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

WA Country Health Service

Annual Report 2014–15

health.wa.gov.au

WA Country Health Service

Annual Report 2014–15

WA Country Health Service

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Statement of compliance

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the Annual Report of the WA Country Health Service for the financial year ended 30 June 2015.

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

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2015

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Overview of agency

Vision statement

Our vision

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

Our mission

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

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

Our values

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

Our values can be summarised as:

Executive summary

The WA Country Health Service (WACHS) is the largest country health service in Australia, covering an area of nearly 2.5 million square kilometres. It plays a pivotal role in Western Australia's broader public health system, delivering comprehensive health services to about half-a-million people – approximately 7.6 per cent of whom are Aboriginal. WACHS faces many challenges in providing high quality health services and meeting community needs and expectations across vast distances and diverse geographical locations.

WACHS employs approximately 10,000 staff in its range of hospital and community health services across 70 rural and remote sites. During the past year WACHS has supported 80 per cent as many births as the State's major maternity centre, King Edward Memorial Hospital and managed 40 per cent of WA's emergency presentations. In addition, non-emergency WACHS' health services were accessed more than 815,000 times.

Caring for individuals and the community

WACHS is leading a once-in-a-generation transformation of country health care, with a $1.5 billion capital works program ensuring country residents have access to high quality hospital and health services.

The new $120.4 million Busselton Health Campus was opened in early 2015, bringing state-of-the-art medical facilities to Busselton and surrounding towns. In the Goldfields, most work on Kalgoorlie's new $59.6 million Health Campus has been completed and the $31.3 million Esperance Health Campus redevelopment is underway. Work commenced in late 2014 on the $34.9 million 'twin' redevelopment of Carnarvon Health Campus and Exmouth Health Service, which is on track to be completed by the end of 2015. WACHS' next flagship project, the $207.15 million Karratha Health Campus, has now entered the design phase. This will be the biggest investment in a public country hospital in WA and will deliver the best health care now and into the future for the people of the West Pilbara. Pilbara residents will also be well served by the soon to be expanded Onslow Hospital and Health Service.

A $22.2 million Remote Health Clinics program is continuing in the State's north to upgrade and refurbish clinics that serve Aboriginal communities. Mulan and Billiluna Clinics were officially opened in October 2014, each including a large general treatment room, emergency treatment room, consulting rooms and culturally secure features such as separate entrances for males and females. Other clinics included in this refurbishment program are located at Bayulu, Wangkatjungka, Yandeyarra and Jigalong.

The half-a-billion-dollar Royalties for Regions-funded Southern Inland Health Initiative (SIHI) continues to provide improved access to medical and emergency care and primary health care services for people in 37 towns across the Wheatbelt and Great Southern. This year has seen an unprecedented level of refurbishment and redevelopment underway in Merredin, Northam, Narrogin, Katanning, Collie and Manjimup, as well as 26 small hospitals and nursing posts.

WACHS has led the introduction of some of the most important technological advances in remote area health care. Since its inception in 2011 as a key WACHS strategy to address long-term problems with the delivery of health care in rural and remote WA, the telehealth service has rapidly expanded. As at 30 June 2015, telehealth has conducted more than 40,000 'virtual' clinical consults (including emergency and outpatient consults) across WA. The Premier's Award-winning Emergency Telehealth Service has been implemented across 63 regional sites and delivered 8,855 consultations.

Caring for those who need it most

Under the current National Healthcare Agreement with the Commonwealth Government, the Australian States and Territories are funded primarily to provide acute hospital, emergency care and some sub-acute services. The Commonwealth is principally responsible for primary care, general practitioner and residential and community aged care services.

The State, through WACHS, has continued to provide extensive funding to achieve access to essential primary care, and residential and community aged care services for communities where few primary and aged care service providers exist, such as in the northern and inland areas of WA.

WA's regional population is estimated to grow by an average of 2 per cent each year. However, growth in individual regions has varied greatly over recent years in response to lifestyle and economic factors. The South West and the North of WA have grown faster than other regions, placing additional pressure on services.

The ageing population in regional WA is also having a significant impact. The total number of people aged 70 years and above has increased 21 per cent in the past five years, to more than 44,500. This age group is projected to grow 25 per cent in the next five years. An ageing population changes both the mix and volume of medical procedures and services required.

The population in country areas is also developing chronic disease in record numbers. WACHS has continued to work with service providers and communities to gain a better understanding of the system changes required to improve health outcomes in this area. This work provides the foundation for a strategic approach to chronic conditions prevention and management, such as implementation of the WACHS Chronic Conditions Strategy and expansion of the Diabetes Telehealth Service in the future. A SIHI-funded Health Navigator Program is delivered in partnership with Silver Chain Nursing Association.

To address some of these issues, an additional 17 dialysis chairs have been provided at Kalgoorlie, Fitzroy Crossing, Esperance and Roebourne, bringing the total to 94 across WACHS. A total of 92 renal hostel beds are now provided at Broome, Derby, Kununurra, Fitzroy Crossing, Kalgoorlie and Carnarvon.

Work is also being undertaken to ensure that regional patients diagnosed with a clinical condition have access to the same levels of care and service as those with the same conditions who live in metropolitan areas. Clinical pathways have been developed for stroke and some cancers, with work progressing on the development of other clinical pathways.

WACHS is introducing innovative ways to take services to where children are located, e.g. child care centres and kindergartens. This has led to approximately 27 new child health nurses employed in country WA through child health investment (16 directly employed by WACHS and 11 full-time equivalent or FTE employed through the community services sector). The success of this strategy is demonstrated by the results at Australind's Kingston Primary School, where almost 240 health checks were conducted in less than a year, along with almost 200 screenings of women for perinatal anxiety and depression.

In the North West, the foundations have been laid for a generation of improved oral health in children with the planning phase of the landmark Ear, Eye and Oral Health Initiative almost complete and implementation due to commence early in 2015–16.

Making the best use of funds and resources

WACHS accepts the challenge of being able to deliver services more efficiently and where possible, identify areas to reduce future budget pressures. It has improved the revenue and cost profile of its services with the following:

- business process strategies to increase efficiency through improved business management
- revenue enhancement strategies
- cost savings and procurement/contract strategies to reduce expenditure.

WACHS is also working to fully understand the costs of delivering services in a rural and remote environment and the key cost drivers to support negotiations and discussions with its funding authorities around future budget requirements.

The Royalties for Regions (RfR) program has been a major source of capital and recurrent funding to improve regional health infrastructure and services. WACHS maintains positive relationships with the Department of Regional Development regarding the use of approved funds.

This year approximately $154.4 million was committed under RfR for programs including the Patient Assisted Travel Scheme, Royal Flying Doctor Service, ambulance services, SIHI and infrastructure projects.

Supporting our team

The Western Australian public health sector is facing increasing pressure to meet the growing demand for healthcare services, with the second lowest medical specialist-to-population ratio in Australia and a tight fiscal environment.

Maintaining a skilled and stable workforce is a key priority for WACHS; however, there are a number of health professions that are either not represented or are under-represented in regional WA.

WACHS is addressing workforce shortages in rural areas by:

- improving early-career exposure to rural and remote areas
- supporting increased generalist training pathways
- identifying recruitment and retention challenges in rural and remote areas
- implementing incentive programs.

Significant effort has also been made to reduce reliance on the locum medical and agency nursing workforce, which has improved workforce stability in a number of regional sites.

Innovative ideas are starting to pay off. For example, the placement of graduate nurses in community mental health settings is having a positive effect on recruitment for mental health nurses. Additionally, exposing junior doctors to rural areas leads to more doctors choosing a rural medicine career path.

In 2015, WACHS provided rural employment for 72 junior doctors in a mix of part-time/full-time and six- and 12-month contracts. There were also 30 junior doctor placements (11–22 week) in WACHS sites under various Commonwealth programs. These initiatives give future doctors a taste of working in a challenging and rewarding health environment, as well as a ‘real life’ experience of living and working in country WA.

Within WACHS, a strong culture of inclusion has developed for Aboriginal staff. The *Aboriginal Employment Strategy 2014–2018* and the WACHS Aboriginal Mentorship Program 'Your Footsteps Our Future' are helping to attract, build and retain a skilled Aboriginal workforce, which is vital for delivering culturally appropriate health services and ensuring improvements in Aboriginal health.

Since the employment of Aboriginal Mental Health Coordinators in each region, there has been a 132 per cent increase in the people seen since this program commenced.

Investment has also been made in the employment and training of Aboriginal Health Workers to identify ear disease in children in remote Aboriginal communities.

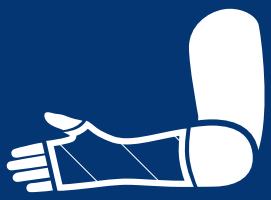
WACHS enters the new year keen to consolidate and build upon the achievements of 2014–15.

Professor Bryant Stokes
A/DIRECTOR GENERAL
DEPARTMENT OF HEALTH

Country WA at a glance

In country WA a male is expected to live to **80.0** years of age and females to **84.9** years of age

116,779
discharges from country public hospitals in 2014



825
people on any day will present to a major country emergency department

356
deaths in country WA are caused by coronary heart disease

2,699
people in country WA were diagnosed with cancer in 2013

26%
of 16–24 year olds in WA experience a mental health condition each year

53.9%
of all potentially preventable hospitalisations in WA were due to chronic conditions

50.6%
of children living in country WA do not undertake sufficient physical activity

33.7%
of adults living in country WA are obese

93.3%
of adults living in country WA do not eat two serves of fruit and five serves of vegetables daily

6,602
patients accessed the Royal Flying Doctor Service in 2014

14,846
patients accessed Telehealth services in 2014

Operational structure

Enabling legislation

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

Administered legislation

Please refer to the *Department of Health Annual Report 2014–15* for administered legislation.

Accountable authority

The Acting Director General of Health, Professor Bryant Stokes, was the accountable authority for the WA Country Health Service in 2014–15.

Responsible Minister

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

WA Health structure

WA Health encompasses five health service areas:

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

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

Figure 1: **WA Health structure**

<table>
<tr><th colspan="4">WA Health</th></tr>
<tr>
<td>Department of Health
Office of the Director General
Office of the Deputy Director General
Public Health and Clinical Services
Office of the Chief Medical Officer
Innovation & Health System Reform
Patient Safety and Clinical Quality
Office of the Chief Procurement Officer
Office of the Chief Psychiatrist
Resourcing and Performance
Office of Mental Health</td>
<td>Metropolitan Health Service
North Metropolitan Health Service (includes Dental Health Services and PathWest Laboratory Medicine WA)
South Metropolitan Health Service
Child and Adolescent Health Service
Fiona Stanley Hospital</td>
<td>WA Country Health Service
Aboriginal Health
Corporate Services
Executive Services
Infrastructure
Medical Services
Nursing and Midwifery
Primary Health and Engagement</td>
<td>Queen Elizabeth II Medical Centre Trust

Quadriplegic Centre</td>
</tr>
</table>

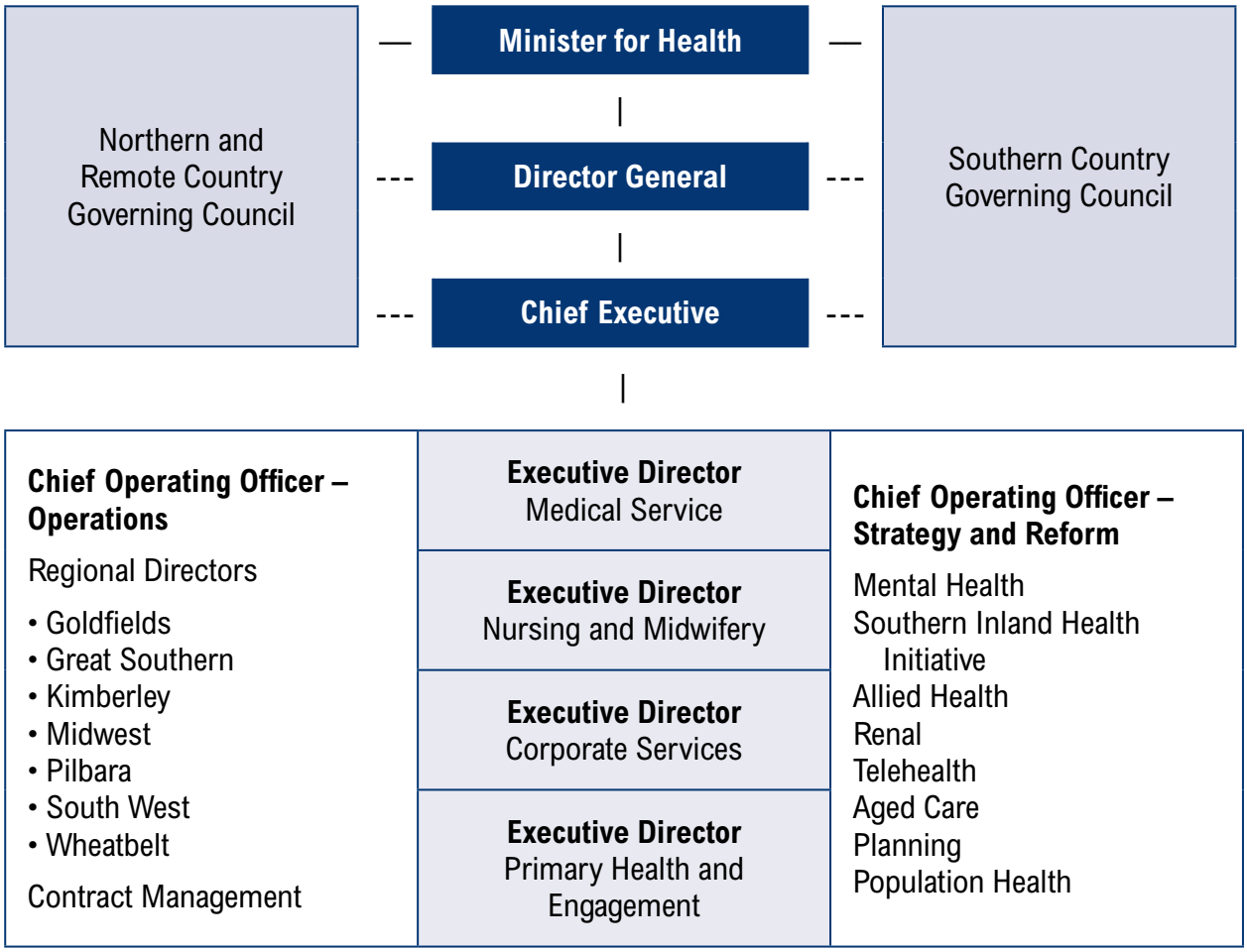
WA Country Health Service management structure

The WA Country Health Service has two governing councils (Northern and Remote Country, and Southern Country) and seven administrative regions supported by a central office in Perth (see Figure 2).

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

The WA Country Health Service Chief Executive is also on the State Health Executive Forum that advises the Director General. For information on the management structure of the State Health Executive Forum, please refer to the *Department of Health Annual Report 2014–15*.

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



Senior officers

Senior officers and their area of responsibility for the WA Country Health Service as at 30 June 2015 are listed in Table 1.

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

Area of responsibility	Title	Name	Basis of appointment
WA Country Health Service	Chief Executive Officer	Jeffrey Moffet	Term Contract
Corporate Services	Executive Director	Jordan Kelly	Acting
Medical Services	Executive Director	Dr Tony Robins	Term Contract
Nursing and Midwifery	Executive Director	Marie Baxter	Term Contract
Operations	Chief Operating Officer	Shane Matthews	Acting
Primary Health and Engagement	Executive Director	Vacant	Vacant
Regional Operations	Regional Director Goldfields	Geraldine Ennis	Substantive
Regional Operations	Regional Director Kimberley	Kerry Winsor	Substantive
Regional Operations	Regional Director Midwest	Margaret Denton	Acting
Regional Operations	Regional Director Great Southern	David Naughton	Acting
Regional Operations	Regional Director Pilbara	Ronald Wynn	Term Contract
Regional Operations	Regional Director South West	Grace Ley	Term Contract
Regional Operations	Regional Director Wheatbelt	Caroline Langston	Term Contract
Strategy & Reform	Chief Operating Officer	Melissa Vernon	Acting

WA Country Health Service 2014–15

The WA Country Health Service is the largest country health service in Australia and one of the biggest in the world, delivering a range of comprehensive health services to more than 542,000 people (ABS ERP 2013) including over 49,000 Aboriginal people (ABS ERP 2012) across a 2.5 million square kilometre area.

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

Across its 70 hospitals, the WA Country Health Service handles almost as many emergency presentations as hospitals in the metropolitan area combined, and almost as many births as the State's major maternity hospital. As well as the many country hospitals, there are also a number of smaller health centres and nursing posts spread across country WA.

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

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

WA Country Health Service strategic directions and priorities

The WA Country Health Service continues to work with regional communities to deliver a healthier country WA. Following the success of the *Revitalising Country Health Services Strategic Direction 2009–12*, new strategic priorities were introduced for the following three years in the *Towards Healthier Country Communities 2013–15* strategic plan. This strategic plan will soon be superseded by a new 2015–18 plan.

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

Key strategies will focus on service redesign to move from a reliance on acute hospital service models. To meet community needs the WA Country Health Service aims to further improve access to primary care, emergency care, ambulatory care programs and enhanced telehealth services.

Priorities for the WA Country Health Service continue to be Aboriginal Health, maternal and child health, health promotion, disease control, mental health, sub-acute care and community and residential aged care. Timely access to services and improving the quality and safety of health care delivery also remain priorities. See Figure 3 for the purpose and values of the WA Country Health Services.

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

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

Performance management framework

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

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

WA Health's outcomes and key performance indicators for 2014–15 are aligned to the State Government goal of 'greater focus on achieving results in key service delivery areas for the benefit of all Western Australians' (see Figure 4 and Figure 5).

The WA Health outcomes for achievement in 2014–15 are as follows:

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

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

The health service activities that are aligned to Outcome 1 and 2 are cited below.

Activities related to Outcome 1 aim to:

1. Provide quality diagnostic and treatment services that ensure the maximum restoration to health after an acute illness or injury.
2. Provide appropriate after-care and rehabilitation to ensure that people's physical and social functioning is restored as far as possible.
3. Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.
4. Provide appropriate care and support for patients and their families during terminal illness. This activity is reported as part of the WA Country Health Service annual report under key performance indicator 'average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents'.

Activities related to Outcome 2 aim to:

1. Increase the likelihood of optimal health and wellbeing by:
   - providing programs which support the optimal physical, social and emotional development of infants and children
   - encouraging healthy lifestyles (e.g. diet and exercise).
2. Reduce the likelihood of onset of disease or injury by:
   - immunisation programs
   - safety programs.
3. Reduce the risk of long-term disability or premature death from injury or illness through prevention, early identification and intervention, such as:
   - programs for early detection of developmental issues in children and appropriate referral for intervention
   - early identification and intervention of disease and disabling conditions (e.g. breast and cervical cancer screening; screening of newborns) with appropriate referrals
   - programs that support self-management by people with diagnosed conditions and disease (e.g. diabetic education)
   - monitoring the incidence of disease in the population to determine the effectiveness of primary health measures.
4. Provide continuing care services and programs that improve and enhance the wellbeing and environment for people with chronic illness or disability, enabling people with chronic illness or disability to maintain as much independence in their everyday life as their illness or disability permits, supporting people in their homes for as long as possible and providing extra care when long-term residential care is required. Services and programs are delivered to:
   - ensure that people experience the minimum of pain and discomfort from their chronic illness or disability
   - maintain the optimal level of physical and social functioning
   - prevent or slow down the progression of the illness or disability
   - enable people to live, as long as possible, in the place of their choice supported by, for example, home care services or home delivery of meals
   - support families and carers in their roles
   - provide access to recreation, education and employment opportunities.

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

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

WA Strategic Outcome (Whole of Government)

Outcome-based service delivery:
Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

WA Health strategic intent

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

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

Outcome 1

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

Outcome 2

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

Key effectiveness indicators contributing to Outcome 1

- percentage of public patients discharged to home after admitted hospital treatment
- survival rates for sentinel conditions
- rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition
- rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition
- percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery.

Key effectiveness indicators contributing to Outcome 2

- rate of hospitalisations for gastroenteritis in children (0–4 years)
- rate of hospitalisations for selected respiratory conditions
- rate of hospitalisations for falls in older persons
- percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit
- percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units.

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

Outcome 1

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

Outcome 2

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

Services delivered to achieve Outcome 1

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

Services delivered to achieve Outcome 2

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

Key efficiency indicators for services within Outcome 1

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

Key efficiency indicators for services within Outcome 2

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

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Agency performance

Financial

The total cost of providing health services to WA in 2014–15 was 8 billion. Results for 2014–15 against agreed financial targets (based on Budget statements) are presented in Table 2.

Full details of the WA Country Health Service's financial performance during 2014–15 are provided in the Financial statements.

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

Financial	2014–15 Target $'000	2014–15 Actual $'000	Variation $ +/–
Total cost of service	8,009,452	8,039,055	-29,603
Net cost of service	4,846,427	4,789,204	57,223
Total equity	9,308,623	9,421,256	-112,633
Net increase/decrease in cash held	(174,275)	91,796	-266,071
Approved full time equivalent staff level (salary associated with FTE)	4,622,167	4,594,477	27,690

Note: 2014–15 targets are specified in the 2014–15 Budget Statements.
Data sources: Budget Strategy Branch, Health Corporate Network.

Summary of key performance indicators

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

A summary of the WA Country Health Service key performance indicators and variation from the 2014–15 targets is given in Table 3.

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

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

Key performance indicators	2014–15 Target	2014–15 Actual	Variation
Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.			
Key effectiveness indicators:			
Percentage of public patients discharged to home after admitted hospital treatment	≥97.4%	97.5%	0.1%
Survival rates for sentinel conditions:			
Stroke, by age group:			
0–49 years	≥98.5%	98.1%	-0.4%
50–59 years	≥97.9%	92.2%	-5.7%
60–69 years	≥98.7%	94.9%	-3.8%
70–79 years	≥95.3%	92.2%	-3.1%
80+ years	≥80.1%	78.4%	-1.7%
Acute Myocardial Infarction (AMI), by age group:			
0–49 years	≥99.1%	100.0%	0.9%
50–59 years	≥99.2%	99.0%	-0.2%
60–69 years	≥99.2%	98.5%	-0.7%
70–79 years	≥98.7%	97.6%	-1.1%
80+ years	≥96.0%	90.7%	-5.3%
Fractured neck of femur (FNOF), by age group:			
70–79 years	≥98.7%	100.0%	1.3%
80+ years	≥97.8%	93.9%	-3.9%
Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition	≤3.0%	3.2%	0.2%
Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	≤4.8%	9.6%	4.8%

Key performance indicators	2014–15 Target	2014–15 Actual	Variation
Percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery, by birth weight:			
0–1499 grams	14.3%	37.5%	23.2%
1500–1999 grams	4.0%	0.0%	-4.0%
2000–2499 grams	0.7%	0.6%	-0.1%
2500+ grams	0.1%	0.3%	0.2%
Key efficiency indicators:			
Average cost per casemix adjusted separation for non-tertiary hospitals	$7,248	$6,830	-$418
Average cost per bed-day for admitted patients (selected small rural hospitals)	$1,736	$2,102	$366
Average cost per emergency department/ service attendance	$737	$838	$101
Average cost per non-admitted hospital based occasion of service for rural hospitals	$139	$247	$108
Average cost per non-admitted occasion of service provided in a rural nursing post	$361	$368	$7
Average cost per trip of Patient Assisted Travel Scheme	$564	$447	-$117
Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.			
Key effectiveness indicators:			
Rate of hospitalisations for gastroenteritis in children (0-4 years)	≤5.0	9.1	4.1
Rate of hospitalisation for selected respiratory conditions:			
Acute asthma, by age group:			
0–4 years	≤5.0	5.2	0.2
5–12 years	≤2.8	2.5	-0.3
13–18 years	≤0.9	0.7	-0.2
19–34 years	≤0.8	0.8	0.0
35+ years	≤0.7	1.0	0.3
Acute Bronchitis (0-4 years of age)	≤0.5	0.6	0.1
Bronchiolitis (0-4 years of age)	≤9.7	16.3	6.6
Croup (0-4 years of age)	≤2.6	4.6	2.0

Key performance indicators	2014–15 Target	2014–15 Actual	Variation
Rate of hospitalisation for falls in older persons	0.5% reduction per annum	24.1%	-0.4%
Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	70%	48.5%	-21.5%
Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	75%	62.5%	-12.5%
Key efficiency indicators:			
Average cost per capita of Population Health Units	$486	$353	-$133
Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents	$487	$397	-$90
Average cost per bed-day in specialised mental health inpatient units	$1,894	$2,194	$300
Average cost per three month period of care for community mental health	$2,593	$2,829	$236

Performance towards the National Partnership Agreement targets

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

National Elective Surgery Target (NEST)

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

The urgency categories and clinically desirable times are:

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

Part 1: Treating patients within the clinically recommended time

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

From 2010 to 2014, the number of patients treated within clinically recommended times has gradually increased by approximately 12.2 per cent for category 1, by approximately 15.8 per cent for category 2 and approximately 1.3 per cent for category 3 (see Table 4).

From 1 January to 31 December 2014, 98.1 per cent of urgency category 1 patients were admitted within 30 days, marginally lower than the set target of 100 per cent. For urgency category 2 patients, 91.7 per cent were admitted within the recommended 90 days, which is below the set target of 95.0 per cent, while 98.5 per cent of urgency category 3 patients were admitted within the recommended 365 days, which is equivalent to the set target.

WA Health is performing above baseline for all urgency categories and on target for urgency category 3.

Table 4: **Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2014**

		2010 (%) (baseline)	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Category 1	Performance	87.4	86.6	86.3	95.9	**98.1**
	Target	-	87.4	94.0	100.0	**100.0**
Category 2	Performance	79.2	83.5	82.0	89.4	**91.7**
	Target	-	79.2	84.0	88.0	**95.0**
Category 3	Performance	97.2	96.3	96.4	97.7	**98.5**
	Target	-	97.2	98.0	98.0	**98.5**

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

Part 2: Reducing the average waiting time for overdue patients

Performance against the elective surgery targets from 1 January to 31 December 2014 shows that WA did not meet the 2014 targets for each urgency category (see Table 5).

Table 5: **Average overdue wait time (in days) for WA patients who have waited beyond clinically recommend times, by category, 2010–2014**

		31 Dec 2010 (baseline)	31 Dec 2011	31 Dec 2012	31 Dec 2013	31 Dec 2014
Category 1	Performance	27.0	27.3	12.1	12.9	**36.3**
	Target	-	27.0	0	0	**0**
Category 2	Performance	90.0	77.4	54.2	55.0	**48.5**
	Target	-	90.0	68.0	45.0	**23.0**
Category 3	Performance	87.0	69.3	66.9	75.8	**62.9**
	Target	-	87.0	65.0	44.0	**22.0**

Notes: As part of the National agreement, this measure is assessed at the 31 December as a point in time measure.
Data sources: Wait List Data Collection, Inpatient Data Collections.

WA Health aims to ensure that patients who have waited beyond the clinically recommended time (long waits) will have received surgery, or have appropriate alternative treatment options identified. From September 2014 all categories of long wait overdue patients were found to have either had surgery or received appropriate alternative treatment. (see Table 6).

Table 6: **The number of overdue long wait patients as at 31 December 2013 remaining on elective surgery wait lists at 31 December 2014**

Period	Category 1	Category 2	Category 3
31 Dec 13	2	16	13
31 Mar 14	0	1	4
30 Jun 14	0	0	1
30 Sep 14	0	0	0
31 Dec 14	0	0	0

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

National Emergency Access Target (NEAT)

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

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

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

Results for WA Country Health Service compared to the State result and National targets are presented in Table 7. In 2014, 85.8 per cent of patients presenting to a WA Country Health Service emergency department were admitted, transferred or discharged within four hours. This is above the 2014 State average and National target of 79.7 per cent and 85.0 per cent respectively.

Table 7: **Percentage of emergency department presentations at WA Country Health Service hospitals with a length of stay of 4 hours or less, 2011–2014**

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

Note: Peel Health Campus data is not included due to data quality issues.

Data source: Emergency Department Data Collection.

Improvements towards emergency department access

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

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

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

The triage process and scores are recognised by the Australasian College for Emergency Medicine and is recommended for prioritising those who present to an emergency department. A patient is allocated a triage code between 1 (most severe) and 5 (least severe) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 8).

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

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

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

In 2014–15, the proportion of WA country patients in emergency departments who were seen within the recommended time was above the minimum benchmarks for all triage categories except triage 1 (see Table 9). For triage 1 patients, the result of 98.5 per cent is an increase from the 2013–14 performance.

Table 9: **Percentage of emergency department patients seen within recommended times, by triage category, 2010–11 to 2014–15**

Triage category	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013-14 (%)	2014-15 (%)	Target
1	93.4	95.8	98.6	98.2	**98.5**	**100%**
2	86.1	89.7	93.3	91.0	**87.0**	**≥80%**
3	84.0	86.8	87.1	83.6	**81.7**	**≥75%**
4	85.0	90.5	90.3	87.6	**85.2**	**≥70%**
5	94.0	97.7	97.2	96.9	**96.6**	**≥70%**

Data source: Emergency Department Data Collection.

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

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

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

In 2014–15, the percentage of emergency department attendances triaged 4 and 5 not admitted, increased from 2013-14 to 93.9 per cent and 98.3 per cent respectively (see Table 10).

Table 10: **Percentage of emergency attendances with a triage score of 4 and 5 not admitted, 2010–11 to 2014–15**

Triage category	2010–11 (%)	2011–12 (%)	2012–13 (%)	2013-14 (%)	2014-15 (%)
4	92.9	93.2	93.3	92.7	**93.9**
5	97.9	98.3	98.2	98.1	**98.3**

Data source: Emergency Department Data Collection.

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Significant issues

The WA Country Health Service (WACHS) is the largest country health service in Australia, covering 2.5 million square kilometres, which presents many challenges in providing high quality health services and meeting community needs and expectations across large and diverse geographical distances.

The overall health status of country people is evidenced to be worse than the metropolitan population, with a higher rate of illness and co-morbidity, particularly in areas where general practitioners and other primary health care is lacking. Population growth and ageing in many country communities is also shifting the demand and the range of services needed.

There are higher levels of health costs per capita in regional areas, which are impacted by workforce challenges, geographical spread, scale of operations, accommodation costs and significant transport costs.

WACHS' vision is for healthier, longer and better quality lives for all country Western Australians. The underpinning strategies are set out in *Towards Healthier Country Communities: WA Country Health Service Strategic Priorities 2013–2015*. These strategies build on past successes and layout how WACHS will continue to address key country health challenges to deliver high quality health services in regional WA.

Demand and activity

WA's regional population growth is estimated to grow by an average of 2 per cent each year. However, growth in different country areas has been variable over recent years, with above average population growth in the South West and in the North, placing additional pressure on services in these regions.

The ageing population in regional WA is also having a significant impact on demand for services. The total number of people aged 70 years and above has increased 21 per cent in the past five years, to more than 44,500. This age group is projected to grow 25 per cent in the next five years. It is well established that an ageing population changes both the mix and volume of medical procedures and services required.

The population in country areas is developing chronic disease in record numbers. In response, WACHS, in partnership with other health services, is providing a full spectrum of services across a continuum of care to ensure overall patient care and management in a range of different settings.

These business and health drivers require changes in models of care. There is now an increased integration between hospital and community care settings, and greater coordination of care across professions and other providers of care which require different management and funding models.

In addition, a significant $1.5 billion capital works program is being implemented across WACHS that underpins service delivery reforms to allow country residents to continue to have access to high quality hospital and health services.

In early, 2015 the new $120.4 million Busselton Health Campus was opened. It delivers a wider range of acute and community health services, including increased hospital bed capacity. A number of other major projects have also commenced that will help meet future demand, including a $59.6 million redevelopment of Kalgoorlie Health Campus, $31.3 million Esperance Health Campus redevelopment, $26.8 million redevelopment of Carnarvon Health Campus, $207.1 million new Karratha Health Campus, new $42 million Onslow Health Service; plus an ongoing program to replace a number of health clinics in remote Aboriginal communities.

A number of initiatives under the Southern Inland Health Initiative (SIHI) to improve health services for people in WA's southern inland areas have continued. Approximately $120 million has been spent on the initiative to the end of this financial year, with a further $445 million allocated from 2015–16 to 2019–20 to provide improved access to health care services throughout the Great Southern, Midwest, Goldfields, South West and Wheatbelt regions, which also includes considerable investment in infrastructure upgrades.

One of the cornerstones of SIHI is an emphasis on building capacity in country emergency departments and in primary health services (Stream 1). This program is aimed at attracting general practitioners, allied health workers and other health professionals to country areas to support people to be healthy and stay out of hospital or to support them return to home or, in the case of older citizens, remain at home as long as possible.

The Office of the Auditor General released its audit findings on SIHI Stream 1 in 2015, which reported that emergency department services have been stabilised through more consistent 24/7 medical cover; 95 general practitioners have signed up to the program; emergency specialist, general practitioner proceduralists and emergency nurse practitioners have been engaged; general practitioners are being retained in towns longer; and delivery of GP services at general community and Aboriginal health clinics has increased. The report also notes that the Emergency Telehealth Service (ETS), which provides videoconferencing capability by specialist emergency physicians from Perth to support remote emergency staff treat patients, has expanded to 49 sites. This Premier's-Award-winning service is planned to cover 70 sites by the end of 2015.

There is still work to be done and further detailed evaluation of the SIHI programs required; however, the evidence thus far indicates that good outcomes are being achieved on improving access to medical and health services.

Planning is well under way on the North West Health Initiative (NWHI), which was an election commitment announced by the Minister for Health, involving an investment by Government of $161 million over five years. The NWHI will comprise a combination of investment strategies including new purpose-built hospitals; redevelopment and renewal projects; strategic partnerships; workforce incentive schemes; enhanced aged care services; investment in telehealth and eHealth; and development of public health, environmental health and early years services, which are essential to effectively address the challenges of servicing a diverse, rural population over time in the North West.

Workforce challenges

Maintaining and developing a skilled stable workforce is a key priority for WACHS; however, there are many ongoing medical and health workforce challenges to be overcome related to recruitment in regional areas. The Western Australian public health sector is facing increasing pressure to meet the growing demand for healthcare services. It has the second-lowest medical specialist-to-population ratio in Australia and is functioning within a tight fiscal environment. There are a number of health professions that are not represented or are under-represented in rural and remote areas of WA.

Several strategies have been developed to address the workforce shortages in rural areas including:

- Improve early career exposure to rural and remote areas.
- Support increased generalist training pathways.
- Investigate and identify recruitment and retention challenges in the rural and remote areas.
- Workforce incentive programs.

In accordance with these strategies, innovative ideas are being implemented to build a sustainable country health workforce, such as placement of graduate nurses in community mental health settings, which in turn impacts positively on recruitment to address mental health nursing shortages. Significant effort has also been made to reduce reliance on the locum medical and agency nursing workforce in regional areas, resulting in increased workforce stability in a number of regional sites.

In 2015, WACHS provided rural employment for a total of 72 junior doctors on a mix of part-time/fulltime and six- and 12-month contracts. There were also 30 junior doctor placements (11-22 week) in WACHS sites under various Commonwealth programs. These placements expose our future doctors to working in a challenging and rewarding health environment, as well as providing them with a real life experience of living and working in country WA. Exposing junior doctors to rural areas leads to a greater number of practitioners who choose a rural medicine career path, and are attracted to return to work in a country setting in the future.

The Aboriginal Employment Strategy 2014–2018 and the WACHS Aboriginal Mentorship Program, Your Footsteps Our Future, are helping to attract, build and retain a skilled Aboriginal workforce, which is vital for delivering culturally appropriate health services and ensuring improvements in Aboriginal health. As an example, Aboriginal Mental Health Coordinators have been appointed in each region to support the delivery of mental health services to Aboriginal people. There has been a 132 per cent increase in the people seen since this program commenced. Investment has also been made in the employment and training of Aboriginal health workers to identify ear disease in children in remote Aboriginal communities.

Accreditation and standards

Ensuring services are delivered to the highest level of safety and quality is a core priority that requires the involvement and commitment of all health service staff. All WACHS regions are accredited by the Australian Council on Health Standards.The Goldfields health region was the first health service in the State to be fully accredited against the 10 new National Safety and Quality Health Service Standards (NSQHS) and National Standards for Mental Health Services.

The organisation has also commenced work towards EQuIPNational Corporate accreditation, evidencing a continued commitment to quality improvement across all areas of the business. This includes the creation of an EQuIPNational Corporate Program Manager position to support and facilitate the implementation of an engagement and education strategy, leading to a pilot survey and final accreditation within the organisation.

Managing funding reform and costs efficiently

Implementing reforms and cost efficiencies across country WA is challenging and is affected by the higher costs in distant and remote areas. The higher cost associated with staff accommodation, goods and services, and transport are significantly impacted by other market sectors such as the mining sector, and the small scale of operation in some sites. Workforce and recruitment costs add to the overall cost of service delivery.

WACHS accepts the challenge of being able to deliver services more efficiently and, where possible, identify areas to reduce future budget pressures.

WACHS has developed strategies to improve the revenue and cost profile of its services including:

- business process strategies to increase efficiency through improved business management
- revenue enhancement strategies
- cost savings and procurement/contract strategies to reduce expenditure.

WACHS is also undertaking considerable work to fully understand the costs of delivering services in a rural and remote environment, and the key cost drivers to support negotiations and discussions with our funding authorities around future budget requirements.

The Royalties for Regions (RfR) program has been a major vehicle for injecting capital and recurrent funding into the improvement of infrastructure and services in country areas. WACHS maintains positive relationships with the Department of Regional Development regarding the use of approved funds. This year approximately $154.4 million was committed under RfR for programs including Patient Assisted Travel Scheme, Royal Flying Doctor Service, ambulance services, SIHI and infrastructure projects.

Health inequalities

Remoteness and the distance to access health services in country WA leads to people delaying seeking assistance until their condition is more acute. The lack of transport options in country communities makes accessing health services difficult. Without ready access to services, children do not reach their full potential and experience issues such as delayed development, poor school performance and increased unemployment.

These issues are compounded where there are limited primary care services or general practitioners available.

A key strategy is the introduction of new service delivery models to take services to where children are located, e.g. child care centres and kindergartens. This has led to approximately 27 new child health nurses employed in country WA through child health investment (16 directly employed by WACHS and 11 full-time equivalent, or FTE, employed through the community services sector).

The review of Aboriginal health service programs and contracts by Professor D'Arcy Holman in 2014–15 provides a sound foundation for future funding and contracting for Aboriginal health. This report identified that 88 per cent of the programs reviewed were rated as good or better.

There has also been a continuation of the ear, eye and oral health program for Aboriginal children living in rural and remote communities through the employment and training of Aboriginal Health Workers; and continuation of school health, child health and child development initiatives.

The $52.8 million Bringing Renal Dialysis Services Closer to Home project commenced in March 2014 and will provide an additional 17 dialysis chairs (Kalgoorlie, Fitzroy Crossing, Esperance, and Roebourne) to the existing 77 chairs; and a total of 92 renal hostel beds (Broome, Derby, Kununurra, Fitzroy Crossing, Kalgoorlie and Carnarvon).

For the first time, a special exemption was given by the WA Chief Pharmacist allowing health workers, other than dental practitioners, to use fluoride varnish. This represents a significant step in the treatment and prevention of tooth decay among Aboriginal children in remote communities.

Work is being undertaken to develop clinical pathways for care to ensure that rural patients diagnosed with a clinical condition have access to the same levels of care and service as those with the same conditions who live in metropolitan areas. Clinical pathways have been developed for stroke and some cancers, and work is progressing on the development of other clinical pathways.

Disclosure and compliance

Auditor General

INDEPENDENT AUDITOR'S REPORT

To the Parliament of Western Australia

WA COUNTRY HEALTH SERVICE

Report on the Financial Statements
I have audited the accounts and financial statements of the WA Country Health Service.

The financial statements comprise the Statement of Financial Position as at 30 June 2015, the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows for the year then ended, and Notes comprising a summary of significant accounting policies and other explanatory information.

Director General's Responsibility for the Financial Statements
The Director General is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards and the Treasurer's Instructions, and for such internal control as the Director General determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

Opinion
In my opinion, the financial statements are based on proper accounts and present fairly, in all material respects, the financial position of the WA Country Health Service at 30 June 2015 and its financial performance and cash flows for the year then ended. They are in accordance with Australian Accounting Standards and the Treasurer's Instructions.

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

Report on Controls
I have audited the controls exercised by the WA Country Health Service during the year ended 30 June 2015.

Controls exercised by the WA Country Health Service are those policies and procedures established by the Director General to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions.

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

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

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

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

Opinion
In my opinion, the controls exercised by the WA Country Health Service are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2015.

Report on the Key Performance Indicators
I have audited the key performance indicators of the WA Country Health Service for the year ended 30 June 2015.

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

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

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

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

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

Opinion
In my opinion, the key performance indicators of the WA Country Health Service are relevant and appropriate to assist users to assess the Health Service's performance and fairly represent indicated performance for the year ended 30 June 2015.

Matters of Significance
Elective Surgery Waiting Times
The WA Country Health Service received approval from the Under Treasurer to remove the 'Elective Surgery Waiting Times' Key Performance Indicator (KPI) from the audited KPIs for the year ended 30 June 2012. The approval was conditional on the inclusion of unaudited performance indicators measuring elective surgery waiting times in the agency's 2011-12 Annual Report and that elective surgery waiting times be reinstated as an audited KPI following the successful definition of national elective surgery waiting time indicators. The definition of national elective surgery waiting times has been developed. Implementation is proposed from 1 July 2016 in line with the national implementation date. Consequently, the 'Elective Surgery Waiting Times' KPI has not been included in the audited KPIs for the year ended 30 June 2015. My opinion is not modified in respect of this matter.

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

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

The approval was conditional on their inclusion as unaudited performance indicators in the agency's 2013-14 Annual Report and that they be reinstated as audited KPIs following the implementation of a new Emergency Department data collection system. A new system had not been developed at 30 June 2015. Consequently, the two KPIs have not been included in the audited KPIs for the year ended 30 June 2015. My opinion is not modified in respect of these matters.

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

Matters Relating to the Electronic Publication of the Audited Financial Statements and Key Performance Indicators

This auditor's report relates to the financial statements and key performance indicators of the WA Country Health Service for the year ended 30 June 2015 included on the Health Service's website. The Health Service's management is responsible for the integrity of the Health Service's website. This audit does not provide assurance on the integrity of the Health Service's website. The auditor's report refers only to the financial statements and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements or key performance indicators. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial statements and key performance indicators to confirm the information contained in this website version of the financial statements and key performance indicators.

COLIN MURPHY
AUDITOR GENERAL
FOR WESTERN AUSTRALIA
Perth, Western Australia
18 September 2015

Certification of financial statements

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2015

The accompanying financial statements of the WA Country Health Service have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to represent fairly the financial transactions for the financial year ending 30 June 2015 and financial position as at 30 June 2015.

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

Graeme Jones
CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

Date: 16 September 2015

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

Date: 16 September 2015

Financial statements

WA Country Health Service

Statement of Comprehensive Income

For the year ended 30 June 2015

	Note	2015 $000	2014 $000
COST OF SERVICES			
Expenses			
Employee benefits expense	7	901,814	840,187
Fees for visiting medical practitioners		78,727	81,179
Patient support costs	8	319,061	300,206
Finance costs	9	369	438
Depreciation and amortisation expense	10	63,757	66,187
Loss on disposal of non-current assets	11	4,956	528
Repairs, maintenance and consumable equipment	12	35,666	32,982
Other expenses	13	153,893	138,820
Total cost of services		**1,558,243**	**1,460,527**
INCOME			
Revenue			
Patient charges	14	51,783	50,304
Commonwealth grants and contributions	15(i)	368,328	340,306
Other grants and contributions	15(ii)	83,026	78,039
Donation revenue	16	829	885
Other revenue	17	23,966	22,405
Total revenue		527,932	491,939
Total income other than income from State Government		**527,932**	**491,939**
NET COST OF SERVICES		**1,030,311**	**968,588**
INCOME FROM STATE GOVERNMENT			
Service appropriations	18	966,870	902,737
Assets transferred	19	-	188
Services received free of charge	20	74	75
Royalties for Regions Fund	21	83,456	74,690
Total income from State Government		**1,050,400**	**977,690**
SURPLUS FOR THE PERIOD		**20,089**	**9,102**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	37	(7,341)	83,110
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**12,748**	**92,212**

Refer also to note 54 'Schedule of Income and Expenses by Service'.

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

WA Country Health Service

Statement of Financial Position

As at 30 June 2015

	Note	2015 $000	2014 $000
ASSETS			
Current Assets			
Cash and cash equivalents		17,594	8,428
Restricted cash and cash equivalents	22	35,819	23,678
Receivables	23	24,994	21,468
Inventories	25	5,554	5,271
Other current assets	26	4,521	5,130
Non-current assets classified as held for sale	27	65	-
Total Current Assets		88,547	63,975
Non-Current Assets			
Amounts receivable for services	24	509,870	429,154
Property, plant and equipment	28	1,787,004	1,755,148
Intangible assets	30	235	180
Total Non-Current Assets		2,297,109	2,184,482
Total Assets		**2,385,656**	**2,248,457**
LIABILITIES			
Current Liabilities			
Payables	32	116,300	98,124
Borrowings	33	1,518	1,303
Provisions	34	123,965	115,953
Other current liabilities	35	104	392
Total Current Liabilities		241,887	215,772
Non-Current Liabilities			
Borrowings	33	6,865	8,529
Provisions	34	25,377	23,577
Total Non-Current Liabilities		32,242	32,106
Total Liabilities		**274,129**	**247,878**
NET ASSETS		**2,111,527**	**2,000,579**
EQUITY			
Contributed equity	36	1,581,246	1,483,046
Reserves	37	498,179	505,520
Accumulated surplus	38	32,102	12,013
TOTAL EQUITY		**2,111,527**	**2,000,579**

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

WA Country Health Service

Statement of Changes in Equity

For the year ended 30 June 2015

	Note	2015 $000	2014 $000
CONTRIBUTED EQUITY	36		
Balance at start of period		1,483,046	1,386,545
Transactions with owners in their capacity as owners:			
Capital appropriations		52,489	51,664
Royalties for Regions Fund		36,720	45,137
Other contributions by owners		8,991	-
Distributions to owners		-	(300)
Balance at end of period		1,581,246	1,483,046
RESERVES	37		
Asset Revaluation Reserve			
Balance at start of period		505,520	422,410
Comprehensive income for the period		(7,341)	83,110
Balance at end of period		498,179	505,520
ACCUMULATED SURPLUS	38		
Balance at start of period		12,013	2,911
Surplus for the period		20,089	9,102
Balance at end of period		32,102	12,013
TOTAL EQUITY			
Balance at start of period		2,000,579	1,811,866
Total comprehensive income for the period		12,748	92,212
Transactions with owners in their capacity as owners		98,200	96,501
Balance at end of period		**2,111,527**	**2,000,579**

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

WA Country Health Service

Statement of Cash Flows

For the year ended 30 June 2015

	Note	2015 $000 Inflows (Outflows)	2014 $000 Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		885,774	836,210
Capital appropriations		51,041	50,280
Holding account drawdown		-	4,141
Royalties for Regions Fund		120,174	119,826
Net cash provided by State Government	39	**1,056,989**	**1,010,457**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(887,555)	(831,816)
Supplies and services		(566,555)	(544,517)
Receipts			
Receipts from customers		50,036	49,962
Commonwealth grants and contributions		368,328	340,306
Other grants and contributions		82,694	78,370
Donations received		829	868
Other receipts		22,787	20,723
Net cash used in operating activities	39	**(929,436)**	**(886,104)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current physical assets		(106,248)	(124,490)
Receipts			
Proceeds from sale of non-current physical assets	11	2	61
Net cash used in investing activities		**(106,246)**	**(124,429)**
Net increase / (decrease) in cash and cash equivalents		21,307	(76)
Cash and cash equivalents at the beginning of the period		32,106	32,182
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	39	**53,413**	**32,106**

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

Notes to the Financial Statements
For the year ended 30th June 2015

Note 1 Australian Accounting Standards

General

The Health Service's financial statements for the year ended 30 June 2015 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' includes Standards and Interpretations issued by the Australian Accounting Standards Board (AASB).

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

Early adoption of standards

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

Note 2 Summary of significant accounting policies

(a) General Statement

The Health Service is a not-for-profit reporting entity that prepares general purpose financial statements in accordance with Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board as applied by the Treasurer's instructions. Several of these are modified by the Treasurer's instructions to vary application, disclosure, format and wording.

The *Financial Management Act 2006* and the Treasurer's instructions impose legislative provisions that govern the preparation of financial statements and take precedence over the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of Preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for land and buildings which have been measured at fair value .

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

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

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

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

(c) Contributed Equity

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

The transfer of net assets to/from other agencies, other than as a result of a restructure of administrative arrangements, are designated as contributions by owners where the transfers are non-discretionary and non-reciprocal.

See also note 36 'Contributed equity'.

(d) Income

Revenue recognition

Revenue is recognised and measured at the fair value of consideration received or receivable. The following specific recognition criteria must also be met before revenue is recognised as follows:

Sale of goods
Revenue is recognised from the sale of goods and disposal of other assets when the significant risks and rewards of ownership are transferred to the purchaser and can be measured reliably.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

Note 2 Summary of significant accounting policies (continued)

(d) Income (continued)

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

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

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

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

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

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

(e) Borrowing Costs

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

(f) Property, Plant and Equipment

Capitalisation/Expensing of assets
Items of property, plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
Property, plant and equipment are initially recognised at cost:

For items of property, plant and equipment acquired at no cost or for nominal cost, the cost is the fair value at the date of acquisition.

Subsequent measurement
Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of land and buildings and historical cost for all other property, plant and equipment. Land and buildings are carried at fair value less accumulated depreciation (buildings) and accumulated impairment losses. All other items of property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

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

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

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

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

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

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

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

Note 2 Summary of significant accounting policies (continued)

(f) Property, Plant and Equipment (continued)

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

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

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

The depreciation method for plant and equipment was changed to straight line on 1 July 2014. Up to 30 June 2014, plant and equipment were depreciated using the diminishing value with a straight line switch method under which the cost amounts of the assets are allocated on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

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

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

Artworks controlled by the Health Service are classified as property, plant and equipment. These are anticipated to have indefinite useful lives. Their service potential has not, in any material sense, been consumed during the reporting period and consequently no depreciation has been recognised.

(g) Intangible Assets

Capitalisation/Expensing of assets
Acquisitions of intangible assets costing $5,000 or more and internally generated intangible assets costing $5,000 or more are capitalised. The cost of utilising the assets is expensed (amortised) over their useful life. Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

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

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

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

Estimated useful lives for each class of intangible asset are:

Computer software	5 - 10 years

Computer software

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

(h) Impairment of Assets

Property, plant and equipment and intangible assets are tested for any indication of impairment at the end of each reporting period. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount. Where an asset measured at cost is written down to recoverable amount, an impairment loss is recognised as expense in the Statement of Comprehensive Income. Where a previously revalued asset is written down to recoverable amount, the loss is recognised as a revaluation decrement in other comprehensive income. As the Health Service is a not-for-profit entity, unless a specialised asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

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

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

Note 2 Summary of significant accounting policies (continued)

(h) Impairment of Assets (continued)

Intangible assets not yet available for use are tested for impairment at the end of each reporting period irrespective of whether there is any indication of impairment.

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

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

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

(i) Non-Current Assets (or Disposal Groups) Classified as Held for Sale

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

(j) Leases

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

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

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

(k) Financial Instruments

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

Financial instruments have been disaggregated into the following classes:

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

Financial liabilities:
* Payables
* Borrowings

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(l) Cash and Cash Equivalents

For the purpose of the Statement of Cash Flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(m) Accrued Salaries

Accrued salaries (see note 32 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Health Service considers the carrying amount of accrued salaries to be equivalent to its fair value.

(n) Amounts Receivable for Services (holding account)

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

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

Note 2 Summary of significant accounting policies (continued)

(o) Inventories

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

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

(p) Receivables

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

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

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

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

(q) Payables

Payables are recognised when the Health Service becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value, as they are generally settled within 30 days.

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

(r) Borrowings

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

See also note 2(k) 'Financial instruments' and note 33 'Borrowings'.

(s) Provisions

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

See also note 34 'Provisions'.

Provisions - employee benefits

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

Annual Leave and Time Off in Lieu Leave

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

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

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

Long service leave

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

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

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

Unconditional long service leave provisions are classified as current liabilities as the Health Service does not have an unconditional right to defer settlement of the liability for at least 12 months after the end of the reporting period. Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the Health Service has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

Sick Leave

Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Statement of Comprehensive Income for this leave as it is taken.

Deferred Salary Scheme

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

Superannuation

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

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

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

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

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

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

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

Gratuities

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

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

Note 2 Summary of significant accounting policies (continued)

(s) Provisions (continued)

Employment on-costs

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

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

(t) Superannuation Expense

Superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the WSS, the GESBS or other superannuation funds. The employer contribution paid to the GESB in respect of the GSS is paid back into the Consolidated Account by the GESB.

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

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

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

(v) Assets Transferred between Government Agencies

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

(w) Comparative Figures

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

(x) Trust Accounts

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

Details of Trust Accounts are reported as a note to the financial statements (refer to note 51).

Note 3 Judgements made by management in applying accounting policies

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

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

Buildings

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

Note 4 Key sources of estimation uncertainty

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

Buildings

In order to estimate fair value on the basis of existing use, the depreciated replacement costs are determined on the assumption that the buildings will be used for the same functions in the future. A major change in utilisation of the buildings may result in material adjustment to the carrying amounts.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

Note 4 Key sources of estimation uncertainty (continued)

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Health Service each year on account of resignation or retirement at 11.1%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year period. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

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

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Health Service has applied the following Australian Accounting Standards effective for annual reporting periods beginning on or after 1 July 2014 that impacted on the Health Service.

Title	
AASB 1031	*Materiality* This Standard supersedes AASB 1031 (February 2010), removing Australian guidance on materiality not available in IFRSs and refers to guidance on materiality in other Australian pronouncements. There is no financial impact.
AASB 1055	*Budgetary Reporting* This Standard requires specific budgetary disclosures in the financial statements of a not-for-profit entity within the general government sector, where the entity's budgeted statement of financial position, statement of comprehensive income, statement of changes in equity or statement of cash flows is presented to parliament and is separately identified as relating to that entity. There is no financial impact to the Health Service, as its budget has not been presented to parliament separately but has been consolidated into a single Division of the Consolidated Account Expenditure Estimates with the Department of Health and statutory authorities within WA Health. However, Treasurer's Instruction 954 '*Explanatory Statement*' requires each general government sector agency consolidated into a single Division of the Consolidated Account Expenditure Estimates to disclose the additional budgetary information and explanations of major variances between actual and budgeted amounts. The Health Service has received an exemption from TI 954 for the 2014-15 financial year. The Explanatory Statement disclosed in note 52 is in accordance with the estimates as approved by the Minister under section 40 of the Financial Management Act.
AASB 2013-3	*Amendments to AASB 136 – Recoverable Amount Disclosures for Non-Financial Assets* This Standard introduces editorial and disclosure changes. There is no financial impact.
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments.* Part B of this omnibus Standard makes amendments to other Standards arising from the deletion of references to AASB 1031 in other Standards for periods beginning on or after 1 January 2014. It has no financial impact.
AASB 2014-1	*Amendments to Australian Accounting Standards* Part A of this Standard consists primarily of clarifications to Accounting Standards and has no financial impact for the Health Service. Part B of this Standard has no financial impact as the Health Service contributes to schemes that are either defined contribution plans, or deemed to be defined contribution plans. Part C of this Standard has no financial impact as it removes references to AASB 1031 *Materiality* from a number of Accounting Standards.
AASB 2015-7	*Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities* This Standard relieves not-for-profit public sector entities from the reporting burden associated with various disclosures required by AASB 13 for assets within the scope of AASB 116 that are held primarily for their current service potential rather than to generate future net cash inflows. It has no financial impact.

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

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 9	*Financial Instruments* This Standard supersedes AASB 139 *Financial Instruments: Recognition and Measurement*, introducing a number of changes to accounting treatments. The mandatory application date of this Standard is currently 1 January 2018 after being amended by AASB 2012-6, AASB 2013-9 and AASB 2014-1 *Amendments to Australian Accounting Standards*. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 15	*Revenue from Contracts with Customers* This Standard establishes the principles that the Health Service shall apply to report useful information to users of financial statements about the nature, amount, timing and uncertainity of revenue and cash flows arising from a contract with a customer. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2017
AASB 2010-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Int 2, 5, 10, 12, 19 & 127]* This Standard makes consequential amendments to other Australian Accounting Standards and Interpretations as a result of issuing AASB 9 in December 2010. The mandatory application date of this Standard has been amended by AASB 2012-6 and AASB 2014-1 to 1 January 2018. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018
AASB 2013-9	*Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments* Part C of this omnibus Standard defers the application of AASB 9 to 1 January 2017. The application date of AASB 9 was subsequently deferred to 1 January 2018 by AASB 2014-1. The Health Service has not yet determined the application or the potential impact of AASB 9.	1 Jan 2015
AASB 2014-1	*Amendments to Australian Accounting Standards* Part E of this Standard makes amendments to AASB 9 and consequential amendments to other Standards. It has not yet been assessed by the Health Service to determine the application or potential impact of the Standard	1 Jan 2015
AASB 2014-4	*Amendments to Australian Accounting Standards – Clarification of Acceptable Methods of Depreciation and Amortisation [AASB 116 & 138]* The adoption of this Standard has no financial impact for the Health Service as depreciation and amortisation is not determined by reference to revenue generation, but by reference to consumption of future economic benefits.	1 Jan 2016
AASB 2014-5	*Amendments to Australian Accounting Standards arising from AASB 15* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 15. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2017
AASB 2014-7	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* This Standard gives effect to the consequential amendments to Australian Accounting Standards (including Interpretations) arising from the issuance of AASB 9 (December 2014). The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2018

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

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

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

Title		Operative for reporting periods beginning on/after
AASB 2014-8	*Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) - Application of AASB 9 (December 2009) and AASB 9 (December 2010) [AASB 9 (2009 & 2010)]* This Standard makes amendments to AASB 9 *Financial Instruments* (December 2009) and AASB 9 *Financial Instruments* (December 2010), arising from the issuance of AASB 9 *Financial Instruments* in December 2014. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2015
AASB 2014-9	*Amendments to Australian Accounting Standards - Equity Method in Separate Financial Statemetns [AASB 1, 127 & 128]* This Standard amends AASB 127, and consequentially amends AASB 1 and AASB 128, to allow entities to use the equity method of accounting for investment in subsidiaries, joint ventures and associates in their separate financial statements. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2016
AASB 2014-10	*Amendments to Australian Accounting Standards - Sale or Contribution of Assets between an Investor and its Associate or Joint Venture [AASB 10 & 128]* This Standard amends AASB 10 and AASB 128 to address an inconsistency between the requirements in AASB 10 and those in AASB 128 (August 2011), in dealing with the sale or contribution of assets between an investor and its associate or joint venture. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2016
AASB 2015-1	*Amendments to Australian Accounting Standards - Annual Improvements to Australian Accounting Standards 2012-2014 Cycle (AASB 1, 2, 3, 5, 7, 11, 110, 119, 121, 133, 134, 137 & 140)* These amendments arise from the issuance of International Financial Reporting Standard Annual Improvements to IFRSs 2012-2014 Cycle in September 2014, and editorial corrections. The Health Service has not yet determined the application or the potential impact of the Standard.	1 Jan 2016
AASB 2015-2	*Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 (AASB 7, 101, 134 & 1049)* This Standard amends AASB 101 to provide clarification regarding the disclosure requirements in AASB 101. Specifically, the Standard proposes narrow-focus amendments to address some of the concerns expressed about existing presentation and disclosure requirements and to ensure entities are able to use judgement when applying a Standard in determining what information to disclose in their financial statements. There is no financial impact.	1 Jan 2016
AASB 2015-3	*Amendments to Australian Accounting Standards arising from the Withdrawal of AASB 1031 Materiality* This Standard completes the withdrawal of references to AASB 1031 in all Australian Accounting Standards and Interpretations, allowing that Standard to effectively be withdrawn. There is no financial impact.	1 Jul 2015
AASB 2015-6	*Amendments to Australian Accounting Standards - Extending Related Party Disclosures to Not-for-Profit Public Sector Entities (AASB 10, 124 & 1049)* The amendments extend the scope of AASB 124 to include application by not-for-profit public sector entities. Implementation guidance is included to assist application of the Standard by not-for-profit public sector entities. There is no financial impact.	1 Jul 2016

Note 6 Services of the Health Service

Information about the Health Service's services and, the expenses and revenues which are reliably attributable to those services are set out in Note 54. The key services of the Health Service are:

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

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

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

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

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

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

Continuing Care
Aged and continuing care services include the HACC Program, Transition Care programs, residential care in rural areas, chronic illness support and non-government continuing care programs. The Healthcare activities provided under this service includes domestic assistance, respite, food and meal services, services for frail or younger persons with a disability unable to access Commonwealth aged care, nursing home care and chronic disease support services.

Mental Health
Contracted mental health services includes specialist inpatient mental health care delivered in designated ward and community-based mental health services, provided by Health Services under an agreement with the Mental Health Commission.

Note 7 Employee benefits expense

	2015 $000	2014 $000
Salaries and wages (a)	833,434	775,983
Superannuation - defined contribution plans (b)	68,380	64,204
	901,814	840,187

(a) Includes the value of the fringe benefits to employees plus the fringe benefits tax component, the value of superannuation contribution component of leave entitlements and redundancy payments of $1.736 million ($0.840 million in 2013/14).

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

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

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 8 Patient support costs		
Medical supplies and services	84,840	73,628
Domestic charges	9,196	8,546
Fuel, light and power	28,608	25,923
Food supplies	10,247	9,826
Patient transport costs	80,193	81,976
Aboriginal health services	44,136	33,533
Pathology services	15,191	14,378
Purchase of health care services	12,647	10,249
Purchase of outsourced medical services	23,259	26,124
Purchase of other outsourced services	3,504	3,472
Grants payments	7,240	12,551
	319,061	300,206
Note 9 Finance costs		
Interest expense	369	438
Note 10 Depreciation and amortisation expense		
Depreciation		
Buildings	51,232	52,689
Leasehold improvements	809	230
Computer equipment	321	352
Furniture and fittings	195	225
Motor vehicles	896	955
Medical equipment	9,015	10,276
Other plant and equipment	1,249	1,421
	63,717	66,148
Amortisation		
Computer software	40	39
	63,757	66,187
Note 11 Loss on disposal of non-current assets		
Carrying amount of non-current assets disposed:		
Property, plant and equipment	4,958	589
Proceeds from disposal of non-current assets:		
Property, plant and equipment	(2)	(61)
Net loss	4,956	528
Note 12 Repairs, maintenance and consumable equipment		
Repairs and maintenance	22,134	22,730
Consumable equipment	13,532	10,252
	35,666	32,982

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 13 Other expenses		
Communications	4,544	4,185
Computer services	2,165	2,812
Workers compensation insurance (a)	14,454	12,886
Other employee related expenses	23,804	20,857
Insurance	4,606	4,194
Legal expenses (b)	11,852	159
Motor vehicle expenses	5,329	5,405
Operating lease expenses	43,781	47,459
Printing and stationery	4,052	3,919
Doubtful debts expense	1,521	1,805
Purchase of outsourced services	19,033	15,801
Write-down of assets	4,542	4,789
Donations to non government organisations (c)	-	3,949
Other	14,210	10,600
	153,893	138,820

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

(b) $11.656 million was paid in 2014/15 as settlement on a litigation claim, for which $10.000 million was included in contingent liabilities for 2013/14 (see note 46).

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

Note 14 Patient charges		
Inpatient bed charges	25,020	25,040
Inpatient other charges	258	269
Outpatient charges	26,505	24,995
	51,783	50,304
Note 15 Grants and contributions		
(i) Commonwealth grants and contributions		
Recurrent		
Nursing homes	5,477	3,009
Aged Care Training Program	35	-
Bringing Them Home	105	111
Carelink	-	219
Community Aged Care Program	956	875
Customs	179	159
Dept of Veteran Affairs - Home & Domiciliary Care	156	-
Extended Aged Care in the Home	618	622
FaHCSIA Respite for Young Carer, RSCYP and Mental Health	209	209
Healthy for Life	1,250	1,197
Indigenous Traineeship	-	95
Job Creation Packages	751	738
Mobile Respite Program	572	698
National Respite Carers Program	1,548	1,284
National Health Reform Agreement via the Department of Health (a)	308,242	281,275
National Health Reform Agreement via the Mental Health Commission (a)	23,168	17,873
New Directions Mothers & Babies	1,147	1,098
New Directions OATSIH OVAHS	1,034	100
Office of Aboriginal and Torres Strait Islander Health	1,902	3,452
Primary Health Care Access Program - Kimberley	1,701	1,627
Substance Abuse	473	544
Other	189	521

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2015

	2015 $000	2014 $000
Note 15 Grants and contributions (continued)		
(i) Commonwealth grants and contributions (continued)		
Capital		
Busselton Health Campus	500	1,000
COAG ED 4-HR Rule Solutions(FHRS) Stage 3	-	441
HHF – Redevelopment of Bunbury, Narrogin, and Collie Hospitals (Regional Priority Round)	20	-
Kalgoorlie Regional Resource Centre	300	-
Kalgoorlie Day Therapy Unit	-	3,525
Kalumburu Remote Aged Care Redevelopment	-	1,544
Kimberley Renal - Kununurra capital grant	-	1,100
Kimberley Renal - Derby capital grant	-	1,100
Kimberley Renal - Support Services (b)	(1,290)	-
Narrogin General Health Clinic	-	2,300
NPA Broome ED Redevelopment	4,225	-
NPA Kununurra CT Scanner	-	1,555
NPA Bunbury Day Therapy Unit	121	-
NPA Bunbury Sub Acute Inpatient Beds	-	2,642
NPA Bunbury Rehab Beds	3,997	-
NPA Bunbury RP Day Therapy Unit	-	656
NPA Bunbury Wireless LAN	-	103
Renal Dialysis and Support Services	10,000	2,000
Redevelopment of Bunbury, Narrogin and Collie Hospitals	-	3,500
Simulated Learning Environment Program (b)	(11)	-
Strengthening Regional Cancer Services	750	3,100
Other	4	34
	368,328	340,306

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

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

(ii) Other grants and contributions

Australian College of Emergency Medicine - EMET Funding	599	844
Australian College of Emergency Medicine - STP	600	430
Centre Care - 1 Life Suicide	-	104
Closing the Gap	119	-
Disability Services Commission - Community Aids & Equipment Program	2,757	2,150
WA Alcohol and Drug Authority - Community Drug Service Team & other programs	4,681	4,114
Ear Health Funding	48	-
Global Diagnostics Bunbury StP - Radiology Registrar	110	-
Home Care Nursing OVAHS	159	-
Kimberley Paediatric Outreach Program	-	109
McGrath Foundation - Breast Care Nurse Funding	393	286
Medical Specialists Outreach Assistance Program	1,666	1,871
Medicare Local - For Ante Natal Program	161	190
Medicare Local - Rural Primary Health Services	2,395	3,711
Mental Health Commission - Independent Community Living Strategy	400	400
Mental Health Commission - Perinatal Program	124	-
Mental Health Commission - service delivery agreement	57,669	50,299
Mental Health Commission - SSAMHS	4,710	4,436
National Partnership Payments - improving public hospital Services	-	1,646
Mental Health Commission- Recovery Centre	-	250
New Directions OVAHS	221	-
Nindilingarri Cultural Health	136	136
Paediatric Outreach Services for Indigenous & Chronic Disease	387	313
Personally Controlled Electronic Health Records	-	908
Practise Incentive Payments	118	-
Prevocational General Practice Placements	901	934
Royal Australian & New Zealand College of Anesthetists	360	210
Royal Australian & New Zealand College of General Medicine & Geriatrics	243	-

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 15 Grants and contributions (continued)		
(ii) Other grants and contributions (continued)		
Royal Australian & New Zealand College of Obestricicians & Gynaecologists	366	409
Royal Australian & New Zealand College of Ophthalmologists	110	-
Royal Australian & New Zealand College of Psychiatrists - Specialist Training Program	120	-
Royal Australian College of Physicians Specialist Training Program	708	620
Royal Australian College of Physicians - STP Progress Report & Rural Support Loading	180	450
Royal Australian College of Surgeons	360	406
Rural Health West Hedland Health Campus outpatients visiting specialists	291	-
St John of God Private Hospital - Bunbury Mental Health STP	-	-
St John of God Private Hospital - Bunbury STP Orthopaedic & General Surgical	-	160
Telethon Funding	402	368
Other	1,032	2,285
Capital		
Enhancing Pilbara Health	500	-
	83,026	78,039
Note 16 Donation revenue		
General public contributions	268	340
Hospital auxiliaries	134	174
Community fund-raising (a)	-	(82)
Deceased estates	427	453
	829	885
(a) A refund was made to the donor in 2013/14, as the Health Service could not fulfill the specific purpose for which the funds were donated in the previous financial year.		
Note 17 Other revenue		
Services to external organisations	7,337	7,270
Use of hospital facilities	1,018	1,014
Rent from commercial properties	396	476
Rent from residential properties	499	464
Staff and boarders' accommodation	8,996	9,109
Home and Community Care client fees	1,670	1,660
RiskCover insurance premium rebate	424	902
Act of Grace payments received for patients (note 23)	2,476	-
Other	1,150	1,510
	23,966	22,405
Note 18 Service appropriations		
Appropriation revenue received during the period:		
Service appropriations (via the Department of Health)	966,870	902,737
Service appropriations fund the net cost of services delivered. Appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the budgeted depreciation expense for the year and any agreed increase in leave liability during the year.		
Note 19 Assets transferred		
Assets transferred from/(to) other State government agencies during the period:		
Land from Metropolitan Health Services	-	182
Medical equipment from Department of Health	-	6
	-	188
Discretionary transfers of net assets (assets and liabilities) between State Government agencies free of charge, are reported under Income from State Government. Transfers of assets and liabilities in relation to a restructure of administrative arrangements are recognised as distribution to owners by the transferor and contribution by owners by the transferee under AASB 1004 '*Contributions*' in respect of the net assets transferred.		

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 20 Services received free of charge		
Services received free of charge from other State government agencies during the period:		
State Solicitor's Office - legal advisory services	-	33
Department of Finance - government accommodation	74	42
	74	75

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

Note 21 Royalties for Regions Fund		
Regional Community Services Account:		
District Allowances	12,582	19,399
Ear Health	1,500	-
Fitzroy Kids Health	200	-
Patient Assisted Travel Scheme	10,080	9,741
Pilbara Cardiovascular Screen Program	123	91
Regional Palative Care	1,000	-
Royal Flying Doctor Service	4,000	4,077
Royal Flying Doctor Service - Replacement Aircraft	-	8,048
Rural Generalists Pathways	2,400	1,800
Rural in Reach - Women Support	250	364
St John Ambulance Services	2,844	2,031
Regional Infrastructure Headworks Account:		
Busselton Health Campus - ICT	7,973	1,305
Pilbara Health Partnership (Asset Investment)	5,182	2,500
Renal Dialysis Service Expansion	463	210
Southern Inland Health Initiative		
- District Medical Workforce Investment Program (Stream 1)	26,499	20,516
- Residential Aged and Dementia Care Investment Program	153	-
- Redevelopment Integrated District HS (Stream 2)	4,869	2,947
- Telehealth Investment Program (Stream 5)	3,338	1,661
	83,456	74,690

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

Note 22 Restricted cash and cash equivalents (a)		
Current		
Royalties for Regions Fund	7,423	2,848
Capital grant from the Commonwealth Government (b)	23,828	16,017
Patient receipts under section 19 (2) of the Health Insurance Act 1973	3,362	3,216
Bequests	1,010	722
Statewide specialist Aboriginal Mental health Service Project	-	352
Mental Health Commission Funding	196	-
Other	-	523
	35,819	23,678

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

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

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 23 Receivables		
Current		
Patient fee debtors	12,679	12,346
Other receivables	5,802	7,384
Less: Allowance for impairment of receivables	(4,889)	(6,303)
Accrued revenue	7,363	4,601
GST receivable	4,039	3,440
	24,994	21,468
Reconciliation of changes in the allowance for impairment of receivables:		
Balance at start of period	6,303	4,502
Doubtful debts expense	1,521	1,805
Amounts written off during the period	(459)	(4)
Amounts recovered during the period (a)	(2,476)	-
Balance at end of period	4,889	6,303

(a) Amounts recovered through the Act of Grace payments received from the Department of Health in 2014/15.

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

See also note 2(p) 'Receivables' and note 53 'Financial instruments'.

Note 24 Amounts receivable for services (Holding Account)		
Current	-	-
Non-current	509,870	429,154
	509,870	429,154

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

Note 25 Inventories		
Current		
Supply stores - at cost	1,985	1,975
Pharmaceutical stores - at cost	2,479	2,267
Other inventories - at cost	1,090	1,029
	5,554	5,271

See note 2(o) 'Inventories'.

Note 26 Other current assets		
Prepayments	4,521	5,130

Note 27 Non-current assets classified as held for sale		
Opening balance	-	-
Land reclassified as held for sale	37	-
Buildings reclassified as held for sale	28	-
Less assets sold	-	-
Closing balance	65	-

Information on fair value measurements is provided in Note 29.

WA Country Health Service

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For the year ended 30th June 2015

	2015 $000	2014 $000
Note 28 Property, plant and equipment		
Land		
At fair value (a)	169,984	192,198
Buildings		
At fair value (a) (b)	1,473,514	1,358,372
Accumulated depreciation	-	-
	1,473,514	1,358,372
Total land and buildings	1,643,498	1,550,570
Leasehold improvements		
At cost	3,598	2,441
Accumulated depreciation	(2,008)	(1,198)
	1,590	1,243
Computer equipment		
At cost	3,257	3,173
Accumulated depreciation	(1,745)	(1,477)
	1,512	1,696
Furniture and fittings		
At cost	4,230	3,343
Accumulated depreciation	(1,192)	(1,141)
	3,038	2,202
Motor vehicles		
At cost	7,884	7,894
Accumulated depreciation	(6,600)	(5,740)
	1,284	2,154
Medical equipment		
At cost	100,486	97,742
Accumulated depreciation	(58,051)	(51,806)
	42,435	45,936
Other plant and equipment		
At cost	15,281	15,932
Accumulated depreciation	(9,701)	(8,915)
	5,580	7,017
Works in progress		
Buildings under construction (at cost)	76,245	140,827
Other Work in Progress (at cost)	11,557	3,433
	87,802	144,260
Artworks		
At cost	265	70
Total property, plant and equipment	1,787,004	1,755,148

(a) Land and buildings (excluding site works and external services) were revalued as at 1 July 2014 by the Western Australian Land Information Authority (Valuation Services). The valuations were performed during the year ended 30 June 2015 and recognised at 30 June 2015. In undertaking the revaluation, fair value was determined by reference to the market value for land: $77.106 million and buildings: $101.741 million. For the remaining balance, fair value of buildings was determined on the basis of depreciated replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land). See also note 2(f) 'Property, plant and equipment'.

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

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

	2015 $000	2014 $000
Note 28 Property, plant and equipment (continued)		
Reconciliations		
Reconciliations of the carrying amount of property, plant and equipment at the beginning and end of the reporting period are set out below.		
Land		
Carrying amount at start of period	192,198	202,760
Additions	-	122
Transfer from/(to) other reporting entities	-	(4)
Disposals	(32)	(219)
Classified as held for sale	(37)	-
Revaluation increments / (decrements)	(22,145)	(10,238)
Donations to non government organisations	-	(223)
Carrying amount at end of period	169,984	192,198
Buildings		
Carrying amount at start of period	1,358,372	1,276,025
Additions	4,237	931
Transfers from Work in Progress	142,163	41,094
Transfer from/(to) other reporting entities	8,991	(114)
Disposals	(4,495)	(150)
Classified as held for sale	(28)	-
Revaluation increments / (decrements)	14,804	93,348
Depreciation	(51,232)	(52,689)
Transfer between asset classes	800	-
Write-down of assets	(98)	(9)
Donations to non government organisations	-	(64)
Carrying amount at end of period	1,473,514	1,358,372
Leasehold improvements		
Carrying amount at start of period	1,243	958
Additions	-	515
Depreciation	(809)	(230)
Transfer between asset classes	1,156	-
Carrying amount at end of period	1,590	1,243
Computer equipment		
Carrying amount at start of period	1,696	1,397
Additions	1,108	650
Transfers from Work in Progress	12	43
Disposals	(4)	(2)
Depreciation	(321)	(352)
Transfer between asset classes	(957)	-
Write-down of assets	(22)	(40)
Carrying amount at end of period	1,512	1,696
Furniture and fittings		
Carrying amount at start of period	2,202	1,947
Additions	1,133	665
Transfers from Work in Progress	256	-
Disposals	(11)	(51)
Impairment losses (a)	-	-
Depreciation	(195)	(225)
Transfer between asset classes	(79)	-
Write-down of assets	(268)	(134)
Carrying amount at end of period	3,038	2,202

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Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 28 Property, plant and equipment (continued)		
Motor vehicles		
Carrying amount at start of period	2,154	2,219
Additions	29	893
Depreciation	(896)	(955)
Write-down of assets	(3)	(3)
Carrying amount at end of period	1,284	2,154
Medical equipment		
Carrying amount at start of period	45,936	46,934
Additions	6,597	8,962
Transfers from Work in Progress	206	740
Transfer from/(to) other reporting entities	-	6
Disposals	(305)	(167)
Depreciation	(9,015)	(10,276)
Transfer between asset classes	(165)	-
Write-down of assets	(819)	(255)
Donations to non government organisations	-	(8)
Carrying amount at end of period	42,435	45,936
Other plant and equipment		
Carrying amount at start of period	7,017	6,901
Additions	631	942
Transfers from Work in Progress	111	740
Disposals	(111)	(60)
Depreciation	(1,249)	(1,421)
Transfer between asset classes	(755)	-
Write-down of assets	(64)	(85)
Carrying amount at end of period	5,580	7,017
Works in progress		
Carrying amount at start of period	144,260	95,417
Additions	89,753	99,376
Capitalised to asset classes	(142,943)	(42,616)
Write-down of assets	(3,268)	(4,263)
Donations to non government organisations	-	(3,654)
Carrying amount at end of period	87,802	144,260
Artworks		
Carrying amount at start of period	70	70
Transfers from Work in Progress	195	-
Carrying amount at end of period	265	70
Total property, plant and equipment		
Carrying amount at start of period	1,755,148	1,634,628
Additions	103,488	113,057
Disposals	(4,958)	(649)
Transfer from/(to) other reporting entities	8,991	(112)
Classified as held for sale	(65)	-
Revaluation increments / (decrements)	(7,341)	83,110
Depreciation	(63,717)	(66,148)
Write-down of assets	(4,542)	(4,789)
Donations to non government organisations	-	(3,949)
Carrying amount at end of period	1,787,004	1,755,148

Note 29 Fair value measurements

(a) Fair value hierarchy

AASB 13 requires disclosure of fair value measurements by level of the following fair value measurement hierarchy:
1) quoted prices (unadjusted) in active markets for identical assets (level 1).
2) input other than quoted prices included within level 1 that are observable for the asset either directly or indirectly (level 2); and
3) Inputs for the asset that are not based on observable market data (unobservable input) (level 3).

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Asset measured at fair value 2015				
Land				
Non-Current assets classified as held for sale (Note 27)	-	37	-	37
Vacant land	-	7,105	-	7,105
Residential	-	70,001	-	70,001
Specialised	-	-	92,878	92,878
Buildings				
Non-Current assets classified as held for sale (Note 27)	-	28	-	28
Residential	-	101,741	-	101,741
Specialised	-	-	1,371,773	1,371,773
	-	178,912	1,464,651	1,643,563

	Level 1 $000	Level 2 $000	Level 3 $000	Total $000
Asset measured at fair value 2014				
Land				
Vacant land	-	8,223	-	8,223
Residential	-	85,239	-	85,239
Specialised	-	-	98,736	98,736
Buildings				
Residential	-	109,242	-	109,242
Specialised	-	-	1,249,130	1,249,130
	-	202,704	1,347,866	1,550,570

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

The Health Service obtains independent valuations of land and buildings from the Western Australian Land Information Authority (Landgate Valuation Services). Two principal valuation techniques are applied to the measurement of fair values:

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

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

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

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

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

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

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Note 29 Fair value measurements (continued)

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

Cost Approach (continued)

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

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

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

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

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

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

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

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

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

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

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

2015	**Land $000**	**Buildings $000**
Fair value at start of period	98,736	1,249,130
Additions	-	151,424
Disposals	(32)	(4,495)
Revaluation increments/(decrements)	(6,236)	25,331
Transfers from/(to) Level 2 (a)	410	-
Depreciation	-	(49,617)
Fair value at end of period	92,878	1,371,773

(a) Residential land amalgamated into a hospital site.

Note 29 Fair value measurements (continued)

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

The following table represents the changes in level 3 items for the period ended 30 June 2014:

2014	Land $000	Buildings $000
Fair value at start of period	100,843	1,157,878
Additions	-	40,539
Disposals	(223)	(2,011)
Revaluation increments/(decrements)	(2,205)	99,892
Transfers from/(to) Level 2 (a)	321	-
Depreciation	-	(47,168)
Fair value at end of period	98,736	1,249,130

(a) Residential land amalgamated into a hospital site.

(d) Valuation processes

The Financial Services Branch at the Health Corporate Network (HCN) manages the valuation processes for the Health Service. These include the provision of property information to quantity surveyor and Landgate Valuation Services and the review of the valuation reports. Discussions of valuation processes and results are held between the HCN and the chief finance officer at least once every year.

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

	2015 $000	2014 $000
Note 30 Intangible assets		
Computer software		
At cost	331	291
Accumulated amortisation	(266)	(227)
	65	64
Works in progress		
Computer software under development (at cost)	170	116
Total intangible assets	235	180

Reconciliation:

Reconciliation of the carrying amount of intangible assets at the beginning and end of the period is set out below.

Computer software		
Carrying amount at start of period	64	63
Additions	40	40
Amortisation expense	(40)	(39)
Carrying amount at end of period	65	64
Works in progress		
Carrying amount at start of year	116	35
Additions	54	81
Carrying amount at end of year	170	116

Note 31 Impairment of assets

There were no indications of impairment to property, plant and equipment or intangible assets as at 30 June 2015.

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

All surplus assets at 30 June 2015 have either been classified as assets held for sale or written off.

WA Country Health Service

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 32 Payables		
Current		
Trade creditors	24,129	20,274
Accrued expenses	56,416	46,532
Accrued salaries	35,727	31,279
Accrued interest	28	39
	116,300	98,124

See also note 2(q) 'Payables' and note 53 'Financial instruments'.

Note 33 Borrowings		
Current		
Department of Treasury loans (a)	1,518	1,303
Non-current		
Department of Treasury loans (a)	6,865	8,529
	8,383	9,832

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

Note 34 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	59,876	56,126
Time off in lieu leave (a)	22,110	21,164
Long service leave (b)	38,679	35,490
Gratuities	1,361	1,237
Deferred salary scheme (c)	1,939	1,936
	123,965	115,953
Non-current		
Employee benefits provision		
Long service leave (b)	25,101	23,281
Gratuities	276	296
	25,377	23,577
	149,342	139,530

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

Within 12 months of the end of the reporting period	63,766	60,437
More than 12 months after the end of the reporting period	18,220	16,853
	81,986	77,290

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

Within 12 months of the end of the reporting period	9,811	9,204
More than 12 months after the end of the reporting period	53,969	49,567
	63,780	58,771

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

Within 12 months of the end of the reporting period	1,076	1,171
More than 12 months after end of the reporting period	863	765
	1,939	1,936

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 35 Other current liabilities		
Current		
Income received in advance	-	331
Other	104	61
	104	392
Note 36 Contributed equity		
The Western Australian Government holds the equity interest in the Health Service on behalf of the community. Equity represents the residual interest in the net assets of the Health Service. The asset revaluation reserve represents that portion of equity resulting from the revaluation of non-current assets (note 37).		
Balance at start of period	1,483,046	1,386,545
Contributions by owners		
Capital appropriation (a)	52,489	51,664
Royalties for Regions Fund – Regional Infrastructure and Headworks Account	36,720	45,137
Transfer of net assets from other agencies (b) (c) (d)	8,991	-
	98,200	96,801
Distributions to owners		
Transfer of net assets to other agencies (b) (c)	-	(300)
Balance at end of period	1,581,246	1,483,046

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

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

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

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

(d) 24 apartments in the Pelago East Development in Karratha have been transferred from the Department of Housing to provide rental accommodation to the Health Service's employees.

Note 37 Reserves		
Asset revaluation reserve (a)		
Balance at start of period	505,520	422,410
Net revaluation increments / (decrements) (b) :		
Land	(22,145)	(10,238)
Buildings	14,804	93,348
Balance at end of period	498,179	505,520

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

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

WA Country Health Service

Notes to the Financial Statements

For the year ended 30th June 2015

	2015 $000	2014 $000
Note 38 Accumulated surplus/(deficit)		
Balance at start of period	12,013	2,911
Result for the period	20,089	9,102
Balance at end of period	32,102	12,013
Note 39 Notes to the Statement of Cash Flows		
Reconciliation of cash		
Cash assets at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
Cash and cash equivalents	17,594	8,428
Restricted cash and cash equivalents	35,819	23,678
	53,413	32,106
Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(929,436)	(886,104)
Increase/(decrease) in assets:		
GST receivable	599	(741)
Receivables	3,989	3,824
Inventories	283	157
Prepayments and other current assets	(608)	1,131
Decrease/(increase) in liabilities:		
Payables	(20,843)	(3,897)
Current provisions	(8,012)	(3,324)
Non-current provisions	(1,800)	(1,529)
Income received in advance	331	(331)
Other current liabilities	(43)	(20)
Non-cash items:		
Doubtful debts expense (note 13)	(1,521)	(1,805)
Depreciation and amortisation expense (note 10)	(63,757)	(66,187)
Loss from disposal of non-current assets (note 11)	(4,956)	(528)
Interest paid by Department of Health	(380)	(442)
Donation of non-current assets	-	17
Services received free of charge (note 20)	(74)	(75)
Write off of Receivables (note 23)	459	4
Write down of property, plant and equipment (note 13 and note 28)	(4,542)	(4,789)
Donations of property, plant and equipment (note 28)	-	(3,949)
Net cost of services (Statement of Comprehensive Income)	(1,030,311)	(968,588)
Notional cash flows		
Service appropriations as per Statement of Comprehensive Income	966,870	902,737
Royalties for Regions Fund as per Statement of Comprehensive Income	83,456	74,690
Royalties for Regions Fund credited directly to Contributed Equity (Refer Note 36)	36,720	45,137
Capital contributions credited directly to Contributed Equity (Refer Note 36)	52,489	51,664
Holding account drawdowns credited to Amounts Receivable for Services	-	4,141
	1,139,535	1,078,369
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to Department of Treasury	(380)	(442)
Repayment of interest-bearing liabilities to Department of Treasury	(1,450)	(1,385)
Accrual appropriations	(80,716)	(66,085)
	(82,546)	(67,912)
Cash Flows from State Government as per Statement of Cash Flows	1,056,989	1,010,457

At the end of the reporting period, the Health Service had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000
Note 40 Revenue, public and other property written off		
a) Revenue and debts written off under the authority of the Accountable Authority.	459	-
b) Public and other property written off under the authority of the Accountable Authority.	275	-
	734	-
Note 41 Gifts of public property		
Gifts of public property provided by the Health Service	19	295
Note 42 Services provided free of charge		
Mental Health Commission - contracted mental health services (a)	523	-

(a) The costs of mental health services provided under the Service Delivery Agreement is $0.523 million above the level of funding received from the Mental Health Commission.

Note 43 Remuneration of senior officers

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

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

$70,001 - $80,000	1	-
$90,001 - $100,000	-	2
$100,001 - $110,000	-	1
$140,001 - $150,000	1	-
$150,001 - $160,000	1	1
$170,001 - $180,000	-	1
$180,001 - $190,000	-	1
$190,001 - $200,000	-	3
$200,001 - $210,000	3	1
$210,001 - $220,000	-	1
$220,001 - $230,000	2	2
$230,001 - $240,000	2	2
$240,001 - $250,000	1	1
$280,001 - $290,000	1	-
$380,001 - $390,000	1	-
$420,001 - $430,000	-	1
$440,001 - $450,000	1	-
$460,001 - $470,000	1	-
Total	15	17

	$000	$000
Base remuneration and superannuation	3,679	3,288
Annual leave and long service leave accruals	(14)	22
Other benefits	67	94
The total remuneration of senior officers	3,732	3,404

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

Note 44 Remuneration of auditor

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

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

WA Country Health Service

Notes to the Financial Statements
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	2015 $000	2014 $000

Note 45 Commitments

The commitments below are inclusive of GST where relevant.

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

Within 1 year	109,153	158,721
Later than 1 year, and not later than 5 years	318,827	219,339
	427,980	378,060

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

Within 1 year	13,424	16,296
Later than 1 year, and not later than 5 years	6,928	9,033
Later than 5 years	313	924
	20,665	26,253

Operating lease commitments predominantly consist of contractual agreements for office accommodation and residential accommodation. The basis of which contingent operating leases payments are determined is the value for each lease agreement under the contract terms and conditions at current values.

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

Within 1 year	102,041	94,509
Later than 1 year, and not later than 5 years	24,820	39,677
	126,861	134,186

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

Within 1 year	40,191	29,028
Later than 1 year, and not later than 5 years	73,474	37,610
Later than 5 years	20,889	12,294
	134,554	78,932

Note 46 Contingent liabilities and contingent assets

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

Litigation in progress		
Pending litigation that are not recoverable from RiskCover insurance and may affect the financial position of the Health Service.	10,175	20,187
Number of claims	6	10
Contaminated sites		
Estimated cost to remediate contaminated and suspected contaminated sites reported to the Department of Environment and Regulation (DER)	-	608

Under the *Contaminated Sites Act 2003*, the Health Service is required to report known and suspected contaminated sites to the Department of Environment and Regulation (DER). In accordance with the Act, DER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as *contaminated – remediation required* or *possibly contaminated – investigation required*, the Health Service may have a liability in respect of investigation or remediation expenses.

Contingent assets

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

Notes to the Financial Statements
For the year ended 30th June 2015

	2015 $000	2014 $000

Note 47 Events occurring after the end of the reporting period

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

Note 48 Related bodies

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

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

Note 49 Affiliated bodies

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

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

Note 50 Special purpose accounts

Mental Health Commission Fund (WA Country Health Service) Account

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

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

Balance at the start of period	-	
Add Receipts:		
Service delivery agreement		
State contributions (note 15(ii))	57,669	
Commonwealth contributions (note 15(i))	23,168	
Other (note 15(ii))	5,233	
	86,070	
Less Payments	(85,874)	
Balance at the end of period	196	

Note 51 Administered trust accounts

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

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

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

Balance at the start of period	953	981
Add Receipts	1,588	1,712
	2,541	2,693
Less Payments	(1,474)	(1,740)
Balance at the end of period	1,067	953

WA Country Health Service

Notes to the Financial Statements

For the year ended 30 June 2015

Note 52 Explanatory Statement

Significant variances between actual results for 2014 and 2015

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

	Note	2015 Actual $000	2014 Actual $000	Variance $000
Expenses				
Employee benefits expense		901,814	840,187	61,628
Fees for visiting medical practitioners		78,727	81,179	(2,452)
Patient support costs		319,061	300,206	18,856
Finance costs		369	438	(69)
Depreciation and amortisation expense		63,757	66,187	(2,430)
Loss on disposal of non-current assets	(a)	4,956	528	4,428
Repairs, maintenance and consumable equipment		35,666	32,982	2,684
Other expenses	(b)	153,893	138,820	15,072
Income				
Patient charges		51,783	50,304	1,479
Commonwealth grants and contributions		368,328	340,306	28,022
Other grants and contributions		83,026	78,039	4,987
Donation revenue		829	885	(56)
Other revenue		23,966	22,405	1,561
Service appropriations	(c)	966,870	902,737	64,133
Assets transferred		-	188	(188)
Services received free of charge		74	75	(1)
Royalties for Regions Fund	(d)	83,456	74,690	8,766

(a) Loss on disposal of non-current assets
The increase relates to losses associated with the de-recognition of clinics in Warmun and Wickham that are not expected to generate any future economic benefits, and the closure of the Coonanna clinic that was not able to be relocated and reused due to its asbestos construction.

(b) Other expenses
The increase is attributable to a one off pre Riskcover legal settlement, with the balance of the increase resulting from standard cost escalation of goods and services between the financial years.

(c) Service appropriations
Service Appropriations provided by Government increased in 2014/15 in response to changes in industrial agreements, increasing costs for other goods and services, anticipated activity growth in public hospitals and Emergency Departments and the funding of new and expanded services.

(d) Royalties for Regions Fund
Revenues for Royalties for Regions projects vary according to the cashflow requirements of new and continuing projects. Changes in contributions from the Royalties for Regions Fund between 2013/14 and 2014/15 are detailed in Note 21.

Significant variances between estimated and actual results for 2015

Significant variations between the estimates and actual results for 2015 are detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2015 Actual $000	2015 Estimates $000	Variance $000
Operating expenses				
Employee benefits expense		901,814	891,453	10,361
Other goods and services		656,429	704,786	(48,357)
Total expenses		1,558,243	1,596,239	(37,996)
Less: Revenues	(a)	(527,932)	(600,533)	72,601
Net cost of services		1,030,311	995,706	34,605

(a) Revenues
Under the National Health Reform Agreement, hospital services, and health teaching, training and research have been funded through a combination of Revenue from the Commonwealth Sourced State Funding Pool which is recognised as Revenue, and Service Appropriations. In 2014/15, $92.1 million which was initially budgeted to be received from the State Pool Account as Revenue was received as Service Appropriations.

Actual Non Patient Revenue included Commonwealth Capital Grants totalling $18.6 million, as set out in Note 15 (i), which were not included in the initial budget. This was offset in part by various other operating revenues being $1.6 million below budget, including grants that were not received for which there was a corresponding reduction in expenditures against budget.

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial instruments

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

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

Credit risk

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

The maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any allowance for impairment as shown in the table at note 53 c) 'Financial Instrument disclosures' and note 23 'Receivables'.

Credit risk associated with the Health Service's financial assets is generally confined to patient fee debtors (see note 23). The main receivable is the amounts receivable for services (holding account). For receivables other than government, the Health Service trades only with recognised, creditworthy third parties. The Health Service has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the Health Service's exposure to bad debts is minimal. At the end of the reporting period, there were no significant concentrations of credit risk.

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

Allowance for impairment of financial assets is calculated based on objective evidence such as observable data indicating changes in client credit ratings. For financial assets that are either past due or impaired, refer to note 53 c) 'Financial Instruments disclosures'.

Liquidity risk

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

The Health Service has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial Instruments (continued)

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

Market risk
Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Health Service's income or the value of its holdings of financial instruments. The Health Service does not trade in foreign currency and is not materially exposed to other price risks. The Health Service's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations. The Health Service's borrowings are with the Department of Treasury and are at variable interest rates with varying maturities. The risk is managed by the Department of Treasury through portfolio diversification and variation in maturity dates.

b) **Categories of financial instruments**

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

	2015 $000	2014 $000
Financial Assets		
Cash and cash equivalents	17,594	8,428
Restricted cash and cash equivalents	35,819	23,678
Loans and receivables	530,825	447,182
Financial Liabilities		
Financial liabilities measured at amortised cost	124,683	107,956

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

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial Instruments (continued)

c) **Financial Instrument disclosures**

Credit Risk

The following table discloses the Health Service's maximum exposure to credit risk and the ageing analysis of financial assets. The Health Service's maximum exposure to credit risk at the end of the reporting period is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Health Service.

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

Aged analysis of financial assets

	Carrying amount	Not past due and not impaired	Past due but not impaired				Impaired Financial assets
			1 - 3 months	3 - 12 months	1 - 5 years	More than 5 years	
	$000	$000	$000	$000	$000	$000	$000
2015							
Cash and cash equivalents	17,594	17,594	-	-	-	-	-
Restricted cash and cash equivalents	35,819	35,819	-	-	-	-	-
Receivables	20,955	12,515	2,364	3,156	2,705	215	-
Amounts receivable for services	509,870	509,870	-	-	-	-	-
	584,238	575,798	2,364	3,156	2,705	215	-
2014							
Cash and cash equivalents	8,428	8,428	-	-	-	-	-
Restricted cash and cash equivalents	23,678	23,678	-	-	-	-	-
Receivables	18,028	11,538	2,221	2,397	1,742	130	-
Amounts receivable for services	429,154	429,154	-	-	-	-	-
	479,288	472,798	2,221	2,397	1,742	130	-

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

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial Instruments (continued)

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

Liquidity risk and interest rate exposure

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

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

		Interest rate exposure					Maturity dates			
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2015										
Financial Assets										
Cash and cash equivalents	-	17,594	-	-	17,594	17,594	17,594	-	-	-
Restricted cash and cash equivalents	-	35,819	-	-	35,819	35,819	35,819	-	-	-
Receivables	-	20,955	-	-	20,955	20,955	20,955	-	-	-
Amounts receivable for services	-	509,870	-	-	509,870	509,870	-	-	-	509,870
		584,238	-	-	584,238	584,238	74,368	-	-	509,870
Financial Liabilities										
Payables	-	116,300	-	-	116,300	116,300	116,300	-	-	-
Department of Treasury Loans	4.11%	8,383	-	8,383	-	9,200	452	1,357	7,301	90
		124,683	-	8,383	116,300	125,500	116,752	1,357	7,301	90

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

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial Instruments (continued)

c) Financial instrument disclosures (continued)

Liquidity risk and interest rate exposure (continued)

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

		Interest rate exposure				Maturity dates				
	Weighted average effective interest rate	Carrying amount	Fixed interest rate	Variable interest rate	Non-interest bearing	Nominal Amount	Up to 1 month	1 month to 1 year	1-5 years	More than 5 years
	%	$000	$000	$000	$000		$000	$000	$000	$000
2014										
Financial Assets										
Cash and cash equivalents	-	8,428	-	-	8,428	8,428	8,428	-	-	-
Restricted cash and cash equivalents	-	23,678	-	-	23,678	23,678	23,678	-	-	-
Receivables	-	18,028	-	-	18,028	18,028	18,028	-	-	-
Amounts receivable for services	-	429,154	-	-	429,154	429,154	-	-	-	429,154
		479,288	-	-	479,288	479,288	50,134	-	-	429,154
Financial Liabilities										
Payables	-	98,124	-	-	98,124	98,124	98,124	-	-	-
Department of Treasury Loans	4.10%	9,832	-	9,832	-	11,110	458	1,191	6,594	2,867
		107,956	-	9,832	98,124	109,234	98,582	1,191	6,594	2,867

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

Notes to the Financial Statements
For the year ended 30 June 2015

Note 53 Financial Instruments (continued)

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

Interest rate sensitivity analysis

The following table represents a summary of the interest rate sensitivity of the Health Service's financial assets and liabilities at the end of the reporting period on the surplus for the period and equity for a 1% change in interest rates. It is assumed that the change in interest rates is held constant throughout the reporting period.

	Amount Exposed to Interest Rate Risk $000	-100 basis points		+100 basis points	
		Surplus $000	Equity $000	Surplus $000	Equity $000
2015					
Financial Liabilities					
Department of Treasury Loans	8,383	84	84	(84)	(84)
Total Increase/(Decrease)		84	84	(84)	(84)
2014					
Financial Liabilities					
Department of Treasury Loans	9,832	98	98	(98)	(98)
Total Increase/(Decrease)		98	98	(98)	(98)

Fair values

All financial assets and liabilities recognised in the Statement of Financial Position, whether they are carried at cost or fair value, are recognised at amounts that represent a reasonable approximation of fair value unless otherwise stated in the applicable notes.

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Notes to the Financial Statements

For the year ended 30 June 2015

Note 54 Schedule of income and expenses by service

	Public Hospital (a) Admitted Patients		Palliative Care		Emergency Department (a)		Public Hospital Non-Admitted Patients (a)		Patient Transport (b)	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES										
Expenses										
Employee benefits expense	380,748	414,971	1,954	3,361	154,847	115,371	119,000	69,983	6,771	3,499
Fees for visiting medical practitioners	60,081	64,322	-	325	9,497	9,197	5,925	4,242	7	-
Patient support costs	133,840	166,381	482	1,058	42,729	37,056	37,032	19,205	34,521	41,365
Finance costs	312	395	2	2	4	13	51	8	-	-
Depreciation and amortisation expense	33,544	52,279	-	265	11,238	1,831	8,956	68	675	-
Loss on disposal of non-current assets	2,608	528	-	-	1,199	-	370	-	52	-
Repairs, maintenance and consumable equipment	15,282	20,208	5	132	5,736	2,786	4,509	1,200	184	11
Other expenses	35,764	23,088	1,197	555	11,443	6,332	5,053	17,890	41,372	232
Total cost of services	662,179	742,172	3,640	5,698	236,693	172,586	180,896	112,596	83,582	45,107
Income										
Patient charges	27,437	29,396	-	201	227	6,109	23,030	4,387	-	-
Commonwealth grants and contributions	192,069	180,988	1,473	1,361	44,727	41,324	32,125	29,681	-	-
Other grants and contributions	18,292	19,286	-	-	532	500	396	372	-	-
Donation revenue	485	518	3	4	101	107	72	77	-	-
Other revenue	14,005	13,092	96	90	2,910	2,721	2,090	1,954	-	-
Total income other than income from State Government	252,288	243,280	1,572	1,656	48,497	50,761	57,713	36,471	-	-
NET COST OF SERVICES	**409,891**	**498,892**	**2,068**	**4,042**	**188,196**	**121,825**	**123,183**	**76,125**	**83,582**	**45,107**
INCOME FROM STATE GOVERNMENT										
Service appropriations	403,270	476,345	1,062	3,611	162,133	109,622	118,712	78,735	67,969	29,739
Assets transferred	-	103	-	1	-	23	-	16	-	6
Services received free of charge	42	42	-	-	9	9	6	7	2	2
Royalties for Regions Fund	15,150	17,785	1,027	7,110	30,590	18,142	6,931	3,555	17,023	10,673
Total income from State Government	418,462	494,275	2,089	10,722	192,732	127,796	125,649	82,313	84,994	40,420
SURPLUS FOR THE PERIOD	**8,571**	**(4,617)**	**21**	**6,680**	**4,536**	**5,971**	**2,466**	**6,188**	**1,412**	**(4,687)**

(a) A new cost allocation system was implemented in 2014-15 resulting in a more accurate reflection in Public Hospital Admitted Patients; Emergency Department; and Public Hospital Non-admitted Patients.
(b) Payment for Royal Flying Doctors Service for 2013-14 was mainly grouped as Public Hospital Admitted Patients.
(c) Includes services in addition to those provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

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

Notes to the Financial Statements

For the year ended 30 June 2015

Note 54 Schedule of income and expenses by service (continued)

	Prevention, Promotion & Protection		Continuing Care		Mental Health (c)		Total	
	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000	2015 $000	2014 $000
COST OF SERVICES								
Expenses								
Employee benefits expense	100,085	96,108	62,374	57,402	76,035	79,492	901,814	840,187
Fees for visiting medical practitioners	1,150	732	107	147	1,960	2,214	78,727	81,179
Patient support costs	28,227	13,413	17,689	15,057	24,541	6,671	319,061	300,206
Finance costs	-	1	-	19	-	-	369	438
Depreciation and amortisation expense	6,032	2,987	2,068	8,670	1,244	87	63,757	66,187
Loss on disposal of non-current assets	469	-	161	-	97	-	4,956	528
Repairs, maintenance and consumable equipment	5,118	3,628	1,621	2,202	3,211	2,815	35,666	32,982
Other expenses	53,376	50,653	3,221	28,909	2,467	11,161	153,893	138,820
Total cost of services	194,457	167,522	87,241	112,406	109,555	102,440	1,558,243	1,460,527
Income								
Patient charges	-	6,053	1,089	4,158	-	-	51,783	50,304
Commonwealth grants and contributions	44,322	40,950	30,445	28,129	23,167	17,873	368,328	340,306
Other grants and contributions	535	503	368	346	62,903	57,032	83,026	78,039
Donation revenue	100	106	68	73	-	-	829	885
Other revenue	2,884	2,696	1,981	1,852	-	-	23,966	22,405
Total income other than income from State Government	47,841	50,308	33,951	34,558	86,070	74,905	527,932	491,939
NET COST OF SERVICES	**146,616**	**117,214**	**53,290**	**77,848**	**23,485**	**27,535**	**1,030,311**	**968,588**
INCOME FROM STATE GOVERNMENT								
Service appropriations	138,354	108,628	52,772	74,618	22,598	21,439	966,870	902,737
Assets transferred	-	23	-	16	-	-	-	188
Services received free of charge	9	9	6	6	-	-	74	75
Royalties for Regions Fund	11,127	10,315	1,608	7,110	-	-	83,456	74,690
Total income from State Government	149,490	118,975	54,386	81,750	22,598	21,439	1,050,400	977,690
SURPLUS FOR THE PERIOD	**2,874**	**1,761**	**1,096**	**3,902**	**(887)**	**(6,096)**	**20,089**	**9,102**

(a) A new cost allocation system was implemented in 2014-15 resulting in a more accurate reflection in Public Hospital Admitted Patients; Emergency Department; and Public Hospital Non-admitted Patients.
(b) Payment for Royal Flying Doctors Service for 2013-14 was mainly grouped as Public Hospital Admitted Patients.
(c) Includes services in addition to those provided under agreement with the Mental Health Commission for specialised admitted patients and community mental health.

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

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Certification of key performance indicators

WA COUNTRY HEALTH SERVICE

CERTIFICATION OF KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2015

I hereby certify the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the WA Country Health Service's performance and fairly represent the performance of the Health Service for the financial year ended 30 June 2015.

Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

16 September 2015

Key performance indicators

Outcome 1

Percentage of public patients discharged to home after admitted hospital treatment	87
Survival rates for sentinel conditions	88
Rate of unplanned readmissions within 28 days to the same hospital for a related condition	91
Rate of unplanned readmission within 28 days to the same hospital for a mental health condition	93
Percentage of liveborn infants with an Apgar score of three or less, five minutes post delivery	95
Average cost per casemix adjusted separation for non-tertiary hospitals	97
Average cost per bed-day for admitted patients (selected small rural hospitals)	98
Average cost per emergency department/service attendance	99
Average cost per non-admitted hospital based occasion of service for rural hospitals	100
Average cost per non-admitted occasion of service provided in a rural nursing post	101
Average cost per trip of Patient Assisted Travel Scheme	102

Outcome 2

Rate of hospitalisation for gastroenteritis in children (0–4 years)	103
Rate of hospitalisation for selected respiratory conditions	105
Rate of hospitalisation for falls in older persons	112
Percentage of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	114
Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from a public mental health acute inpatient units	115
Average cost per capita of Population Health Units	116
Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents	117
Average cost per bed-day in specialised mental health inpatient units	118
Average cost per three month period of community care provided by a public community mental health service.	119

Percentage of public patients discharged to home after admitted hospital treatment

Outcome 1
Effectiveness KPI

Rationale

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

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

Target

The 2014 target is 97.4 per cent.

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

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

Results

During 2014, a total of 97.5 per cent of public patients in country WA, across all ages, were discharged to home after receiving admitted hospital treatment (see Table 11). This result is slightly above the target of 97.4 per cent.

Table 11: **Percentage of public patients discharged to home after admitted hospital treatment, by age group, 2010–2014**

Age group (years)	Calendar years				
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)
0–39	97.1	96.7	96.9	97.0	**97.2**
40–49	96.0	95.8	96.2	96.1	**96.0**
50–59	97.7	97.6	97.9	97.9	**97.9**
60–69	98.4	98.7	98.7	98.7	**98.7**
70–79	98.3	98.4	98.4	98.6	**98.7**
80+	96.6	96.6	96.9	97.1	**97.2**
All ages	97.3	97.1	97.3	97.4	**97.5**
Target (≥)	97.4	97.4	97.4	97.4	**97.4**

Data source: Hospital Morbidity Data System.

Survival rates for sentinel conditions

Outcome 1
Effectiveness KPI

Rationale

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

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

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

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

Target

The 2014 target for each condition by age group:

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

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

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

Results

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

In 2014, the survival rate for stroke was below target for country WA patients aged 0-49, 50-59, 60-69,70-79 and 80 years and over (see Table 12).

Table 12: **Survival rate for stroke, by age group, 2010–2014**

Age group (years)	Calendar years					
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
0–49	97.6	98.5	93.5	100.0	**98.1**	**≥98.5**
50–59	94.4	97.9	95.8	96.6	**92.2**	**≥97.9**
60–69	93.0	96.8	98.7	92.2	**94.9**	**≥98.7**
70–79	86.9	88.4	90.4	95.3	**92.2**	**≥95.3**
80+	79.3	72.4	76.6	80.1	**78.4**	**≥80.1**

Note: Due to the low number of cases within some age categories, care should be taken when considering fluctuations in results.

Data source: Hospital Morbidity Data System.

In 2014, the survival rate for people who had an acute myocardial infarction was below the target for people aged 50-59, 60-69, 70-79 and 80 years and over in country WA. Survival rates for the 0-49 year aged group reported 100 per cent survival rate, which was above the target of 99.1 per cent (see Table 13).

Table 13: **Survival rate for acute myocardial infarction, by age group, 2010–2014**

Age group (years)	Calendar years					
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
0–49	100.0	100.0	100.0	99.1	**100.0**	**≥99.1**
50–59	99.0	100.0	98.2	99.2	**99.0**	**≥99.2**
60–69	97.2	99.2	98.7	99.2	**98.5**	**≥99.2**
70–79	98.7	95.0	96.6	98.1	**97.6**	**≥98.7**
80+	90.5	89.9	92.1	96.0	**90.7**	**≥96.0**

Data source: Hospital Morbidity Data System.

The survival rate for country WA patients who had a fracture of the femur reported 100 per cent which was above the target of 98.7 per cent for the 70-79 age group and below the target for the 80 years and over age groups (see Table 14).

Table 14: **Survival rate for fractured neck of femur, by age group, 2010–2014**

Age group (years)	Calendar years					
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
70–79	96.6	98.7	95.0	98.5	**100.0**	**≥98.7**
80+	96.1	97.8	96.3	96.9	**93.9**	**≥97.8**

Data source: Hospital Morbidity Data System.

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

Outcome 1
Effectiveness KPI

Rationale

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall health care system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. There are some conditions that may require numerous admissions to enable the best level of care to be given. However, in most of these cases hospital readmission is planned.

A low unplanned readmission rate suggests that good clinical practice is in operation. These readmissions necessitate patients spending additional periods of time in hospital as well as using additional hospital resources.

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

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

Target

The 2014 target is ≤3.0 per cent.

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

Results

In 2014, the percentage of unplanned readmissions within 28 days to a country hospital for a related condition was 3.2 per cent (see Table 15). This result was above the target of 3.0 per cent.

Table 15: **Percentage of unplanned readmissions within 28 days to the same hospital for a related condition, 2010–2014**

	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Unplanned readmissions	3.4	3.8	3.0	3.8	**3.2**
Target					**≤3.0**

Notes:

1. This indicator is based on a 3 month period each year. For 2014 data is reported from 1 September – 30 November.
2. Fluctuations in performance are a result of relatively small population numbers, which can result in small changes in activity having a disproportionate influence on the overall performance.
3. In 2014, the denominator data source was revised to remove renal and chemotherapy cases. Data for all previously published years (2010–2013) has been restated for comparability purposes. Previously reported results no longer considered appropriate are as follows:

	2010	2011	2012	2013
Results	2.8	2.9	2.3	2.8
Target	≤2.2	≤2.2	≤2.2	≤2.2

Data source: Hospital Morbidity Data System.

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

Outcome 1
Effectiveness KPI

Rationale

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

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

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

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

Target

The 2014 target is ≤4.8 per cent.

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

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

Results

In 2014, the percentage of unplanned readmissions within 28 days to a country hospital by paitents with a mental health condition was 9.6 per cent (see Table 16). This was above the target of 4.8 per cent. Relatively small changes in population numbers has resulted in a higher percentage of unplanned readmission for a mental health condition than previous years.

Table 16: **Percentage of unplanned readmissions within 28 days to the same hospital relating to the previous mental health condition for which they were treated, 2010–2014**

	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Unplanned readmissions	4.8	6.1	6.1	6.3	**9.6**
Target	≤5.2	≤4.8	≤4.8	≤4.8	**≤4.8**

Notes:

1. This indicator is based on a 3 month period each year. For 2014 data is reported from 1 September – 30 November.
2. Fluctuations in performance are a result of relatively small population numbers, which can result in small changes in activity having a disproportionate influence on the overall performance.

Data source: Hospital Morbidity Data System.

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

Outcome 1
Effectiveness KPI

Rationale

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

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

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

Target

The 2014 target for liveborn infants with an Apgar score of three or less, by birth weight:

Birth weight (grams)	Percentage
0–1499	14.3
1500–1999	4.0
2000–2499	0.7
2500+	0.1

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

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

Results

In 2014, the percentage of liveborn infants with a birth weight of 0-1499 grams or over 2500 grams, and an Apgar score of 3 or less, was 37.5 per cent and 0.3 per cent respectively (see Table 17). For infants with a birth weight between 1500-2499 grams, performance achieved a result below target.

Table 17: **Percentage of liveborn infants with an Apgar score of three or less, five minutes post-delivery, by birth weight, 2010–2014**

Birth weight (grams)	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
0–1499	40.0	40.0	14.3	30.0	**37.5**	**14.3**
1500–1999	6.7	0.0	4.2	4.0	**0.0**	**4.0**
2000–2499	0.0	0.8	1.4	0.7	**0.6**	**0.7**
2500+	0.1	0.2	0.2	0.2	**0.3**	**0.1**

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

Data source: Midwives Notification System.

Average cost per casemix adjusted separation for non-tertiary hospitals

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

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

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

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

Target

The target for 2014–15 is $7,248 per casemix weighted separation from a non-tertiary hospital.

A result below the target is desirable.

Results

The average cost per casemix weighted separation for country WA non-tertiary hospitals for 2014–15 was $6,830 (see Table 18). This was below the target of $7,248.

Table 18: **Average cost per casemix weighted separation for non-tertiary hospitals, 2010–11 to 2014–15**

	2013-14 (%)	2014-15 (%)
Average cost	$6,995	**$6,830**
Target	$7,547	**$7,248**

Note: A new methodology for calculating the weighted separations for non-tertiary hospital has been developed and applied. The new methodology more accurately calculates the weighted average due to improvements in data reporting processes introduced in 2013–14. Previously reported results, non longer considered appropriate, are as follows.

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

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

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

Outcome 1
Efficiency KPI
Service 1: Public hospital admitted patients

Rationale

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

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

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

Target

The target for 2014–15 is $1,736 per bed-day for admitted patients (selected small rural hospitals).

A result below the target is desirable.

Results

The average cost per bed-day for admitted patients for selected small rural hospitals for 2014–15 was $2,102 (see Table 19) which was above the target. A new cost allocation system was implemented in 2014–15. This resulted in a more accurate reflection in admitted, emergency department and non-admitted patients. The 2013–14 average cost was also re-calculated to reflect the counting and classification methodology under the National Activity Based funding framework.

Table 19: **Average cost per bed-day for admitted patients (selected small rural hospitals), 2010–11 to 2014–15**

	2013-14 (%)	2014-15 (%)
Average cost	$2,406	**$2,102**
Target	$1,873	**$1,736**

Note:

1. In 2014–15, a new costing model was introduced.
2. Changes and improvements in the counting and classification methodology under the National Activity Based funding framework has resulted in results from 13–14 onward no longer considered appropriate. Previously reported results are as follows.

	2010-11	2011-12	2012-13	2013-14
Average cost	$1,616	$1,855	$2,357	$1,365
Target	$1,392	$1,727	$1,721	$1,873

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

Average cost per emergency department/service attendance

Outcome 1
Efficiency KPI
Service 4: Emergency department

Rationale

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

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

Target

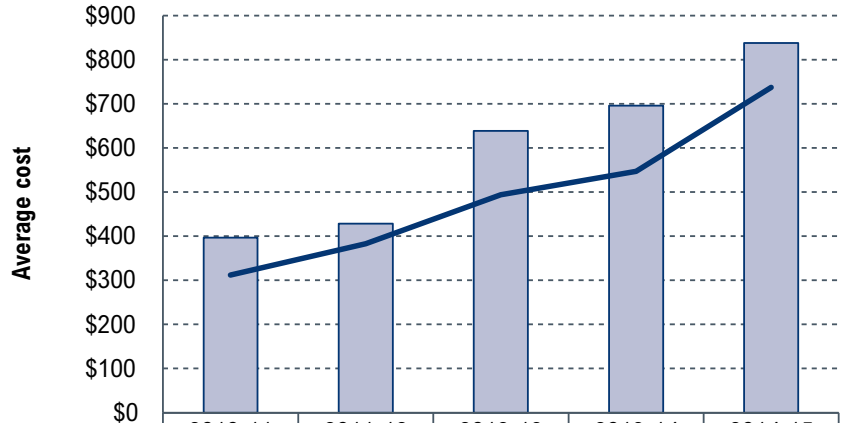
The target for 2014–15 is $737 per emergency department attendance.

A result below the target is desirable.

Results

For 2014–15, the average cost per emergency department attendances for WA country hospitals was $838 (see Figure 6) and above the target of $737. The Southern Inland Health initiative funding increased in 2014–15 to support improved services in emergency departments, this has contributed to higher costs in this indicator.

Figure 6: **Average cost per emergency department attendances, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$396	$429	$638	$696	$838
Target	$312	$383	$494	$547	$737

Data sources: Emergency Department Data Collection, Health Service financial systems.

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

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

Rationale

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

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

Target

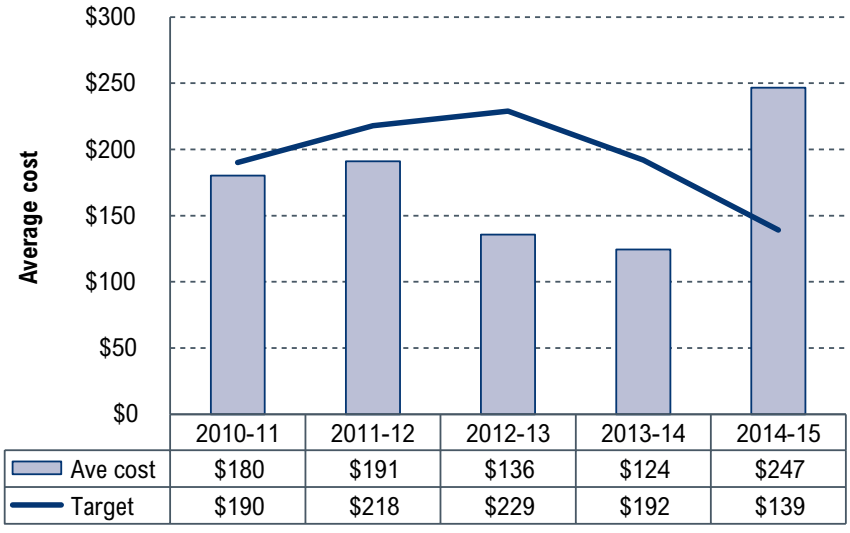
The target for 2014–15 is $139 per non–admitted occasion of service (rural hospitals).

A result below the target is desirable.

Results

The average cost per non-admitted occasion of service for WA country hospitals in 2014–15 was $247 (see Figure 7). This figure is above the target. The higher than average cost is attributed to a new costing allocation system implemented in 2014–15. This resulted in a more accurate reflection in admitted, emergency department and non-admitted patients.

Figure 7: **Average cost per non-admitted hospital based occasion of service for rural hospitals, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$180	$191	$136	$124	$247
Target	$190	$218	$229	$192	$139

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

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

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

Rationale

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

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

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

Target

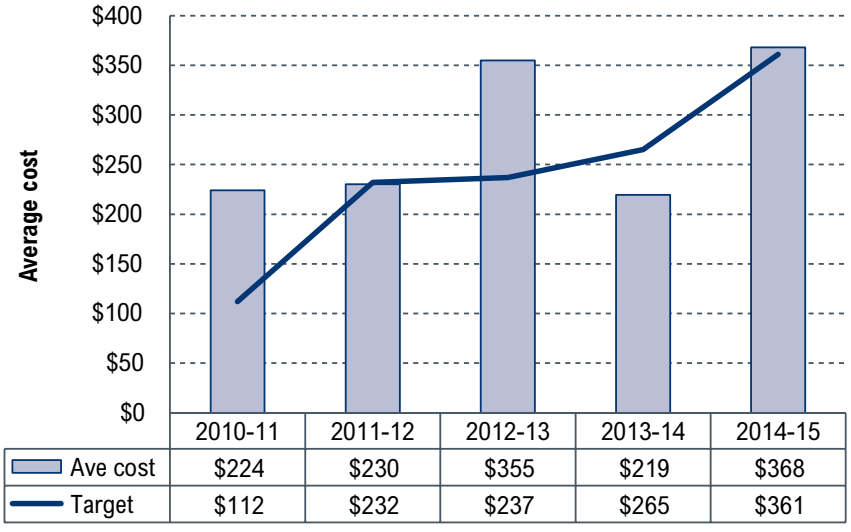
The target for 2014–15 is $361 per non–admitted occasion of service (rural nursing post).

A result below the target is desirable.

Results

In 2014–15, the average cost per non-admitted occasion of service for country WA nursing posts was $368 (see figure 8) which is slightly higher than the target. The average cost per non admitted occasion of service provided in a rural nursing post is in line with target. Nursing Posts have a relatively fixed cost profile which can lead to variability in the actual average cost per unit of activity when compared to prior reporting periods.

Figure 8: **Average cost per non-admitted occasion of service in a rural nursing post, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$224	$230	$355	$219	$368
Target	$112	$232	$237	$265	$361

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

Average cost per trip of Patient Assisted Travel Scheme

Outcome 1
Efficiency KPI
Service 6: Patient transport

Rationale

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

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

Target

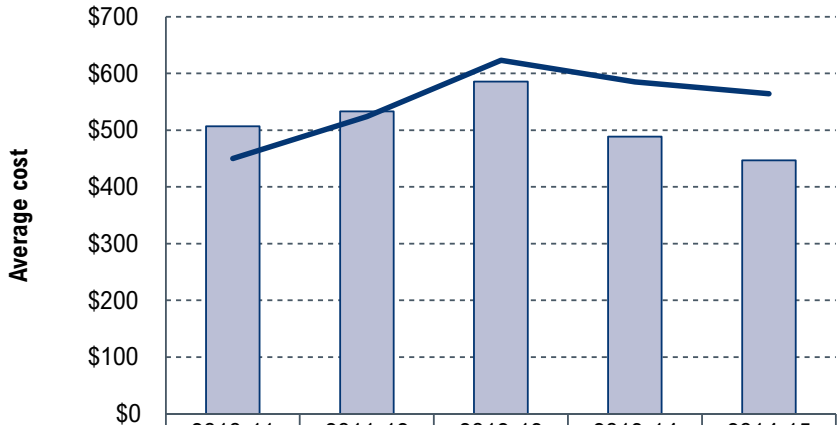
The target for 2014–15 is $564 per trip of Patient Assisted Travel Scheme trip.

A result below the target is desirable.

Results

In 2014–15, the average cost per Patient Assisted Travel Scheme trip was $447, and below the target (see Figure 9). The lower average cost is attributed to the new PATS database being improved. This has increased the capture and reporting of activity in 2014–15 when compared to the target.

Figure 9: **Average cost per trip, Patient Assisted Travel Scheme, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave Cost	$507	$533	$586	$489	$447
Target	$450	$524	$623	$585	$564

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

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

Outcome 2
Effectiveness KPI

Rationale

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

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

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

Target

The target for 2014 is ≤5.0 hospitalisations per 1,000 children less than 5 years of age.

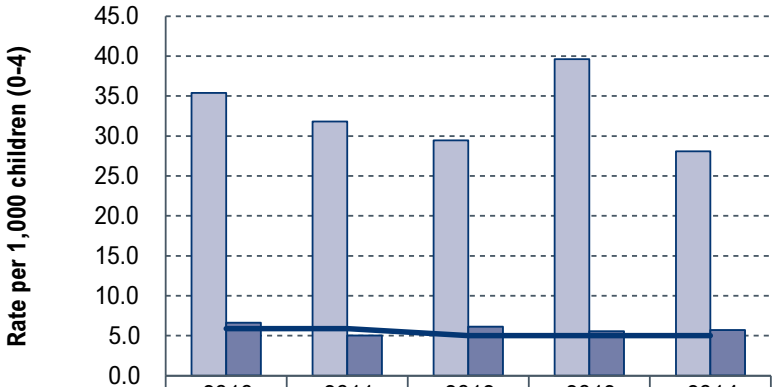
The target is based on the best result achieved within the previous five years for either Aboriginal or non-Aboriginal population groups.

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

Results

In 2014, the rate of non-Aboriginal chidren aged 0–4 years hospitalised for gastroenterisis in country WA was 5.7 per 1,000 children (see Figure 10). The rate for aboriginal children is consistent with prior years. The rate of hospital admissions due to gastroenteritis for both non-Aboriginal and Aboriginal children exceeded the target of 5.0 per 1,000 children.

Figure 10: **Rate of hospitalisations for gastroenteritis per 1,000 children aged 0–4 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	35.4	31.8	29.4	39.6	28.1
Non-Aboriginal	6.6	5.0	6.1	5.5	5.7
Target (≤)	5.9	5.9	5.0	5.0	5.0

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. Caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal children for gastroenteritis due to small population numbers that can result in significant variations across reporting years.

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

Rate of hospitalisation for selected respiratory conditions

Outcome 2
Effectiveness KPI

Rationale

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

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

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

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

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

Target

The 2014 targets, by respiratory condition, are outlined in the table below. The targets are based on the best result recorded within the previous five years for either population group reported i.e. Aboriginal and non-Aboriginal groups.

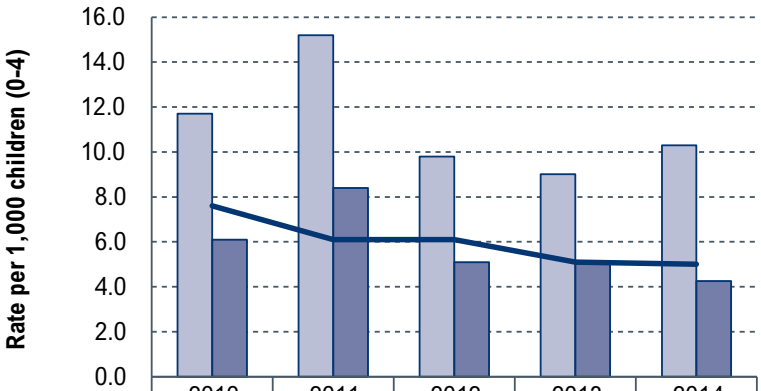
Respiratory condition	Age group (years)	Target
Acute Asthma	0–4	≤ 5.0
	5–12	≤ 2.8
	13–18	≤ 0.9
	19–34	≤ 0.8
	35+	≤ 0.7
Acute Bronchitis	0–4	≤ 0.5
Bronchiolitis	0–4	≤ 9.7
Croup	0–4	≤ 2.6

Results

Acute asthma

In 2014, country WA non-Aboriginal people in age groups 0-4, 5-12, 13-18, 19-34 and 35 years and over achieved a result lower than the target rate for hospitalisation for acute asthma (see Figure 11 to 15). For all Aboriginal children the age group target was not met. The rate of Aboriginal children hospitalised for acute asthma in country WA declined in all age groups except 0–4 years.

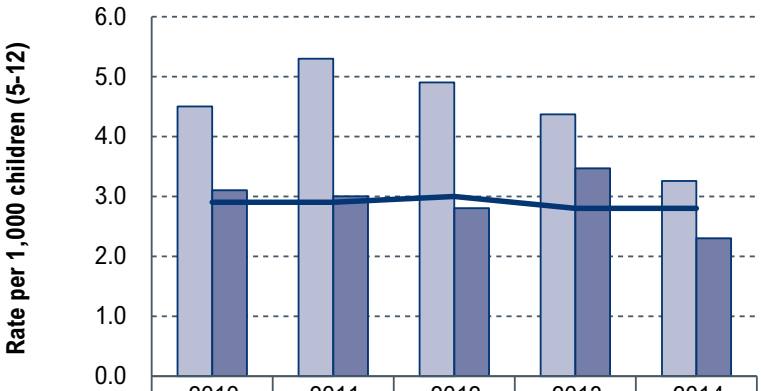
Figure 11: **Rate of hospitalisation for acute asthma per 1,000 children aged 0–4 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	11.7	15.2	9.8	9.0	10.3
Non-Aboriginal	6.1	8.4	5.1	5.0	4.3
Target (≤)	7.6	6.1	6.1	5.1	5.0

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

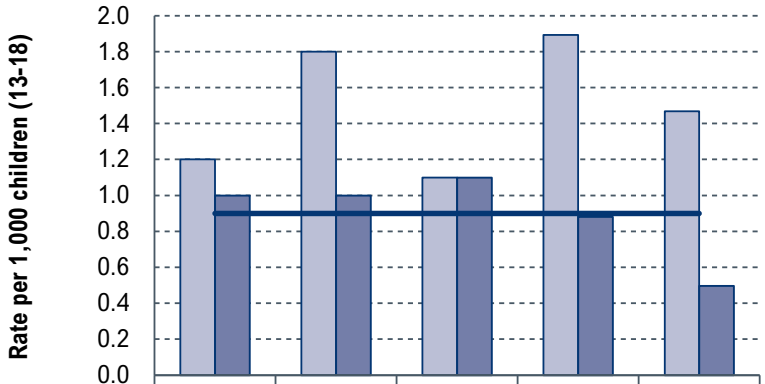
Figure 12: **Rate of hospitalisation for acute asthma per 1,000 children aged 5–12 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	4.5	5.3	4.9	4.4	3.3
Non-Aboriginal	3.1	3.0	2.8	3.5	2.3
Target (≤)	2.9	2.9	3.0	2.8	2.8

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

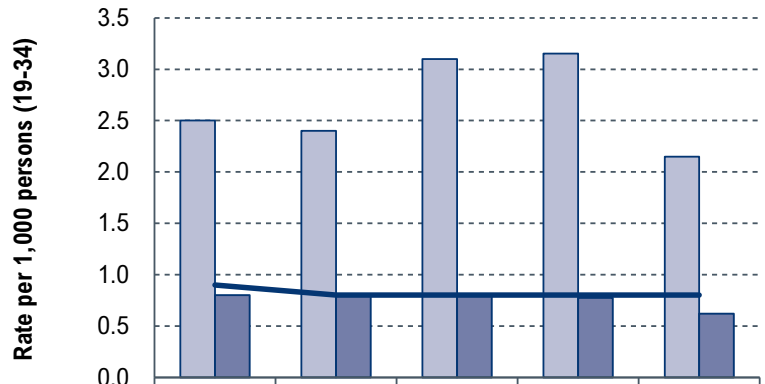
Figure 13: **Rate of hospitalisation for acute asthma per 1,000 children aged 13–18 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	1.2	1.8	1.1	1.9	1.5
Non-Aboriginal	1.0	1.0	1.1	0.9	0.5
Target (≤)	0.9	0.9	0.9	0.9	0.9

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

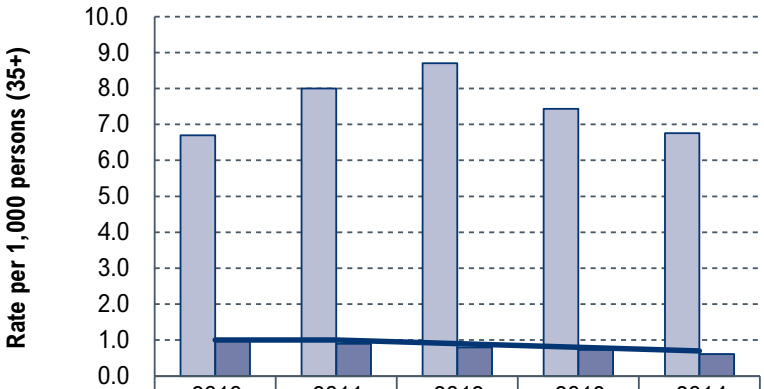
Figure 14: **Rate of hospitalisation for acute asthma per 1,000 persons aged 19–34 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	2.5	2.4	3.1	3.2	2.1
Non-Aboriginal	0.8	0.8	0.8	0.8	0.6
Target (≤)	0.9	0.8	0.8	0.8	0.8

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

Figure 15: **Rate of hospitalisation for acute asthma per 1,000 persons aged 35 years and older, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	6.7	8.0	8.7	7.4	6.8
Non-Aboriginal	1.0	0.9	0.8	0.7	0.6
Target (≤)	1.0	1.0	0.9	0.8	0.7

Notes:

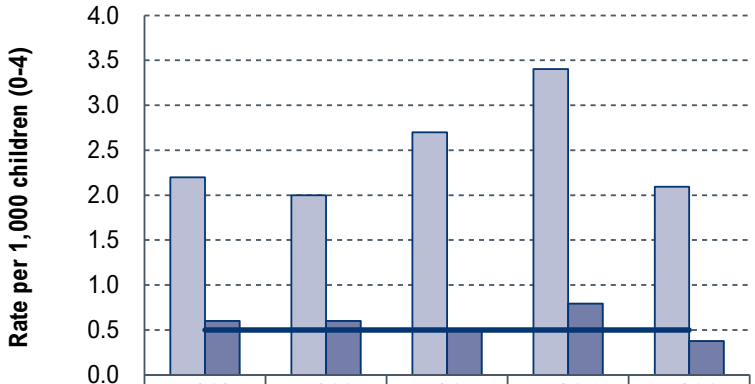
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. For acute asthma, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

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

Acute bronchitis

In 2014, the rate of non-Aboriginal children in country WA hospitalised for acute bronchitis was 0.4 for every 1,000 children (see Figure 16) this was below the target of 0.5 per 1,000 children. The rate of Aboriginal children hospitalised for acute bronchitis was 2.1 for every 1,000 children. This was an improvement from 2013.

Figure 16: **Rate of hospitalisation for acute bronchitis per 1,000 children aged 0–4 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	2.2	2.0	2.7	3.4	2.1
Non-Aboriginal	0.6	0.6	0.5	0.8	0.4
Target (≤)	0.5	0.5	0.5	0.5	0.5

Notes:

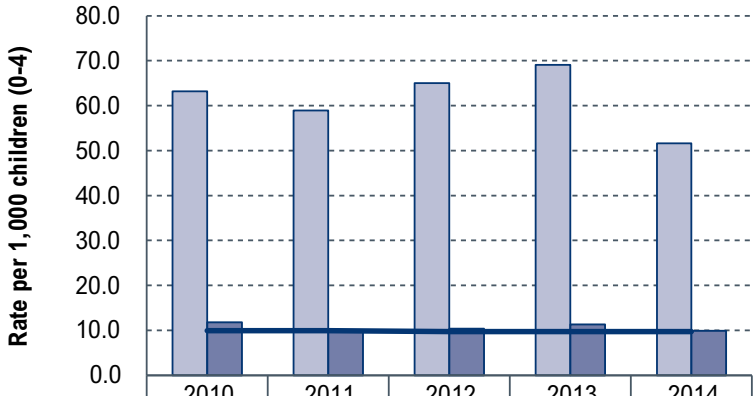
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. For acute bronchitis, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

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

Bronchiolitis

In 2014, the rate of hospitalisation for bronchiolitis was 51.6 per 1,000 for Aboriginal children and 9.9 per 1,000 for non-Aboriginal children (see Figure 17) in country WA. The rate for both Aboriginal and non-Aboriginal children has declined since 2013.

Figure 17: **Rate of hospitalisation for bronchiolitis per 1,000 children aged 0–4 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	63.2	58.9	65.0	69.1	51.6
Non-Aboriginal	11.8	9.7	10.4	11.4	9.9
Target (≤)	9.9	9.9	9.7	9.7	9.7

Notes:

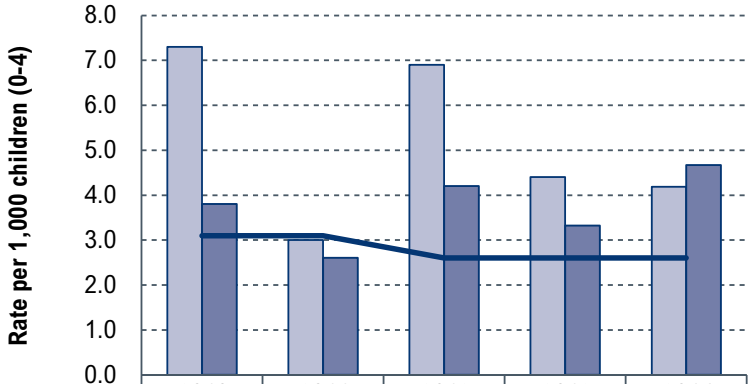
1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. For bronchiolitis, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

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

Croup

In 2014, the rate of Aboriginal and non-Aboriginal children in country WA hospitalised for croup was 4.2 and 4.7 respectively (see Figure 18). The results were above the target.

Figure 18: **Rate of hospitalisation for croup per 1,000 children aged 0–4 years, 2010–2014**



	2010	2011	2012	2013	2014
Aboriginal	7.3	3.0	6.9	4.4	4.2
Non-Aboriginal	3.8	2.6	4.2	3.3	4.7
Target (≤)	3.1	3.1	2.6	2.6	2.6

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. For croup, caution should be taken in the interpretation of the rates of hospitalisation of Aboriginal people due to small population numbers that can result in significant variations across reporting years.

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

Rate of hospitalisation for falls in older persons

Outcome 2
Effectiveness KPI

Rationale

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

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

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

Target

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

Results

In 2014, the rate of hospitalisations for falls in Aboriginal people in country WA populations decrease in the 55-64 and 80 years and over age groups with a slight increase in the 65-79 year age group. The rate for non-Aboriginal people increase slightly in age groups 55-64 and 65-79 but reported a decline in the 80 years and over age group (see Table 20).

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

Table 20: **Rate of hospitalisations for falls per 1,000 by age group, 2010–2014**

Age group (years)		Years					Target
		2010	2011	2012	2013	2014	
55–64	Aboriginal	29.1	40.1	28.1	42.6	**26.0**	**0.5 per cent per annum reduction for a sustained period for both subgroup populations by 2020**
	Non-Aboriginal	4.6	5.9	5.7	5.9	**6.1**	
65–79	Aboriginal	44.1	51.0	40.8	43.1	**45.4**	
	Non-Aboriginal	16.7	18.7	18.7	21.0	**21.1**	
80+	Aboriginal	70.2	58.8	91.5	119.7	**111.7**	
	Non-Aboriginal	83.7	97.3	101.7	109.3	**104.3**	

Notes:

1. The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.
2. Caution needs to be taken in the interpretation of the rate of hospitalisation for falls (per 1,000 population) among the Aboriginal population. Small population numbers have resulted in significant variations across the years and comparison is not recommended.

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

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

Outcome 2
Effectiveness KPI

Rationale

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

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

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

Target

The target for 2014 was 70 per cent.

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

Results

In 2014, 48.5 per cent of country WA people who were admitted to a WA country public mental health inpatient unit had been in contact with a community–based public mental health non-admitted service in the previous seven days (see Table 21). This result was below the target of 70 per cent but an increase on previous years.

Table 21: **Percentage of contacts with a community-based mental health non-admitted service seven days prior to admission, 2010–2014**

	Year					
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
Pre-admission community-based contacts	45.6	44.6	41.2	43.0	**48.5**	**70**

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

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

Outcome 2
Effectiveness KPI

Rationale

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

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

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

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

Target

In 2014, the target was 75 per cent.

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

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

Results

In 2014, 62.5 per cent of country WA people who were admitted to a public mental health inpatient unit had been in contact with a community-based public mental health non-admitted service within seven days following their discharge (see Table 22). This result was higher than 2013 and continues to trend upwards.

Table 22: **Percentage of contacts with a community-based mental health non-admitted service seven days post discharge, 2010–2014**

	Year					
	2010 (%)	2011 (%)	2012 (%)	2013 (%)	2014 (%)	Target (%)
Post-admission community-based contacts	48.6	45.2	51.0	55.8	**62.5**	**75**

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

Average cost per capita of Population Health Units

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

Rationale

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

Population health units support individuals, families and communities to increase control over and improve their health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by utilising the *WA Health Promotion Strategic Framework 2012–2016*. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

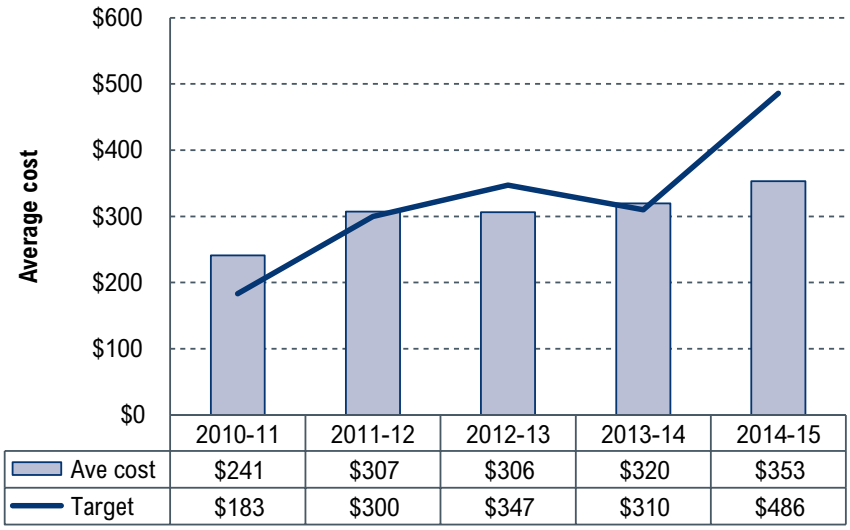
The target for 2014–15 is $486 per capita of population health units.

A result below the target is desirable.

Results

In 2014–15, the average cost per capita of country WA Population Health Units was $353 (see Figure 19). The Southern Inland Health initiative funding increased in 2014–15 supporting greater investment in population health services, this has contributed to higher costs in this indicator.

Figure 19: **Average cost per capita of Population Health Units, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$241	$307	$306	$320	$353
Target	$183	$300	$347	$310	$486

Note: The total population used in the calculation of this KPI is based on the Australian Bureau of Statistics Estimated Resident Population for 2013 for areas defined by the Australian Standard Geographical Classification.

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

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

Outcome 2
Efficiency KPI
Service 9:
Continuing care

Rationale

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

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

Target

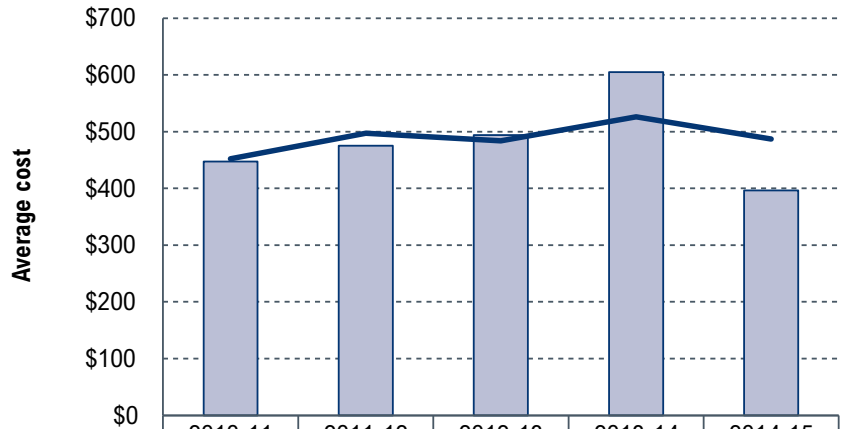
The target for 2014–15 is $487 per bed-day in a specified residential care facility flexible care (hostels) and nursing home type residents. For 2014–15, the target has been changed to reflect the unit cost within the 2015–16 budget papers.

A result below the target is desirable.

Results

In 2014–15, the average cost per bed-day for specified residential care facilities, flexible care and nursing home type residents in country WA was $397 (see Figure 20), which is below the target. The lower than average cost is attributed to improved costing delineation and accuracy between specified residential care and hospital services.

Figure 20: **Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$447	$475	$494	$605	$397
Target	$452	$497	$484	$526	$487

Note: The 2014–15 target was revised to the 2014–15 budget figure within the 2015–16 budget papers.

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

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

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

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

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

Target

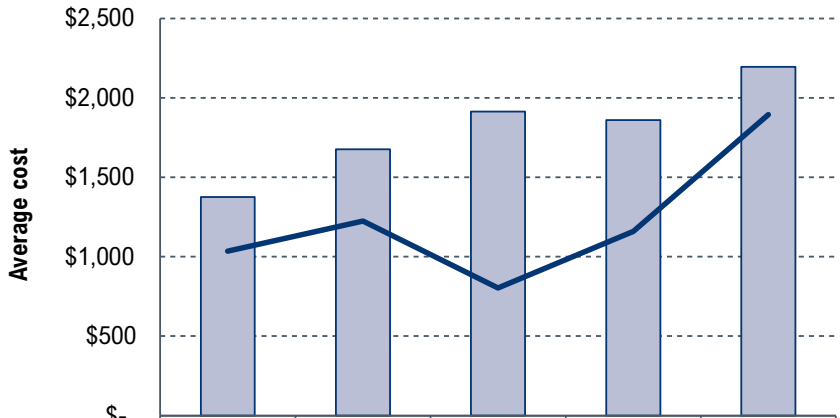
The target for 2014–15 is $1,894 per bed-day in a specialised mental health unit.

A result below the target is desirable.

Results

In 2014–15, the average cost per bed-day in a specialised mental health inpatient unit in country WA was $2,194 (see Figure 21). The higher expenditure to target is partly attributable to additional costs borne by WA Country Health Service that were not included in the target methodology or the Mental Health Commission service provision agreement.

Figure 21: **Average cost per bed-day in specialised mental health inpatient units, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$1,375	$1,676	$1,914	$1,859	$2,194
Target	$1,034	$1,225	$804	$1,159	$1,894

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

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

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

Outcome 2
Efficiency KPI
Service 10: Contracted mental health

Rationale

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

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

Target

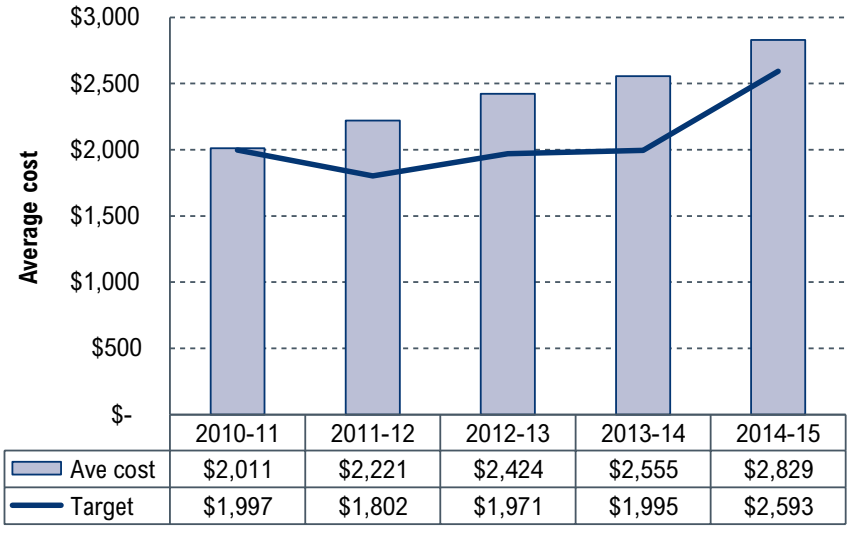
The target for 2014–15 is $2,593 per three month period of care for a person receiving public community mental health services.

A result below the target is desirable.

Results

In 2014–15, the average cost per three month period of care for a person receiving public community mental health services in country WA was $2,829. The higher expenditure to target is partly attributable to additional costs borne by WA Country Health Service that were not included in the target methodology or the Mental Health Commission service provision agreement.

Figure 22: **Average cost per three month period of care for a person receiving public mental health services, 2010–11 to 2014–15**



	2010-11	2011-12	2012-13	2013-14	2014-15
Ave cost	$2,011	$2,221	$2,424	$2,555	$2,829
Target	$1,997	$1,802	$1,971	$1,995	$2,593

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

Ministerial directives

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

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

Summary of board and committee remuneration

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

Table 23: **Summary of State Government boards and committees within the WA Country Health Service, 2014–15**

Board/Committee name	Total remuneration ($)
Albany Medical Advisory Committee	0
Blackwood District Health Advisory Council	574
Blackwood Hospital Medical Advisory Council	0
Bunbury District Health Advisory Council	5,156
Bunbury Hospital Medical Advisory Council	2,720
Busselton Medical Advisory Council	0
Broome and Surrounding Communities District Health Advisory Council	0
Central Great Southern District Health Advisory Council	8,101
Central Great Southern Medical Advisory Committee	2,310
Denmark Medical Advisory Committee	0
Donnybrook Hospital Medical Advisory Council	0
Derby and Surrounding Communities District Health Advisory Council	0
Eastern District Health Advisory Council (Wheatbelt)	6,258
Eastern Medical Advisory Council (Wheatbelt)	2,422
Gascoyne District Health Advisory Council	1,584

Board/Committee name	Total remuneration ($)
Geraldton District Health Advisory Council	0
Geraldton Medical Advisory Council (name changed to Midwest Medical Advisory Committee)	154
Goldfields District Health Advisory Council	2,264
Kununurra/Wyndham and Surrounding Communities District Health Advisory Council (name changed to East Kimberley District Health Advisory Council)	550
Leschenault District Health Advisory Council	100
Lower Great Southern District Health Advisory Council	3,519
Margaret River Medical Advisory Council	1,965
Midwest District Health Advisory Council	4,596
Naturaliste District Health Advisory Council	300
Northern and Remote Country Governing Council	142,414
Plantagenent Cranbrook Health Service Medical Advisory Committee	701
Port Hedland Medical Advisory Council (name changed to East Pilbara-Hedland Health Campus Medical Advisory Committee)	0
South East District Health Advisory Council	0
Southern Country Governing Council	166,581
Southern District Health Advisory Council (Wheatbelt)	0
Southern District Medical Advisory Council (Wheatbelt)	550
Warren District Health Advisory Council	1,050
Warren District Hospital Medical Advisory Council	900
Western District Health Advisory Council (Wheatbelt)	10,952
Western Medical Advisory Council (Wheatbelt)	0
WA Country Health Service Audit Liaison Committee	0

Other financial disclosures

Pricing policy

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

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

Please refer to the *Department of Health Annual Report 2014–15* for further information on the pricing policy.

Capital works

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

Please refer to the *Department of Health Annual Report 2014–15* for financial details of the full WA Country Health Service capital works program.

Employment profile

Government agencies are required to report a summary of the number of employees, by category, in comparison with the preceding financial year. Table 24 shows the year-to-date (June 2015) number of WA Country Health Service full-time equivalent employees for 2013–14 and 2014–15.

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

Category	Definition	2013–14	2014–15
Administration and clerical	Includes all clerical-based occupations together with patient-facing (ward) clerical support staff.	1,528	1,596
Agency	Includes full-time equivalent employees associated with the following occupational categories: administration and clerical, medical support, hotel services, site services, medical salaried (excludes visiting medical practitioners) and medical sessional.	85	118

Category	Definition	2013–14	2014–15
Agency nursing	Includes workers engaged on a 'contract for service' basis. Does not include workers employed by NurseWest.	92	116
Assistants in nursing	Support registered nurses and enrolled nurses in delivery of general patient care.	51	56
Dental nursing	Includes registered dental nurses and dental clinic assistants.	0	0
Hotel services	Includes catering, cleaning, stores/supply, laundry and transport occupations.	1,271	1,267
Medical salaried	Includes all salary-based medical occupations including interns, registrars and specialist medical practitioners.	356	378
Medical sessional	Includes specialist medical practitioners that are engaged on a sessional basis.	14	13
Medical support	Includes all allied health and scientific/technical related occupations.	796	803
Nursing	Includes all nursing occupations. Does not include agency nurses.	2,877	2,913
Site services	Includes engineering, garden and security-based occupations.	177	171
Other categories	Includes Aboriginal and ethnic health worker related occupations.	137	132
	Total	**7,384**	**7,563**

Notes:

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

Staff development

WA Country Health Service aims to ensure the delivery of safe, high quality care and services. This is achieved by supporting and facilitating learning programs that provide for the development and maintenance of professional skills through contemporary workforce education and learning pathways.

Professional development for all staff is provided in a range of formats including eLearning, face-to-face, videoconference, essential skills days and workplace-based education. WA Country Health Service also encourages participation in mentoring and coaching as informal forms of professional development. In addition, WA Country Health Service aims to standardise learning and development approaches to ensure consistent standards and content across and within regions.

WA Country Health Service staff, agency staff, locums, contractors and volunteers use the WA Country Health Service Capabiliti Learning Management System to access core essential and role specific training as well as participating in local training programs. Clinical skills development is a major component of staff development programs. The Capabiliti Learning Management System includes a range of training resources that support the National Safety and Quality Health Standards.

In 2014–15, a number of initiatives have been planned, developed and implemented including:

- Management Development Program modules which provide customised management training to new and aspiring managers
- a nursing and midwifery clinical management program, currently in the design phase, which aims to support new and existing Senior Registered Nurses
- a project which articulates clinical competencies and scope of practice pertinent to acute service for nursing and midwifery staff.

In addition, a new Workforce Learning and Development policy and procedure was developed to provide governance for program initiation, design and development. This acknowledges the important role of consumers in the design of workforce learning programs.

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

Industrial relations

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

For further details please refer to the *Department of Health Annual Report 2014–15*.

Workers' compensation

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

WA Country Health Service is committed to providing staff with a safe and healthy work environment, and recognises this as pivotal in attracting and maintaining the workforce necessary to deliver effective and efficient health care services. In 2014–15 a total of 365 workers' compensation claims were made (see Table 25).

Table 25: **Number of WA Country Health Service workers' compensation claims in 2014–15**

Employee category	Number
Nursing Services/Dental Care Assistants	145
Administration and Clerical	38
Medical Support	26
Hotel Services	127
Maintenance	21
Medical (salaried)	8
Total	**365**

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

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

Governance requirements

Pecuniary interests

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

In 2014–15, no senior officers of the WA Country Health Service declared a pecuniary interest.

Other legal disclosures

Advertising

In accordance with section 175Z of the *Electoral Act 1907*, WA Country Health Service incurred a total advertising expenditure of $21,295 in 2014-15 (see Table 26). There was no expenditure in relation to advertising agencies, market research, polling, or direct mail organisations.

Table 26: **Summary of WA Country Health Service advertising for 2014–15**

Summary of advertising	Amount ($)
Advertising agencies	0
Market research organisations	0
Polling organisations	0
Direct mail organisations	0
Media advertising organisations	21,495
Total advertising expenditure	**21,495**

The organisations from which advertising services were procured and the amount paid to each organisation are detailed in Table 27.

Table 27: **WA Country Health Service advertising, by class of expenditure, 2014–15**

Recipient /organisations	Amount ($)
Advertising agencies	
Total	**0**
Market research organisations	
Total	**0**
Polling organisations	
Total	**0**
Direct mail organisations	
Total	**0**
Media advertising organisations	
Adcorp Australia Limited	14,615
Carat Australia Media Services Pty Ltd	171
Denmark Bulletin	22
Directories Of Australia Pty Ltd	886
Gnowangerup Community Newspaper	6
Kellerberrin Pipeline Newsletter	19
Market Creations Pty Ltd	1,900
Minnis Journals Pty Ltd	1,500
My South West	45
Pingelly Times	30
Rural Press Region Media WA Pty Ltd	131
Rural Press Regional Media	33
The Fence Post	60
The Muddy Waters	720
Watershed News Incorporated	24
The West Australian	1,333
Total	**21,495**

Disability access and inclusion plan

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

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

WA Health ensures compliance with this and all other principles through the implementation of the *WA Health Disability Access and Inclusion Plan 2010–15*.

The following information details the current initiatives and programs being implemented by the WA Country Health Service inline with the *WA Health Disability Access and Inclusion Plan 2010–15*.

Access to service

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

This has been achieved through progressive implementation of the *WA Country Health Service Disability Action and Inclusion Plan 2010–15* at both a regional and network level. This has included actions such as ensuring staff are made aware of the *Disability Services Act 1993* and both the WA Health and WACHS Disability Access and Inclusion Plans through recruitment and orientation processes and during their performance development.

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

Access to buildings

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

The new Busselton Health Campus and Albany Health Campus have considered the needs of people with disabilities through incorporation of the following design features:

- easy wheelchair access
- wide corridors and doorways
- adequate disabled parking located close to main entrances
- non-slip surfaces in ward areas for those persons requiring walking aids.

WA Country Health Service continues to review its operations to ensure they meet the requirements of the *WA Country Health Service Disability Action and Inclusion Plan 2010–15*. Regional health services undertake regular audits of facilities and buildings and address issues that arise from the audits through existing minor works and capital works approval processes.

Access to information

Stipulations under the Department of Health Communications Style Guide have been adopted in the preparation of all information developed for public distribution. All information is available in alternative formats upon request. WA Country Health Service facilitates the use of interpreters for people who have difficulty speaking, hearing, seeing and/or reading. Sound Shuttle Hearing Loop Systems have been installed in some regional health services.

WA Country Health Service promotes disability access and inclusion through its own information posters as well as those provided by the Disability Services Commission. Information on patient rights and responsibilities is displayed at WA Country Health Service sites. This specifies that information can be made available in alternative formats.

Quality of service by staff

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

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

Opportunity to provide feedback

WACHS conducts regular regional and area-wide audits of its complaints processes, especially in relation to ensuring that people with a disability have the same opportunities as others in the community.

To assist an individual to register a complaint, regions have patient and customer liaison officers. Regions review complaint forms and lodgment processes to ensure these provide the appropriate platform for initiating a complaint. WA Country Health Service provides information on the complaint process for the hearing impaired and can facilitate access to translating and interpreting services upon request.

Information on how to access Advocare support services is available across the WA Country Health Service enabling community members, including those with a disability, to state their concerns to an external body if required.

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

Participation in public consultation

Public consultations undertaken by WA Country Health Service actively seek to include the voice of consumers with disabilities. People with disabilities are encouraged to participate in and have been appointed to WA Country Health Service District Health Advisory Councils. Information and advice from District Health Advisory Councils informs health services as to the appropriate healthcare services to meet the needs of community members, including those with a disability.

Recently WA Country Health Service undertook public consultation to inform development of the *WA Country Health Service Disability Action and Inclusion Plan 2015–20*. Advertising for the consultation was undertaken via radio, newspaper, and online and information was made available in a variety of accessible formats.

Compliance with public sector standards

Details of the WA Health compliance with the *WA Public Sector Code of Ethics, Public Sector Standards in Human Resource Management* and the *WA Health Code of Conduct* can be found in the *Department of Health Annual Report 2014–15*.

Freedom of Information

The *Western Australian Freedom of Information Act 1992* gives all Western Australians a right of access to information held by the WA Country Health Service.

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

- medical records
- patient records
- corporate records.

Members of the public can access varying types of WA Country Health Service information from the WA Health internet website WA Health (http://ww2.health.wa.gov.au). This includes health – related reports and publications, information concerning health service performance, research and health data/statistics.

Access to information can also be made through a Freedom of Information application that involves the lodgement of a written request. The written request must provide sufficient detail to enable the application to be processed including contact details and an Australian address for correspondence. In the case of an application for amendment or annotation of personal information, it is required that the request include:

- detail of the matters in relation to which the applicant believes the information is inaccurate, incomplete, out-of-date or misleading
- the applicant's reasons for holding that belief
- detail of the amendment that the applicant wishes to have made.

Applications should be addressed to the relevant Freedom of Information Office, and may be lodged in person, by mail, email or facsimile. Local contact details include:

Region	Contact Details
Central Office	Manager Policy – 189 Wellington Street, PERTH WA 6000
Goldfields	Freedom of Information Clerk – Locked Bay 7, KALGOORLIE WA 6433
Great Southern	Health Information Manager – PO Box 252, ALBANY WA 6331
Kimberley	Coordinator Executive Services – Locked Bag 4011, BROOME WA 6725
Midwest	Clinical Information Coordinator – PO Box 22, GERALDTON WA 6531
Pilbara Region	Health Information Manager – Hedland Health Campus, 26-34 Colebatch Way, SOUTH HEDLAND WA 6722
South West	Freedom of Information/Complaints Officer – PO Box 1510, BUNBURY WA 6230
Wheatbelt	Administration Coordinator – PO Box 690, NORTHAM WA 6401

All requests for information can be granted, partially granted or may be refused in accordance with the *Western Australian Freedom of Information Act 1992*. The applicant can appeal if dissatisfied with the process or the reasons provided, in the event of an adverse access decision.

For the year ending 30 June 2015, the WA Country Health Service dealt with 2,712 applications for information, of which 2,440 applications were granted full or partial access and 58 were refused (see Table 28).

Table 28: **Freedom of Information applications to the WA Country Health Service in 2014–15**

Summary of number of applications	Number
Applications carried over from 2013–14	71
Applications received in 2014–15	2,594
Total number of applications active in 2014–15	2,665
Applications granted – full access	764
Applications granted – partial or edited access[1]	1,676
Applications withdrawn by applicant	47
Applications refused	58
Applications in progress	158
Other applications[2]	9
Total number of applications dealt with in 2014–15	**2,712**

Notes:

1. Partial or edited access to information includes the number of applications accessed in accordance with sections 28 of the Freedom of Information Act 1992 (WA).
2. Other applications include exemptions, deferments or transfers to other departments/agencies.

Recordkeeping plans

The *State Records Act 2000* was established to mandate the standardisation of statutory recordkeeping practices for every State Government agency. Government agency practice is subject to the provision of the Act, the standards and policies. Government agencies are also subject to scrutiny by the State Records Commission.

WA Country Health Service's Recordkeeping Plan and supporting framework have been developed to specifically address the geographic rural and remote challenges in country WA. The recordkeeping plan and framework was approved by the State Records Commission on 3 August 2013 for a 5-year period.

WA Country Health Service Records and the electronic document and records management system (TRIM) team have developed a central support model that covers capture and creation activities through the delivery of an effective and measurable training and support program. The program has been developed as an online training and assessment tool, in conjunction with Records and TRIM Services. This service provides helpdesk assistance and support. The main aim of the program has been to ensure staff are aware of their recordkeeping obligations and possess the appropriate skills to manage corporate records effectively.

During 2014–15, a number of information management projects have been completed to ensure the capture of information assets in the TRIM system. These have included:

- TRIM implementation at the Wheatbelt and Pilbara regional executive offices and consolidation of the electronic document and records management system use within the South West region
- upgrading server infrastructure of the electronic document and records management system to support the longevity of the system
- capture of historic and significant electronic records previously stored within regional shared drives
- establishment of the electronic document and records management system Business Advisory Group for WA Health to promote the use of TRIM.

The success of the information management program within the provisions of the WA Country Health Service Recordkeeping Plan and the above mentioned projects have contributed to an increase of users by over 54 per cent compared to the same period last year. WA Country Health Service TRIM users contributed to the corporate memory with over 265,000 records saved during 2014–15.

Substantive equality

WA Health contributes towards achieving substantive equality for all Western Australians by continuing to concentrate on the *Policy Framework for Substantive Equality*.

WA Country Health Service is committed to improving the health outcomes of Aboriginal people through a coordinated approach to the planning, funding and delivery of Aboriginal health programs. The Aboriginal Health Improvement Unit is responsible for procurement of Aboriginal health programs, increasing Aboriginal workforce and cultural security.

Achievements in 2014–15 include:

- ongoing implementation of the *WA Country Health Service Aboriginal Employment Strategy 2014–18*
- ongoing promotion and implementation of cultural security initiatives for Aboriginal staff and clients
- ongoing development, implementation, monitoring and reporting of Aboriginal health programs delivered through the *WA Footprints to Better Health Strategy 2014–18*
- establishment of Regional Aboriginal Health Consultant positions in all regions
- establishment of Aboriginal school-based traineeships in the Great Southern, Goldfields and Kimberley regions.

Occupational safety, health and injury

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

Commitment to occupational safety and health injury management

WA Country Health Service remains committed to Occupational Safety and Health through the Occupational Safety and Health Statement of Commitment, released in March 2014.

In addition, the WA Country Health Service *Occupational Safety and Health Policy* and the *Occupational Safety and Health Management Framework* provide guidance and direction for managers and staff to fulfil specific occupational safety and health responsibilities. This supports the development and implementation of safe systems of work and work practices.

Occupational safety and health risk is also managed through a suite of policies and procedures including:

- Safety Risk Reporting Procedure
- Safe Work Method Statements
- Personal Protective Equipment Policy
- workplace inspections
- risk assessments.

Compliance with occupational safety and health injury management

To support the workers compensation process including the development of return to work programs, WA Country Health Service provides an injury management service. This service is guided by the requirements of both the *Workers' Compensation and Injury Management Act 1981* and the *Workers' Compensation Code of Practice (Injury Management) 2005*.

Employee consultation

As part of a formative consultative process WA Country Health Service has established Occupational Safety and Health Committees in each region. Committees support the dissemination of safety information, performance indicators and provide opportunities for staff involvement and communication in occupational safety and health work practices.

Occupational Safety and Health Committees are supported by a WA Country Health Service Occupational Safety and Health Network that ensures consultation and coordination on occupational safety and health matters between regions is consistent and standardised across country WA.

Employee rehabilitation

WA Country Health Service is committed to assisting injured workers to return to work as soon as is medically appropriate through its Injury Management System. The aim of the Injury Management System is to ensure that the WA Country Health Service is able to respond to Workers' Compensation claims in an appropriate timely manner so that injured workers can remain at work or return to work at the earliest appropriate time.

Injury management services utilise a case management approach which involves the relevant Injury Management Coordinator, the injured worker and their treating practitioner. This ensures the injury management process and vocational rehabilitation is commenced as early as possible.

WA Country Health Service supports return to work programs where required. Return to work programs are established in consultation with the injured employee and in accordance with the *Workers' Compensation and Injury Management Act 1981*.

Occupational safety and health assessment and performance indicators

In 2014, WA Health conducted an internal audit to evaluate the effectiveness of occupational safety and health practices in accordance with the Code of Practice, *Occupational Safety and Health in the Western Australian Public Sector (2007)*.

Audit findings for WA Country Health Service were presented in January 2015 and identified four improvement recommendations, of which two have been completed. The remaining two recommendations are planned for completion between September and October 2015.

Table 29: **WA Country Health Service's occupational safety, health and injury performance for 2014–15**

	2014–15
Fatalities	0
Lost time injury/diseases (LTI/D) incidence rate (rate per 100)	2.35
Lost time injury severity rate (rate per 100)	39.33
Percentage of injured workers returned to work within 26 weeks	69.8%
Percentage of managers trained in occupational safety, health and injury management responsibilities	30.6%

Appendices

Appendix 1: WA Country Health Service addresses and locations

WA Country Health Service (WACHS)

Street address:
189 Wellington Street, PERTH WA 6000
Postal address:
PO Box 6680, EAST PERTH BUSINESS CENTRE WA 6892
Phone: (08) 9223 8500
Fax: (08) 9223 8599
Email: centralofficereception.WACHS@health.wa.gov.au
Web: www.wacountry.health.wa.gov.au

WACHS – Kimberley

Street address:
Yamamoto House, Unit 4, 9 Napier Terrace,
BROOME WA 6725
Postal address:
Locked Bag 4011, BROOME WA 6725
Phone: (08) 9194 1600
Fax: (08) 9194 1666
Email: KHS.ExecSecretary@health.wa.gov.au

WACHS – Pilbara

Street address:
Level 2, State Government Building, Corner Brand and Tonkin Street, SOUTH HEDLAND WA 6722
Postal address:
PMB 12, SOUTH HEDLAND WA 6722
Phone: (08) 9174 1600
Fax: (08) 9172 4167
Email: wachspb_execservices@health.wa.gov.au

WACHS – Midwest

Street address:
Ground floor, 45 Cathedral Avenue,
GERALDTON WA 6530
Postal address:
PO Box 22, GERALDTON WA 6531
Phone: (08) 9956 2209
Fax: (08) 9956 2421
Email: Margaret.Denton@ health.wa.gov.au

WACHS – Wheatbelt

Street address:
Shop 4, 78 Wellington Street,
NORTHAM WA 6401
Postal address:
PO Box 690, NORTHAM WA 6401
Phone: (08) 9621 0700
Fax: (08) 9621 0701
Email: wheatbeltreception@health.wa.gov.au

WACHS – Goldfields

Street address:
The Palms, 68 Piccadilly Street,
KALGOORLIE WA 6430
Postal address:
PO Box 716, KALGOORLIE WA 6433
Phone: (08) 9080 5710
Fax: (08) 9080 5724
Email: Geraldine.ennis@health.wa.gov.au

WACHS – South West

Street and postal address:
4th floor, Bunbury Tower, 61 Victoria Street,
BUNBURY WA 6230
Phone: (08) 9781 2350
Fax: (08) 9781 2385
Email: execservices.wachssw@health.wa.gov.au

WACHS – Great Southern

Street address:
Albany Health Campus, Corner Warden Avenue
and Hardie Road, ALBANY WA 6330
Postal address:
PO Box 165, ALBANY WA 6331
Phone: (08) 9892 2672
Fax: (08) 9841 8557
Email: gs.ces@health.wa.gov.au

Appendix 2: Board and committee remuneration

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Albany Medical Advisory Committee				
Chair	Dr Frans Cronje	Per meeting	12 months	$0
Member	Dr Clark Wasiun	Not eligible	Not applicable	$0
Member	Dr Pui Poon	Not eligible	Not applicable	$0
Member	Dr Michelle Middlemost	Not eligible	Not applicable	$0
Member	Dr Alasdair Millar	Not eligible	Not applicable	$0
Member	Dr Paul Salmon	Not eligible	Not applicable	$0
Member	Dr David Tadj	Not eligible	Not applicable	$0
Member	Dr Justin Yeung	Not eligible	Not applicable	$0
Member	Dr Brian Cunningham	Not eligible	Not applicable	$0
Member	Dr Thomas Bowles	Not eligible	Not applicable	$0
Member	Dr Ben Onyeka	Not eligible	Not applicable	$0
Ex-officio Member	Dr Helen Van Gessel	Not eligible	Not applicable	$0
Ex-officio Member	Barbara Marquand	Not eligible	Not applicable	$0
Ex-officio Member	Kylie Oliver	Not eligible	Not applicable	$0
Ex-officio Member	Cindy Stainton	Not eligible	Not applicable	$0
			Total:	**$0**
Blackwood District Health Advisory Council				
Chair	Max Barrington	Per meeting	12 months	$0
Deputy Chair	Philippe Kaltenrieder	Per meeting	12 months	$216
Member	Bonnie Hook	Per meeting	12 months	$0
Member	Patricia Twiss	Per meeting	12 months	$258
Member	Michael Wood	Per meeting	12 months	$100
Member	Terry Linz	Per meeting	12 months	$0
Ex-officio Member	Anne-Maree Martino	Per meeting	12 months	$0
			Total:	**$574**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Blackwood Hospital Medical Advisory Council				
Chair	Dr Michael Hoar	Per meeting	12 months	$0
Member	Dr Michael Dewing	Not eligible	Not applicable	$0
Member	Dr Michel Mel	Not eligible	Not applicable	$0
Member	Dr Thomas Nigel Jones	Not eligible	Not applicable	$0
Member	Dr Neil Wells	Not eligible	Not applicable	$0
Member	Dr Karl Erath	Not eligible	Not applicable	$0
Ex-officio Member	Anne-Maree Martino	Not eligible	Not applicable	$0
Ex-officio Member	Marie Hill	Not eligible	Not applicable	$0
Ex-officio Member	Nicholas Booker	Not eligible	Not applicable	$0
Ex-officio Member	Michael Cock	Not eligible	Not applicable	$0
			Total:	**$0**
Bunbury District Health Advisory Council				
Chair	John Gardyne	Per meeting	12 months	$2,246
Deputy Chair	Margaret Smith	Per meeting	12 months	$0
Member	Lera Bennell	Per meeting	12 months	$0
Member	Joan Birkett	Per meeting	12 months	$1,890
Member	Lynne King	Per meeting	12 months	$1,020
Member	Margaret Leatherborrow	Per meeting	12 months	$0
Member	Maria Fitzgerald	Per meeting	6 months	$0
Member	Joanne Penman	Per meeting	6 months	$0
Member	Mark Lawther	Per meeting	6 months	$0
			Total:	**$5,156**
Bunbury Hospital Medical Advisory Council				
Chair	Dr Stephen Hinton	Per meeting	12 months	$2,720
Member	Yvonne Bagwell	Not eligible	Not applicable	$0
Member	Dr Adam Coulson	Not eligible	Not applicable	$0
Member	Dr Emma Crampin	Not eligible	Not applicable	$0
Member	Dr Iain Gilmore	Not eligible	Not applicable	$0
Member	Dr Samir Heble	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Andrea Hickert	Not eligible	Not applicable	$0
Member	Dr Neil Kling	Not eligible	Not applicable	$0
Member	Dr Vijaya Mohan	Not eligible	Not applicable	$0
Member	Dr Dianne Mohen	Not eligible	Not applicable	$0
Member	Dr Koula Pratsis	Not eligible	Not applicable	$0
Member	Dr Jonathan Purday	Not eligible	Not applicable	$0
Member	Dr Ramesh Parthasarathy	Not eligible	Not applicable	$0
Member	Marianne Slattery	Not eligible	Not applicable	$0
Member	Dr Ivan Jansz	Not eligible	Not applicable	$0
Member	Dr Lila Stephens	Not eligible	Not applicable	$0
Member	Dr Winston McKean	Not eligible	Not applicable	$0
			Total:	**$2,720**
Busselton Medical Advisory Council				
Chair	Dr John Pollard	Per meeting	12 months	$0
Member	Dr Stephen Arthur	Not eligible	Not applicable	$0
Member	Dr Phillip Chapman	Not eligible	Not applicable	$0
Member	Dr Vinod Pushpalingham	Not eligible	Not applicable	$0
Member	Dr Sarah Moore	Not eligible	Not applicable	$0
Member	Dr Sven Geldermann	Not eligible	Not applicable	$0
Member	Dr Trent Healy	Not eligible	Not applicable	$0
Member	Rachel Jenkin	Not eligible	Not applicable	$0
Member	Lucy Murphy	Not eligible	Not applicable	$0
Member	Jeremy Higgins	Not eligible	Not applicable	$0
Member	Chris Love	Not eligible	Not applicable	$0
Member	Lisa Ramakrishnan	Not eligible	Not applicable	$0
Ex-officio Member	Kerry Winsor	Not eligible	Not applicable	$0
			Total:	**$0**
Broome and Surrounding Communities District Health Advisory Council				
Member	Adam Vincent	Not eligible	Not applicable	$0
Member	Alex Ramirez	Not eligible	Not applicable	$0
Member	Dr Harpreet Singh	Not eligible	Not applicable	$0
Member	Chris Mitchell	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Jennifer Bullen	Not eligible	Not applicable	$0
Member	June Walley	Not eligible	Not applicable	$0
Member	Kaz Fitzpatrick	Not eligible	Not applicable	$0
Member	Marie Shinn	Not eligible	Not applicable	$0
Member	Margaret Moore	Not eligible	Not applicable	$0
Member	Mark Malone	Not eligible	Not applicable	$0
Member	Tracey Chamberlain	Not eligible	Not applicable	$0
			Total:	**$0**
Central Great Southern District Health Advisory Council				
Chair	Hilary Harris	Per meeting	12 months	$3,068
Deputy Chair	Gladys Wells	Per meeting	12 months	$1,493
Member	Norma Hersey	Per meeting	12 months	$1,227
Member	Pauline Roosendaal	Per meeting	12 months	$1,334
Member	Bronwyn Bradley	Per meeting	12 months	$369
Member	Lola Brown	Per meeting	12 months	$610
			Total:	**$8,101**
Central Great Southern Medical Advisory Committee				
Chair	Dr Nicholas du Preez	Per meeting	12 months	$2,310
Member	Dr Bilal Ahmad	Not eligible	Not applicable	$0
Member	Dr Ashik Varghese	Not eligible	Not applicable	$0
Member	Dr Arcadie Moscaliov	Not eligible	Not applicable	$0
Member	Dr Samantha Weaver	Not eligible	Not applicable	$0
Member	Dr Ayman Mitri	Not eligible	Not applicable	$0
Member	Dr Petrus Lotter	Not eligible	Not applicable	$0
Member	Dr Anthony King	Not eligible	Not applicable	$0
Member	Dr Oluwole Oluyede	Not eligible	Not applicable	$0
Member	Dr Sarbjit Sidhu	Not eligible	Not applicable	$0
Member	Dr Amir Ishak	Not eligible	Not applicable	$0
Member	Dr Ketharanathan Sitparan	Not eligible	Not applicable	$0
Ex-officio Member	Hazel MacKenzie	Not eligible	Not applicable	$0
Ex-officio Member	Paul Totino	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Ex-officio Member	Robyn Millar	Not eligible	Not applicable	$0
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
			Total:	**$2,310**
Denmark Medical Advisory Committee				
Chair	Dr Hector Faulkner	Per meeting	12 months	$0
Member	Dr Tine Adams	Not eligible	Not applicable	$0
Member	Dr Jane James	Not eligible	Not applicable	$0
Member	Dr Amirthalingan Prathalingam	Not eligible	Not applicable	$0
Ex-officio Member	Sam Barron	Not eligible	Not applicable	$0
Ex-officio Member	Robyn Millar	Not eligible	Not applicable	$0
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
			Total:	**$0**
Donnybrook Hospital Medical Advisory Council				
Chair	Dr Peter Rae	Not eligible	Not applicable	$0
Deputy Chair	Dr Amba Roy-Choudhury	Not eligible	Not applicable	$0
Member	Dr Wietske van der Velden Schuijling	Not eligible	Not applicable	$0
Member	Dr Loren Geyer	Not eligible	Not applicable	$0
Ex-officio Member	Kerry Winsor	Not eligible	Not applicable	$0
Ex-officio Member	Robyn Phillips	Not eligible	Not applicable	$0
Ex-officio Member	Derrick Simpson	Not eligible	Not applicable	$0
Ex-officio Member	Glen Matters	Not eligible	Not applicable	$0
Ex-officio Member	Leanne Northrop	Not eligible	Not applicable	$0
Ex-officio Member	Sharon Lawtie	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Derby and Surrounding Communities District Health Advisory Council				
Chair	Susan Murphy	Not eligible	Not applicable	$0
Member	Bec Smith	Not eligible	Not applicable	$0
Member	Margi Faulkner	Not eligible	Not applicable	$0
Member	Elsia Archer	Not eligible	Not applicable	$0
Member	Lyn Henderson Yates	Not eligible	Not applicable	$0
Member	Jenny Roberts	Not eligible	Not applicable	$0
Member	Dave Dench	Not eligible	Not applicable	$0
Member	Chris Travers	Not eligible	Not applicable	$0
Member	Charles Numendumah	Not eligible	Not applicable	$0
Member	Alis Hart	Not eligible	Not applicable	$0
Member	Darren Perrett	Not eligible	Not applicable	$0
Member	Ruth Southern	Not eligible	Not applicable	$0
			Total:	**$0**
Eastern District Health Advisory Council (Wheatbelt)				
Chair	Onida Truran	Per meeting	12 months	$0
Deputy Chair	Sandra Waters	Per meeting	12 months	$1,522
Member	Wendy Jardine	Not eligible	Not applicable	$0
Member	Jill Hatch	Per meeting	12 months	$0
Member	Alan McAndrew	Per meeting	12 months	$1,870
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Robyn Richards	Per meeting	12 months	$294
Member	Adrian Wesley	Per meeting	12 months	$0
Member	Sharon Hearns	Not eligible	Not applicable	$0
Member	Mary Cowan	Per meeting	12 months	$255
Member	Lyn White	Per meeting	12 months	$2,317
			Total:	**$6,258**
Eastern Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Lines	Per meeting	12 months	$2,422
Member	Dr Adenola Adeleye	Not eligible	Not applicable	$0
Member	Dr Caleb Chow	Not eligible	Not applicable	$0
Member	Dr Modupe Olanrewaju	Not eligible	Not applicable	$0
Member	Dr Jonathan Ruiz	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Mirielsa Ruiz	Not eligible	Not applicable	$0
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Andrew Van Ballegooyen	Not eligible	Not applicable	$0
Member	Dr Patrick Bushe	Not eligible	Not applicable	$0
Member	Dr Gabrielle Adeniyi	Not eligible	Not applicable	$0
Member	Dr Thyagaraj Ramakrishna	Not eligible	Not applicable	$0
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Wendy Jardine	Not eligible	Not applicable	$0
Member	Sharon Hearns	Not eligible	Not applicable	$0
			Total:	**$2,422**
Gascoyne District Health Advisory Council				
Chair	Greg Rose	Per meeting	12 months	$551
Member	Sandra Bell	Per meeting	6 months	$0
Member	Gino Gianatsis	Per meeting	12 months	$716
Member	Leanne Norman	Per meeting	6 months	$0
Member	Cathy Gianatsis	Per meeting	12 months	$0
Member	Jennifer Raymond	Per meeting	12 months	$317
Member	John Newton	Per meeting	6 months	$0
			Total:	**$1,584**
Geraldton District Health Advisory Council				
Chair	Don Rolston	Not eligible	Not applicable	$0
Deputy Chair	Glenn Jones	Not eligible	Not applicable	$0
Member	Sheena Bryne	Not eligible	Not applicable	$0
Member	Glenise Ullrich	Not eligible	Not applicable	$0
Member	Rae Peel	Not eligible	Not applicable	$0
Member	Jodie Green	Not eligible	Not applicable	$0
Member	Kym Coulthard	Not eligible	Not applicable	$0
Member	Fred Block	Not eligible	Not applicable	$0
Member	Todd Teakle	Not eligible	Not applicable	$0
Member	Heather Corbett	Not eligible	Not applicable	$0
Member	Sandra Comeagain	Not eligible	Not applicable	$0
Member	Pam Syme	Not eligible	Not applicable	$0
			Total :	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Geraldton Medical Advisory Council (Name changed to Midwest Medical Advisory Committee)				
Chair	Dr Ian Taylor	Per meeting	12 months	$154
Member	Dr Andrew Jamieson	Not eligible	Not applicable	$0
Member	Dr Roy Varghese	Not eligible	Not applicable	$0
Member	Dr Geoffrey Rudeforth	Not eligible	Not applicable	$0
Member	Dr Helko Schenk	Not eligible	Not applicable	$0
Ex-officio Member	Dr Paul Drury	Not eligible	Not applicable	$0
Member	Marie Norris	Not eligible	Not applicable	$0
Member	Dr Jaques Perry	Not eligible	Not applicable	$0
Member	Dr Sara Armitage	Not eligible	Not applicable	$0
Member	Dr Ken Whiting	Not eligible	Not applicable	$0
			Total:	**$154**
Goldfields District Health Advisory Council				
Chair	Graham Thomson	Per meeting	12 months	$295
Deputy Chair	Kirsty McCluskey	Per meeting	12 months	$90
Member	Margaret Christie	Per meeting	12 months	$230
Member	Debbie Van Luxemborg	Per meeting	12 months	$270
Member	Billie Ingham	Per meeting	12 months	$649
Member	Dave Loudon	Per meeting	12 months	$90
Member	Diane Paddon	Per meeting	12 months	$320
Member	Nola Wolski	Per meeting	12 months	$230
Member	Greg Baxter	Per meeting	12 months	$90
			Total :	**$2,264**
Kununurra/Wyndham and Surrounding Communities District Health Advisory Council (Name changed to East Kimberley District Health Advisory Council)				
Chair	Maxine Middap	Per meeting	12 months	$550
Member	Brenda Bradley	Not eligible	Not applicable	$0
Member	Terry Howe	Not eligible	Not applicable	$0
Member	Jane Parker	Not eligible	Not applicable	$0
Member	Chris Loessl	Not eligible	Not applicable	$0
Member	Donna Hindmarsh	Not eligible	Not applicable	$0
Member	Jane Drew	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	May Lorraine	Not eligible	Not applicable	$0
Member	Marcella Hegarty	Not eligible	Not applicable	$0
Member	Peter Frewen	Not eligible	Not applicable	$0
Member	Robyn Long	Not eligible	Not applicable	$0
Member	Virginia O'Neill	Not eligible	Not applicable	$0
Member	Dr Bill Beresford	Not eligible	Not applicable	$0
			Total:	**$550**
Leschenault District Health Advisory Council				
Chair	Amanda Lovitt	Not eligible	Not applicable	$0
Deputy Chair	William Adams	Per meeting	12 months	$100
Member	Diane Canale	Not eligible	Not applicable	$0
Member	Colin Beauchamp	Not eligible	Not applicable	$0
Member	Vincent Cosentino	Not eligible	Not applicable	$0
			Total :	**$100**
Lower Great Southern District Health Advisory Council				
Chair	Irene Montefiore	Per meeting	12 months	$0
Member	Debbie Blanchette	Per meeting	12 months	$0
Member	Sara Lembo	Per meeting	12 months	$0
Member	Ivan Edwards	Per meeting	12 months	$3,519
Member	Pamela Smyth	Per meeting	12 months	$0
Member	Graham Carthew	Per meeting	12 months	$0
Member	Dr Ceinwen Gearon	Per meeting	12 months	$0
Member	Ruth McLean	Per meeting	12 months	$0
Member	Denise Kay	Per meeting	12 months	$0
Member	Eliza Woods	Per meeting	12 months	$0
Member	Dot Price	Per meeting	12 months	$0
			Total:	**$3,519**
Margaret River Medical Advisory Council				
Chair	Dr Verelle Roocke	Per meeting	12 months	$1,965
Ex-officio Member	Jeremy Higgins	Not eligible	Not applicable	$0
Ex-officio Member	Jennifer King	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	John Pollard	Not eligible	Not applicable	$0
Member	Mary Allen	Not eligible	Not applicable	$0
Member	Alison Abbey	Not eligible	Not applicable	$0
Member	Marie Tweedie	Not eligible	Not applicable	$0
Member	Dr Peter Durey	Not eligible	Not applicable	$0
Member	Dr Ray Clarke	Not eligible	Not applicable	$0
Member	Dr Cathy Milligan	Not eligible	Not applicable	$0
Member	Dr Adam Bancroft	Not eligible	Not applicable	$0
Member	Dr Bob Bucat	Not eligible	Not applicable	$0
Member	Dr John Collis	Not eligible	Not applicable	$0
Member	Dr Marigold Jones	Not eligible	Not applicable	$0
Member	Dr Tagen Robertson	Not eligible	Not applicable	$0
Member	Dr Kirsty MacGregor	Not eligible	Not applicable	$0
Member	Dr Fraser Wood	Not eligible	Not applicable	$0
Member	Dr Shannon Tucker	Not eligible	Not applicable	$0
Member	Dr Graham Velterop	Not eligible	Not applicable	$0
Member	Dr Shaun O'Rourke	Not eligible	Not applicable	$0
Member	Dr Sharyn Bennier	Not eligible	Not applicable	$0
Member	Dr Peter Carroll	Not eligible	Not applicable	$0
Member	Dr Dana Luscher	Not eligible	Not applicable	$0
Member	Dr Richard Roddy	Not eligible	Not applicable	$0
Member	Dr Martin Ibach	Not eligible	Not applicable	$0
Member	Dr Nathalie Maron	Not eligible	Not applicable	$0
Member	Dr Louise Marsh	Not eligible	Not applicable	$0
Member	Dr Allan Walley	Not eligible	Not applicable	$0
Member	Dr Karen Wickham	Not eligible	Not applicable	$0
Member	Dr Gareth Mann	Not eligible	Not applicable	$0
Member	Dr Katina Koukourou	Not eligible	Not applicable	$0
			Total :	**$1,965**
Midwest District Health Advisory Council				
Chair	Merle Isbister	Per meeting	12 months	$1,095
Deputy Chair	Graeme Bedford	Per meeting	12 months	$495
Member	Anne Browning	Per meeting	12 months	$354

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Steph Bligh-Lee	Per meeting	12 months	$258
Member	Iris Annear	Per meeting	12 months	$1,116
Member	Jennifer Teakle	Per meeting	12 months	$650
Member	Lynette Fabling	Per meeting	12 months	$628
			Total :	**$4,596**
Naturaliste District Health Advisory Council				
Chair	Elizabeth Jones	Per meeting	12 months	$60
Deputy Chair	Max Kewish	Per meeting	12 months	$240
Secretary	Leanne Howlett	Not eligible	Not applicable	$0
Member	Lorrae Loud	Not eligible	Not applicable	$0
Member	Creena Holly	Per meeting	12 months	$0
Member	Tanya Gillett	Not eligible	Not applicable	$0
Member	David McDonald	Per meeting	12 months	$0
Member	Naomi Grimshaw	Per meeting	6 months	$0
Member	Jeremy Higgins	Not eligible	Not applicable	$0
Member	Andrea Preece	Not eligible	Not applicable	$0
			Total:	**$300**
Northern and Remote Country Governing Council				
Chair	Nola Wolski	Annual	12 months	$58,450
Deputy Chair	Marani Hutton	Not eligible	Not applicable	$0
Member	Dr Roger Goucke	Not eligible	Not applicable	$0
Member	Dr Philip Montgomery	Not eligible	Not applicable	$0
Member	Sandy Davies	Annual	12 months	$5,058
Member	Maureen Carter	Annual	12 months	$26,302
Member	Mark Casserly	Annual	12 months	$26,302
Member	Brian Wall	Annual	12 months	$26,302
			Total:	**$142,414**
Plantagenet Cranbrook Health Service Medical Advisory Committee				
Chair	Dr Victor Seah	Per meeting	12 months	$701
Member	Dr Carol Fitzpatrick	Not eligible	Not applicable	$0
Member	Dr Ligia Galvez	Not eligible	Not applicable	$0
Member	Dr Amanda Villis	Not eligible	Not applicable	$0
Member	Dr Elaine Sabin	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Ex-officio Member	Ruth York	Not eligible	Not applicable	$0
Ex-officio Member	Ruth Godden	Not eligible	Not applicable	$0
			Total:	**$701**
Port Hedland Medical Advisory Council (Name changed to East Pilbara-Hedland Health Campus Medical Advisory Committee)				
Chair	Dr Ganesan Sakarapani	Not eligible	Not applicable	$0
Member	Dr Philip Montgomery	Not eligible	Not applicable	$0
Member	Dr Farhan Aizaz	Not eligible	Not applicable	$0
Member	Dr Anita Banks	Not eligible	Not applicable	$0
Member	Dr Stephanie Breen	Not eligible	Not applicable	$0
Member	Dr Christoper Buck	Not eligible	Not applicable	$0
Member	Dr Bruce Campbell	Not eligible	Not applicable	$0
Member	Dr Cystal Claite	Not eligible	Not applicable	$0
Member	Dr Hans Dahl	Not eligible	Not applicable	$0
Member	Dr John Van Bocksmeer	Not eligible	Not applicable	$0
Member	Dr Annie Lang	Not eligible	Not applicable	$0
Member	Dr Cynthia Leeuwin	Not eligible	Not applicable	$0
Member	Dr Sing Lok	Not eligible	Not applicable	$0
Member	Dr Heather Lyttle	Not eligible	Not applicable	$0
Member	Dr Tadzoka Mangwana	Not eligible	Not applicable	$0
Member	Dr Sarah McEwan	Not eligible	Not applicable	$0
Member	Dr Vafa Naderi	Not eligible	Not applicable	$0
Member	Dr Anura Padmasiri	Not eligible	Not applicable	$0
Member	Dr Daniel Saplontai	Not eligible	Not applicable	$0
Member	Dr Smirti Shah	Not eligible	Not applicable	$0
Member	Dr Servaas Terblanche	Not eligible	Not applicable	$0
Member	Dr John Walker	Not eligible	Not applicable	$0
Member	Dr Justin Withnall	Not eligible	Not applicable	$0
Ex-officio Members	Jaime Gunn	Not eligible	Not applicable	$0
Ex-officio Members	Brian Wilson	Not eligible	Not applicable	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
South East District Health Advisory Council				
Chair	Thuriyya Ibrahim	Not eligible	Not applicable	$0
Deputy Chair	Meredith Waters	Not eligible	Not applicable	$0
Member	Gabrielle Lilley	Not eligible	Not applicable	$0
Member	Pamela Kerr	Not eligible	Not applicable	$0
Member	Ellen Saltmarsh	Not eligible	Not applicable	$0
			Total:	**$0**
Southern Country Governing Council				
Chair	Prof. Geoffrey Dobb	Not eligible	Not applicable	$0
Deputy Chair	Kathleen Finlayson	Annual	12 months	$35,071
Member	Adjunct Prof. Bernard Laurence	Annual	12 months	$26,302
Member	Dr Michiel Mel	Not eligible	Not applicable	$0
Member	David Barton	Annual	12 months	$26,302
Member	Jennifer Grieve	Annual	12 months	$26,302
Member	Irene Mills	Annual	12 months	$26,302
Member	Joydeep Choudhury	Annual	12 months	$26,302
			Total:	**$166,581**
Southern District Health Advisory Council (Wheatbelt)				
Chair	Stan Sherry	Annual	12 months	$0
Deputy Chair	Julie Christensen	Annual	12 months	$0
Member	Mel Crosby	Per meeting	12 months	$0
Member	Amanda Milton	Annual	12 months	$0
Member	Geoff Hodgson	Annual	12 months	$0
Member	Moya Carne	Annual	12 months	$0
Member	Bronwen O'Sullivan	Annual	12 months	$0
Member	Frank Heffernan	Annual	12 months	$0
Member	Dee Hollett	Not eligible	Not applicable	$0
Member	Jenny Menasse	Not eligible	Not applicable	$0
Member	Debrah Clarke	Annual	12 months	$0
			Total:	**$0**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Southern District Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Maguire	Per meeting	12 months	$275
Deputy Chair	Dr Peter Smith	Per meeting	12 months	$275
Member	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Alan Kerrigan	Not eligible	Not applicable	$0
Member	Dr Safi Ansari	Not eligible	Not applicable	$0
Member	Dr Nigel Chikolwa	Not eligible	Not applicable	$0
Member	Dr Paul Griffiths	Not eligible	Not applicable	$0
Member	Dr Ilario DaSilva	Not eligible	Not applicable	$0
Member	Dr Reinier De Villiers	Not eligible	Not applicable	$0
Member	Dr Coert Erasmus	Not eligible	Not applicable	$0
Member	Dr Megan Hardie	Not eligible	Not applicable	$0
Member	Dr JP Lalonde	Not eligible	Not applicable	$0
Member	Dr Beom Koh	Not eligible	Not applicable	$0
Member	Dr Stephen Lai	Not eligible	Not applicable	$0
Member	Dr Nnaji Nwoko	Not eligible	Not applicable	$0
Member	Dr Peter Beaton	Not eligible	Not applicable	$0
Member	Dr Peter Van Maarseveen	Not eligible	Not applicable	$0
Member	Dr Raquel Diego	Not eligible	Not applicable	$0
Member	Kerry Fisher	Not eligible	Not applicable	$0
Member	Jenny Menasse	Not eligible	Not applicable	$0
			Total:	**$550**
Warren District Health Advisory Council				
Chair	Ray Curo	Per meeting	12 months	$1,050
Deputy Chair	Neroli Logan	Not eligible	Not applicable	$0
Member	Carla Logan	Not eligible	Not applicable	$0
Member	Sue Priddis	Not eligible	Not applicable	$0
Member	Amanda Poller	Not eligible	Not applicable	$0
Member	Anne Trent/Polley	Not eligible	Not applicable	$0
Member	Sydney Brunelli	Not eligible	Not applicable	$0
Member	Lesley Polley	Not eligible	Not applicable	$0
			Total:	**$1,050**

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Warren District Hospital Medical Advisory Council				
Chair	Dr John Davies	Per meeting	12 months	$900
Member	Dr Alison Turner	Not eligible	Not applicable	$0
Member	Dr James Bowie	Not eligible	Not applicable	$0
Member	Dr Lucas Vesely	Not eligible	Not applicable	$0
Member	Dr Mildred Chiwara	Not eligible	Not applicable	$0
			Total:	**$900**
Western District Health Advisory Council (Wheatbelt)				
Chair	Irene Mills	Per meeting	12 months	$3,721
Deputy Chair	Jan Court	Per meeting	12 months	$0
Member	Michelle Thompson	Per meeting	12 months	$1,962
Member	Kerrie Roberts	Per meeting	12 months	$1,316
Member	Sandra Randell	Per meeting	12 months	$798
Member	Georgina Mackintosh	Per meeting	12 months	$1,303
Member	Diane Kelly	Per meeting	12 months	$105
Member	Patricia Walters	Per meeting	12 months	$0
Member	Keith Murray	Per meeting	12 months	$1,127
Member	Cynthia McMorran	Per meeting	12 months	$620
Member	Doreen Mackie	Per meeting	12 months	$0
Member	Margaret Cadenhead	Not eligible	Not applicable	$0
Member	Eric Anda	Not eligible	Not applicable	$0
Member	Beverley Hamerton	Not eligible	Not applicable	$0
			Total:	**$10,952**
Western District Medical Advisory Council (Wheatbelt)				
Chair	Dr Peter Barratt	Not eligible	Not applicable	$0
Member	Dr Bernard Chapman	Not eligible	Not applicable	$0
Member	Dr Colin Smyth	Not eligible	Not applicable	$0
Member	Dr Kevin Christianson	Not eligible	Not applicable	$0
Member	Dr Duncan Steed	Not eligible	Not applicable	$0
Member	Dr Herma Inverarity	Not eligible	Not applicable	$0
Member	Dr Gavin Osgarby	Not eligible	Not applicable	$0
Member	Dr Marie Fox	Not eligible	Not applicable	$0
Member	Dr Mark Daykin	Not eligible	Not applicable	$0

Position	Name	Type of remuneration	Period of membership	Gross/actual remuneration
Member	Dr Matt Archer	Not eligible	Not applicable	$0
Member	Dr Nina McLellan	Not eligible	Not applicable	$0
Member	Jenny Lee	Not eligible	Not applicable	$0
Member	Dr Richard Spencer	Not eligible	Not applicable	$0
Member	Dr Hendrik Smit	Not eligible	Not applicable	$0
Member	Dr Stephanie Spencer	Not eligible	Not applicable	$0
Member	Dr Michele Genevieve	Not eligible	Not applicable	$0
Member	Beverley Hamerton	Not eligible	Not applicable	$0
Member	Dr Tony Mylius	Not eligible	Not applicable	$0
			Total:	**$0**
WA Country Health Service Audit Liaison Committee				
Chair	Joydeep Choudhury	Not eligible	Not applicable	$0
Member	Jeffrey Moffet	Not eligible	Not applicable	$0
Member	Jordan Kelly	Not eligible	Not applicable	$0
Member	Shane Matthews	Not eligible	Not applicable	$0
Member	Dr Tony Robins	Not eligible	Not applicable	$0
Member	Grace Ley	Not eligible	Not applicable	$0
Member	Steve Jensen	Not eligible	Not applicable	$0
Member	Colin Xanthis	Not eligible	Not applicable	$0
Member	Trevor Wynn	Not eligible	Not applicable	$0
Member	Allison Wilkinson	Not eligible	Not applicable	$0
Member	Brian Wall	Not eligible	Not applicable	$0
Member	Kerry Winsor	Not eligible	Not applicable	$0
Member	Angela Berragan	Not eligible	Not applicable	$0
			Total:	**$0**

Notes:

1. The above list of Boards is as per the State Government Boards and Committees Register.
2. Remuneration is provided to private sector and consumer representative members of a board/committee. Individuals are ineligible for remuneration if their membership on the board/committee is considered to be an integral part of their organisational role.
3. Remuneration amounts can vary depending on the type of remuneration, the number of meetings attended, and whether a member submitted a remuneration claim.
4. 'Period of membership' is defined as the period (in months) that an individual was a member of a board/committee during the 2014–15 financial year. If a member was ineligible to receive remuneration, their period of membership is immaterial to the remuneration amount and has been defined as 'Not applicable'.

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