services.

Target

The target for 2012–13 was $1,971 per three month period of care for a person receiving public community mental health services.

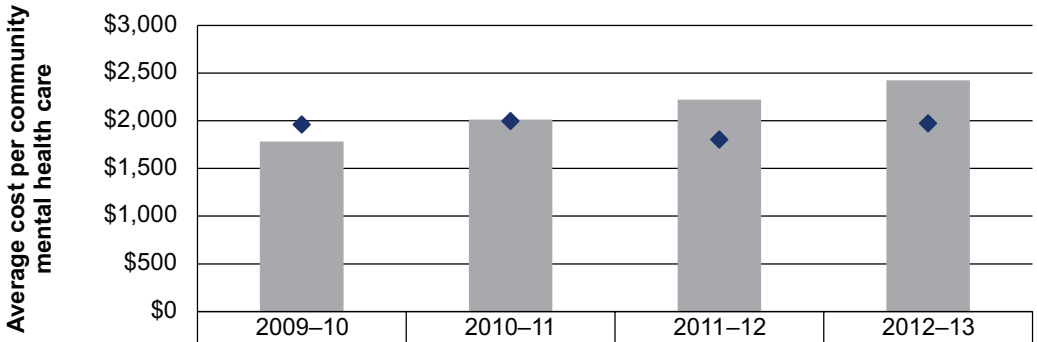
A result below the target was desirable.

Results

For 2012–13, the WA Country Health Service reported the cost per community mental health period of care to be $2,424, above the target where the activity projections were greater than that realised and the corresponding expenditure significantly under-estimated.

When compared to 2011–12, 2012–13 activity was nearly 10 per cent higher and expenditure 19 per cent greater than that of prior year, producing a 9 per cent increase in the unit cost.

Figure 23: **Average cost per three month period of community mental health care**



	2009–10	2010–11	2011–12	2012–13
Actual cost	$1,783	$2,011	$2,221	$2,424
Target	$1,959	$1,997	$1,802	$1,971
CPI adjusted cost	$1,740	$1,905	$2,056	$2,192

Note: Efficiency indicator target and result includes statewide corporate overheads. While these costs are borne by WA Health, and are not included in the Mental Health Commission service provision agreement, they have been included in the reported result as they contributed to the total unit cost for this health service product.
Data source: Mental Health Information System/Bedstate and WA Country Health Service financial systems.

Service 10: Contracted mental health Efficiency KPI

Average cost per bed-day in specialised mental health units

Rationale

This indicator measures the average cost per bed-day in the specialised mental health units of WA Country Health Service hospitals in Albany, Kalgoorlie, Broome and Bunbury.

Specialised mental health inpatient units provide admitted patient care in specific hospitals or hospital wards for the treatment and care of patients with mental or behavioural disorders.

To ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient units. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

In the context of the services provided, admitted mental health activity is better reported separately to other admitted activity, and as bed-days provided rather than by weighted separations.

Target

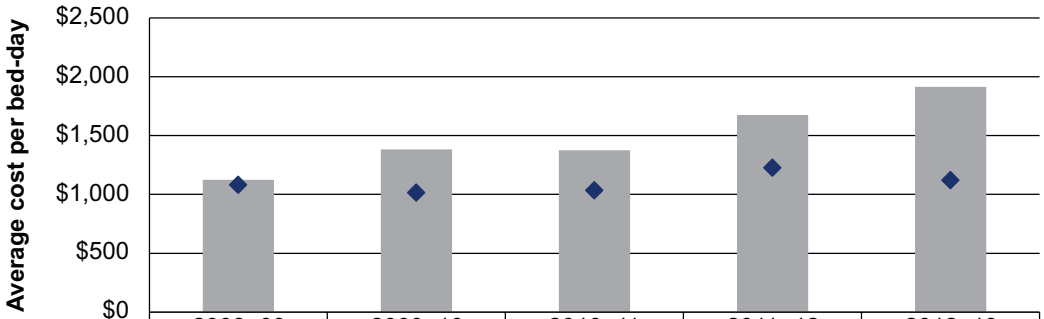
The target for 2012–13 was $804 per specialised mental health bed-day as set in the State Government Budget Statements published in May 2012.

A result below the target was desirable.

Results

For 2012–13, the average cost per bed-day in WA Country Health Service specialised mental health units was $1,914 and significantly above the target. This is largely due to additional costs borne by Health Services that were not included in the Mental Health Commission service provision agreement or the target methodology. As a result, the actual expenditure is higher than the projection used for the budget. This, coupled with lower activity volume actually realised, increased the actual unit cost to vary significantly from the target.

Figure 24: **Average cost per bed-day in specialised mental health unit**



	2008–09	2009–10	2010–11	2011–12	2012–13
Actual cost	$1,125	$1,383	$1,375	$1,676	$1,914
Target	$1,081	$1,015	$1,034	$1,225	$804
CPI adjusted	$1,125	$1,349	$1,302	$1,551	$1,731

Disclosure and Compliance

Disclosure and Compliance

Enabling legislation

The WA Country Health Service is established 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.

Public sector standards and ethical codes compliance

Details of the WA Health compliance with the Western Australia Public Sector Code of Ethics, Public Sector Standards in Human Resource Management and the WA Health Code of Conduct can be found in the *2012–13 Department of Health Annual Report*.

Employee profile

Agencies are required to report a summary of the number of employees by category, in comparison with the preceding financial year. Table 16 shows the average number of full-time equivalent staff employed by the WA Country Health Service for 2012–13 by category.

Table 16: **WA Country Health Service total full-time employees by category**

Category	Definition	2011–12	2012–13
Administration and clerical	Includes all clerical-based occupations – ward and clerical support staff, finance managers and officers	1,413	1,493
Agency	Includes contract staff in occupational categories: administration and clerical, medical support, hotel and site services and medical	82	93
Agency nursing	Includes nurses engaged on a "contract for service" basis	117	94
Assistants in nursing	Supports registered nurses and enrolled nurses in delivery of general patient care	29	44
Dental nursing	Includes dental clinic assistants	0	0
Hotel services	Includes catering, cleaning, stores/supply laundry and transport occupations	1,258	1,268
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners	298	318
Medical sessional	Includes sessional-based medical occupations	8	13
Medical support	Includes all allied health and scientific/ technical related occupations	763	793
Nursing	Includes all nursing occupations. Does not include agency nurses	2,684	2,807
Site services	Includes engineering, garden and security-based occupations	177	175
Other categories	Includes Aboriginal and ethnic health worker related occupations	121	140
Total		**6,950**	**7,237**

Totals may not add due to rounding.

Note: FTE is calculated as the monthly average FTE and is the average hours worked during a period of time divided by the Award full-time ours for the same period. Hours include ordinary time; overtime; all leave categories; public holidays, time off in lieu and workers' compensation.

FTE figures provided are based on actual (paid) month to date FTE.

Data source: HR Data Warehouse, extracted 11 July 2013.

Capital works

Refer to the Department of Health's Annual Report 2012–13 for financial details of the full WA Country Health Service capital works program.

Advertising

In accordance with section 175ZE of the *Electoral Act 1907*, the WA Country Health Service incurred the following expenditure on advertising agencies, market research, polling, direct mail and media advertising. Total advertising expenditure for the WA Country Health Service in 2012–13 was $189,364.

Table 17: **WA Country Health Service advertising**

Summary of advertising	Amount ($)
Advertising agencies	117,194
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	72,170
Total advertising expenditure	**189,364**

Recipient/organisations	Amount ($)
Advertising agencies	
ADCorp Australia Limited	22,628
Boddington Community Newsletter	42
Central Wheatbelt Division of General Practice Incorporated	38
Collie Mail	143
Dalwallinu Telecentre Incorporated	95
Green Man Media Productions	220
HCN Recruitment	37,577
Kellerberrin Health Service	17
Market Creations Pty Ltd	4,690
Media Decisions OMD	3,003
Mills Wilson Communication Consultants	20,515
Mitchell and Partners Australia Pty Ltd	1,007
National Emergency Services Magazine	484
Newman Mainstreet Project Incorporated	1,800
Pilbara Echo	965

Recipient/organisations	Amount ($)
Queensland Newspaper	6,063
Quality Press WA	906
Radiowest	1,622
Reed Business Information	3,260
Rural Press	163
Sensis Pty Ltd	151
Stones Publishing Pt	633
Streetsmart	550
The Weekend Australian	9,381
WA Newspapers	451
Whistling Moose Graphics	680
York Telecentre	110
Total	**117,194**
Market research organisations	
Total	**0**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
ACRMM	4,500
Albany Advertiser	6,312
Albany Weekender	1,587
Augusta Telecentre Inc	42
Austel Australia Pty Ltd	824
Australian Medical PC	7,284
Australian Orthopaedic Association	275
Boddington Community Newsletter	66
Boyup Brook Community Resource Centre	60
Brookton Telegraph	33
Countrywide Austral Pty Limited	1,580
Denmark Bulletin	36
Esperance Express	94

Recipient/organisations	Amount ($)
Gemma Fisher	99
Geraldton Newspapers Pty Ltd	820
Harvey Community Resource Centre Inc	100
Hits Radio	173
Kalgoorlie Miner	2,897
Leishman Associates Pty Ltd	364
Medical Forum Magazine	1,850
MIMS	6,500
Nationwide News Pty Limited	3,804
NZMA	864
Pingelly Times	30
Redwave Media Pty Ltd	1,940
Rural Press Regional Media	554
Sensis Pty Ltd	81
Southern Cross Media Group	187
The Muddy Waters	390
The Royal Australasian College Of Medical Administrators	3,527
Tremain Media	4,422
UBM Medica	1,370
Upper Great Southern Hockey (Radio)	500
Watershed News	132
West Australian Newspapers Limited	5,489
Western Indigenous Media Limited	13,357
Williams Community Newsletter	27
Total	**72,170**

Pricing policy

Refer to the Department of Health's annual report 2012–13 for the pricing policy.

Industrial relations

Refer to the Department of Health's annual report 2012–13 for industrial relations.

Substantive equality

Refer to the Department of Health's annual report 2012-13 for substantive equality.

Recordkeeping

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

The WA Country Health Service must comply with the Department of Health's Recordkeeping Plan. The WA Country Health Service has finalised the agency-specific Recordkeeping Plan and supporting framework and is awaiting approval from the State Records Commission. The completion of the Recordkeeping Plan by the WA Country Health Service is a result of an internal review of recordkeeping processes and the review of the WA Health Recordkeeping Plan framework.

The WA Country Health Service corporate recordkeeping strategy commenced at the beginning of 2012. An agency-specific TRIM dataset was developed and launched on 1 July 2012. Legacy electronic documents and folders contained within the Department of Health's TRIM dataset were mapped and imported into the new environment prior to its launch. This dataset was developed specifically for the management of electronic documents and folders using the new WA Country Health Service related business classification scheme.

The success of this strategy has been demonstrated by the increase in the number of WA Country Health Service users and records saved. For 2011–12 there were 41 regular users creating more than 16,500 records compared with 2012–13 with 140 regular users creating more than 137,000 records.

These marked improvements have also been attributed to the online recordkeeping awareness and TRIM training package with just under 190 staff completing the training this year. This package is distributed to staff as part of the induction program for new starters in order to raise recordkeeping awareness and their individual responsibilities in managing the WA Country Health Service records.

Recordkeeping strategies

The Records and TRIM services team has made significant progress in raising recordkeeping awareness within the WA Country Health Service. The WA Country Health Service implemented an electronic document and records management solution for business areas. These areas are responsible for managing corporate records that are current and relate to functional business activities.

A major part of the WA Country Health Service recordkeeping strategy has been to develop an effective and measurable training program to ensure staff members are aware of their recordkeeping obligations and have the skills to manage corporate records effectively. This program addresses recordkeeping awareness and electronic document and records management system training as an induction for new starters and for existing staff. This program has been developed as an online training and assessment solution.

The recordkeeping training program is supported by a comprehensive array of resources on the WA Country Health Service intranet including compliance and policy documents, forms and TRIM help guides and user manuals. To further support the agency, a help desk has been created to attend to and resolve enquiries as they arise.

Regular reporting on the success of the recordkeeping and training program is provided to senior management. These reports include training assessments, follow-up training, electronic document and records management system user numbers, statistics on records created, data integrity evaluation and 'help-desk' support requests. These reports have helped drive the message of compliance with the Recordkeeping Plan throughout the business areas in the WA Country Health Service.

Freedom of information

For the year ending 30 June 2013, the WA Country Health Service considered 3,628 applications for access to information in accordance with the *Freedom of Information Act 1992.*

Table 18: **Freedom of information applications for 2012–13**

Applications	Number
Carried over from 2011–12	101
Received in 2012–13	3,527
Total applications received for 2012–13	**3,628**
Granted – full access	1,725
Granted – partial or edited access[1]	1,507
Withdrawn by applicant	27
Refused	89
In progress	127
Other[2]	153
	3,628

Note:

[1] Includes the number accessed in accordance with section s 28 of the *Freedom of Information Act 1992* (WA).

[2] Includes exemptions, deferments or transfers to other departments/agencies.

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

- patient medical and dental records (including imaging)
- medical test and pathology results
- social work and Child Protection Unit notes
- state and community child development centre notes
- psychological medicine notes
- patient instruction sheets, information and employment brochures
- policy development documents and policy and procedures manuals
- engineering records (such as hospital plans), programmed planned maintenance and tender documents
- occupational safety and health information
- human resource records such as staff rosters, time and wages records and monthly management reports
- financial and accounting records and annual reports
- administrative records such as committee meeting minutes and business correspondence
- results, request forms, evidentiary documents
- complaint files.

Disability access and inclusion plan

The *Disability Services Act 1993* was introduced to ensure that people with disabilities have the same opportunities as other West Australians. In 2004, the Act was amended requiring WA Health to develop and implement a Disability Access and Inclusion Plan.

Under the WA Health Disability Access and Inclusion Plan, the WA Country Health Service aims to ensure that people with disabilities:

- have the same opportunities as people without a disability to access the services of, and events organised by the WA Country Health Service
- have the same opportunities as people without a disability to access the buildings and other facilities of the WA County Health Service
- receive information from the WA Country Health Service in a format that will enable them to access the information as readily as people without a disability
- receive the same level and quality of service from the staff of the WA Country Health Service as people without a disability
- have the same opportunities as people without a disability to make complaints to the WA Country Health Service
- have the same opportunities as people without a disability to participate in any public consultation held by the WA Country Health Service.

Access to services

Throughout 2012–13 the WA Country Health Service continued to progress the implementation of the Health Service Disability Access Plans at both a regional and network level. This is to ensure relevance and compliance to current issues pertaining to people with a disability.

Access to buildings

Disability access and inclusion planning is reviewed for WA Country Health Service capital works projects. This is to ensure building access as per the Australian Building Code has been incorporated. This is evident at the Albany Health Campus, where the needs of people with disabilities have been incorporated in design features such as wheelchair access, wide corridors and doorways.

Adequate disabled parking has been provided for both the staff and public with parking sites located close to the main entrances. Ward areas have non-slip surfaces for people using walking aids.

Access to information

Stipulations under the Department of Health's Communications Style Guide have been adopted in the preparation of all information developed for public distribution. All information is available in alternative formats including the health service's 'Rights and Responsibilities' information.

The 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 WA Country Health Service has also developed a self directed learning package for staff.

Quality of service by staff

Disability awareness is included in mandatory training days, induction sessions and self-directed learning packages. This ensures all staff can deliver consistent services and healthcare to people with a disability.

The WA Country Health Service facilitates regular education sessions using e-learning packages, Disability Services Commission training packages and DVDs, to assist staff to achieve competencies (certificate level) in appropriate training courses.

Participation in public consultation

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 WA Country Health Service district health advisory councils informs the Health Service as to the appropriate healthcare services required. This is to meet the needs of all community members, including those with a disability.

Internal audits

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

Table 19: **Internal audits completed in 2012–13**

Audit	Area audited
Review of controls over pharmaceuticals 2012	WA Country Health Service South Metropolitan Health Service North Metropolitan Health Service Child and Adolescent Health Service
Review of clinical waste management	South Metropolitan Health Service North Metropolitan Health Service WA Country Health Service
Review of acceptance of gifts – part 1	South Metropolitan Health Service North Metropolitan Health Service Child and Adolescent Health Service WA Country Health Service Health Corporate Network Health Information Network Department of Health
Review of arrangement A and B	South Metropolitan Health Service North Metropolitan Health Service Child and Adolescent Health Service WA Country Health Service Health Corporate Network
Review of data integrity (emergency department data)	South Metropolitan Health Service North Metropolitan Health Service Child and Adolescent Health Service WA Country Health Service Health Information Network Department of Health
Review of ambulatory surgery initiative	South Metropolitan Health Service North Metropolitan Health Service WA Country Health Service

Recruitment

The WA Country Health Service undertakes targeted and general recruitment activities to assist in ensuring the availability of a skilled health workforce.

Medical recruitment

A centralised and co-ordinated approach is undertaken to the recruitment and appointment of medical practitioners to permanent vacancies. Recruitment for locum positions is undertaken by the region.

Vacancies are advertised on the WA Country Health Service internet site, by referral, direct applications to the regions and direct applications to Central Office. Medical recruitment pools are advertised on the WA Health jobs board.

In 2012–13, 186 medical practitioners commenced employment. Of these, 45 were international medical graduates who were granted limited registration by the Medical Board of WA to work in Australia.

Recruitment was also assisted by the Rural Generalist Pathway which offers career pathways to junior doctors wishing to train in rural areas. This is a collaborative initiative between Rural Health West, WA General Practice Education and Training, the Postgraduate Medical Council of WA, the Rural Clinical School and Australian Medical Association Doctors in Training.

Royalties for Regions funding assisted the growth of rural junior doctor training positions from 25 in 2008 to 86 in 2012–2013. WA Coutry Healt Service also assists applicants seeking employment as a rural GP through the Southern Inland Health Initiative.

Nursing recruitment

Nursing recruitment across the WA Country Health Service has been managed at a regional level according to demand, with central coordination for some rotational programs, and graduate positions.

The Oceans to Outback and Country to Coast programs were reviewed in 2012–13. Participant and site feedback resulted in some changes to program numbers and business rules. This is to ensure quality clinical placement experiences.

Nurse practitioner recruitment has been successful for the Southern Inland Health Initiative.

A Nurse Practitioner Candidacy working group has explored models of candidacy programs with a view to building capacity in nurse practitioner recruitment across the WA Country Health Service.

Promotional activities to support recruitment included a presence at the annual Nursing Careers Expo held in April 2013. This generated a high level of interest in rural nursing from both graduate and experienced nurses and midwives.

The WA County Health Service's continued participation in the Graduate Nurse Connect recruitment program resulted in recruitment of registered nurses, enrolled nurses and midwives into programs across WA Country Health Service sites.

Aboriginal employment

The WA Country Health Service Aboriginal Employment Strategy remained a focus during 2012–13. Initiatives such as the Aboriginal Mentorship Program and promotion of Aboriginal cultural learning programs supported the recruitment process.

The WA Country Health Service Country Health Aboriginal Workforce Committee was established to facilitate the Aboriginal Employment Strategy and provide a regional forum for Aboriginal employment initiatives.

The continuation of programs implemented through the *Closing the Gap* and Indigenous Early Childhood Development programs have contributed to a marked increase in the number of Aboriginal employees in the WA Country Health Service.

In recognition of the increased Aboriginal workforce, Regional Aboriginal Health Coordinator positions have been established in some regions. These roles are to lead a range of initiatives including Aboriginal workforce development, Aboriginal employee networks and community engagement.

The Specialist Aboriginal Mental Health Service, (funded through *Closing the Gap* and the Mental Health Commission) increased its Aboriginal mental health workforce to 31 full-time employees.

Allied health recruitment

Allied health recruitment across the WA Country Health Service has been managed at a regional level. This is assisted with a central contact point provided on the WA Country Health Service internet for job seekers. Enquiries from job seekers including locums and those seeking sponsorship positions are screened and communicated to regions.

The Allied Health Program coordinates a transition to practice program. This is to support new graduates making the transition to rural and remote practice. This program commenced in 2012 and targets audiology, dietetics, health promotion, occupational therapy, physiotherapy, podiatry, social work and speech pathology graduates.

The Health Workforce Australia Clinical Training Fund project has been a significant body of work in 2012–13. This project aims to build the capacity of student training programs within the WA Country Health Service.

Visa management

The WA Country Health Service ensures compliance with Department of Immigration and Citizenship requirements and in 2012–13 processed:

- 131 long-stay business 457 visas
- 12 employer nominations for permanent residency for doctors
- 63 regional sponsored migration scheme applications for permanent residency for nurses and allied health staff.

An individualised and comprehensive orientation program is available to medical practitioners working in regional WA for the first time. This assists to improve patient safety and quality, and improve staff satisfaction and retention.

Staff development

During 2012–13, learning and development activities across the WA Country Health Service have been governed by the WA Country Health Service Learning and Development Policy, Induction and Orientation Policy and Core Essential Training Policy. Learning and development activities have been supported in each of the regions by regional learning and development coordinators and staff development educators.

A central learning and development team maintains system responsibility for the development and maintenance of systems of recording and reporting training and development activities within and across regions.

The development and enhancement of a range of discipline-specific and general e-learning programs and resources has been led as a collaboration between the Learning and Development team and clinical and non-clinical discipline leads.

Key focus areas for learning and development activities have included:

- alignment of programs and resources to the National Safety and Quality Health Standards and EQUIP National
- intra-professional learning
- enhanced accessibility to learning and development in regional areas
- induction.

Nursing and midwifery education and training

Funding from Health Workforce Australia has enabled the expansion of the nursing and midwifery student clinical placement program. Students from all WA university campuses, regional institutes of technology and a variety of training organisations were provided with clinical placement opportunities in a highly diverse range of nursing and midwifery clinical practice contexts. Some interstate students were also placed.

The collaborative Nursing and Allied Health Clinical Supervision Support Program has seen (in partnership with WA universities) the development of e-learning modules for supervisor education. The 'Art of Supervision' training program has also been implemented across the State.

The WA Country Health Service continues to support newly graduated nurses and midwives across all regions. A total of 78 graduates (registered nurses, enrolled nurses and registered midwives) were provided with support into the workforce through the graduate programs.

The implementation of the Paediatric Observation and Response Charts was supported by an education implementation plan. This included the engagement of an external facilitator to provide essential paediatric skills education. This was to ensure that clinical deterioration in paediatric patients was recognised and responded to, by both nursing and medical staff across all regions.

The development of an online Midwifery Learning Resource Repository has also enhanced access to flexible learning opportunities for WA Country Health Service midwives.

Mental health education and training

Specific mental health learning and development programs were made available via video conferencing for mental health and other staff. This includes child and adolescent mental health, older adult mental health and cognitive behaviour therapy.

Mental Health Professional On-Line Development is a series of 59 modules on differing aspects of mental health practice and knowledge. These are accessed online by registered staff. It is a national program and is based on the Mental Health Practice Standards. Since its inception in 2011, 256 staff have completed the program. This program continues to play a key role in the development of mental health professionals.

Postgraduate medical education

The WA Country Health Service has an established Postgraduate Medical Education Unit which provides post-graduate medical education services. These include the supervision and ongoing training of junior medical officers, as well as providing support to the Directors of clinical training and medical education officers.

The unit provides consultative services within the area of clinical simulation training and has led the development of simulator education workshops. This has enabled further exploration in the use of simulation as an educational methodology. A number of healthcare practitioners involved in the delivery of simulation-based education across the WA Country Health Service attended workshops held in Bunbury and Perth.

Workers' compensation and rehabilitation

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

Table 20: **Numbers WA Country Health Service workers' compensation claims for 2012–13**

Employee category	Number
Nursing services/dental care assistant	103
Administration and clerical	26
Medical support	16
Hotel services	110
Maintenance	13
Medical (salaried)	2
Total	**270**

The WA Country Health Service has implemented a workers' compensation and injury management system as required by the *Workers' Compensation and Injury Management Act 1981*. The system adopts a case management approach to ensure that return-to-work outcomes of injured workers is optimised.

The WA Country Health Service injury management coordinators:

- coordinate return-to-work programs
- prepare and monitor, in consultation with the case management team, written return-to-work plans.

The WA Country Health Service Injury management system is available on the intranet and details are provided to injured workers. This is by letter on initial contact when lodging a workers' compensation claim and again 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, health and injury management

The WA Country Health Service has an integrated risk-management approach to occupational safety and health underpinned by policies in accordance with the *Occupational Safety and Health Act 1984*.

The WA Country Health Service maintains and enhances its commitment to assisting injured workers to return to work as soon as medically appropriate and adheres to the requirements of the *Workers' Compensation and Injury Management Act 1981* in the event of a work-related injury or illness.

Employee consultation

The 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 an agreed terms of reference and is consistent with the *Occupational Safety and Health Act 1984*. Supporting policies and procedures exist to further support the WA Country Health Service Safety Management System, including a formal occupational safety and health issue resolution procedure.

Occupational safety and health assessment

An assessment of the WA Country Health Service Safety Management System was conducted by an external consultant in 2012. A report of its findings was presented to the WA Country Health Service Chief Executive Officer and executive in early 2013 and 27 improvement opportunities were identified.

A preliminary draft action plan was endorsed by the WA Country Health Service executive in June 2013 to address these. No recommendations have yet been completed.

Table 21: **Occupational safety, health and injury performance for 2012–13**

Fatalities	Lost time injury/ diseases (LTI/D) incidence rate (rate per 100)	Lost time injury severity rate (rate per 100)	Percentage of injured workers returned to work within 26 weeks	Percentage of managers trained in occupational safety, health and injury management responsibilities
1	2.54	34.24	68.6	39.5

Financial Statements

Certification Statement

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2013

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 2013 and financial position as at 30 June 2013.

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
ACTING CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 18 September 2013

Professor Bryant Stokes
ACTING DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

Date: 18 September 2013

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 2013, 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 2013 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 2013.

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.

7th Floor Albert Facey House 469 Wellington Street Perth MAIL TO: Perth BC PO Box 8489 Perth WA 6849 TEL: 08 6557 7500 FAX: 08 6557 7600

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 2013.

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 2013.

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 qualified audit opinion.

Basis for Qualified Opinion
Controls over the initial recording of waiting time data used for the effectiveness indicator "Percentage of emergency service patients seen within recommended times (major rural hospitals)" were inadequate. Audit tests of a sample of attendance and treatment times identified a significant number of differences between source records and the database. Consequently, I was unable to determine whether this effectiveness indicator was fairly presented.

Qualified Opinion
In my opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, 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 2013.

Emphasis of Matter
As reported by the Health Service in the key performance indicators, the effectiveness indicators for "Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition" and "Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition" are based on the sample period 1 September to 30 November 2012. My opinion is not modified in respect of this matter.

Matter of Significance
WA Country Health Service has 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 2013. Consequently, the "Elective Surgery Waiting Times" KPI has not been included in the audited KPIs for the year ended 30 June 2013. My opinion is not modified in respect of this matter.

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 2013 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
20 September 2013

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WA Country Health Service

Statement of Comprehensive Income

For the year ended 30 June 2013

	Note	2013 $000	2012 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	797,260	723,879
Fees for visiting medical practitioners		75,285	69,803
Patient support costs	8	270,734	213,953
Finance costs	9	552	716
Depreciation and amortisation expense	10	58,997	42,860
Loss on disposal of non-current assets	11	716	608
Repairs, maintenance and consumable equipment	12	38,054	33,077
Other expenses	13	146,749	120,245
Total cost of services		**1,388,347**	**1,205,141**
INCOME			
Revenue			
Patient charges	14	48,110	43,928
Commonwealth grants and contributions	15(i)	321,961	66,446
Other grants and contributions	15(ii)	62,387	66,965
Donation revenue	16	679	1,151
Interest revenue		-	16
Other revenue	17	22,759	22,241
Total revenue		455,896	200,747
Total income other than income from State Government		**455,896**	**200,747**
NET COST OF SERVICES		**932,451**	**1,004,394**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	840,624	1,010,914
Assets transferred	19	1,429	304
Services received free of charge	20	25	12
Royalties for Regions Fund	21	39,653	44,468
Total income from State Government		**881,731**	**1,055,698**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(50,720)**	**51,304**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	36	68,092	12,244
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**17,372**	**63,548**

Refer also to note 52 '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 2013

	Note	2013 $000	2012 $000
ASSETS			
Current Assets			
Cash and cash equivalents		4,512	13,450
Restricted cash and cash equivalents	22	27,670	41,564
Receivables	23	16,006	15,991
Amounts receivable for services	24	6,600	-
Inventories	25	5,114	4,974
Other current assets	26	3,999	4,044
Total Current Assets		63,901	80,023
Non-Current Assets			
Amounts receivable for services	24	360,610	303,974
Property, plant and equipment	28	1,634,628	1,515,271
Intangible assets	29	98	99
Total Non-Current Assets		1,995,336	1,819,344
Total Assets		**2,059,237**	**1,899,367**
LIABILITIES			
Current Liabilities			
Payables	31	101,437	72,909
Borrowings	32	1,436	1,373
Provisions	33	112,629	103,758
Other current liabilities	34	41	31
Total Current Liabilities		215,543	178,071
Non-Current Liabilities			
Borrowings	32	9,780	11,164
Provisions	33	22,048	18,578
Total Non-Current Liabilities		31,828	29,742
Total Liabilities		**247,371**	**207,813**
NET ASSETS		**1,811,866**	**1,691,554**
EQUITY			
Contributed equity	35	1,386,545	1,283,605
Reserves	36	422,410	354,318
Accumulated surplus/(deficit)	37	2,911	53,631
TOTAL EQUITY		**1,811,866**	**1,691,554**

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

WA Country Health Service

Statement of Changes in Equity

For the year ended 30 June 2013

	Note	2013 $000	2012 $000
CONTRIBUTED EQUITY	35		
Balance at start of period		1,283,605	1,141,999
Transactions with owners in their capacity as owners:			
Capital appropriations		54,746	98,873
Royalties for Regions Fund		48,702	42,522
Other contributions by owners		-	390
Distributions to owners		(508)	(179)
Balance at end of period		1,386,545	1,283,605
RESERVES	36		
Asset Revaluation Reserve			
Balance at start of period		354,318	342,074
Comprehensive income for the period		68,092	12,244
Balance at end of period		422,410	354,318
ACCUMULATED SURPLUS/(DEFICIT)	37		
Balance at start of period		53,631	2,327
Surplus/(deficit) for the period		(50,720)	51,304
Balance at end of period		2,911	53,631
TOTAL EQUITY			
Balance at start of period		1,691,554	1,486,400
Total comprehensive income for the period		17,372	63,548
Transactions with owners in their capacity as owners		102,940	141,606
Balance at end of period		**1,811,866**	**1,691,554**

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 2013

	Note	2013 $000 Inflows (Outflows)	2012 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		776,824	959,532
Capital appropriation		53,425	97,612
Royalties for Regions Fund		88,355	86,990
Net cash provided by State Government	38	**918,604**	**1,144,134**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(780,183)	(708,216)
Supplies and services		(490,927)	(425,398)
Receipts			
Receipts from customers		46,973	41,464
Commonwealth grants and contributions		321,961	69,905
Other grants and contributions		62,387	64,046
Donations received		584	1,136
Interest received		-	16
Other receipts		23,882	20,166
Net cash used in operating activities	38	**(815,323)**	**(936,881)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(126,207)	(183,548)
Receipts			
Proceeds from sale of non-current physical assets	11	94	297
Net cash provided used in investing activities		**(126,113)**	**(183,251)**
Net increase / (decrease) in cash and cash equivalents		(22,832)	24,002
Cash and cash equivalents at the beginning of the period		55,014	31,012
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	38	**32,182**	**55,014**

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 2013

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2013 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 Jun 2013.

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 35 '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.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2013

(d) Income (continued)

Interest
Revenue is recognised as the interest accrues.

Service Appropriations
Service Appropriations are recognised as revenues at fair value in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited to the bank account or credited to the 'Amounts receivable for services' (holding account) held at Treasury.
See also note 18 'Service appropriations' for further information.

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Health Service obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

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

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

(e) Borrowing Costs

Borrowing costs are expensed in the period in which they are incurred.

(f) Property, Plant and Equipment

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 buying 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 assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the depreciated replacement cost.

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

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

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 2013

(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. Expected 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.

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

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

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

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

Computer software	5 - 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 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 and an impairment loss is recognised, 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 in profit or loss. 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 an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2013

(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 30 'Impairment of assets' for the outcome of impairment reviews and testing.
Refer also to note 2(p) 'Receivables' and note 23 'Receivables' for impairment of receivables.

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

Non-current assets (or disposal groups) held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are disclosed separately from other assets in the Statement of Financial Position. Assets classified as held for sale are not depreciated or amortised.

(j) Leases

Leases of property, plant and equipment, where the Health Service has substantially all of the risks and rewards of ownership, are classified as finance leases. The Health Service does not have any finance leases.

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases.

Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(k) Financial Instruments

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

Financial instruments have been disaggregated into the following classes:

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

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 31 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(n) Amounts Receivable for Services (holding account)

The Health Service receives income from the State Government partly in cash and partly as an asset (holding account receivable). The accrued amount appropriated is accessible on the emergence of the cash funding requirement to cover leave entitlements and asset replacement.
See also note 18 'Service appropriations' and note 24 'Amounts receivable for services'.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

(o) Inventories

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

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

(p) Receivables

Receivables are recognised at original invoice amounts less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off against the allowance account. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Health Service will not be able to collect the debts. The carrying amount is equivalent to fair value as it is due for settlement within 30 days.
See also note 2(k) 'Financial Instruments' and note 23 'Receivables'.

Change to accounting procedure for Goods and Services Tax
Rights to collect amounts receivable from the Australian Taxation Office (ATO) and responsibilities to make payments for GST have been assigned to the 'Department of Health. This accounting procedure was a result of application of the grouping provisions of "A New Tax System (Goods and Services Tax) Act 1999" whereby the Department of Health became the Nominated Group Representative (NGR) for the GST Group as from 1 July 2012. The 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services) was the NGR in the previous six 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 from and payables to ATO for the GST group are recorded in the accounts of the Department of Health. GST payables are recognised upon the receipt of tax invoices for purchases of goods and services. Accordingly, accrued expense amounts are generally exclusive of GST.

(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 31 '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 32 'Borrowings'.

(s) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at the end of each reporting period.

See also note 33 'Provisions'.

Provisions - employee benefits

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

Annual Leave

The liability for annual leave that is expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

Annual leave that is not expected to be settled 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.

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 is 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

The liability for long service leave that is expected to be settled within 12 months after the end of the reporting period is recognised and measured at the undiscounted amounts expected to be paid when the liability is settled.

Long service leave that is not expected to be settled 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 2013

(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. The liability has been calculated on current remuneration rates in respect of services provided by employees up to the reporting date and includes related on-costs. It is reported as a current provision since 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 2013

(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 13 'Other expenses' and note 33 '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. The employer contribution paid to the GESB in respect of the GSS is paid back into the Consolidated Account by GESB.

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

Services received free of charge or for nominal cost are recognised as income at the fair value of those services that can be reliably measured and the Health Service would otherwise pay for. 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 assets between State Government agencies free of charge, are reported under Income from State Government at the fair value of those assets that the Health Service would otherwise pay for. 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 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 financial year.

(x) Trust Accounts

Trust Accounts are used by the Health Service to account for funds that they may be holding on behalf of another party, such as patients' cash. The Health Service does not have control of the use of these funds, and cannot deploy them to meet its objectives. Trust Accounts do not form part of the resources available to the Health Service, and are not reported as assets in the financial statements.

Details of Trust Accounts are reported as a note to the financial statements (refer to note 49).

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 2013

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 years period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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 2012 that impacted on the Health Service.

Title	
AASB 2011-9	*Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]* This Standard requires to group items presented in other comprehensive income on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). There is no financial impact.

Future impact of Australian Accounting Standards not yet operative

The Health Service cannot early adopt an Australian Accounting Standard unless specifically permitted by 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. AASB 2012-6 *Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transition Disclosures* amended the mandatory application date of this Standard to 1 January 2015. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 10	*Consolidated Financial Statements* This Standard supersedes AASB 127 *Consolidated and Separate Financial Statements and Int 112 Consolidation – Special Purpose Entities*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10 *Amendments to Australian Accounting Standards - Transition Guidance and Other Amendments*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 11	*Joint Arrangements* This Standard supersedes AASB 131 *Interests in Joint Ventures*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2013

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

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 12	*Disclosure of Interests in Other Entities* This Standard supersedes disclosure requirements under AASB 127 *Consolidated and Separate Financial Statements* and AASB 131 *Interests in Joint Ventures*. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 13	*Fair Value Measurement* This Standard defines fair value, sets out a framework for measuring fair value and requires additional disclosures about fair value measurements. There is no financial impact.	1 Jan 2013
AASB 119	*Employee Benefits* This Standard supersedes AASB 119 (October 2010), making changes to the recognition, presentation and disclosure requirements. The Health Service does not have any defined benefit plans, and therefore the financial impact will be limited to the effect of discounting annual leave and long service leave liabilities that were previously measured at the undiscounted amounts.	1 Jan 2013
AASB 127	*Separate Financial Statements* This Standard supersedes AASB 127 *Consolidated and Separate Financial Statements*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 128	*Investments in Associates and Joint Ventures* This Standard supersedes AASB 128 *Investments in Associates*, introducing a number of changes to accounting treatments. Mandatory application of this Standard was deferred by one year for not-for-profit entities by AASB 2012-10. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 1053	*Application of Tiers of Australian Accounting Standards* This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements. There is no financial impact.	1 Jul 2013
AASB 1055	*Budgetary Reporting* This Standard specifies the nature of budgetary disclosures, the circumstances in which they are to be included in the general purpose financial statements of not-for-profit entities within the GGS. 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 2010-2	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 1, 2, 3, 5, 7, 8, 101, 102, 107, 108, 110, 111, 112, 116, 117, 119, 121, 123, 124, 127, 128, 131, 133, 134, 136, 137, 138, 140, 141, 1050 & 1052 and Int 2, 4, 5, 15, 17, 127, 129 & 1052]* This Standard makes amendments to Australian Accounting Standards and Interpretations to introduce reduced disclosure requirements for certain types of entities. There is no financial impact.	1 Jul 2013

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

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

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
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. AASB 2012-6 amended the mandatory application date of this Standard to 1 January 2015. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 2011-2	*Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & 1054]* This Standard removes disclosure requirements from other Standards and incorporates them in a single Standard to achieve convergence between Australian and New Zealand Accounting Standards for reduced disclosure reporting. There is no financial impact.	1 Jul 2013
AASB 2011-6	*Amendments to Australian Accounting Standards – Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation – Reduced Disclosure Requirements [AASB 127, 128 & 131]* This Standard extends the relief from consolidation, the equity method and proportionate consolidation by removing the requirement for the consolidated financial statements prepared by the ultimate or any intermediate parent entity to be IFRS compliant, provided that the parent entity, investor or venturer and the ultimate or intermediate parent entity comply with Australian Accounting Standards or Australian Accounting Standards – Reduced Disclosure Requirements. There is no financial impact.	1 Jul 2013
AASB 2011-7	*Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139,1023 & 1038 and Int 5, 9, 16 & 17]* This Standard gives effect to consequential changes arising from the issuance of AASB 10, AASB 11, AASB 127 Separate Financial Statements and AASB 128 Investments in Associates and Joint Ventures. For not-for-profit entities it applies to annual reporting periods beginning on or after 1 January 2014. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2014
AASB 2011-8	*Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 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.	1 Jan 2013
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 Employee Benefits in September 2011. There is no financial impact.	1 Jan 2013
AASB 2011-11	*Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements* This Standard gives effect to Australian Accounting Standards – Reduced Disclosure Requirements for AASB 119 (September 2011). There is no financial impact.	1 Jul 2013
AASB 2012-1	*Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, 7, 13, 140 & 141]* This Standard establishes and amends reduced disclosure requirements for additional and amended disclosures arising from AASB 13 and the consequential amendments implemented through AASB 2011-8. There is no financial impact.	1 Jul 2013

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

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

Future impact of Australian Accounting Standards not yet operative

Title		Operative for reporting periods beginning on/after
AASB 2012-2	*Amendments to Australian Accounting Standards - Disclosures - Offsetting Financial Assets and Financial Liabilities [AASB 7 & 132]* This Standard amends the required disclosures in AASB 7 to include information that will enable users of an entity's financial statements to evaluate the effect or potential effect of netting arrangements, including rights of set-off associated with the entity's recognised financial assets and recognised financial liabilities, on the entity's financial position. There is no financial impact.	1 Jan 2013
AASB 2012-3	*Amendments to Australian Accounting Standards - Offsetting Financial Assets and Financial Liabilities [AASB 132]* This Standard adds application guidance to AASB 132 to address inconsistencies identified in applying some of the offsetting criteria, including clarifying the meaning of "currently has a legally enforceable right of set-off" and that some gross settlement systems may be considered equivalent to net settlement. There is no financial impact.	1 Jan 2014
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.	1 Jan 2013
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. Further amendments are also made to consequential amendments arising from AASB 9 that will now apply from 1 January 2015 and to consequential amendments arising out of the Standards that will still apply from 1 January 2013. There is no financial impact.	1 Jan 2013
AASB 2012-7	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements [AASB 7, 12, 101 & 127]* This Standard adds to or amends the Australian Accounting Standards to provide further information regarding the differential reporting framework and the two tiers of reporting requirements for preparing general financial statement. There is no financial impact.	1 Jul 2013
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 makes amendments to AASB 10 and related Standards to revise the transition guidance relevant to the initial application of those Standards, and to clarify the circumstances in which adjustments to an entity's previous accounting for its involvement with other entities are required and the timing of such adjustments. The Standard was issued in December 2012. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2013
AASB 2012-11	*Amendments to Australian Accounting Standards - Reduced Disclosure Requirements and Other Amendments [AASB 1, 2, 8, 10, 107, 128, 133, 134 & 2011-4]* This Standard makes various editorial corrections to Australian Accounting Standards - Reduced Disclosure Requirements (Tier 2). These corrections ensure that the Standards reflect decisions of the AASB regarding the Tier 2 requirements. The Standard also extends the relief from consolidation and the equity method (in the new Consolidation and Joint Arrangement Standards) to entities complying with Australian Accounting Standards - Reduced Disclosure Requirements. There is no financial impact.	1 Jul 2013

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

Note 6 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 52. The key services of the Health Service are:

Public Hospital Admitted Patients
Public hospital admitted patient services describe the care services provided to inpatients in public hospitals (excluding specialised mental health wards) and to public patients treated in private facilities under contract to WA Health. An admission to hospital can be for a period of one or more days and includes medical and surgical treatment, renal dialysis, oncology services, and obstetric care.

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

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

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

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

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

Continuing Care
Aged and continuing care services include:

•the Home and Community Care (HACC) program providing services such as domestic assistance, social support, nursing care, respite, food and meal services, transport and home maintenance. These services aim to support people to stay at home where their capacity for independent living is at risk of premature admission to long-term residential care;

• the Transition Care program aims to help older people's independence and 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 organisation 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 authorised hospitals and specialist mental health inpatient units located within general hospitals, and community-based services provided by Health Services. These include services in addition to those provided under agreement with the Mental Health Commission for specialised admitted and community mental health.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 7 Employee benefits expense		
Salaries and wages (a)	734,351	671,385
Superannuation - defined contribution plans (b)	62,909	52,494
	797,260	723,879

(a) Includes the value of the fringe benefits to employees plus the fringe benefits tax component and the value of superannuation contribution component of leave entitlements.

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

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

Employment on-costs liability is included at note 33 'Provisions'.

Note 8 Patient support costs		
Medical supplies and services	58,654	55,513
Domestic charges	8,207	8,088
Fuel, light and power	25,137	20,398
Food supplies	9,745	9,779
Patient transport costs	76,059	44,188
Aboriginal Health services	45,924	36,048
Pathology services	13,701	12,528
Purchase of external services	33,307	27,411
	270,734	213,953
Note 9 Finance costs		
Interest expense	552	716
Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	45,046	31,848
Leasehold improvements	200	292
Computer equipment	246	215
Furniture and fittings	170	154
Motor vehicles	1,097	882
Medical equipment	10,848	8,348
Other plant and equipment	1,357	1,076
	58,964	42,815
Amortisation		
Computer software	33	45
	58,997	42,860
Note 11 Loss on disposal of non-current assets		
Cost of disposal of non-current assets		
Property, plant and equipment	810	905
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(94)	(297)
Net loss	716	608
Note 12 Repairs, maintenance and consumable equipment		
Repairs and maintenance	24,547	20,822
Consumable equipment	13,507	12,255
	38,054	33,077

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 13 Other expenses		
Communications	4,421	4,355
Computer services	1,706	2,550
Workers compensation insurance (a)	10,644	8,651
Other employee related expenses	22,408	19,240
Insurance	3,896	3,560
Legal expenses	53	1,012
Motor vehicle expenses	5,468	5,878
Operating lease expenses	46,401	41,010
Printing and stationery	3,974	4,287
Doubtful debts expense	1,118	709
Purchase of external services	17,012	15,518
Write-down of assets	710	3,068
Donations to non government organisations (b)	15,021	-
Act of Grace payment	250	-
Other	13,667	10,407
	146,749	120,245

(a) The employment on-costs include workers' compensation insurance only. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 33 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

(b) Predominantly represents the construction costs of renal clinics at Derby and Kununurra ($9.7 million), environmental health centres in Warmun, Kalumburu, Oombulgarri and local communities ($3.6 million) and the refurbishment of the sobering up centres in Wyndham and Kununurra ($0.6 million) for which the funding was received as part of the National Partnership agreement on health infrastructure projects. In addition the land and construction cost of two houses ($1.12 million) were transferred to the Kimberley Aboriginal Medical Services Council Inc. for the purposes of Renal staff housing. 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 14 Patient charges		
Inpatient bed charges	24,460	24,996
Inpatient other charges	145	238
Outpatient charges (a)	23,505	18,694
	48,110	43,928

(a) The 2012 income ($2.386 million) for Pharmaceutical Benefits Scheme has been reclassified from 'Commonwealth grants and contributions' to 'Outpatient charges' in order to be comparable with the figure presented in 2013.

Note 15 Grants and contributions		
(i) Commonwealth grants and contributions		
Recurrent		
Nursing homes	3,316	2,594
Aboriginal Health and Cadetship Program	194	118
Aged Care Housing Assistance	-	126
Bringing Them Home	109	107
Carelink	464	565
Community Aged Care Program	829	784
Communicable Disease Program	-	162
Customs	159	196
Ear Health	645	1,520
Extended Aged Care in the Home	570	244
FaHCSIA Respite for Young Carer, RSCYP and Mental Health	207	-
Healthy for Life	1,177	1,155
Indigenous Traineeship	357	-
Job Creation Packages	635	1,102
Mobile Respite Program	378	215
National Respite Carers Program	1,527	1,422
National Health Reform Agreement (a)	282,747	-
New Directions Mothers & Babies	790	774

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 15 Grants and contributions		
(i) Commonwealth grants and contributions		
Recurrent (continued)		
New Directions OATSIH OVAHS	158	-
Office of Aboriginal and Torres Strait Islander Health	2,955	2,215
Primary Health Care Access Program - Kimberley	1,600	1,570
Rheumatic Heart Disease Register	-	810
Rural Primary Health Services	4,097	4,091
Substance Abuse	516	245
Trachoma & Healthy Kids Check	739	459
Other	1,370	708
Capital		
Albany Heath Campus	4,200	-
Bromme High Dependency Unit	200	-
Broome - Paediatrics capital grants	-	6,400
Bunbury Radiotherapy Facility capital grant	-	1,900
Bunbury Hospital Intensive Care Unit capital grant	-	13,597
Busselton Health Campus	1,051	-
COAG ED 4-HR Rule Solutions(FHRS) Stage 3	1,699	-
East Kimberley Environmental Health	30	1,720
Kalumburu Remote Aged Care Redevelopment	3,000	-
Kimberley Renal - Kununurra capital grant	2,100	3,490
Kimberley Renal - Derby capital grant	-	1,500
Kununurra Hospital expansion capital grant	2,500	4,000
Kununurra Service providers housing	2,300	2,000
Kununurra Short Stay Patient Accomodation	3,100	-
Projects funded under National Partnership Agreement (b)	(6,854)	9,025
Simulated Learning Environment Program	346	-
Warmun Remote Clinic Redevelopment	2,750	-
Other	-	1,632
	321,961	66,446

(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's Hospital Fund.

Commonwealth Grants and Contributions (via Department of Health)	265,118	-
Commonwealth Grants and Contributions (via Mental Health Commission)	17,630	-
	282,748	-
Grants and contributions from Mental Health Commission	43,483	49,993
Service Appropriations (via Department of Health)	840,624	1,010,914
	1,166,855	1,060,907

(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.

(c) The 2012 income ($2.386 million) for Pharmaceutical Benefits Scheme has been reclassified from 'Commonwealth grants and contributions' to 'Patient charges' in order to be comparable with the figure presented in 2013.

(ii) Other grants and contributions

Australian College of Emergency Medicine - EMET Funding	725	-
Broome Network Recovery Centre	-	444
Centre Care - 1 Life Suicide	160	-
Disability Services Commission - Community Aids & Equipment Program	2,057	1,989
WA Alcohol and Drug Authority - Community Drug Service Team	4,065	-
Enhancing the Pilbara	-	2,430
General Medicine Progress Report	-	117
Great Southern GP Network	119	118
HealthWays	-	90

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 15 Grants and contributions		
(ii) Other grants and contributions (continued)		
McGrath Foundation - Breast Care Nurse Funding	399	260
Medical Specialists Outreach Assistance Program	1,595	1,401
Medicare Local - For Ante Natal Program	158	-
Mental Health Commission (service delivery agreement) (a)	43,483	49,993
Mental Health Commission (SSAMHS)	4,863	2,269
Mental Health Commission Recovery Centre	250	-
Midwest Development Commission - Bidi Bidi Centre & Programs	-	100
Nindilingarri Cultural Health	136	136
Novartis Pharmaceuticals - Grant for Opthalmic Equipment	105	-
Ord Valley Aboriginal Health Service	-	442
Personally Controlled Electronic Health Record	611	1,220
Pharmaceutical Benefit Scheme Reform	-	113
Prevocational General Practice Placements	339	262
Royal Australian & New Zealand College of Anesthetists	634	-
Royal Australian & New Zealand College of Obestricicians & Gynaecologists	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	797	2,270
Royal Australian College of Physicians - STP Progress Report & Rural Support Loading	318	-
St John of God Private Hospital - Bunbury Mental Health STP	80	-
Telethon Funding	428	-
Other	690	3,311
	62,387	66,965

(d) Certain 2012 amounts ($1.073 million) have been reclassified from 'Commonwealth grants and contributions' to 'Other grants and contributions' in order to be comparable with the figures presented in 2013.

Note 16 Donation revenue

General public contributions	460	459
Hospital auxiliaries	137	351
Community fund-raising	82	-
Deceased estates	-	341
	679	1,151

Note 17 Other revenue

Services to external organisations	9,778	9,735
Use of hospital facilities	1,525	1,529
Rent from commercial properties	208	182
Rent from residential properties	225	235
Boarders' accommodation	7,917	6,811
Other	3,106	3,749
	22,759	22,241

Note 18 Service appropriations

Appropriation revenue received during the period:

Service appropriations (via the Department of Health)	840,624	1,010,914

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.

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. In previous financial years, the equivalent Commonwealth funding was received in the form of Service Appropriations via the Department of Health. See note 15 'Grants and contributions' for further information.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 19 Assets transferred		
Assets transferred from/(to) other State government agencies during the period:		
Land from Metropolitan Health Services	340	-
Land from Department of Health	4	-
Building from Metropolitan Health Services	131	-
Medical equipment from Metropolitan Health Services	26	-
Patient entertainment system from Metropolitan Health Services	1,028	-
Building to Metropolitan Health Service	(101)	-
Video conferencing equipment from the Department of Health	-	18
Mammogram equipment from Metropolitan Health Services	1	286
	1,429	304

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

Note 20 Services received free of charge		
Services received free of charge from other State government agencies during the period:		
Department of Finance - government accommodation	25	12

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

Note 21 Royalties for Regions Fund		
Regional Community Services Account:		
District Allowances	12,937	15,986
Nickol Bay Hospital	-	1,000
Patient Assisted Travel Scheme	-	8,816
Pilbara Cardiovascular Screen Program	596	-
Pilbara Health Partnership (Asset Investment)	2,829	2,826
Royal Flying Doctor Service	5,063	-
Rural Generalists Pathways	1,203	1,500
Rural in Reach - Women Support	500	635
Southern Inland Health Initiative		
- District Medical Workforce Investment Program (Stream 1)	11,432	9,780
- Redevelopment Integrated District HS (Stream 2)	2,416	3,017
- Telehealth Investment Program (Stream 5)	1,338	654
St John Ambulance Services	1,339	254
	39,653	44,468

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.

Note 22 Restricted cash and cash equivalents (a)		
Current		
Royalties for Regions Fund	2,183	5,296
Capital grant from the Commonwealth Government (b)	21,605	34,193
Patient receipts under section 19 (2) of the Health Insurance Act 1973	2,525	1,527
Bequests	499	548
Statewide specialist Aboriginal Mental health Service Project	594	-
Other	264	-
	27,670	41,564

(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.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 23 Receivables		
Current		
Patient fee debtors	10,202	8,896
Other receivables	6,625	7,740
Less: Allowance for impairment of receivables	(4,501)	(4,333)
Accrued revenue	3,680	3,688
	16,006	15,991
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	4,333	3,624
Doubtful debts expense	1,118	709
Amounts written off during the period	(937)	-
Amount recovered during the year	(12)	-
Balance at end of period	4,502	4,333

The Health Service does not hold any collateral or other credit enhancements as security for receivables.
See also note 2(p) 'Receivables' and note 51 'Financial instruments'.

Note 24 Amounts receivable for services (Holding Account)		
Current	6,600	-
Non-current	360,610	303,974
	367,210	303,974

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

Note 25 Inventories		
Current		
Supply stores - at cost	1,874	1,940
Pharmaceutical stores - at cost	2,419	2,141
Other inventories - at cost	821	893
	5,114	4,974

See note 2(o) 'Inventories'.

Note 26 Other current assets		
Prepayments	3,999	4,044

Note 27 Non-current assets classified as held for sale		
Opening balance	-	79
Less assets sold	-	(79)
Closing balance	-	-

Note 28 Property, plant and equipment		
Land		
At fair value (a)	202,760	178,876
Buildings		
At fair value (a)	1,276,025	1,060,246
Accumulated depreciation	-	-
	1,276,025	1,060,246
Total land and buildings	1,478,785	1,239,122

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2013

	2013 $000	2012 $000
Note 28 Property, plant and equipment (continued)		
Leasehold improvements		
At cost	1,926	1,682
Accumulated depreciation	(968)	(769)
	958	913
Computer equipment		
At cost	2,649	1,714
Accumulated depreciation	(1,252)	(1,154)
	1,397	560
Furniture and fittings		
At cost	2,919	2,556
Accumulated depreciation	(972)	(841)
	1,947	1,715
Motor vehicles		
At cost	7,090	5,585
Accumulated depreciation	(4,871)	(3,846)
	2,219	1,739
Medical equipment		
At cost	90,230	83,594
Accumulated depreciation	(43,296)	(35,505)
	46,934	48,089
Other plant and equipment		
At cost	14,512	16,317
Accumulated depreciation	(7,611)	(6,755)
	6,901	9,562
Works in progress		
Buildings under construction (at cost)	90,000	209,711
Other Work in Progress (at cost)	5,417	3,790
	95,417	213,501
Artworks		
At cost	70	70
Total property, plant and equipment	1,634,628	1,515,271

(a) Land and buildings were revalued as at 1 July 2012 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2013 and recognised at 30 June 2013. In undertaking the revaluation, fair value was determined by reference to the market value for land: $112.741 million and buildings: $123.361 million. For the remaining balance, fair value of land and buildings was determined on the basis of depreciated replacement cost. See also note 2(f) 'Property, plant and equipment'.

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	178,876	165,527
Additions	898	450
Transfer from/(to) other reporting entities	(164)	211
Disposals	(84)	(253)
Revaluation increments / (decrements)	23,544	12,941
Donations to non government organisations	(310)	-
Carrying amount at end of period	202,760	178,876

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 28 Property, plant and equipment (continued)		
Buildings		
Carrying amount at start of period	1,060,246	1,070,037
Additions	1,924	3,505
Transfers from Work in Progress	214,637	19,676
Transfer from/(to) other reporting entities	30	-
Disposals	(290)	(278)
Revaluation increments / (decrements)	44,548	(697)
Depreciation	(45,046)	(31,848)
Transfer between asset classes	-	(149)
Write-down of assets	(24)	-
Carrying amount at end of period	1,276,025	1,060,246
Leasehold improvements		
Carrying amount at start of period	913	885
Additions	245	-
Transfers from work in progress	-	320
Depreciation	(200)	(292)
Carrying amount at end of period	958	913
Computer equipment		
Carrying amount at start of period	560	512
Additions	161	167
Transfers from Work in Progress	-	120
Transfer from/(to) other reporting entities	1,028	-
Disposals	(21)	(9)
Depreciation	(246)	(215)
Transfer between asset classes	(19)	(15)
Write-down of assets	(66)	-
Carrying amount at end of period	1,397	560
Furniture and fittings		
Carrying amount at start of period	1,715	1,421
Additions	501	379
Transfers from Work in Progress	17	108
Disposals	(30)	(6)
Depreciation	(170)	(154)
Transfer between asset classes	(28)	108
Write-down of assets	(58)	(141)
Carrying amount at end of period	1,947	1,715
Motor vehicles		
Carrying amount at start of period	1,739	1,739
Additions	970	926
Transfers from Work in Progress	641	-
Disposals	(3)	(26)
Depreciation	(1,097)	(882)
Transfer between asset classes	(31)	-
Write-down of assets	-	(18)
Carrying amount at end of period	2,219	1,739
Medical equipment		
Carrying amount at start of period	48,089	45,302
Additions	7,830	9,395
Transfers from Work in Progress	742	2,182
Transfer from/(to) other reporting entities	26	190
Disposals	(651)	(176)
Depreciation	(10,848)	(8,348)
Transfer between asset classes	1,888	(386)
Write-down of assets	(142)	(70)
Carrying amount at end of period	46,934	48,089

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 28 Property, plant and equipment (continued)		
Other plant and equipment		
Carrying amount at start of period	9,562	7,176
Additions	527	2,981
Transfers from Work in Progress	139	112
Transfer from/(to) other reporting entities	-	18
Disposals	(148)	(75)
Depreciation	(1,356)	(1,076)
Transfer between asset classes	(1,811)	442
Write-down of assets	(12)	(16)
Carrying amount at end of period	6,901	9,562
Works in progress		
Carrying amount at start of period	213,501	72,986
Additions	113,212	165,856
Capitalised to asset classes	(216,177)	(22,518)
Write-down of assets	(408)	(2,823)
Donations to non government organisations	(14,711)	-
Carrying amount at end of period	95,417	213,501
Artworks		
Carrying amount at start of period	70	71
Disposals	-	(1)
Carrying amount at end of period	70	70
Total property, plant and equipment		
Carrying amount at start of period	1,515,271	1,365,656
Additions	126,268	183,660
Disposals	(1,227)	(825)
Transfer from/(to) other reporting entities	920	419
Revaluation increments / (decrements)	68,092	12,244
Depreciation	(58,963)	(42,815)
Write-down of assets	(710)	(3,068)
Donations to non government organisations	(15,021)	-
Carrying amount at end of period	1,634,628	1,515,271
Note 29 Intangible assets		
Computer software		
At cost	252	293
Accumulated amortisation	(189)	(194)
	63	99
Works in progress		
Computer software under development (at cost)	35	-
Total intangible assets	98	99
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	99	146
Disposals	(3)	(2)
Amortisation expense	(33)	(45)
Carrying amount at end of period	63	99

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000

Note 30 Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets as at 30 June 2013.

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 2013 have either been classified as assets held for sale or written off.

Note 31 Payables

Current		
Trade creditors	26,732	12,162
Accrued expenses	46,900	37,663
Accrued salaries	27,762	23,028
Accrued interest	43	56
	101,437	72,909

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

Note 32 Borrowings

Current		
Department of Treasury loans (a)	1,436	1,373
Non-current		
Department of Treasury loans (a)	9,780	11,164
	11,216	12,537

(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 33 Provisions

Current		
Employee benefits provision		
Annual leave (a)	55,513	52,331
Time off in lieu leave (a)	20,674	19,174
Long service leave (b)	33,091	29,472
Gratuities	1,095	849
Deferred salary scheme (c)	2,256	1,932
	112,629	103,758
Non-current		
Employee benefits provision		
Long service leave (b)	21,856	18,324
Gratuities	192	254
	22,048	18,578
	134,677	122,336

(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	60,402	55,386
More than 12 months after the end of the reporting period	15,784	16,119
	76,186	71,505

(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:

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

	2013 $000	2012 $000
Note 33 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	1,073	772
More than 12 months after end of the reporting period	1,184	1,160
	2,257	1,932
Note 34 Other liabilities		
Current		
Refundable deposits	1	1
Other	40	30
	41	31
Note 35 Contributed equity		
The 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 36).		
Balance at start of period	1,283,605	1,141,999
Contributions by owners		
Capital appropriation (a)	54,746	98,873
Royalties for Regions Fund – Regional Infrastructure and Headwork Account	48,702	42,522
Transfer of net assets from other agencies (b) (c)	-	390
	103,448	141,785
Distributions to owners		
Transfer of net assets to other agencies (b) (c)	(508)	(179)
Balance at end of period	1,386,545	1,283,605

(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 36 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	354,318	342,074
Net revaluation increments / (decrements) (b) :		
Land	23,544	12,941
Buildings	44,548	(697)
Balance at end of period	422,410	354,318

(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 2013

	2013 $000	2012 $000
Note 37 Accumulated surplus/(deficit)		
Balance at start of period	53,631	2,327
Result for the period	(50,720)	51,304
Balance at end of period	2,911	53,631
Note 38 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	4,512	13,450
Restricted cash and cash equivalents	27,670	41,564
	32,182	55,014
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(815,323)	(936,881)
Increase/(decrease) in assets:		
Receivables	195	2,866
Inventories	140	180
Prepayments and other current assets	(45)	1,187
Decrease/(increase) in liabilities:		
Payables	(28,528)	(15,342)
Current provisions	(8,871)	(8,208)
Non-current provisions	(3,470)	(2,032)
Income received in advance	-	1,845
Other current liabilities	(10)	(30)
Non-cash items:		
Doubtful debts expense (note 23)	(1,118)	(709)
Depreciation and amortisation expense (note 10)	(58,997)	(42,860)
Loss from disposal of non-current assets (note 11)	(716)	(608)
Interest paid by Department of Health	(565)	(735)
Donation of non-current assets	95	16
Services received free of charge (note 20)	(25)	(12)
Write off of Receivables (note 23)	937	-
Write down of property, plant and equipment (note 28)	(710)	(3,068)
Donations of property, plant and equipment (note 28)	(15,021)	-
Adjustment for other non-cash items	(420)	(3)
Net cost of services (Statement of Comprehensive Income)	(932,451)	(1,004,394)
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	840,624	1,010,914
Royalties for Regions Fund as per Statement of Comprehensive Income	39,653	44,468
Royalties for Regions Fund credited directly to Contributed Equity (Refer Note 35)	48,702	42,522
Capital contributions credited directly to Contributed Equity (Refer Note 35)	54,746	98,873
	983,725	1,196,777
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	(565)	(735)
Repayment of interest-bearing liabilities to Department of Treasury	(1,321)	(1,261)
Accrual appropriations	(63,235)	(50,647)
	(65,121)	(52,643)
Cash Flows from State Government as per Statement of Cash Flows	918,604	1,144,134

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 2013

	2013 $000	2012 $000
Note 39 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 40 Gifts of public property		
Gifts of public property	310	275
Note 41 Services provided free of charge		
Mental Health Commission - contracted mental health services	2,620	-

Note 42 Remuneration of members of the Accountable Authority and senior officers

Remuneration of members of the Accountable Authority

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

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

	2013	2012
$110,001 - $120,000	1	-
$400,001 - $410,000	1	-
$610,001 - $620,000	-	1
Total	2	1

	$000	$000
Base remuneration and superannuation	627	555
Annual leave and long service leave accruals	(100)	63
Other benefits	-	-
The total remuneration of members of the Accountable Authority	527	618

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:

$40,001 - $50,000	-	1
$50,001 - $60,000	-	1
$70,001 - $80,000	-	1
$100,001 - $110,000	-	1
$140,001 - $150,000	1	-
$160,001 - $170,000	-	1
$170,001 - $180,000	1	2
$180,001 - $190,000	4	-
$190,001 - $200,000	1	-
$200,001 - $210,000	2	4
$210,001 - $220,000	1	2
$220,001 - $230,000	1	-
$240,001 - $250,000	-	1
$250,001 - $260,000	1	-
$390,001 - $400,000	-	1
$410,001 - $420,000	2	1
$430,001 - $440,000	1	1
Total	15	17

	$000	$000
Base remuneration and superannuation	3,450	3,204
Annual leave and long service leave accruals	60	226
Other benefits	115	90
The total remuneration of senior officers	3,625	3,520

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 2013

	2013 $000	2012 $000
Note 43 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	618	595
Note 44 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	150,366	158,246
Later than 1 year, and not later than 5 years	289,552	188,935
	439,918	347,181
The capital commitments include amounts for buildings:	435,661	297,206
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	20,522	18,505
Later than 1 year, and not later than 5 years	14,198	8,434
Later than 5 years	1,629	1,624
	36,349	28,563
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	45,519	32,076
Later than 1 year, and not later than 5 years	41,026	27,743
Later than 5 years	5,828	25,717
	92,373	85,536
Note 45 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.	16,379	9,310
Number of claims	6	7
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Environment and Conservation (DEC)	268	970
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 2013

	2013 $000	2012 $000

Note 46 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 47 Related bodies

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

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

Note 48 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 49 Administered trust accounts

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

a) The Health Service administers a trust account for the purpose of holding patients' private moneys.

A summary of the transactions for this trust account is as follows:

Balance at the start of period	1,240	953
Add Receipts	2,141	1,821
	3,381	2,774
Less Payments	(2,400)	(1,534)
Balance at the end of period	981	1,240

b) The Health Service administers a trust account for salaried medical practitioners under the rights to private practice scheme.

A summary of the transactions for this trust account is as follows:

Balance at the start of period	-	154
Add Receipts	-	-
	-	154
Less Payments	-	(154)
Balance at the end of period	-	-

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

Staff Development and Diabetes Education Fund

Balance at start of period	-	4
Add Receipts	-	-
	-	4
Less Payments	-	(4)
Balance at end of period	-	-

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

Note 50 Explanatory Statement

Significant variances between actual results for 2012 and 2013

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	2013 Actual $000	2012 Actual $000	Variance $000
Expenses				
Employee benefits expense	(a)	797,260	723,879	73,381
Fees for visiting medical practitioners		75,285	69,803	5,482
Patient support costs	(b)	270,734	213,953	56,781
Finance costs		552	716	(164)
Depreciation and amortisation expense	(c)	58,997	42,860	16,137
Loss on disposal of non-current assets		716	608	108
Repairs, maintenance and consumable equipment	(d)	38,054	33,077	4,977
Other expenses	(e)	146,749	120,245	26,504
Income				
Patient charges		48,110	43,928	4,183
Commonwealth grants and contributions	(f)	321,961	66,446	255,515
Other grants and contributions	(g)	62,387	66,965	(4,578)
Donation revenue		679	1,151	(472)
Interest revenue		-	16	(16)
Other revenue		22,759	22,241	518
Service appropriations	(h)	840,624	1,010,914	(170,290)
Assets transferred	(i)	1,429	304	1,125
Services received free of charge		25	12	13
Royalties for Regions Fund	(j)	39,653	44,468	(4,815)

(a) Employee benefits expense

Employee benefits expenses increased due to the combined effects of changes in salary rates under approved industrial agreements, increases in district allowance expenses, a back payment for superannuation due to a change in the range of allowances included in superannuation calculations, growth in inpatient separations and Emergency Department presentations, and funded new or expanded programs.

(b) 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 the State's funding agreement with the Royal Flying Doctor Service. Other factors include increasing demand for public hospital and ED services, the full year operation of the Broome Psychiatric Unit, expansion of Renal Dialysis in the Kimberley and financial support for the South West Radiotherapy Oncology Service have resulted in increased patient support costs. Electricity and water charges have also contributed to cost increases.

(c) Depreciation and amortisation expense

Depreciation on buildings has increased due to the write down of the residual value of the decommissioned Port Hedland Hospital, the full year impact of the South West radiotherapy facility which was commissioned in 2011/12, and the 2012/13 commissioning of the new Albany Health Campus and the Kununurra Ochre Health Centre. Investments in medical equipment, including medical imaging and the expansion of Telehealth infrastructure, have also contributed to increased annual depreciation expenses.

(d) Repairs, maintenance and consumable equipment

Increases in expenditures include non-capital equipment purchases for new facilities including Albany Health Campus, the Kalgoorlie Hospital expansion and the Kununurra Ochre Health Centre. In addition maintenance charges and maintenance contract expenditures are increasing in line with ongoing investments in medical and imaging equipment.

(e) Other expenses

Other Expenses increased due to the transfer of a number of clinics and other facilities to Aboriginal Medical Services in the Kimberley ($15m) and increases in staff accommodation costs ($6m). Increases beyond general cost escalation were also experienced in Workers Compensation and Fringe Benefits Tax

(f) Commonwealth grants and contributions

Commonwealth Grants and Contributions are received for specific and/or non recurrent programs and, consequently, are variable from year to year. Changes in Commonwealth Grants and Contributions are detailed in Note 15 (i).

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. Under the new arrangements these funds which were previously received by Health Services as Services Appropriation are now received from the State Pool Account and recognised as Commonwealth grants and contributions.

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2013

Note 50 Explanatory Statement (continued)

Significant variances between actual results for 2012 and 2013

(g) Other grants and contributions
Other 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 15 (ii).

(h) Service appropriations
Increases in Services Appropriations to support general cost increases and for new and expanded services in 2012/13 were offset by changes to funding arrangements for various hospital related services under the National Health Reform Agreement.

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. Under the new arrangements these funds which were previously received by Health Services as Services Appropriation are now received from the State Pool Account and recognised as Commonwealth grants and contributions.

(i) Assets transferred
Assets transferred in 2012/13 include 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.

(j) 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 2011/12 and 2012/13 are detailed in Note 21.

Significant variances between estimated and actual results for 2013

Significant variations between the estimates and actual results for 2013 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2013 Actual $000	2013 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense		797,260	760,040	37,220
Other goods and services	(a)	591,087	532,845	58,242
Total expenses		1,388,347	1,292,885	95,462
Less: Revenues	(b)	(455,896)	(137,742)	(318,154)
Net cost of services		932,451	1,155,143	(222,692)

(a) Other goods and services
The variance in Other Goods and Services is primarily attributable to costs expensed from the Capital Works Program for which some budget adjustments were received during the year ($26.3 million), various continuing and new services for which funding was not included in the initial budget but was the subject of subsequent budget allocations ($6.9 million), and staff accommodation costs in excess of budgets ($8.3 million). Other factors include Inpatient and ED activity above target ($1.0 million) and costs associated with services funded from Revenues above budget ($2.7 million). The balance represents expenditures on Workers Compensation, and Other Staffing Costs for which the initial budget was incorrectly included in Employee Benefits Expenses and was subsequently realigned to Other Goods and Services.

(b) Revenues
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. Under the new arrangements $270.9 million which was initially budgeted as Services Appropriation was received from the State Pool Account and recognised as Revenue.

Non Patient Revenue received in excess of the initial budget included Commonwealth Capital Grants totalling $16.4 million for projects associated with the East Kimberley Redevelopment, the Emergency Departments' National Partnership Agreement, and Geraldton Cancer Centre, and various other non patient revenues received for services not included in the initial budget but for which some budget adjustments were received during the year ($29.4 million).

Notes to the Financial Statements

For the year ended 30 June 2013

Note 51 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 51(c) 'Financial Instrument disclosures' and note 23 '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 51(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 2013

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 due to 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**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are :

	2013 $000	2012 $000
Financial Assets		
Cash and cash equivalents	4,512	13,450
Restricted cash and cash equivalents	27,670	41,564
Loans and receivables	383,216	319,965
Financial Liabilities		
Financial liabilities measured at amortised cost	112,653	85,446

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2013

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
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	-	-
2012							
Cash and cash equivalents	13,450	13,450	-	-	-	-	-
Restricted cash and cash equivalents	41,564	41,564	-	-	-	-	-
Receivables	15,991	9,308	2,617	2,190	1,876	-	-
Amounts receivable for services	303,974	303,974	-	-	-	-	-
	374,979	368,296	2,617	2,190	1,876	-	-

Notes to the Financial Statements
For the year ended 30 June 2013

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
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	-	101,437	-	-	101,437	101,437	101,437	-	-	-
Department of Treasury Loans	4.65%	11,216	-	11,216	-	13,436	353	1,605	7,821	3,657
		112,653	-	11,216	101,437	114,873	101,790	1,605	7,821	3,657

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2013

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
2012										
Financial Assets										
Cash and cash equivalents	-	13,450	-	-	13,450	13,450	13,450	-	-	-
Restricted cash and cash equivalents	-	41,564	-	-	41,564	41,564	41,564	-	-	-
Receivables	-	15,991	-	-	15,991	15,991	15,991	-	-	-
Amounts receivable for services	-	303,974	-	-	303,974	303,974	-	-	6,600	297,374
		374,979	-	-	374,979	374,979	71,005	-	6,600	297,374
Financial Liabilities										
Payables	-	72,909	-	-	72,909	72,909	72,909	-	-	-
Department of Treasury Loans	5.39%	12,537	-	12,537	-	15,950	162	1,886	8,079	5,823
		85,446	-	12,537	72,909	88,859	73,071	1,886	8,079	5,823

Notes to the Financial Statements
For the year ended 30 June 2013

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.

A change in banking arrangement effective from 1 July 2011 in accordance with the State Government's direction has resulted in the loss of interest earning capacity for all of the Health Service's bank accounts.

	Amount Exposed to Interest Rate Risk	-100 basis points		+100 basis points	
2013	$000	Surplus $000	Equity $000	Surplus $000	Equity $000
Financial Liabilities					
Department of Treasury Loans	11,216	112	112	(112)	(112)
Total Increase/(Decrease)		112	112	(112)	(112)

	Amount Exposed to Interest Rate Risk	-100 basis points		+100 basis points	
2012	$000	Surplus $000	Equity $000	Surplus $000	Equity $000
Financial Liabilities					
Department of Treasury Loans	12,537	125	125	(125)	(125)
Total Increase/(Decrease)		125	125	(125)	(125)

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 2013

Note 52 Schedule of income and expenses by service

	Public Hospital Admitted Patients		Palliative Care		Emergency Department		Public Hospital Non-Admitted Patients		Patient Transport	
	2013 $000	2012 $000	2013 $000	2012 $000	2013 $000	2012 $000	2013 $000	2012 $000	2013 $000	2012 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	410,843	336,681	3,189	2,215	96,813	58,446	69,535	108,810	2,359	2,142
Fees for visiting medical practitioners	39,013	46,308	301	13	9,142	8,339	6,566	12,387	5	5
Patient support costs	115,750	86,972	954	1,104	28,961	13,318	20,801	21,545	40,096	32,227
Finance costs	284	466	2	-	67	112	48	105	2	3
Depreciation and amortisation expense	29,933	25,128	236	16	7,164	4,725	5,146	6,791	644	468
Loss on disposal of non-current assets	370	248	3	-	87	39	62	69	1	1
Repairs, maintenance and consumable equipment	19,688	15,662	152	59	4,621	3,309	3,319	4,685	35	30
Other expenses	75,180	45,100	587	338	17,820	7,191	12,799	18,553	877	719
Total cost of services	691,061	556,565	5,424	3,745	164,675	95,479	118,276	172,945	44,019	35,595
Income										
Patient charges	28,114	16,848	192	-	5,842	735	4,196	20,255	-	-
Commonwealth grants and contributions	170,511	23,955	1,288	33	39,096	973	28,081	6,401	-	258
Other grants and contributions	12,860	3,293	(60)	14	400	417	298	872	(385)	110
Donation revenue	397	765	3	1	82	69	59	195	-	28
Interest revenue	-	10	-	-	-	1	-	2	-	-
Other revenue	13,299	14,781	91	11	2,764	1,337	1,985	3,772	-	543
Total income other than income from State Government	225,181	59,652	1,514	59	48,184	3,532	34,619	31,497	(385)	939
NET COST OF SERVICES	**465,880**	**496,913**	**3,910**	**3,686**	**116,491**	**91,947**	**83,657**	**141,448**	**44,404**	**34,656**
INCOME FROM STATE GOVERNMENT										
Service appropriations	443,571	509,622	3,362	3,865	102,079	95,617	73,317	149,175	27,693	4,375
Assets transferred	788	140	6	1	173	24	125	44	47	9
Services received free of charge	14	5	-	-	3	1	2	2	1	-
Royalties for Regions Fund	9,442	8,471	3,775	4,233	9,632	10,801	1,887	2,117	5,666	6,355
Total income from State Government	453,815	518,238	7,143	8,099	111,887	106,443	75,331	151,338	33,407	10,739
SURPLUS/(DEFICIT) FOR THE PERIOD	**(12,065)**	**21,325**	**3,233**	**4,413**	**(4,604)**	**14,496**	**(8,326)**	**9,890**	**(10,997)**	**(23,917)**

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 2013

Note 52 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Continuing Care		Mental Health (a)		Total	
	2013 $000	2012 $000	2013 $000	2012 $000	2013 $000	2012 $000	2013 $000	2012 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	95,936	83,682	65,900	77,352	52,684	54,551	797,260	723,879
Fees for visiting medical practitioners	9,059	331	6,223	1,335	4,976	1,085	75,285	69,803
Patient support costs	28,699	42,646	19,713	13,378	15,760	2,763	270,734	213,953
Finance costs	66	2	46	24	37	4	552	716
Depreciation and amortisation expense	7,099	1,746	4,877	3,661	3,899	325	58,997	42,860
Loss on disposal of non-current assets	86	216	59	23	48	12	716	608
Repairs, maintenance and consumable equipment	4,579	5,210	3,145	1,973	2,515	2,149	38,054	33,077
Other expenses	17,659	23,585	12,130	11,130	9,697	13,629	146,749	120,245
Total cost of services	163,183	157,418	112,093	108,876	89,616	74,518	1,388,347	1,205,141
Income								
Patient charges	5,789	-	3,977	4,803	-	1,287	48,110	43,928
Commonwealth grants and contributions	38,742	21,752	26,613	10,641	17,630	2,433	321,961	66,446
Other grants and contributions	402	3,236	276	2,236	48,596	56,787	62,387	66,965
Donation revenue	82	-	56	87	-	6	679	1,151
Interest revenue	-	-	-	2	-	1	-	16
Other revenue	2,739	-	1,881	1,679	-	118	22,759	22,241
Total income other than income from State Government	47,754	24,988	32,803	19,448	66,226	60,632	455,896	200,747
NET COST OF SERVICES	**115,429**	**132,430**	**79,290**	**89,428**	**23,390**	**13,886**	**932,451**	**1,004,394**
INCOME FROM STATE GOVERNMENT								
Service appropriations	101,154	138,082	69,484	93,856	19,964	16,322	840,624	1,010,914
Assets transferred	172	40	118	28	-	18	1,429	304
Services received free of charge	3	2	2	1	-	1	25	12
Royalties for Regions Fund	5,476	6,141	3,775	4,233	-	2,117	39,653	44,468
Total income from State Government	106,805	144,265	73,379	98,118	19,964	18,458	881,731	1,055,698
SURPLUS/(DEFICIT) FOR THE PERIOD	**(8,624)**	**11,835**	**(5,911)**	**8,690**	**(3,426)**	**4,572**	**(50,720)**	**51,304**

(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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