South West Area Health Service

Annual Report 2002/2003

Department of Health
Government of Western Australia

Statement of Compliance

To the Hon Jim McGinty MLA
MINISTER FOR HEALTH

In accordance with Section 62 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of the South West Area Health Service for the year ended 30 June 2003.

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

Michael Daube
Director General of Health
Accountable Authority for South West Health Board

August 2003

Director General's Overview

The 2002-2003 financial year was both eventful and challenging. What began as a busy year, with the Department in the midst of a major restructure of its operations, quickly became frenetic when several unforeseen events were thrust upon us, including the SARS epidemic and the aftermath of the Bali bombing incident.

It was testimony to the high quality of our staff, systems and infrastructure that the State's health service rose to meet these and many other challenges, and performed so well in the process.

During the year, a major restructure of the entire health system has been successfully completed, which brought together all parts of a previously fragmented system in terms of organisational reporting arrangements. This has resulted in a single health system with a State Health Management Team providing a solid basis for system-wide coordination, reporting and accountability. This has clearly been a time-consuming process, the outcome which ensures that our system is much better placed to address all the challenges that inevitably face health systems.

An important and successful development was the establishment of the WA Country Health Service, which has brought together the regional health services into one unified country system with six new administrative regions. This has led to greater coordination for country services, with the Executive Director also holding a place on the State Health Management Team.

District Health Advisory Councils have been established. Drawn from the community, consumers, agency providers and health services, their members will play a very important role in influencing health policies and developments. These councils will take us into a new era in community participation and ensure that country people are in a better position to influence policy and health developments.

The State's first Clinical Senate was established, with representation from a broad range of health sector professionals – including doctors, nurses and allied health professionals from the public and private sectors, and from metropolitan and rural areas. The Senate will provide advice to the Director General of Health and the State Health Management Team on the coordination and development of clinical planning, clinical and resource decision-making and other relevant clinical issues for health service delivery in Western Australia.

The new Health Reform Committee, which was established in March 2003, has provided the system with a tight focus on improving clinical services and ensuring expenditure growth remains sustainable. The committee has an ongoing role, with its final report due in March 2004.

In acknowledgment of the steady ageing of the Australian population a statewide consultation process was undertaken, drawing on the expertise of key health and aged care stakeholders and the wider community. This culminated in the release of the State Aged Care Plan in March 2003, which provides clear objectives for future services that will be diverse while at the same time sensitive to individual client preferences.

In August 2002 existing arrangements to improve quality care processes and patient outcomes in the WA health system were strengthened by the establishment of the WA Council for Safety and Quality in Health Care. This Council has a leadership and strategic management role in Safety and Quality and focuses on developing strategies and programs to support consumer focussed health care, clinical practice improvement, risk management and system improvement and accountability.

In May 2003 the Council, in conjunction with the Department's Office of Safety and Quality in Health Care finalised the 2003-2008 Strategic Safety and Quality Plan for Western Australia which provides a unified platform for an improved system approach to better meet the care needs of consumers and patients using WA health services.

A capital works program totalling almost $100 million was undertaken, including the provision of new facilities and major equipment upgrades and purchases. These ranged from state-of-the-art CT scanning facilities and a MRI scanner, to a $10.3 million expansion at Osborne Park Hospital.

Several milestones were reached: Royal Perth Hospital's Cardiac Transplant Unit undertook its 50th heart transplant operation and Osborne Park Hospital, which celebrated 40 years of operation, saw the delivery of its 50,000th baby. All health campuses that sought re-accreditation by the Australian Council on HealthCare Standards were successful, with many receiving bonus commendations.

The Centre for Nursing Research – a collaborative project between Sir Charles Gairdner Hospital and Edith Cowan University – was launched and will focus on acute care nursing, aged care nursing, and cancer care nursing.

The Department made a major effort to reduce the reliance on agency nursing staff. A high profile media campaign for attracting former nurses back to the profession was very successful. At Fremantle Hospital, for example, agency staff numbers were able to be reduced from 70 per day to an average of 15, resulting in both significant savings as well as improved productivity.

Throughout the year, the calibre of Department of Health services was acknowledged with awards and public accolades. For example:

- Fremantle Hospital and Health Service won the National Industry Award for Excellence in Training in Community Services and Health;
- The Department's State Forensic Mental Health Service Community Program and the Oral Health Centre (University of WA-Health Department joint project) were both finalists in the 2002 Premier's Award for Excellence in Public Sector Management category;
- Royal Perth Hospital's Shenton Park Campus received a Road Safety Council award for commitment to patients; and
- The Health Promotion Directorate's "Go for 2&5" nutrition education campaign won the Campaign Effectiveness Award at the major advertising and media industry awards event for WA. Quit WA won the award for Best Print Campaign.

Acknowledgments of excellence were also received by individual staff members. For example, the Indigenous Nurse of the Year award went to Ms Teresa Peucker,

a community nurse with the East Metropolitan Population Health Unit; while in January 2003 Professor Assen Jablensky accepted an invitation to join the Prime Minister's Science, Engineering and Innovation Council as a member of its Neuroscience Working Group.

The Department is also proud to be associated with colleagues in the system who have achieved wide National recognition; Professor Fiona Stanley – Australian of the Year, and Professor Linda Kristjanson, named Telstra's 2002 Business Woman of the Year (community and government category).

I want to pay a special tribute to the efforts of the army of volunteers and service sponsors. Their selfless contributions are greatly appreciated by patients, families and staff alike.

The significant progress that was made in service provision and administrative improvements during the year was punctuated by several unusual events that tested the system's resilience and capacity.

A unique infectious disease threat emerged in the form of the SARS epidemic (Severe Acute Respiratory Syndrome), which arose in East Asia. The Department's Communicable Disease Control Directorate worked closely with other Departmental staff and the Commonwealth in developing and implementing a National response, the result of which is that we are now in a high state of readiness should SARS cases emerge in Western Australia.

The Bali bombing incident in October 2002 was another test of the State's emergency preparedness. From the outset, there was excellent coordination and cooperation across the entire health system, within both Government and non-government agencies. Fremantle Hospital Disaster Response Team staff were on the tarmac to meet all aircraft carrying casualties. They set up an airport triage and stabilised all incoming casualties before sending them to various hospitals. The Royal Perth Hospital Burns Unit, assisted by the Princess Margaret Hospital Burns Team and staff from the entire system, received and treated over 34 badly injured victims, including some Balinese patients. A Bali Mental Health Disaster Management Strategy Group was formed and provided counselling for in-patients and their relatives. The experience was the impetus for establishment of a State Mental Health Disaster Response Plan.

The coordinated effort and rapid action taken in WA to address the SARS epidemic and the Bali bombing incident is a testimony to the professionalism and dedication of all of the staff involved.

The public health risks associated with international terrorism were acknowledged in a review of the State health system's chemical, biological and radiological response capabilities. In collaboration with other State and Commonwealth agencies the Department participated in Exercise New Horizon and Exercise Raw Horizon, which included a testing of Fremantle Hospital's decontamination procedures. In April 2003 the Emergency Management Service coordinated medical supplies from Perth to the Middle East, as part of Operation Baghdad Assist.

A fire at the Brookdale Liquid Waste Treatment Facility saw the Department take a lead role, alongside the Department of the Environment, in identifying toxic emissions and assessing health complaints.

In 2002-2003, a comprehensive process was in place to ensure implementation of the recommendations of the Douglas Inquiry. A review of Western Australia's obstetric services was completed (Cohen Report). The report's recommendations are currently undergoing a period of public consultation. Meanwhile, major changes were made to the operation of the State's key maternity institution, King Edward Memorial Hospital and a new Medical Director for Obstetrics and Gynaecology was appointed to KEMH in March 2003. At year's end 233 of the 237 recommendations of the Douglas Inquiry had been implemented.

There has been a strong focus on emergency department issues, including a more than $20 million capital works program to improve emergency Departments at Sir Charles Gairdner Hospital, Rockingham/Kwinana District Hospital, Princess Margaret and Swan District Hospital, and a range of further initiatives. In recognition of the importance of addressing these issues on a coordinated, system-wide basis John Burns was appointed State Health Emergency Department Director, supported by the establishment of an Acute Demand Management Unit.

During the year the Department of Health also faced the enormous challenge of medical indemnity insurance. Despite the complexity of this issue, it was well handled with good cooperation from medical organisations and has led to some good and sustainable resolutions.

The health system is one of the State's largest organisations, providing a range of complex services across a vast area. Inevitably, there will be problems and some mistakes, but we should be proud of the calibre of the system and the high level of services the Western Australian public receive.

This was a momentous year but one which I have no doubt left the Department of Health stronger and more focussed than ever on its primary role of delivering to Western Australians health services of a quality equal to any in the world.

Michael Daube
DIRECTOR GENERAL OF HEALTH

August 2003

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ADDRESS AND LOCATION

South West Area Health Service
18 West St
BUSSELTON WA 6280

☎ (08) 9754 0555
(08) 9754 0544

MISSION STATEMENT

Our Mission
To lead in the creation of healthier communities through the provision and coordination of a comprehensive range of quality, affordable and accessible health care services for the population.

BROAD OBJECTIVES

The objectives of the South West Area Health Service are:

- To actively engage the community as partners to develop a shared sense of responsibility, direction and priorities.
- To work in partnership with other agencies to improve health services and outcomes, and promote healthy public policy.
- To develop new and innovative models of service delivery.
- To improve access to services and increase self-sufficiency.
- To develop and retain a skilled and committed health work force.

SERVICES PROVIDED

The following is a list of health services and facilities available to the community:

Direct Patient Services
Accident and emergency
Acute medical
Acute surgical
Domiciliary Midwifery
Extended Care Services
Gynaecological
Nursing Home Type Care
Orthopaedics
Obstetrics
Paediatrics

Medical Support Services
Audiology
Dietetics
Medical Imaging
Pathology
Pharmacy
Physiotherapy
Podiatry
Occupational Therapy
Social Work
Speech Pathology

Services Provided cont.

Direct Patient Services cont.
Palliative Care
Psychiatric Services
Respite Care
Same Day Surgery

Other Support Services
Hotel Services
Medical Records

Other Services
Emergency Response Planning
Food Surveillance
Health Information and Advice
Mosquito Borne Disease Control
Notifiable Disease Surveillance
Sexual Health
Water Surveillance

Community Services
Aged Care Assessment Program
Alcohol and Other Drugs Project
Breast Care Service
Child Development
Child Health
Community Depression Project
Community Mothers Program
Continence Adviser
Home Care
Immunisation
Injury Prevention
Integrated Diabetes Project
Meals on Wheels
Positive Parenting Program
Primary Health Care
Respite and Transport
School Health

ENABLING LEGISLATION

The South West Area Health Service is incorporated under the *Hospitals and Health Services Act 1927*, which provides for the establishment of public hospitals and for incidental and other purposes.

The Minister for Health is incorporated as the Board of the Hospitals formally comprised in the South West Area Health Service under section 7 of the *Hospitals and Health Services Act 1927.* The Minister has delegated all the powers and duties as such to the Director General of Health.

The Accountable Authority is the Commissioner of Health due to the gazettal of a notice under the *Financial Administration and Audit Act 1985* on 30 June 1986.

To reflect consistency within the Department of Health nomenclature, the South West Health Board is known as the South West Area Health Service in Departmental deliberations and in the general public arena.

MINISTERIAL DIRECTIVES

The Minister for Health did not issue any directives on Health Service operations during the 2002-2003 year.

STATEMENT OF COMPLIANCE WITH PUBLIC SECTOR STANDARDS

In the administration of the South West Area Health Service, I have complied with the *Public Sector Standards in Human Resource Management*.

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

Human Resource Management
The South West Area Health Service (SWAHS) has monitored and assessed compliance with the *Public Sector Standards in Human Resource Management* using an analysis of the breach of standards claims lodged. This is monitored by internal HR practitioners through appropriate policy and procedures being followed. Documentation is evidenced and kept in accordance with the *State Records Act 2000*.

Statement of Compliance with Public Sector Standards cont.

Summary of Extent of Compliance with Public Sector Standards
SWAHS has had no reported breaches of any Public Sector Standards in Human Resource Management in 2002-2003.

Summary of Breach of Standards Claims
There were no breach of standards applications lodged within the SWAHS in 2002-2003. One claim lodged that was in 2001-2002 in relation to redeployment is still pending within the SWAHS.

Code of Ethics and Code of Conduct
Compliance with the Public Sector Code of Ethics and SWAHS Code of Conduct are monitored by internal human resource practitioners, who ensure that appropriate policy and procedures are being followed. Documentation is evidenced and kept in accordance with the *State Records Act 2000*.

Summary of extent of compliance with ethical codes
There were no material breaches of the Public Sectors Code of Ethics in SWAHS 2002-2003.

The SWAHS has developed a Code of Conduct which is compliant with Public Sector Standards. This is provided to all new employees and is signed off by staff when commencing.

Complaints alleging non-compliance with the Code of Ethics or the Code of Conduct
There have been 9 complaints lodged within the SWAHS relating to non-compliance with the Public Sector Code of Ethics. These were investigated and resolved internally within the SWAHS.

The SWAHS has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to June 30 2003.

Michael Daube
Director General of Health
Accountable Authority for South West Health Board

August 2003

ACCOUNTABLE AUTHORITY

The Director General of Health Mike Daube is the Accountable Authority for the South West Area Health Service (SWAHS), in his capacity as Commissioner of Health.

PECUNIARY INTERESTS

Board members and senior officers of the SWAHS have declared no pecuniary interests other than those reported in the Financial Statements.

SENIOR OFFICERS

The senior officers of the SWAHS and their areas of responsibility are listed below:

Table 1: Senior Officers

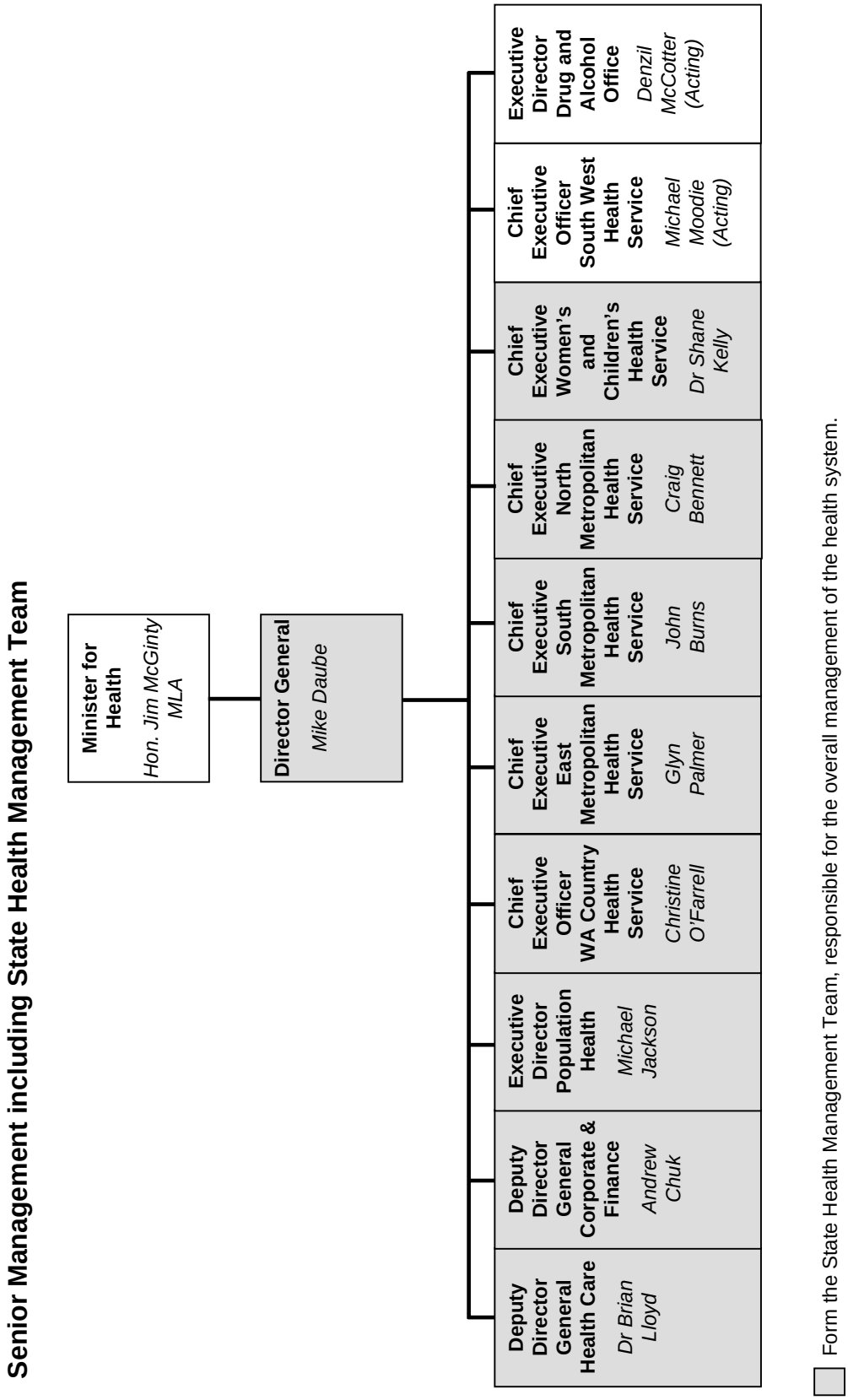
Area of Responsibility	Title	Name	Basis of Appointment
Overall responsibility	Chief Executive Officer	Michael Moodie	Acting
Finance and Performance	Director Finance and Performance	Hugh Thomson	Acting
Corporate and Support Services	Director Corporate and Support Services	John McCredden	Acting
Community Health Services	Director Communities First	Anne Donaldson	Acting
Service Development	Director Health Service Development	Noel Carlin	Acting
Population Health	Director South West Population Health	David Naughton	Permanent
Clinical Services	Director Clinical Services	Dr Jon Mulligan	Permanent
Infrastructure	Director Infrastructure	Ron Hickey	Term Contract
Mental Health	Director Mental Health	Carolyn Ngan	Acting
Executive Services	Manager Executive Services	Gail Good	Acting
Operations	Manager Operations	Susan Jones	Acting
Human Resources	Manager Human Resources	Jeff Travers	Permanent
Hotel Services	Manager Hotel Services	Martin Jones	Acting
Health Service Management	Health Service Manager Bunbury Hospital	Marilyn Horner	Permanent
Health Service Management	Health Service Manager Margaret River	Fran Temby	Permanent
Health Service Management	Health Service Manager Donnybrook	Meg Woodhouse	Acting
Health Service Management	Health Service Manager Augusta	Terry Hicks	Acting
Health Service Management	Health Service Manager Boyup Brook	June Green	Term Contract

Senior Officers Cont.

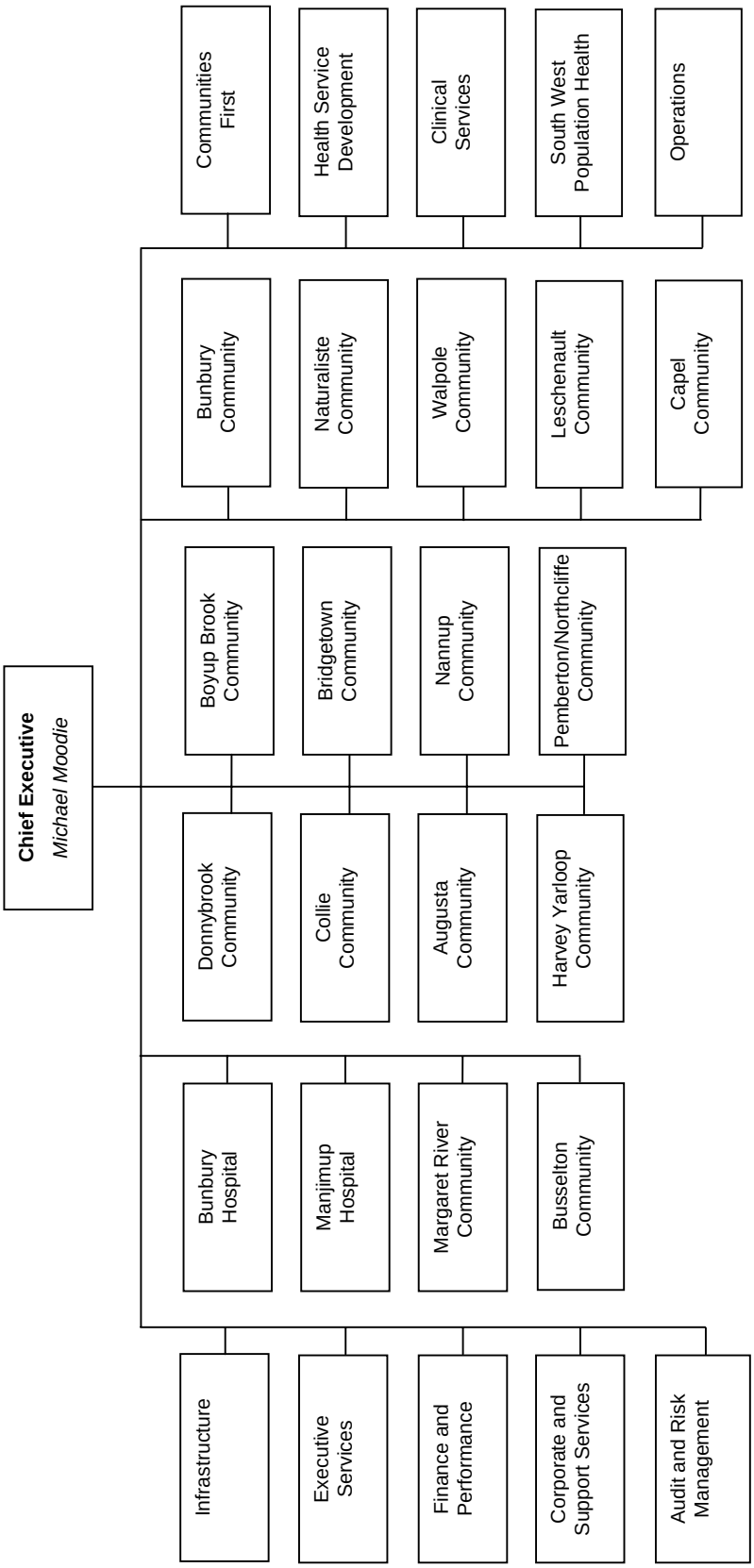
Area of Responsibility	Title	Name	Basis of Appointment
Health Service Management	Health Service Manager Nannup	Mair Jones	Acting
Health Service Management	Health Service Manager Manjimup	Duncan Corbett	Permanent
Health Service Management	Health Service Manager Busselton	Linda Jackson	Acting
Health Service Management	Health Service Manager Collie	Louise Julian	Acting
Health Service Management	Health Service Manager Harvey Yarloop	Derrick Simpson	Permanent
Health Service Management	Health Service Manager Bridgetown	Ann-Maree Martino	Acting
Health Service Management	Health Service Manager Pemberton/Northcliffe	Gordon Palmer	Permanent
Community Health Management	Health Service Manager Bunbury Community	Andrea Hickett	Acting
Community Health Management	Health Service Manager Naturaliste Community	Michael Bradley	Acting
Community Health Management	Health Service Manager Walpole Community	Sharon McBride	Acting
Community Health Management	Health Service Manager Leschenault Community	Simone Perry	Acting

The following organisational chart outlines the unified health system including the State Health Management Team (SHMT). The organisational chart for the South West Area Health Service follows.

DEPARTMENT OF HEALTH STRUCTURE AT 30 JUNE 2003



SOUTH WEST AREA HEALTH SERVICE STRUCTURE AT 30 JUNE 2003



SOUTH WEST AREA HEALTH SERVICE MODEL

Background

Since its inception on 1st January 2002, the South West Area Health Service (SWAHS) has been progressing the development of a Strategic Vision and direction, the purpose of which is to position SWAHS to deal with a number of key challenges and change drivers. Foremost among these are issues such as safety and quality; current and future resource planning and management; accountability and care coordination. The dominant criterion in the creation of the SWAHS model has been the need to develop systems and methodologies which recognise the complexity experienced by consumers when using health and related human services and the need for coordination of care within "Health" and between Health and other agencies and stakeholders.

It is recognised that the consumers' encounters with the health system can often be complex and difficult. The patient "journey" through the system necessitates interaction with, and care provision by, a multitude of players within the health system and its various settings. From the consumer perspective entry into the health system is often "unplanned" and frequently undertaken without any form of organised guidance or direction.

In a rural setting such as that managed by Health Service the complexity is increased by factors such as distance and remoteness; reduced availability of services and choice and added complications created by difficulties in travel and communication.

In the course of the "journey" a patient or client will be subjected to a wide range of "experiences". These will include the more obvious experiences of progressing through investigative, diagnostic, procedural and treatment services often provided in multiple locations by multiple players. In addition the consumer will also be exposed to a range of other experiences including informational and educational experiences about disease/conditions and its management; administrative experiences including dealings with general practitioners, hospitals, private medical practitioners, diagnostic and investigative services; financial experiences.

Unless the "journey" and consumer experiences are well managed and coordinated, the inevitable results are confusion, frustration and, potentially, sub-optimal care.

The Model

The SWAHS approach to the challenge has been to develop a client/consumer centred model of health care to guide service planning, management and delivery. The strategies involved include the establishment of a clear set of health Programs and to progress the development of defined care pathways and protocols within these. This process involves not only planning within the public health system but also developing links to coordinate the services of Health and other providers and agencies in the development of coordinated consumer care and case management.

The Service has developed “SW 24” as its pro-active case management vehicle. Established in April 2003, South West 24 is a 24 hour, 7 day a week telephone support, information and case management service which is available to consumers, carers, case managers and clinicians such as GPs and specialists. The service offers care coordination across different settings and providers and can establish consolidated patient and client information across all of these. SW 24 has a particular focus on coordinating care for those with complex or chronic needs and has been established, in the first instance, to address mental health services case management. As SWAHS progresses its program rollout, SW 24 will be applied to other health conditions and programs.

The SW 24 service uses call centre technology as a tool to make the case management effective. In its first full month of operation the SW 24 service has handled 650 incoming calls and made 219 outgoing calls covering a wide spectrum of mental health related issues and disorders; providing information, crisis management, counselling, referral and case management services; offering around the clock and immediate mental health professional support.

SW 24 will be externally evaluated, initially after 6 months operation and subsequently after 12 months. It is expected the evaluation will address key objectives of the call centre and case management service including its capacity to enhance early intervention and prevention; more effective daily self-monitoring and self care; problem detection and crisis management; educational reinforcement for clients and carers and the impact on the reduction in use of hospital and emergency department services.

HealthCare Framework

The development of the Service’s approach to case management/care co-ordination is at the centre of the SWAHS HealthCare Framework. The components of this framework are an approach to health based on a Healthy Communities concept and the implementation of the “Communities First” strategy. This aligns the internal structure of the Health Service with the 16 natural communities in the SW and creates arrangements which align management with these communities and their health, rather than the traditional role of management of institutional and centre based services.

In addition, Health Service has established a new health condition based Program structure. This is based on a set of programs which cover all relevant health issues and define the full spectrum of a health condition ranging from its absence through health promotion; illness prevention; presentation, diagnosis and treatment and continuing care. This model facilitates planning across the entire continuum and promotes care coordination and case management by taking the consumer perspective. The work in establishing its Program model has been based on work undertaken by DOH in 1997 and published in the document “Foundations for a Healthier Future”.

To support this model the Service is developing framework tools and methodologies, based on the UK National Health Services HealthCare Frameworks, which have been in development since 1995. This approach has also been adapted for use in planning in Australia (Northern Territory) and more recently in Western Pacific World Health Organisation region.

The Health Service program frameworks are being designed as planning and management tools to link individuals, populations and services and promote the development of care pathways and protocols. These are important aspects of improving case management and providing consumer "travel agency". In addition the frameworks are intended to promote safety and quality by embodying protocols and pathways based on best practice. They will also assist SWAHS in establishing an appropriate mix of services across the continuum of each program and will support the important task of health investment decision making over time. They also provide a meaningful format to address health issues with the community.

Using its program structure and program frameworks to progress planning, the Health Service is employing a planning methodology which involves consumers and carers; other human services agencies and non- government organisations in addition to health system stakeholders. This is aimed at promoting the development of program plans and pathways to promote coordinated care within health and between health and other key players.

Model Implementation

Implementation of the SWAHS model is progressing with initial focus on two priority programs. These are Mental Health and Pregnancy, Newborn, Early Childhood. An immediate additional priority area will be the Cancer Program where there is a pronounced need for care coordination and case management, given the particular complexities of the rural setting.

It is anticipated that all Programs will be part of a planning roll out in the 2003-2004 financial year and that there will be established a rolling planning cycle based on the programs and program frameworks. An important component of the planning process is the establishment of collaboration and partnerships with other key providers and human services agencies. Work is progressing on the development of memoranda of understanding with key SW organisations. SWAHS and Disability Services Commission have entered into a partnership plan for the 2003-2004 financial year to develop a unified response to South West residents with disabilities and particularly for those who interact with both Health and Disabilities Services Commission.

The integrated model of the Health Service represents a fundamental shift in thinking. Significant implications include the development needs for staff and, in particular, for health service managers. This is being progressed through a structured action-learning based program and collaboration with Edith Cowan University in the progression of personal and group development programs.

Prior to progressing the implementation the model there has been significant lead time in re-aligning SW health services and building collaborate arrangements with other organisations, essential for planning and case management.

Particular challenges will be in the area of data collection and service mapping necessary to fully define and measure activity in the health condition programs and mobilising the research and evaluation capacity to support decision making and resource allocation, within and between programs. The SW Population Health Unit, in collaboration with Edith Cowan University, has been developed to support this research and evaluation capacity.

Implementation of the model is also highlighting the importance of completing comprehensive services planning and the need to move to population based funding to support predictability and equity, both for the South West as a whole and within the South West communities.

Fundamental to the model is also an accountability framework to bring transparency and identify accountability for all of the services, outputs, outcomes and resources of the Health Service. This framework embodies all of the key concepts and objectives of the SWAHS model and focuses in particular on the key imperatives of care co-ordination, planning and evaluation.

COMMUNITIES FIRST

The SWAHS has developed a strategic direction based on WHO “Healthy Communities” “Safer Communities” concept.

The vision is underpinned by the corner stones of:

- Effective community participation;
- Collaborative partnerships with providers of Health & Human Services;
- Comprehensive information on the community profile;
- Transparent Health pathways developed by key stakeholders to provide clear information on how consumers enter, move through and exit health services;
- A case management approach to support consumers accessing appropriate services in a timely way;
- Commitment to health care closer to home; and
- Emphasis on a learning organisation to support staff to move through the transition from a predominantly operational management base to a community management focus.

The SWAHS is committed to implementing a “Healthy Communities” framework in the 16 identified communities of the South West, to be known as the “Communities First” program. Each of the 16 communities will have a Health Service Manager appointed who will be responsible for facilitating the introduction and ongoing development of the “Communities First” program.

The Communities First program will require the Manager to oversee or facilitate the development of:

- Comprehensive community profile;
- Structures for collaboration and partnership between providers of human services; and
- A mechanism for community consultation.

To support this, negotiations are currently in train with the South West Development Commission to establish a Human Services "CEOs Forum".

The CEO has met with the South West Local Government Association to establish an opportunity for collaboration. A process for Memorandum of Understanding between key organisations is being established.

SOUTH WEST POPULATION HEALTH UNIT

The year has seen the South West Population Health Unit (SWPHU) increase its role in gathering public health intelligence with the development of 16 South West health site epidemiological profiles and an accompanying analysis of health issues. The profiles will be used by the health sites to assist in determining the health priorities for their communities. The unit has also been integral to the process of community development and the introduction of the healthy communities settings approach to health promotion in the South West. Occasional papers have been published and a partnership formalised with the two South West Divisions of General Practice to promote the healthy communities concept. A training needs analysis was completed on building capacity within SWAHS to provide health professionals with core health promotion skills. The Certificate IV in Health Promotion continues to provide accredited training across the South West. A needs assessment on the Needle and Syringe Program was completed and disseminated with a similar study on sexual health services commenced. Implementation of the Yarloop Community Clinic in response to recommendations of the Medical Practitioners Forum was completed in October 2002.

CORPORATE AND SUPPORT SERVICES

Shared Services

Corporate & Support Services has progressed the implementation of an area model for all service functions to maximise the efficient use of staffing and financial resources. This has included reviewing all functional areas to determine appropriate structures and identify opportunities for improving service delivery mechanisms.

Shared Services have now been largely implemented for the following areas:

- Human Resources and Industrial Relations;
- Hotel Services (including CSSD);
- Medical Imaging Services;
- Transport Services (including PATS, St John Ambulance and RFDS);
- Pharmacy Services;
- Pathology services; and
- Materials Management (Supply and Purchasing).

Reviewed current service provision and historical structures

Managers of the functional areas detailed above have reviewed respective services in accordance with the requirements of the new organisation and the strategic move to a service culture. Emphasis has been placed on developing service mechanisms which support the new regional structure and work is progressing towards the achievement of staffing and expenditure levels defined by industry benchmarks.

Industry Benchmarks

Agreed industry benchmarks have been identified for most service areas and have been used as a basis for determining staff rosters and budget allocations. Identified benchmarks are being progressively introduced as opportunities present. This is being achieved by job redesign, restructuring of work processes and the implementation of new service delivery mechanisms.

Reduction of Corporate & Support Service Infrastructure Costs

Strategies are being implemented to reduce the organisation's overhead costs and to maximise available funding for clinical service areas. Primarily the focus has been on the control of staffing, leave and relief, and expenditures for consumables.

Key Performance Indicators (KPIs)

Corporate and Support Services are developing appropriate KPIs to monitor the effectiveness of service reforms for respective functional areas.

Voluntary Severance Program

Corporate and Support Services coordinated the roll out of the June 2002 Voluntary Severance program for the SWAHS. A reduction of 37.36 FTE was achieved as a result of this program and the flow on effect created by this opportunity.

MAJOR CAPITAL WORKS

Table 2: Major Capital Works - Projects Completed During the Year

Project Description	Year project began	Actual total cost '000s
1 Organ Imaging Equipment	October 2002	126.527
2 Theatre and Sterilising Equipment	August 2002	379.262
SWAHS Total		**505.789**

Notes:
1: Radiography equipment for Manjimup Hospital
2: Anaesthetic, sterilising and sundry other theatre equipment for theatres throughout the Health service

Projects in Progress

There were no major capital projects in progress at 30 June 2003.

DEMOGRAPHY

The SWAHS covers an area of 23,978 square kilometres in the south west corner of Western Australia. In 2001, its total population was 129,925, which represents 6.8% of the State's population. The population density of the area is 5 people per sq km, which is greater than State average (0.8 per sq km; Country: 0.18 per sq km). The age-structure is similar to that of the State. Aboriginal people account for 2.2% of the area's population, which is lower than the State average (3.5%).

The SWAHS delivers services to communities in the following local authorities:

Table 3: Demography

Local Authority	Population as at 2001	Projected Growth to 2006	Change (%)
Augusta–Margaret River	10,266	11,901	15.9
Boyup Brook	1,655	1,702	2.8
Bridgetown–Greenbushes	4,217	4,399	4.3
Bunbury	30,493	29,998	-1.6
Busselton	23,337	27,002	15.7
Capel	7,112	7,801	9.7
Collie	9,056	9,101	0.5
Dardanup	9,001	12,596	39.9
Donnybrook–Balingup	4,673	4,801	2.7
Harvey	18,611	20,698	11.2
Manjimup	10,246	10,800	5.4
Nannup	1,211	1,399	15.5

Data Sources:
ABS 2001, *Population Estimates by Age, Sex and Statistical Local Area, WA, Cat. No. 3235.5.*
Ministry of Planning 2000, *Population Projections by Age, Sex and Local Government Area, WA.*

The rugged coastline, world-class surfing, caves and wineries, are some of the attractions for visitors. The region's activities include agriculture and horticulture; timber and forest products; mineral extraction, processing and manufacturing; retailing; tourism; construction; other manufacturing; service industries; and fishing and aquaculture. There is increased growth and demands within the area and the challenge will be to meet this demand with infrastructure and support services.

The dependency ratio (i.e. the proportion of people aged less than 20 and more than 64 years of age) in the South West area was 0.71 (State: 0.65). This indicates that the area has a higher proportion of non-working people than the State average. By 2010, the dependency ratio will have decreased to 0.65. Most of this change in the dependency ratio is due to a decrease in the proportion of young children in the population. By 2010, the population of the South West area is anticipated to increase by 1.3%. While there is little variation between the rates of disease and death in the SWAHS catchment area compared to the State, there are some differences. Some of this variation may be attributed to socio-economic factors. Census data shows that, compared to the State average, there is a smaller percentage of people born overseas in the South West area.

Demography cont.

It is important to remember that the socio-demographics within the South West area can be quite diverse. Rural communities differ in size from regional centres to small towns. Similarly there is a diverse range of occupations but often with fewer opportunities for teenagers and young adults than for those who live in the metropolitan area. Many rural centres have a high Aboriginal population but may also have a sizeable ethnic community.

Factors Influencing Health

People living in the South West area experience similar health problems to those seen across the State with circulatory diseases, cancer, respiratory diseases, digestive diseases and injury and poisoning being major causes of hospitalisation and death.

Local variations do occur however. It is widely accepted that *health risk factors* such as smoking, cholesterol, diet and exercise impact on health. For both males and females who live in the SWAHS communities, no risk behaviours for smoking, consumption of vegetables and fruit and exercise rates had a higher prevalence compared to the State.

The state-weighted prevalence for males and females respectively who live in the South West area were diabetes (4.7%, 4.5%), heart disease (6.1%, 5.1%), arthritis (16.6%, 19.3%), cancer (4.5%, 5.8%), asthma (6.6%, 9.9%), other respiratory diseases (0.8%, 1.6%), stroke (0.8%, 1.2%), osteoporosis (0.0%, 4.0%) and mental health problems (6.2%, 13.5%). For both males and females who live in the South West area, the prevalence of none of the chronic conditions mentioned above was higher compared to the State.

Based on the Health and Well Being Survey, the proportion of residents who accessed different types of health care were primary care services (81.9%), mental health services (4.6%), allied health services (38.5%) and hospital services (30.0%). These figures are similar to those for the State as a whole.

In the South West area, the prevalence of feeling a medium to very high level of psychological distress in males and females was 5.0% and 9.1% respectively. The proportion having no sense of control over their lives most of the time was 3.5% and 1.6%. These findings are similar to those of the State.

(Reference: Profile Of Health and Wellbeing Developed by Dr Jim Codde, Epidemiology Branch, Health Information Centre, DOH (Last modified: 12 January, 2003)

DISABILITY SERVICES

Our Policy
The SWAHS is committed to ensuring all people with disabilities can access the facilities provided by and within the Health Service.

Programs and Initiatives
The SWAHS has aimed to improve its disability services plan during 2002-2003, according to objectives outlined in the *Disability Service Act 1993*. This goal has been achieved through programs and initiatives run on behalf of the following key outcome areas:

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

- Disability service issues are considered when new polices are developed and endorsed.
- Representatives participate in the reference group for the facility.
- Redevelopment to ensure adequate provision for disabled clients.
- All public events are now conducted in accessible venues.
- Appropriate patient transport can be organised for patients with disabilities.

OUTCOME 2
Access to buildings and facilities is improved.

- Appropriate changes to existing facilities are made as funds become available.
- Regular reviews undertaken to ensure access to buildings and facilities.
- Hand rails/railings have been added to facilities.
- Toilets and bathrooms upgraded to allow wheelchair access.
- Access ramps added to entrances.

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

- Availability of published materials in alternative formats such as Braille, IBM compatible disk, large print or audio cassette.

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

- New staff are provided disability awareness training as part of an orientation program.
- Programs implemented to train health workers how to meet the needs of people with disabilities in particular settings.

Disability Services cont.

OUTCOME 5

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

- Community consultation programs are undertaken as part of planning processes.
- Complaint procedures have been redesigned to meet the needs of clients who are unable to make written complaints.
- Grievance mechanisms are in place that allow people with disabilities to participate without impediment.

EQUITY AND DIVERSITY

Our Policy

The ability of an organisation to provide high health services to the general public is closely related to workforce diversity. That diversity needs to be tapped for planning, decision-making and service delivery.

The SWAHS aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of sex, marital status, pregnancy, family status, race, religion or political conviction, or age, and by promoting equal opportunity for all people.

Programs and Initiatives

The SWAHS aims to promote equal opportunity for all persons, according to the *Equal Opportunity Act 1984*. This goal is achieved through activities and programs run on behalf of the outcomes outlined below.

OUTCOME 1

The organisation values EEO and diversity and the work environment is free from racial and sexual harassment.

- The SWAHS EEO Management Plan and associated Equality and Diversity policies currently under review.
- All SWAHS employees are aware of and have access to Health Service-specific EEO policies as well as Codes of Ethics/Conduct which serve to underpin principles of valuing equity and diversity.

OUTCOME 2

Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.

- EEO documentation is included in orientation kits for all new SWAHS employees. On appointment all employees receive appropriate resource material for signing and returning and receipt of EEO brochures is documented. The majority of new employees have attended formal EEO training sessions during 2002-2003.

Equity and Diversity Cont.

- The Manager Workforce Risk, SWAHS has been delegated the roles of EEO Contact Officer for all employees.
- All SWAHS employees, including potential employees, are aware of issue resolution procedures and Public Sector Standards in Human Resource Management concerning bias and discrimination in employment practices. This is achieved through receipt of appropriate resource material for signing, returning and filing.
- No breaches of the Equal Opportunity Act have occurred within the organisation for 2002-2003.

OUTCOME 3
Employment programs and practices recognise and include strategies for EEO groups to achieve workforce diversity.

- All SWAHS management and supervisory position Job Description Forms specify EEO responsibilities as essential selection criteria. All other positions specify EEO knowledge and awareness in the desirable criteria. EEO employee data is stored electronically and updated on a monthly basis. Data trends are monitored by management to ensure the diversity of the workforce is catered for. Data is reported to the Equal Opportunity Commission annually.

EEO Indicators
The following table indicates strategic plans or processes the Department of Health aims to have in place across the health system to achieve equity and diversity in the workplace and the level to which the SWAHS has been able to meet these goals.

Table 4: Equity and Diversity

Plan or Process	Level of Achievement
EEO Management Plan	Under review
Organisational plans reflect EEO	Under review – *Programs in progress to address this indicator*
Policies and procedures encompass EEO requirements	Under review
Established EEO contact officers	Under review
Training and staff awareness programs	Implemented for all new employees – *Programs for existing employees under review*
Diversity	Under review

CULTURAL DIVERSITY AND LANGUAGE SERVICES

Our Policy
The SWAHS strives to ensure there is no discrimination against members of the public based upon race, ethnicity, religion, language or culture.

Programs and Initiatives
The SWAHS operates in conjunction with the *Western Australian Government Language Services Policy*, and has the following ongoing strategies and initiatives in place to assist people who experience cultural barriers or communication difficulties while accessing the service's facilities:

- Staff members of the SWAHS who interpret accredited with National Accreditation Authority for Translators and Interpreters (NAATI);
- All the important information about our services has been translated into the languages relevant to our client base;
- Staff are aware of what to do when they are presented with a Western Australian Interpreter Card. Guidelines have been provided to staff on when to use telephone or on-site Interpreting and staff are trained on how to work with interpreters;
- Procedures have been put in place to record feedback from clients.
- Conference/dual handset telephones/TTYs have been installed in public contact areas and interview rooms;
- Consultation with appropriate groups has been carried out before producing multilingual information for clients;
- Staff throughout the SWAHS have been trained in cross-cultural communication; and
- Interpreter services are available at all hospitals using telephone and/or personal service.

YOUTH OUTCOMES

Our Policy
The SWAHS acknowledges the rights and special needs of youth, and endeavours to provide appropriate services, supportive environments and opportunities for young people.

The SWAHS is committed to the following objectives as outlined in *Action: A State Government Plan for Young People, 2000-2003:*

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

Youth Outcomes cont.

Programs and Initiatives

The SWAHS has run numerous programs targeting youth groups and introduced a number of innovations such as:

- Child and Adolescent Mental Health Program;
- Positive Parenting Program;
- School Health Program – the SWAHS has 12.25 FTE invested in the school health program throughout the South West. The role incorporates immunisation and screening, counselling, support and referral of high-risk students in a case management framework. The role extends to building capacity with education services. Recent emphasis has been on alcohol and other drugs in partnership with the South West Population Health Unit;
- School Nutrition Program - a series of nutrition education sessions offered to schools in the Greater Bunbury Area with the overall aim being to increase school students' knowledge about food and nutrition, and the importance of healthy eating. In addition a campaign is run in high schools during the Health Promotion "Healthy Bones Week" in which the messages of good nutrition and physical activity are presented through a series of activities including talks, community walks and supermarket tours;
- Investing in Our Youth - Bunbury Community Health, SWAHS, has membership on the community board of the community-based organisation "Investing In Our Youth". This is a multi agency organisation that is working to facilitate community-wide collaboration in promoting the healthy development of children and young people; and
- Young Mums Group - This program is a support group for young parents or expectant young mums, it provides an opportunity for participants to be exposed to healthy parenting practices from their peers and to socialise and talk to others in a similar situation. It has been recognised that these mothers often don't fit the mainstream services provided. Sessions include presentations on health, personal development and legal issues.

EMPLOYEE PROFILE

The following table shows the number of full time equivalent staff by category employed by the South West Area Health Service (SWAHS)

Table 5: Employee Profile

CATEGORY	2000-2001	2001-2002	2002-2003
Nursing Services	550.44	518.92	524.30
Administration and Clerical*	184.46	195.65	205.22
Medical Support*	113.92	114.97	120.22
Hotel Services*	211.59	232.79	218.03
Maintenance	26.83	23.15	22.34
Medical (salaried)	11.12	15.92	34.85
Total	**1,080.45**	**1,101.40**	**1,124.96**

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

RECRUITMENT

Attendance at the annual nursing Expo last year paid dividends for the SWAHS, improving the recruitment of new graduates for the 2002-2003 Graduate Registered Nurse program. The Health Service has developed close links with Edith Cowan University (Bunbury Campus) in relation to students completing their nursing degree, thus providing the region with a continued supply of new graduate nurses. The numbers expected to graduate this year are about 50 rising to 75 and 100 over the next two years.

Increased usage of web-based recruitment sites has increased our range and placement of advertisements. In particular, the Nursing and Allied Health website has improved our success rate in recruiting Registered Nurses.

The benefits of an area-wide service have resulted in improved identification and coordination of specialised staff being able to be deployed to areas where an interim need is required. Additional discretionary study leave and assistance has also been offered to retain and retrain staff in hard-to-recruit areas.

Recruitment of medical staff into emergency medicine and psychiatry remains difficult and the Health Service relies on the extensive usage of recruitment agencies and overseas-trained doctors.

STAFF DEVELOPMENT

The development of the SWAHS has provided the opportunity to maximise available resources in the provision of best practice staff education and training activities. SWAHS has committed to the development of an area-wide Research and Development function. A key aspect of the development of this function has been the formal signing of a Memorandum of Understanding between Edith Cowan University and SWAHS.

This function is currently in a developmental phase. Key agreed initial tasks include:

- Coordination of an area wide staff induction and orientation program;
- Coordination of an area wide graduate nurse program; and
- Coordination of an area wide manual handling program.

Research and Development will have a major role in coordinating health service education and training activities within the South West region. The program, which is under development, will ensure a continuing emphasis on:

- Addressing essential minimum competencies in safe practice and the effective use of the training and development expertise of staff within the South West region;
- The efficient use of resources to ensure skill gaps are identified and addressed;
- The ongoing capacity of health workers in the South West to provide quality services to external and internal customers;
- Identifying potential research activities;
- In liaison with Edith Cowan University, monitor and support health-based research activity; and
- Promote opportunities for flexible learning.

SWAHS will not seek ongoing accreditation of its Registered Training Organisation status under the Australian Quality Training Framework. SWAHS will work in partnership with the local South West TAFE to enable best practice in flexible training and assessment to meet identified health industry standards with the opportunity to grant nationally recognised qualifications.

WORKERS' COMPENSATION AND REHABILITATION

The following table shows the number of workers' compensation claims made through the SWAHS:

Table 6: Workers' Compensation and Rehabilitation

Category	2002-2003
Nursing Services	47
Administration and Clerical*	6
Medical Support*	4
Hotel Services*	36
Maintenance	2
Medical (salaried)	3
Other	1
Total SWAHS	**99**

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

The above figures are a true record of all reported and documented workers' compensation claims throughout the SWAHS as provided by our insurers Riskcover. There are no hidden or cost absorbed strategies as all compensable injuries are processed as per requirements.

The SWAHS Injury Management policy and specific guidelines endeavour to maximise the outcome and minimise the risk for both the employee and employer. Our objective is a reduction of lost time through injury by applying early intervention strategies that increase the potential of an injured employee's safe return to work.

Induction and orientation training assist in reducing risks associated with new and existing employees in providing a safer environment that allows a more responsible proactive approach to injury prevention. Mandatory training throughout the SWAHS is also a preventative measure towards ensuring a safe as possible working environment. Staff awareness and reporting of identified hazards in the workplace and their early rectification, contribute to minimising the possibility of staff injury.

On-site inspections and task-specific training have also been effective strategies in the early intervention of identified risk to employees. These inspections, training and subsequent recommendations have been provided by qualified employees within the SWAHS or by an external provider.

Early rehabilitation intervention, and support for injured workers continue to prove valuable in effective return-to-work programs. A combination of in-house and externally provided programs specific to each worker has been used effectively depending on the nature and severity of the injury.

INDUSTRIAL RELATIONS

To improve services the SWAHS has restructured some service delivery teams and as a consequence there has been an increased need to consult with employees and the relevant unions as part of the change management process.

This level of consultation has been productive and has not provided any insurmountable problems. As services are improved other workforce changes may be required, and as a consequence, this level of consultation will continue.

As a result of the consolidation of five separate payrolls into a single payroll for the whole of the SWAHS, a small number of issues in relation to the consistent application of Awards and Agreement have been identified. As the conditions of service are now applied through a single team this has ensured a higher level of compliance with industrial awards and conditions of service.

FREEDOM OF INFORMATION

The South West Area Health Service (SWAHS) received and dealt with the following applications under the Freedom of Information guidelines during 2002-2003:

Table 7: Freedom of Information

APPLICATIONS	NUMBER
Total Received in 2002-2003	250
Carried over from 2001-2002	7
Granted – Full Access	226
Granted – Partial or Edited access	6
Withdrawn	2
Refused	6
Transferred and Other	10

Description
1. Includes the number accessed in accordance with section S28 of the Act
2. Includes exemptions, deferments or transfers to other departments/agencies

Types of documents held by the SWAHS
The types of documents held by the SWAHS include:
- Medical Records/Client Files;
- Corporate and Financial Records;
- Human Resource and Industrial Relations Files; and
- Policies and Procedures.

How to obtain information
The public can access documents by making application in accordance with the *Freedom of Information Act 1992*. An application form is available to those who do not feel comfortable applying in writing. Patients can access their own medical record in accordance with SWAHS policy or in accordance with the Freedom of Information Act.

Process for obtaining information:
- Applications may be lodged with Executive Services, SWAHS.
- Applications are processed in accordance with the requirements of the Freedom of Information Act.
- Application forms, letters and brochures detailing the application, internal review and external review processes are available.

Freedom of Information cont.

Applications and initial inquiries can be lodged with:

Freedom of Information Coordinator
Executive Services
South West Area Health Service
18 West Street
BUSSELTON WA 6280

ADVERTISING AND SPONSORSHIP

The following table lists the expenditure on advertising and sponsorship made by the South West Area Health Service, by category, published in accordance with Section 175ZE of the *Electoral Act 1907.*

Table 8: Advertising and Sponsorship

Expenditure Category	2001-2002	2002-2003
Advertising Agencies	$84,335	$131,205
Market Research Organisations	-	-
Polling Organisations	-	-
Direct Mail Organisations	-	-
Media Advertising Organisations	-	$12,167
Total	**$84,335**	**$143,372**

Detail of expenditure for 2002-2003:

Expenditure Category	Name of Agency/Organisation	Amount $
Advertising Agencies	Marketforce	53,808
	Access Programs	7,431
	Bower Bird Information Services	1,550
	OSA Group	2,246
	Seabreeze Communications	3,400
	Wavelength	62,770
Market Research Organisations	N/A	-
Polling Organisations	N/A	-
Direct Mail Organisations	N/A	-
Media Advertising Organisations	Chameleon Creative	550
	Rural Press Regional Media	5,032
	South West Printing & Publishing	6,195
	West Australian Newspaper	390

PUBLIC RELATIONS AND MARKETING

Community awareness of the SWAHS for 2002-2003 was achieved through the following activities:

- Use of local press and radio to inform the community on health issues and new service developments;
- Health promotion activities at local agricultural shows;
- Health promotional pamphlets produced by community health and South West Population Health for distribution throughout the community;
- Be Active competitions and programs encouraging the community to take part in regular exercise;
- Community consultation workshops involving former board members, key local stakeholders, local government representatives and representatives of the Aboriginal communities; and
- Directors of Nursing have been engaging local key community identities to initiate discussions on the principles of Communities First and explaining the objectives of the SWAHS model and the HealthCare framework in which communities will be closely involved.

The SWAHS recognises the importance of establishing a climate of good community relations and has actively sought to raise the profile of the hospitals, community health and related services.

PUBLICATIONS

The SWAHS produced many internal and external publications during 2002-2003 to provide the general public with information on health initiatives, facilities and other relevant areas of service delivery. These publications took the form of pamphlets, brochures, posters, newsletters and booklets, and included the following

- Staff newsletters, available at each hospital;
- Patient information brochures, and brochures on patient's rights and responsibilities;
- Information brochures on prevention, health conditions and treatment, available from hospitals and Primary Health Centres;
- Health promotional brochures;
- Annual Report 2001-2002, available on the Department of Health website (www.health.wa.gov.au); and
- Published journal articles - Stone G, Strikwerda-Brown J and Gregg C. (2002). Physical activity levels, sporting, recreational and cultural preferences of students and staff at a regional university campus. *ACHPER Healthy Lifestyles Journal* 49(3-4), 39-43.

RESEARCH AND DEVELOPMENT

The SWAHS carried out no major research and development programs during 2002-2003.

EVALUATIONS

Since its formation the SWAHS has been evaluating its means of health services delivery with the aim of raising the community's awareness of its own health and issues of priority setting in treatment.

The administrative and support functions have also been evaluated and varied to provide a greater emphasis on risk management, quality, efficient output and a more uniform profile across the Service.

The following table shows the various evaluations carried out by the SWAHS:

Table 9: Evaluations

Title	Purpose of Evaluation	Main Outcomes	Action Taken or Proposed
Healthy Communities program	To improve the general standard of health in the community thereby reducing the rate of cost increase in health service provision.	Concept researched and developed with staff and key community representatives. 16 communities' groupings identified within the South West.	Health Service Managers actively engaging groups within their own communities in the program through a variety of techniques.
Support services consolidation	To establish a more uniform and efficient approach to risk management, allocation and maintenance of resources.	Functions of operational coordination and bed management, pharmacy, quality and clinical risk, hotel services, clerical support, finance, human resources, payroll, materials management and asset maintenance are now centrally managed.	Management arrangements have been instituted and quality measures and performance indicators are under continual development.

INTERNAL AUDIT CONTROLS

The Health Service has established a system of internal controls to provide reasonable assurance that assets are safeguarded, proper accounting records are maintained and financial information is reliable. The Department of Health Internal Audit Branch has been engaged to review internal processes and procedures within the SWAHS.

PRICING POLICY

The SWAHS raises a number of fees and charges to recover the estimated cost of providing certain services, except where a public service obligation exists.

A daily bed fee is raised against all patients other than those treated under the public health system. These fees contribute towards the cost of services required to treat patients. The only exception to this is professional medical services, which are provided privately by medical practitioners.

No fees are raised by the SWAHS against registered public and private outpatients of the hospital.

RISK MANAGEMENT

SWAHS Risk Management Policy has been developed encompassing all aspects of risk in line with Treasurers Instruction 825 and Australian/New Zealand Standard 4360:1999.

A Risk Assessment Code has been developed and trialed successfully across SWAHS.

Clinical Risk Management has been implemented across SWAHS including the Australian Incident Monitoring System (AIMS). Ongoing training is an important element of the policy. This process includes patients, staff and visitors with regular reporting and management of incidents.

Regular meetings of the SWAHS Risk Coordinating Committee promote and consolidate the Risk Management program across the organisation in conjunction with the ACHS EQuIP guide. In June 2002 the Committee was established as an 'approved committee' under the Health Services (Quality Improvement) Act 1994 to further facilitate closer review of clinical incidents. One of the Committee's major projects was an audit of Adverse Events in Bunbury Regional Hospital, which was reported publicly through a project report to the Australian Council on Safety and Quality in Health Care.

Risk Management cont.

There has been ongoing review and evaluation of Risk Management Registers suitable for the SWAHS geographic and reporting requirements.

Risk Management responsibility is now being included in all Service Level Agreements and Job Descriptions.

ENERGY SMART GOVERNMENT PROGRAM

In accordance with the Energy Smart Government policy the Department of Health is required to achieve a 12% reduction (relative to 2001-2002) in non-transport related energy use by 2006-2007 with a 5% reduction targeted for 2002-2003. The full Energy Smart Government Program report and interpretations – for the whole Department of Health – is reported in the Department of Health (Royal Street) Annual Report 2002-2003.

WASTE PAPER RECYCLING

The Western Australian government directs all agencies to operate paper-recycling programs.

Collection of waste paper by contractors continued at Bunbury and Augusta Health Services. Health Services that do not have recycling facilities in the community continued to reduce paper based documentation/communications and distribute shredded paper to individuals in the community for various purposes including composting, worm farms and mulching. Non-confidential paper is used as scrap paper/notepads around the sites.

MAJOR TERMS USED IN THIS REPORT

ACAT	Aged Care Assessment Team
ACHS	Australian Council on HealthCare Standards
AIMS	Australian Incident Monitoring System
CEO	Chief Executive Officer
CGS	Central Great Southern
CSSD	Corporate and Support Services Division
CWLB	Central Wait List Bureau
DOH	Department of Health
DON	Director of Nursing
DRG	Diagnostic Related Group
DSP	Disability Services Plan
EEO	Equal Employment Opportunity
EQuIP	Evaluation and Quality Improvement Program
FOI	Freedom of Information
FTE	Full Time Equivalent
GP	General Practitioner
HACC	Home and Community Care
HARC	Health Administration Review Committee
HR	Human Resources
ISO	International Standards Organisation
IT	Information Technology
KPI	Key Performance Indicator
MHS	Metropolitan Health Service
MHSB	Metropolitan Health Service Board
MPS	Multi Purpose Service
NAAT	National Association for Translators and Interpreters
NH&MRC	National Health and Medical Research Council
OHS	Occupational Health and Safety
OPSSC	Office of the Public Sector Standards Commissioner
PATS	Patient Assistant Travel Scheme
PSA	Public Sector Award
RFDS	Royal Flying Doctor Service
SW	South West
SWAHS	South West Area Health Service
SWPHU	South West Public Health Unit
TTY	Teletype
VMP	Visiting Medical Practitioner
UWA	University of Western Australia
WA	Western Australia
WACHS	WA Country Health Service
WAIMR	Western Australian Institute for Medical Research

SOUTH WEST HEALTH BOARD
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2003

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the South West Health Board and fairly represent the performance of the Health Service for the financial year ending 30 June 2003.

Michael Daube
Director General of Health
Accountable Authority for South West Health Board

August 2003

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2003

Qualification
Key Effectiveness Indicators
The key effectiveness indicators reported for Outcome 3 are not key measures of the Health Service's achievement of the outcome "Improvement in the quality of life of people with chronic illness and disability". As such, no opinion is provided on these indicators.

Qualified Audit Opinion
In my opinion, except for the matter referred to in the qualification, the South West Health Board's key effectiveness and efficiency performance indicators reported are relevant and appropriate and fairly represent indicated performance.

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

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

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

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

D D R PEARSON
AUDITOR GENERAL
November 20, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Outcome 1 Improvement in health by a reduction in the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse

100A Rate of screening in children
100B Rate of referral as a result of childhood screening schedule
101 Rate of childhood immunisation
102 Rate of hospitalisation for tonsillectomies (0-12 years)
103 Rate of hospitalisation for gastroenteritis in children (0-4 years)
104 Rate of hospitalisation for respiratory conditions

Output 1 Prevention and promotion

105 Cost of service for community health services

Outcome 2 Restoration to health of people with acute illness

200 Elective surgery waiting times for public patients
201 Proportion of Emergency Department patients seen within recommended times
202 Rate of emergency presentations with a triage score of 4 and 5 not admitted
204 Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a related condition
205 Rate of unplanned hospital re-admissions within 28 days, to the same hospital, for a mental health condition
206 Rate of post operative pulmonary embolism
208 Survival rates for sentinel conditions

Output 2 Diagnosis and treatment

212 Average cost per casemix adjusted separation for non-teaching hospitals
216 Average cost per non admitted hospital based service
217 Average cost per non admitted occasion of service in Northcliffe nursing post
218 Average cost per bed day for admitted patients (selected small rural hospitals)
220 Average cost of patient assisted travel scheme (PATS)

Outcome 3 Improvement in the quality of life of people with chronic illness and disability

301 Median waiting time for community and allied health services (hospitals and community based)
302 Median bed-days for persons under mental health community management who were admitted to hospital
304 Aged Care Assessment Team (ACAT) assessments

Output 3 Continuing care

303 Average cost per person with mental health illness under community management
305 Average cost per care awaiting placement (CAP) day

Note: Not in sequential order

The South West Area Health Service is required, under the Financial Administration and Audit Act 1985 (FAAA) and the Treasurer's Instruction TI 904, to present to Parliament annual indicators of efficiency and effectiveness. The Key Performance Indicators (KPIs) presented in this report address the extent to which the Department of Health's three desired outcomes have been achieved.

A key aim in presenting this information, and that reported by all the separate legal reporting entities of the DOH is to assist the public to understand the complex and diverse nature of the services and activities of the health system and how these contribute to its performance.

The performance indicators reported in the following pages address the extent to which the strategies and activities of the South West Area Health Service have contributed to the DOH's required health outcomes and outputs, viz.,

OUTCOME 1
Improvement in health by a reduction in the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.
(Output 1 - Prevention and Promotion)

OUTCOME 2
Restoration to health of people with acute illness.
(Output 2 - Diagnosis and Treatment)

OUTCOME 3
Improvement in the quality of life of people with chronic illness and disability.
(Output 3 - Continuing Care)

While some of the indicators reported are similar to those in previous South West Area Health Service Annual Reports, some are new indicators reported for the first time. Where possible comparisons with previous years' data have been provided.

CPI INFLATOR SERIES (CPI)

The index figures are derived from the CPI all groups, weighted average of the 8 capital cities index numbers. For the financial year series the index is the average of the December and March quarter and is rebased to reflect a mid year point of the 5 year series that appears in the annual reports. The average of the December and March quarter is used, because the full year index series is not available in time for the annual reporting cycle. The calendar year series uses a similar methodology but is based on the average of the June and September quarter.

The financial year costs for the annual report can be adjusted by applying the following formula, the results will be all financial data will be converted to 00/01 dollars:

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

The index figures for the financial years and calendar years to be applied are provided below:

Calendar year	1998	1999	2000	2001	2002
Index (base 2000)	94.24	95.57	100.00	104.24	107.39
Financial year	1998/99	1999/00	2000/01	2001/02	2002/03
Index (base 2000/01)	92.31	94.43	100.00	103.03	106.36

Improvement in health by a reduction in the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

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

The services (outputs) of the South West Area Health Department Service as well as the other divisions of the Department of Health are contained on the table below. The greatest proportion of the services provided by the South West Area Health Service in this outcome is directed to children. Other health service divisions for example the Royal Street Division and the Drug and Alcohol Authority provide more services directed to the prevention of injury and illness and the impact of drug abuse.

Table 10: Respective Indicators by Health Sector

Outcome 1: Reducing the incidence of preventable disease, injury, disability and premature death and the impact of drug abuse.	**South West Area Health Service**	**Metropolitan Health Service**	**Peel Health Services**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Reduce the likelihood of onset of disease or injury by:						
• Immunisation programs	101	101	101	101	R107	
• Childhood screening & appropriate referrals	100A 100B	100A 100B 106 107 108	100A 100B	100A 100B	R113	
• Safety program					R101	
• Encouraging healthy lifestyles (examples diet and exercise)			109		R110 R111	
2. Reduce the risk of long term disability or premature death from injury or illness through:						
• Early identification of breast, cervical screening cancer (screening & referral if positive results)					R104 R105A R105B	
• Surveillance	105	105	105	105	R103 R106 R108 R109 R112 R114	
3. Monitoring the incidence of disease in the population to ensure primary health measures are effective	102 103 104	102 103 104	102 103 104	102 103 104		
4. Monitoring and surveillance of suicide rates and drug & alcohol use					R102	See D&AA Report

100A: Rate of screening in children

This indicator reports screening rates per 1,000 of population, for children who reside in the South West Area Health Service catchment area.

Rationale

Screening programs for children are carried out to ensure early identification and intervention of developmental delays or other health problems. The early identification and management of problems improves the life and health outcomes for children. Different screening methods are used to determine if children have a developmental delay or issue, or are at increased risk of poor health outcomes due to factors impacting on their physical, social or emotional development. The National Health & Medical Research Council (NH & MRC) recommends screening protocols for certain age groups to ensure that disabilities such as poor hearing, sight problems and congenital disabilities are recognised at an early age.

In most circumstances, the recognition of a problem leads to intervention which will address the issue and improve the child's quality of life.

Results

Screening rates were measured in two age groups (0 to 4) and (5 to 12) and across two ethnic groups - non-Aboriginal and Aboriginal children:

Table 11: Rate of screening in children per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	856	382	1077	382	904	319
5 – 12 Years	429	180	406	255	268	108

Data Sources:
HCARe Community Health data.
Health Service Population data.

Comments

With new knowledge about the importance of a child's social and emotional development in their early years of life, the focus of universal screening of physical development has shifted. The adoption of a more holistic and family-centred approach to supporting children in the early years has led to a shift from universal screening programs to the screening of those children deemed to be at higher risk. This has led to a reduction in the number of formalised screenings of all children in a certain age-group and an increased focus on those identified as being at higher risk.

In some parts of the metropolitan area, the screening of Year 6 students for vision was carried out only for those children who were identified as having vision difficulties (in line with the most recent NH&MRC recommendations).

100B: Rate of referral as a result of childhood screening schedule

This indicator reports post-screening referral rates per 1,000 of population, for children who reside in the South West Area Health Service catchment area.

Rationale

Once children have been through screening programs, it is important that those who have failed to meet the screening criteria are referred on to an appropriate specialist to receive more detailed assessments and, where it is needed, therapy. Variations in post-screening referral rates are examined on an ongoing basis and year to year comparisons are used to alert health service planners to potential problems.

Results

Post screening referral rates (per 1,000 of population) were measured in two age groups (0 to 4) and (5 to 12) and across two ethnic groups - non-Aboriginal and Aboriginal children:

Table 12: Rate of referral as a result of childhood screening schedule per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	41.5	40.6	48.5	12.7	41.6	10.6
5 – 12 Years	29.9	26.4	27.1	87.5	15.9	4.6

Data Sources:
HCARe community Health data.
Health Service Population data.

Note

The differences in the rates of referral can be a reflection of the work practices and experience of the clinicians providing a service, as well as environmental factors and the general health of the targeted population. As the clinicians in the Southwest have a holistic approach to the services that they provide, referral and intervention in problems and issues that arise are dealt with at an earlier stage rather than waiting for screening timelines.

The Southwest demographically has a much smaller Aboriginal population than other health regions and this can alter the information from year to year and affect the average rate. Within the Aboriginal community the rate may be higher as not all Aboriginal people choose to be identified as Aboriginal.

101: Rate of childhood immunisation

This part of the indicator reports immunisation rates per 1,000 of population, for children who reside in the South West Area Health Service catchment area.

Rationale

The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill, but also to maintain a state of 'wellness' that allows them to develop to their full potential. One of the key components of this is to ensure that the majority of children are immunised according to internationally recognised vaccination practices.

Immunisation of the individual is important not only for that individual, but also for the entire community – if the majority of people are immunised the community benefits from "herd immunity" which prevents epidemics.

Without access to immunisation the consequences of any illness or disability are likely to be more disabling, lead to a higher hospitalisation rate and contribute to a higher rate of premature death.

This indicator measures the rate of immunisation against particular diseases (by age group) of the resident child population in the Southwest catchment area. It also measures the hospitalisation rate for children who need treatment for the infectious diseases in question.

Results

Immunisation rates (per 1,000 of population) were measured in three age groups (12 to 15 months), (24 to 27 months) and (72 to 75 months) and across two ethnic groups - non-Aboriginal and Aboriginal children:

Table 13: Rate of childhood immunisation per 1,000 of population

	2001		2002		2003	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
12 – 15 months	882	818	906	800	878	833
24 – 27 months	854	805	855	786	881	500
72 – 75 months	-	-	815	800	812	857

Data Sources:
HCARe community Health data.
Health Service Population data.

101: Rate of childhood immunisation cont.

This part of the indicator reports hospitalisation rates per 1,000 of population, for children who reside in the South West Area Health Service catchment area.

Table 14: Rate of hospitalisation per 1,000 of population for children with infectious diseases

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
Diphtheria	0.0	0.0	0.0	0.0	0.0	0.0
Hepatitis B	0.0	0.0	0.0	0.0	0.0	0.0
Measles	0.0	0.0	0.0	0.0	0.0	0.0
Pertussis	0.04	0.0	0.16	0.0	0.08	2.9
Polio	0.0	0.0	0.0	0.0	0.0	0.0
Tetanus	0.0	0.0	0.0	0.0	0.0	0.0

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Note

During 2002 there were 5 admissions for pertussis across the South West Area Health Service catchment area. There were 2 admissions for non-Aboriginal children and 3 admissions for Aboriginal children. With small populations, movements in case rates need to be interpreted with caution.

102: Hospital separations for tonsillectomies (0 – 12 Years)

This indicator reports hospitalisation for tonsillectomy rates per 1,000 of population, for children who reside in the South West Area Health Service catchment area.

Rationale
Surgical removal of tonsils (tonsillectomy) is a treatment for children who have recurrent tonsillitis. Treatment of tonsillitis can be undertaken either in the community or in hospital. It would be expected that the number of hospital admissions will decrease as performance and quality of service in the primary health care area (prevention and promotion) improves. The number of children who are admitted to hospital per 1,000 population for tonsillectomies may be an indication of improved primary care or community health strategies – for example, health education by a primary health care professional ie general practitioner, community health or school health nurse.

Note
While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the health service providing the hospitalisation.

Table 15: Rate of hospitalisation for removal of tonsils in children per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 12 Years	4.9	0.0	5.9	1.9	6.9	2.9

Data Sources:
HCARe Community Health data.
Health Service Population data.

Note
The increase in the rate for tonsillectomy within the Aboriginal cohort is the result of an increase by one episode of care coupled with a reduction in the population in this age group and this has resulted in increased the rate for tonsillectomy.

103: Hospital separations for gastroenteritis in children (0 – 4 Years)

This indicator reports hospitalisation for gastroenteritis rates per 1,000 of population, for children (0 to 4 years) who reside in the South West Area Health Service catchment area.

Rationale

Gastroenteritis is a condition for which a high number of patients are treated either in the hospital or in the community. It would be expected that hospital admissions for this condition would decrease as performance and quality of service in many different health areas improves. The number of children who are admitted to hospital for treatment of gastroenteritis may be an indication of improved primary care or community health strategies - for example, health education. It is important to note, however, that other factors such as environmental issues will also have an impact on the prevalence of transmissible diseases like gastroenteritis.

Note

While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the Health service providing the hospitalisation.

Table 16: Rate of hospitalisation for gastroenteritis in children per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	8.3	16.7	11.7	32.9	11.7	16

Data Sources:
HCARe Community Health data.
Health Service Population data.

104: Hospital separations for respiratory conditions

This indicator reports hospitalisation for respiratory conditions rates per 1,000 of population, for people who reside in the South West Area Health Service catchment area.

Rationale
A reduced number of people who are admitted to hospital for treatment of respiratory conditions such as acute bronchitis, bronchiolitis, croup and acute asthma may be an indication of the effectiveness of primary care or community health strategies - for example, health education.

It is important to note however, that other factors may influence the number of people hospitalised with these conditions. These conditions are ones which have a high number of patients treated either in hospital or in the community.

Note
While this indicator uses hospital separations, it is a measure of primary health care performance and not a measure of the performance of the Health service providing the hospitalisation.

Results
Because some of the respiratory conditions affect only the very young, different age groups were used to report for the different conditions.

Table 17: Rate of hospitalisation for asthma per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	9.9	16.7	9.6	10.1	10.8	21.3
5 – 12 Years	3.6	6.2	3.3	0.0	3.3	1.5
13 – 18 Years	2.3	2.9	2.2	2.7	2.0	0.0
19 – 35 Years	1.4	6.9	1.3	5.4	1.5	8.0
36+ Years	1.9	29.2	1.5	32.5	1.5	20.7

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Note
Seasonal factors such as springtime and high pollen levels, as well as the cold and wet weather of winter in the Southwest, have a significant impact on the rates of admission for this condition.

104: Hospital separations for respiratory conditions cont.

Table 18: Rate of hospitalisation for bronchiolitis per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	11.2	23.9	6.1	10.1	8.8	29.3

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Note
Environmental factors such as the cold and wet weather in the Southwest also have an impact on the rates of admission for this condition.

Table 19: Rate of hospitalisation for croup per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	8.5	2.4	3.1	0.0	5.3	5.3

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Table 20: Rate of hospitalisation for acute bronchitis per 1,000 of population

	2000		2001		2002	
	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal	Non Aboriginal	Aboriginal
0 – 4 Years	0.7	0.0	0.9	5.1	0.7	5.3

Data Sources:
Hospital Morbidity Data System.
WA Population Estimates, HIC.

Note
As the Southwest has a smaller Aboriginal population than other health regions, slight variances in admissions to hospital can lead to increases and decreases in the admission rate.

105: Cost of service for community health services

This indicator reports the average cost per community health service.

Rationale
The efficiency of community health services may be gauged by measuring the average cost per occasion of service, over a number of years.

Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational and speech therapy are some examples of the types of community based services provided under this indicator.

A wide range of interventions by practitioners from many specialties are used, singularly and in combination, to effect changes in the health of individuals, their families and their community. These interventions are quantified as occasions of service but can cover a wide range in terms of time and complexity.

Table 21: Cost of service for community health services

	2001/2002	2002/2003
Average cost of community occasions of service	$63.00	$80.79
CPI adjusted	$61.15	$75.23

Data Sources:
HCARe Community Health data.
Health Service Financial Information System.

Restoration of the health of people with acute illness

The achievement of this component of the health objective involves activities in the South West Area Health Service which:

- Ensure that people have access to acute care services when they need them so that intervention occurs as soon as possible. Timely and appropriate access ensures that acute illnesses do not progress.
- Provide quality diagnostic and treatment services to ensure the maximum restoration to health after an acute injury or illness.
- Provide appropriate after-care and rehabilitation to ensure physical and social functioning is restored.
- Provide appropriate obstetric care during pregnancy and the birth episode to both mother and child.

Outcome 2 indicators report the largest proportion of South West Area Health Service activities.

Table 22: Respective Indicators by Health Sector

Outcome 2: Restoration to health of people with acute illness.	**South West Area Health Service**	**Metropolitan Health Service**	**Peel Health Services**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Ensures that people have access to acute care services by:						
• Prioritising access to elective surgery	200 201	200 201		200 201	R207	See D&AA Report
• Providing timely transport to hospital	220		220	220	R206 R213 R214	
• Prioritising access to dental services		219 221			R202 R216	
2. Provide quality diagnostic services and treatment by:						
• Providing appropriate and quality admitted patient services when people are ill or injured.	204 205 206 208 212	204 205 206 208 209 210 211 212	204 205 208	204 205 206 208 212	R201 R203 R204 R205 R208 R209 R211 R212 R215	See D&AA Report
• Providing timely and appropriate ambulatory services for people who do not require admitted patient care.	202 216 217	213 214 215	216 217	202 216 217	R210	See D&AA Report
• Providing appropriate obstetric and neonatal care.		207		207		
• Providing appropriate treatment in hospital of patients who require long term nursing care.	218		218	218		

200: Elective surgery waiting times for public patients

This indicator reports waiting list information.

Rationale
For health services to be effective, access to them needs to be provided on the basis of clinical need. In general terms, surgical procedures are performed to either restore a person to good health, or to improve the quality of life. If patients requiring surgical procedures are required to wait for excessively long periods of time, they may have to tolerate ongoing pain, dysfunction or disability. It is also possible that their condition might worsen.

This indicator measures the waiting times for people who are booked in for elective surgical procedures. It reports:

- The number of people admitted from the waiting list for Bunbury Hospital during 2002/2003.

The Australian Institute of Health and Welfare (AIHW) has identified a suite of surgical procedures (indicator procedures) which, typically, are of high volume and are often associated with long waiting periods. This performance indicator reports the following for the indicator procedures:

- Bunbury Hospital public patients remaining on the waiting list for elective surgery at the end of each month during the 2002/2003 year.

- Median and mean waiting times at the end 30 June 2003 compared with 30 June 2002.

Results
The number of people admitted from the wait list for Bunbury Hospital in 2002/2003 was 4,807.

200: Elective surgery waiting times for public patients cont.

Table 23: Bunbury Hospital public patients remaining on the elective surgery waiting list at the end of each month during 2002/2003

Indicator Procedures	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cholecystectomy	11	13	12	14	7	6	8	11	15	21	20	16
Haemorrhoidectomy	5	5	6	6	4	5	7	6	8	9	6	6
Inguinal Hernia Repair	4	5	8	8	7	6	7	5	6	9	11	15
Myringoplasty	8	8	8	8	7	7	8	6	6	5	6	6
Myringotomy	22	16	21	21	25	25	28	23	19	15	12	14
Septoplasty	23	25	23	25	26	28	31	30	30	32	32	32
Tonsillectomy	54	54	51	57	54	53	55	56	52	59	63	62
Varicose Veins	7	4	4	5	6	5	7	8	8	11	14	11
Uncoded	18	17	19	17	21	19	20	27	23	20	19	21
Other	108	136	146	137	141	129	141	144	145	151	132	124
TOTAL	260	283	298	298	298	283	312	316	312	332	315	307

Data Source:
TOPAS hospital files provided to the CWLB.

Note: Patients waiting for ophthalmology and orthopaedic procedures are included in *uncoded and other* above.

Table 24: Median and mean waiting times in weeks

	30 Jun-02		30 Jun-03	
	Mean	Median	Mean	Median
Cholecystectomy	16.6	5.7	11.3	4.7
Haemorrhoidectomy	30.7	31.3	35.6	20.7
Inguinal Herniorrhaphy	16.4	16.4	10.9	7.6
Myringoplasty	32.9	23.7	40.5	45.7
Myringotomy	10.4	10.3	27.4	21.7
Septoplasty	23.3	19.9	30.0	26.6
Tonsillectomy	22.1	22.3	32.3	28.1
Repair of Varicose Veins	8.1	7.7	18.9	11.6
Uncoded	52.7	41.7	48.1	34.4
Other	17.7	9.6	28.5	16.8
TOTAL	**21.6**	**14.6**	**29.0**	**17.9**

Data Source:
TOPAS hospital files provided to the CWLB.

Note: Patients waiting for ophthalmology and orthopaedic procedures are included in *uncoded and other* above.

201: Proportion of Emergency Department patients seen within recommended times

This indicator reports the proportion of Emergency Department patients seen within recommended times.

Rationale
When patients first enter an Emergency Department, they are assessed by specially trained nurses, who judge how urgently treatment should be provided. This process, which is known as triage, is to ensure that treatment is given within the appropriate timeframe. This lessens the likelihood that the sicker patients will deteriorate. Treatment within recommended times facilitates restoration to health - either during the emergency visit or, if the patient is admitted to hospital, during the hospital stay.

The triage process and scores are recognised by the Australasian College for Emergency Medicine (ACEM) and are recommended for prioritising all patients who present to an Emergency Department. In a busy Emergency Department, where several people present at the same time the service aims for the best outcome for all.

The triage code indicates how quickly patients should be reviewed by medical staff. A patient is allocated a code between 1 and 5, with category 1 patients being the sickest. This indicator measures the percentage of patients in each triage category who were seen within the time periods recommended by ACEM.

Table 25: Proportion of Emergency Department patients seen within recommended times at Bunbury Hospital

	TARGET	2000/01	2001/02	2002/03
Triage category 1(immediately)	**100%**	100%	100%	100%
Triage category 2 (within 10 minutes)	**80%**	82.7%	69.3%	84.1%
Triage category 3 (within 30 minutes)	**75%**	81.5%	78.0%	83.8%
Triage category 4 (within 60 minutes)	**70%**	78.3%	76.8%	82.3%
Triage category 5 (within 2 hours)	**70%**	91.2%	92.2%	96.1%

Data source:
Bunbury Health Service Emergency Department database.

Note
The Bunbury Hospital is staffed 24 hours a day with Resident Medical Staff. Other health sites rely on Visiting Medical Practitioners.

The Emergency Department waiting times at the Bunbury Health Service have maintained their intervention levels above the ACEM threshold in all 5 Triage categories.

There has been a marked improvement in the intervention rate for Triage category 2 from the previous year. The rate has improved from 69.3% to 84.1%, which can be attributed to improvement in urgency assessment skills and the appropriate triaging of patients.

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

This indicator reports the number of patient presentations to the hospitals where the Emergency Department does not have 24-hour on site by doctors.

Rationale
When emergency patients attend hospital they are initially received in Emergency Departments where assessment, treatment and a decision on whether to admit for further care takes place.

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

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

The numbers of presentations include doctor attended assessments and treatment, as well as nursing assessment and treatment. Note Bunbury Hospital Emergency Department is not reported within this indicator (PI 201 reports Bunbury Hospital Emergency Department information).

Table 26: South West Area Health Service rate of emergency presentations for 2002/2003 with a triage category score of 4 and 5 who were not admitted

Triage Category 4	Triage Category 5
85%	93%

Data Source:
HCARe database.

Note
1. Excludes Bunbury Hospital.

2. No comparative data is available as this is the first year that this performance indicator has been reported.

204: Unplanned hospital re-admissions within 28 days to the same hospital for a related condition

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

Rationale

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

A high percentage of readmissions may indicate that improvements could be made to discharge planning or to aspects of the inpatient treatment. Appropriate medical and/or surgical intervention, together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

The unplanned re-admission rate for 2002/2003 South West Area Health Service was 1.6%.

Data Sources:
HART data.
HCARe, Client Management System.

Comments

The re-admission percentages for South West hospitals are low. These results suggest that good clinical practice and discharge planning are in place.

205: Unplanned hospital re-admissions within 28 days to the same hospital for a mental health condition

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

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

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

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

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

The unplanned re-admission rate for patients with mental health conditions in the South West Area Health Service was 2.7% for 2002/2003.

Data Sources:
HART data.
HCARe, Client Management System.

Comments
The re-admissions rate is well below the ACHS threshold of 10% which suggests that appropriate standards of clinical practice and discharge planning are in place.

206: Rate of post-operative pulmonary embolism

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

Rationale
Post-operatively, patients can develop blood clots in the deep veins of the leg. These clots can travel to the lungs and cause circulatory problems. This is known as a pulmonary embolism and is one of the main causes of death in fit people undergoing elective surgery and it is often preventable.

This indicator measures the percentage rate of patients who underwent surgery and subsequently developed pulmonary embolism. Hospitals have in place protocols that minimise the risk of clots developing and, by monitoring the incidence of post-operative pulmonary embolism, can improve the protocols as necessary. A low percentage of patients developing pulmonary embolism post-operatively suggests that the appropriate precautions have been taken.

The monitoring of post-operative complications is important in ensuring the optimum recovery rate for people with acute illness.

Cases are selected for reporting using the criteria as defined by the Australian Council on Health Care Standards (ACHS). The ACHS standard for good practice is a rate less than 0.8%. Cases are reported for pulmonary embolisms if the post-operative length of stay is greater than or equal to 7 days.

Table 27: Rate of post-operative pulmonary embolism at Bunbury Hospital

ACHS Threshold	2000/2001	2001/2002	2002/2003
0.2% - 0.8%	1.52%	0.96%	0.51%

Data Source:
HART data.

Comments
The post operative pulmonary embolism rates are within the ACHS parameters, suggesting that Bunbury Hospital surgical treatment and care protocols represent good clinical practice.

208: Survival rates for sentinel conditions

This indicator reports the survival rates for stroke, heart attack and fractured hip.

Rationale
The survival of patients in hospitals can be affected by many factors including the patient's diagnosis, the severity of the condition, the patient's age, co-morbid conditions and complications arising. The treatments given and/or procedures performed also contribute to whether or not the patient survives or succumbs to the illness or injury.

Reviewing survival rates is one way to determine if a health service is performing effectively. However, because all patients and their conditions and treatments are different, it is very hard to reach meaningful conclusions by across-the-board comparisons. To overcome this difficulty 'sentinel' conditions have been identified – these are conditions where there is a reasonable expectation that, given the appropriate hospital care, most (but not all) patients are likely to survive.

Three 'sentinel' conditions have been selected and survival rates are measured by specified age groups. For each of these conditions – stroke, heart attack and fractured hip, a good recovery is more likely when there is early intervention and appropriate care.

This indicator measures the South West Area Health Service's performance in relation to restoring the health of people who have had a stroke, myocardial infarction (heart attack) or fractured neck of femur (fractured hip) by measuring those who survive the illness and are discharged from hospital. Some may be transferred to another hospital for specialist rehabilitation or to a hospital closer to home for additional rehabilitation at the end of the acute admission.

Table 28: Rate of stroke survival

	2000	2001	2002
0 – 49 Years	87.5%	100%	100%
50 – 59 Yeas	100%	100%	100%
60 – 69 Years	76.5%	94.7%	100%
70 – 79 Years	91.3%	87.3%	84.2%
80 Years +	66.7%	56.1%	76.1%

Data Source:
Hospital Morbidity Data System.

208: Survival rates for sentinel conditions cont.

Table 29: Rate of acute myocardial infarction (AMI) heart attack survival

	2000	2001	2002
0 – 49 Years	100%	90%	100%
50 – 59 Years	95%	96.55%	100%
60 – 69 Years	100%	93.10%	100%
70 – 79 Years	86.05%	93.18%	87.8%
80 Years +	77.78%	87.10%	76.6%

Data Source:
Hospital Morbidity Data System.

Table 30: Rate of fractured neck of femur survival

	2000	2001	2002
70 – 79 Years	100%	100%	100%
80 Years +	100%	94.44%	96.4%

Data Source:
Hospital Morbidity Data System.

212: Average cost per casemix adjusted separation for South West hospitals

This indicator reports average cost per casemix adjusted separation for South West hospitals.

Rationale
The efficiency of hospitals may be gauged by measuring the average cost of its various services in comparison to previous years' average costs. This indicator, which is a measure of the efficiency of the non-teaching hospitals inpatient services, measures the average cost of providing a single hospital inpatient episode.

Because every hospital has a different mix of cases and every patient is different to every other one, there is a need to standardise the inpatient episodes. Casemix is used to standardise the inpatient activity measures. The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provided against the use of resources. Hence, the number of separations in a hospital may be adjusted from the actual raw number by a casemix index to reflect the complexity of the services provided. South West Area Health Service hospitals utilise the Australian Refined National Diagnostic Related Groups (AR-DRGs) Version 4.2 to which cost weights are allocated.

Table 31: Average cost per casemix adjusted separation for South West hospitals

	2001/2002	2002/2003
Average cost per casemix adjusted separation	$2,469	$3,330
CPI adjusted	$2,396	$3,131

Data Sources:
Hospital Morbidity Data System.
Hospital Financial System.

216: Average cost per non-admitted hospital based service

Rationale
The efficient use of hospital resources can help minimise the overall costs of providing health care and mean that more patients can be treated for the same amount of resources.

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

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

Table 32: Average cost per non-admitted hospital based service

	2001/2002	2002/2003
Average cost per service	$128.24	$105.67
CPI adjusted	$124.47	$99.35

Data Sources:
Hospital Morbidity Data System.
Hospital Financial System.

217: Average cost per non-admitted occasion of service in Northcliffe nursing post

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

Rationale
The effective use of nursing post resources can help minimise the overall costs of providing health care, or mean that more patients can be treated for the same amount of resources.

Because of variations in patient characteristics and service types between sites and across time, there may be differences in service delivery costs. It is important to monitor the unit cost of these specialised service units, which often provide the only health service facility in rural or remote localities.

Table 33: Average cost per non-admitted occasion of service in Northcliffe nursing post

	2001/2002	2002/2003
Northcliffe Nursing Post	$71.00	$150.81
CPI adjusted	$68.91	$141.79

Data Sources:
Northcliffe activity data.
Health Service Financial System.

Comments
Direct comparisons with 2001/2002 cannot be made due to changes in the calculations of the 2002/2003 figure.

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

This indicator reports the average cost per bed-day for admitted patients.

Rationale
While the use of Casemix is a recognised methodology for measuring the cost and complexity of admitted patients in hospitals where there is a wide range of different medical and surgical patients, it is not the accepted method of costing patients in small rural hospitals.

Most small hospitals do not have the advantage of economies of scale. Minimum nursing services may have to be rostered for very few patients. Accordingly the hospitals with limited beds, which provide acute and Nursing Home Type Patient (NHTP) care report patient costs by bed-days.

Table 34: Average cost per bed-day for admitted patients (selected small rural hospitals)

	2002/2003
Average cost per bed-day	$497.62
CPI adjusted	$467.87

Data Sources:
Hospital Morbidity Data System.
Health Service Financial System.

Note
This indicator is being used for the first time and therefore no comparable figures are available.

220: Average cost of patient assisted travel scheme (PATS)

The indicator shows the average cost per trip for PATS.

Rationale
The aim of PATS is to assist permanent country residents to access the nearest medical specialist medical services.

Subsidy is provided towards the cost of travel and accommodation for patients and where necessary an escort for people who have to travel more than 100 kilometres (one way) to attend medical appointments.

Table 35: Average cost of patient assisted travel scheme (PATS)

	2002/2003
Average cost per trip	$89
CPI adjusted	$84

Data Source:
PATS data.

IMPROVEMENT IN THE QUALITY OF LIFE FOR PEOPLE WITH CHRONIC ILLNESS AND DISABILITY

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

To enable people with chronic illness or disability to maintain as much independence in their everyday life as their illness permits, services are provided in clients' homes to enable normal patterns of living that are valued in the general community. Sometimes services are provided in residential facilities when the care needs of the clients exceed what can be provided in a normal home environment.

Indicators developed to measure performance of the South West Area Health Service in Outcome 3 link to the areas indicated in the framework table below.

Table 36: Respective Indicators by Health Sector

Outcome 3: Improving the quality of life for people with chronic illness and disability.	**South West Area Health Service**	**Metropolitan Health Service**	**Peel Health Services**	**WA Country Health Service**	**Royal Street Division**	**WA Drug & Alcohol Authority**
The achievement of this component of the health objective involves activities which:						
1. Supporting people with chronic illness by:						
▪ Providing palliative care services.					R304 R308 R310	
▪ Providing support services to people with chronic illnesses and disabilities.	301	300 301	301	301	R305 R309	
▪ Providing appropriate home care services for the frail aged.	304	304	304	304	R302 R306 R307	
• Providing community support for those with mental illness.	302 303	302 303	302 303	302 303	R311	
• Providing temporary care for those awaiting permanent nursing home care.	305	305				
• Providing appropriate rehabilitative care.					R301 R303	See D&AA Report

301: Median waiting times for community and allied health services (hospital and community based)

This indicator reports the waiting times for Occupational Therapy Services, Speech Pathology Services and Physiotherapy Services. The services are provided at different sites in the South West Area Health Service catchment area.

Rationale

To ensure that their condition and symptoms are managed, and to achieve and maintain an optimal quality of life, people with chronic illness and disability require timely access to appropriate on-going Community and Allied Health treatment services (which may be based in the hospitals or in the community). Without access to appropriate intervention or treatment, the consequences may be more disabling and may lead to a lesser quality of life

This indicator measures the time people wait for appointments at Community and Allied Health services where they can access treatment for their chronic illness or disability.

Results

This indicator measures the median waiting time (in days) for all clients seen during the 2002/2003 from the date of referral to the initial presentation for the first occasion of service. Where available, wait times for 2001/2002 and 2000/2001 are also presented for comparative purposes.

Table 37: South West Area Health Service median waiting times by locality for physiotherapy

	2002/2003
Physiotherapy	14
Occupational Therapy	34
Speech Therapy	35

Data Sources:
HCARe.
Other Health Records.

Note

This is the first year that this indicator has been reported as whole of health service therefore there is no comparative data.

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

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

Rationale

The aim of community management of people with mental illness is to provide the treatment and support required to prevent the recurrence of acute episodes of a severity requiring extended hospitalisation. This indicator shows the extent to which community mental health services have achieved this aim, by measuring the number of bed-days of people under Mental Health community management. This indicator consists of all overnight psychiatric (mental health diagnosis) admissions to public hospitals.

Table 38: South West Area Health Service median bed days for people under community management admitted to hospital

	2000	2001	2002
South West Area Health Service Mental Health Units	10	8	8

Data Source:
Local Area Mental Health Information System (LAMIS).

304: Aged Care Assessment Team (ACAT) assessments

This indicator is in four parts and reports the number of ACAT assessments, the number of first assessments, the waiting time for ACAT assessment for a first referral and the recommended care outcomes for aged care assessments.

Rationale

People within the targeted age groups (70 and over in the non Aboriginal group and 50 and over in the Aboriginal group) are at risk of experiencing a poorer quality of life because of frailty, chronic illness or disability reducing their capacity to manage their activities of daily living. A range of services are available to people requiring support to improve or maintain their optimal quality of life. There are supports available to people living in their own homes as well as supported accommodation options.

ACAT assess the support needs of people who may require services to improve or maintain their quality of life. Appropriate coverage of the 'at risk' population is a measure of ensuring that the needs of this population are adequately assessed and the plans for the provision of required levels of support are developed.

304A: Number of ACAT assessments within targeted age groups per 1,000 population

This indicator reports the extent to which people within the targeted age groups are assessed by Aged Care Assessment Teams.

Table 39: Number of ACAT assessments within targeted age groups per 1,000 population in the South West Area Health Service

Ethnicity	Age group	2001	2002
Non-Aboriginal	70+ years	75.5	77.9
Aboriginal	50+ years	59.8	29.5

Data Source:
University of WA, ACAT data.

304: Aged Care Assessment Team (ACAT) assessments cont.

304B: Number of first ACAT assessments within targeted age groups per 1,000 population

This indicator reports the number of first assessments by Aged Care Assessment Teams per 1,000 of population.

Table 40: Number of first assessments by Aged Care Assessment Teams per 1,000 of population in the South West Area Health Service

	Age group	2001	2002
Non-Aboriginal	70+ years	39.5	40.6
Aboriginal	50+ years	27.2	21.1

Data Source:
University of WA, ACAT data.

304C Median waiting time (Days) for ACAT assessment for a first referral

The median waiting time for ACAT assessment for a first referral in the South West Area Health Service was 3 days.

304: Aged Care Assessment Team (ACAT) assessments cont.

304D Recommended Care Outcomes for Aged Care Assessments

This indicator reports the outcomes achieved through the ACAT process in 2002 in the South West Area Health Service.

Rationale

Aged Care Assessment Teams (ACAT) assess the support needs of people who may require services to improve or maintain their quality of life. The core objective of the service is to comprehensively assess the needs of frail older people to assist them to gain access to the services most appropriate to their needs.

The primary purpose of ACATs and the assessment role is underpinned by the principles of supporting the people in their own homes, in their own communities and recommending residential care, only where their support systems are not appropriate to meet their needs.

Table 41: South West Area Health Service recommended outcomes for all ACAT assessments

	2002			
Outcome	**Aboriginal 50 + years**		**Non Aboriginal 70 + years**	
	Number	**%**	**Number**	**%**
Died before ACAT process completed	0	0%	1	0.1%
Transferred before ACAT process completed	0	0%	6	0.7%
Returned home with services	5	71.4%	338	40.4%
Returned home – no services	0	0%	63	7.5%
Admitted to a nursing home	0	0%	245	29.3%
Remained or returned to a nursing home	1	14.3%	2	0.2%
Admitted to a hostel	1	14.3%	165	19.7%
Remained or returned to a hostel	0	0%	9	1.1%
Other (eg Psychiatric extended care, palliative care)	0	0%	7	0.8%
Total	7		836	

Data Source:
UWA Aged Care Assessment Team data.

303: Average cost per person with mental illness under community management

This indicator reports the South West Area Health Service health services' average cost per person for someone who is being treated for a mental health illness, under Community management.

Rationale
The efficiency of health services may be gauged by measuring the average cost of its various services in comparison to previous years' average costs.

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

Table 42: Average cost per person with mental illness under community management

	2001/2002	2002/2003
Actual average cost	$2,385	$2,316
CPI Adjusted Cost	$2,315	$2,178

Data Sources:
Mental Health Data System.
Health Service Financial Data.

305: Average cost per care awaiting placement (CAP) day

This indicator reports the South West Area Health Service's average cost per CAP for those patients awaiting a permanent placement.

Rationale
The efficiency of health services may be gauged by measuring the average cost of its various services in comparison to previous years' average costs.

Some people with chronic illness or disability, even with regular respite care and HACC service, are not able to be cared for at home. They may need long term residential care to ensure that their quality of life is maintained and, in some instances, there may be a period of waiting before long term residential care becomes available.

The Department of Health manages a Care Awaiting Placement (CAP) program to ensure that those who need residential placement can remain in temporary care while awaiting more permanent placement.

Table 43: Average cost per care awaiting placement (CAP) Day

	2002/2003
Cost per CAP day	$352
CPI adjusted	$331

Data Sources:
Hospital Morbidity Data System.
Health Service Financial System.

Note
This is the first year that this indicator has been reported therefore there is no comparative data.

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2003

The accompanying financial statements of the South West Health Board have been prepared in compliance with the provisions of the Financial Administration and Audit Act 1985 from proper accounts and records to present fairly the financial transactions for the reporting period ending 30 June 2003 and the financial position as at 30 June 2003.

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.

Michael Daube
Director General of Health
Accountable Authority for South West Health Board

28/08/03

Philip Aylward
Principal Accounting Officer
South West Health Board

28/08/03

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

SOUTH WEST HEALTH BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2003

Audit Opinion
In my opinion,

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

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at June 30, 2003 and its financial performance and cash flows for the year ended on that date.

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

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

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

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

D D R PEARSON
AUDITOR GENERAL
November 20, 2003

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Statement of Financial Performance
For the year ended 30 June 2003

	Note	2003 $	2002 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	4	65,485,644	61,786,385
Fees for visiting medical practitioners		10,948,126	10,278,166
Patient support costs	5	12,887,661	11,832,268
Patient transport costs		1,305,367	1,186,230
Borrowing costs expense	6	250,252	276,271
Repairs, maintenance and consumable equipment expense		2,251,053	3,549,698
Depreciation expense	7	4,283,105	4,378,081
Capital user charge	9	8,175,931	8,067,396
Other expenses from ordinary activities	10	5,577,611	5,841,002
Total cost of services		111,164,750	107,195,497
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	11	3,027,518	3,157,035
Commonwealth grants and contributions	12	543,072	979,641
Other revenues from ordinary activities	14a	2,145,051	3,097,294
Revenue from non-operating activities			
Donations revenue	13	133,137	89,334
Interest revenue		46,432	38,537
Proceeds from disposal of non-current assets	8	0	98,378
Other revenues from non operating activities	14b	241,463	309,229
Total revenues from ordinary activities		6,136,673	7,769,448
NET COST OF SERVICES		**105,028,077**	**99,426,049**
Revenues from State Government			
Output appropriations	15	105,221,976	99,788,356
Assets assumed / (transferred)	16	0	94,116,981
Liabilities assumed by the Treasurer	17	0	109,382
Resources received free of charge	18	173,333	107,000
Total revenues from State Government		105,395,309	194,121,719
Change in net assets before extraordinary items		367,232	94,695,670
Change in net assets		**367,232**	**94,695,670**
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	31	(71,153)	0
Total revenues, expenses and valuation adjustments recognised directly in equity		(71,153)	0
Total changes in equity other than those resulting from transactions with WA State Government as owners		**296,079**	**94,695,670**

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

Statement of Financial Position
As at 30 June 2003

	Note	2003 $	2002 $
CURRENT ASSETS			
Cash assets	19	2,604,933	2,973,688
Restricted cash assets	20	221,775	213,815
Receivables	21	1,933,336	2,327,429
Amounts receivable for outputs	22	941,000	0
Inventories	23	412,748	525,857
Other assets	24	256,013	64,727
Total current assets		6,369,805	6,105,516
NON-CURRENT ASSETS			
Amounts receivable for outputs	22	6,558,411	4,447,725
Property, plant and equipment	25	108,355,375	110,636,642
Total non-current assets		114,913,786	115,084,367
Total assets		**121,283,591**	**121,189,883**
CURRENT LIABILITIES			
Payables	26	4,315,853	3,478,273
Interest-bearing liabilities	27	116,218	120,579
Provisions	28	8,929,172	8,271,864
Other liabilities	29	2,669,905	3,882,418
Total current liabilities		16,031,148	15,753,134
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	27	3,122,094	3,239,072
Provisions	28	4,985,896	5,494,658
Total non current liabilities		8,107,990	8,733,730
Total liabilities		**24,139,138**	**24,486,864**
Net Assets		**97,144,453**	**96,703,019**
EQUITY			
Contributed equity	30	2,152,703	2,007,349
Accumulated surplus / (deficiency)	31	94,991,750	94,695,670
Total Equity		**97,144,453**	**96,703,019**

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

Statement of Cash Flow
For the year ended 30 June 2003

	Note	2003 $ Inflows (Outflows)	2002 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Output appropriations	32(c)	92,644,516	87,613,103
Net cash provided by State Government		92,644,516	87,613,103
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(37,350,632)	(36,629,581)
Employee costs		(61,338,337)	(54,342,095)
GST payments on purchases		(3,156,083)	(3,191,203)
Receipts			
Receipts from customers		2,919,282	3,174,299
Commonwealth grants and contributions		579,572	958,998
Donations		136,902	89,334
Interest received		47,234	39,656
GST receipts on sales		346,654	389,922
GST receipts from taxation authority		3,012,004	2,399,081
Other receipts		2,896,737	2,757,272
Net cash (used in) / provided by operating activities	32(b)	(91,906,667)	(84,354,317)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	25	(1,098,644)	(1,134,857)
Proceeds from disposal of non-current assets	8	0	222,006
Net cash (used in) / provided by investing activities		(1,098,644)	(912,851)
Net increase / (decrease) in cash held		(360,795)	2,345,935
Cash assets at the beginning of the financial year		3,187,503	841,568
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	32(a)	2,826,708	3,187,503

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

Note 1 Significant accounting policies

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

(a) General Statement

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

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

(b) Basis of Accounting

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

(c) Output Appropriations

Output Appropriations are recognised as revenues in the period in which the Health Service gains control of the appropriated funds. The Health Service gains control of appropriated funds at the time those funds are deposited into the Health Service's bank account or credited to the holding account held at the Department of Treasury and Finance.

(d) Contributed Equity

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

(e) Acquisitions of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.
Assets acquired at no cost or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

(f) Depreciation of non-current assets

Non-current assets are carried at cost.

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

Note 1 Significant accounting policies (continued)

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

Buildings	50 years
improvements	lease
equipment	5 to 15 years
fittings	5 to 50 years
vehicles	4 to 10 years
and	4 to 50 years

(g) Revaluation of Land, Buildings and Infrastructure

South West Area Health Service has a policy of valuing land, buildings and infrastructure at fair value. The annual revaluations of the South West Area Health Service land and buildings undertaken by the Valuer General Office are recognised in the financial statements. Infrastructure assets have been bought into South West Area Health Service as fair value at the date of consolidation. Land and buildings will be progressively revalued to fair value under the transitional provisions in AASB 1041 (8.12)(b).

(h) Leases

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

(i) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets net of outstanding bank overdrafts. These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(j) Receivables

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

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

(k) Inventories

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

(l) Payables

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

(m) Accrued Salaries

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

(n) Interest-bearing liabilities

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

Note 1 Significant accounting policies (continued)

(o) Employee Benefits

Annual Leave

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

Long Service Leave

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

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

Superannuation

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

The Pension Scheme is unfunded and the liability for future payments is provided for at reporting date.

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

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

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

Deferred Salary Scheme

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

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

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses.

(p) Revenue Recognition

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

Note 1 Significant accounting policies (continued)

(q) Grants and Other Contributions Revenue

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

Contributions are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

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

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

(s) Rounding of amounts

Amounts in the financial statements have been rounded to the nearest dollar.

(t) Comparative Figures

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

Note 2 Outputs of the Health Service

Information about the Health Service's outputs and, the expenses and revenues which are reliably attributable to those outputs is set out in Note 44. The three key outputs of the Health Service are:

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

Diagnosis and Treatment
The objective for the diagnosis and treatment services is to improve the health of Western Australians by restoring the health of people with acute illness. The services provided to diagnose and treat patients include emergency services; ambulatory care or outpatient services and services for those people who are admitted to hospitals.

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

Note 3 Administered trust accounts

	2003 $	2002 $

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

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

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

Opening Balance	152,889	140,383
Add Receipts		
- Patient Deposits	233,899	301,568
- Interest	1,075	1,024
	387,863	442,975
Less Payments		
- Patient Withdrawals	239,930	290,016
- Interest / Charges	80	70
Closing Balance	147,854	152,889

Note 4 Employee expenses

Salaries and wages	54,636,233	50,877,701
Superannuation	5,147,028	4,622,642
Annual leave	4,556,846	5,029,119
Long service leave	1,145,537	1,256,923
	65,485,644	61,786,384

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

The related on-costs liability is included in employee benefit liabilities at Note 28.

Note 5 Patient support costs

Medical supplies and services	6,096,947	4,962,724
Domestic charges	981,433	910,480
Fuel, light and power	1,468,330	1,651,100
Food supplies	1,746,357	1,679,476
Purchase of external services	2,594,592	2,628,487
	12,887,661	11,832,268

Note 6 Borrowing costs expense

Interest paid	250,252	276,271
	250,252	276,271

Note 7 Depreciation expense

Buildings	2,890,636	2,961,960
Computer equipment and software	402,725	404,978
Furniture and fittings	254,696	211,975
Motor vehicles	45,942	71,577
Other plant and equipment	689,106	727,591
	4,283,105	4,378,081

Note 8 Net gain / (loss) on disposal of non-current assets	2003 $	2002 $
a) Proceeds from disposal of non-current assets	0	98,378
b) Gain / (Loss) on disposal of non-current assets:		
Computer equipment and software	(1,388)	(4,354)
Furniture and fittings	(4,988)	68,460
Motor vehicles	0	54,393
Other plant and equipment	(5,205)	(20,121)
	(11,581)	98,378

Note 9 Capital user charge

	8,175,931	8,067,396

A capital user charge rate of 8% has been set by the Government for 2002/03 and represents the opportunity cost of capital invested in the net assets of the Health Service used in the provision of outputs. The charge is calculated on the net assets adjusted to take account of exempt assets. Payments are made to the Department of Treasury and Finance on a quarterly basis by the Department of Health on behalf of the Health Service.

Note 10 Other expenses from ordinary activities

Workers compensation insurance	1,166,751	1,335,009
Staff related expenses	661,702	572,794
Motor vehicle expenses	596,055	604,652
Insurance	582,702	588,223
Communications	815,484	700,358
Printing and stationery	544,201	446,568
Rental of property	242,236	260,861
Audit fees - external	149,353	158,042
Bad and doubtful debts expense	9,697	9,098
Carrying amount of non-current assets disposed of	11,581	0
Other	797,849	1,165,398
	5,577,611	5,841,002

Note 11 Patient charges

Inpatient charges	2,912,649	3,041,642
Outpatient charges	114,870	115,393
	3,027,518	3,157,035

Note 12 Commonwealth grants and contributions	2003 $	2002 $
Grant for nursing homes	0	428,154
Commonwealth Specific Grants		
PTAC Funding (Interns)	0	13,000
Primary Health Care	0	29,127
CAEP Funding	288,865	281,686
Additional Counselling Support	0	57,500
Safety Inovations In Practice (SIIP)	55,000	9,000
Epidural Practice Improvement Program	0	9,000
Nursing Clinical Placement Program	0	19,250
Stay On Your Feet Program	0	263
Diabetes Program	69,367	33,327

	2003 $	2002 $
Note 12 Commonwealth grants and contributions (continued)		
HACC Funding	7,194	3,320
DH & AC Administered Carer Funding	7,491	15,277
Warren Blackwood Mental Health Project	24,400	63,636
Speech Therapy Funding	2,500	2,500
Dieticians Program	0	12,600
Play To Grow Program	0	2,000
HFS Rural56 DHA Administered Program	25,988	0
Podiatry Monitoring For Diabetes Program	7,000	0
PGR Nutrition Small Grant	45	0
Health Education / Promotion Activities (Asthma) Program	361	0
Rural Chronic Disease Initiative	31,180	0
South West Clinical Placement Program	23,625	0
Keep Diabetes At Bay	57	0
	543,072	979,641
Note 13 Donations revenue		
General public contributions	133,137	89,334
	133,137	89,334
Note 14 Other revenues from ordinary activities		
a) Revenue from operating activities		
Recoveries	1,682,154	2,535,805
Use of hospital facilities	462,897	561,488
	2,145,051	3,097,294
b) Revenue from non-operating activities		
Rent from properties	102,165	140,255
Boarders' accommodation	5,745	2,359
Other	133,554	166,615
	241,463	309,229
	2,386,514	3,406,523
Note 15 Output appropriations		
Appropriation revenue received during the year:		
Output appropriations	105,221,976	99,788,356

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

	2003	2002
Note 16 Assets assumed / (transferred)	**$**	**$**
The following assets have been assumed from / (transferred to) other state government agencies during the financial year:		
- Bunbury Health Service	0	42,350,281
- Harvey Yarloop Health Service	0	3,068,704
- Vasse Leeuwin Health Service	0	13,878,715
- Warren Blackwood Health Service	0	23,160,040
- Wellington Health Service	0	11,659,241
Total assets assumed / (transferred)	0	94,116,981

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

Note 17 Liabilities assumed by the Treasurer

Superannuation	0	109,382

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

Note 18 Resources received free of charge

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

Office of the Auditor General		
- Audit services	152,000	107,000
Other (please specify)		
- PR777 Scanning Laser donated to Collie Hospital by Coalminers Institute	21,333	0
	173,333	107,000

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

Note 19 Cash assets

Cash on hand	67,640	23,340
Cash at bank - general	2,205,046	2,109,729
Cash at bank - donations	332,247	840,620
	2,604,933	2,973,688

Note 20 Restricted cash assets	2003 $	2002 $
Cash assets held for specific purposes		
Cash at bank - Donations Percy Dewe Account	221,775	213,815
	221,775	213,815

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

Note 21 Receivables

Patient fee debtors	480,447	417,553
GST receivable	507,593	638,968
Other receivables	1,030,662	1,404,256
	2,018,703	2,460,778
Less: Provision for doubtful debts	(85,367)	(133,349)
	1,933,336	2,327,429

Note 22 Amounts receivable for outputs

Current	941,000	0
Non-current	6,558,411	4,447,725
	7,499,411	4,447,725

Balance at beginning of year	4,447,725	0
Capital subsidy from DoH	(2,738,316)	4,447,725
Accrual appropriations - Depreciation	4,692,289	0
Accrual appropriations - Employee Entitlements	1,097,713	0
Balance at end of year	7,499,411	4,447,725

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

Note 23 Inventories

Supply stores - at cost	347,916	416,759
Pharmaceutical stores - at cost	53,564	100,865
Engineering stores - at cost	11,268	8,233
	412,748	525,857

Note 24 Other assets

Prepayments	256,013	64,727

Note 25 Property, plant and equipment	2003 $	2002 $
Land		
At cost	6,651,000	6,651,000
	6,651,000	6,651,000
Buildings		
Clinical:		
At cost	98,438,566	98,231,889
Accumulated Depreciation	(5,802,139)	(2,936,347)
	92,636,427	95,295,542
Total of clinical buildings	92,636,427	95,295,542
Non-Clinical:		
At cost	974,022	974,022
Accumulated depreciation	(50,457)	(25,613)
	923,565	948,409
Total of non clinical buildings	923,565	948,409
Total of all land and buildings	100,210,992	102,894,951
Computer equipment and software		
At cost	1,974,782	1,649,171
Accumulated depreciation	(803,789)	(404,978)
	1,170,993	1,244,193
Furniture and fittings		
At cost	3,101,804	2,520,971
Accumulated depreciation	(462,216)	(211,927)
	2,639,588	2,309,044
Motor vehicles		
At cost	187,748	187,748
Accumulated depreciation	(111,182)	(65,240)
	76,566	122,508
Other plant and equipment		
At cost	5,618,908	4,744,557
Accumulated depreciation	(1,410,652)	(727,591)
	4,208,256	4,016,966
Works in progress		
Other Work in Progress	48,980	48,980
	48,980	48,980
Total of property, plant and equipment	108,355,375	110,636,642

Land and buildings

(i)

Land, clinical buildings and non-clinical buildings are carried at the fair value.

Payments for non-current assets

Payments were made for purchases of non-current assets during the reporting period as follows:

Paid as cash by the Health Service from output appropriations	980,790	1,029,763
Paid as cash by the Health Service from capital contributions	22,400	105,094
Paid as cash by the Health Service from donations account	95,454	0
Paid by the Department of Health	943,236	6,813,759
Gross payments for purchases of non-current assets	2,041,880	7,948,616

Note 25 Property, plant and equipment (continued)

Reconciliations

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

	2003 $
Land	
Carrying amount at start of year	6,651,000
Carrying amount at end of year	6,651,000
Buildings	
Carrying amount at start of year	96,243,951
Additions	206,677
Depreciation	(2,890,636)
Carrying amount at end of year	93,559,992
Computer equipment and software	
Carrying amount at start of year	1,244,193
Additions	328,220
Disposals	(8,714)
Depreciation	(402,725)
Adjustments for amalgamation of health service	2,693
Write-back of accumulated depreciation on disposal of assets	7,326
Carrying amount at end of year	1,170,993
Furniture and fittings	
Carrying amount at start of year	2,309,044
Additions	614,464
Disposals	(32,029)
Depreciation	(254,696)
Adjustments for amalgamation of health service	(24,236)
Write-back of accumulated depreciation on disposal of assets	27,041
Carrying amount at end of year	2,639,588
Motor vehicles	
Carrying amount at start of year	122,508
Depreciation	(45,942)
Carrying amount at end of year	76,566
Other plant and equipment	
Carrying amount at start of year	4,016,966
Additions	892,519
Disposals	(36,375)
Depreciation	(689,106)
Adjustments for amalgamation of health service	(6,918)
Write-back of accumulated depreciation on disposal of assets	31,170
Carrying amount at end of year	4,208,256
Works in progress	
Carrying amount at start of year	48,980
Carrying amount at end of year	48,980
Total property, plant and equipment	
Carrying amount at start of year	110,636,642
Additions	2,041,880
Disposals	(77,118)
Depreciation	(4,283,105)
Adjustments for amalgamation of health service	(28,461)
Write-back of accumulated depreciation on disposal of assets	65,537
Carrying amount at end of year	108,355,375

	2003 $	2002 $
Note 26 Payables		
Current		
Trade Payables	4,315,853	3,478,273
Note 27 Interest-bearing liabilities		
Current liabilities:		
Western Australian Treasury Corporation loans	20,891	21,752
Department of Treasury and Finance loans	95,327	98,826
	116,218	120,579
Non-current liabilities:		
Western Australian Treasury Corporation loans	524,565	546,196
Department of Treasury and Finance loans	2,597,529	2,692,876
	3,122,094	3,239,072
Total interest-bearing liabilities	3,238,312	3,359,651
Western Australian Treasury Corporation (WATC) loans		
Balance at beginning of year	567,949	589,946
Less repayments this year	(22,493)	(21,997)
Balance at end of year	545,455	567,949

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

Department of Treasury and Finance loans		
Balance at beginning of year	2,791,703	2,886,178
Less repayments this year	(98,846)	(94,475)
Balance at end of year	2,692,856	2,791,703

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

Note 28 Provisions		
Current liabilities:		
Annual leave	6,356,064	6,004,075
Long service leave	2,379,840	2,015,104
Superannuation	193,268	252,685
	8,929,172	8,271,864
Non-current liabilities:		
Long service leave	2,396,141	2,542,837
Deferred salary scheme	37,742	0
Superannuation	2,552,014	2,951,821
	4,985,896	5,494,658
Total employee benefit liabilities	13,915,068	13,766,522

	2003 $	2002 $

Note 28 Provisions (continued)

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

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

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

Note 29 Other liabilities

Accrued salaries	2,669,905	3,882,418
	2,669,905	3,882,418

Note 30 Contributed equity

Balance at beginning of the year	2,007,349	0
Capital contributions (i)	145,354	2,007,349
Balance at end of the year	2,152,703	2,007,349

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

Note 31 Accumulated surplus / (deficiency)

Balance at beginning of the year	94,695,670	0
Change in net assets	367,232	94,695,670
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	(71,153)	0
Balance at end of the year	94,991,749	94,695,670

Note 32 Notes to the statement of cash flows

a) **Reconciliation of cash**

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

Cash assets (Refer note 19)	2,604,933	2,973,688
Restricted cash assets (Refer note 20)	221,775	213,815
	2,826,708	3,187,503

Note 32 Notes to the statement of cash flows (continued)	2003 $	2002 $
b) **Reconciliation of net cash flows used in operating activities to net cost of services**		
Net cash used in operating activities (Statement of Cash Flows)	(91,906,667)	(84,354,317)
Increase / (decrease) in assets:		
GST receivable	(131,375)	346,187
Other receivables	(310,700)	285,890
Inventories	(113,109)	16,964
Prepayments	191,286	13,631
Decrease / (increase) in liabilities:		
Doubtful debts provision	47,982	6,315
Payables	(837,580)	539,068
Accrued salaries	1,212,513	(1,935,151)
Provisions	(148,546)	(1,063,116)
Income received in advance	0	0
Non-cash items:		
Depreciation expense	(4,283,105)	(4,378,081)
Net gain / (loss) from disposal of non-current assets	(11,581)	98,378
Interest paid by Department of Health	(250,252)	(276,271)
Capital user charge paid by Department of Health	(8,175,931)	(8,067,396)
Superannuation liabilities assumed by the Treasurer	0	(109,382)
Resources received free of charge	(173,333)	(107,000)
Other	(137,679)	(441,767)
Net cost of services (Statement of Financial Performance)	(105,028,077)	(99,426,049)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	105,221,976	99,788,356
Capital appropriations credited directly to Contributed Equity (Refer Note 30)	145,354	2,007,349
Holding account drawdowns credited to Amounts Receivable for Outputs (Refer Note 22)	2,738,316	0
	108,105,645	101,795,705
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to WA Treasury Corporation	(32,893)	(31,921)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(22,493)	(21,997)
Interest paid to Department of Treasury & Finance	(217,359)	(244,350)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	(98,846)	(94,475)
Capital user charge	(8,175,931)	(8,067,396)
Capital subsidy transferred to equity	(1,123,611)	(1,218,621)
Output appropriations accrual	(5,790,000)	(4,447,725)
Other non cash adjustments to output appropriations	3	(56,115)
	(15,461,129)	(14,182,602)
Cash Flows from State Government as per Statement of Cash Flows	92,644,516	87,613,103

Note 33 Revenue, public and other property written off or presented as gifts		
a) Revenue and debts written off by the accountable authority.	9,697	15,188

Note 34 Losses through theft, defaults and other causes

	2003 $	2002 $
Losses of public moneys and public or other property through theft or default	0	7,136
Less amount recovered	0	8,468
Net losses	0	(1,332)

Note 35 Remuneration of members of the accountable authority and senior officers

Remuneration of senior officers

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

	2003	2002
$30,001 - $40,000	1	0
$50,001 - $60,000	2	0
$60,001 - $70,000	3	0
$70,001 - $80,000	8	7
$80,001 - $90,000	0	7
$90,001 - $100,000	5	5
$100,001 - $110,000	4	1
$110,001 - $120,000	2	0
$140,001 - $150,000	1	0
$170,001 - $180,000	1	0
$210,001 - $220,000	1	0
Total	28	20

	$	$
The total remuneration of senior officers is:	2,607,754	1,800,000

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

Numbers of Senior Officers presently employed who are members of the Pension Scheme:	0	0

Note 36 Commitments for Expenditure

a) **Capital expenditure commitments**

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

Within one year	171,210	0
	171,210	0

The capital commitments include amounts for:

- Buildings	0	0

Note 36 Commitments for Expenditure (continued)	2003 $	2002 $
b) **Operating lease commitments:**		
Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:		
Within one year	333,456	384,880
Later than one year, and not later than five years	113,467	104,027
	446,923	488,907

These commitments are all inclusive of GST.

Note 37 Contingent liabilities and contingent assets

At the reporting date, the Health Service is liable for an outstanding debt to the Insurance Commission of Western Australia of $75,553.00. The Health Service is not aware of any other contingent liabilities and contingent assets at the time of reporting.

Note 38 Events occurring after reporting date

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

Note 39 Related bodies

A related body is a body which receives more than half its funding and resources from the Health Service and is subject to operational control by the Health Service. Related bodies are generally government agencies which have no financial administration responsibilities.

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

Note 40 Affiliated bodies

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

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

Note 41 Net Revenues from restructuring

A new statutory authority was formed under section 16 of the Hospitals and Health Services Act 1927 on 1st July 2002. Net assets transferred to the Board by the amalgamation are :

	2003 $	2002 $
- Bunbury Health Service	0	42,350,281
- Harvey Yarloop Health Service Board	0	3,068,704
- Vasse Leeuwin Health Board	0	13,878,715
- Warren Blackwood Health Service Board	0	23,160,040
- Wellington Health Service Board	0	11,659,241
	0	94,116,981

Note 42 Explanatory statement

a) **Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.**
Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10%.

	2003 $	2002 $	Variation %
Expenses from Ordinary Activities			
Employee expenses	65,485,644	61,786,385	5.99%
Fees for visiting medical practitioners	10,948,126	10,278,166	6.52%
Patient support costs	12,887,661	11,832,268	8.92%
Patient transport costs	1,305,367	1,186,230	10.04%
PATS expenditure is dependent on clients meeting the PATS guidelines and as such health service does not have full control of expenditure in this area. Patient transport has been impacted upon by normal CPI increases along with the increase in patient activity the health service has experienced in the 2002/2003 financial year.			
Borrowing costs expense	250,252	276,271	(9.42%)
The borrowing cost expense has decreased in line with the decrease in principal to be repaid.			
Repairs, maintenance and consumable equipment expens	2,251,053	3,549,698	(36.58%)
A thorough review of all repairs and maintenance in 2002/2003 resulted in the capitalisation of many items that have previously been expensed. Also repairs and maintenance programs were deferred until 2003/2004 due to budgetary constraints.			
Depreciation expense	4,283,105	4,378,081	(2.17%)
Capital user charge	8,175,931	8,067,396	1.35%
Other expenses from ordinary activities	5,577,611	5,841,002	(4.51%)
Revenues from Ordinary Activities			
Revenue from operating activities			
Patient charges	3,027,518	3,157,035	(4.10%)
Commonwealth grants and contributions	543,072	979,641	(44.56%)
The health service lost approximately $540,000 of nursing home revenue due to the Forrest Lodge Nursing Home being transferred to private interests.			
Other revenues from ordinary activities	2,145,051	3,097,294	(30.74%)
The decrease in other revenues is attributed to the amalgamation of the health service. In prior financial years, some revenue received from separate health services was reported as separate revenue collections.			
Revenue from non-operating activities			
Donations revenue	133,137	89,334	49.03%
Public donations by nature are not under the control of the health service and will vary from year to year.			
Interest revenue	46,432	38,537	20.49%
Increased bank balances in the separate health services bank accounts has resulted in a slight increase in the bank interest received in this financial year.			
Proceeds from disposal of non-current assets	0	98,378	(100.00%)
No asset were sold in the current financial year.			

Note 42 Explanatory statement (continued)	2003 $	2002 $	Variation %
Other revenues from non operating activities	241,463	309,229	(21.91%)

A medical practice renting rooms in the Busselton Community Health Centre relocated to private premises during the financial year resulting in a decrease in rent from properties.

b) **Significant variations between estimates and actual results for the financial year.**

Section 42 of the Financial Administration and Audit Act requires the health service to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget and will always include any reported extradinary items in the statement of financial performance.

	2003 Actual $000's	2003 Estimate $000's	Variation %
COST OF SERVICES			
Expenses from Ordinary Activities			
Salaries and wages	60,338.6	62,277.3	(3.11%)
Fees for visiting medical practitioners	10,948.1	10,791.9	1.45%
Superannuation	5,147.0	4,964.6	3.67%
Direct patient support cost	10,293.1	9,392.1	9.59%
Indirect patient support cost	3,900.0	3,911.3	(0.29%)
Borrowing costs expense	250.3	300.0	(16.58%)

Less than anticipated borrowing cost expenses due to the decrease in interest rates.

Repairs, maintenance and consumable equipment	2,251.1	3,362.5	(33.05%)

A thorough review of all repairs and maintenance in 2002/2003 resulted in the capitalisation of many items that have previously been expensed. Also repairs and maintenance programs were deferred until 2003/2004 due to budgetary constraints.

Depreciation expense	4,283.1	4,400.0	(2.66%)
Net loss on disposal of non-current assets	11.6	0.0	100.00%

No asset were sold in the current financial year.

Capital user charge	8,175.9	8,080.0	1.19%
Other expenses from ordinary activities	5,566.0	5,731.4	(2.89%)
Total cost of services	**111,164.7**	**113,211.1**	**(1.81%)**
Revenues from Ordinary Activities			
Patient charges	3,027.5	3,150.0	(3.89%)
Commonwealth grants and contributions	543.1	1,180.0	(53.98%)

The health service lost approximately $540,000 of nursing home revenue due to the Forrest Lodge Nursing Home being transferred to private interests.

Donations revenue	133.1	65.0	104.83%

Public donations by nature are not under the control of the health service and will vary from year to year.

Interest revenue	46.4	40.0	16.08%

Increased bank balances in the separate health services bank accounts has resulted in a slight increase in the bank interest received in this financial year.

Note 42 Explanatory statement (continued)	2003 Actual $000's	2003 Estimate $000's	Variation %
Recoveries	1,682.2	2,540.0	(33.77%)
The decrease in other revenues is attributed to the amalgamation of the health service. In previous financial years, some revenue received from separate health services was reported as separate revenue collections.			
Use of facilities	452.6	545.0	(16.96%)
External billing processes beyond the health servives control have resulted in a reduced income for the current financial year. This issue is under review.			
Other revenues	251.8	370.0	(31.94%)
The decrease in other revenues is attributed to the amalgamation of the health service. In previous financial years, some revenue received from separate health services was reported as separate revenue collections.			
Total revenues from ordinary activities	**6,136.7**	**7,890.0**	**(22.22%)**
NET COST OF SERVICES	**105,028.1**	**105,321.1**	**(0.28%)**
Revenues from State Government			
Output appropriations	105,222.0	108,482.0	(3.01%)
Resources received free of charge	173.3	110.0	57.58%
Total revenues from State Government	**105,395.3**	**108,592.0**	**(2.94%)**

Note 43 Financial instruments

a) **Interest rate risk exposure**

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

	Weighted average effective interest rate	Variable interest rate	Fixed interest rate maturities			Non interest bearing	Total
			Less than 1 year	1 to 5 years	Over 5 years		
	%	$000	$000	$000	$000	$000	$000
As at 30th June 2003							
Financial Assets							
Cash assets	0.0%	2,537.4	0.0	0.0	0.0	67.6	2,605.0
Restricted cash assets	0.0%	222.0	0.0	0.0	0.0		222.0
Receivables						1,933.3	1,933.3
		2,759.4	0.0	0.0	0.0	2,000.9	4,760.3
Financial Liabilities							
Payables						4,315.9	4,315.9
Interest-bearing liabilities							
- W A Treasury Corporation loans	5.7%		21.0	525.0	0.0		546.0
- Department of Treasury & Finance loans	7.8%		95.0	2,598.0	0.0		2,693.0
- Other loans	0.0%		0.0	0.0	0.0		0.0
- Finance lease liabilities	0.0%		0.0	0.0	0.0		0.0
		0.0	116.0	3,123.0	0.0	4,315.9	7,554.9
Net financial assets / (liabilities)		2,759.4	(116.0)	(3,123.0)	0.0	(2,315.0)	(2,794.6)

Note 43 Financial instruments (continued)

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.0%	2,950.4	0.0	0.0	0.0	23.3	2,973.7
Restricted cash assets	0.0%	213.8	0.0	0.0	0.0		213.8
Receivables						2,327.4	2,327.4
		3,164.2	0.0	0.0	0.0	2,350.7	5,514.9
Financial Liabilities							
Payables						3,478.3	3,478.3
Interest-bearing liabilities							
- W A Treasury Corporation loans	5.7%		21.8	91.9	454.3		568.0
- Department of Treasury & Finance loans	8.6%		98.8	443.3	2,249.6		2,791.7
- Other loans	0.0%		0.0	0.0	0.0		0.0
- Finance lease liabilities	0.0%		0.0	0.0	0.0		0.0
		0.0	120.6	535.2	2,703.9	3,478.3	6,838.0
Net financial assets / (liabilities)		3,164.2	(120.6)	(535.2)	(2,703.9)	(1,127.6)	(1,323.1)

b) **Credit risk exposure**

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

c) Net fair values

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

Note 44 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Totals	
	2003	2002	2003	2002	2003	2002	2003	2002
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	5,068.6	4,782.3	56,088.5	52,920.0	4,328.6	4,084.1	65,485.6	61,786.4
Fees for visiting medical practitioners	847.4	795.5	9,377.1	8,803.2	723.7	679.4	10,948.1	10,278.2
Patient support costs	997.5	915.8	11,038.3	10,134.3	851.9	782.1	12,887.7	11,832.3
Patient transport costs	101.0	91.8	1,118.0	1,016.0	86.3	78.4	1,305.4	1,186.2
Borrowing costs expense	19.4	21.4	214.3	236.6	16.5	18.3	250.3	276.3
Repairs, maintenance and consumable equipment expen	174.2	274.7	1,928.0	3,040.3	148.8	234.6	2,251.1	3,549.7
Depreciation expense	331.5	338.9	3,668.5	3,749.8	283.1	289.4	4,283.1	4,378.1
Asset revaluation decrement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital user charge	632.8	624.4	7,002.7	6,909.7	540.4	533.3	8,175.9	8,067.4
Other expenses from ordinary activities	431.7	452.1	4,777.2	5,002.8	368.7	386.1	5,577.6	5,841.0
Total cost of services	8,604.2	8,296.9	95,212.6	91,812.9	7,348.0	7,085.6	111,164.7	107,195.5
Revenues from Ordinary Activities								
Revenue from operating activities								
Patient charges	234.3	244.4	2,593.1	2,704.0	200.1	208.7	3,027.5	3,157.0
Commonwealth grants and contributions	42.0	75.8	465.1	839.1	35.9	64.8	543.1	979.6
Other revenues from operating activities	166.0	239.7	1,837.2	2,652.8	141.8	204.7	2,145.1	3,097.3
Revenue from non-operating activities								
Donations revenue	10.3	6.9	114.0	76.5	8.8	5.9	133.1	89.3
Interest revenue	3.6	3.0	39.8	33.0	3.1	2.5	46.4	38.5
Proceeds from disposal of non-current assets	0.0	7.6	0.0	84.3	0.0	6.5	0.0	98.4
Other revenues from non operating activities	18.7	23.9	206.8	264.9	16.0	20.4	241.5	309.2
Total revenues from ordinary activities	475.0	601.4	5,256.1	6,654.5	405.6	513.6	6,136.7	7,769.4
NET COST OF SERVICES	**8,129.2**	**7,695.6**	**89,956.5**	**85,158.4**	**6,942.4**	**6,572.1**	**105,028.1**	**99,426.0**

Note 44 Output information (continued)

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Totals	
	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000	2003 $000	2002 $000
Revenues from State Government								
Output appropriations	8,144.2	7,723.6	90,122.6	85,468.7	6,955.2	6,596.0	105,222.0	99,788.4
Assets assumed / (transferred)	0.0	7,284.7	0.0	80,611.2	0.0	6,221.1	0.0	94,117.0
Liabilities assumed by the Treasurer	0.0	8.5	0.0	93.7	0.0	7.2	0.0	109.4
Resources received free of charge	13.4	8.3	148.5	91.6	11.5	7.1	173.3	107.0
Total revenues from State Government	8,157.6	15,025.0	90,271.1	166,265.3	6,966.6	12,831.4	105,395.3	194,121.7
Change in net assets before extraordinary items	**28.4**	**7,329.4**	**314.5**	**81,106.8**	**24.3**	**6,259.4**	**367.2**	**94,695.7**
Change in net assets	**28.4**	**7,329.4**	**314.5**	**81,106.8**	**24.3**	**6,259.4**	**367.2**	**94,695.7**