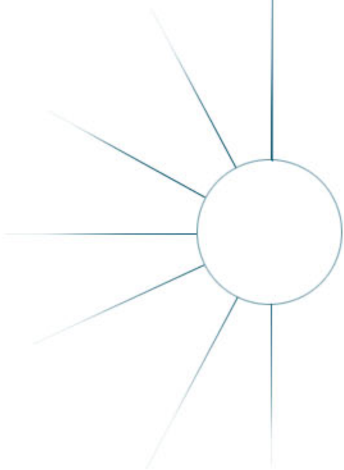


Annual Report 2001/2002

Department of Health
Government of Western Australia

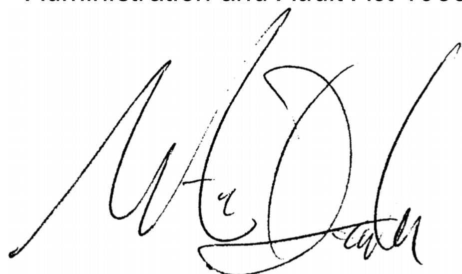
Statement of Compliance

To the Hon Bob Kucera MLA

MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985*, I hereby submit for your information and presentation to Parliament, the Report of Ashburton Health Service for the year ended 30 June 2002.

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



Mike Daube
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY
14 March 2003

ANNUAL REPORT

The past year has seen significant changes in the WA health system, in the context of an increasing recognition of its place in to our national health system.

The State Government health system does not exist in isolation. We work alongside other Government and non-Government services in the context of a national health system that remains fragmented and at times competitive. Much of our work and many of our challenges are informed by national and international trends, and decisions taken elsewhere. Nowhere is this clearer than in areas that tend to attract most public attention and place the greatest stresses for our system, such as workforce issues and the pressures on our teaching hospitals. These are understandably seen locally as local problems for local solution, but the reality is that they are significantly influenced by international trends and national policy and funding decisions.

We in Western Australia face all the challenges of contemporary health systems, together with high community expectations and often optimistic or disingenuous expectations that long-standing problems faced by all health systems can be resolved overnight in our State.

Against this backdrop have been steadily implementing change to ensure that the WA Government health system is as well placed as possible to face the challenges of the future. While ever more conscious of the size and complexity of our system and the challenges we face, remain optimistic that with good support and community understanding we can move well towards achieving our common objectives.

Our community enjoys outstanding health and health care by any standards. When we see and hear about problems we face, it is tempting to imagine that our system is failing us overall or that we are doing badly by national or international standards.

Of course there are areas of deficit, but Western Australians enjoy some of the best health and health care in the world. We live longer than people in almost all other countries, and even within Australia some parts of Western Australia are notable for the longevity of their populations.

Our health professionals are as well trained and qualified as those anywhere around the world, and we rightly adopt the most stringent standards in relation to their training and practice.

Those in the system will be more aware than any others of areas in which we can do better, but above all our community should be aware and rightly proud that we have a system in which first class professionals deliver high quality health care to a community with health outcomes that would be envied in almost any other country.

The world of health and health care has changed dramatically in recent years, and especially in the last decade. Around Australia, Governments and health systems are faced with identical problems and pressures including increasing costs of labour, equipment and pharmaceutical products, the changing roles of health professionals, a

very proper emphasis on quality (and the inevitable costs and changes that this will impose on us), the needs of ageing populations and more.

The Department of Health is a vast and complex organisation, employing some 30,000 staff operating from more than 650 sites around the State. It is not a simple agency. We deliver some services ourselves; we work collaboratively with Commonwealth and local Governments; and we fund several hundred non-Government organisations, ranging in size from those such as St John Ambulance Association and the Royal Flying Doctor Service to small groups providing equally important local services.

During 2001/2002 we restructured the Department so that it is now a single unified health system. We now have a State Health Management Team, which works as a single Departmental Executive Committee. The four Metropolitan Areas have been established. Our Country Health Services have been rationalised; and an enormous amount of work has been carried out to move away from silo mentalities and towards a recognition that we must indeed work as a unified system.

During the year, the Department has recognised its responsibilities arising out of matters such as the Douglas Report on King Edward Memorial Hospital, as well as resolving some important industrial negotiations.

As the work of consolidation, always slower than one would hope, develops, my hope is that during the coming year we will be able to address further some of the high profile priorities for both Government and the community – for example coping with winter pressures, reduce waiting lists and valuing and supporting our workforce; that we will be able to demonstrate our values as a health system committed to quality, prevention and remedying disadvantage; that we will be able to focus on the medium and long term planning that are crucial if the needs of the next generation are to be well serviced; and that we will be able to engender an understanding in the community of the national and international context within which our system works. In the latter regard, negotiations on the next phase of the Australian Health Care Agreements will be of fundamental importance.

I would like to convey special appreciation to all the staff and volunteers working within the Department of Health. They know as well as anyone else the pressures we all face, but also the excellent service they provide and the commitment they display on a daily basis.

Mike Daube
DIRECTOR GENERAL

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About Us

Address and Location

Ashburton Health Service
Mine Rd
TOM PRICE WA 6751

PO Box 56
TOM PRICE WA 6751

☎ *(08) 9189 1199*
(08) 9189 1602

Mission Statement

Our Mission
To provide an innovative and community-focused Health Service through the promotion of culturally appropriate and responsive quality health care.

Broad Objectives

The objectives of the Ashburton Health Service are:

- To provide accessible hospital care to those who require it.
- To deliver health services according to recognised standards of quality, and in a manner that is acceptable to members of the public.
- To improve access to primary health care services in the Ashburton Shire.
- To allocate resources according to community and patient needs, and to provide quality care to members of the public.
- To deliver an appropriate range and level of rehabilitation services to meet the needs of the local community.

Enabling Legislation

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

The Health Service is directed and controlled by a Board of Management constituted under Section 15 of the *Hospitals and Health Services Act 1927*.

As the Accountable Authority for the Ashburton Health Service, the Board of Management is responsible to the Minister for Health, Hon. R. C. Kucera APM MLA, for the general administration of the Health Service.

The Health Service does not operate in coordination with any subsidiary, related or affiliated bodies.

Ministerial Directives

The Minister for Health did not issue any directives on Health Service operations during 2001/2002.

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Ashburton Health Service's deadline for submission of key performance indicators and financial statements to the Auditor General to 14 October 2002.

Statement of Compliance with Public Sector Standards

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

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

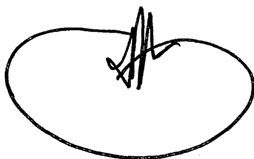
Such processes include:

- Adopting guidelines and processes to support the *Public Sector Standards in Human Resource Management*. While policies and guidelines currently exist, updates on the transfer, redeployment, discipline and grievance resolution standards are required.
- Having policies and supporting guidelines available in the Human Resource Manual, which is made accessible to all staff.
- Making copies of the *Code of Conduct* and *Code of Ethics* available on the Health Service's Intranet. All updated policies and a revised Human Resources Manual will be included on the Intranet in the near future.
- Making the General Manager, Health Service Manager and the Human Resource Manager responsible for compliance with public sector standards and ethical codes. This responsibility is reflected in each manager's job description form.

The applications made to report a breach in standards and the corresponding outcomes for the reporting period are:

- Number of applications lodged — None
- Number of material breaches found — None
- Applications under review — None

The Ashburton Health Service has not been investigated or audited by the Office of the Public Sector Standards Commissioner for the period to 30 June 2002.



Tim Shackleton
REGIONAL DIRECTOR
PILBARA GASCOYNE HEALTH REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

The following table lists the expenditure on advertising and sponsorship made by the Ashburton Health Service published in accordance with Section 175ZE of the *Electoral Act 1907*:

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies — Marketforce Productions	3,141.00	3,400.00	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations — *The West Australian*	–	–	3,243.33
TOTAL	**$3,141.00**	**$3,400.00**	**$3,243.33**

Freedom of Information Act 1992

The Ashburton Health Service received and dealt with 12 formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

- Are in writing.
- Give enough information to enable the requested documents to be identified.
- Give an address in Australia to which notices under the *Freedom of Information Act 1992* can be sent.
- Give any other information or details required under FOI regulations.
- Are lodged at an office of the agency with any application fee required under FOI regulations.

Applications are usually received from existing or former patients wanting to read or have a copy of their medical record, while others are from lawyers, authorised next of kin or authorised agencies.

Specific details regarding the type of information an applicant seeks may serve to identify and clarify the requested documents. The applicant's motive or reasons — or the agency's beliefs as to the applicant's reasons — for access cannot be taken into account.

Effective searches are conducted for documents that meet the requirements of the application. Accurate records exist that document the processing of an application, and provide clear reasoning explaining the decisions regarding the FOI inquiry made by the Health Service.

Open communication exists between the Health Service and all parties throughout the application process. The Health Service assists the applicant when necessary to clarify and particularise the requested documents within the scope of the application. Decisions on FOI access are made promptly, and all involved parties are informed of the result as soon as possible.

The types of documents held by the Health Service include:

- Patient medical records.
- Staff employment records.
- Department of Health reports, plans and guidelines.
- Other health-related agency reports.
- Agreements with the Department of Health.
- Statistical data and reports.
- Books relating to health planning and management.
- Books relating to the treatment of illness and disease.
- General administrative correspondence.

In accordance with Part Five of the *Freedom of Information Act 1992*, an information statement detailing the nature and types of documents held by the organisation is available from the:

Business Support Officer
Ashburton Health Service
Mine Rd
TOM PRICE WA 6751

☎ *(08) 9189 1199*

Ashburton Health Service

Key Operations and Achievements

- Completing a three-year Health Service strategic plan.

Completing a Three-Year Strategic Plan
One key aspect of the Ashburton Health Service Board's role is to regularly establish a strategic direction for the Health Service. The three-year plan completed during 2001/2002 was designed to ensure the provision of ongoing, quality health services for the benefit of the local community. Questions addressed by the plan included the following:

- What was the preferred future of the Health Service?
- What must the Health Service be like to meet the future needs of patients and staff?
- What role should the Health Service perform in the future?
- What outcomes should we aim to achieve?

Major Capital Projects

Projects Completed during the Year

The Ashburton Health Service did not complete any major capital projects during 2001/2002.

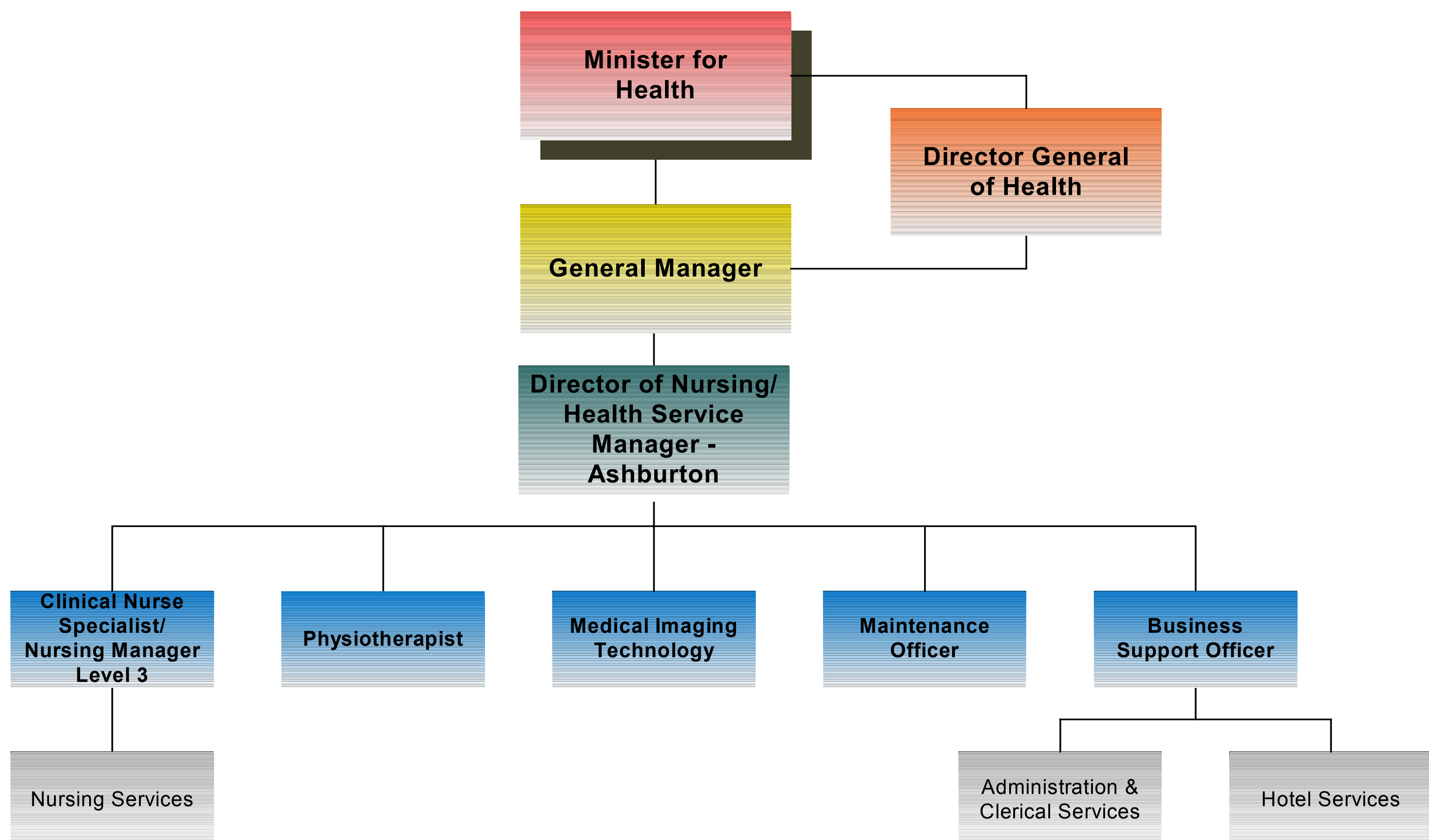
Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete	Estimated Total Cost
Kitchen Upgrade — Tom Price and Paraburdoo Hospitals	2002	*	*

*These figures were unavailable at the time of reporting for 2001/2002.

Management Structure

Organisational Chart



Accountable Authority

The Ashburton Health Service Board represents the Accountable Authority for the Health Service. The board is comprised of the following members:

Name	Position	Term of Office Expires
Quenten Jackson	Chairperson	30 June 2002
Greg Emms	Deputy Chairperson	30 June 2002
Ingrid Chrisp	Member	30 June 2002
Jodi Cox	Member	30 June 2002
Jennifer Fallaver	Member	30 June 2002
Neil Thoars	Member	30 June 2002
Lynne Spice	Member	30 June 2002
David Thomas	Member	30 June 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Ashburton Health Service Board to form one board, with the assigned name WA Country Health Service, with effect from 1 July 2002. Notice to this effect was published in the Government Gazette on 28 June 2002.

Senior Officers

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

Area of Responsibility	Title	Name	Basis of Appointment
Health Service and Corporate Management	General Manager	Tim Shackleton	Acting
Tom Price and Paraburdoo District Hospitals/ Ashburton Community Health	Director of Nursing/Health Service Manager	Alison Pash	Permanent
Engineering	Maintenance Officer	Trevor Herron	Permanent

Pecuniary Interests

Members of the Ashburton Health Service Board and senior officers at the Health Service have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Ashburton Health Service delivers services to communities covered by the following local authority:

- Ashburton Shire

The following table shows population figures for the local authority within the Ashburton region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Ashburton Shire	7395	5991	7298

*Data sources:

Australian Bureau of Statistics 1996, *Estimated Resident Population by Age and Sex in Statistical Local Areas, WA*, Cat. No. 3203.5.

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 Shire of Ashburton constitutes 4.2 per cent of the Pilbara region's population, with the majority of residents residing in the mining towns of Tom Price and Paraburdoo. The population of the area is significantly affected by seasonal tourism.

The communities served by the Health Service include the mining towns of Tom Price and Paraburdoo as well as the following Aboriginal communities:

- Wakathuni.
- Bellary Springs.
- Youngaleena.

The Indigenous population at both Tom Price and Paraburdoo is increasing steadily with the establishment of Aboriginal communities in the area and plans to develop more in the future.

The Health Service also serves several satellite mines, including those located at Brockman, Marandoo and Lynas. The satellite mines function on a fly-in, fly-out basis with this trend predicted to continue in the near future.

Available Services

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

Direct Patient Services	**Medical Support Services**
Accident and Emergency	Medical Imaging
Day Surgery	Palliative Care
Medical Services	Physiotherapy
Obstetrics	
Paediatrics	
Respite Care	
Surgical Services	
Community Services	**Other Support Services**
Community Health Nursing Services	Administration and Clerical Services
	Catering
	Domestic Services
	Engineering
	Gardening
	Orderly

Specialist Services
Visiting specialist services are provided in the areas of:

Ear, Nose and Throat	Orthopaedic
General Surgery	Paediatrics
Occupational Therapy	Physiotherapy
Ophthalmology	Speech Pathology

Other Services
None

Disability Services

Our Policy

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

Programs and Initiatives

The Health Service has aimed to improve its disability services plan during 2001/2002, according to objectives outlined in the *Disability Services Act 1993.* This goal has been achieved through programs and initiatives run on behalf of the following five key outcome areas:

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

- The Health Service reviewed its disability services plan during 2001/2002, and put the revised version into practice.

Outcome 2: Access to buildings and facilities is improved.

- Regular audits occur to ensure all Health Service buildings continue to remain accessible for people with disabilities.

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

- Hospital information was not made available in any formats specifically designed for people with disabilities.

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

- The Health Service continues to provide training to employees on disability services as part of the staff orientation program.
- The skills of experts in the area of disability services are drawn upon when these people visit the region.
- Managers at the Health Service monitor the needs of patients with disabilities.

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

- People with disabilities, their families and carers are given every opportunity to contribute to and influence decisions impacting upon individual health care.

Future Direction

The Health Service will continue to review and amend its policies, practices and procedures to identify possible barriers experienced by people with disabilities.

Cultural Diversity and Language Services

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

Programs and Initiatives
The Health Service has not yet developed any strategies or programs specific to the *Western Australian Government Language Services Policy*.

Youth Services

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

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

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

Programs and Initiatives
The Health Service has run numerous programs targeting youth groups and introduced a number of innovations such as:

- Running an antenatal clinic.
- Running Smarter than Smoking programs.
- Offering self-esteem courses on topics such as safe-sex awareness.
- Providing information to young people on breast and testicular cancer.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Ashburton Health Service:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	25.10	16.00	24.48
Administration and Clerical*	3.68	4.90	5.13
Medical Support*	2.31	2.31	2.31
Hotel Services*	13.34	12.60	10.81
Maintenance	1.10	1.38	1.34
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**45.53**	**37.19**	**44.07**

*Note these categories include the following:

- **Administration and Clerical** — receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners and caterers.

Recruitment Practices

The recruitment and retention of adequately skilled nursing staff continues to be a challenge at the Paraburdoo District Hospital.

Staff Development

The Ashburton Health Service is committed to providing staff with appropriate access to relevant training and developmental opportunities.

The Health Service has a great depth of skills and competencies among its current staff, and has been encouraging in-house multi-skilling to further improve employee capabilities.

Staff development networks have also been encouraged not only within but also between Health Services.

Industrial Relations Issues

There was no industrial action taken that impacted upon patient care during 2001/2002.

There was little industrial impact on the Health Service as a result of the recent Australian Nursing Federation Enterprise Bargaining Agreement negotiations.

Workers' Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Ashburton Health Service:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	0	0
Administration and Clerical*	0	0	0
Medical Support*	0	0	0
Hotel Services*	0	0	0
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**0**	**0**	**0**

*Note these categories include the following:

- **Administration and Clerical** — receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners and caterers.

Equity and Diversity Outcomes

Our Policy
The ability of an organisation to provide high quality 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 Ashburton Health Service aims to achieve equity and diversity in the workplace by eliminating any discrimination in employment based upon grounds of sex, marital status, pregnancy, family status, race, religious or political conviction, or age, and by promoting equal opportunity for all people.

Programs and Initiatives
The Health Service 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 following outcomes:

Outcome 1 — The organisation values EEO and diversity, and the work environment is free from racial and sexual harassment.

- The hospitals within the Health Service recognise the need to provide a safe working environment free from all forms of discrimination and harassment.
- The Health Service encourages all employees to take action when confronted with, or having witnessed any form of discrimination or harassment.

Outcome 2 — Workplaces are free from employment practices that are biased or discriminate unlawfully against employees or potential employees.

- The Health Service places significant emphasis on its attraction, recruitment, and retention standards and practices to ensure there is no bias or discrimination against employees or potential employees. This is achieved by complying with the *Public Sector Standards in Human Resource Management* and with EEO legislation.

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

- The Health Service is committed to equitable, open, merit-based processes to ensure the most suitable applicants are selected and recruited to the workforce. A commitment also exists to meet the principles and standards of the *Public Sector Standards in Human Resource Management*. All employees are afforded equal opportunities to secure promotion and advancement in their area of employment through performance management processes.

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 Ashburton Health Service has been able to meet these goals:

Plan or Process	Level of Achievement
EEO Management Plan	Implemented
Organisational plans reflect EEO	Implemented
Policies and procedures encompass EEO requirements	Implemented
Established EEO contact officers	Needs further development
Training and staff awareness programs	Programs in place
Diversity	Implemented

Marketing

Community awareness of the Ashburton Health Service was raised through forums conducted once every two months at each individual health care unit within the region.

Publications

The Annual Report 2000/2001 for the Ashburton Health Service was published by the West Pilbara Health Service, and is available for public access.

Research and Development

Strategic Plan
The Ashburton Health Service Board completed a three-year strategic plan in late 2001. The plan outlined new processes for the delivery of health services in the region.

The plan is designed to improve the current situation experienced at the Paraburdoo District Hospital. It has become apparent over the past few years the scope of service delivery currently practiced at the hospital cannot be sustained. There has been a gradual decline in the population of Paraburdoo, which has contributed to a reduced need for traditional health services currently available at the hospital. There is little indication this crisis would have improved if existing conditions were maintained given the great difficulties in obtaining nursing staff to supplement those who are permanently employed at Paraburdoo.

Evaluations

The Ashburton Health Service carried out no major evaluations during 2001/2002.

Risk Management

Our Policy
The Ashburton Health Service aims to achieve the best possible practice in the management of all risks that threaten to adversely impact upon the Health Service itself, its patients, staff, assets, functions, objectives, operations, or upon members of the public.

Strategies and Initiatives
Successful risk management strategies used during 2001/2002 include:

- Having senior staff attend workshops on risk management, and involving employees in risk management processes.
- Continuing work on defining a systematic process of policies, procedures and practices to identify, analyse, assess, treat and monitor risks inherent in the operations of the Health Service.

Future Direction
The Health Service will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

The Ashburton Health Service has established a system of internal controls as a means of providing reasonable assurance that assets are safeguarded, proper accounting records are maintained, and financial information is reliable. The Ashburton Health Service Board oversees the operation of internal audit functions, and ensures management addresses any findings arising from internal and external audit reports.

There were no significant audit findings identified during 2001/2002.

Waste Paper Recycling

There are no recycling or waste paper storage facilities available due to the remote rural location of the Ashburton Health Service. No records were kept of the amount of waste paper recycled during 2001/2002 as a result.

Pricing Policy

The Ashburton Health Service 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 against registered public and private outpatients of the Health Service.

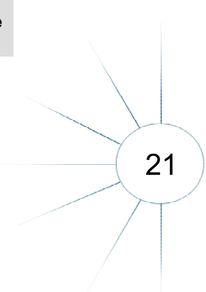
Client Satisfaction Surveys

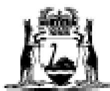
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey Questionnaires for various health service client groups with special forms for parents to answer on behalf of their children. The questionnaires have been standardised and have demonstrated valid and reliable results over time.

Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 42) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL

	ASHBURTON	Laverton/ Leonora	Nickol Bay	Roebourne
GETTING TO THE HOSPITAL	68.4	74.7	84.6	73.0
ATTENTION FROM DOCTORS AND NURSING STAFF	85.2	93.2	80.8	94.7
INFORMATION AND COMMUNICATION	90.0	89.1	85.8	97.8
MEETING PERSONAL NEEDS	92.4	97.1	93.0	97.7
CONTINUITY OF CARE	81.0	90.4	71.4	89.6
RESIDENTIAL ASPECTS OF THE HOSPITAL	78.5	70.3	65.9	76.7
YOUR RIGHTS AS A PATIENT	48.6	60.5	56.2	45.7





AUDITOR GENERAL

To the Parliament of Western Australia

ASHBURTON HEALTH SERVICE
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope
I have audited the key effectiveness and efficiency performance indicators of the Ashburton Health Service for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Director General, Department of Health was responsible for developing and maintaining proper records and systems for preparing and presenting performance indicators. I have conducted an audit of the key performance indicators in order to express an opinion on them to the Parliament as required by the Act. The key performance indicators reflect the progress made to date as part of the staged process to develop more enhanced measurement of the performance of the Ashburton Health Service.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, evidence supporting the amounts and other disclosures in the performance indicators, and assessing the relevance and appropriateness of the performance indicators in assisting users to assess the Health Service's performance. These procedures have been undertaken to form an opinion as to whether, in all material respects, the performance indicators are relevant and appropriate having regard to their purpose and fairly represent the indicated performance.

The audit opinion expressed below has been formed on the above basis taking into account the ongoing development of the key performance indicators.

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the Ashburton Health Service are relevant and appropriate for assisting users to assess the Health Service's performance and fairly represent the indicated performance for the year ended June 30, 2002.

D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

ASHBURTON HEALTH SERVICE

Under the provisions of section 94 of the Financial Administration and Audit Act 1985, I advise that it will not be possible to complete the audit of the financial statements and performance indicators of the Ashburton Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Ashburton Health Service an extension to October 14, 2002 to prepare and submit performance indicators, my Office did not receive these until November 29, 2002. The indicators submitted were not of an appropriate standard and were returned for further revision. These were resubmitted to my Office on January 28, 2003 in a form adequate to enable my staff and audit contractors to undertake audit testing against the supporting documentation held at the Health Service site. Audit testing and a review of the results of that work is currently in course to enable the forming of an audit opinion.

It is anticipated that the opinions will be issued by March 31, 2003.

D D R PEARSON
AUDITOR GENERAL
February 28, 2003

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

ASHBURTON HEALTH SERVICE
CERTIFICATION OF PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2002

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 Ashburton Health Service and fairly represent the performance of the Health Service for the financial year ending 30 June 2002.

Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

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Background

The Performance Indicators reported in the following pages address the extent to which the strategies and activities of the Health Service have contributed to the 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 services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

OUTCOME 2 - Restoration of the health of people with acute illness.

> **Output 2 -** Diagnosis and treatment services aim to improve the health of Western Australians by restoring the health of people with acute illness.

OUTCOME 3 - Improvement in the quality of life for people with chronic illness and disability.

> **Output 3 -** Continuing care services are provided to improve the quality of life for those who need continuing care.

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

Output 1: *Prevention and Promotion*

- Community and Public health services
- Mental health services
- Drug abuse strategy coordination, treatment and prevention services

Output 2: *Diagnosis and Treatment*

- Hospital services (emergency, outpatient & in-patient)
- Nursing posts
- Community health services (post discharge care)
- Mental health services

Output 3: *Continuing Care*

- Services for frail aged and disabled people (eg, Aged Care Assessments, in-patient respite, outpatient services for chronic pain and disability, Nursing Home Type hospital care)
- Services for the terminally ill (eg, in-patient palliative care)
- Mental health services

There are some services, such as Community Health, which address all three of the outputs. Current information systems do not easily allow the distinction to be made between the three and this is therefore an important area for future development. To assure consistency in reporting and evaluation the Health Service has, during the year, continued to develop clear guidelines for the collection and interpretation of data for performance reporting. Whilst steps have been taken to minimise inconsistencies, some still exist.

General Approach

One of the aims of the Health Service has been to deliver activity, equitably distributed to, and accessible by, all sectors of the community.

For most of those performance indicators of health service delivery which target the

- reduction of the incidence of preventable disease, injury, disability and premature death and
- the improvement of the quality of life of people with chronic illness and disability,

the graphs used indicate performance for those who live in each catchment area irrespective of where service is provided and whether service is delivered in private or public hospitals.

For most services restoring the health of those with acute illness, performance is graphed according to where the service has been provided, irrespective of where people live and only includes service delivered by the public sector.

The indicators for these intervention strategies are the first step in a staged process leading to more comprehensive and meaningful measurement and reporting of performance in the above. Further indicators are being developed to assist in measurement, management and reporting.

Comparative Results

In certain cases results for other Health Services are assessed as being helpful in illustrating the performance of the Health Service being principally reported, ie the subject matter of the Report.

In the labelling of graphs, the technique has been used in which the results of the principally reported Health Service is always placed first (on the left), using UPPER CASE lettering.

After leaving a space, those results for comparative Health Services are shown to the right of this and use Lower Case identification to differentiate clearly between principal and comparative Health Services.

Output Measures

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

Quantity measures describe outputs in terms of how much, or how many are performed and require a unit of measurement to be defined.

Quality measures usually reflect service standards based on customer needs. The dimensions of quality as an output measure include: accuracy; completeness; accessibility; continuity; and a customer acceptability of the output.

Timeliness measures provide parameters for how often, or within what time frame, outputs will be produced.

Cost measures reflect the full accrual cost to an agency of producing each output.

Hospitals and Health Services are required to report output measures of quantity, quality, timeliness and cost together with a comparison between actual and target performance.

Assessing the Performance of the Health Service

It is not only the KPIs and Output Measures which readers of this report should examine when assessing the performance of the Health Service. The Key Performance Indicators, Financial Statements and Hospitals/Health Services reports, all provide information relevant to assessment of Health Service performance for 2001/02.

Glossary of Terms

Performance Indicator *– information about output performance or outcome achievement, usually expressed as a unit, index or ratio.*
Efficiency Indicator *– a performance indicator that relates an output to the level of resource input required to produce it.*
Effectiveness Indicator *– a performance indicator which provides information on the extent to which a government desired outcome has been achieved through the funding and production of an agreed output.*

MEDIAN WAITING TIMES FOR COMMUNITY AND ALLIED HEALTH SERVICES (HOSPITAL AND COMMUNITY BASED)	KPI 1.1

Timely and easy access to health services is effective in reducing the incidence of preventable diseases and premature death by providing clinically appropriate treatment of illness and injury.

Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

This indicator measures the median (middlemost) waiting time in weeks that clients waited from the date of referral or initial presentation for their first occasion of service. It must be noted that the time waiting for first available appointment in each of the specialties may differ. This indicator highlights different waiting times for different specialities.

Availability of practitioners for rural Health Services vary significantly from year to year and are in some situations available for some parts of the year and not able to be provided continuously; all of which make comparisons from one year to another of limited value.

Different Health Services for which peer comparisons are appropriate for other Output 1 Indicators operate such a different range and mix of clinics that comparisons here are of limited value.

Ashburton Health Service has a four-week waiting period for physiotherapy due to a staff vacancy.

RATE OF SCREENING IN CHILDREN	KPI 1.2

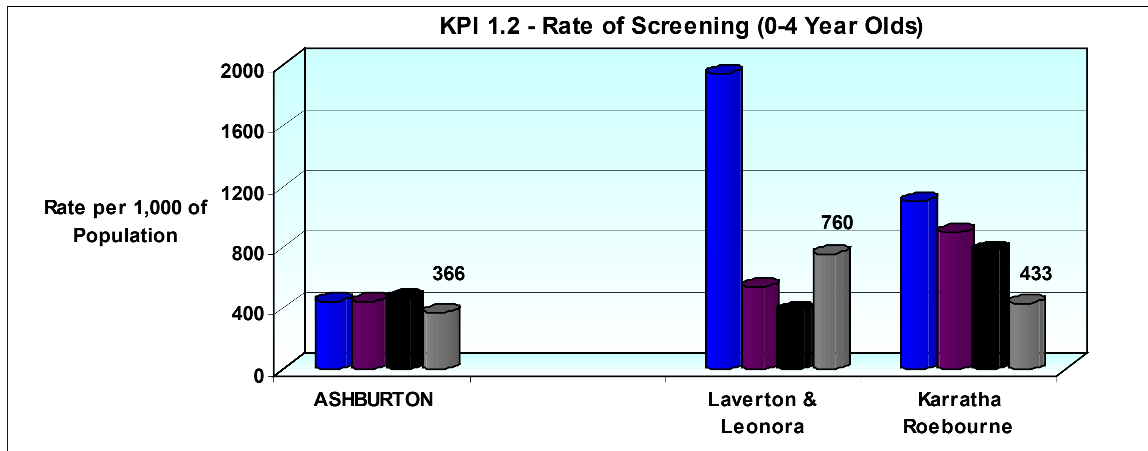
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential. The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule.

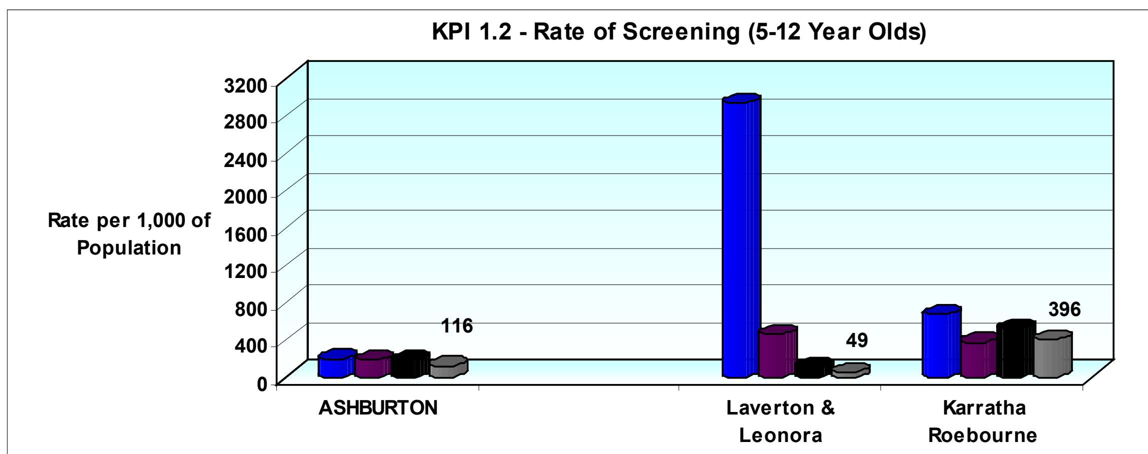
The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

This indicator measures the rate of NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

Ashburton Community Health Service sets a 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. NH&MRC guidelines determine five screenings to occur to each child in the 0–4 age group and two screenings for each child in the 5–12 age group. Screening Services for children from 0–12 years in the Ashburton Shire are considered to be satisfactory.

Note : A rate in excess of 1,000 per thousand can occur due to the same child attending more than once a year.





Calendar Year 1998 1999 2000 2001

RATE OF CHILDHOOD IMMUNISATION	KPI 1.5

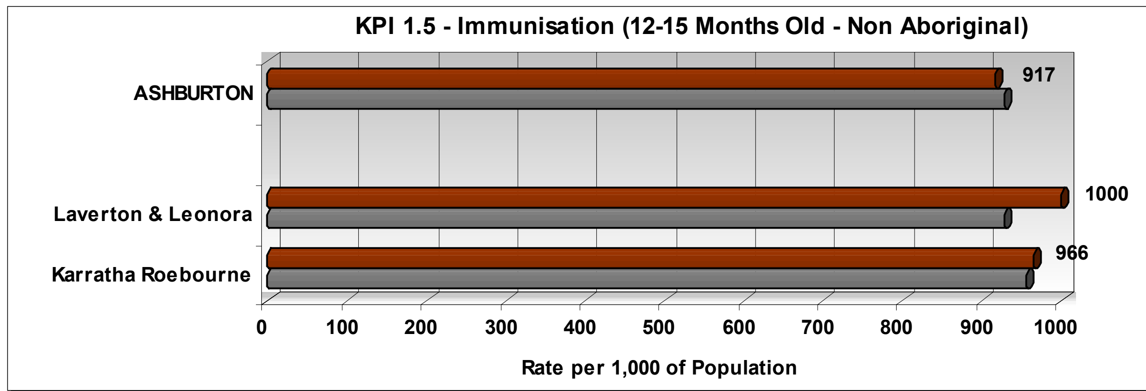
Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage at key milestones (12 and 24 months of age) can be assessed.

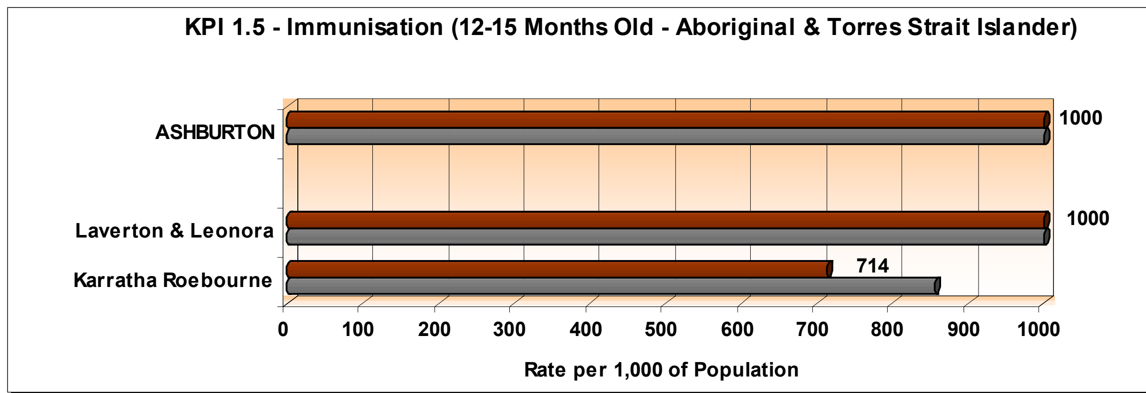
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

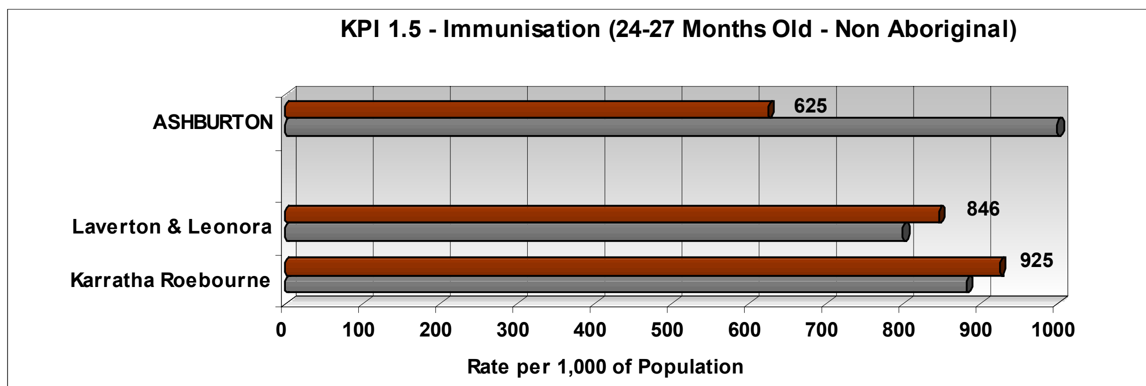
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

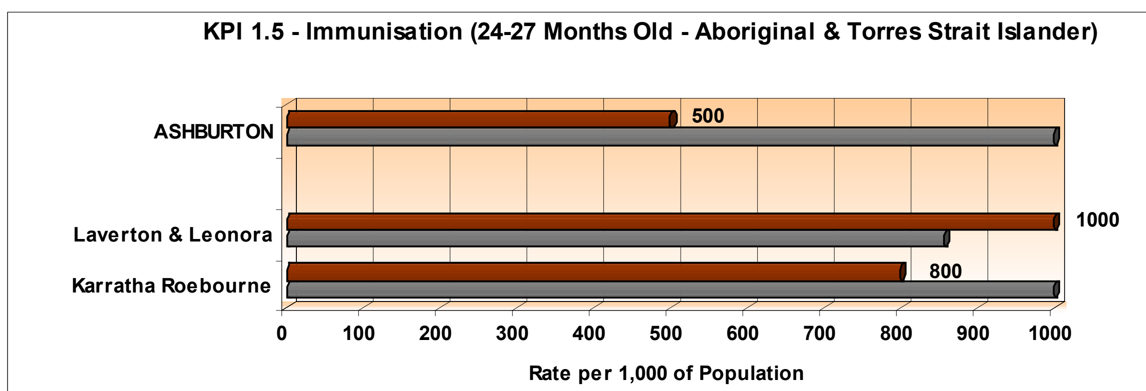
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the children shown even up to the calendar year 2002. The data shown for calendar year 2002 is from the first six months of the 2001/02 financial year and is therefore appropriate for this Report.









Calendar Year 2001 2002

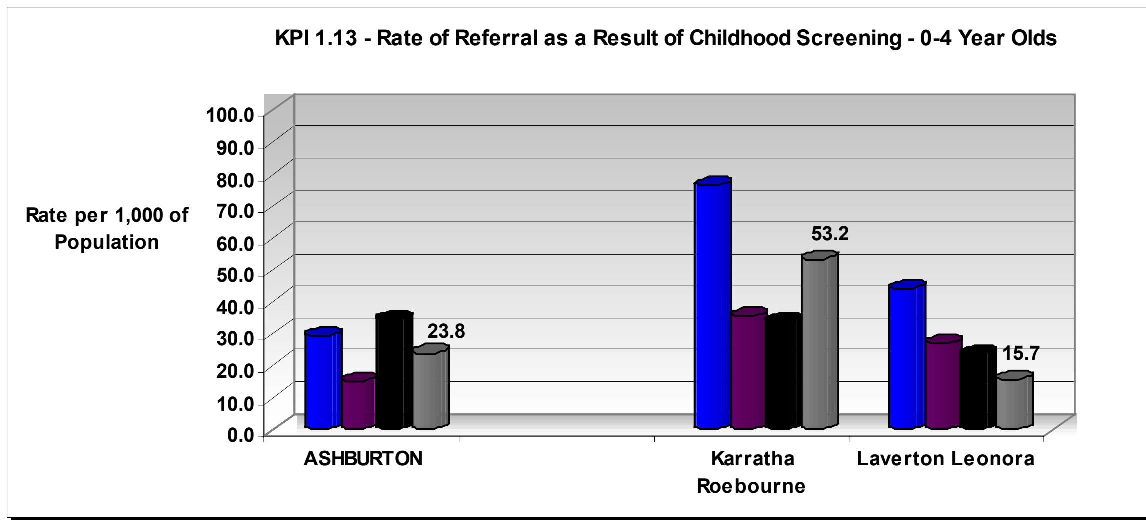
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

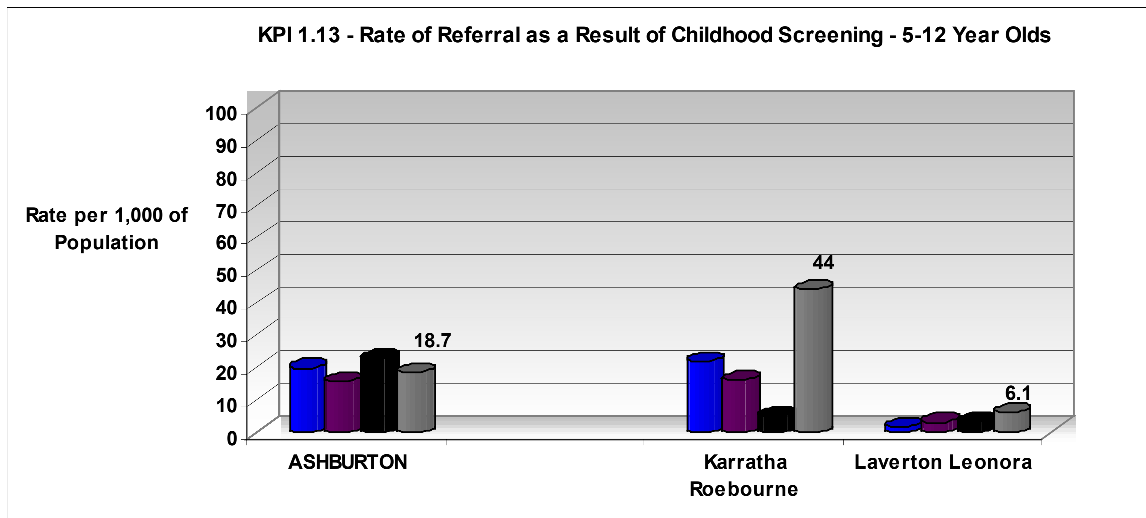
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only to restore children to good health when they become ill, but also help to maintain a state of 'wellness' that allows them to develop to their full potential.

The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule. This program includes appropriate referral for children needing further assessment and treatment. Timely referral can improve health outcomes for children in preventing disease or disability in later years.

This indicator measures the rate of referral after NH&MRC screening, by 0-4 and 5-12 year age groups of the resident child population in the catchment for the health service.

In previous years the data was reported by episodes; this year is by population.





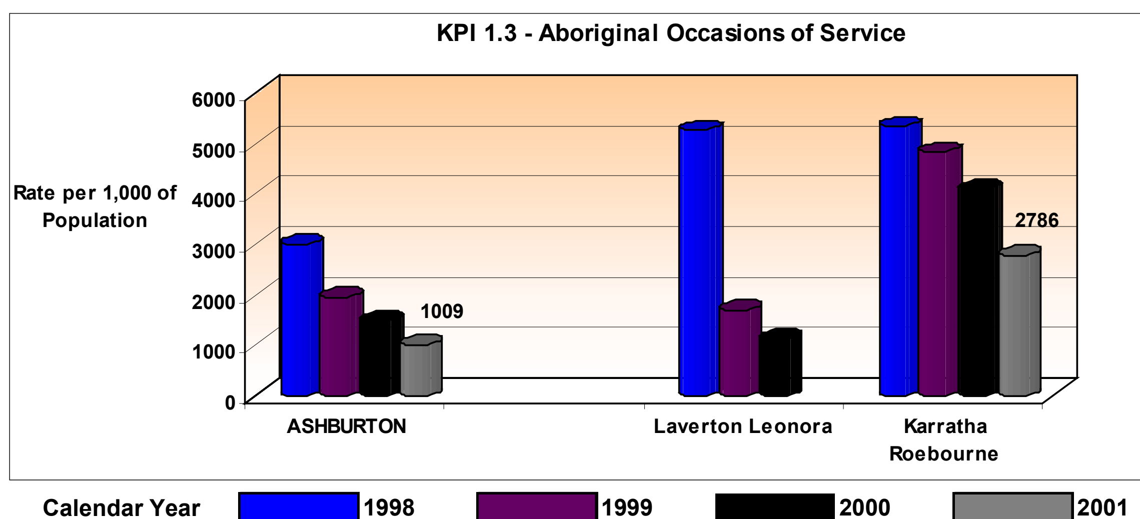
Calendar Year 1998 1999 2000 2001

RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

The lower level of health experienced by Aboriginal people has been of ongoing concern not just to the local community but to the world at large. National and State policies focus attention and resources on the area in an attempt to bring the health of Aboriginal people to a state that is comparable to the rest of Australia.

It is assumed that with poorer health, Aboriginal people will need to access health services at least as frequently as non-Aboriginal people. However, it must be noted that cultural differences which make them reluctant or unable to access available services and the inconsistent reporting of Aboriginality could mean that the number of services credited to the population may display inconsistent patterns.

A rate in excess of 1,000 occurs when individuals attend more than once in a year.



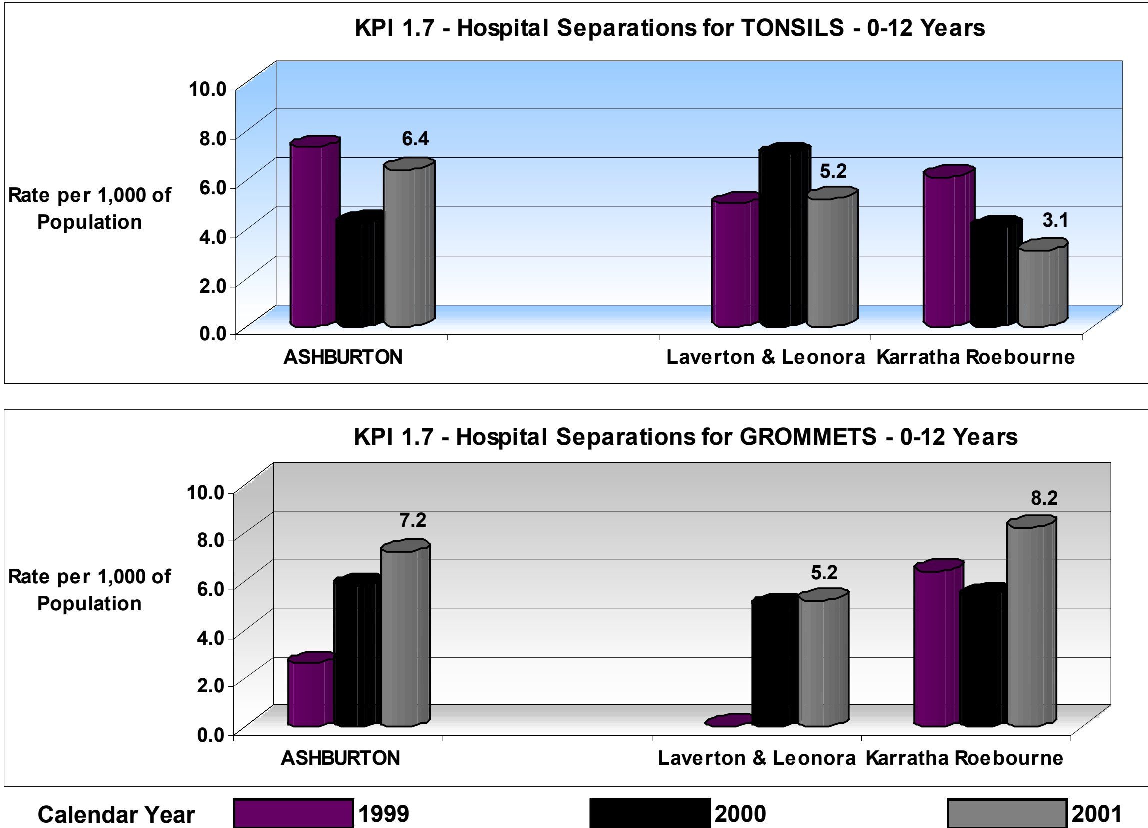
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS	KPI 1.7

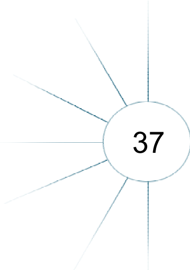
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

Successful management and treatment of children with chronic infections by community health staff could be anticipated to reduce the level of surgical intervention. As the success of this intervention program cannot be measured directly, an indirect measure of its success can be estimated by determining the rate of hospitalisation for these procedures.

Comparison of the rate of hospitalisation for tonsillectomies and grommet insertions with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Both of the conditions for which these procedures are performed, are ones which have a high number of patients treated either in hospital or the community. It would be expected that hospital admissions would decrease as performances and quality of service in the many different health areas increases.





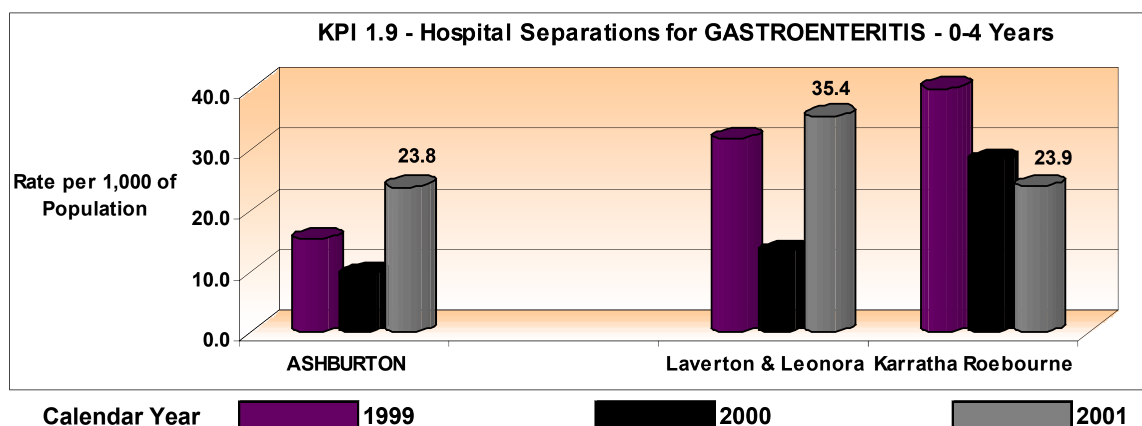
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN — KPI 1.9

Public health and environmental health programs are aimed at maintaining safe water and sewerage disposal systems, and establishing and enforcing effective food processing and handling practices.

Effective delivery of these programs reduces the rate of transmissible disease like gastroenteritis, of which severe cases can result in hospitalisation.

An indirect measure of the success of community and public health prevention strategies is the rate of hospitalisation due to gastroenteritis. Improved primary management will reflect a decrease in the number of admissions for this condition.

Comparison of the rate of hospitalisation for gastroenteritis with other comparable areas can help identify those areas where improvements in primary care could be necessary.



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS | KPI 1.10

Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute asthma, acute bronchitis, bronchiolitis and croup.

Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Bronchiolitis

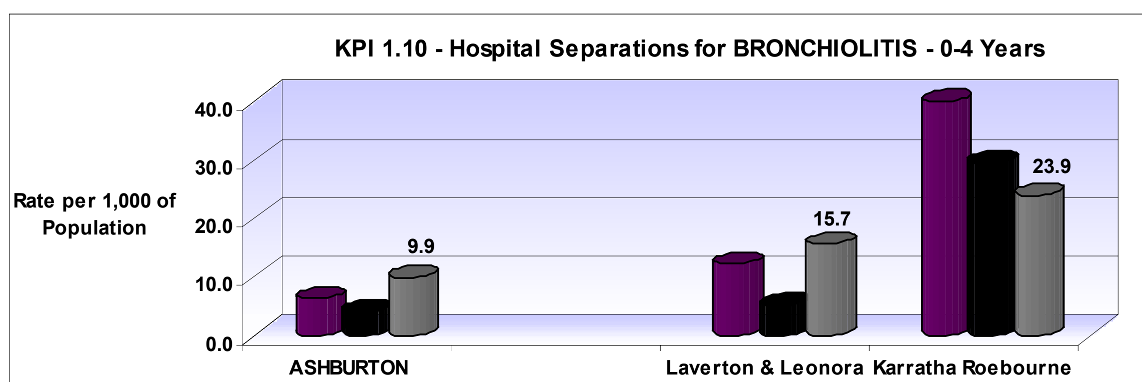
The graph shows individuals aged 0-4. Of those aged 5-12 and 13-18, none were hospitalised this year.

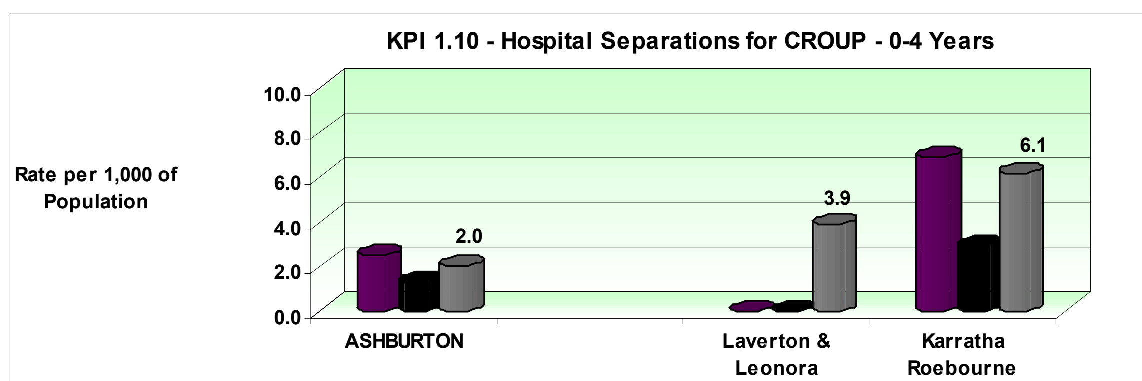
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised this year.

Acute Bronchitis

Only 1 individual aged 0-4 at a rate of 2 per thousand was hospitalised this year, with no individuals being admitted aged 5-12 or 13-18 years.





Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

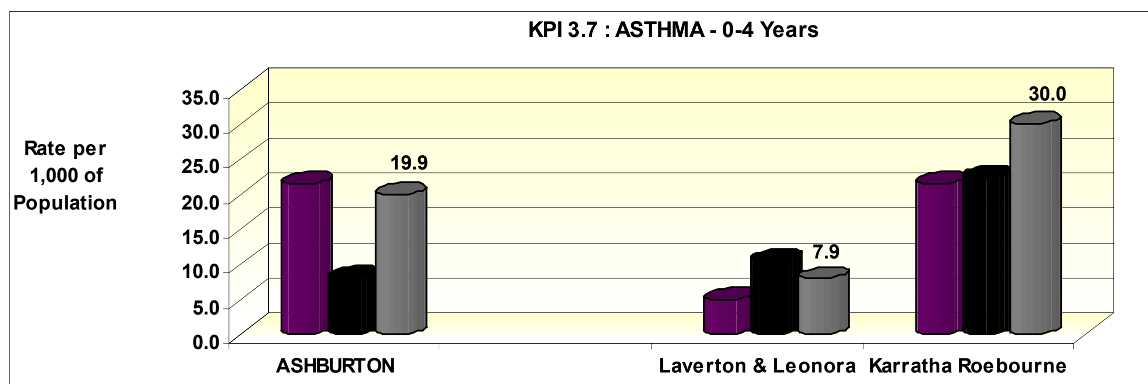
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

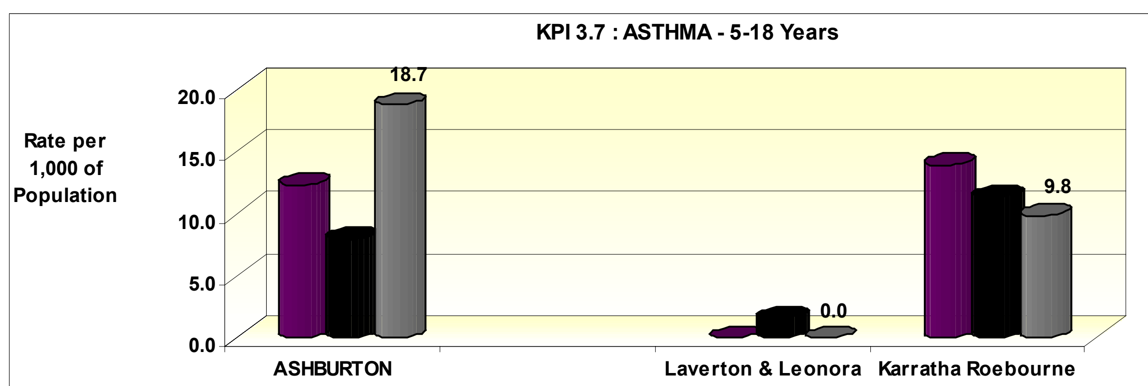
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

The number of patients who are admitted to hospital per 1,000 population for treatment of Asthma 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 allergic and climatic responses for example - may influence the number of people hospitalised with Asthma. This condition is one which has a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for Asthma may decrease as performance and quality of service increases thus indicating an improvement in the quality of life of people with a chronic illness.

The graphs show individuals aged 0-4 and 5-12. Only 1 individual aged 13-18 at a rate of 3.1 per thousand was hospitalised this year, I aged 19-34 at a rate of 0.7 per thousand with 9 individuals being admitted aged 35 years and over at a rate of 4.9 per thousand.





Calendar Year 1999 2000 2001

COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE — KPI 1.14

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. It provides a measure of, on average, how cost effective these activities are over time.

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 communities. These interventions are quantified as occasions of service but can cover a wide range of services in terms of time and complexity.

This indicator measures the average cost of an occasion of service for the particular use of programs that each health service provides. Given what has been said above, it is only useful for broad comparisons of trends and must be considered in conjunction with an understanding of current program delivery priorities.

The cost per occasion of service for community health in Ashburton, is an average for the West Pilbara.

HEALTH SERVICE	COST PER OCCASION OF COMMUNITY HEALTH SERVICE
West Pilbara	$39.84

NOTE:

- This is the first year that this indicator has been reported. It is expected that over time the collection of Community Health data and the reporting of this indicator will become more refined.
- The figures used to calculate the cost per community occasion of service were based on 6 months (July to December 2001) expenditure and activity data.

CLIENT SATISFACTION	KPI 2.2

This indicator is a measurement of how clients have rated the personal care and the way services are provided by hospitals and other health services.

Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if patients' perception of health service provision are favourable they will be more likely to seek timely help, assistance or treatment.

Ashburton Health Service reported an overall satisfaction score of 77 for emergency patients over the last financial year with a standard error of 3.04 on a confidence interval of 95%. The estimated population of individuals surveyed were 3648 Emergency Services patients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients	99	32	34%

EMERGENCY DEPARTMENT WAITING TIMES — KPI 2.18

Access to health services must be provided on the basis of clinical need and if a hospital has large numbers of patients waiting longer than the accepted standards, or transfers a significant percentage of those patients to another facility, it may be that there are "gaps" in its ability to provide emergency services. This may reflect sub-optimal practices, under-resourcing and/or poor recognition of the need for hospital and community services.

In smaller rural communities in Western Australia, medical services are predominantly provided by solo or small group medical practices. In these areas standards for availability and provision of services applicable to larger towns and cities may not be met due to the heavy demand for services and due to periods of time when the GP is not in the town.

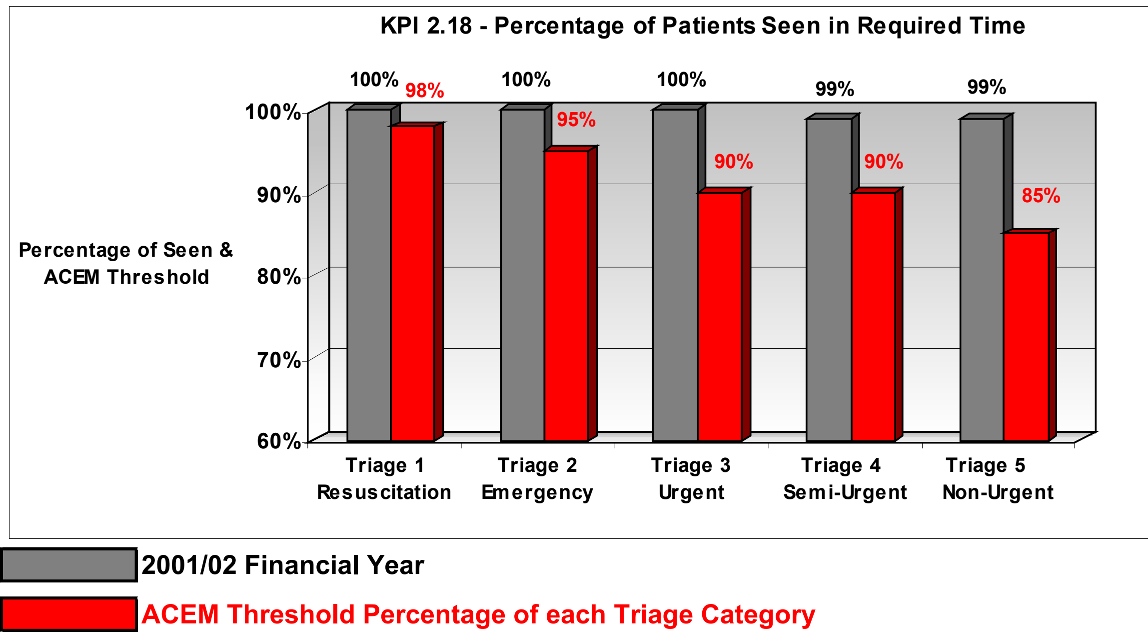
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner is not available (eg; GP out of town etc), timely review by Nursing staff should be measured (and clearly documented in the explanatory notes).

Data relevant to this indicator should be linked to data on the transfer of patients to other health care units, for example, larger hospitals and tertiary metropolitan centres.

This indicator assesses what percentage of patients in each triage category were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) – in rural areas, this may include for example, telephone advice given by GP.

TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage 5	Non-Urgent	Within 120 Minutes	85%


KPI 2.18 - Percentage of Patients Seen in Required Time
Percentage of Seen & ACEM Threshold
100%
90%
80%
70%
60%
100%
98%
100%
95%
100%
90%
99%
90%
99%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Non-Urgent
2001/02 Financial Year
ACEM Threshold Percentage of each Triage Category

AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

The use of casemix in hospitals is a recognised methodology for adjusting actual activity data to reflect the complexity of service provision and the use of resources. Hence the number of separations in a hospital may be adjusted from an actual number of 50,000 to 60,000 by a casemix index of 1.2 to reflect that very complex services have been provided. In Australia, hospitals utilise the Australian Diagnostic Related Groups (AN-DRGs) Version 4.2 to which cost weights are allocated. In Western Australia, cost weight allocations utilise scaled central episodes.

The use of a casemix index together with expenditure data allows a reasonable comparison between hospitals on the efficient use of resources in providing inpatient services.

This indicator measures the average cost of a casemix-adjusted separation.

HEALTH SERVICE	AVERAGE COST PER CASEMIX ADJUSTED SEPARATION
Ashburton Health Service	$7,004.29

The average cost per case-mix adjusted separation is an average of Tom Price and Paraburdoo hospitals' performance.

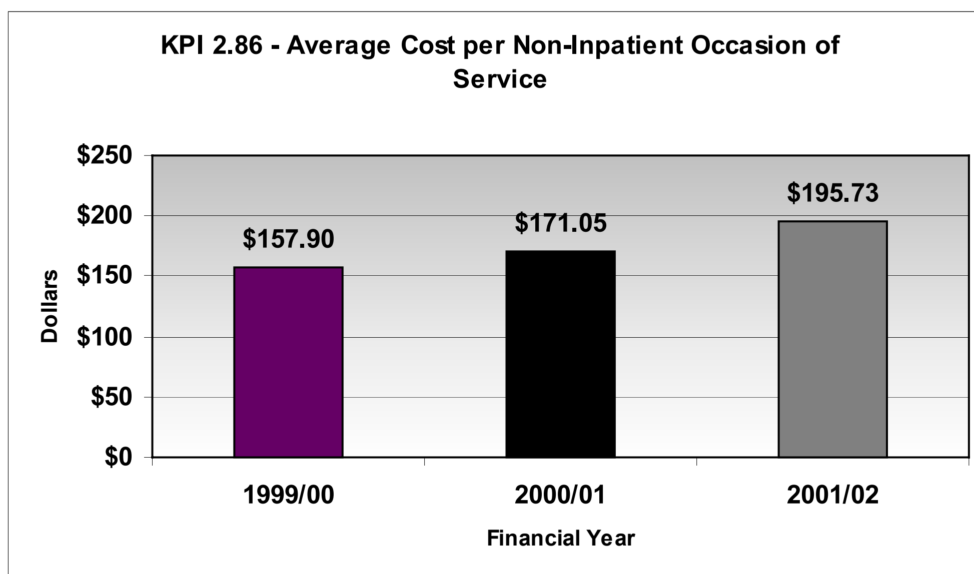
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE — KPI 2.86

The effective use of hospital resources can help minimise the overall costs of providing health care or can provide for more patients to be treated for the same cost.

Excessive costs in providing non-inpatient services compared to other hospitals may indicate the inefficient use of resources.

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

The average cost per non-inpatient occasion of service is an average of Tom Price and Paraburdoo hospitals' performance.



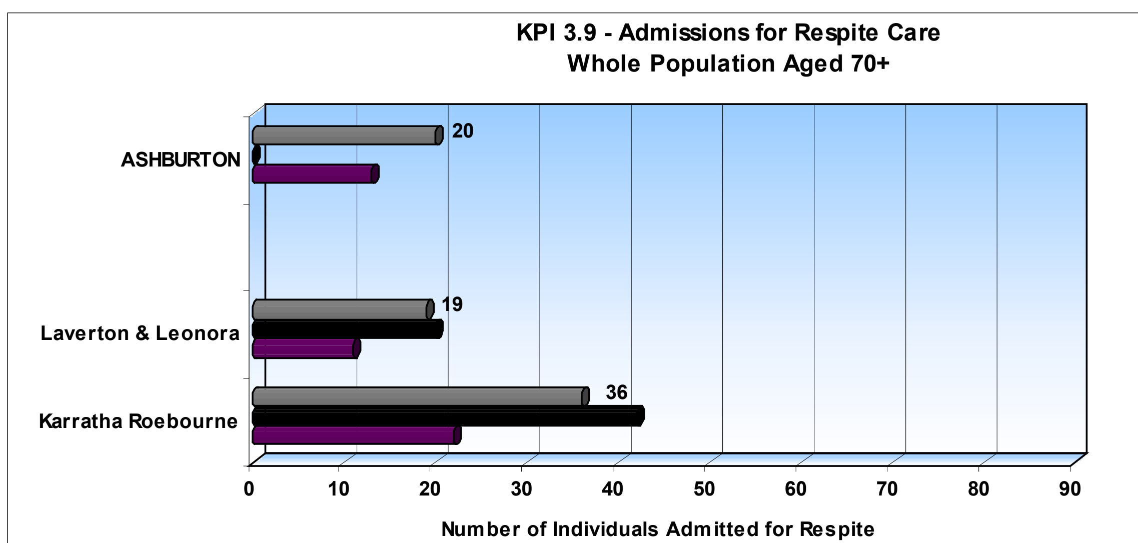
KPI 3.7 : Hospital separations for Asthma

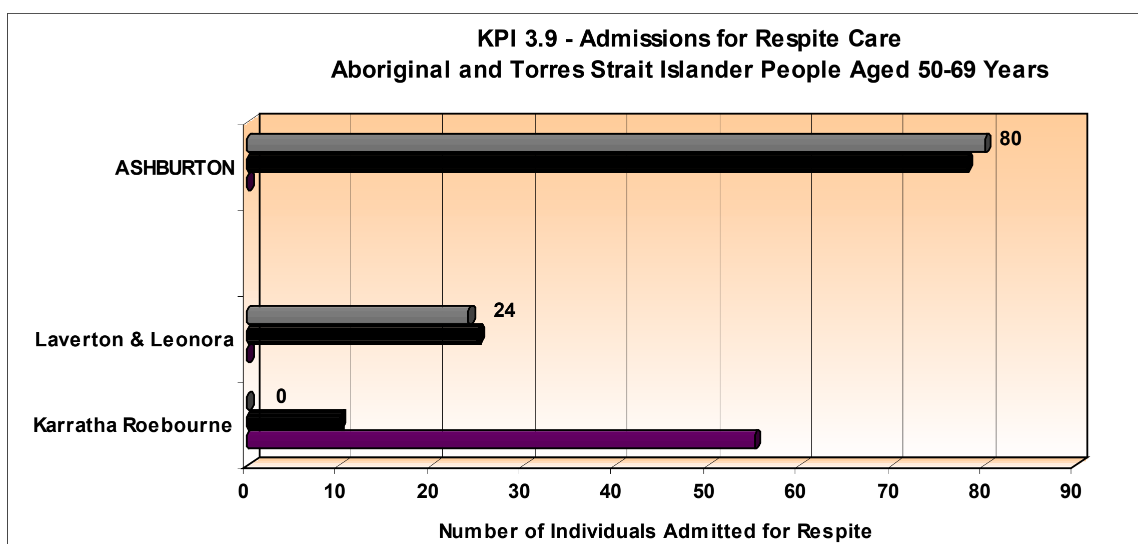
Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

Some people with chronic illness and disability are cared for at home or in a family member's home with the support of local community services including Home & Community Care (HACC). To enable the carer to have a break from the continual carer role, short-term care may be provided in country facilities. This short-term (or Respite) care may be provided on a planned (and sometimes on an emergency) basis for day(s) or night(s) to enable the carer to have a break. Without access to this type of service more people with chronic illness may require permanent Nursing Home Type Care earlier.

The number of individuals within the targeted age group, ie. over 70 years for non Aboriginal patients and over 50 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Respite Care in the Health Service.





Financial Year 1999/00 2000/01 2001/02

AUDITOR GENERAL

To the Parliament of Western Australia

ASHBURTON HEALTH SERVICE
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope
I have audited the accounts and financial statements of the Ashburton Health Service for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985.

The Director General, Department of Health was responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing and presenting the financial statements, and complying with the Act and other relevant written law. The primary responsibility for the detection, investigation and prevention of irregularities rests with the Director General.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, the controls exercised by the Health Service to ensure financial regularity in accordance with legislative provisions, evidence to provide reasonable assurance that the amounts and other disclosures in the financial statements are free of material misstatement and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions so as to present a view which is consistent with my understanding of the Health Service's financial position, its financial performance and its cash flows.

The audit opinion expressed below has been formed on the above basis.

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

Ashburton Health Service
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

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

(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of 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, 2002 and its financial performance and its cash flows for the year then ended.

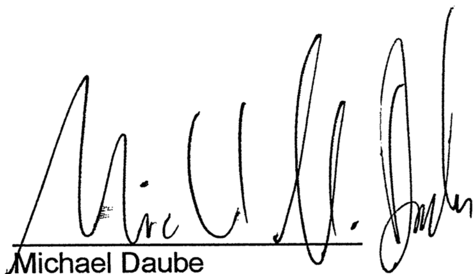
D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

CERTIFICATION OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2002

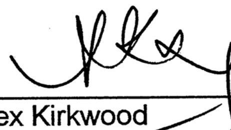
The accompanying financial statements of the Ashburton Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the financial position as at 30 June 2002.

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
Ashburton Health Service

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Ashburton Health Service

30 August 2002

	Note	2001/02	2000/01
		$	$
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		2,612,683	2,556,473
Fees for visiting medical practitioners		219,495	192,042
Superannuation expense		157,323	141,392
Patient support costs	3	360,905	354,959
Patient transport costs		649,400	595,487
Repairs, maintenance and consumable equipment expense		115,476	293,758
Depreciation expense	4	289,730	292,297
Net loss on disposal of non-current assets	5	22,941	1,192
Capital user charge	6	636,608	0
Other expenses from ordinary activities	7	443,694	475,138
Total cost of services		5,508,255	4,902,738
Revenues from Ordinary Activities			
Patient charges	8	45,678	73,389
Donations revenue	9	1,947	3,443
Interest revenue		8	177
Other revenues from ordinary activities	10	62,916	59,576
Total revenues from ordinary activities		110,549	136,585
NET COST OF SERVICES		**5,397,706**	**4,766,152**
Revenues from Government			
Output appropriations	11	5,327,374	3,902,900
Capital appropriations	11	0	174,493
Liabilities assumed by the Treasurer	12	0	141,392
Resources received free of charge	13	12,500	16,000
Total revenues from government		5,339,874	4,234,785
Change in net assets		**(57,832)**	**(531,367)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(57,832)**	**(531,367)**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	14	(142,853)	(116,304)
Receivables	15	63,116	105,187
Inventories	17	37,476	71,407
Total current assets		(42,261)	60,290
NON-CURRENT ASSETS			
Amounts receivable for outputs	16	297,000	0
Property, plant and equipment	18	7,956,317	8,238,783
Total non-current assets		8,253,317	8,238,783
Total assets		**8,211,056**	**8,299,073**
CURRENT LIABILITIES			
Payables		240,138	342,100
Accrued salaries	19	115,564	91,109
Provisions	20	254,868	256,955
Total current liabilities		610,570	690,164
NON-CURRENT LIABILITIES			
Provisions	20	78,002	61,340
Total non-current liabilities		78,002	61,340
Total liabilities		**688,572**	**751,504**
Net Assets		**7,522,484**	**7,547,569**
EQUITY			
Contributed equity	21	32,748	0
Asset revaluation reserve	22	391,527	391,527
Accumulated surplus	23	7,098,209	7,156,042
Total Equity		**7,522,484**	**7,547,569**

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

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	24(c)	4,393,766	3,902,900
Capital contributions (2000/01 appropriation)	24(c)	0	73,100
Net cash provided by Government		4,393,766	3,976,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(1,907,054)	(1,965,587)
Employee costs		(2,615,987)	(2,444,181)
GST payments on purchases		(183,132)	(170,805)
Receipts			
Receipts from customers		60,201	71,639
Donations		1,947	2,048
Interest received		8	177
GST receipts on sales		3,231	1,938
GST receipts from taxation authority		164,581	169,085
Other receipts		55,890	75,426
Net cash used in operating activities	24(b)	(4,420,315)	(4,260,260)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	18	0	(33,033)
Net cash used in investing activities		0	(33,033)
Net decrease in cash held		(26,549)	(317,293)
Cash assets at the beginning of the reporting period		(116,304)	200,989
Cash assets at the end of the reporting period	24(a)	(142,853)	(116,304)

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 Australian 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 Australian 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.

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 valuation.

(b) 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.

(c) 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. All other transfers have been recognised in the Statement of Financial Performance. Prior to the current reporting period, capital appropriations were recognised as revenue in the Statement of Financial Performance. Capital appropriations which are repayable to the Treasurer are recognised as liabilities.

(d) Acquisition 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.

(e) Valuation of Non-Current Assets

The Health Service has applied the transitional provisions in AASB 1041 "Revaluation of Non-Current Assets" for land and buildings, and as a consequence assets are reported at cost, valuation and fair value. Fair value is the amount for which an asset could be exchanged, between knowledgeable, willing parties in an arm's length transaction.

i) Land and Non-Clinical Buildings

The revaluations of land and non-clinical buildings have been undertaken by the Valuer General's Office in Western Australia, on the following bases:

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

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

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

Buildings	50 years
Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Motor vehicles	4 to 10 years
Other mobile plant	10 to 20 years
Other plant and equipment	4 to 50 years

(g) 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.

The Health Service has no contractual obligations under finance leases.

(h) Cash

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

(i) Receivables

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

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

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

Accrued salaries 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.

(m) Provisions

Employee Entitlements

i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Health Service has a present obligation to pay resulting from employees' services up to the reporting date. The liability has been calculated on current remuneration rates and includes related on-costs.

The liability for long service leave is recognised, and is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including related on-costs, experience of employee departures and periods of service. Expected future payments are discounted using interest rates on national government securities to obtain the estimated future cash outflows.

The methods of measurement of the liabilities are consistent with the requirements of Australian Accounting Standard AAS 30 "Accounting for Employee Entitlements".

ii) 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 liability for future payments under the Pension Scheme are 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.

From 1 July 2001 employer contributions were paid to the GESB in respect of the Gold State Superannuation Scheme and West State Superannuation Scheme. Prior to 1 July 2001, the unfunded liability in respect of these schemes was assumed by the Treasurer. An amount equivalent to the employer contributions which would have been paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme if the Health Service had made concurrent employer contributions to those schemes, was included in superannuation expense. This amount was also included in the revenue item "Liabilities assumed by the Treasurer".

The note disclosure required by paragraph 51(e) of AAS30 (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.

(n) 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.

(o) 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.

(p) 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.

(q) Comparative Figures

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

	2001/02 $	2000/01 $
Note 2 Administered trust accounts		

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

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

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

	2001/02 $	2000/01 $
Opening Balance	908	946
Add Receipts		
- Interest	1	12
	909	958
Less Payments		
- Patient Withdrawals	81	50
- Interest / Charges	30	0
Closing Balance	797	908

b) Other trust accounts

Ashburton Diabetes Education Fund

	2001/02 $	2000/01 $
Opening Balance	420	0
Add Receipts		
- Deposits	860	1,120
- Interest	1	4
	1,281	1,124
Less Payments		
- Withdrawals	287	698
- Charges	1	6
Closing Balance	993	420

Note 3 Patient support costs

	2001/02 $	2000/01 $
Medical supplies and services	127,712	107,482
Domestic charges	20,423	27,028
Fuel, light and power	176,407	183,047
Food supplies	34,353	36,381
Purchase of external services	2,010	1,021
	360,905	354,959

Note 4 Depreciation expense

	2001/02 $	2000/01 $
Buildings	228,702	235,776
Computer equipment and software	12,737	14,098
Furniture and fittings	11,437	12,002
Other plant and equipment	36,854	30,421
	289,730	292,297

Note 5 Net profit / (loss) on disposal of non-current assets

a) **Profit / (Loss) on disposal of non-current assets:**

	2001/02 $	2000/01 $
Computer equipment and software	(2,084)	0
Furniture and fittings	(8,915)	(951)
Other plant and equipment	(11,942)	(241)
	(22,941)	(1,192)

Note 6 Capital user charge

	2001/02 $	2000/01 $
	636,608	0

A capital user charge rate of 8% has been set by the Government for 2001/02 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.

	2001/02 $	2000/01 $
Note 7 Other expenses from ordinary activities		
Other employee expenses	39,932	85,564
Motor vehicle expenses	69,297	64,507
Insurance	29,790	51,386
Communications	41,207	47,322
Printing and stationery	13,936	32,724
Rental of property	41,477	48,425
Audit fees - external	12,500	16,000
Bad and doubtful debts expense	25,274	1,200
Other	170,281	128,010
	443,694	475,138

Note 8 Patient charges

	2001/02 $	2000/01 $
Inpatient charges	11,714	0
Outpatient charges	33,964	73,389
	45,678	73,389

Note 9 Donations revenue

	2001/02 $	2000/01 $
General public contributions	1,947	3,443

Note 10 Other revenues from ordinary activities

	2001/02 $	2000/01 $
Rent from properties	7,939	1,200
Recoveries	18,843	37,309
Use of hospital facilities	35,351	18,162
Other	783	2,905
	62,916	59,576

Note 11 Government appropriations

	2001/02 $	2000/01 $
Output appropriations (I)	5,327,374	3,902,900
Capital appropriations (II)	0	174,493
	5,327,374	4,077,393

(I) Output appropriations are accrual amounts as from 1 July 2001, reflecting the full price paid for outputs purchased by the Government. 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.

(II) Capital appropriations were revenue in 2000/01 (year ended 30 June 2001). From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 12 Liabilities assumed by the Treasurer

	2001/02 $	2000/01 $
Superannuation	0	141,392

The change in funding arrangements for the Gold State Superannuation and the West State Superannuation Scheme has resulted in the decrease in "Liabilities Assumed by the Treasurer".

Note 13 Resources received free of charge

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

	2001/02 $	2000/01 $
Office of the Auditor General - Audit services	12,500	16,000

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues 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 14 Cash assets

	2001/02 $	2000/01 $
Cash on hand	(2,415)	4,075
Cash at bank - general	(161,366)	(137,834)
Cash at bank - donations	20,928	17,455
	(142,853)	(116,304)

Note 15 Receivables

	2001/02 $	2000/01 $
Patient fee debtors	12,548	23,738
GST receivable	29,283	23,684
Other receivables	47,646	61,126
	89,477	108,548
Less: Provision for doubtful debts	(26,361)	(3,361)
	63,116	105,187

Note 16 Amounts receivable for outputs

	2001/02 $	2000/01 $
Non-current	297,000	0

This asset represents the non-cash component of output appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

Note 17 Inventories

	2001/02 $	2000/01 $
Supply stores - at cost	29,476	63,407
Pharmaceutical stores - at cost	8,000	8,000
	37,476	71,407

Note 18 Property, plant and equipment

	2001/02 $	2000/01 $
Land		
At fair value	213,000	213,000
	213,000	213,000
Buildings		
Clinical:		
At cost (i)	2,030,427	2,030,427
Accumulated depreciation	(175,119)	(117,738)
	1,855,308	1,912,689
At valuation - June 1999 (ii)	12,175,000	12,175,000
Accumulated depreciation	(7,031,278)	(6,872,194)
	5,143,722	5,302,806
Non-Clinical:		
At valuation - June 1999 (ii)	433,500	433,500
Accumulated depreciation	(37,864)	(25,627)
	395,636	407,873
Computer equipment and software		
At cost	83,012	100,403
Accumulated depreciation	(54,981)	(61,798)
	28,031	38,605
Furniture and fittings		
At cost	189,373	229,246
Accumulated depreciation	(95,403)	(114,924)
	93,970	114,322
Other plant and equipment		
At cost	586,866	630,191
Accumulated depreciation	(360,216)	(380,703)
	226,650	249,488
Total of property, plant and equipment	7,956,317	8,238,783

Note 18 Property, plant and equipment - continued	2001/02 $	2000/01 $

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to revalued are carried at their cost of acquisition.
(ii) Land, clinical buildings and non-clinical buildings have been subject to a recent revaluation and are carried at their fair value.
(iii) Land, clinical buildings and non-clinical buildings are yet to be revalued at fair value.

Payments for non-current assets

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

	2001/02 $	2000/01 $
Paid as cash by the Health Service from output appropriations	0	33,033
Paid by the Department of Health	28,175	110,747
Gross payments for purchases of non-current assets	28,175	143,780

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.

	2001/02 $
Land	
Carrying amount at start of year	213,000
Carrying amount at end of year	213,000
Buildings	
Carrying amount at start of year	7,623,368
Depreciation	(228,702)
Carrying amount at end of year	7,394,666
Computer equipment and software	
Carrying amount at start of year	38,605
Additions	4,247
Disposals	(2,084)
Depreciation	(12,737)
Carrying amount at end of year	28,031
Furniture and fittings	
Carrying amount at start of year	114,322
Disposals	(8,915)
Depreciation	(11,437)
Carrying amount at end of year	93,970
Other plant and equipment	
Carrying amount at start of year	249,488
Additions	25,958
Disposals	(11,942)
Depreciation	(36,854)
Carrying amount at end of year	226,650

Note 19 Accrued salaries	2001/02 $	2000/01 $
Amounts owing for:	115,564	91,109

All staff
10 working days from 17 June to 30 June 2002
(2001: 10 working days from 18 June to 30 June 2001)

Note 20 Provisions	**2001/02 $**	**2000/01 $**
Current liabilities:		
Annual leave	231,862	227,368
Long service leave	23,006	29,587
	254,868	256,955
Non-current liabilities:		
Long service leave	78,002	61,340
Total employee entitlements	332,870	318,295

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

Note 21 Contributed equity

	2001/02 $	2000/01 $
Balance at beginning of the year	0	0
Capital contributions (i)	32,748	0
Balance at end of the year	32,748	0

(i) From 1 July 2001, capital appropriations, termed Capital Contributions, have been designated as contributions by owners and are credited directly to equity in the Statement of Financial Position.

Note 22 Asset revaluation reserve

	2001/02 $	2000/01 $
Balance at beginning of the year	391,527	391,527
Balance at end of the year	391,527	391,527

(i) Revaluation increments and decrements are offset against one another within the same class of non-current assets.

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

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

Note 23 Accumulated surplus

	2001/02 $	2000/01 $
Balance at beginning of the year	7,156,042	7,687,409
Change in net assets	(57,832)	(531,367)
Balance at end of the year	7,098,210	7,156,042

Note 24 Notes to the statement of cash flows	2001/02 $	2000/01 $
a) Reconciliation of cash		
Cash assets at the end of the reporting period 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 14)	(142,853)	(116,304)
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)	(4,420,315)	(4,260,260)
Increase / (decrease) in assets:		
GST receivable	5,599	23,442
Other receivables	(24,670)	11,138
Inventories	(33,931)	(17,650)
Decrease / (increase) in liabilities:		
Doubtful debts provision	(23,000)	(1,200)
Payables	101,962	(21,004)
Accrued salaries	(24,455)	(40,994)
Provisions	(14,575)	(18,097)
Non-cash items:		
Depreciation expense	(289,730)	(292,297)
Loss from disposal of non-current assets	(22,941)	(1,192)
Capital user charge paid by Department of Health	(636,608)	0
Other expenses paid by Department of Health	(4,573)	0
Superannuation liabilities assumed by the Treasurer	0	(141,392)
Resources received free of charge	(12,500)	(16,000)
Other	2,031	9,354
Net cost of services (Statement of Financial Performance)	(5,397,706)	(4,766,152)
c) Notional cash flows		
Output appropriations as per Statement of Financial Performance	5,327,374	3,902,900
Capital appropriations as per Statement of Financial Performance	0	174,493
Capital appropriations credited directly to Contributed Equity	32,748	0
	5,360,122	4,077,393
Less non-cash component of ouput appropriations (Refer to Note 16)	(297,000)	0
	5,063,122	4,077,393
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:		
Capital user charge	(636,608)	0
Capital subsidy	(32,748)	(174,493)
Other non cash adjustments to output appropriations	0	73,100
	(669,356)	(101,393)
Net Cash Provided by Government as per Statement of Cash Flows	4,393,766	3,976,000

Note 25 Revenue, public and other property written off or presented as gifts

	2001/02 $	2000/01 $
a) Revenue and debts written off.	420	1,854
b) Public and other property written off.	0	20,369

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

Note 26 Remuneration of members of the accountable authority and senior officers

Remuneration of senior officers
The number of Senior Officers (other than members of the Accountable Authority), whose total of fees, salaries, superannuation and other benefits for the reporting period, fall within the following bands are:

	2001/02	2000/01
$70,001 - $80,000	1	1
Total	1	1

	$	$
The total remuneration of senior officers is:	75,601	73,757

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of Senior Officers (other than members of the Accountable Authority).

Note 27 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%.

	2001/02 $	2000/01 $	Variation $
Employee expenses Increase was due to use of agency staff, EBA Award increases and gratuity payments.	2,612,683	2,556,473	56,210
Patient transport costs Increase in the cost of airfares with the collapse of Ansett.	649,400	595,487	53,913
Repairs, maintenance and consumable equipment expense Upgrade of hospitals and staff accommodation completed in 2000/01.	115,476	293,758	(178,282)
Net loss on disposal of non-current assets General review in asset ledger for assets with a value below $1000 in value.	22,941	1,192	21,749
Capital user charge Refer to Note 6.	636,608	0	636,608
Fees for visiting medical practitioners General fee increase and arrangement for obstetric cover	219,495	192,042	27,453

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.

	2001/02 Actual $	2001/02 Estimate $	Variation $
Visiting medical practitioners General fee increase and arrangement for obstetric cover	219,495	199,000	20,495
Patient transport costs Increase in the cost of airfares.	649,400	565,000	84,400
Patient support costs Anticipated increases in energy costs did not occur	360,905	415,000	(54,095)

Note 28 Commitments for Expenditure	2001/02 $	2000/01 $
a) Operating lease commitments: Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	40,723	40,338
Later than one year, and not later than five years	18,151	37,967
	58,874	78,305

These commitments are all inclusive of GST.

Note 29 Contingent liabilities

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

Note 30 Events occurring after reporting date

The Ashburton Health Service will cease to exist as a legal entity as at 1 July 2002. The health service will be amalgamated with other health services to form the WA Country Health Service on 1 July 2002. The amalgamation was gazetted on 28 June 2002.

Note 31 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 32 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 33 Financial instruments

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

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.0%	(141)	0	0	0	(2)	(143)
Receivables		0	0	0	0	63	63
		(141)	0	0	0	61	(80)
Financial Liabilities							
Payables		0	0	0	0	240	240
Net financial liabilities		(141)	0	0	0	(179)	(320)
As at 30th June 2001							
Financial Assets							
Cash assets	0.0%	(120)	0	0	0	4	(116)
Receivables		0	0	0	0	105	105
		(120)	0	0	0	109	(11)
Financial Liabilities							
Payables		0	0	0	0	342	342
Net financial liabilities		(120)	0	0	0	(233)	(353)

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. In respect of other financial assets, the carrying amounts represent the Health Service's maximum exposure to credit risk in relation to those assets.

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

Note 34 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	140	177	2,473	2,380	0	0	2,613	2,556
Fees for visiting medical practitioners	0	0	219	192	0	0	219	192
Superannuation expense	10	12	147	129	0	0	157	141
Patient support costs	1	0	360	355	0	0	361	355
Patient transport costs	0	0	649	594	0	0	649	594
Borrowing costs expense	0	0	0	1	0	0	0	1
Repairs, maintenance and consumable equipment expense	2	1	113	293	0	0	115	294
Depreciation expense	4	4	286	288	0	0	290	292
Net loss on disposal of non-current assets	0	0	23	1	0	0	23	1
Capital user charge	0	0	637	0	0	0	637	0
Other expenses from ordinary activities	28	47	416	429	0	0	444	475
Total cost of services	185	241	5,323	4,661	0	0	5,508	4,902
Revenues from Ordinary Activities								
Patient charges	0	0	46	73	0	0	46	73
Donations revenue	0	0	2	3	0	0	2	3
Other revenues from ordinary activities	2	2	61	58	0	0	63	60
Total revenues from ordinary activities	2	2	109	135	0	0	111	137
NET COST OF SERVICES	**183**	**239**	**5,214**	**4,526**	**0**	**0**	**5,398**	**4,765**
Revenues from Government								
Output appropriations	200	230	5,127	3,673	0	0	5,327	3,903
Capital appropriations	0	0	0	174	0	0	0	174
Liabilities assumed by the Treasurer	0	12	0	129	0	0	0	141
Resources received free of charge	0	0	13	16	0	0	13	16
Total revenues from government	200	243	5,140	3,992	0	0	5,340	4,234
Change in net assets	**17**	**3**	**(75)**	**(534)**	**0**	**0**	**(58)**	**(531)**

Note 34 Output information (continued)

Output groups as defined in the budget papers are as follows:

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. Services provided in this output include community health services; screening services; communicable disease management; health regulation and control; and community information and education.

* **Community Health Services**
  Community health services include a range of community based services with the focus on improving the overall health of Western Australians. This is achieved by developing health promotion and prevention activities, supporting early child development, enhancing and ensuring universal access to community services, building capacity and assessing determinants of health as they relate to inequality.

* **Screening Services**
  Screening services assist in the early identification and intervention of disease or conditions that can lead to long-term disability or premature death.

* **Communicable Disease Management**
  Communicable disease management includes a range of strategies which aim to reduce the incidence and effects of communicable diseases.

* **Health Regulation and Control**
  Health regulation and control is used to prevent and/or reduce the risk of disease, injury or premature death in those areas where health risk factors can be managed.

* **Community Information and Education**
  A key strategy to prevent disease, injury or premature death is the provision of community information and education. The purpose of these services is to promote a healthy lifestyle and educate Western Australians about appropriate preventive health behaviours.

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 or outpatient services and services for those people who are admitted to hospitals. Services provided in this output include admitted care, ambulatory care and emergency services.

* **Admitted Care**
  The types of services admitted patients may receive include obstetric care, services to cure illness or provide definitive treatment of injury, surgery, relief of symptoms or a reduction of severity of injury or illness (excluding palliative care), protection against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, and diagnostic or therapeutic procedures.

* **Ambulatory Care**
  Ambulatory care includes same day procedures, outpatient attendance, pre-admission assessments and home-based treatment and care. With these services patients do not undergo the formal hospital admission process.

* **Emergency Services**
  Emergency services are provided to treat people with sudden onset of illness or injury of such severity and urgency that they need immediate medical help which is either, not available from their General Practitioner, or for which their General Practitioner has referred them for treatment. Emergency departments provide a range of services from immediate resuscitation to urgent medical advice. An emergency department patient may subsequently undergo a formal admission process and would then be classified as an admitted patient, or be treated and discharged directly from the Emergency department without admission.

Continuing Care
Services provided to improve the quality of life for those who need continuing care. Services provided in this output include home care and residential services.

* **Home Care**
  Community based care and support to maintain and enhance, as far as possible, people's quality of life (eg home nursing, home help, transport service, home maintenance, delivered meals, respite care); care and support for terminally ill people and their families and carers (eg hospice services and palliative care); and care and support for people with long term disabilities to ensure an optimal quality of life.

* **Residential Care**
  Residential aged care services are for people assessed as being no longer able to live in their own home (eg nursing home services, nursing home type services in public hospitals and hostel services).