WA Country Health Service

Annual Report 2003-04

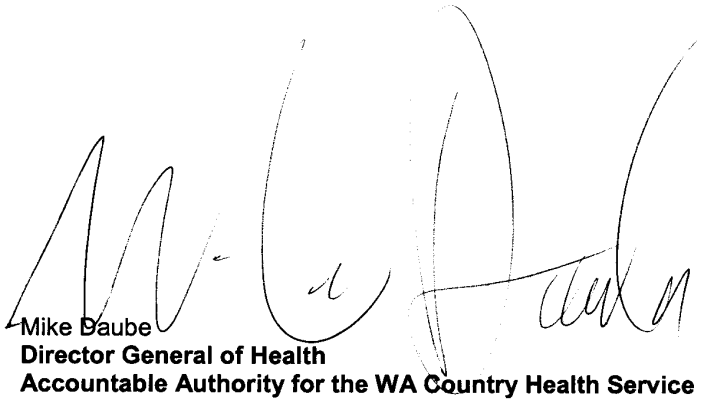
Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 62 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of the Department of Health, WA Country Health Service for the year ended 30 June 2004.

This report has been prepared in accordance with the provisions of the *Financial Administration and Audit Act 1985*.



Mike Daube
Director General of Health
Accountable Authority for the WA Country Health Service

31 August 2004

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ILLUSTRATIONS

Director General's Overview

The 2003-04 year has been one of consolidation for the WA Country Health Service, with significant achievements in organisational and service improvement. The report and recommendations of the Health Reform Committee supports the vision outlined in the Country Health Services Review. Much of this work is already under way and a number of new corporate and service programs have commenced and will be advanced over the next few years.

District Health Advisory Councils have been implemented throughout the area health service and they will continue to have an important role in health services. The WA Country Health Service has facilitated an orientation and training support program for the new councils. A conference of the District Advisory Councils Chairpersons was also held in April 2004.

Country health services continue to face major challenges in attracting and retaining medical service providers, nursing and allied health staff. The WA Country Health Service has made considerable progress in reducing reliance on agency nurses by attracting more permanent nursing staff. The Country Allied Health Scholarship Scheme allocated undergraduate scholarships and contributed funding to students to support country placements. This scheme has been very successful with ten new graduates being retained in employment in rural areas.

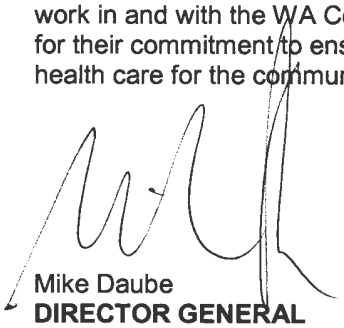
New Directors of Medical Services have been appointed with the aim of maximising medical workforce retention and strengthening clinical governance. Partnerships with private GPs, community groups and indigenous organisations have resulted in the development of a number of new and innovative service and staffing models to meet local needs and priorities.

In 2003-04, capital investment in the WA Country Health Service exceeded $15 million for projects at various stages of development with continued investment planned for 2004-05 in excess of $47 million. Significant highlights for the year were:

- Completion of the new Ravensthorpe District Health Centre at a cost of $3.9 million;
- Commencement of construction on the new Geraldton Regional Resource Centre which will cost $49 million, and is due for completion in late 2005-06;
- Reinstatement of the Moora Hospital replacement project in the 2004-05 Capital Works Program with construction expected to commence in late 2004;
- Announcement of a new 54 bed residential care facility to be constructed in South Hedland as Stage 1 of the Hedland Regional Resource Centre redevelopment. This will eventually replace the ageing Port Hedland Regional Hospital;
- Continuation of redevelopment of Kimberley health infrastructure with construction commencing on the new Halls Creek Hospital replacement, approval for a new CT scanning service for Broome, and advanced planning on redevelopments in Derby, Broome, Wyndham and Kununurra.

A number of reviews that support service development commenced this year and will be completed in the forthcoming financial year. The Transport Review is focusing on transport requirements and issues for country services whilst the MPS Leading Practice Project seeks to enhance the quality and sustainability of aged care services in rural towns and communities.

This year has seen substantial achievement in all areas of operation across the area health service and I look forward to our continuing efforts to deliver high quality and sustainable health services to country communities. In particular, our continued efforts will be focused on the implementation of the regional and district health service networking arrangements. We will continue to develop strategic partnerships with other service providers and agencies in developing effective and innovative solutions to strengthening country health services. I would like to express my appreciation to all those who work in and with the WA Country Health Service for their commitment to ensuring the best possible health care for the communities we serve.



Mike Daube
DIRECTOR GENERAL

31 August 2004

ADDRESS AND LOCATION

The WA Country Health Service (WACHS) is one part of the Western Australian Government health system managed by the Director General of Health. In addition to the WA Country Health Service, five other services report to the Director General. These services are the Metropolitan Health Service, South West Area Health Service, Peel Health Services, Hawthorn Hospital and the Royal Street Divisions.

WA Country Health Service Head Office
1st Floor 'B' Block
189 Royal Street
EAST PERTH WA 6004

☎ (08) 9222 4160
(08) 9222 2034

The WACHS Head Office will be relocating to new office premises late this year at the former School of Dentistry, Perth Dental Hospital at 189 Wellington Street Perth. Contact details will be announced at that time.

WACHS is accountable for health service provision in the

- Kimberley.
- Pilbara Gascoyne.
- Midwest and Murchison.
- Wheatbelt.
- Great Southern.
- Goldfields South East.

Contact details for regional offices are provided below.

The Kimberley Regional Office
Postal Address:
Locked Bag 4011
BROOME WA 6725

'Yamamoto House'
Unit 5, Napier Terrace
BROOME WA 6725

☎ (08) 9194 1600
(08) 9194 1666

The Pilbara Gascoyne Regional Office
Postal Address:
PO Box 63
PORT HEDLAND WA 6721

Morgans Street
PORT HEDLAND WA 6721

☎ (08) 9158 1794
(08) 9173 2964

The Midwest and Murchison Regional Office
Postal Address:
PO Box 22
GERALDTON WA 6531

Onslow Street
GERALDTON WA 6530

☎ (08) 9956 2209
(08) 9956 2421

The Wheatbelt Regional Office
Postal Address:
PO Box 690
NORTHAM WA 6401

Unit 2 Avon Mall
178 Fitzgerald Street
NORTHAM WA 6401

☎ (08) 9622 4350
(08) 9622 4351

The Goldfields South East Regional Office
Postal Address:
PO Box 716
KALGOORLIE WA 6433

1st Floor, Viskovich House
377 Hannan Street
KALGOORLIE WA 6430

☎ (08) 9026 2331
(08) 9091 6592

Great Southern Regional Office
Postal Address:
PO Box 165
ALBANY WA 6331

'Callistemon House'
Warden Avenue
ALBANY WA 6330

☎ (08) 9892 2662
(08) 9842 1095

DEPARTMENT OF HEALTH - VISION STATEMENT

To ensure that the health status of the Western Australian population leads the world and the standard of health care is acknowledged as international best practice.

MISSION STATEMENT

The State health system is dedicated to ensuring the best achievable health status for all of the Western Australian community.

In particular, the system will deliver:

- Strong public health and preventive measures to protect the community and promote health.
- First class acute and chronic health care to those in need.
- Appropriate health, rehabilitation and domiciliary care for all stages of life.
- A continuing and co-operative emphasis on improving the health status of our indigenous, rural and remote and disadvantaged populations.

VALUES

- Evidence-based practices leading to high quality and effective health care at all levels.
- Ethical behaviour, equity and justice.
- Collaboration and cooperation between all parts of the health portfolio and with other agencies.
- Excellence in communication within the system and externally.
- Transparency of operations.
- Commitment to engaging the community.
- A workforce that is valued.
- Supporting and recognising those individuals and groups demonstrating effective leadership in the achievement of the vision and mission of the Western Australian health system.

GOALS

The State health system strives for excellence in:

- The delivery of health services and care to the WA population.
- Preventive measures and activities to maintain and improve the health status of the WA community.
- Indigenous health.
- Evaluation and research aimed at improving the health of people and the services they need.

WA COUNTRY HEALTH SERVICE - VISION STATEMENT

To create unified, well networked and strengthened systems in the WA Country Health Service and a 'Whole of Community' approach to new and innovative future solutions.

MISSION STATEMENT

To provide a robust and sustainable system of health service delivery that meets contemporary health needs.

KEY STRATEGIC INITIATIVES AND OBJECTIVES IN 2003-04

The WA Country Health Service has undertaken and continued a number of initiatives implemented to develop and deliver quality health services. Specifically these initiatives have been:

- Implementing new District Health Advisory Councils and developing the communications networks and support programs to sustain their effectiveness and contribution to area health service planning and service delivery.
- Working with key stakeholders to identify cost effective staff attraction and retention strategies, and the development and implementation of flexible and innovative approaches to overcoming key skills shortages.
- Developing a nursing leadership advisory network.
- Developing an allied health reference group.
- Undertaking a Multi Purpose Service Leading Practice Reform project focused on developing a sustainable service model for small rural communities with particular reference to aged care in the Wheatbelt.
- Continuing the development and implementation of new regional service networking arrangements.
- Engaging key stakeholders and establishing alliances and formal partnerships.
- Developing and implementing flexible and innovative service delivery and pursuing outcomes that will sustain viable medical services in regional centres and larger towns.
- Implementing a quality framework and clinical governance system.
- Progressing the capital investment plan across the area health service.

SERVICES PROVIDED

The WA Country Health Service provides acute and primary health care services. In 2003-04 the health service was responsible for administering and managing a large number of properties and assets used to deliver these services. These include:

- 57 hospitals;
- 21 nursing posts;
- 16 aged care facilities;
- 56 health centres;
- 125 child, community, dental, alcohol and drug, mental and public health facilities;
- 493 staff accommodation facilities; and
- over 50 office and general service buildings and facilities.

Hospitals throughout the area health service made available 1291 multi-day beds and 134 same-day beds (February 2004). In 2003 the WACHS delivered 3,246 live born infants, provided 22,498 same day procedures and discharged 71,747 hospital cases with an average length of stay of 3.1 days.

The major acute hospitals managed by the WA Country Health Service are:

Kimberley
Broome Hospital
Derby Hospital
Kununurra Hospital

Pilbara Gascoyne
Port Hedland Hospital
Carnarvon Hospital
Newman Hospital
Nickol Bay Hospital

Midwest and Murchison
Geraldton Hospital

Goldfields South East
Kalgoorlie Hospital
Esperance Hospital

Great Southern
Albany Hospital
Katanning Hospital

Wheatbelt
Northam Hospital
Narrogin Hospital
Merredin Hospital
Moora Hospital

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

Direct Patient Services
Accident and Emergency
Acute, general and specialist medical and surgical
Renal dialysis
Paediatrics
Obstetrics and gynaecology
Aged and extended care
Psychiatric and mental health
Occupational medicine
Pain management

Medical Support Services
Ambulance
Audiology
Medical imaging
Occupational therapy
Pathology
Pharmacy
Dietetics and nutrition
Physiotherapy
Podiatry
Social work
Speech pathology

Community and Support Services
Aged care assessments
Community, child and maternal health
Public health
Health promotion
Residential aged care
Home and Community Care
Community Aged Care Packages
Community mental health
Palliative care
Community aids and appliances

Other Services
Patient Assisted Travel Scheme
Telehealth facilities
Hospital in the Home
General administration and management
Engineering and maintenance
Hotel and catering
Medical records

ENABLING LEGISLATION

Acts administered

Acts Amendment (Abortion) Act 1998
Alcohol and Drug Authority Act 1974
Anatomy Act 1930
Animal Resources Authority Act 1981
Blood Donation (Limitation of Liability) Act 1985
Cannabis Control Act 2003
Chiropractors Act 1964
Co-opted Medical and Dental Services for the Northern Portion of the State Act 1951
Cremation Act 1929
Dental Act 1939
Dental Prosthetists Act 1985
Fluoridation of Public Water Supplies Act 1966
Health Act 1911
Health Legislation Administration Act 1984
Health Professionals (Special Events Exemption) Act 2000
Health Services (Conciliation and Review) Act 1995
Health Services (Quality Improvement) Act 1994
Hospital Fund Act 1930
Hospitals and Health Services Act 1927
Human Reproductive Technology Act 1991
Human Tissue and Transplant Act 1982
Medical Act 1894
Mental Health Act 1996
Mental Health (Consequential Provisions) Act 1996
Nuclear Waste Storage (Prohibition) Act 1999
Nurses Act 1992
Occupational Therapists Registration Act 1980
Optical Dispensers Act 1966
Optometrists Act 1940
Osteopaths Act 1997
Perth Dental Hospital Land Act 1942
Pharmacy Act 1964
Physiotherapists Act 1950
Podiatrists Registration Act 1984
Poisons Act 1964
Psychologists Registration Act 1976
Public Dental Hospital Land Act 1934
Queen Elizabeth II Medical Centre Act 1966
Radiation Safety Act 1975
Tobacco Control Act 1990
University Medical School Act 1955
University Medical School Teaching Hospitals Act 1955
Western Australian Bush Nursing Trust Act 1936

Acts Passed During 2003-04

Cannabis Control Act 2003
Nurses Amendment Act 2003

Acts in Parliament at 30 June 2004

Human Reproductive Technology Amendment Bill 2003
Human Reproductive Technology Amendment Bill (Prohibition of Human Cloning) 2003
Health Amendment Bill 2004
Health Legislation Amendment Bill 2004

Amalgamation and Establishment of Boards

There were no boards amalgamated or established during 2003-04.

MINISTERIAL DIRECTIVES

The Minister for Health did not issue any directives on Department of Health operations during 2003-04.

STATEMENT OF COMPLIANCE WITH PUBLIC SECTOR STANDARDS

In the administration of the WA Country Health Service, I have complied with the *Public Sector Standards in Human Resources Management,* the *Western Australian Public Sector Code of Ethics* and our *Code of Conduct.*

I have put in place procedures designed to ensure such compliance and have undertaken appropriate internal processes to satisfy myself the statement made above is correct.

Human Resource Management
The WA Country Health Service ensures compliance with Public Sector Standards in administering the requirements of human resource management. The importance of compliance with standards is emphasised significantly in staff training sessions and staff orientation programs.

Human Resource Coordinators regularly conduct reviews of human resource management especially recruitment and selection processes. Coordinators ensure that staff are aware of the processes for making complaints and raising issues.

Where appropriate external accredited consultants are commissioned to conduct reviews. Exit interviews and questionnaires are conducted. All documentation is evidenced and kept in accordance with the Records Management Act.

During 2003-04 the Internal Audit Branch of the Department of Health conducted a review of human resource management practices in the Goldfields South East and reached a satisfactory assessment.

Compliance with Public Standards
The WACHS has adopted guidelines and systematic processes to apply and support the Public Sector Standards.

The Chief Executive Officer of the WA Country Health Service has overall responsibility for compliance with standards. Regional Directors ensure compliance at that level and senior officers at branch and health unit level are responsible for the day-to-day management of human resource matters. Human resource coordinators provide a monitoring and advisory role of human resource management.

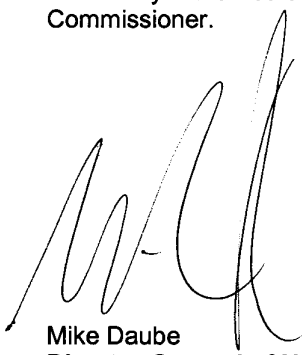
Summary of Breach of Standards Claims
The organisation has processed six applications in relation to recruitment, selection and appointment regarding breaches in standards in 2003-04. Four applications were withdrawn in the agency, one was resolved and one has been referred to the Office of the Public Sector Standards Commissioner. One Performance Management breach claim was received which is still pending. Two grievance resolution breach claims were received, one was withdrawn and one is still pending as at 30 June, 2004.

Code of Ethics
The WACHS monitors compliance with the Code of Ethics, which is promoted actively in the workplace. New staff are provided with information regarding the code. Where appropriate, issues relating to the compliance with the Code of Ethics are investigated internally or by the Internal Audit Branch. Customer and employee satisfaction surveys also provide feedback regarding compliance with the Code of Ethics.

Code of Conduct
The organisation has adopted formal codes of conduct and a variety of methods are used to ensure that staff are informed about the Code of Conduct. Where appropriate staff are required to acknowledge receiving Code of Conduct information.

Complaints alleging non-compliance with the Code of Ethics or the Code of Conduct
In 2003-04 the area health service investigated four breaches of either the Code of Ethics or Conduct. Three were resolved internally and one was referred to an external investigative agency.

In 2003-04 the WACHS was not investigated or audited by the Office of Public Sector Standards Commissioner.



Mike Daube
Director General of Health
Accountable Authority for WA Country Health Service

31 **August 2004**

ACCOUNTABLE AUTHORITY

The Director General of Health Mike Daube, in his capacity as Commissioner of Health, is the Accountable Authority for the WA Country Health Service.

PECUNIARY INTERESTS

No senior officers of the WA Country Health Service have declared any pecuniary interests in 2003-04.

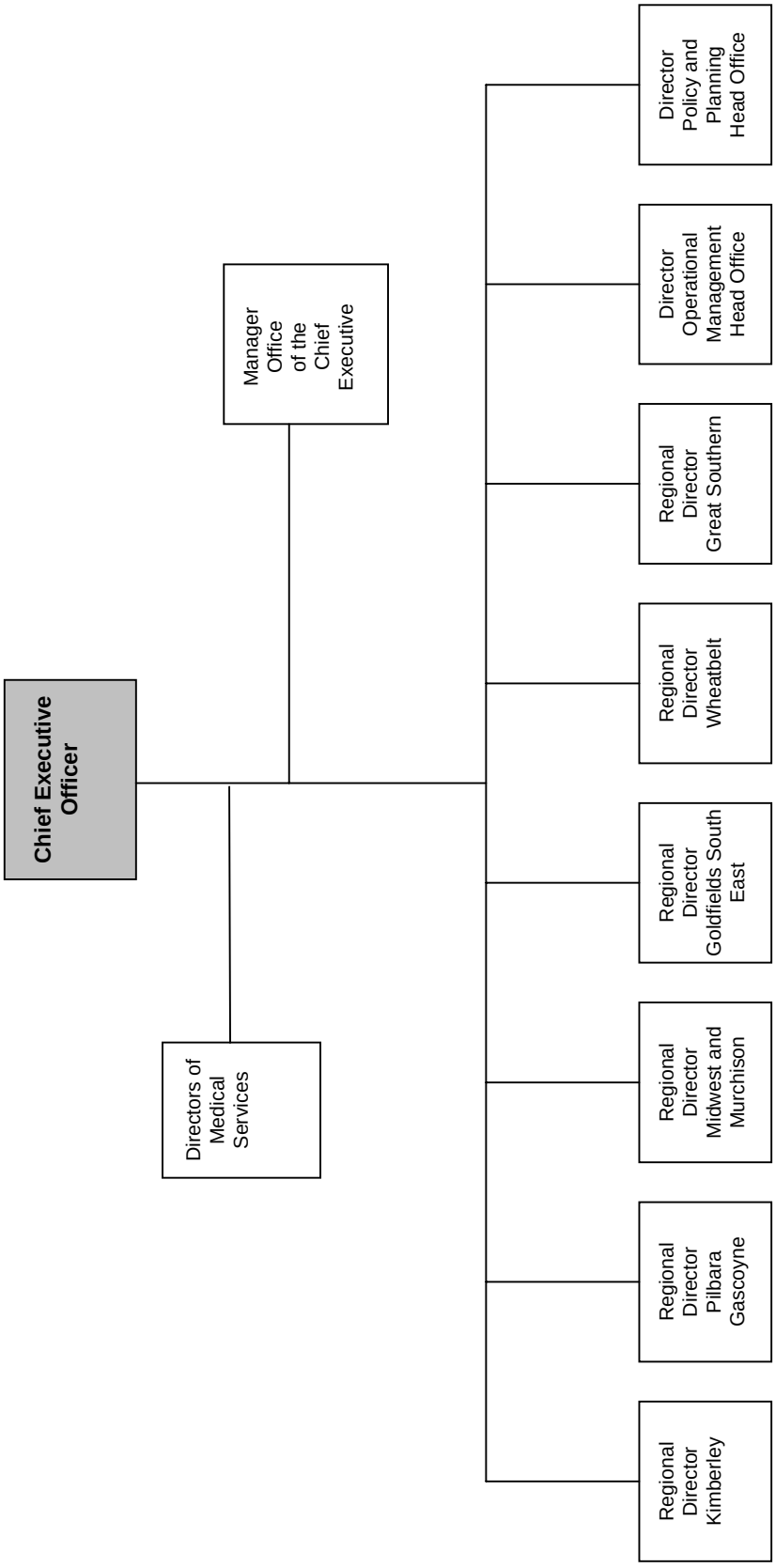
SENIOR OFFICERS

The senior officers of the WA Country Health Service and their areas of responsibility are listed below:

Table 1: **Senior Officers**

Area of Responsibility	Title	Names	Basis of Appointment
WA Country Health Service	Chief Executive Officer	Christine O'Farrell	Contract
WACHS - Goldfields South East	Regional Director	Bronwen Scott	Permanent
WACHS - Great Southern	Regional Director	Keith Symes	Permanent
WACHS - Kimberley	Regional Director	Ian Smith	Permanent
WACHS-Midwest and Murchison	Regional Director	Shane Matthews	Permanent
WACHS - Pilbara Gascoyne	Regional Director	Tim Shackleton	Permanent
WACHS - Wheatbelt Region	Regional Director	Kim Darby	Permanent
WACHS - Operational Management Head Office	Director	Trevor Canning	Permanent
WACHS - Policy and Planning Head Office	Director	Sandy Thomson	Permanent

WA COUNTRY HEALTH SERVICE STRUCTURE AS AT 30 JUNE 2004



WA COUNTRY HEALTH SERVICE

- **Report of the Health Reform Committee**
  The organisation has continued to progress the vision, goals and directions outlined in the Country Health Services Review of January 2003. The report of the Health Reform Committee "A Healthy Future for Western Australians" released in March 2004 endorsed the vision outlined in the Review.

- **New District Health Advisory Councils were Established**
  The service has completed the implementation of District Health Advisory Councils fulfilling a strategic objective for this year.

- **Improving Infrastructure**
  In 2003-04 the WACHS invested over $15 million in capital works with continued investment of $47 million planned in 2004-05. Projects have included the Ravensthorpe District Health Centre, the commencement of construction of the Geraldton Regional Resource Centre and a number of projects in the Kimberley.

- **New Royal Flying Doctor Service Aircraft**
  The organisation brokered an agreement between the Department of Health, the DHAC and the RFDS and announced in December 2003, a State Government contribution of $1.5 million towards the acquisition of a new aircraft, for the Western Operations Division of the Royal Flying Doctor Service.

- **Boosting Sexually Transmitted Infection Services**
  In June 2003 the State Government announced a commitment of $600,000 for 2004-05 for a special team located in the Kimberley to address sexually transmitted infections in a health program to operate in the Kimberley, Pilbara Gascoyne and Goldfields South East.

- **Improving Access To Dental Care**
  The Premier announced in February 2004 that the State Government was allocating $2 million to assist 3000 public patients waiting to receive dental health care. A significant proportion of the program's capacity was targeted at patients in the Goldfields South East and Great Southern.

- **Implementing Reforms**
  The organisation implemented more service reforms in small hospitals and appointed new Directors of Medical Services for the Wheatbelt, Great Southern and Goldfields South East.

IN THE REGIONS

Goldfields South East

- **A new Multipurpose Centre in Ravensthorpe**
  Construction of the new $4.6 million Ravensthorpe District Health Centre was completed in December 2003. This state of the art facility includes a new residential aged care wing, inpatient wing, palliative care suite, emergency department and multi-purpose consulting rooms for visiting allied and community health services.

  The construction project received input from the local community through the previous Ravensthorpe Health Service Board and later the South East District Health Advisory Council.

- **New Esperance Dental Clinic**
  Public dental services commenced in Esperance in July 2003 with the opening of the new dental clinic in the Esperance District Hospital. The $290,000 facility has been well received within the local community.

  The two chair clinic opened in July 2003 and operates from 8:00am to 12:00 Monday to Friday with eight appointments allocated per day for the treatment of public patients. Two appointments are left unbooked for urgent cases.

  The opening of the clinic improved access to public dental services and provided opportunities for final year dental students to train in a rural environment.

- **More Access to Local Renal Dialysis Services**
  In May 2004 the Minister for Health announced that renal dialysis services are to be expanded in 2004-05 at the Kalgoorlie Regional Resource Centre with $535,000 being provided for additional services and $30,000 allocated towards an additional dialysis machine. This will increase the number of patients able to be treated locally.

- **New Clinical Appointments**
  In October 2003 the Kalgoorlie Regional Resource Centre appointed its first Senior Medical Officer to the Emergency Department.

  In May 2004, a new dentist was appointed to the Kalgoorlie – Boulder Dental Clinic enabling the resumption of public dental health services from the clinic.

- **A New Specialist Obstetrics Service**
  In March 2004, a salaried specialist obstetrician gynaecologist was appointed to a permanent position at the Kalgoorlie Regional Resource Centre.

- **Regional Needs Analysis Released**
  The Goldfields South East Regional Health Needs Analysis was a joint initiative between the Goldfields South East and the Eastern Goldfields Medical Division of General Practice. The project commenced in June 2003 and was completed in December. The report of this comprehensive health needs analysis will inform strategic and service planning.

  The project provided a detailed demographic overview and up-to-date information on the health status of residents of the Goldfields South East. Valuable information was collected from the community through a variety of qualitative and quantitative means including surveys and focus groups. The final report was released in February 2004 and results of the analysis were presented to communities.

- **The Pit Stop Program for Men**
  The Pit Stop Program for Men is a men's health screening program developed for rural WA. The Goldfields South East provided the Pit Stop program at the Goldfields Mining Expo during October 2003, where over 400 men went over the 'Pits' and had their health status screened. The program has also been successfully implemented at workplaces across the state.

  During May 2004, a Pit Stop forum was held in Esperance and resulted in the recruitment of a Pit Crew (screening staff). The Pit Stop Program will continue to run at agricultural shows, workplaces and other venues in 2004-05.

Great Southern

- **The Regional Mental Health Service Gets a Good Scorecard**
  The Great Southern Mental Health Service was the first rural service reviewed by the Office of the Chief Psychiatrist. The review tested compliance with the National Standards for Mental Health and DOH policies.

  The service was originally reviewed in 2002 and again in December 2003 and identified that high standards of clinical services were being provided. The latest review confirmed that the previous recommendations have been satisfactorily addressed.

- **Albany Regional Resource Centre Paediatric Ward Upgrades Completed**
  This project valued at $1 million was officially opened by the Minister for Health on 22 March 2004.

  The new facilities include a four bed day ward for children recovering from surgery, a play room and enclosed play deck, a new parents' lounge and a specially designed treatment room, bathroom and preparation room.

  This project was notable for the involvement of the Channel 7 Telethon Trust, which contributed $400,000 through fundraising initiatives such as the Telethon Toyota Trek and the auction of a Charity Home.

- **A New Chronic Disease Program in Mount Barker**
  Funding was received from the Commonwealth Department of Health and Ageing for a Rural Chronic Disease pilot project. Mt Barker was chosen as the site for the project and major outcomes arising out of the initiative have been the creation of the Mt Barker Health Bank, the development of a Health Promoting Health Service and agreement on the formation of the Plantagenet/Cranbrook Multi Purpose Service.

Practical improvements include:
- an Aboriginal Mosaic Art Project;
- formation of a Walking Group;
- formation of an Active Ageing Group;
- development of the community Art for Health Project;
- initiation of the Healthy Learning and Leadership Development Student Workshops;
- initiation of Teacher, Parent and Community Members Workshops; and
- the Youth Exhibition – "Jest Fest".

Pilbara Gascoyne

- **Service Quality Improvement**
  Root Cause Analysis (RCA) training has been completed at Carnarvon, Karratha and Port Hedland. The process has been shown to be beneficial for all involved and helps to identify and prevent adverse clinical events.

- **More Access to Local Renal Dialysis Services**
  In May 2004 the Minister for Health announced an additional allocation of $395,272 in 2004-05 to expand renal dialysis services at the Port Hedland Regional Resource Centre. This will increase the number of people who can be locally treated.

- **Using Telehealth to Improve Services**
  On 14 April 2004, Nickol Bay Hospital trialled a new service Telehealth linking the operating theatre to a specialist in Perth to perform gastroscopies and endoscopies. The specialist in Perth guided the doctor through a complex procedure providing technical advice.

- **New Regional Resource Centre Facilities in the Pilbara**
  In January 2004, the Minister for Health announced plans to develop a new health campus in South Hedland. The first phase of the development is the construction of a new 54 bed residential aged care facility to be completed by the end of 2005 at a cost of $11 million. The Town of Port Hedland is to transfer $2.5 million of Commonwealth capital funding to the Department of Health on completion of the project as a contribution to the total cost. The second phase will be a new Resource Centre on the South Hedland site.

Kimberley

- **Key Clinical Appointments**
  Staff were recruited for existing and new child health, community midwifery, a specialist paediatrician and regional pharmacist positions. Two additional District Medical Officers were appointed to hospitals in Broome and Halls Creek.

- **A Big Boost for Primary Health Care Comes with a New Partnership**
  The Primary Health Care Access Program is an initiative that provides a mechanism to fund Aboriginal primary health care services from pooled State and Commonwealth resources. Remote sites in the West and East Kimberley were identified to participate in this program, which provides expanded primary care services and targets health promotion and illness prevention activities. This is a joint initiative with the members of the Kimberley Aboriginal Health Planning Forum.

- **New District Health Advisory Councils (DHAC)**
  Five DHACs were appointed in the Kimberley for Broome, Derby, Fitzroy Valley, Halls Creek and Kununurra/Wyndham. Work plans were developed and the first joint meeting held between DHAC Chairs and the Regional Executive Team.

- **Accreditation for Kimberley Health Care Units**
  An application has been made to the Australian Council for HealthCare Standards (ACHS) for the accreditation of all Kimberley health units through the Evaluation and Quality Improvement Program (EQuIP). Broome and Derby services are already accredited through EQuIP. Region wide accreditation will bring Kununurra, Wyndham, Fitzroy Crossing and Halls Creek Health Care Units up to EQuIP standards.

- **Rebuilding Health Facilities in the Kimberley**
  Construction commenced on the new Halls Creek Hospital and a residential care unit co-located with Kununurra Hospital. The new aged care service is made possible by the redistribution of current places throughout the region. Working Groups were established to progress the Derby and Broome Hospital redevelopments.

- **Special Ambulances**
  In June 2004 the Department of Health announced a special vehicle grant to provide new four wheel drive ambulances to access the rugged terrain of the Kimberley.

Wheatbelt

- **Stabilising Clinical Staffing**
  Overseas trained doctors have settled in and consolidated relationships with local health services. The appointment of the Director of Medical Services has impacted positively on communication, and the process of resolving issues with local General Practitioners. Directors of Clinical Services appointed in three locations have contributed to improved local management, support and communication at the district level and local support for service delivery.

- **Meeting Mental Health Care Demands**
  A multi-disciplinary and multi-agency approach has been adopted to manage the increasing demand for mental health services. Care provided is now more appropriate with a safer environment for patients and staff and greater support being provided in the district hospitals. This approach has also led to demonstrably improved cooperation between the local police and clinical staff.

- **Accreditation for Eastern Wheatbelt District**
  An accreditation program has commenced under the auspices of ACHS EQuIP. The self-assessment phase will occur in September 2004, with a formal survey scheduled for September 2005.

- **A Cancer Support Centre for Narrogin**
  A Cancer Support Centre has been opened at the Narrogin Hospital to help support carers and relatives. Services include a library with Internet access, relaxation therapy and massage, and group education sessions.

- **Better Efficiency for Corporate and Administrative Services**
  Corporate functions have been centralised in Northam. A review of supply services was completed in June 2004. Human resource policies and procedures have also been reviewed and standardised in all Wheatbelt units and a comprehensive risk management plan is in place.

  Multi-skilling of support services staff has enabled increased levels of direct patient care. The introduction of a falls assessment tool has led to a reduction of falls by hospital patients.

  In December 2003 Dalwallinu Telehealth received an award for excellence in delivering clinical services and education to clients and staff.

Midwest and Murchison

- **New Hospital Medical Services for Geraldton**
  Medical services at the Geraldton Resource Centre underwent significant change over the course of the year with the announcement in December 2003 that a core of salaried medical officers would be introduced. This has progressed through the implementation phase and has resulted in a blended model with obstetric and anaesthetic services being provided by local doctors and inpatient and emergency department work performed by salaried and sessional doctors.

- **Geraldton Health Campus Redevelopment**
  Works have commenced on the $49 million redevelopment of the Geraldton Health Campus with the builder taking possession of the site in early January 2004. Phase one completing 90% of the redevelopment and enabling occupancy is planned for May 2005. Demolition of the existing hospital and finalisation of the redevelopment will follow.

- **Accreditation Achievement**
  The WACHS has become the tenth organisation in Australia to successfully achieve ACHS Corporate Accreditation through its achievements in the Midwest and Murchison. This is the only Western Australian corporate accreditation awarded to date.

DEMOGRAPHY

The WACHS was gazetted in July 2002 and provides health services across an area covering 2,525,306 square kilometres stretching from the Great Southern to the Kimberley and the coast to the WA/NT/SA border.

The population in 2003 for the area health service was 315,679 representing 16.2% of the State's population. This was an increase from 276,123 in 1981 and represents an average increase of 1,798 persons per year. The number of Aboriginal people in 2003 was 41,603 representing 13.2% of the WACHS population.

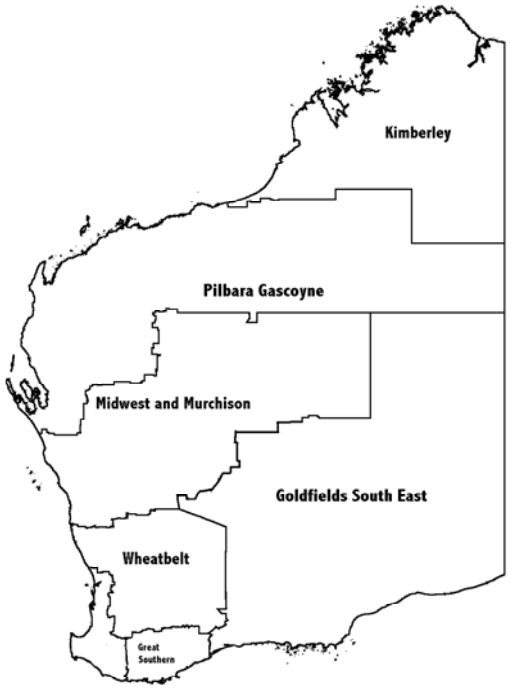
There is a higher percentage of children aged between 0-14 than the rest of the State but a lower proportion of people aged 65 years and over. The dependency ratio of 0.66 (the proportion of people aged less than 20 years and more than 64 years) is comparable to the State's ratio of 0.65.

By the year 2011 it is estimated that the WACHS population will increase by 19% to 375,859 with a dependency ratio similar to that experienced now.

In 2001 there were 45,944 people who were not born in Australia resided in the WACHS and 19,437 who do not speak English at home.

The area health service comprises 97 local government authorities. In 2003 the largest resident population resided in the City of Kalgoorlie-Boulder with 29,047 people while the Shire of Derby-West Kimberley had the largest number of Aboriginal residents with 4,942 people.

Map 1: Areas of the WA Country Health Service



Employment

The major industries providing rural employment in 2003 were agriculture, forestry or fishing 15.7%, mining 10.3%, retail 11.5%, health and community service 7.0%, education 6.9%, construction 7.3%, manufacturing 5.5%, and hospitality 5.0%. Other employment industries include cultural and recreational, transport, communications, essential services, finance and insurance and property or small business.

Table 2: Total Population of the WA Country Health Service

Area	2003 Population Percentage	2003 Resident Population	2006 Resident Population Projections	2011 Resident Population Projections
Kimberley	11.2	35,238	34,223	37,067
Pilbara Gascoyne	15.5	48,959	55,227	57,696
Midwest and Murchison	15.9	50,064	57,682	60,439
Goldfields South East	17.1	54,039	68,850	74,637
Great Southern	17.2	54,276	56,088	59,286
Wheatbelt	23.1	73,103	79,466	86,734
WACHS TOTAL	100.0	315,679	351,536	375,859

HEALTH OVERVIEW

Factors Influencing Health
Demographic data and general health behaviour information informs the organisation in regard to developing and implementing health services and programs. People living in country areas experience similar health problems to those seen across the State with circulatory diseases, cancer, respiratory disease, digestive diseases, and injury and poisoning being the major causes of hospitalisation and death.

While there are many local influences affecting health status, it is generally accepted that specific health risk factors such as smoking, cholesterol, diet and exercise will affect health.

Each year the WA Health and Wellbeing Surveillance System conducts a survey of Western Australians obtaining self reported information on a number of health risk factors. For some of these factors country residents record population percentages above the State levels for the gender groups.

In 2003 the percentage of males in the WACHS area who smoke is 26.8% with the State rate at 21.8%, while for females the rates are 21.9% and 16.4% respectively. The percentage of males who drink alcohol outside of the National Health and Medical Research Council guidelines is 29.7% with the State rate at 22.0%.

Country rates for factors such as consumption of fruit and vegetables, obesity, high blood pressure and high cholesterol are similar to those occurring in the rest of the State.

In 2003 the weighted prevalence for some selected chronic health conditions for males and females respectively who reside in the WACHS area was heart disease (6.7%, 3.1%), stroke (0.8%, 1.6%), arthritis (19.8%, 22.0%), asthma (9.0%, 11.7%), cancer (4.7%, 4.7%), diabetes (4.2%, 4.2%) and mental health conditions (5.6%, 8.0%). These results are not significantly different to rates that occurred throughout the State.

The survey also provides current information on the proportion of residents who access primary health, allied health, hospital based, dental and mental health services at least once in the last 12 months.

In 2003 males and females residing in the WACHS utilised primary health services at rates below the State levels. For males 83.3% used primary health services with the State rate at 89.3% while females recorded rates of 90.4% and 94.0% respectively. However females used allied and hospital based health services at rates significantly above the State levels specifically 39.8% (34.3% State) and 26.3% (19.4% State). Utilisation rates for dental and mental health services are similar to State recorded values.

Population Health Initiatives
The formation of Population Health Units has led to the implementation of a range of new initiatives and programs. There is a strong focus on the development of joint programs with other Government and non-Government organisations to provide more effective and accessible services to the community. Programs include immunisation programs, antenatal clinics, cancer screening, notifiable disease programs, and injury and suicide prevention programs.

For the WACHS in the period 1998-2002 the occurrence of enteric disease and Sexually Transmitted Infections (STIs) were higher per 1000 population than the rest of State. The age-standardised rates per 1000 for enteric disease were 3.3 with 2.1 for the State and 6.3 with a State rate of 1.9 for STIs.

In 2002 the birth rate per 1000 for women aged 15-44 was 72.6 with a State rate of 57.7. The percentage of births for teenage mothers occurring in the WACHS was 8.9% while for the State it was 5.9%.

In the period 1993-2002 the rate per 100,000 of population of male suicide aged 15-24 years was 46.6 while for the State it was 27.8.

Data Source
Epidemiological Branch, Health Information Centre.

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DISABILITY SERVICE PLAN OUTCOMES

The *Disabilities Services Act 1993* was introduced to ensure that people with disabilities have the same opportunities as other West Australians and the WACHS is committed to providing all people with access to facilities and services.

As required under the Act the area health service has developed and implemented a Disability Services Plan and undertakes a continuous process of review to meet the outcomes outlined in the Act. In 2003-04 a number of initiatives were implemented to achieve these outcomes:

OUTCOME 1
Existing services are adapted to ensure they meet the needs of people with disabilities

- The WACHS ensures its Disability Service Plan remains current and is considered in the development and management of service delivery. New facility construction must comply with current disability access requirements stipulated under applicable legislative codes.
- People with disabilities are encouraged to participate in consumer consultations and public events are conducted in accessible venues.
- When required, appropriate patient transport is provided for people with disabilities needing to attend a health facility.

OUTCOME 2
Access to buildings and facilities is improved

- The organisation has continued to audit existing facilities to ensure appropriate access for people with a disability. Projects to modify buildings to provide better access especially for people confined to wheelchairs have been undertaken.
- Modifications have included the provision of access ramps, automatic doors, wider entrances to buildings and internal facilities, upgrading toilets and bathrooms for better access, installation of hand rails and supports and accessible parking facilities.

OUTCOME 3
Information about services is provided in formats that meet the communication requirements of people with disabilities

The WACHS provides information for people with disabilities in a variety of forms appropriate to their particular needs. Information is disseminated verbally, in Braille and electronic formats for sight, hearing and reading impaired people. Information brochures are produced in large fonts with pictures and diagrams for the visually impaired.

OUTCOME 4
Advice and services are delivered by staff who are aware of and understand the needs of people with disabilities

- Staff are provided with training resources and staff development opportunities to ensure the needs of people with disabilities are understood and their awareness of current issues affecting disability services is maintained.
- Orientation programs for new staff members include disability awareness training.
- Staff are assessed in regard to their knowledge of the needs of people with a disability and this information is used to design and implement training courses.
- Selection criteria for staff positions require applicants to demonstrate awareness of current disability issues.

OUTCOME 5
Opportunities are provided for people with disabilities to participate in public consultations, grievance mechanisms and decision making processes

- Community consultation is a key component of the organisation's policies and processes. This allows people with disabilities to have input into needs assessment projects via inter-agency liaison meetings and health networks, with representation on District Health Advisory Councils.
- Client evaluations and surveys are also undertaken to obtain feedback regarding a range of health service issues including those specific to the needs of people with disabilities.
- Appropriate grievance and complaint mechanisms have been implemented that provide people with disabilities the opportunity to raise issues regarding access to health services.

CULTURAL DIVERSITY AND LANGUAGE SERVICES OUTCOMES

The Western Australian Government seeks to ensure that the cultural diversity of indigenous communities and the complexity and diversity of languages is recognised and that language is not a barrier to providing services for people who require assistance in English.

The WA Country Health Service has adopted Cultural Diversity and Language Service guidelines that are regularly reviewed. This includes identifying training requirements for staff working with interpreters and understanding the requirements when presented with a Western Australian Interpreter card.

The organisation monitors particular programs that audit staff skills in:

- cultural diversity and languages other than English;
- training programs in cross-cultural communications;
- programs to monitor and evaluate Language Service policies; and
- the development of guidelines on the use of telephone and on site interpreting services.

Programs, Initiatives and Achievements
The WACHS provides orientation programs for new and existing staff in the areas of cultural diversity, and cross-cultural and language skills.

Examples of these programs include:

- Strength from Elders – this program, developed by the Kimberley Aged and Community Services Unit, is designed to strengthen cultural ties and inter-agency cooperation in order to improve cultural and gender appropriateness in service delivery.

- The North West Mental Health Service has published service information brochures that are culturally appropriate.

- Ways of Working Together – this program continues to provide Aboriginal Cultural Orientation Training across the Kimberley.

- Miriwong Language and Culture – this program continues to provide language and cultural training specific to East Kimberley services.

- Multicultural Access in the Pilbara Gascoyne – regular meetings are conducted with community-based advisory groups to assist health service management in identifying strategies to ensure culturally appropriate services are provided. Other units actively engage ethnic groups to assist with health service planning and development. The Gascoyne District receives advice in matters relating to service provision to the Vietnamese population by a specified position designated on the Gascoyne District Health Advisory Council.

- Aboriginal Health Workers in Emergency Department, Kalgoorlie – this program, which commenced in 2002-03, was initiated to improve communication and cultural sensitivity of services to Aboriginal people attending the Emergency Department at the Kalgoorlie Regional Resource Centre.

- The Goldfields South East conducted a Joint Planning Forum with Aboriginal stakeholders to improve understanding of Aboriginal issues and to improve Aboriginal input to service planning. It also continues its Aboriginal Cultural Awareness program that delivers cultural awareness training sessions to staff involved in the delivery of services to Aboriginal people.

- In the Wheatbelt the culturally appropriate resources "A Pap Smear Chart" and an "Antenatal Package" were developed for use when undertaking education sessions with Aboriginal communities. The Wheatbelt has also developed multilingual obstetrics and surgical procedure educational and information packages.

YOUTH OUTCOMES

The WA Country Health Service acknowledges the rights and special needs of youth and is committed to the objectives outlined in the State Government 2000-2003 Plan for Young People.

These objectives include-

- Promoting a positive image of young people.
- Promoting the broad social health, safety and wellbeing of young people.
- Better preparing young people for work and adult life.
- Encouraging employment opportunities for young people.
- Promoting the development of personal and leadership skills.
- Encouraging young people to take on roles and responsibilities, which lead to active adult citizenship.

WA Country Health Service Achievements

A range of youth orientated initiatives and programs have been adopted and implemented to meet the Youth Plan objectives. These include health information, health promotion, establishing support networks, providing counselling services, and encouraging learning and education in health matters as well as in employment in a health profession.

Resources have been allocated to support youth programs either through mainstream health service delivery or via specific youth workers.

There is significant participation in youth support and education programs in school environments that promotes the broad social health, safety and well-being of young people. This includes the allocation of staff and resources to school based health care programs. Regional interagency forums are also held promoting youth health and providing activities and events such as Safer WA and Youth Week.

Other programs that target youth and the health issues that affect youth have been implemented and these include:

- Work experience and placement programs.
- Canning Stock Route Challenge – healthy lifestyle program for primary school children.
- Alcohol and drug awareness.
- Adolescent development and self esteem
- Mental health and counselling – Young Men's Groups.
- Child injury prevention.
- Road trauma.
- Participation in events such as the Carnarvon Dragon Boat Races, Gascoyne Youth Festival, Annual Croc Fest.
- Sexual health.
- Culture and health.
- Peer skills training.
- Health and nutrition for sport and general physical fitness and activities.
- Indigenous employment.
- Community participation in youth health.
- Parenting skills.

MAJOR CAPITAL WORKS

The projects outlined below are the capital works approved for the WA Country Health Service. Projects commenced and completed as part of the system-wide Capital Works Program are also included in the Department of Health (Royal Street) Annual Report 2003-04.

Table 3: Capital Works Completed

Projects Completed	Year Project Commenced	Actual Total Cost $	Estimated Total Cost $
Broome Staff Accommodation	2001	1,241,622	1,220,260
Fitzroy Crossing Staff Accommodation [1]	2001	791,721	600,000
Kalumburu Staff Accommodation	2002	427,020	450,000
Derby Staff Accommodation	2002	1,119,678	1,155,200
Kimberley Regional Office Broome	2002	273,873	275,000
Broome Laundry Upgrade	2003	150,000	150,000
Nullagine Clinic - replacement	2002	878,208	878,208
Rural Doctors and Nurses Accommodation	2002	900,644	900,644
Ravensthorpe Hospital Replacement	2003	3,346,844	3,399,000
Narrogin Hospital – Electrical Switchboard Upgrade	2003	139,000	139,000
Wickepin Health Centre	2003	618,176	600,000
Albany Paediatric Ward Upgrade	2003	1,149,884	1,200,000

1-Increased costs incurred for additional site and road access works.

Table 4: Capital Works in Progress

Projects in Progress	Expected Year for Project Completion	Estimated Cost to Complete $	Estimated Total Cost $
Purchase of a CT Scanner for the Kimberley with facilities in Broome	2005	1,518,000	1,518,000
Broome Hospital Redevelopment	2007	24,974,000	25,000,000
Derby Acute Care Redevelopment [1]	2006	10,940,400	10,990,000
Derby Aged Care Redevelopment	2006	4,790,000	4,790,000
Derby Ambulatory Care (Dental)	2006	600,000	600,000
Halls Creek Hospital Replacement [2]	2005	8,192,000	8,750,000
Halls Creek Staff Accommodation	2005	550,000	550,000
Kununurra Staff Accommodation	2005	857,000	1,170,000
Kununurra Aged Care Redevelopment [3]	2004	1,739,500	1,200,000
Looma Staff Accommodation / Clinic Upgrade	2005	450,000	450,000
Oombulgurri Clinic Replacement	2004	100,000	1,500,000
Port Hedland Resource Centre Redevelopment		10,204,081	11,000,000
Carnarvon Hospital Ward Reconfiguration	2006	1,431,189	1,600,000
Geraldton Resource Centre Redevelopment	2006	39,853,301	49,569,223
Laverton Staff Accommodation	2004	92,000	531,180
Leonora Community Health Centre	2005	826,000	1,099,000
Moora Hospital Redevelopment	2006	7,900,000	7,900,000
Quairading Hospital Renovations [4]	2005	1,000,000	1,116,000

1-Budget increased following review to account for escalation.
2-Budget increased following review to account for escalation.
3-Budget increased following review to account for escalation.
4 Quairading Hospital Renovations fully funded from donations.

WASTE PAPER RECYCLING

The Western Australian Government has directed all agencies to operate waste paper recycling programs.

The WA Country Health Service participates in a number of programs across the organisation. The WACHS Head Office makes use of the waste paper receptacles provided by Paper Recycling Industries.

Regional offices have actively adopted office based or locally managed recycling programs wherever practicable. However, high volume recycling programs are not often viable in country areas due to the high cost of transporting waste paper to a recycling centre or the lack local infrastructure to support programs.

Waste paper recycling programs currently implemented in WACHS offices include

- Using shredded waste paper for local worm farms and environmental mulch.
- Re-using non-confidential paper as office notebooks and message pads.
- Double sided printing where appropriate.
- Recycling newspapers from various Resource Centres.

ENERGY SMART GOVERNMENT POLICY

The performance of the WA Country Health Service in regard to the application of Energy Smart Government Policies is included in the Department of Health (Royal Street) Annual Report.

REGIONAL DEVELOPMENT POLICY

Commencing in 2003-04 Government agencies are required to report on their contribution to the State's Strategic Planning Framework "Better Planning: Better Services". The Framework outlines four specific regional development objectives:

- Understanding, partnering and delivering better outcomes for regions.
- Growing a diversified economy.
- Educated, healthy, safe and supportive communities.
- Valuing and protecting the environment.

The Department of Health has developed a number of outcome priorities and strategies, which inform area health service strategic planning and service provision delivery.

Outcome Priorities

- Better health outcomes for residents of regional Western Australia.
- Substantial improvement in health and health conditions of those who are disadvantaged, including indigenous people.
- Demonstrated improvement in access to safe and sustainable regional health services.
- Greater numbers of health professionals resident in rural areas.

Service Strategies

- Implement a regional health service system based on strong and effective partnerships between three levels of government, other human service agencies, the non-government sector and private sector.
- Improve access to safe and sustainable primary and secondary treatment and prevention health services in regions, particularly for specialist and general practitioners, community and allied health services, and lifestyle education programs.
- Develop a regional network of health infrastructure that supports delivery of safe and sustainable health services to regional communities.
- Increase access to support services for regional people with mental illness, their carers and families.
- Develop and strengthen whole of government and community partnerships and initiatives aimed at improving the health and health conditions of indigenous people.
- Encourage the Commonwealth Government and aged care industry to address the shortage of aged care beds.
- Attract and retain general practitioners, nurses, specialists and other health professionals to country areas.

Specific achievements and service provision initiatives implemented by the WA Country Health Service to address the Framework's objectives and the Department's outcome priorities and service strategies are:

- The establishment of District Health Advisory Councils (DHACs), which enable people living in regional communities to have greater input into the running of their local health services. DHACs ensure people from rural areas can play an important role in influencing health policy and service developments and improving access and equity of services.
  A total of 17 new DHACs have been established to provide input into area health service planning and service delivery. DHACs also provide a key link with local communities.
  A DHAC Chairs network will provide advice directly to the Minister. This network held its first meeting in April 2004.

- The Health Reform Committee has endorsed the findings of the Country Health Services Review 2003. Establishing regional networking arrangements is the centrepiece of this review. This includes building the capacity of Resource Centres in Broome, Port Hedland, Geraldton, Kalgoorlie and Albany.

- In conjunction with the Department of Health, WACHS continues to develop an agenda for State and Commonwealth negotiations about flexible new approaches to overcome policy and funding barriers and improve the future sustainability of country services.

- A review of health related transport issues across country WA is currently under way. This review has broad country input and is to be completed in December 2004. The DHACs have played an important role in advising the area health service on specific transport issues and ways to improve access to health services.

- A review of multi-purpose aged care services in the Wheatbelt was undertaken in 2003-04 with input from key regional stakeholders including the Division of General Practice and the Wheatbelt Regional Development Commission.

- A specific initiative providing better service delivery outcomes in country areas is the provision of dialysis services in the Kimberley. Recently opened facilities in Broome will enable 26 Kimberley residents to be treated locally where previously these patients had to stay in Perth for treatment.

- In 2003-04 the WA Country Health Service implemented policies decreasing its reliance on short-term agency nurses by 35%. An additional 37 permanent nursing positions have been filled and a further 35 allied health staff have been recruited. These initiatives have not only improved service delivery but also benefited local economies.

- Five new salaried specialist positions in Kalgoorlie, Albany and Kimberley were established.

- The redevelopment of facilities in Geraldton, Port Hedland, Broome and Kalgoorlie Regional Resource Centres commenced.

EMPLOYEE PROFILE

The table below shows the average number of full-time equivalent staff employed by the WA Country Health Service during 2003-04 by category and in comparison with 2002-03.

Table 5: Total FTE by Category

CATEGORY	2002-03	2003-04
Nursing Services	1903	1916
Administration & Clerical	806	843
Medical Support	365	388
Hotel Services	962	957
Maintenance	161	158
Medical (salaried)	85	100
TOTAL	**4282**	**4362**

These categories include the following:
Administration and Clerical – senior management, health project officers, ward clerks, receptionists and clerical staff
Medical Support – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
Hotel Services – cleaners, caterers and patient service assistants
Medical – salaried officers.

RECRUITMENT

All recruitment and selection procedures and practices adopted by the WA Country Health Service comply with Public Sector Standards in Human Resource Management.

All appointments are based on proper assessment of merit and equity with full disclosure of the provisions and entitlement contained under numerous applicable acts, awards and employment agreements. Opportunities are provided to staff involved in recruitment and employee selection to undertake appropriate training courses in these areas.

A variety of media is used to advertise vacant positions including newspapers, industry and government publications and health service websites.

Employment and position information packages outlining the standards and procedures involved in selection processes are distributed to prospective applicants.

In 2003-04 the WACHS has continued its emphasis on recruiting and retaining permanent employees especially medical, nursing and Aboriginal staff. A number of strategies were used to promote employment including graduate programs, encouragement to upgrade nursing qualifications and representations at careers seminars. The area health service participated extensively in overseas recruiting programs especially to fill medical and nursing vacancies.

STAFF DEVELOPMENT

The WA Country Health Service is committed to delivering quality health services. Achieving this outcome is directly related to the quality and skill of the staff employed.

The WACHS has implemented staff development policies that encourage individuals to seek opportunities for professional advancement and personal development. While in most circumstances employees are responsible for their own skills maintenance and enhancement, some training courses are compulsory for all employees. Examples of courses include first aid, fire and cyclone safety and off road vehicle driving where necessary.

The organisation actively supports its staff development process with a variety of mechanisms to assist staff including study leave, financial support, supported placement in approved courses and graduate training programs, peer support and mentoring programs and access to Telehealth video conferencing and training programs.

Specific staff development and training opportunities have been provided to staff in 2003-04 in areas such as:

- Medical information and technology.
- Employee induction and workplace orientation.
- Aboriginal culture and disability awareness training.
- Aggression in the workplace, bullying and dealing with difficult clients and patients.
- Occupational safety and health.
- First aid and emergency training.
- Ongoing training in a number of clinical subjects and areas.
- Quality assurance and risk management.
- Corporate and administrative subjects including financial and service management.
- Information technology.
- Team building and leadership.

The WACHS is currently in the process of developing health service wide staff development policies to support regional programs.

Several sites contribute to the training and education of student nurses with the placement of students into learning environments in various health and medical facilities.

WORKER'S COMPENSATION AND REHABILITATION

The following table provides information on the number of worker's compensation claims made through the WA Country Health Service.

Table 6: Worker's Compensation Claims

	Nursing Services	Administration & Clerical	Medical Support*	Hotel Services	Maintenance	Medical
Goldfields South East	3	0	2	0	3	0
Great Southern	22	1	1	17	5	0
Kimberley	5	4	0	12	6	1
Midwest and Murchison	22	5	0	20	0	0
Pilbara Gascoyne	16	3	5	23	4	1
Wheatbelt	20	1	0	34	2	0
Head Office	0	0	0	0	0	0
Total WACHS	**88**	**14**	**8**	**106**	**20**	**2**

These categories include the following:
Administration and Clerical – health project officers, ward clerks, receptionists and clerical staff
Medical Support – physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dieticians and social workers
Hotel Services – cleaners, caterers and patient service assistants
Medical – salaried officers.

In 2003-04 the WACHS has continued to review and evaluate occupational safety and health systems, policies and programs to ensure there is a consistent approach to their application. The organisation has appointed Occupational Safety and Health Officers who are responsible for providing advice to management on workplace safety and occupational health matters, and for undertaking safety and occupational health audits and inspections across all areas.

The organisation continues to work with clinicians to review clinical governance policies and procedures.

There is an ongoing focus on improving quality and safety through education, collaboration, the development of good information systems, research and clinical leadership. This process has been aided by the appointment of District Medical Specialists.

The WACHS Head Office had no worker's compensation claims or incidents in 2003-04. When necessary head office staff can access occupational safety and health, and rehabilitation services provided at the Royal Street offices.

Occupational Safety and Health Initiatives
All staff are provided with employment induction training in personal safety and aggression management, fire and emergency practice, manual handling and a range of clinical practice issues. Where relevant, staff are given off road driving and general vehicle maintenance training, and cyclone preparation instruction and advice.

Across the organisation specific programs to promote occupational injury prevention and provide employee rehabilitation have been implemented. These include:

Occupational Injury Prevention
Throughout the WA Country Health Service, workplace and practice modifications have been undertaken in response to identified hazards, screening programs and incident examination and review. Occupational Safety and Health officers and management representatives perform regular hazard inspections across all areas. Hazard registers are being implemented across the organisation.

Regional offices conduct pre-employment health screening programs where appropriate and the organisation provides regular training in occupational safety and health, and in hazard management.

Specific injury prevention initiatives in 2003-04 were as follows.

The Kimberley
- A comprehensive hazard management system aimed at preventing occupational injuries has been implemented. This system includes a reporting procedure that highlights potential hazards and encourages staff to become involved in implementing corrective action.

- Accident/incident reporting procedures have been adopted requiring an investigation to be undertaken to determine contributing factors and identify local system improvements to prevent reoccurrences.

The Pilbara Gascoyne
- An audit was commissioned of worker's compensation claims and injury management policies and programs by the Internal Audit Branch to determine the adequacy of these programs and identify opportunities for improvement to programs. The overall assessment of these policies and programs was found to be satisfactory meeting current workplace occupational safety and health objectives and goals.

  A consequence of the audit was a change to the worker's compensation claims process where all injuries sustained by an employee requiring any medical treatment are now recorded as a worker's compensation claim. Subsequently the number of no-time lost injury claims has increased whereas previously these were not recorded as incidents.

The Midwest and Murchison
- A new occupational safety and health framework and plan has been introduced setting the direction and outlining the network of systems for the coordinated approach to effective management of occupational safety and health. This has led to a renewed emphasis on the development and maintenance of occupational safety and health committees, appointing workplace representatives and increasing hazard inspection and management.

The Goldfields South East
- An accident, incident and hazard reporting system is available through its occupational safety and health program. This program records all reports received and can be used to examine contributory factors and document remedial actions taken to control identified hazards.

The Wheatbelt
- A comprehensive incident reporting system has been implemented and a database established to record and monitor reported incidents;

- An audit was completed in 2003-04 of all Wheatbelt facilities and a comprehensive review was conducted of occupational policy and procedures for mental health services;

- A refurbishment of the reception area at Narrogin Hospital was completed providing a safe and secure work environment; and

- A duress alarm system was trialled for consideration at all hospital sites.

Employee Rehabilitation
The WA Country Health Service is committed to providing comprehensive rehabilitation programs to assist injured and ill employees back into the workforce.

- A combination of internal and external rehabilitation programs exists. The process for rehabilitation involves assessment to define the worker's needs by providers accredited by WorkCover WA.

- Staff involved in rehabilitation programs undergo training in injury management and are provided with appropriate instruction to undertake their responsibilities.

- Workplace based programs aimed at reviewing the organisation's injury management objectives have been developed.

- Information regarding injury management is provided to all personnel.

- The injury management model endorsed by WorkCover has been adopted in the management of employee rehabilitation programs and where necessary external providers are used to assist sick or injured workers back into the workforce.

The organisation provides specific programs to enable employees to return to work especially those on restricted duties. These programs are developed in conjunction with the employee, their doctor, their work supervisor and the Occupational Safety and Health coordinator and include structured return-to-work programs.

INDUSTRIAL RELATIONS

Department of Health
A number of new industrial agreements were negotiated and registered during the year by the Department of Health that impact on the WACHS.

The new agreement covering Medical Practitioners provides salary increases totalling 9% during its three year term and addresses issues associated with working hours and workload.

For Hospital Salaried Officers, a new agreement was registered providing salary increases of 8.55% as well as improved conditions for balancing work and family life. This agreement has a term of two and half years.

Engineering and Building Trades employees will receive salary increases totalling 10.2% over the life of a new three-year agreement.

The agreement covering Registered Nurses expired on 1 May 2004 and the Department of Health commenced negotiations for a replacement agreement with the Australian Nursing Federation. As a sign of good faith in commencing the negotiations, the Department of Health increased the salary of all nurses covered by the agreement by 3.4% from 2 May 2004.

The Exceptional Matters Order providing the framework for regulating the workload of registered nurses expired on 28 February 2004. Health services are continuing to apply the terms of the order on an administrative basis. The Department of Health has maintained its commitment to the achievement of workload targets and has extended the application of the nursing hours per patient day model to include intensive care units, coronary care units and emergency departments.

The translation of Senior Nursing positions into the Senior Registered Nurses classification structure was completed with outcomes backdated to 1 April 2002.

WA Country Health Service
In 2003-04 the WA Country Health Service ensured its industrial relations policies and practices complied with all relevant State and Commonwealth Industrial Relations legislation, awards and industrial and certified employment agreements. Management is required to adopt proactive cooperation and consultation processes between employer, employees and any respective employee representative bodies.

Industrial issues raised during 2003-04 involved staffing levels, conditions of employment, classification of positions, unfair dismissal and staff replacement.

The level of disputation occurring in the organisation that involved disruption in a workplace was low in 2003-04 with only minor disputes involving the Liquor Hospitality and Miscellaneous Union.

As of December 2003, all Visiting Medical Practitioners (VMPs) must have a signed agreement with the Department of Health before they can provide services in the WACHS.

EQUITY AND DIVERSITY

The State Government is committed to developing a public sector workforce that is representative of the Western Australian community and enables employees to combine work and family responsibilities. In 2001 the Government implemented its *Equity and Diversity Plan for the Public Sector Workforce 2001-2005*. All agencies are expected to develop performance and workforce objectives that will contribute to the achievement of equity and diversity in their workforces.

The WA Country Health Service aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of sex, marital status, pregnancy, family status, race, religious or political conviction, or age, by promoting equal opportunity for all people, and by recognising the contributions that indigenous Australians, people with disabilities, people from culturally diverse backgrounds, youth and women can make to the public sector workplace.

The organisation's goals and objectives for equal opportunity and diversity comply with the Equal Opportunity Act 1984 and are achieved through workplace programs and initiatives to meet the specific outcomes.

Outcome 1
The organisation values EEO and diversity and the work environment is free from racial and sexual harassment.
The WACHS has adopted Departmental policies and practices to ensure the workplace is free of discrimination and racial and sexual harassment, and provides equal opportunity in employment. Policies have been adopted to deal with events of discrimination or harassment. New employees are provided with information regarding equal opportunity and discrimination legislation, the organisational culture and avenues of redress during induction and orientation programs, and are provided with information packages including the 'Code of Conduct'. Staff surveys and employee exit interviews contain questions regarding issues of discrimination.

A Country Health Service 2002-2005 Equity and Diversity Plan to further support equal opportunity has been implemented. Initiatives have been adopted to support the employment of Aboriginal people and those from culturally diverse backgrounds.

Outcome 2
Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.
The WACHS is committed to ensuring a workplace free from practices that are biased or discriminate unlawfully against current or potential employees by developing and implementing workplace practices and procedures that comply with obligations defined by the Office of the Commissioner of Public Sector Standards. Discussion on equity and equal opportunity issues is a mandatory component of the performance management process.

Workplace practices support innovative and appropriate employee recruitment strategies, and allow flexible employment conditions that can address cultural and family needs.

In 2003-04 the Department of Health released policies and guidelines on the prevention of bullying, and harassment and discrimination in the workplace. These have been implemented throughout the WACHS.

Outcome 3
Employment programs and practices recognise and include strategies for EEO groups to achieve workforce diversity.
The WACHS recognises the benefits and encourages the development of a diverse workforce. Programs and strategies to support the achievement of a diverse workforce include traineeships, school-to-work programs, work experience and cadetships. There is a strong focus on Aboriginal employment, employing young people and providing opportunities for people with a disability.

Achievement/Progress Indicators

- Equal Employment Opportunity (EEO) management plan – the WACHS has implemented EEO Management Plans and is currently reviewing these in a number of sites.

- Organisational Plans, Policies and Procedures Reflect EEO – the organisation has complied with these requirements with strategic and business planning identifying the principles of equity and diversity in the workplace.

- EEO Contact Officers and Staff Training – EEO contact officers have been appointed to provide training and staff awareness programs in equity and equal opportunity in the workplace.

- Diversity – the organisation ensures recruitment, selection and appointment documentation and processes encompass diversity and reflect its importance in the workplace. The value of increasing the diverse nature of its workforce is also emphasised and specific employment strategies targeting Aboriginal employment have been introduced.

EVALUATIONS

State Government agencies are required to undertake evaluations of their programs and strategies as part of routine management responsibilities. The dynamic nature of health care service delivery requires providers to operate in an evolving environment and the WA Country Health Service is committed to reviewing its various programs and service initiatives against required outcomes, standards and community needs.

ACHS Accreditation
A number of service sites in the organisation participated in evaluation assessments undertaken by the Australian Council on HealthCare Standards (ACHS) Evaluation and Quality Improvement Program (EQuIP) to maintain or achieve accreditation.

The Kimberley commenced a process to achieve ACHS EQuIP accreditation by 2006. Currently Broome and Derby Health Services are accredited. As part of this process the Kimberley is reviewing and evaluating policies, procedures and programs in order to improve quality of service delivery.

The Lower Great Southern is an accredited health service provider and a periodic review was held in June 2004. The Central Great Southern will commence the self assessment phase of the accreditation process in October 2004.

The North West Mental Health Service has implemented an ongoing clinical and service delivery evaluation to improve service delivery. This includes compliance with proposed National Mental Health Standards and development of systems to achieve ACHS EQuIP accreditation.

Other specific evaluations undertaken in 2003-04 include:

Review of specialist services
A review of specialist services was undertaken with a view to developing a more coordinated range of specialist services consistent with the hub and spoke model outlined in the Country Services Review. The review was completed in May 2004 and its recommendations will be progressively implemented during 2005.

Transport Review
A review of health related transport needs across the WA Country Health Service commenced in January and will be completed by December 2004. The scope of this review focuses on transport related barriers to accessing services. This review will also identify any issues with patient accommodation and the Patient Assisted Travel Scheme (PATS).

MPS Leading Practice Project
Funding provided by the Australian Government's Leading Practice Support Program has enabled the WACHS to review Multi-Purpose Services (MPS) to ensure that services are aligned with the regional network arrangements. The first stage of this project focused on aged care services in the Wheatbelt and was due for completion in July 2004.

Wheatbelt Public Health Unit:
Bowel Cancer Beat It Project – Final Report
Purpose: to measure the impact of the project on the target group's knowledge, attitudes and behaviour.
Main Outcome: a significant increase in knowledge and awareness of the message and prevention methods, and an increase in referrals for screening.
Action Taken/Proposed: possible implementation of project strategies and sharing of resources across the organisation.

Wheatbelt Childbirth Stress and Depression Regional Reference Group 2004:
Promoting Healthy Families in the Wheatbelt Final Report.
Purpose: to measure the impact of the project on the target group's knowledge, attitudes and confidence, and to measure participant satisfaction in the project and obtain suggestions for improvement
Main Outcome: improved access for families to professional and community support. Increased confidence and understanding by parents of positive parenting practices. Increased confidence and enhanced utilisation of Telehealth facilities.
Action Taken/Proposed: program to continue and possibly expand with minor recommendations for changes to sessions.

Wheatbelt Public Health Unit 2003: Shape Up Healthy Lifestyle Review Report.
Purpose: to determine participant and facilitator satisfaction and process evaluation with the program and suggestions for improvement.
Main Outcome: provided positive feedback and identified current program needs and staff refresher training requirements.
Action Taken/Proposed: promote management support for staff participation and action to reduce the length of the program. Proposed change of program name and that provision be made to enable health professionals and General Practitioners to refer into program.

Wheatbelt Public Health Unit 2004:
Aboriginal Health Focus Group Report.
Purpose: to discuss the issues of Aboriginal health and to seek opinions, suggestions and comments from various Aboriginal community groups about what they think can be done to improve Aboriginal health service delivery.
Main Outcome: a summary of how Aboriginal people in the Wheatbelt would like to see programs and resources developed for and with them. Suggestions for improving service delivery to Aboriginal people.
Action Taken/Proposed: to implement the recommendations of the report relating to the availability and cultural appropriateness used in developing Aboriginal programs or resources.

Wheatbelt Public Health Unit 2004:
Brief Intervention Workshop Evaluation Report
Purpose: to measure the effect of the workshop on the knowledge and skill levels of the participants
Main Outcome: an improvement in the knowledge and confidence in use of Brief Intervention and motivation interviewing
Action Taken/Proposed: further training for other health service workers requested and currently being explored

Avon/Central Primary Health Unit 2003:
Rural Art of Road Safety Project Final Report
Purpose: measure the impact of the project on target group's awareness, knowledge and attitudes.
Main Outcome: improved awareness of project messages and measured the effectiveness of project strategies.
Action Taken/Proposed: possible transferability of project strategies and sharing of resources across the organisation.

Kimberley Population Health Unit:
Disease control, health promotion, nutrition, audiology and environmental health programs.
Purpose: to ensure program objectives, practice standards, quality improvement and capacity building strategies have been met.
Main Outcome: improved services and reduction in preventable disease.
Action Taken/Proposed: undertook continuous evaluation of processes and procedures in order to ensure improved service delivery.

Kimberley Aged and Community Services Unit:
Dementia, respite, ACAP policy, HACC and CACP programs.
Purpose: to ensure programs met national standards, to assess needs, survey client and consumer satisfaction and to maintain quality improvement and staff competencies.
Main Outcome: identified service gaps, improved use of Telehealth, and increased community education and the development of skills and competencies.
Action Taken/Proposed: reviewed internal policies, procedures, education and training practices, increased service promotion and improved service quality.

Albany Hospital Nursing Restructure
Purpose: review existing management structure.
Main Outcome: to combine separate areas into streams to improve effectiveness.
Action Taken/Proposed: review has been completed and the outcome was achieved.

FREEDOM OF INFORMATION

During 2003-2004 the WA Country Health Service received the following applications under the Freedom of Information guidelines established under the *Freedom of Information Act 1992*.

Table 7: Summary Freedom of Information Applications

	Kimberley	Pilbara Gascoyne	Midwest and Murchison	Goldfields South East	Great Southern	Wheatbelt	**Total WACHS**[3]
Received 2003-04	36	226	90	175	104	167	**798**
2002-03 carried over	0	0	3	0	3	2	**8**
Total 2003-04	36	226	93	175	107	169	**806**
Granted Full Access	29	208	86	160	85	154	**722**
Granted Partial /Edited Access[1]	2	17	2	0	5	8	**34**
Withdrawn by Applicant	2	0	5	0	1	0	**8**
Refused	1	0	0	0	7	1	**9**
Other[2]	2	1	0	0	0	6	**9**
Carried forward to 2004-05	0	0	0	15	9	0	**24**

1.- Includes the number accessed in accordance with Section S28 of the Act.
2.- Includes exemptions, deferments or transfers to other Departments or Agencies.
3.- Information on FOI applications relevant to the WACHS Head Office are reported as part of the Royal Street Annual Report.

Description of Documents
The types of documents covered in Freedom of Information (FOI) applications received by the WA Country Health Service include

- Administration and minutes of meetings and committee proceedings.
- Finance, accounting and statistics.
- Equipment and supplies.
- Works and buildings.
- Staffing.
- Health and hospital services.
- Accreditation and quality assurance.
- Medical and allied health records.
- Information technology.
- Health information and pamphlets.

Access to Documents
Access to documents being provided to applicants is done so under the FOI guidelines and can be posted or faxed to applicants or their authorised representative depending on the applicant's request. Arrangements to view medical records are scheduled at times convenient to both parties.

FOI Procedures
The organisation has adopted procedures in accordance with the *Freedom of Information Act* and guidelines.

Applications are made in writing although where literacy or English language skills are poor, formal verbal representation may also be accepted. Confirmation of receipt of the application for information is provided. In the case of medical records the applicant may be offered a medical summary of the information as an alternative.

The FOI Coordinator provides decisions on access to documents under the *Freedom of Information A*ct in writing and applicants can appeal the decision.

Governance – Reports on other Accountable Issues

In accordance with the *Freedom of Information Act 1992* the WA Country Health Service has FOI coordinators and officers at numerous sites designated to receive FOI applications and they can provide information regarding the nature and types of documents held.

The sites where applications and information can be sought are:

WACHS Head Office
1st Floor 'B' Block
189 Royal St
EAST PERTH WA 6004

☎ (08) 9222 4222
(08) 9222 2034

Kimberley
Locked Bag 4011
BROOME WA 6725

☎ (08) 9194 1600
(08) 9194 1666

Pilbara Gascoyne
PO Box 63
PORT HEDLAND WA 6721

☎ (08) 9158 1794
(08) 9173 2964

Midwest and Murchison
PO Box 22
GERALDTON WA 6531

☎ (08) 9956 2209
(08) 9956 2421

Wheatbelt
PO Box 690
NORTHAM WA 6401

☎ (08) 9622 4350
(08) 9622 4351

Goldfields South East
PO Box 716
KALGOORLIE WA 6433

☎ (08) 9026 2331
(08) 9091 6592

Great Southern
PO Box 165
ALBANY WA 6331

☎ (08) 9892 2662
(08) 9842 1095

RECORD KEEPING

Standard 2, Principle 6 of the *"State Records Principles and Standards 2002"* requires that the WA Country Health Service include in its annual report a section that addresses the minimum compliance requirements of its Record Keeping Plan. These requirements are that the:

- Efficiency and effectiveness of the area health services record keeping systems is evaluated not less than once every five years.
- The area health service conducts a record keeping training program.
- Efficiency and effectiveness of the record keeping training program is reviewed from time to time.
- Health service induction program addresses employee roles and responsibilities in regard to their compliance with the Department's record keeping plan.

The WACHS has implemented the following activities to ensure that all staff are aware of their record keeping responsibilities and compliance with the Record Keeping Plan and that the organisation is progressing towards compliance with the Standards. Activities include:

- Presentations on various aspects of the record keeping plan are delivered to all appropriate staff during staff meetings and orientation and induction programs.
- Record keeping system users are made aware of their *State Records Act* responsibilities.
- New employees are provided with information to ensure they are aware of their role and responsibilities in terms of record keeping.
- Performance indicators will be developed to measure the efficiency and effectiveness of the record keeping systems. It is planned to have these in operation by 2010.
- A review of the organisation's record keeping systems will be addressed progressively by 2011.

PUBLIC INTEREST DISCLOSURES

The *Public Interest Disclosure Act* came into effect on July 1, 2003. This Act facilitates the disclosure of public interest information by providing protection for those who make disclosures and those who are the subject of disclosures.

The Department of Health is committed to the aims and objectives of the Act. It recognises the value and importance of staff to enhance administrative and management practices and strongly supports disclosures being made by staff regarding corrupt or other improper conduct.

Appointments under the Act
The principle public interest disclosure officer for the Department of Health is the Manager Accountability, Corporate Governance Directorate. This position acts in its capacity as the PID officer but also acts to assist communications between the Office of the Commissioner for Public Sector Standards and the whole of the Department of Health on matters that fall within the jurisdiction of the *Public Interest Disclosure Act 2003.*

However, due to the size and complexity of the structure of the Department of Health, a number of public interest disclosure officers have also been appointed at area health sites and these officers have also been registered with the Office of the Commissioner for Public Sector Standards.

Procedures
The organisation advises and continually updates staff on the processes and reporting procedures associated with the *Public Interest Disclosure Act 2003* through global e-mails, staff seminars, and staff induction and orientation programs.

Public Interest Disclosure information and procedures are accessed through the Department's intranet site including information in regard to sanctions applicable under the Act for any staff member who attempts reprisal actions against another staff member who has or intends to make a disclosure of public information. The Department of Health's procedures comply with the Public Sector Standards Commission guidelines.

Protection
The Department of Health has ensured all public interest disclosure officers are fully aware of their obligations to strict confidentiality in all issues related to public interest disclosure matters.

Files and investigation notes are maintained in locked and secure cabinets at all times with strict access to authorised personnel only.

All efforts are made to ensure maximum confidentiality is maintained in all investigations and follow up action.

ADVERTISING AND SPONSORSHIP

The following table lists expenditure on advertising and sponsorship made by the WA Country Health Service and published in accordance with the requirements of Section 175ZE of the Electoral Act 1907.

The total expenditure for Advertising and Sponsorship for the WACHS in 2003-04 was $627,220. In 2002-03 the WACHS reported expenditure of $921,992. The main reason for the reduced expenditure is a marked reduction in expenditure on advertising from $855,929 in 2002-03 to $530,549 in 2003-04.

Table 8: Advertising and Sponsorship

Expenditure Category	Recipient/Organisation	Amount $	Total $
Advertising Agencies	Marketforce	514,829	
	Nursing Careers	4,830	
	Northern Guardian/Albany Advertiser	4,600	
	Pelican Graphics	780	
	Telecentre Mingenew	33	
	Norwood House Publishers	2,115	
	Strathayr Publishing	3,362	**530,549**
Market Research Organisations	Midwest Times	297	
	Yamatji News	527	**824**
Polling Organisations	Nil		
Direct Mail Organisations	Nil		
Media Advertising Organisations	Broome Advertiser/Kimberley Echo	1,481	
	North West Telegraph	24,667	
	The West Australian	27,141	
	Carnarvon Community News	1,662	
	Yamatji Media Aboriginal Group	5,665	
	Pilbara Classics	97	
	Geraldton 4 Cinemas	1,794	
	Geraldton Newspapers	9,242	
	Geraldton Seniors Week Committee	250	
	Geraldton Signmakers	455	
	Market Creations	1,100	
	Midwest Times	6,406	
	Northern Guardian	365	
	Police Down Under	295	
	Telecentre Mingenew	56	
	Three Springs Shire Council	25	
	Wicked Prints	2,000	
	Yamatji News	3,028	
	Albany Advertiser	5,627	
	Albany & Great Southern Weekender	4,491	**95,847**

PUBLIC RELATIONS AND MARKETING

The WA Country Health Service has undertaken a number of public relations and marketing initiatives in 2003-04.

A significant event held in May 2004 was the Nurses' Expo at the Burswood International Casino Resort. This event was presented by the Royal College of Nursing Australia and provided the opportunity to profile the nursing profession and its image, and promote recruitment and retention in the nursing profession. The WACHS presented a display booth at the Expo which enabled it to showcase rural practice and employment to prospective student nurses, encourage student nurses to seek rural student placements and to promote and market nursing careers and opportunities in rural areas of Western Australia. The display booth won the "Display of the Expo" Award.

In March 2004 the WA Country Health Service presented its 2003-04 Business Plan and its Report Card for 2002-03. Similar reports are planned for each financial year.

During 2003-04 the WACHS opened service facilities at:

- Ravensthorpe Hospital.
- Geraldton Sobering Up Centre.
- Newman Dental Clinic.
- Nullugine Clinic – replacement.
- Oombulgurri Clinic – replacement.
- Wickepin Health Centre.

The organisation has undertaken and participated in a range of activities to promote health and service development at a local level. These activities include contributing to local media, producing regional and site based newsletters, establishing websites and producing resources and promotional materials.

Regional offices were active in involving their communities in consumer forums and seminars. These included nursing, carers and seniors expos and participation in specific promotional activities such as art competitions and health promotion displays at local fairs and agricultural shows and field days.

Local communities were also involved in health service development through the District Health Advisory Councils and community consultation meetings to discuss and highlight health issues of importance in the community. Local communities were encouraged to participate in the opening of health facilities.

The WACHS participated in regional, State and National Health conferences and networking opportunities including providing presentations to these forums on health programs and initiatives.

Some achievements receiving specific recognition include:

- Recognition for the Wheatbelt's Road Safety and Colorectal Cancer Prevention Projects in the Premier's Awards and the Healthways Awards.

- The production of a Palliative Care video in the Kimberley titled *"Caring for Elizabeth"*.

- The development of a mental health promotion program resource package for school children in the Great Southern.

- The new Wickepin Health Centre was completed in October 2003 at a cost of $618,000 and officially opened by the Minister for the Wheatbelt Hon. Kim Chance in February 2004.

PUBLICATIONS

The WA Country Health Service produced a variety of publications in 2003-04 providing health information.

A major publication for the organisation was the 2003-04 Business Plan and the Report Card for 2002-03.

The WACHS has access to the Department's health promotion and information publications, which it distributes throughout the area health service. Local publications focusing on subjects and/or client groups specific to country areas are also produced.

The following publications are available to communities from their local WACHS facilities:

- Local hospital and health service newsletters.
- Patients' rights and responsibilities.
- Patient information brochures.
- Departmental and specific program newsletters and brochures on a variety of health and medical subjects.
- Local information on emergency and accident procedures.

Locally produced publications include:

- *Home to the Kimberley*: *Taking Care of Aged Patients from Remote Communities* – Kimberley Aged and Community Services Unit, October 2003.
- *Aboriginal Community Smoking Project,* Kimberley Population Health Unit April 2004.
- *The Corrugated Road to Developing Community Partnerships for Health Promotion in the Kimberley*, Kimberley Population Health Unit, April 2004.
- *Population Health in the Kimberley*, Kimberley Population Health Unit April 2004.
- *Dialysis in the Kimberley*, Kimberley Health Region, June 2004.
- Health Services at the Paraburdoo Health Service.
- Health Services at the Wickham Health Service.
- Review of Residential Aged Care Services in the Midwest.
- Review of Community Based Care in the Midwest.
- Murchison Needs Analysis.
- Geraldton Needs Analysis.
- Review of Home and Community Care Services in Geraldton.
- *Regional Strategic Directions 2004-2007*, Goldfields South East.
- *Bowel Cancer Beat It Project Final Report* – Wheatbelt Public Health Unit 2004.
- *Promoting Healthy Families in the Wheatbelt Final Report* – Wheatbelt Childbirth Stress and Depression Regional Reference Group 2004.
- *Shape Up Health Lifestyle Review Report* - Wheatbelt Public Health Unit 2004
- *Aboriginal Health Focus Group Report* - Wheatbelt Public Health Unit 2004

A variety of mediums are used to distribute information and publications including hard copy documents available in health and community facilities including doctors' surgeries and public libraries, notice board displays, local newspapers, professional journals and the intranet, Internet and electronic media.

RESEARCH AND DEVELOPMENT IN THE WA COUNTRY HEALTH SERVICE

The WA Country Health Service has undertaken the following research and development projects:

- Discharge Planning Framework, Discharge Risk Tools and Discharge Checklist for the Broome Health Service. The framework has been distributed throughout the Kimberley for wider application.
- Facilitation of a cross sectional survey of an Aboriginal community designed to identify evidence of diabetes and early renal disease.
- Developing the business case for the redevelopment of health facilities at Denmark.
- The Mount Barker Chronic Disease Initiative in conjunction with the Commonwealth Government. The purpose of this initiative is to identify, plan, develop and implement activities for health gain in consultation and collaboration with the community. Outcomes included the incorporation of health promotion into health service providers in Mount Barker and to adopt a 'whole of community / interagency' collaboration to improving the capacity and resiliency of the community.

The WA Country Health Service is undertaking or participating in the following research and development projects:

- The National Medication Safety Breakthrough Collaborative that aims to reduce medication error and patient harm by 50%.
- Accessing Palliative Care designed to build cooperative relationships between providers and the community, develop culturally appropriate models of service delivery and increased knowledge regarding palliative care.
- Review of Renal Disease in the Kimberley – projections established in the review will form the basis for program and service development over the next ten years.
- The Fitzroy Valley health service and the Nindilingarri Cultural Health Partnership have commissioned a community consultation with local indigenous people to discuss experiences at both health services. The project seeks to improve service delivery, address service gaps and duplication, and identify barriers to access and enhance community participation.
- The Kimberley Population Health Unit is monitoring the correlation between jellyfish envenomations and climatic conditions.
- The development of a Multi Purpose Health Service for Plantagenet / Cranbrook.

INTERNAL AUDIT CONTROLS

Internal Audit has the role of accountability adviser and independent appraiser, reporting directly to the Director General of Health, Mike Daube. Audits conducted were generally planned audits, however on occasion, management initiated audits or special audits were also conducted. The reviews predominantly were compliance based, however, a number of operational performance-based reviews have also been conducted. Under the direction of the Director, Corporate Governance, external consultants have conducted a number of audits. All audits conducted aim to assist senior management in achieving sound managerial control.

Specific internal audits conducted over the period include:

Compliance Audits
- Hospitality, alcohol and entertainment expenditure.
- Use of mobile phones.
- Subscriptions, memberships and professional development.
- Financial returns.
- Asset management.

Payroll Audits
- NorPay.

Country Audits
- Goldfields South East.
- Kimberley.
- Great Southern.
- Pilbara Gascoyne.
- Financial Statement Close Process/ Annual Report Preparation Plan.
- Visiting Medical Practitioner Payments.

FAAA Health Checks
- Wheatbelt.
- Goldfields South East.

Operational Audits
- Call Centre (Poisons Information Centre, Health Direct & Drug & Alcohol Information Centre).
- Employee Support Strategies.

Information Systems Audits
- Telehealth Report.

IT Controls
Information Systems Reviews
- Midwest and Murchison.
- Wheatbelt.

Special/ Management Initiated Audits
- PSOLIS Project.
- Planning models.

PRICING POLICY

The majority of the Department of Health's services are provided free of charge. Some classes of patients are charged fees, for example patients who have elected to be treated as private patients and compensable patients (i.e. patients for whom a third party is covering the costs, such as patients covered by workers' compensation or third party motor vehicle insurance). Where fees are charged, the prices are based on legislation or government policy, or on a cost recovery basis.

The Funding and Reporting Directorate of the Department of Health sets a schedule of fees each year to cover patients for whom fees apply. These fees are incorporated into the *Hospital (Service Charges) Regulations 1984* and the *Hospital (Service Charges for Compensable Patients) Determination 2002.*

Dental Health Services utilises fees based on the Department of Veterans' Affairs Schedule of Fees with patients charged a 50% of fee if holder of a Health Care Card or Pensioner Card or 25% of fee if holder of one of the above cards and is in receipt of a near full pension or benefit from Centrelink.

The WACHS also receives income from providing Home and Community Care services. Fees are charged in accordance with the HACC Safeguards Policy.

RISK MANAGEMENT

The WA Country Health Service continued to implement programs in 2003-04 to achieve best practice in the management of risk that may impact adversely upon the area health service, its patients, clients and staff, its assets and facilities, its objectives and operations, and upon the public. It is currently preparing an organisational risk management policy.

The WACHS has continued to adopt the Australian Council on HealthCare Standards EQuIP framework to achieve quality accreditation. The organisation has implemented a range of strategies to achieve accreditation where appropriate and to manage risk generally. The WACHS' organisational philosophy is that risk management and risk reduction is everyone's responsibility.

The WACHS is developing policies to minimise preventable adverse incidents, to minimise the consequences of risk, to manage risk exposure, to improve performance and achieve required compliance and governance. Risk registers have been introduced to provide better risk reporting and analysis, and improved understanding and management of clinical and administrative risk

In accordance with the organisation's risk management goals and objectives, regional offices have also implemented a number of specific risk management initiatives. These include:

- The Kimberley has adopted the Australian Standard AS360 as a risk management framework and is working towards fully implementing this standard.

- In the Pilbara Gascoyne, a Clinical Governance Resource Group has been formed charged with the responsibility of implementing the WA Strategy for Safety and Quality and comprises clinicians and other staff engaged in direct health care provision.

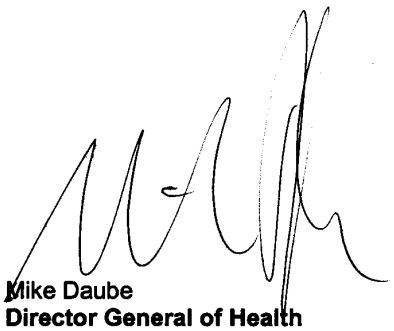
- The Goldfields South East has established a Regional Clinical Risk Management Steering Committee and clinical reviews have commenced in the areas of medicine, palliative care, obstetrics and gynaecology, and paediatrics. A Risk Manager / Coordinator who provides training to key staff in Root Cause Analysis methodology has been appointed.

- In the Wheatbelt risk management is being addressed under two procedural streams – clinical and non-clinical. Following the development of the underlying procedures they have undertaken gap analysis, implemented remedial action, and conducted an ongoing review and audit.

Performance Indicators Certification Statement

THE MINISTER FOR HEALTH IN HIS CAPACITY AS THE DEEMED BOARD OF THE WA COUNTRY HEALTH SERVICE CERTIFICATION OF PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2004

I hereby certify that 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 2004.



Mike Daube
Director General of Health
As the Accountable Authority for the WA Country Health Service

31 August 2004

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the WA Country Health Service are relevant and appropriate to help users assess the Health Service's performance and fairly represent the indicated performance for the year ended June 30, 2004.

Scope
The Director General, Department of Health's Role
The Director General, Department of Health is responsible for developing and maintaining proper records and systems for preparing performance indicators.

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

Summary of my Role
As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

D D R PEARSON
AUDITOR GENERAL
November 30, 2004

Introduction

Health is a complex area and is influenced by many factors outside of the provision of health services. Numerous environmental and social factors as well as access to, and use of, other government services have positive or negative effects on the health of the population.

The Performance Indicators outlined in the following pages, address the extent to which the strategies and activities of the Health Services contribute to the broadly stated health outcome, which is, through the delivery of its health services, the improvement of the health of the Western Australian community by:

- A reduction in the incidence of preventable disease, injury, disability and premature death and the extent of drug abuse.
- The restoration of the health of people with acute illness.
- An improvement in the quality of life for people with chronic disease and disability.

Different divisions of the Health Services are responsible for specific areas of the three outcomes. The largest proportion of Health Services activity is directed to Outcome 2 (Diagnosis and Treatment). To ascertain the overall performance of the health system all reports must be read. All entities contribute to the whole of health performance.

These reports are:

- **Royal Street Division of the DOH.**
- **Metropolitan Health Service.**
- **Hawthorn Hospital.**
- **South West Area Health Service.**
- **Peel Health Services.**
- **WA Country Health Service.**

The different service activities, which relate to the components of the outcome, are outlined below.

Prevention and promotion activities include:

- Community and public health services.
- Mental health services.
- Dental health services.

Diagnosis and treatment activities include:

- Hospital services (emergency, outpatient, inpatient and rehabilitation).
- Community health services (post discharge care).
- Mental health services.
- Dental health services.
- Obstetric services.

Continuing care activities include:

- Services for frail aged and disabled people (eg Aged Care Assessments, outpatient services for chronic pain and disability, Nursing Home Type Patient care).
- Services for those with chronic illness.
- Mental health services.

There are some services, such as Community Health, which address all three of the components.

Results in this section are presented as both Aboriginal and non-Aboriginal population figures where appropriate.

Comparisons across time are provided where possible and appropriate.

TREASURER'S INSTRUCTION 904

Amendments to Treasurer's Instruction 904 'Performance Indicators' specify requirements for performance reporting by departments, statutory authorities and agencies effective 25 May 1999.

For clarification, the Department of Health is required to report:

- Key efficiency indicators for each output, relating outputs to inputs consumed.
- Key effectiveness indicators for each outcome, relating outputs to outcomes achieved.

The four output measures are of quantity, quality, timeliness and cost. These are direct measures of performance, but are not to be confused with Key Performance Indicators of Efficiency and Effectiveness.

Quantity	Measures describe outputs in terms of how much, or how many are performed and require a unit of measurement to be defined.
Quality	Measures usually reflect service standards based on customer needs. The dimensions of quality as an output measure include accuracy; completeness; accessibility; continuity and a customer acceptability of the output.
Timeliness	Measures provide parameters for how often, or within what time frame, outputs will be produced.
Cost	Measures reflect the full accrual cost to an agency of producing each output.

CONSUMER PRICE INDEX (CPI) DEFLATOR SERIES

The index figures are derived from the CPI all groups, weighted average of the eight capital cities index numbers. For the financial year series the index is the average of the December and March quarter 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 quarter is used, because the full year index series is not available in time for the annual reporting cycle.

The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula. The result will be that financial data is converted to 2001-02 dollars:

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

Table 9: CPI Index figures for the financial and calendar years

Calendar year	1998	1999	2000	2001	2002	2003
Index (Base 2001)	90.41	91.68	95.93	100.00	103.02	105.75
Financial year	**1998-99**	**1999-00**	**2000-01**	**2001-02**	**2002-03**	**2003-04**
Index (Base 2001-02)	89.60	91.65	97.06	100.00	103.24	105.48

EFFICIENCY INDICATOR NOTE

All calculations for efficiency indicators include administrative overheads in accordance with relevant Treasury Instructions and are for annual reporting purposes only. These figures are not to be used for any other comparative purpose.

OUTCOME 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse

The services (outputs) of all parts of the DOH contribute to the outcome above. The achievement of this component of the health objective includes activities that reduce the likelihood of disease or injury and reduce the risk of long-term disability or premature death. Strategies include prevention, early identification and intervention and the monitoring of the incidence of disease in the population to ensure primary health measures are working. The impact of drug abuse is also monitored.

The services of the WA Country Health Service (WACHS) as well as the other Health Services and Divisions of the DOH are contained in the table below. The greatest proportion of the services provided by WACHS in this outcome is directed to children. Other Health Services and Divisions of DOH provide more services directed to prevention and surveillance of disease including those effecting the adult population.

Table 10: Respective indicators by health sector for Outcome 1

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Reduce the likelihood of onset of disease or injury by:					
• Immunisation programs	101	101	101	101	
• Childhood screening & appropriate referrals	105 106				
• Safety program					R101
2. Reduce the risk of long term disability or premature death from injury or illness through:					
• Surveillance					R101
3. Monitoring the incidence of disease in the population to ensure primary health measures are effective:					
	103 104	103 104	103 104	103 104	
4. Monitoring and surveillance of suicide rates and drug & alcohol use:					
					R101

101A: Rate of fully immunised children 0-6 years

This indicator reports the rate of fully immunised children 0-6 years who reside in the WACHS catchment area.

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

Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

The agreed targets in the Public Health Funding Agreement are as follows:

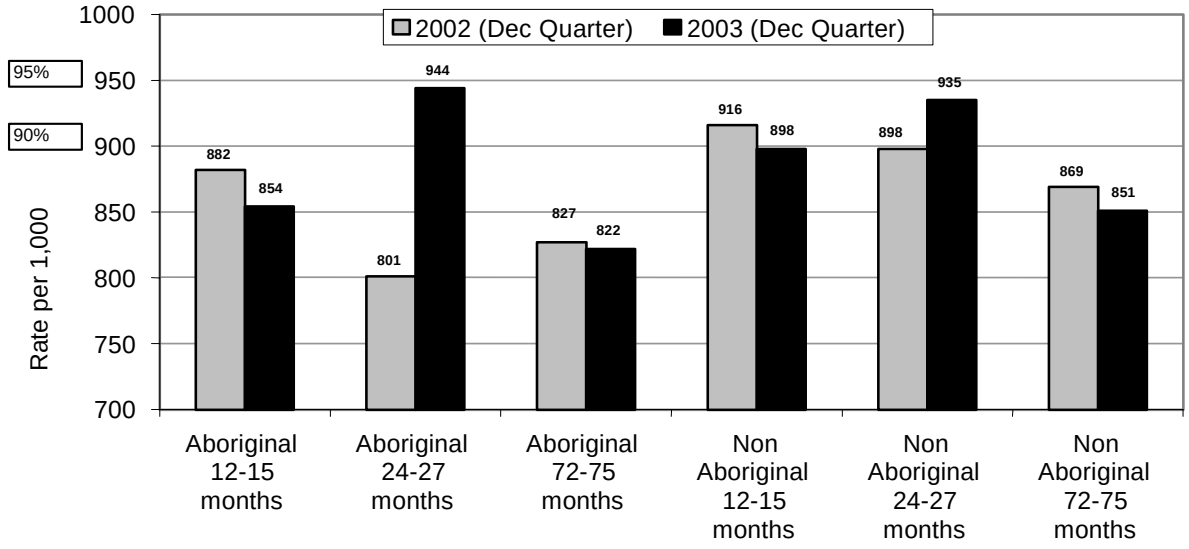
- Proportion of children fully immunised at 12 months – progress towards greater than 90% coverage.
- Proportion of children fully immunised at two years – progress towards greater than 90% coverage.
- Proportion of children fully immunised at six years – progress towards greater than 95% coverage.

Results
The rates of completely immunised children across the age groups per 1000 population in 2003 are comparable with rates recorded in 2002 with the exception of the 24-27 month old age group where a marked increase in fully immunised children for both Aboriginal and non-Aboriginal populations was recorded.

These results are consistent with those results achieved across all areas of Western Australia and can be attributed to a combination of health promotion and improved data collection.

Comments
The mobile nature of the population in remote areas has led health services to adopt communication strategies in an effort to remain in contact with children due immunisations and this has contributed to improvements in performance rates generally.

Figure 1: **Rate of fully immunised children per 1,000**



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

101B: Rate of hospitalisations with an infectious disease for which there is an immunisation program

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

Rationale
There are specific communicable diseases that are preventable by vaccine and thus routine vaccination or immunisation is recommended by the National Health and Medical Research Council.

To provide additional information about the effect of immunisation programs, the rates of hospitalisation for treatment of the infectious diseases of measles, mumps, rubella, diphtheria, pertussis, poliomyelitis, hepatitis B and tetanus are reported.

The conditions reported for 0-12 year old age groups are diphtheria, pertussis, poliomyelitis, tetanus and hepatitis B while measles, mumps and rubella are reported for the 0-17 year old age group. There should be few or no individuals hospitalised for infectious diseases when an immunisation program is effective.

Results
During 2003 there were seven reported hospitalisations for immunisation preventable diseases across the WACHS. There were four cases of pertussis in non-Aboriginal populations, one case of pertussis in Aboriginal populations, and one case of mumps for both the Aboriginal and non-Aboriginal populations.

Comments
The low incidence of recorded infectious disease indicates that immunisation programs are effective.

Table 11: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-12 years

	2002		2003	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Diphtheria	0.00	0.00	0.00	0.00
Pertussis	0.15	0.05	0.08	0.07
Poliomyelitis	0.00	0.00	0.00	0.00
Tetanus	0.00	0.00	0.00	0.00
Hepatitis B	0.00	0.00	0.00	0.00

Table 12: Rate of hospitalisations per 1,000 with an infectious disease for which there is an immunisation program – 0-17 years

	2002		2003	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Measles	0.00	0.00	0.00	0.00
Mumps	N/A	N/A	0.06	0.01
Rubella	N/A	N/A	0.00	0.00

Data Source
Hospital Morbidity Data System.

Note
Mumps and Rubella were not reported in 2002.

103: Rate of hospitalisation for gastroenteritis in children 0-4 years

This indicator reports the rate of hospitalisation for gastroenteritis in children 0-4 years.

Rationale
Gastroenteritis is a condition for which a high number of patients are treated either in a hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves.

The percentage of children who are admitted to hospital per 1,000 population for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. Programs are delivered to ensure there is an understanding of hygiene within homes to assist and prevent gastroenteritis.

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.

The WACHS Population Health Units are engaged in the surveillance of enteric diseases. Some forms of gastroenteritis for example salmonellosis and shigellosis are notifiable diseases and infection rates are monitored.

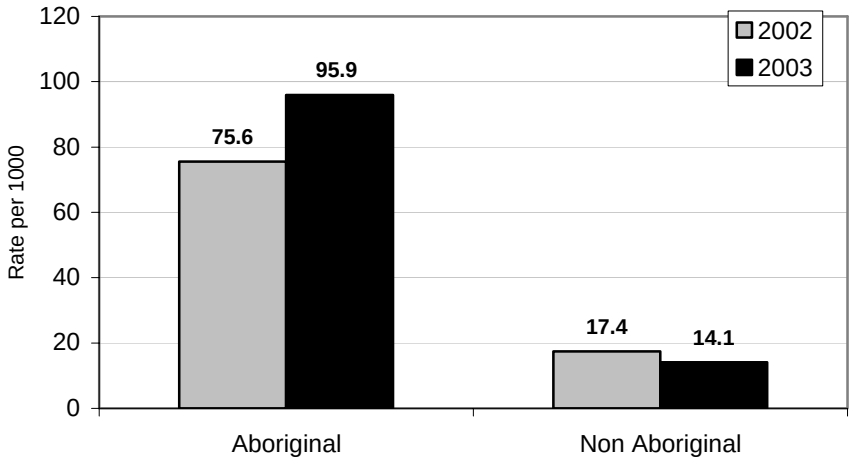
Note
This indicator measures hospital separations of children living in a given location who may attend a hospital close to home or in another Health Service area. This indicator is not necessarily a measure of the performance of the Health Service providing the hospitalisation.

Comments
In 2003, the hospitalisation rate for Aboriginals was 95.9 per 1,000 while the non-Aboriginal rate was 14.1 per 1,000. The recorded rates indicate reduced hospitalisations for non-Aboriginal children while hospitalisations for Aboriginal children increased over the reported years.

Inadequate water supply and hygiene practice, overcrowding and lack of refrigeration in remote communities contribute significantly to the higher rates recorded in Aboriginal populations.

Results

Figure 2: Rate of hospitalisation for gastroenteritis in 0-4 years



Data Source
Hospital Morbidity Data System.

104: Rate of hospitalisation for respiratory conditions

This indicator reports the rate of hospitalisation for respiratory conditions.

Rationale
The percentage of children aged 0-4 years who are admitted to hospital per 1,000 population for treatment of respiratory conditions such as acute bronchitis, bronchiolitis and croup and the rate of all persons admitted for the treatment of acute asthma may be an indication of primary care or community health strategies - for example, health education.

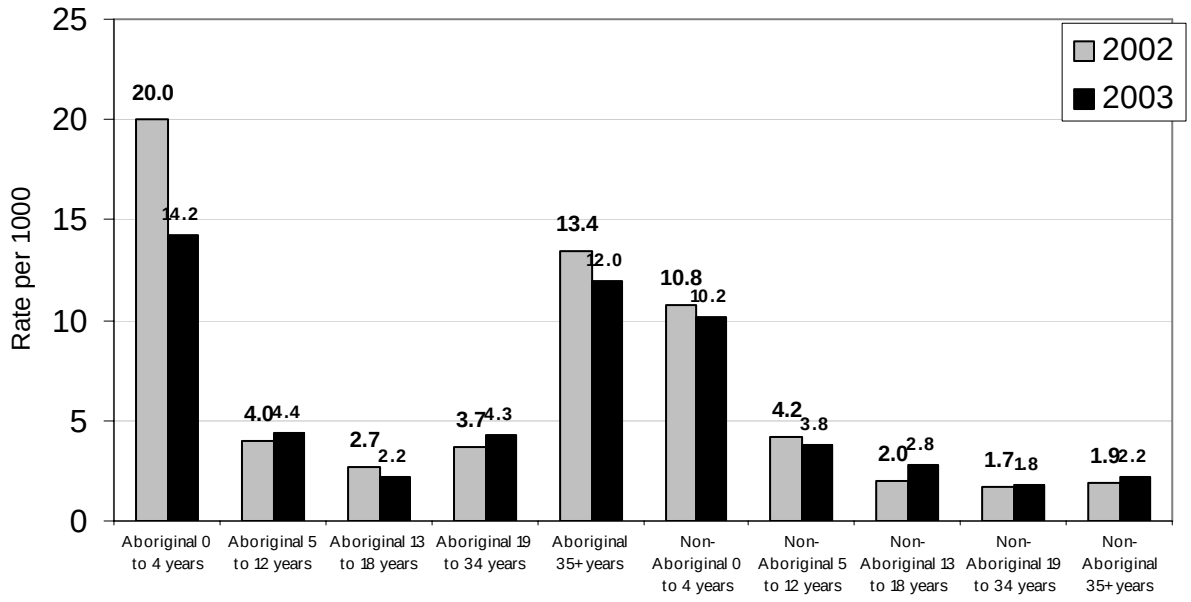
It is important to note however, that other factors may influence the number of people hospitalised with these respiratory conditions. The conditions are ones that have a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for these conditions would decrease as performance and quality of service increases in primary or community health.

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

Results

Acute Asthma
Hospital rates for asthma for the reported age groups have either reduced in comparison to the previous year or have remained consistent with performance in 2002. Recorded rates for Aboriginal populations are generally higher than non-Aboriginal populations. The recorded rates for the WACHS are consistent with hospitalisation patterns occurring across the State.

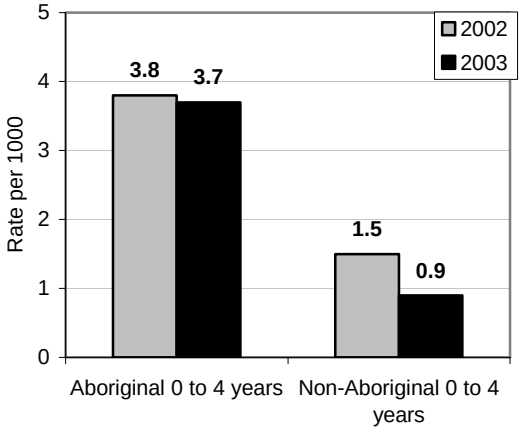
Figure 3: Rate of hospitalisation for acute asthma



104: Rate of hospitalisation for respiratory conditions (cont)

Acute Bronchitis

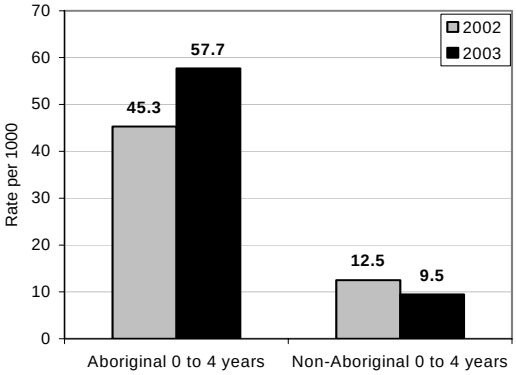
Figure 4: Rate of hospitalisation for acute bronchitis in 0-4 years



Recorded rates for hospitalisation for acute bronchitis occurring in children in the 0-4 year old age group remains consistent with the previous year. However the rate of hospitalisation for Aboriginal children in this age group is significantly higher those rates occurring in non-Aboriginal populations for the same age group. However these incidence patterns are consistent with rates recorded across the State.

Bronchiolitis

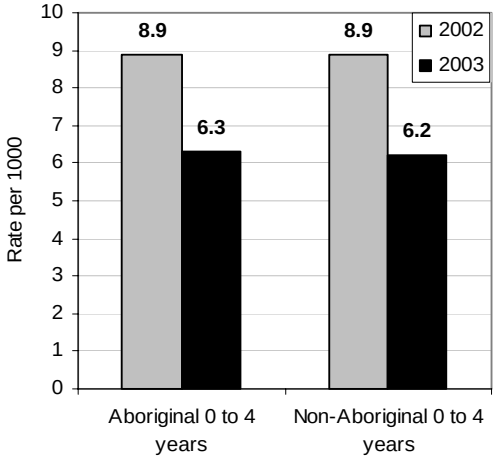
Figure 5 Rate of hospitalisation for bronchiolitis in 0-4 years



Hospitalisation rates for bronchiolitis in the 0-4 year old age group has increased in Aboriginal children while remaining relatively consistent in non-Aboriginal populations over the two reported years. Hospitalisation rates for Aboriginal children are significantly higher than those recorded for non-Aboriginal children. However these incidence patterns are consistent with rates recorded across the State.

Croup

Figure 6: Rate of hospitalisation for croup in 0-4 years



Hospitalisation rates for croup in the 0-4 year old age group have remained relatively consistent in both Aboriginal and non-Aboriginal populations over the two reported years.

Rates for respiratory conditions can be affected by non-compliance with the recommended use of medications and the existence of poor levels of general health and well being.

Data Sources
Hospital Morbidity Data System.
Health Information Centre.

110: Average cost per capita of Population Health units in the WA Country Health Service

This indicator reports the cost per capita of population health units in the WA Country Health Service.

Rationale
Population health considers the health of individuals, groups, families and communities by adopting an approach that addresses the determinants of health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Population health units support individuals, families and communities to increase control over and improve their health. These services and programs include:

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

Notes
The WACHS has seven Population Health units. Expenditure represents the financial year 2003-04 while the residential population for 2003 has been used.

Table 13: Average cost per capita of Population Health Units

	2003-04
Cost per capita	$163

Data Source
Health Information Centre.
WACHS Financial Systems.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

OUTCOME 2: Restoring the health of people with acute illness

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

- Ensure that people have appropriate and timely access to acute care services when they are in need of them so that intervention occurs as early as possible. Timely and appropriate access ensures that the acute illness or the effects of injury do not progress further than necessary, increasing the chance of complete recovery from the illness or injury (for example access to elective surgery).
- Provide quality diagnostic and treatment services which 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.

Table 14: Respective Indicators by Health Sector for Outcome 2

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division
The achievement of this component of the health objective involves activities which:					
1. Ensures that people have access to acute care services by:					
• Prioritising access to elective surgery	200		200	200	R207
• Providing timely transport to hospital					R206
• Prioritising access to dental services	212 213				R202
2. Provide quality diagnostic services and treatment by:					
• Providing appropriate and quality admitted patient services when people are ill or injured.	201 204 205 206 208	204 205	201 204 205 206 208	204 205 206 208	R201 R204 R205
• Providing timely and appropriate ambulatory services for people who do not require admitted patient care.			202	202	
• Providing appropriate obstetric and neonatal care.	207		207	207	

200: Elective surgery waiting times

This indicator reports elective surgery waiting times.

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

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

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

Results
The overall result for waitlist activity indicates that the WA Country Health Service has been effective in managing and providing elective surgery procedures within its surgical capacity for country residents.

However the median waiting times for those remaining on the list as at 30 June 2004 and the percentage of these patients exceeding the desirable period fall outside the recommended times for Category 1 and 2 patients.

The WA Country Health Service is implementing processes to improve waitlist information and to provide better management of elective surgery activity across the organisation in 2004-05.

Notes
This reporting rationale conforms with the Australian Council on Healthcare Standards reporting requirements and is reported for all of the WACHS.

Data extracts provided by the Central Waitlist Bureau used to generate the performance indicators shown here were extracted for activity recorded as at 30 June 2004.

Table 15: Elective Surgery Waiting Times 2003-04 – Admitted Patients

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Percentage admitted within desirable time	1276	89%	6	3683	95%	11	4771	98%	22
Percentage not admitted within desirable time	156	11%		210	5%		78	2%	

Table 16: People remaining on the waiting list as at 30 June 2004

	Category 1			Category 2			Category 3		
	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days	Cases	%	Median waiting time in days
Percentage not admitted (still on the waiting list) but waiting time within desirable time	42	41%	51	320	45%	116	1117	82%	130
Percentage not admitted (still on the waiting list) and waiting time over the desirable time	61	59%		384	55%		244	18%	

Data Source
Central Waitlist Bureau, WA Department of Health.

202: Rate of emergency presentations with a triage score of 4 and 5 not admitted

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

Rationale
When patients attend hospital they are initially assessed in emergency departments where treatment and a decision on whether to admit for further care takes place.

Triaging is an essential function of the emergency department where many people may present simultaneously. The aim of triage is to ensure that patients are treated in order of their clinical urgency and that patients receive timely care. While urgency refers principally to time-critical intervention and is not synonymous with severity, more patients triaged 1 and 2 are admitted to hospital than those with a score of 4 and 5.

Without care provided by staff in an emergency department, the restoration to health of people with an injury or a sudden illness may take longer or result in death. This indicator reports the rate of people presenting to the emergency department given a triage score of 4 or 5 who were assessed, and treated but did not need admitted hospital care ie were restored to health. These are the people who receive primary care in the emergency department. It does not include patients whose sickness or injury requires admitted hospital care.

The indicator reports the number of patient presentations to hospitals where the emergency department does not have 24 hour cover by doctors who are trained in emergency medicine. The numbers of presentations include doctor attended assessments and treatment as well as nursing assessment and treatment.

Results
Recorded results indicate a significant percentage of Triage 4 and Triage 5 presentations were restored to health after treatment in Emergency Departments.

Notes:
In 2003-04 this performance indicator is reported for all of the WACHS. Previously it was reported by selected hospital sites.

Table 17: Rate of emergency presentations with a triage score of 4 and 5 not admitted

2003-04	
Triage Category 4	**Triage Category 5**
87.0%	96.7%

Data Source
HCARe data systems

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

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a related conditions.

Rationale
Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. An unplanned readmission is an unplanned return to hospital as an admitted patient for the same or a related condition as the one for which the patient had most recently been discharged. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases readmission to hospital would be planned. A low unplanned readmission rate suggests that good clinical practice is in operation.

Results
The results recorded in 2003-04 demonstrate a small improvement from those results recorded in 2002-03 and suggest that good clinical practice and discharge planning is being maintained.

Note
A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission. Only actual separations, not statistical discharges, are included.

Table 18: Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition

	2002-03	2003-04
Unplanned readmission rate	4.6%	4.3%

Data Source
Hospital Morbidity Data System.
HCARe

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

This indicator reports the rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition.

Rationale
An unplanned readmission for a patient with a mental health condition is an unplanned return to hospital, as an admitted patient, for the same condition as the one for which the patient had most recently been discharged.

While it is inevitable that some patients will need to be readmitted to hospital with 28 days, in an unplanned way, a high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of inpatient therapy protocols. Appropriate therapy, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Although there are some mental health conditions that may require numerous admissions to enable the best level of care to be given, in most of these cases, readmission to hospital would be planned. A low unplanned readmission percentage suggests good clinical practice is in operation.

Results
The results recorded in 2003-04 demonstrates an improvement from those recorded in 2002-03 and suggest that good clinical practice and discharge planning are in place.

Note
The numbers of patients who receive inpatient mental health care are very low, hence small numbers of patients who have unplanned re-admissions can result in large variations to the annual percentage. The Australian Council on HealthCare Standards (ACHS) considers that a threshold of 10% is an acceptable rate of unplanned re-admissions within 28 days, for patients receiving inpatient mental health services.

A return to hospital is a readmission only if the reason for this admission is the same or is related to the condition treated in the previous admission. Only actual separations, not statistical discharges, are included.

Table 19: Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition

	2002-03	2003-04
Unplanned readmission rate	10.2%	8.1%

Data Source
Hospital Morbidity Data System.

206: Rate of post-operative pulmonary embolism

This indicator reports the rate of post-operative pulmonary embolism.

Rationale
Patients post-operatively can develop a blood clot in the deep veins of the leg. This can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main preventable causes of death in fit people undergoing elective surgery.

Hospital staff can take special precautions to decrease the risk of this happening. A low percentage of cases developing pulmonary embolism post-operatively suggests that the appropriate precautions have been taken.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. By monitoring the incidence of post-operative pulmonary embolism, a hospital can ensure clinical protocols that minimise such risks are in place and are working. The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Results
In 2003 the WACHS recorded only two cases of pulmonary embolism for a surgical procedure with a length of stay equal to or over seven days. The rate of post operative pulmonary embolism was 0.3%, a result below the Australian Council of HealthCare Standards (ACHS) parameter.

This result indicates that the WACHS has adopted surgical treatment and patient care protocols that represent good clinical practice.

Notes
Cases are selected for reporting using the criteria defined by the ACHS. The ACHS standard for good practice is a rate less than 0.8%. Cases are reported for pulmonary emboli if the post-operative length of stay is greater than or equal to seven days.

The data capture period for this performance indicator is the 2003 calendar year.

Table 20: Rate of post operative pulmonary embolism

	2002	2003
Post operative pulmonary embolism rate	0.15%	0.33%

Data Source
Hospital Morbidity Data System.

207: Survival rate of live born babies with an APGAR score of four or less five minutes after delivery

This indicator reports the survival rate of live born babies with an APGAR score of four or less five minutes after delivery

Rationale
A well managed labour will normally result in the birth of a minimally distressed infant. The level of foetal well-being (lack of stress or other complications or conditions) is measured five minutes post delivery by a numerical scoring system (APGAR) through an assessment of heart rate, respiratory effort, muscle tone, reflex irritability and colour.

A high average APGAR score in a hospital will generally indicate that appropriate labour management practices are employed and is also an indication of the wellbeing of the baby.

This indicator reports the survival rates of babies with low APGAR scores at birth (an APGAR score of four or less at five minutes post delivery). A baby with a low APGAR is more likely to have been affected by antenatal or intrapartum events such as maternal haemorrhage, preterm labour, or infection. This indicator measures the survival rate of babies with a low APGAR score and is an elementary measure of how the care in hospital restores the sick or premature baby to health.

Results
In 2003, 12 babies born in country hospitals in the WACHS had an APGAR score of four or less, five minutes after delivery. Eleven out the twelve babies survived to be either discharged or transferred to another hospital.

Table 21: Survival rate of babies born with an APGAR score of four or less

Gestation period in weeks	2003	
	Babies born	Survival rate
	No.	%
20 – 28	1	0
29 – 32	1	100
33 – 36	1	100
37 – 41	9	100
over 41	no event	
Total all periods	12	91.7

Data Source
Midwives Register, Health Information Centre.

208: Survival rates for sentinel condition

This indicator reports the survival rates for sentinel conditions.

Rationale
The survival rate of patients in hospitals can be affected by many factors. This includes the diagnosis, the treatment given or procedure performed, the age, sex and condition of each individual patient including whether the patient had other co-morbid conditions at the time of admission or developed complications while in hospital.

The comparison of 'whole of hospital' survival rates between hospitals may not be appropriate due to differences in mortality associated with different diagnoses and procedures. Three 'sentinel' conditions, therefore, are reported for which the survival rates are to be measured by specified age groups.

For each of these conditions – stroke, heart attack - also known as acute myocardial infarction (AMI), and fractured hip, also known as fractured neck of femur (FNOF) - a good recovery is more likely when there is early intervention and appropriate care.

Additional co-morbid conditions are more likely to increase with age therefore better comparisons can be made if comparing age slices rather than the whole population.

This indicator measures the hospitals' performance in restoring the health of people who have had a stroke, AMI, or FNOF, by measuring those who survive the illness and are discharged well. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

Results
The survival rates for people suffering a stroke have generally remained constant or shown improvement, while the survival rates for AMI and FNOF have remained relatively constant over the two reported years.

The survival rates for stroke and AMI decline as expected in the older age groups. High survival rates indicate effective clinical care.

Figure 7: **Rate of stroke survival**

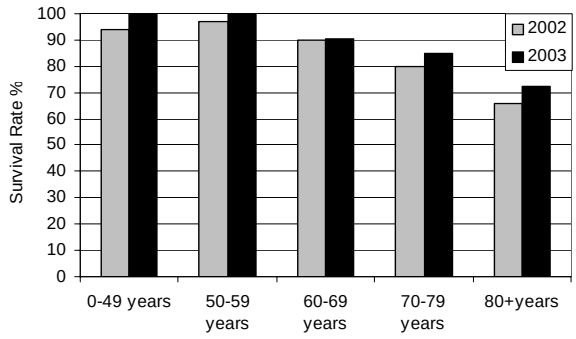


Figure 8: **Rate of acute myocardial infarction (AMI) survival**

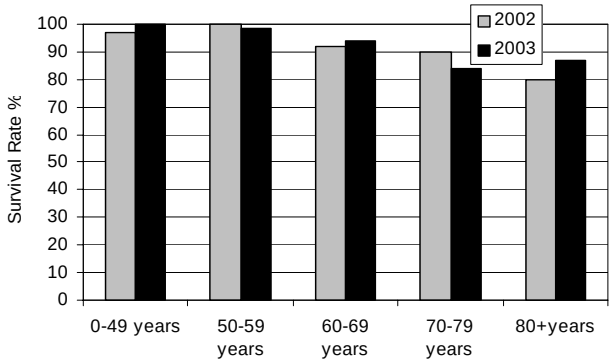
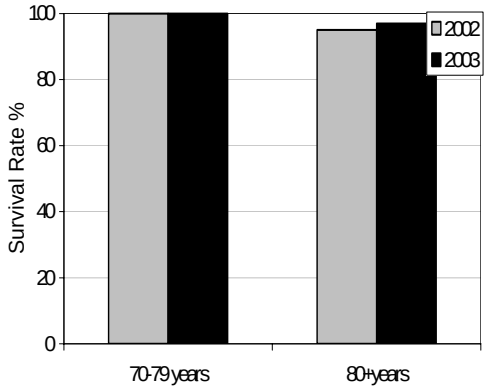


Figure 9: **Rate of fractured neck of femur (FNOF) survival**



Data Sources
Hospital Morbidity Data System.
HCARe.

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

This indicator reports average cost per casemix adjusted separation for non-teaching hospitals.

Rationale
The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may not necessarily equal the number of casemix adjusted separations. The magnitude of the difference will depend on the complexity of the services provided.

The use of a casemix index together with expenditure data allows a reasonable comparison between hospitals on the efficient use of resources in providing inpatient services. This indicator measures the average cost of a casemix-adjusted separation.

Results

Table 22: Average cost per casemix adjusted separation

	2002-03	2003-04
Actual cost	$3,360	$3,767
CPI adjusted	$3,255	$3,571

Data Sources
Hospital Morbidity Data System (HMDS).
HCARe.
WACHS Financial Systems.

225: Average cost per non-admitted hospital based occasion of service

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

Rationale
The efficient use of health service resources can help minimise the overall costs of providing health care, or provide for more patients to be treated for the same amount of resources.

It is important to monitor the unit cost of this non-admitted component of hospital care in order to ensure their overall quality and cost effectiveness. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

Results

Table 23: Average cost per hospital based non-admitted occasion of service

	2002-03	2003-04
Actual cost	$133	$154
CPI adjusted	$129	$146

Data Sources
HCARe.
Non-admitted activity data systems.
WACHS Financial Systems.

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

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

Rationale
The efficient use of health service resources can help minimise the overall costs of providing health care, or provide for more patients to be treated for the same amount of resources.

It is important to monitor the unit cost of this non-admitted component of health service provision in order to ensure their overall quality and cost effectiveness. However, due to variations in patient characteristics and clinic types between sites and across time, there may be differences in service delivery costs.

Results

Table 24: Average cost per nursing post based non-admitted occasion of service

	2002-03	2003-04
Actual cost	$106	$126
CPI adjusted	$103	$119

Data Sources
HCARe.
Non-admitted activity data systems.
WACHS Financial Systems.

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

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

Rationale
The use of casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients. However it is not the accepted method of costing admitted patient activity in a small rural hospital.

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

Accordingly the hospitals with limited beds that provide acute and Nursing Home Type Patient (NHTP) care report patient costs by bed-days.

Results

Table 25: Average cost per bed-day for admitted patients in a small hospital

	2002-03	2003-04
Actual cost	$568	$691
CPI adjusted	$550	$655

Data Sources
HCARe activity data systems.
WACHS Financial Systems.

228: Average cost per trip of Patient Assisted Travel Scheme (PATS)

This indicator reports the average cost per trip of Patient Assisted Travel Scheme (PATS).

Rationale
The Patient Assisted Travel Scheme assists permanent country residents to access the nearest medical specialist and specialist medical services.

A subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for people who have to travel more than 100 kilometres one way to attend medical appointments. Without this assistance many people would be unable to access the services needed to diagnose or treat some conditions.

Results

Table 26: Average cost per trip of the Patient Assisted Travel Scheme

	2002-03	2003-04
Actual cost	$340	$354
CPI adjusted	$329	$336

Data Sources
HCARe and activity data systems.
WACHS Financial Systems.

229: Average cost per bed-day in an authorised mental health unit

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

Rationale
The efficient use of hospital resources can help minimise the overall costs of providing health care, or allow more patients to be treated with a similar amount of resources.

Variations in patient characteristics between sites and across time may result in differences in service delivery costs.

In order to ensure quality and cost effectiveness, it is important to monitor the unit cost per bed day of admitted patient care in authorised mental health units. These are hospitals or hospital wards devoted to the treatment and care of patients with psychiatric, mental or behavioural disorders that are by law able to admit people as involuntary patients for psychiatric treatment.

In the WA Country Health Service there are two authorised units situated in the Albany and Kalgoorlie Regional Resource Centres and the data from each site has been combined.

Results

Table 27: Average cost per bed-day in an authorised mental health unit

	2003-04
Cost per bed-day	$724

Data Sources
Mental Health Information System.
WACHS Financial Systems.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

OUTCOME 3: Improving the quality of life of people with chronic illness and disability

The achievement of this component of the health objective involves provision of services and programs that improve and maintain an optimal quality of life for people with chronic illness or disability.

If a client suffers from a chronic illness they have access to services and supports through a range of organisations, including non-government organisations, which are managed through the DOH (Royal St). The effectiveness and efficiency measures for those supports are reported by DOH (Royal St).

The Health Services in general will only come into contact with those clients when they become acute and require acute care. When this care is completed they are returned to the community where they can again receive ongoing (continuing) care through the other agencies and services provided.

To enable people with chronic illness or disability to maintain as much independence in their every day life as their illness permits, services are provided to enable normal patterns of living. Supports are provided to people in their own homes for as long as possible but when extra care is required long term placement is found in residential facilities. The intent is to support people in their own home for as long as possible. This involves the provision of clinical and other services which:

- Ensure that people experience the minimum of pain and discomfort from their chronic illness or disability.
- Maintain the optimal level of physical and social functioning.
- Prevent or slow down the progression of the illness or disability.
- Make available aids and appliances that maintain, as far as possible, independent living (eg wheelchairs, walking frames).
- 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.

The significant areas of continuing care provided by the Health Services are in the areas of Mental Health Community Care and Aged Care. The Mental Health Community Care consists of multi-disciplinary teams including mental health nurses providing continued and regular contact with clients to ensure, prevent or delay the onset of acuity and thereby allowing them to continue to maintain as close to normal lifestyles as possible.

An important part of ensuring that services are provided to those frail aged who need them is assessment by Aged Care Assessment Teams (ACAT). Without equal access to ACAT assessments appropriate services/aged care may not be provided.

Where a person has a disability, including a younger person, they will receive support through a number of agencies including Disability Services Commission and the Quadriplegic Centre. The DOH also provides assistance to those with disabilities through the provision of Home and Community Care (HACC) services. The HACC program is administered through the DOH (Royal St). The effectiveness and efficiency indicators for HACC are reported by DOH (Royal St). The Health Services will provide acute services to those with disabilities under Outcome 2.

Table 28: Respective Indicators by Health Sector for Outcome 3

	Metropolitan Health Service	Peel Health Services	South West Area Health Service	WA Country Health Service	Royal Street Division	Hawthorn Hospital
The achievement of this component of the health objective involves activities which:						
1. Supporting people with chronic and terminal illness by:						
▪ Providing palliative care services.					R304	
▪ Providing support services to people with chronic illnesses and disabilities.	304	304	304	304		See Hawthorn Hospital report
▪ Providing appropriate home care services for the frail aged.					R302 R303	
• Providing community support for those with mental illness.	301 302	301 302	301 302	301 302		

301: Percent of contacts with community-based public mental health non-inpatient services within seven and fourteen days post discharge from inpatient units

This indicator reports on clients with a principal diagnosis of schizophrenia or bipolar disorder who had contact with a community-based public mental health non-inpatient services within seven and fourteen days following discharge from hospital.

Rationale

A large proportion of people with a severe and persistent psychiatric illness generally have a chronic or recurrent type illness that results in only partial recovery between acute episodes and a deterioration in functioning that can lead to problems in living an independent life. As a result, hospitalisation may be required on one or more occasions a year with the need for ongoing clinical care from community-based non-inpatient services following discharge.

These community services provide ongoing mental health treatment and access to a range of rehabilitation and recovery programs outside of the hospital setting that reduce the length of hospital stays, thereby improving the patient's independent functioning and quality of life.

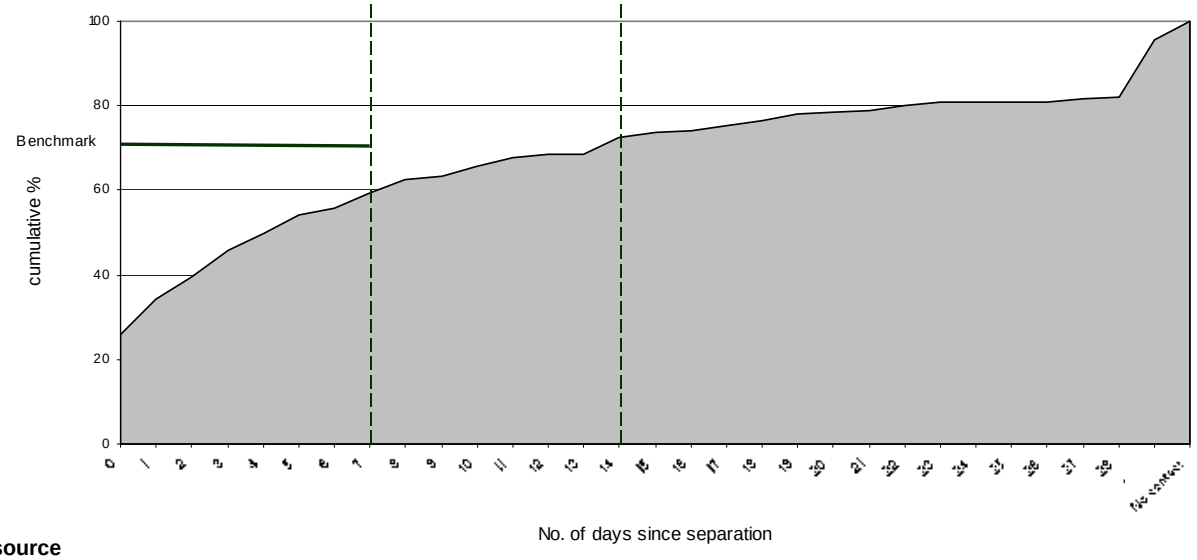
This type of continuing care for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential after discharge to maintain or improve clinical and functional stability. Community psychiatric services can provide effective treatment in circumstances that would otherwise require hospitalisation should relapse occur, reducing the frequency of planned and unplanned hospital admissions.

A severe and persistent mental illness refers to clients who have psychotic disorders with severe and chronic impairment in the conduct of daily life activities. It includes those with a diagnosis of schizophrenia or bipolar disorder.

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

There is currently no agreed target benchmark figure for the proportion of clients to be seen within a seven-day period. At this stage, there appears to be some consensus among clinicians in Western Australia that a reasonable target is around 70%. The seven-day threshold and 70% target benchmark figure are pending an empirical review on their appropriateness.

Figure 10: **Cumulative percentage of schizophrenic and bipolar disorders separations from public designated mental units having contact with a community-based public mental health non-inpatient service**



Data source

Mental Health Information System, Health Information Centre, Department of Health WA.

In 2003, 59% of discharges with a principal diagnosis of schizophrenia or bipolar disorder from WA Country Health Service units resulted in contact with a community-based public mental health non-inpatient service within 7 days of discharge. Of this group 26% had contact on the day of discharge. A further 14% had contact within 8 to 14 days following discharge, which gives a total of 73% of contacts within a two-week period. Twenty three percent had contact within 15 or more days and 4% did not have any contact within a given year.

No contact may indicate that referrals, following discharge, were made to the private sector (e.g. General Practitioners, Private Psychiatrists, Private Psychologists) for which data on contacts is not available.

Explanatory notes

1. Target Group: WA residents discharged from inpatient units with a principal diagnosis of schizophrenia or bipolar disorders (ICD-10-AM range of codes F20 to F29 or F31).

2. Inpatient units: includes all Child and Adolescent, Adult, and Older Person programs at specialised public mental health inpatient units at the following hospitals:
   - Albany Hospital.
   - Kalgoorlie Hospital.

3. Excludes people who:
   - Died in hospital.
   - Were transferred to another inpatient unit.
   - Re-admitted on the same day (includes statistical separations and intra hospital transfer).
   - Left against medical advice.
   - Had a same day admission or were admitted, treated and discharged on the same day.

302: Median bed-days for persons under mental health community management who were admitted to hospital

This indicator reports the median bed-days for persons under mental health community management who were admitted to hospital.

Rationale
The aim of community management of people with mental illness is to provide the treatment and support required to prevent the recurrence of an acute episode that may result in extended hospitalisation. People with mental illness have improved quality of life if their condition is managed with few admissions to hospital. Maintaining good mental health, which may include community mental health management is preferred to hospitalisation.

This indicator shows the extent to which community mental health services have achieved this aim, by measuring the number of bed-days of people under mental health community management. This indicator measures all overnight psychiatric (mental health diagnosis) admissions to public hospitals.

An indication of good performance would be admissions that require fewer bed days. If mental health clients are managed appropriately through community psychiatric services, the length of each hospitalisation is reduced as both clients and clinicians have confidence in the clients' ability to manage in the community.

Results
The median bed-days recorded across the WACHS for 2003 was eight bed-days compared to seven bed-days recorded in 2002.

Data Source
Mental Health Information System, HIC.

Comments
Services in Wheatbelt, Midwest and Murchison, Pilbara Gascoyne, and Kimberley all recorded comparable or reduced median bed-days for 2003 in comparison with 2002. However services provided in the Great Southern and the Goldfields South East recorded an increased bed-day median in 2003 compared with 2002.

Authorised mental health units operate in Kalgoorlie and Albany Resource Centres and the availability of this service enables patients who were previously transferred to Perth for specific care, to be admitted locally.

The Kalgoorlie unit opened in 2002 and admissions have increased in 2003. The appointment of a full-time psychiatrist in the Goldfields South East has also contributed to the increase in admissions.

This performance indicator should be considered in conjunction with performance indicator 205.

304: Completed assessments as a proportion of accepted ACAT referrals

This indicator reports the completed outcomes against the total number of accepted referrals to an ACAT.

Referred ACAT Clients
An ACAT client is usually an older person who is experiencing difficulty managing at home and/or is considering admission to residential care. However on occasion a younger person may seek ACAT assessment due to long term disability where residential care or community support is considered appropriate.

ACATs receive referrals from any source including self referral. The ACAT intake process determines the appropriateness of the referral as per the program guidelines. An ACAT comprehensive assessment will determine the older person's eligibility for services including Commonwealth subsidised aged care services. An ACAT client is not a person who requires acute medical services, post acute services or rehabilitation.

Rationale
An ACAT assessment will identify those clients who are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living and whose needs fall within the capacity of subsidised aged care services.

The assessment is the first step in ensuring the ACAT clients gain access to the appropriate services and receive care either in the community or in an institutional setting.
A range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

A completed assessment is when a comprehensive assessment has been undertaken (and full information on the client is recorded) and has resulted in recommendations being made. This includes approvals to access Commonwealth funded programs (eg residential care, community aged care packages and some flexible care options).

If during an assessment the older person is found to require acute medical services, post acute services or rehabilitation services the assessment is recorded as incomplete. The record is also incomplete if during the process the person withdraws, moves to another services or dies before a comprehensive assessment has been completed and recommendations have been made.

Data
Commencing in 2003-04 the ACAT Program made significant amendments to the minimum data set ACATs collect on their activities. The new data set is being evaluated and revised as the new data is compiled. As a result only interim data is available for the period July to December 2003. Data collected in prior formats is not available in 2003-04 nor is the data presented in the new format comparable to previous years.

Results

Table 29: Completed assessments as a proportion of accepted ACAT referrals

	2003
Completed assessments as a proportion of accepted ACAT referrals	94.4%

Data Source
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.

Notes
In 2003 the ACAT Program amended to the minimum data set, so only interim data is available for the period July – December 2003.

As this is the first year this indicator has been reported previous years' comparisons are not available.

303 Average cost per person with mental illness under community management

This indicator reports the average cost per person with mental illness under community management.

Rationale
The majority of services provided by community mental health services are for people in an acute phase of a mental illness or who are receiving post-acute care. This indicator gives a measure of the cost effectiveness of treatment for public psychiatric patients under community management (non-admitted/ambulatory patients).

Results

Table 30: Average cost per person with a mental illness under community management

	2002-03	2003-04
Actual Cost	$2840	$3043
CPI adjusted	$2751	$2885

Data Sources
Mental Health Information System, HIC.
WACHS Financial Systems.

311: Average cost per ACAT assessment

This indicator measures the average cost per ACAT assessment.

Rationale
People within targeted age groups are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living.

A range of services are available to people requiring support to improve or maintain their optimal quality of life.

The Commonwealth funds the Aged Care Assessment Program based on State health service assessments which determine eligibility for and the level of care required by these aged care services.

Results

Table 31: Average cost per aged care assessment

	2003-04
Actual cost	$1032

Data Sources
Aged Care Assessment Program WA Evaluation Unit Minimum Data Set Reports, July to September 2003 and October to December 2003.
WACHS Financial Systems.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

312: Average cost per bed-day in specified residential care facility

This indicator reports the average cost per bed-day in a specified residential care facility.

Rationale
The Department of Health cares for patients who require long term 24 hour nursing care in a specialist residential facility. The WACHS provides residential care in two State Government Residential Care facilities, Yulunya in the Pilbara Gascoyne and Numbala Nunga in the Kimberley. The indicator reports the average cost per bed-day of patients who reside in these residential care facilities.

Results

Table 32: Average cost per bed-day in specified residential care facility

	2003-04
Actual cost	$236

Data Sources
Residential care facility data systems.
WACHS Financial Systems.

Note
As this is the first year this indicator has been reported previous years' comparisons are not available.

CERTIFICATION OF FINANCIAL STATEMENTS
for the year ended 30 June 2004

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the Financial Administration and Audit Act 1985 from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2004 and the financial position as at 30 June 2004.

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.

Mike Daube
Director General of Health
Accountable Authority for the WA Country Health Service

31 August 2004

John Griffiths
Principal Accounting Officer for the WA Country Health Service

27 August 2004

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion
In my opinion,

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

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at June 30, 2004 and its financial performance and cash flows for the year ended on that date.

Scope
The Director General, Department of Health's Role
The Director General, Department of Health is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing the financial statements, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows and the Notes to the Financial Statements.

Summary of my Role
As required by the Act, I have independently audited the accounts and financial statements to express an opinion on the controls and financial statements. This was done by looking at a sample of the evidence.

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

D D R PEARSON
AUDITOR GENERAL
November 30, 2004

WA COUNTRY HEALTH SERVICE

Statement of Financial Performance

For the year ended 30th June 2004

	Note	2004 $000	2003 $000
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	4	280,654	267,731
Fees for visiting medical practitioners		26,950	25,427
Patient support costs	5	59,808	54,877
Borrowing costs expense	6	2,032	2,201
Depreciation expense	7	28,394	16,142
Asset revaluation decrement	32	(23)	23
Capital user charge	9	28,919	29,196
Costs of disposal of non-current assets		764	461
Other expenses from ordinary activities	10	37,053	37,217
Total cost of services		464,551	433,275
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	11	14,332	13,979
Commonwealth grants and contributions	12a	4,097	4,444
Grants and subsidies from non-government sources	12b	2,390	2,942
Other revenues from operating activities	14a	6,776	7,340
Revenue from non-operating activities			
Donations revenue	13	803	530
Interest revenue		106	141
Proceeds from disposal of non-current assets	8	503	43
Other revenues from non-operating activities	14b	3,405	2,928
Total revenues from ordinary activities		32,412	32,347
NET COST OF SERVICES		**432,139**	**400,928**
Revenues from State Government			
Output appropriations	15	432,915	395,833
Assets assumed / (transferred)	16	173	(159)
Liabilities assumed by the Treasurer	17	280	150
Resources received free of charge	18	0	427
Total revenues from State Government		433,368	396,251
CHANGE IN NET ASSETS		**1,229**	**(4,677)**
Net increase / (decrease) in asset revaluation reserve	32	22,441	0
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	33	0	(250)
Total revenues, expenses and valuation adjustments recognised directly in equity		22,441	(250)
Total changes in equity other than those resulting from transactions with WA State Government as owners		**23,670**	**(4,927)**

The Statement of Financial Performance should be read in conjunction with the notes to the financial statements.

WA COUNTRY HEALTH SERVICE

Statement of Financial Position

As at 30th June 2004

	Note	2004 $000	2003 $000
CURRENT ASSETS			
Cash assets	19	6,408	5,788
Restricted cash assets	20	494	382
Receivables	21	5,576	5,771
Amounts receivable for outputs	22	30,701	19,516
Inventories	23	3,694	3,726
Other assets	24	200	302
Total current assets		47,073	35,485
NON-CURRENT ASSETS			
Amounts receivable for outputs	22	6,149	2,495
Property, plant and equipment	25	434,902	415,603
Other financial assets	26	6	6
Total non-current assets		441,057	418,104
Total assets		488,130	453,589
CURRENT LIABILITIES			
Payables	27	16,075	17,151
Interest-bearing liabilities	28	1,240	1,211
Provisions	29	34,490	31,572
Other liabilities	30	4,508	8,312
Total current liabilities		56,313	58,246
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	28	28,041	29,299
Provisions	29	7,940	13,609
TOTAL NON-CURRENT LIABILITIES		35,981	42,908
Total liabilities		**92,294**	**101,154**
NET ASSETS		**395,836**	**352,435**
EQUITY			
Contributed equity	31	377,093	357,362
Reserves	32	22,441	0
Accumulated surplus / (deficiency)	33	(3,698)	(4,927)
Total Equity		**395,836**	**352,435**

The Statement of Financial Position should be read in conjunction with the notes to the financial statements.

WA COUNTRY HEALTH SERVICE

Statement of Cash Flows

For the year ended 30th June 2004

	Note	2004 $000 Inflows (Outflows)	2003 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Output appropriations	34(c)	368,524	345,265
Capital contributions	34(c)	12,314	3,228
Holding account drawdowns	34(c)	6,671	1,367
Net cash provided by State Government		387,509	349,860
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(122,134)	(112,037)
Employee costs		(281,647)	(263,383)
GST payments on purchases		(13,607)	(12,707)
Receipts			
Receipts from customers		14,039	14,154
Commonwealth grants and contributions		4,073	5,339
Grants and subsidies from non-government sources		2,246	2,112
Donations		601	387
Interest received		103	141
GST receipts on sales		1,044	1,278
GST receipts from taxation authority		12,691	11,029
Other receipts		9,541	10,217
Net cash (used in) / provided by operating activities	34(b)	(373,050)	(343,470)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	25	(14,331)	(10,647)
Proceeds from disposal of non-current assets	8	504	43
Net cash (used in) / provided by investing activities		(13,827)	(10,604)
Net increase / (decrease) in cash held		632	(4,214)
Cash assets at the beginning of the financial year		6,170	10,337
Cash assets transferred from other sources	16	100	47
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	34(a)	6,902	6,170

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

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 1 Significant accounting policies

The following accounting policies have been adopted in the preparation of the financial statements. Unless otherwise stated these policies are consistent with those adopted in the previous year.

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and Urgent Issues Group (UIG) Consensus Views 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 Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and UIG Consensus Views. The modifications are intended to fulfil the requirements of general application to the public sector, together with the need for greater disclosure and also to satisfy accountability requirements.

If any such modification has a material or significant financial effect upon the reported results, details of that modification and where practicable, the resulting financial effect, are disclosed in individual notes to these financial statements.

(b) Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for certain assets and liabilities which, as noted, are measured at fair value.

(c) Output Appropriations

Output Appropriations are recognised as revenues 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 into the Health Service's bank account or credited to the holding account held at the Department of Treasury and Finance.

(d) Contributed Equity

Under UIG 38 "Contributions by Owners Made to Wholly-Owned Public Sector Entities", transfers in the nature of equity contributions must be designated by the Government (owners) as contributions by owners (at the time of, or prior to transfer) before such transfers can be recognised as equity contributions in the financial statements. Capital contributions (appropriations) have been designated as contributions by owners and have been credited directly to Contributed Equity in the Statement of Financial Position. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(e) Acquisitions of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

Assets costing less than $1,000 are expensed in the year of acquisition (other than where they form part of the group of similar items which are significant in total).

(f) Property, Plant and Equipment

Valuation of Land and Buildings

The Health Service has a policy of valuing land and buildings at fair value. The annual revaluations of the Health Service's land and buildings undertaken by the Valuer General's Office are recognised in the financial statements.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken on the following bases:

Land (clinical site)	Market value for Current use
Land (non-clinical site)	Market value for Highest and best use
Buildings (non-clinical)	Market value for Highest and best use

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using a weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Depreciation of Non-Current Assets

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner which reflects the consumption of their future economic benefits.

Depreciation is calculated on the reducing balance basis, using rates which are reviewed annually. Expected useful lives for each class of depreciable asset are:

Buildings	50 years
Leasehold improvements	Term of the lease
Computer equipment and software	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Medical Equipment	4 to 25 years
Other plant and equipment	5 to 50 years

(g) Leases

The Health Service's rights and obligations under finance leases, which are leases that are effectively transfer to the Health Service substantially all of the risks and benefits incident to ownership of the leased items, are initially recognised as assets and liabilities equal in amount to the present value of the minimum lease payments. The assets are disclosed as leased assets, and are depreciated to the Statement of Financial Performance over the period during which the Health Service is expected to benefit from use of leased assets. Minimum lease payments are allocated between interest expense and reduction of the lease liability, according to the interest rate implicit in the lease.

Finance lease liabilities are allocated between current and non-current components. The principal component of lease payments due on or before the end of the succeeding year is disclosed as a current liability, and the remainder of the lease liability is disclosed as a non-current liability.

The Health Service has entered into a number of operating lease arrangements for the rent of buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Statement of Financial Performance over the lease term as this is representative of the pattern of benefits to be derived from the leased items.

(h) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets net of outstanding bank overdrafts.

These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(i) Receivables

Receivables are recognised at the amounts receivable as they are due for settlement no more than 30 days from the date of recognition.

Collectability of receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised where some doubts as to collection exists.

(j) Inventories

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

(k) Payables

Payables, including accruals not yet billed, are recognised when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. Payables are generally settled within 30 days.

(l) Accrued Salaries

Accrued salaries (refer note 30) represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Health Service considers the carrying amount approximates net fair value.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

(m) Interest-bearing liabilities

Interest-bearing liabilities are recognised at an amount equal to the net proceeds received. Borrowing costs expense is recognised on an accrual basis.

(n) Employee Benefits

Annual Leave

This benefit is recognised at the reporting date in respect to employees' services up to that date and is measured at the nominal amounts expected to be paid when the liabilities are settled.

Long Service Leave

The liability for long service leave expected to be settled within 12 months of the reporting date is recognised in the provisions for employee benefits, and is measured at the nominal amounts expected to be paid when the liability is settled. The liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provisions for employee benefits and is measured at 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, when assessing expected future payments, to expected future wage and salary levels including relevant on costs, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

This method of measurement of the liability is consistent with the requirements of Accounting Standard AASB 1028 "Employee Benefits".

Superannuation

Staff may contribute to the Pension Scheme, a defined benefits pension scheme now closed to new members, or to the Gold State Superannuation Scheme, a defined benefit lump sum scheme now also closed to new members. All staff who do not contribute to either of these schemes become non-contributory members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

The Pension Scheme is unfunded and the liability for future payments was provided for up to 30 June 2004.The pension liabilities were assumed by the Treasurer as from 30 June 2004. The transfer was accounted for as a contribution by owner.

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. A revenue "Liabilities assumed by the Treasurer" equivalent to the change in this unfunded liability is recognised in the Statement of Financial Performance.

The liabilities for superannuation charges under the Gold State Superannuation Scheme and West State Superannuation Scheme are extinguished by payment of employer contributions to the GESB.

The note disclosure required by paragraph 6.10 of AASB 1028 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Health Service. Accordingly, deriving the information for the Health Service is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

Deferred Salary Scheme

With the written agreement of the Health Service, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Health Service is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the reporting date and includes related on-costs.

Gratuities

The Health Service is obliged to pay the medical practitioners and nurses for gratuities under Medical Practitioners (WA Country Health Service – North West) AMA Industrial Agreement and the Nurses (WA Government Health Services) Agreement 2001. These groups of employees are entitled to a gratuity payment for each completed year of continuous service in specified regions in Western Australia.

The liability for gratuity payments is measured as the present value of expected future payments to be made in respect of services provided by employees up to the 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 reporting date on national government bonds with terms to maturity and currency 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 2004

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See notes 4 and 29)

(o) Revenue Recognition

Revenue from the sale of goods, disposal of other assets and the rendering of services, is recognised when the Health Service has passed control of the goods or other assets or has delivered the services to the customer.

(p) Grants and Other Contributions Revenue

Grants, donations, gifts and other non-reciprocal contributions are recognised as revenue when the Health Service obtains control over the assets comprising the contributions. Control is normally obtained upon their receipt.

Contributions 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.

(q) Resources Received Free of Charge or For Nominal Value

Resources received free of charge or for nominal value which can be reliably measured are recognised as revenues and as assets or expenses as appropriate at fair value.

(r) Foreign Currency Translation

Transactions denominated in a foreign currency are translated at the rates in existence at the dates of the transactions. Foreign currency receivables and payables at reporting date are translated at exchange rates current at reporting date. Exchange gains and losses are brought to account in determining the result for the year.

(s) Comparative Figures

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

(t) Rounding of amounts

Amounts in the financial statements have been rounded to the nearest thousand dollars.

(u) 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 Serivce 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. However, details of Trust Accounts are reported as a note to the financial statements (refer to Note 3).

(v) Special Purpose Accounts

Special Purpose Accounts are used by the Health Service to account for contributions to which a condition of use has been attached, such as donations, gifts or grants for particular purposes. The Health Service has control of the use of these funds, and can deploy them to meet its objectives, although it has an obligation to only use these funds for the particular purpose for which they were contributed. The use of Special Purpose Accounts enables the contributions to be segregated from the operating funds of the Health Service and to ensure that they are used in a manner that is consistent with the imposed conditions.

Note 2 Outputs of the Health Service

Information about the Health Service's outputs and, the expenses and revenues which are reliably attributable to those outputs is set out in Note 45. The three key outputs of the Health Service are:

Prevention and Promotion
Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death. This output primarily focuses on the health and well being of populations, rather than on individuals. The programs define populations that are at-risk and ensure that appropriate interventions are delivered to a large proportion of these at-risk populations.

Diagnosis and Treatment
The objective for the diagnosis and treatment services is to improve the health of Western Australians by restoring the health of people with acute illness. The services provided to diagnose and treat patients include emergency services; ambulatory care or outpatient services and services for those people who are admitted to hospitals, oral health services and other supporting services such as patient transport and the supply of highly specialised drugs.

Continuing Care
Continuing care services are provided to people and their carers who require support with moderate to severe functional disabilities and/or a terminal illness to assist in the maintenance or improvement of their quality of life.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 3 Administered trust accounts	2004 $000	2003 $000

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

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

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

Opening Balance	282	314
Opening Balance Adjustment for Pilbara - Yulanya trust account (i)	140	
Add Receipts		
- Patient Deposits	1,285	731
- Interest	0	0
	1,707	1,045
Less Payments		
- Patient Withdrawals	1,227	763
- Interest / Charges	0	0
Closing Balance	480	282

(i) Pilbara - Yulanya trust acount for nursing home patients was not reported in 2003 due to an oversight

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

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

Opening Balance	355	375
Add Receipts		
- Fees collected on behalf of medical practitioners	419	387
- Interest	4	5
	778	767
Less Payments		
- Payments to medical practitioners	394	308
- Charges	2	104
Closing Balance	382	355

c) Other trust accounts

Accommodation Bonds Account	187	252
Staff Development and Diabetes Education Fund	6	28
York Health Services MPS Hostel Trust Account	150	174
	343	454
Opening Balance	454	313
Add Receipts		
- Deposits	100	196
- Interest	12	0
	566	509
Less Payments		
- Withdrawals	215	55
- Charges	8	0
Closing Balance	343	454

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 4 Employee expenses

	2004 $000	2003 $000
Salaries and wages (i)	220,428	210,682
Superannuation	20,570	18,988
Annual leave and time in lieu	24,726	21,985
Long service leave	4,397	4,681
Other related expenses	10,533	11,395
	280,654	267,731

(i) These employee expenses include employment on-costs associated with the recognition of annual and long service leave liability.

The related on-costs liability is included in employee benefit liabilities at Note 29.

Note 5 Patient support costs

Medical supplies and services	17,510	15,711
Domestic charges	4,006	4,039
Fuel, light and power	12,431	11,998
Food supplies	4,452	4,419
Patient transport costs	14,725	13,652
Purchase of external services	6,684	5,058
	59,808	54,877

Note 6 Borrowing costs expense

Finance lease finance charges	0	2
Interest paid	2,032	2,199
	2,032	2,201

Note 7 Depreciation expense

Buildings	22,388	10,525
Leasehold improvements	75	0
Leased assets	0	9
Computer equipment and software	1,330	1,155
Furniture and fittings	187	255
Motor vehicles	500	520
Medical Equpment	2,897	2,635
Other plant and equipment	1,017	1,043
	28,394	16,142

Note 8 Net gain / (loss) on disposal of non-current assets

a) Proceeds from disposal of non-current assets	503	43
b) Gain / (Loss) on disposal of non-current assets:		
Land and buildings	54	(69)
Computer equipment and software	(130)	(114)
Furniture and fittings	(26)	(34)
Motor vehicles	50	4
Medical equipment	(116)	(5)
Other plant and equipment	(93)	(170)
	(261)	(388)

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

	2004 $000	2003 $000
Note 9 Capital user charge	28,919	29,196

A capital user charge rate of 8% has been set by the Government for 2003/04 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

Note 10 Other expenses from ordinary activities

Motor vehicle expenses	3,578	3,622
Insurance	2,566	1,886
Communications	3,816	3,667
Printing and stationery	2,105	1,995
Rental of property	2,723	2,584
Audit fees - external	0	401
Bad and doubtful debts expense	140	49
Repairs, maintenance and consumable equipment expense	14,651	14,548
Legal expenses	656	434
Goldfields Operating Lease Expenses	0	565
Other	6,818	7,466
	37,053	37,217

Note 11 Patient charges

Inpatient charges	12,829	13,119
Outpatient charges	1,503	860
	14,332	13,979

Note 12 Grants and contributions

a) Commonwealth grants and contributions

Grant for nursing homes	2,626	2,816
Grant for New Apprenticeship Scheme	0	4
Grant for Dept Veterans Affairs Home & Domicilliary Care	4	0
RHSET - Carnarvon Sea Change	0	39
Heart Foundation - Health Promotion Sponsorship	0	17
Roadwise - Rural Art Road Safety Project	3	16
SMS (HACC)	0	9
Department for Family & Community Services - Stay on Your Feet Project	0	9
Healthway Sponsorship	0	6
Child Health - Feeding Difficulties Project	0	5
Child Health - Literacy Project	0	2
Dept of Employment - National Indigenous Cadetship	15	0
Grant for Speech Pathology	77	71
Grant for Community Drug Service Team	189	400
Grant for Geraldton Sobering up Shelter	59	40
Grant for Community Aids Equipment and School Aged Therapy	222	52
Grant for Cardiorisk Program	19	0
Grant for Immunisations	18	0
Grant for Veterans Home Care	12	0
Grant for Out & About Program	10	0
Grant for Traineeship incentive	6	0
Grant for Disabled School Bus - York	6	0
Other grants	831	958
	4,097	4,444

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 12 Grants and contributions (continued)	2004 $000	2003 $000
b) Grants and subsidies from non-government sources		
Grant for Mental Health and Primary Health Programs	16	28
Community Aids Equipment Program - Disabilities Services	516	202
Disabilities Services - Therapy Funds	224	48
Grant for Employment Training Scheme	2	0
Grant for Denmark Health Service Hostel	2	0
Kuwinyardu Aboriginal Resource Unit	0	4
Grant for Asthma and the Community	0	1
Grant for Alcohol and Drug Service Team and Immunisation	225	733
St John of God - Strong Women, Strong Babies	99	0
Rural Clinical School - Medical Training Funds	31	0
MSOAP	89	0
BHP Billiton - Road Trauma	120	0
Healthway - Mens Health	80	0
Grant for Kids Help Line	56	61
Combined Universities Centre for Rural Health (CUCRH)	20	0
Healthway - Geraldton Young People & Physical Activity Program	80	0
Breast Cancer Awareness	0	0
Other grants	830	1,865
	2,390	2,942

Note 13 Donations revenue		
General public contributions	487	409
Musician Guide of WA - Rammpaage	0	20
Estate of LW Hassler	0	13
Corrigin Apex Club	0	12
Friends of York Hospital - Bladder Scanner	0	10
Northam Hospital Ladies Auxiliary - ECG Machine	0	10
Lions Club of Northam - Hospice Oxygen Fitout	0	7
Friends of York Hospital - Bathroom Upgrade Project	0	6
JJ & A Parker	8	5
Northam Hospital Ladies Auxiliary - PCA Infusion Pump	0	4
Kondut Greater Sports Council	0	3
PM Garret	0	3
Lions Club of Northam - Hospice Oxygen Fitout	0	1
Northam Apex Club - Hospice	0	1
Kunnunopin - Bladder Scanner	0	17
Merredin - Assets	0	9
Specific contribution from Telethon Trust for Paediatric Ward upgrade	133	0
Palliative Care Donations	41	0
Geraldton Hospital Auxiliary	17	0
Yulella	16	0
Estate of CB Parker	24	0
Kunnunopin Hospital Ladies Auxiliary	15	0
York PML	10	0
Corrigin Rotary Club - ECG Machine	9	0
Berringa Lodge	9	0
Merredin Senior Centre	8	0
Narrogin Hospital Ladies Auxiliary	6	0
Kondinin Hospital Ladies Auxiliary	5	0
Beverley Lions Club	4	0
Bruce Rock Masonic Lodge	4	0
Dandaragan Fundraisers	4	0
Merredin Hospital Auxiliary	3	0
	803	530

Note 14 Other revenues from ordinary activities		
a) Revenue from operating activities		
Recoveries	1,593	2,046
Use of hospital facilities	4,084	4,131
Other	1,099	1,163
	6,776	7,340
b) Revenue from non-operating activities		
Rent from properties	468	576
Boarders' accommodation	2,369	2,045
Other	568	307
	3,405	2,928
	10,181	10,268

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 15 Output appropriations

	2004 $000	2003 $000
Appropriation revenue received during the year:		
Output appropriations	432,915	395,833

Output appropriations are accrual amounts reflecting the full cost of outputs delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.

Note 16 Assets assumed / (transferred)

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

- Cash	100	47
- WACHS - Assets & Employee entitlements assumed by WA Country Health Service	0	(26)
- Land and buildings	6	(180)
- Plant and equipment	67	0
Total assets assumed / (transferred)	173	(159)

Discretionary transfers of assets between State Government agencies are recognised as revenues or expense.

Note 17 Liabilities assumed by the Treasurer

Superannuation	280	150

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. The Health Service recognises revenues equivalent to the amount of the liability assumed and an expense relating to the change in this unfunded liability.

Note 18 Resources received free of charge

Resources received free of charge has been determined on the basis of the following estimates provided by agencies.

Office of the Auditor General (i)		
- Audit services	0	401
Other		
- Reverse Osmosis Units x 5 received from Armadale Health Service	0	26
	0	427

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues (except where the contribution of assets or services is in the nature of contributions by owners, in which case the Health Service shall make a direct adjustment to equity) equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

(i) Commencing with the 2003-04 audit, the Office of the Auditor General will be charging a fee for auditing the accounts, financial statements and performance indicators. The fee of $467,500 (GST Inclusive) for the 2003-04 audit will be due and payable in the 2004-05 financial year.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

	2004 $000	2003 $000
Note 19 Cash assets		
Cash on hand	51	69
Cash at bank - general	3,719	3,302
Cash at bank - donations	1,687	2,407
Term deposits and bank bills	951	10
	6,408	5,788
Note 20 Restricted cash assets		
Cash assets held for specific purposes		
Cash at bank	130	382
Term deposits and bank bills	364	0
	494	382

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

Note 21 Receivables		
Patient fee debtors	1,449	1,634
GST receivable	1,719	1,939
Other receivables	2,908	2,588
	6,076	6,161
Less: Provision for doubtful debts	(500)	(390)
	5,576	5,771
Note 22 Amounts receivable for outputs		
Current	30,701	19,516
Non-current	6,149	2,495
	36,850	22,011
Balance at beginning of year	22,011	15,964
Additions to holding account	32,380	21,648
Less holding account drawdowns	(17,541)	(15,601)
Balance at end of year	36,850	22,011

This asset represents the non-cash component of output appropriations which is held in a holding account at the Department of Treasury and Finance. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 23 Inventories		
Supply stores - at cost	2,004	1,972
Pharmaceutical stores - at cost	1,050	1,158
Engineering stores - at cost	640	596
	3,694	3,726
Note 24 Other assets		
Prepayments	200	302
	200	302

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 25 Property, plant and equipment	2004 $000	2003 $000
Land		
At cost	77	19,571
At fair value	22,987	0
	23,064	19,571
Buildings		
Clinical:		
At cost	0	326,723
Accumulated Depreciation	0	(9,745)
	0	316,978
At fair value	318,013	0
Accumulated Depreciation	(21)	0
	317,992	0
Total of clinical buildings	317,992	316,978
Non-Clinical:		
At cost	2,575	27,507
Accumulated depreciation	(152)	(767)
	2,423	26,740
At fair value	40,544	0
Accumulated depreciation	(200)	0
	40,344	0
Total of non clinical buildings	42,767	26,740
Total of all land and buildings	383,823	363,289
Leasehold improvements		
At cost	250	0
Accumulated depreciation	(75)	0
	175	0
Leased assets		
At capitalised cost	0	32
Accumulated depreciation	0	(9)
	0	23
Computer equipment and software		
At cost	6,108	5,391
Accumulated depreciation	(2,351)	(1,131)
	3,757	4,260
Furniture and fittings		
At cost	2,045	2,528
Accumulated depreciation	(313)	(250)
	1,732	2,278
Motor vehicles		
At cost	2,642	1,616
Accumulated depreciation	(969)	(518)
	1,673	1,098
Medical Equipment		
At cost	25,038	21,851
Accumulated depreciation	(5,428)	(2,626)
	19,610	19,225
Other plant and equipment		
At cost	7,267	10,206
Accumulated depreciation	(1,600)	(1,028)
	5,667	9,178
Works in progress		
Buildings under construction	13,092	13,823
Other Work in Progress	5,373	2,429
	18,465	16,252
Total of property, plant and equipment	434,902	415,603

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2004

Note 25 Property, plant and equipment (continued)

The revaluation of land and buildings was performed in June 2004 in accordance with an independent valuation by the Valuer General's Office. Fair value has been determined on the basis of current market buying values for land and non-clinical buildings and replacement capital values for clinical buildings.

Payments for non-current assets Payments were made for purchases of non-current assets during the reporting period as follows:	**2004 $000**	**2003 $000**
Paid as cash by the Health Service from output appropriations	5,047	3,336
Paid as cash by the Health Service from capital contributions	8,176	5,278
Paid as cash by the Health Service from other funding sources	1,107	2,031
Paid by the Department of Health	10,478	10,983
Gross payments for purchases of non-current assets	24,808	21,628

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

	2004 $000
Land	
Carrying amount at start of year	19,571
Additions	382
Transfers from work in progress	0
Disposals	(114)
Revaluation increments / (decrements)	3,231
Transfer between asset classes	(6)
Carrying amount at end of year	23,064
Buildings	
Carrying amount at start of year	343,718
Other additions	6,805
Transfers from work in progress	11,500
Disposals	(275)
Revaluation increments / (decrements)	19,233
Depreciation	(22,388)
Transfer between asset classes	2,166
Carrying amount at end of year	360,759
Leasehold improvements	
Carrying amount at start of year	0
Other additions	9
Transfers from work in progress	241
Disposals	0
Depreciation	(75)
Transfer between asset classes	0
Carrying amount at end of year	175
Leased assets	
Carrying amount at start of year	23
Additions	0
Disposals	0
Depreciation	0
Transfer between asset classes	(23)
Carrying amount at end of year	0
Computer equipment and software	
Carrying amount at start of year	4,260
Other additions	993
Transfers from work in progress	24
Disposals	(145)
Depreciation	(1,330)
Transfer between asset classes	(45)
Carrying amount at end of year	3,757

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements
For the year ended 30th June 2004

Note 25 Property, plant and equipment (continued)

	2004 $000
Furniture and fittings	
Carrying amount at start of year	2,278
Additions	221
Disposals	(30)
Depreciation	(187)
Transfer between asset classes	(550)
Carrying amount at end of year	1,732
Motor vehicles	
Carrying amount at start of year	1,098
Additions	1,038
Disposals	(53)
Depreciation	(500)
Transfer between asset classes	0
Transfers from work in progress	90
Carrying amount at end of year	1,673
Medical Equipment	
Carrying amount at start of year	19,225
Other additions	2,640
Transfers from work in progress	3
Disposals	(107)
Depreciation	(2,897)
Transfer between asset classes	746
Carrying amount at end of year	19,610
Other plant and equipment	
Carrying amount at start of year	9,178
Other additions	993
Transfers from work in progress	20
Disposals	(510)
Depreciation	(1,016)
Transfer between asset classes	(2,998)
Carrying amount at end of year	5,667
Works in progress	
Carrying amount at start of year	16,252
Additions	14,100
Write-off of assets	(9)
Transfers to other asset classes	(11,878)
Carrying amount at end of year	18,465
Total property, plant and equipment	
Carrying amount at start of year	415,603
Additions	26,472
Disposals	(1,234)
Revaluation increments / (decrements)	22,464
Depreciation	(28,394)
Write-off of assets	(9)
Carrying amount at end of year	434,902

Note 26 Other financial assets	2004 $000	2003 $000
Shares in Mount Barker Co-operative at Cost	6	6
	6	6

Note 27 Payables

Trade creditors	10,030	11,108
Accrued expenses	5,803	6,043
Accrued interest	242	0
	16,075	17,151

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 28 Interest-bearing liabilities	2004 $000	2003 $000
Current liabilities:		
Western Australian Treasury Corporation loans	489	470
Department of Treasury and Finance loans	751	729
Finance lease liabilities	0	12
	1,240	1,211
Non-current liabilities:		
Western Australian Treasury Corporation loans	10,599	11,100
Department of Treasury and Finance loans	17,442	18,192
Finance lease liabilities	0	7
	28,041	29,299
Total interest-bearing liabilities	29,281	30,510
Western Australian Treasury Corporation (WATC) loans		
Balance at beginning of year	11,570	13,055
Less repayments this year	(482)	(1,485)
Balance at end of year	11,088	11,570

The debt is held in a portfolio of loans managed by the Department of Health. Repayments of the debt are made by the Department of Health on behalf of the Health Service.

Department of Treasury and Finance loans		
Balance at beginning of year	18,921	19,616
Less repayments this year	(728)	(695)
Balance at end of year	18,193	18,921

This debt relates to funds advanced to the Health Service via the now defunct General Loan and Capital Works Fund. Funds advanced and related interest costs are repaid to the Department of Treasury and Finance by the Department of Health on behalf of the Health Service. Interest rates are linked to the State's debt servicing costs.

Note 29 Provisions		
Current liabilities:		
Annual leave and time in lieu	25,628	23,799
Long service leave	8,396	6,971
Deferred salary scheme	98	35
Gratuities	368	0
Superannuation	0	767
	34,490	31,572
Non-current liabilities:		
Long service leave	7,694	7,327
Deferred salary scheme	5	0
Gratuities	241	0
Superannuation	0	6,282
	7,940	13,609
Total employee benefit liabilities	42,430	45,181

(i) The settlement of annual and long service leave liabilities give rise to the payment of superannuation and other employment on-costs. The liability for such on-costs is included here. The associated expense is included under Employee expenses at Note 4.

(ii) The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.

Under the revised arrangement with the Department of Treasury and Finance (DTF), pension liabilities are transferred to the Treasurer and reported centrally by DTF as from 30 June 2004.

The Health Service considers the carrying amount of employee benefits approximates the net fair value.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 30 Other liabilities

	2004 $000	2003 $000
Accrued salaries	4,026	8,294
Income received in advance	298	18
Other	184	0
	4,508	8,312

Note 31 Contributed equity

Balance at beginning of the year	357,362	0
Capital contributions (i)	14,480	8,698
Contributions by owners		
Constitution of the WA Country Health Service	0	350,035
Other transfers of assets and liabilities (ii)	6,537	0
Distribution to owners (iii)	(1,286)	(1,371)
Balance at end of the year	377,093	357,362

(i) Capital Contributions have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

(ii) Transfer of pension liabilities to the Treasurer.

(iii) Consists of non reciprocal transfers of Land & Buildings - Sandstone ($273k) and sale of staff housing to Health Industry Staff Accommodation (Trust) Fund - Karratha ($345k) and other transfers ($668k) during the current financial year.

Note 32 Reserves

Asset revaluation reserve (i):		
Balance at beginning of the year	0	0
Net revaluation increments / (decrements) :		
- Land	3,208	0
- Buildings	19,233	0
Balance at end of the year	22,441	0
Asset revaluation decrements recognised as an expense (iii):		
Land	(23)	23
	(23)	23

(i) The asset revaluation reserve is used to record increments and decrements on the revaluation of non-current assets. Revaluation increments and decrements are offset against one another within the same class of non-current assets.

(ii) Any net 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.

(iii) Any net decrement is recognised as an expense in the Statement of Financial Performance, except to the extent that any decrement reverses a revaluation increment previously credited to the asset revaluation reserve.

Note 33 Accumulated surplus / (deficiency)

Balance at beginning of the year	(4,927)	0
Change in net assets	1,229	(4,677)
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	0	(250)
Balance at end of the year	(3,698)	(4,927)

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 34 Notes to the statement of cash flows	2004 $000	2003 $000
a) 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 assets (Refer note 19)	6,408	5,788
Restricted cash assets (Refer note 20)	494	382
	6,902	6,170
b) Reconciliation of net cash flows used in operating activities to net cost of services		
Net cash used in operating activities (Statement of Cash Flows)	(373,050)	(343,470)
Increase / (decrease) in assets:		
GST receivable	(220)	675
Other receivables	135	(917)
Inventories	(32)	162
Prepayments	(102)	76
Decrease / (increase) in liabilities:		
Doubtful debts provision	(110)	(37)
Payables	1,076	(4,897)
Accrued salaries	4,268	1,398
Provisions	(3,787)	(4,192)
Income received in advance	(280)	(7)
Non-cash items:		
Depreciation expense	(28,394)	(16,142)
Net gain / (loss) from disposal of non-current assets	(261)	(388)
Interest paid by Department of Health	(2,032)	(2,199)
Capital user charge paid by Department of Health	(28,919)	(29,196)
Other expenses paid by Department of Health	0	(152)
Donation of non-current assets	9	(14)
Asset revaluation decrements	23	(23)
Superannuation liabilities assumed by the Treasurer	(280)	(150)
Resources received free of charge	0	(427)
Other	(183)	(1,028)
Net cost of services (Statement of Financial Performance)	(432,139)	(400,928)
c) Notional cash flows		
Output appropriations as per Statement of Financial Performance	432,915	395,833
Capital appropriations credited directly to Contributed Equity (Refer Note 31)	14,480	8,698
Holding account drawdowns credited to Amounts Receivable for Outputs (Refer Note 22)	17,541	15,601
	464,936	420,132
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 WA Treasury Corporation	(669)	(693)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(482)	(1,485)
Interest paid to Department of Treasury & Finance	(1,363)	(1,506)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(728)	(695)
Capital user charge	(28,919)	(29,196)
Accrual appropriations	(32,380)	(21,648)
Capital works expenditure	(13,379)	(15,816)
Other non cash adjustments to output appropriations	494	767
	(77,427)	(70,271)
Cash Flows from State Government as per Statement of Cash Flows	387,509	349,860

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 35 Revenue, public and other property written off or presented as gifts	2004 $000	2003 $000
a) Revenue and debts written off.	71	42

All of the amounts above were written off under the authority of the Accountable Authority.

Note 36 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 Director General of Health's remuneration is paid by the Department of Health.

Remuneration of senior officers

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

	2004	2003
$40,001 - $50,000	1	0
$110,001 - $120,000	3	7
$120,001 - $130,000	1	0
$130,001 - $140,000	2	0
$140,001 - $150,000	1	1
$220,001 - $230,000	1	0
Total	9	8

	$000	$000
The total remuneration of senior officers is:	1,163	951

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of Senior Officers other than senior officers reported as members of the Accountable Authority.

Numbers of Senior Officers presently employed who are members of the Pension Scheme:	2	1

Note 37 Commitments for Expenditure

a) **Capital expenditure commitments**

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements, are payable as follows:

Within one year	11,025	2,408
Later than one year, and not later than five years	904	1,000
	11,929	3,408

b) **Operating lease commitments:**

Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:

Within one year	2,838	2,393
Later than one year, and not later than five years	2,062	1,291
	4,900	3,684

c) **Finance lease commitments:**

Commitments in relation to finance leases are payable as follows:

Within one year	0	13
Later than one year, and not later than five years	0	7
Later than five years	0	0
Minimum finance lease payments	0	20
Less future finance charges	0	1
Provided for as finance lease liabilities (Refer note 28)	0	19

d) **Other expenditure commitments:**

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

Within one year	93	292
Later than one year, and not later than five years	0	0
Later than five years	0	0
	93	292

These commitments are all inclusive of GST.

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 38 Contingent liabilities and contingent assets	2004 $000	2003 $000
Contingent Liabilities		
In addition to the liabilities incorporated in the financial statements, the Health Service has the contingent liabilities for litigation in progress.		
Pending potential litigation that are not recoverable from RiskCover insurance and may affect the financial position:	5,925	0
Number of claims	7	0

Contingent Assets

The Health Sevice does not have any contingent assets.

Note 39 Events occurring after reporting date

There were no events occurring after reporting date which have significant financial effects on these financial statements.

Note 40 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. Related bodies are generally government agencies which have no financial administration responsibilities.

The Health Service had no related bodies during the reporting period.

Note 41 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Health Service and is not subject to operational control by the Health Service. Affiliated bodies are generally non-government agencies, such as charitable, welfare and community interest groups which receive financial support from government.

The Health Service had the following affiliated bodies during the reporting period:

Berringa Frail Aged Hostel
Merredin Senior Centre and HACC Services

WA COUNTRY HEALTH SERVICE

Notes to the Financial Statements

For the year ended 30th June 2004

Note 42 The Impact of Adopting International Financial Reporting Standards

The International Financial Reporting Standards (IFRSs) will be applicable to reporting periods beginning on or after 1 January 2005. The Australian Accounting Standards Board (AASB) has adopted a convergence policy under which the Australian Accounting Standards are converged with their IFRS equivalents. The AASB will issue Australian equivalents to IFRSs, and Urgent Issues Group abstracts to harmonise with the International Financial Reporting Standards issued by the International Accounting Standards Board. The WA Country Health Service will prepare its first Australian-equivalents-to-IFRSs financial statements for the year ending 30 June 2006.

The Department of Health has established a structure of project teams to manage the transition to IFRSs and report to executive management. These project teams include members representing pertinent function areas within the health sector, an internal audit officer, an expert consultant from an accounting firm and representatives from the Department of Treasury and Finance and the Valuer General's Office. The actions that have been undertaken include the preparation of a timetable, identification of system changes and training of staff. Considerable progress has been made on the projects for impairment of assets and revaluation of land and buildings. To date the project teams have analysed most of the Standards and have identified a number of accounting policy changes that will be required. A Treasurer's Instruction will be issued for application within the Western Australian public sector to mandate an accounting treatment and disclosure where there are alternatives under the IFRSs.

The following are the key differences in accounting policies identified to date that are expected to arise from adopting Australian equivalents to IFRSs:

(a) **Impairment of assets**
Under AASB 136, the Australian equivalent to IAS 36 "Impairment of Assets", assets will be measured at the recoverable amount if there is an indication of impairment.

This will result in a change to the current accounting policy, under which assets are not required to be measured at their recoverable amounts.

(b) **Leases**
Under AASB 117, the Australian equivalent to IAS 17 "Leases", assets and liabilities under finance leases will be recognised at amounts equal at the inception of the lease to the fair value of the leased property or, if lower at the present value of the minimum lease payments.

This will result in a change to the current accounting policy, under which assets and liabilities under finance leases are recognised at amounts equal to the present value of the minimum lease payments.

(c) **Inventories**
Under AASB 102, the Australian equivalent to IAS 2 "Inventories", inventories held for distribution will be measured at the lower of cost and current replacement cost, rather than the lower of cost and net realisable value, which will apply to other general inventories.

This will result in a change to the current accounting policy, under which all classes of inventories are valued at lower of cost and net realisable value.

(d) **Employee benefits**
Under the AASB 119, the Australian equivalent to IAS 19 "Employee Benefits", annual leave that are not short term employee benefits, will be measured at present value.

This will result in a change to the current accounting policy, under which liabilities for annual leave are measured at nominal amounts in all circumstances.

The above should not be regarded as a complete list of changes in accounting policies that will result from the transition to IFRSs, as not all Standards have been analysed as yet. For these reasons it is not yet possible to quantify the impacts of the transition to IFRSs on WA Country Health Service's reported financial position and financial performance.

WA COUNTRY HEALTH SERVICE
Notes to the Financial Statements
For the year ended 30th June 2004

Note 43 Explanatory Statement

(A) Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.

Reasons for 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 $10,000,000

	Note	2004 Actual $000	2003 Actual $000	Variance $000
Statement of Financial Performance - Expenses				
Employee expenses	(a)	280,654	267,731	12,923
Fees for visiting medical practitioners		26,950	25,427	1,523
Patient support costs		59,808	54,877	4,931
Borrowing costs expense		2,032	2,201	(169)
Depreciation expense	(b)	28,394	16,142	12,252
Asset revaluation decrement		(23)	23	(46)
Capital user charge		28,919	29,196	(277)
Other expenses from ordinary activities		37,053	37,217	(164)
Statement of Financial Performance - Revenues				
Patient charges		14,332	13,979	353
Commonwealth grants and contributions		4,097	4,444	(347)
Grants and subsidies from non-government sources	(c)	2,390	2,942	(552)
Other revenues from operating activities		6,776	7,340	(564)
Donations revenue	(d)	803	530	273
Interest revenue	(e)	106	141	(35)
Proceeds from disposal of non-current assets	(f)	503	43	460
Other revenues from non-operating activities	(g)	3,405	2,928	477
Output appropriations	(h)	432,915	395,833	37,082
Assets assumed / (transferred)	(i)	173	(159)	332
Liabilities assumed by the Treasurer	(j)	280	150	130
Resources received free of charge	(k)	0	427	(427)

(a) Employee expenses
The increase was primarily due to increased cost of awards. Cost of awards increased by approximately 3.5% averaged across all categories, leading to an increase in salaries, wages and employee entitlements. There was also an increase in staff numbers associated with new services and programs.

(b) Depreciation expense
Accelerated depreciation totalling $11.7m was charged following a reassessment of the estimated useful life of a number of facilities, including Geraldton Regional Hospital ($8.9m), Ravensthorpe Hospital ($0.9m), Halls Creek Hospital ($0.7m), Kalgoorlie Regional Hospital ($0.6m), Oombulguri Clinic ($0.3m), Boulder Community Health Centre ($0.2m), Nullagine Clinic ($0.09m) and Wickepin Hospital ($0.05m).

(c) Grants and subsidies from non-government sources
An annual funding allocation from the Office of Aboriginal Health ($0.7m) for remote doctor service in the Kimberley that was received as revenue in previous years is now provided by way of budget adjustment to Output Appropriations.

(d) Donations revenue
Donations revenue is largely uncontrollable and can vary significantly from year to year. While there were a number of large donations for specific projects across the State, there were no singly identifiable item contributing to the increase over the prior year.

(e) Interest revenue
The reduction in interest revenue is due primarily to lower cash balances being held in interest bearing accounts throughout the financial year.

(f) Proceeds from disposal of non-current assets
The increase is due to the disposal of two residential properties in Karratha amounting to $345,000 which were deemed surplus to requirements following the development of new staff accommodation facilities in the town. Increase in disposal of vehicles and equipment also occurred over the previous year.

WA COUNTRY HEALTH SERVICE
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For the year ended 30th June 2004

(g) Other revenues from non-operating activities
The increase was due principally to standardisation of practices regarding recognition of some rental and HACC revenues which in prior years had been recognised in a number of different revenue accounts cross the Health Service. In addition, increased rental revenues were received due to expansion of staff accommodation facilities, particularly in the Pilbara.

(h) Output appropriations
Appropriation increased for the year due to (i) increased funding for salary and wages cost of award increases, (ii) annual CPI increases for consumable items, (iii) funding for the accelerated depreciation of various facilities, and (iv) increase in funds received for various Commonwealth Programs.

(i) Assets assumed / (transferred)
The net increase in Assets Assumed (Transferred) results from (i) the receipt of assets associated with palliative care and community care services assumed by the Health Service in the Midwest, and (ii) some properties transferred to the Department of Land Administration for disposal during 2003/04 now being recognised as an equity transfer in the statement of financial position rather than a charge to the statement of financial performance as they have been in previous years.

(j) Liabilities assumed by the Treasurer
Represents the increased actuarially determined value of entitlements assumed by the Treasurer in relation to the State's pension scheme as advised by the Government Employees Superannuation Board.

(k) Resources received free of charge
Commencing with the 2003-04 audit, the Office of the Auditor General will be charging a fee for auditing the accounts, financial statements and performance indicators. Prior to this change in charging policy, the services of the OAG were received free of charge and recognised in the financial statements of the year to which they relate. The fee for the 2003-04 audit is estimated to be $467,500 including GST, and will be due and payable in the 2004-05 financial year.

(B) Significant variations between estimates and actual results for the financial year

Section 42 of the Financial Administration and Audit Act requires the health service to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget.

	Note	2004 Actual $000	2004 Estimates $000	Variance $000
Operating expenses				
Employee expenses	(a)	280,654	277,487	3,167
Other goods and services	(b)	183,897	183,490	407
Total expenses from ordinary activities		464,551	460,977	3,574
Less: Revenues from ordinary activities	(c)	(32,412)	(30,159)	(2,253)
Net cost of services		432,139	430,818	1,321

There were no significant variations from budget for the 2003/04 financial year.

Notes to the Financial Statements

For the year ended 30th June 2004

Note 44 Financial instruments

a) **Interest rate risk exposure**

The following table details the Health Service's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2004							
Financial Assets							
Cash assets	4.2%	3,086	951	0	0	2,371	6,408
Restricted cash assets	4.8%	130	364	0	0	0	494
Receivables						5,576	5,576
		3,216	1,315	0	0	7,947	12,478
Financial Liabilities							
Payables						16,075	16,075
Interest-bearing liabilities							
- W A Treasury Corporation loans	5.9%		489	5,130	5,469		11,088
- Department of Treasury & Finance loans	7.4%		751	9,268	8,174		18,193
		0	1,240	14,398	13,643	16,075	45,356
Net financial assets / (liabilities)		3,216	75	(14,398)	(13,643)	(8,128)	(32,878)
As at 30th June 2003							
Financial Assets	2.1%	4,607	82	0	0	7,252	11,941
Financial Liabilities	6.8%	0	1,211	5,504	23,795	17,151	47,661

b) **Credit risk exposure**

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. The carrying amounts of financial assets recorded in the financial statements, net of any provisions or losses, represent the Health Service's maximum exposure to credit risk.

c) **Net fair values**

The carrying amounts of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in note 1 to the financial statements.

Notes to the Financial Statements

For the year ended 30th June 2004

Note 45 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2004 $000	2003 $000	2004 $000	2003 $000	2004 $000	2003 $000	2004 $000	2003 $000
COST OF SERVICES								
Expenses from Ordinary Activities								
Employee expenses	32,107	33,493	223,513	212,605	25,034	21,633	280,654	267,731
Fees for visiting medical practitioners	452	1,182	25,514	22,993	984	1,252	26,950	25,427
Patient support costs	6,842	6,168	47,631	45,082	5,335	3,627	59,808	54,877
Borrowing costs expense	233	206	1,618	1,931	181	64	2,032	2,201
Depreciation expense	3,248	1,916	22,613	12,914	2,533	1,312	28,394	16,142
Asset revaluation decrement	(5)	5	(9)	9	(9)	9	(23)	23
Capital user charge	3,308	3,212	23,031	23,776	2,580	2,208	28,919	29,196
Costs of disposal of non-current assets	87	51	609	375	68	35	764	461
Other expenses from ordinary activities	4,239	5,878	29,509	28,666	3,305	2,673	37,053	37,217
Total cost of services	50,511	52,111	374,029	348,351	40,011	32,813	464,551	433,275
Revenues from Ordinary Activities								
Revenue from operating activities								
Patient charges	1,559	909	11,539	11,635	1,234	1,435	14,332	13,979
Commonwealth grants and contributions	445	289	3,299	3,699	353	456	4,097	4,444
Grants and subsidies from non-government sources	260	191	1,924	2,449	206	302	2,390	2,942
Other revenues from operating activities	738	477	5,455	6,103	583	760	6,776	7,340
Revenue from non-operating activities								
Donations revenue	87	34	647	441	69	55	803	530
Interest revenue	12	9	85	117	9	15	106	141
Proceeds from disposal of non-current assets	55	3	405	36	43	4	503	43
Commercial activities	0	0	0	0	0	0	0	0
Other revenues from non-operating activities	371	190	2,742	2,437	292	301	3,405	2,928
Total revenues from ordinary activities	3,527	2,102	26,096	26,917	2,789	3,328	32,412	32,347
NET COST OF SERVICES	**46,984**	**50,009**	**347,933**	**321,434**	**37,222**	**29,485**	**432,139**	**400,928**
Revenues from State Government								
Output appropriations	47,101	49,611	348,540	317,481	37,274	28,741	432,915	395,833
Assets assumed / (transferred)	19	(19)	139	(128)	15	(12)	173	(159)
Liabilities assumed by the Treasurer	30	19	226	120	24	11	280	150
Resources received free of charge	0	54	0	342	0	31	0	427
Total revenues from State Government	47,150	49,665	348,905	317,815	37,313	28,771	433,368	396,251
CHANGE IN NET ASSETS	**166**	**(344)**	**972**	**(3,619)**	**91**	**(714)**	**1,229**	**(4,677)**

Abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Awaiting Placement
ACAT	Aged Care Assessment Team
ACHS	Australian Council of HealthCare Standards
ACIR	Australian Childhood Immunisation Register
AMI	Acute Myocardial Infarction
APGAR	Activity (muscle tone/movement), Pulse, Grimace (reflex), Appearance (skin colour - blue etc), Respiration
ATSI	Aboriginal and Torres Strait Islander
CACP	Community Aged Care Packages
CPI	Consumer Price Index
CT	Computed Tomography
DHAC	District Health Advisory Council
EEO	Equal Employment Opportunity
EQUIP	Evaluation and Quality Improvement Program
FNOF	Fractured Neck of Femur
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HCARe	Health Care and Related Information Systems
HIC	Health Information Centre
HMDS	Hospital Morbidity Data System
IT	Information Technology
MPS	Multi Purpose Services
NHTP	Nursing Home Type Patient
PATS	Patient Assisted Travel Scheme
PID	Public Interest Disclosure
PSOLIS	Psychiatric Services Online Information System
RCA	Root Cause Analysis
RFDS	Royal Flying Doctor Service
STI	Sexually Transmitted Infections
VMP	Visiting Medical Practitioners
WACHS	WA Country Health Service

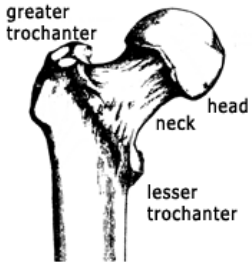
Glossary of Terms

Acute Myocardial Infarction (AMI)
Also known as a heart attack. It literally means sudden death of heart muscle. AMI results in sudden, severe chest pain that occurs when a portion of the heart no longer receives oxygen-rich blood, usually due to total or near-total blockage of a coronary artery by a blood clot formed in an area already narrowed by plaque. The surrounding heart muscle dies and the heart stops working effectively

APGAR Score
The Apgar score is given to newborns and occurs right after a baby's birth. The Apgar test is usually given to a baby twice: once at 1 minute after birth, and again at 5 minutes after birth. Rarely, if there are serious problems with the baby's condition and the first two scores are low, the test will be scored for a third time at 10 minutes after birth. Five factors are used to evaluate the baby's condition, heart rate (pulse), breathing (rate and effort), activity, grimace (reflex irritability) and appearance (skin colouration) and each factor is scored on a scale of 0 to 2.

CT Scan
A Computed Tomography scan or CT is a diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce cross-sectional images (often called “slices”), both horizontally and vertically, of the body. A CT scan shows detailed images of any part of the body, including the bones, muscles, fat, and organs. CT scans are more detailed than general x-rays. This diagnostic tool is sometimes referred to as a CAT scan.

Fractured Neck of Femur
The femur or thigh bone is the longest, largest and strongest bone of the human body. The femur's head forms a ball-and-socket joint at the hip. Classically, this is a fracture of old age that effects men and women in their seventies and eighties. It is often caused when diseases such as osteoporosis have weakened the bone.



Hospital Morbidity Data System (HMDS)
Hospital Morbidity Data System is part of the Health Data Collection program of the Health Information Centre Directorate. The HMDS collects in-patient discharge summary data from all public and private hospitals in Western Australia.

Public Interest Disclosure (PID)
The *Public Interest Disclosure Act 2003* commenced operation on 1 July 2003. The object of the Act is to:
~ facilitate the disclosure of public interest information;
~ provide protection for those who make disclosures; and
~ provide protection for those who are the subject of a disclosure.

This is achieved by:
~ protecting the person making the disclosure from legal or other action;
~ providing for the confidentiality of the identity of the person making the disclosure and a person who is the subject of a disclosure; and
~ providing remedies for acts of reprisal and victimisation that occur substantially because the person has made a disclosure.