Upper Great Southern Health Service

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 Upper Great Southern 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

Contents

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Address and Location

Upper Great Southern Health Service
Narrogin Regional Hospital
Furnival St
NARROGIN WA 6312

PO Box 1136
NARROGIN WA 6312

☎ *(08) 9881 0411*
℻ *(08) 9881 0415*

The Upper Great Southern Health Service is also made up of the following health care units:

Dumbleyung District Memorial Hospital
McIntyre St
DUMBLEYUNG WA 6350

PO Box 39
DUMBLEYUNG WA 6350

☎ *(08) 9863 4022*
℻ *(08) 9863 4023*

Kondinin District Hospital
Graham St
KONDININ WA 6367

PO Box 2
KONDININ WA 6367

☎ *(08) 9889 1000*
℻ *(08) 9889 1203*

Kukerin Health Centre
Lot 65 Manser St
KUKERIN WA 6352

PO Box 19
KUKERIN WA 6352

☎ *(08) 9864 6047*
℻ *(08) 9864 6071*

Lake Grace District Hospital
Stubbs St
LAKE GRACE WA 6353

PO Box 189
LAKE GRACE WA 6353

☎ *(08) 9865 1206*
℻ *(08) 9865 1393*

Narrogin Regional Hospital
Williams Road
NARROGIN WA 6312

PO Box 336
NARROGIN WA 6312

☎ *(08) 9881 1188*
℻ *(08) 9881 3195*

Pingelly District Hospital
Stratford St
PINGELLY WA 6308

PO Box 63
PINGELLY WA 6308

☎ *(08) 9881 1188*
℻ *(08) 9881 3195*

Primary Health Service
(including community, aged care assessment team and allied health)
Narrogin Regional Hospital
Williams Rd
NARROGIN WA 6312

PO Box 339
NARROGIN WA 6312

☎ *(08) 9881 4888*
℻ *(08) 9881 1307*

Wagin District Hospital
Warwick St
WAGIN WA 6315

PO Box 222
WAGIN WA 6315

☎ *(08) 9861 1033*
℻ *(08) 9861 1033*

Wickepin Health Centre
Wogolin Rd
WICKEPIN WA 6370

PO Box 117
WICKEPIN WA 6370

☎ *(08) 9881 1104*
℻ *(08) 9881 1075*

Williams Health Centre
Adam St
WILLIAMS
WA 6391

PO Box 42
WILLIAMS WA 6391

☎ *(08) 9885 1005*
℻ *(08) 9885 1066*

Mission Statement

Our Mission
To improve the health and wellbeing of our community through a continuum of care.

Broad Objectives

The objectives of the Upper Great Southern Health Service are:

- To provide health services that are comprehensive, coordinated and readily accessible to the communities of the district.
- To promote an environment in which all persons are encouraged to contribute to the success of our Health Service.
- To encourage innovation and creativity in the way we deliver health services.
- To manage resources with efficiency and effectiveness in accordance with policies and priorities of the board and state government.
- To motivate and empower all persons within the Health Service to maintain and improve skills to meet their responsibilities.
- To ensure a coordinated approach to the efficient use of information resources for the effective delivery and management of services.
- To provide and maintain facilities and services designed to promote and maintain safe practice and good health.
- To maintain an ongoing program of evaluation and review of all activities.

Enabling Legislation

The Upper Great Southern 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 Upper Great Southern 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.

The names of the nine management committees within the Upper Great Southern Health Service at 30 June 2002 are as follows:

- Dumbleyung Health Service Management Committee.
- Kondinin and Districts Health Service Management Committee.
- Kukerin Health Service Management Committee.
- Lake Grace District Health Service Management Committee.
- Narrogin Regional Health Service Management Committee.
- Pingelly District Health Service Management Committee.
- Wagin District Health Service Management Committee.
- Wickepin Health Service Management Committee.
- Williams Health Service Management Committee.

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 Upper Great Southern 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 Upper Great Southern 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.

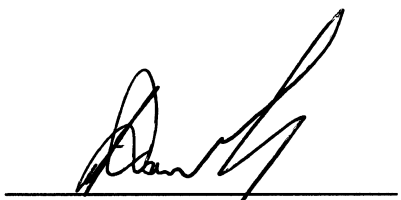
Such processes include:

- Performance management is undertaken for nursing staff. A district-wide performance management system was developed as part of People Focus 1999–2001 strategic planning.
- Policies and guidelines are available in staff meeting areas, libraries and on request from all Health Service Managers and the Human Resource Coordinator.
- Responsibility for compliance with the Public Sector Standards and Codes rests with each Health Service Manager and Human Resource Coordinator. These responsibilities are detailed in the job description forms for those positions.
- Compliance checks and controls are performed by the Human Resource Coordinator to ensure that the standards and codes are adhered to. Specifically for recruitment and selection, a check list of required actions is used to identify each stage of the process. This checklist can be modified to cover the majority of the standards.
- The procedures outlined in the Management Internal Control Assessment (MICA) documentation were used to derive the Upper Great Southern Health Service self-assessment program.
- The Upper Great Southern Health Service *Code of Ethics* and *Code of Conduct* were adopted in 1997. New employees are provided with copies. Compliance with the Codes is monitored on a case-by-case basis. Staff are aware that misconduct is to be reported through the grievance resolution process.

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



Kim Darby
ACTING REGIONAL DIRECTOR
WHEATBELT REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

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

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies			
— Australian Podiatry Association	–	11.00	–
— Bleat	12.50	18.00	24.87
— Country Press Advertising	75.60	–	–
— David Moyses Photography	–	–	250.00
— Dietitians Association of Australia	150.00	–	–
— Dumbleyung Newsagency	100.00	–	–
— Hyden Resource and Telecentre	20.00	5.72	15.00
— Kulin Cultivator	–	–	20.00
— Kulin Telecentre	–	–	10.91
— Label Names	–	–	199.09
— Lake Grace Telecentre	261.50	540.92	748.45
— Lakes Link Centre	–	–	86.00
— Lions Club of Lake Grace	80.00	40.00	–
— Market Force Productions	16,406.00	31,115.05	16,430.84
— Metropolitan Health Service	–	653.88	106.50
— Newdegate Machinery Field Day	–	116.00	25.00
— NT Medic Pty Ltd	–	407.00	–
— Penny Poste	–	–	123.90
— Pingrup District Resource	60.00	–	–
— Ray White Real Estate Narrogin	–	–	220.79
— Rural Press Regional Media	1,899.10	3,398.87	2,877.80
— Seabreeze Communications	640.00	580.80	561.00
— Shire of Wickepin	105.00	–	–
— South West Printing and Publishing	1,548.60	4,703.12	1,606.74
— Telstra Corporation Ltd	1,484.80	–	50.31
Market Research Organisations	–	–	–
Polling Organisations	–	–	–

DIRECT MAIL ORGANISATIONS	–	–	–
Media Advertising Organisations			
— Great Southern Herald	104.00	–	–
— Great Southern Herald	69.00	–	89.60
— Kondinin Calendar	15.00	25.00	40.00
— Merredin Wheatbelt Mercury	200.90	–	–
— Narrogin Observer Pty Ltd	–	–	241.45
— Pacific Access	155.00	105.27	105.00
— Pantaraxia Newsletter	–	–	42.00
— Pingelly Times	267.50	366.00	314.18
— RadioWest	140.00	632.50	–
— The West Australian	–	251.79	1216.80
— Waveline News	–	–	90.00
TOTAL	**$23,794.50**	**$42,970.92**	**$25,496.23**

Freedom of Information Act 1992

The Upper Great Southern Health Service received and dealt with 35 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.

Most applications were from existing or former patients wanting to read or have a copy of their medical record, while others were from lawyers, authorised next of kin or authorised agencies.

The types of documents held by the Upper Great Southern 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:

Mary Saunders
Health Information Coordinator
Narrogin Regional Hospital
PO Box 336
NARROGIN WA 6312

☎ *(08) 9881 0333*

Upper Great Southern Health Service

Key Operations and Achievements

- Building renovations at the Nurses Quarters have brought the outdated style of accommodation up to a reasonable standard.
- Dumbleyung District Hospital and Kukerin Health Centre have applied for a Multi Purpose Service.
- The Health Service is committed to the integration of Telehealth systems into health care delivery.
- The Narrogin Redevelopment Stage Two commenced in May 2001.
- Narrogin Regional Hospital midwives received the most nominations for the Midwife of the Year Award.

Building Renovations at the Nurses Quarters

Building renovations at the Nurses Quarters accommodation throughout the Health Service have brought the outdated style of accommodation up to a reasonable standard. There will be a reduction in beds but there will be an increase of the amount of room per person to improve privacy and comfort. This will assist with the recruitment and retention of staff within the UGSHS.

Multi Purpose Service for the Shire of Dumbleyung

Dumbleyung District Hospital and Kukerin Health Centre have applied for a Multi Purpose Service for the Shire of Dumbleyung. This will ensure a flexible approach to health care for the local community.

Telehealth

The Health Service is committed to the integration of Telehealth systems into health care delivery and as such has employed a Telehealth coordinator and is paying all costs associated with using the systems in place. Future focus will include enhancement of current projects and integration of Telehealth across health service delivery and supporting areas. The Health Service has been one of the initial pilot sites for Telehealth since May 2000. Telehealth has continued to be an effective and efficient tool for service delivery. The Health Service has the most Telehealth-enabled sites in the state with 13 videoconferencing units plus teleradiology and telepsychiatry facilities. The project was established as an inter-regional model with Narrogin Regional Hospital as the hub of delivery. These facilities provide increased access for rural communities to services such as dietetics, extended midwifery, speech pathology, diabetes education, cardiac rehabilitation, wound management and other services offered by clinicians.

Narrogin Redevelopment

The Narrogin Redevelopment commenced in November 2000 with Stage One completing the new Medical Imaging and Rooming-In Facility. Stage Two commenced in May 2001 building new Accident and Emergency and Day Procedures facilities. This redevelopment has enabled Narrogin Regional Hospital to have the highest quality facilities to increase service delivery to the community.

Narrogin Regional Hospital Midwives
Narrogin Regional Hospital midwives received the most nominations for the Midwife of the Year Award, per birth rate.

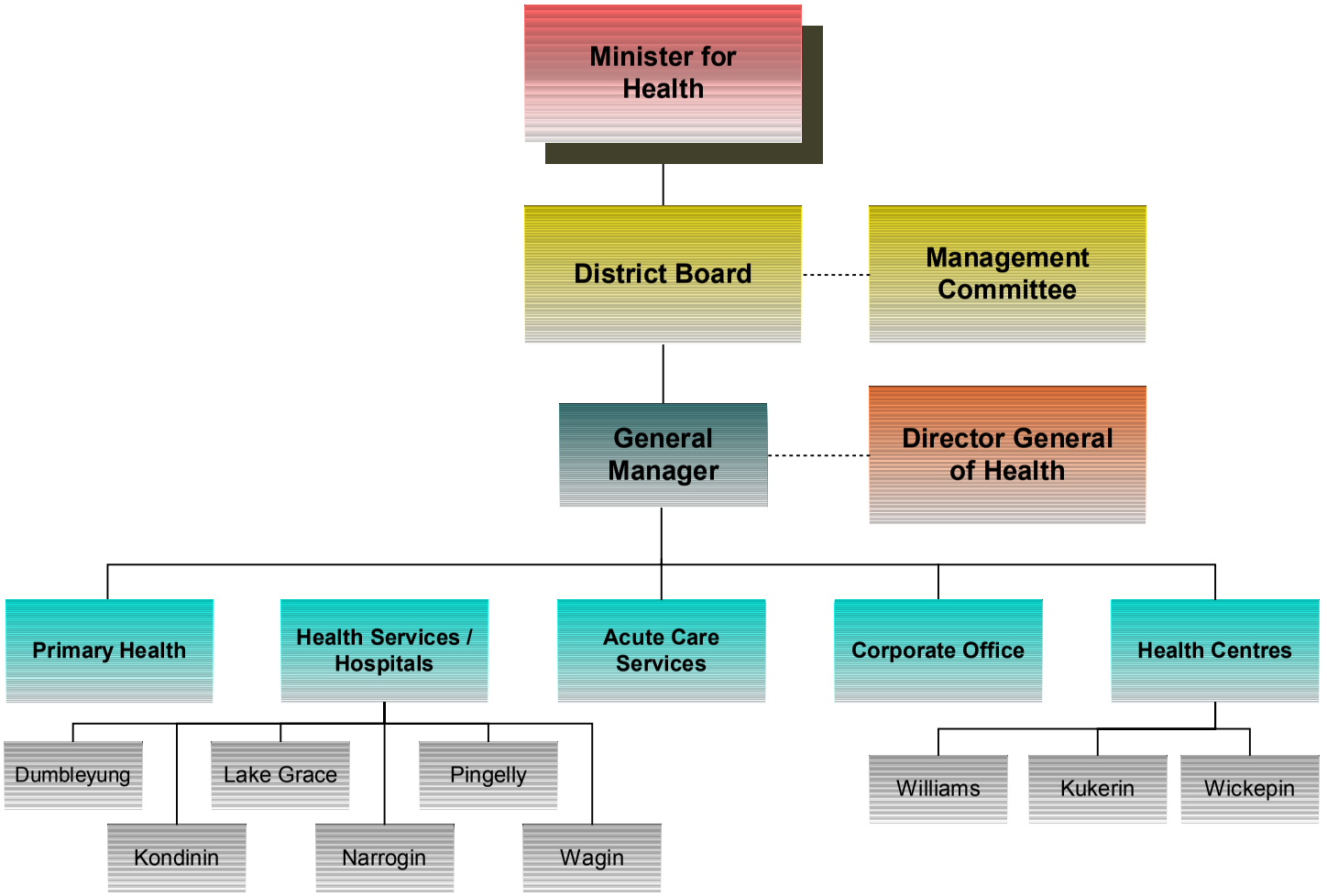
Major Capital Projects

Projects Completed during the Year

PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Wagin Emergency Department	$60,456	$60,456
Lake Grace Ambulance Entry and Upgrade	$156,000	$156,000
TOTAL	**$216,456**	**$216,456**

Projects in Progress
There are no major capital works still in progress.

Organisational Chart



Accountable Authority

The Upper Great Southern 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
Terry Park	Chairperson	30 September 2003
Henry Baxter	Deputy Chairperson	31 December 2002
Patrick O'Neill	Member	31 December 2002
Ann James	Member	30 September 2002
John Nagel	Member	30 September 2003
Sydney Martin	Member	31 December 2002
Michael Clark	Member	30 September 2003
Moya Carne	Member	31 December 2002
Helen Gooding	Member	30 September 2002
Mary Graham	Deputy Member	30 September 2003
Gary Guelfi	Deputy Member	31 December 2002
Colin Hemley	Deputy Member	31 December 2002
Dianne Warren	Deputy Member	31 December 2002
Teresa Wigg	Deputy Member	31 December 2002
Ian Astill	Deputy Member	31 December 2002
Jim West	Deputy Member	31 December 2002
Geoff Hodgson	Deputy Member	30 September 2002

Note: The Governor in Executive Council approved the amalgamation of several hospital boards including the Upper Great Southern 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 Upper Great Southern Health Service Board and their areas of responsibility are listed below:

Area of Responsibility	Title	Name	Basis of Appointment
Chief Executive Officer	General Manager	Kim Darby	Permanent
Health Service and Nursing Management	Health Service Manager, Kondinin	Jody Morton and Monica Graham (job share)	Permanent
Health Service and Nursing Management	Health Service Manager, Dumbleyung	Merilyn McLean	Permanent
Health Service and Nursing Management	Health Service Manager, Lake Grace	June McEncroe	Permanent
Health Service and Nursing Management	District Director of Acute Care Services, Upper Great Southern Health Service	Sue Woods	Permanent
Health Service and Nursing Management	Health Service Manager, Pingelly	Karen Blakely	Permanent
Health Service and Nursing Management	Health Service Manager, Wagin	Tammy Lynch	Permanent
Health Service and Nursing Management	Primary Health Service Manager	Sean Conlan	Permanent
Medical Services	Chairperson Medical Advisory Committee	Dr A. Kerrigan	Elected MAC Representative for 2001/2002

Pecuniary Interests

Members of the Upper Great Southern Health Service Board have declared no pecuniary interests other than those reported in the Financial Statements section of this report.

Demography

The Upper Great Southern Health Service delivers services to communities covered by the following local authorities:

- Cuballing Shire
- Dumbleyung Shire
- Kondinin Shire
- Kulin Shire
- Lake Grace Shire
- Narrogin Shire
- Narrogin Town
- Pingelly Shire
- Wagin Shire
- Wandering Shire
- West Arthur Shire
- Wickepin Shire
- Williams Shire

The following table shows population figures for each local authority within the Upper Great Southern region:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Cuballing	742	726	753
Dumbleyung	895	761	883
Kondinin	1188	1012	1219
Kulin	966	892	951
Lake Grace	1819	1567	1779
Narrogin Shire	862	774	900
Narrogin Town	4632	4712	4761
Pingelly	1200	1207	1250
Wagin	1979	1840	1950
Wandering	364	336	352
West Arthur	1003	909	999
Wickepin	860	746	871
Williams	1040	942	1099

*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*.

It is not expected there will be any significant changes to the demographics by the year 2006. The Upper Great Southern Health Service has an agricultural and service based economy.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Acute Surgical
Cardiology
Extended Care
Geriatrics
Gynaecological
Obstetrics
Palliative Care
Permanent Care
Respite Care
Same Day Surgery

Community Services
Aged Care Packages
Home and Community Care
Home Care
Home Modification
Hostel Meals
Meals on Wheels

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

Other Support Services
Central Sterilising
Hotel Services
Medical Records

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Upper Great Southern 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 Upper Great Southern 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.

- A district-wide Disability Services Plan has been developed.
- Occasions of service will be identified by the Health Information Officer.
- Staff are trained in disability service provisions as part of the induction program.

Outcome 2: Access to buildings and facilities is improved.

- Access needs continued to be identified for Upper Great Southern Health Service.
- Modifications to physical assets across the Upper Great Southern Health Service have been made to accommodate clients and prospective employees with disabilities. Units within the Upper Great Southern Health Service have participated in temporary placement and rehabilitation for people with disabilities through Hotham Personnel, an employment agency for people with disabilities. This process will continue.

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, however, any requests will be accommodated.

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

- Staff are provided with awareness training by the Human Resource Coordinator.

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 Upper Great Southern 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 Upper Great Southern 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 Upper Great Southern Health Service operates in conjunction with the *Western Australian Government Language Services Policy*.

There have been no outcomes achieved for the Upper Great Southern Health Service through the Cabinet endorsed Language Service Policy. Development will commence in the 2002/2003.

Youth Services

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

The Upper Great Southern 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 Upper Great Southern Health Service has run numerous programs targeting youth groups and introduced a number of innovations such as:

- The Community Development Placement Program which consists of youth undertaking community service work in a supervised environment in the Health Service.
- Central Area Training Scheme Program for youth apprenticeships.
- Structured Workplace Learning work experience for students.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	121.15	121.32	118.63
Administration and Clerical*	36.34	40.61	42.04
Medical Support*	16.29	19.67	19.96
Hotel Services*	71.43	72.25	76.82
Maintenance	6.88	7.65	7.88
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**252.09**	**261.50**	**265.33**

*Note these categories include the following:

- **Administration and Clerical** — health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners, caterers and patient service assistants.

Recruitment Practices

The Upper Great Southern Health Service has followed the Public Sector Standards in Human Resource Management relating to recruitment and selection for the employment of staff. As an outcome of the human resources plan, People Focus 1999 to 2001, recruitment has been centralised within the Corporate Office. Human resources representation is maintained on most recruitment panels as a quality assurance activity and as a training opportunity for new panel members.

Staff Development

A total of 6973 hours of study leave was granted during the year.

The Staff Development Unit with its offices at Narrogin Hospital now provides integrated comprehensive staff development for all staff of the Upper Great Southern Health Service. The district-wide approach takes into consideration current moves within the health sector for a more inclusive, cooperative basis for quality health care delivery. Staffing levels have risen, commensurate with the Health Services commitment to the district-wide approach. A Regional Staff Development Advisory Committee comprising staff developers and managers has been established to complement individual Health Service staff development committees and activities. Broad ranging methodologies have been introduced to build the capacity of the workforce. These include:

- Introduction of reflective practice within clinical settings for students.
- Support in developing training and secondment opportunities for staff.
- Scholarship and mentoring programs.
- Specific funding to address key issues such as leadership in change management.
- Development of competency-based standards associated with job descriptions.
- Provision of competency based-training courses and workshops.
- Funding for attendance at external staff development and conference activities.
- Facilitation of peer support systems and opportunities for supervision.
- Assistance with professional development and career planning choices.
- Clinical teaching.

Structural and organisational support for capacity building activities listed above include:

- Ongoing establishment of a district-wide library system.
- Ongoing development of staff development record-keeping capabilities.
- Provision of suitable electronic learning arrangements for employees including:

  Computer support with intranet and internet access, access to 'best practice' data bases, access to pharmacological databases, access to university library catalogues and on-line learning facilities, training in software, training in Department of Health databases, access for all employees to computers through library facilities, and hardware support.

  Videoconferencing support via Telehealth in a number of educational pursuits. An example of best practice includes the initiation and use of Telehealth in the first ever re-certification of staff as cardio-pulmonary resuscitation instructors. Kondinin hospital was linked with assessors at the National Heart Foundation in Perth to achieve this milestone in the use of technology.

The types of educational activities included:

- Advanced Life Support and Defibrillation certification.
- Rural RN Competencies: suturing, IV cannulation, venipuncture, plastering.
- Competency-based generic orientation program.
- Chainsaw use and maintenance certification.
- EN Competency Study Day: insertion of nasogastric tubes, male and female urinary catheterisation, cardiac monitoring with the 12 lead ECG, recording observations.

Industrial Relations Issues

Throughout this financial year, no major industrial issues have taken place within the Upper Great Southern Health Service.

Salary Sacrificing

Salary sacrificing policy within the Government Health Industry has been altered in line with legislative changes introduced by the Commonwealth Government, which places a cap of $17,000.00 (grossed up) on all employee packages, with any benefits in excess of the cap being subject to Fringe Benefits Tax (FBT). Previously through the UGSHS status as a Public Benevolent Institution, hospitals were not liable to pay FBT.

Workers' Compensation and Rehabilitation

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	2	5	3
Administration and Clerical*	1	1	0
Medical Support*	0	0	0
Hotel Services*	2	4	9
Maintenance	0	1	2
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**5**	**11**	**14**

*Note these categories include the following:

- **Administration and Clerical** — health project officers, ward clerks, receptionists and clerical staff.
- **Medical Support** — physiotherapists, speech pathologists, medical imaging technologists, pharmacists, occupational therapists, dietitians and social workers.
- **Hotel Services** — cleaners, caterers and patient service assistants.

Occupational Safety and Health Committees have been established in various forms at the regional and district hospitals across the Health Service. A cooperative and coordinated approach towards occupational safety and health has resulted in the appointment of an Injury Management Coordinator. The coordinator will manage and monitor rehabilitation and return-to-work programs for staff subject to workers' compensation claims. The IMC liaises with the newly appointed Claims Manager.

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 Upper Great Southern 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.

- There have been no claims of discrimination or harassment in the Upper Great Southern Health Service during 2001/2002.
- The total number of non-English speaking employees is 16, being 3.88 per cent of our work force.
- The total number of Aboriginal employees is five, being 1.21 per cent of our work force.
- The Upper Great Southern Health Service employs 412 people of whom 372, or 90.29 per cent, are female.

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

- The Health Service will continue providing training and employment opportunities to identified groups who have historically experienced discrimination.
- There have been no claims of discrimination or harassment in the Health Service during 2001/2002.

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

- All employees have received EEO training as part of their orientation program. This occurs in conjunction with provision of information pertaining to EEO as part of their employment documentation. Training is ongoing.
- Modifications to physical assets across the Health Service have been made to accommodate clients and prospective employees with disabilities.
- The total number of employees with disabilities is eight, being 1.94 per cent of our work force.

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 Upper Great Southern Health Service has been able to meet these goals:

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

Marketing

No public relations or marketing activities were conducted this financial year.

The Health Service continued the development of the internet and intranet site but this has been put on hold while health services undergo the current restructure.

Publications

No publications were issued by the Health Service in this financial year.

Research and Development

The Upper Great Southern Health Service carried out no major research and development programs during 2001/2002.

Evaluations

A staff satisfaction survey was undertaken this financial year with the results to be available in September 2002. No other evaluations were undertaken this financial year.

Risk Management

Our Policy
The Upper Great Southern 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 initiated during 2001/2002 include:

- The Health Service now has a permanent Quality and Risk Management Coordinator who oversees the Risk Management Plan.
- The plan encompassed clinical and non-clinical adverse occurrence minimisation strategies, occupational health and safety, safe environment, fraud prevention, audit, insurance and fixed asset management programs.
- Managers and staff have attended workshops on the risk management process and risk management surveys have been conducted. Risk management is an ongoing process and is included as an agenda item at all meetings that are held in the Upper Great Southern 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 Upper Great Southern 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.

A District Board is established to oversee the operation of internal audit functions and to ensure that management addresses any findings made by the Health Service's internal and external audits.

Waste Paper Recycling

No waste paper recycling has commenced in this financial year. The Health Service will commence operating a worm farm in 2002/2003. This has already been set up with the worms purchased this financial year.

Pricing Policy

The Upper Great Southern 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.

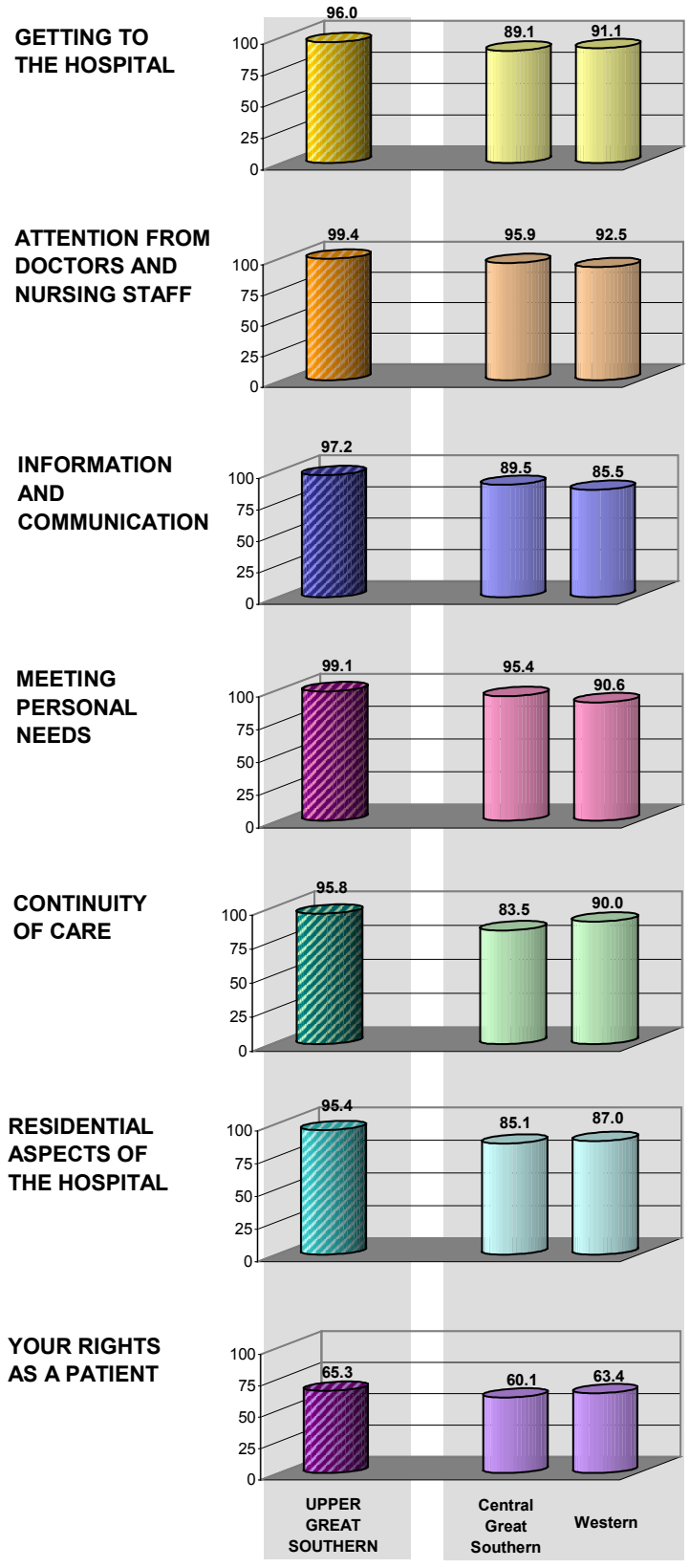
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

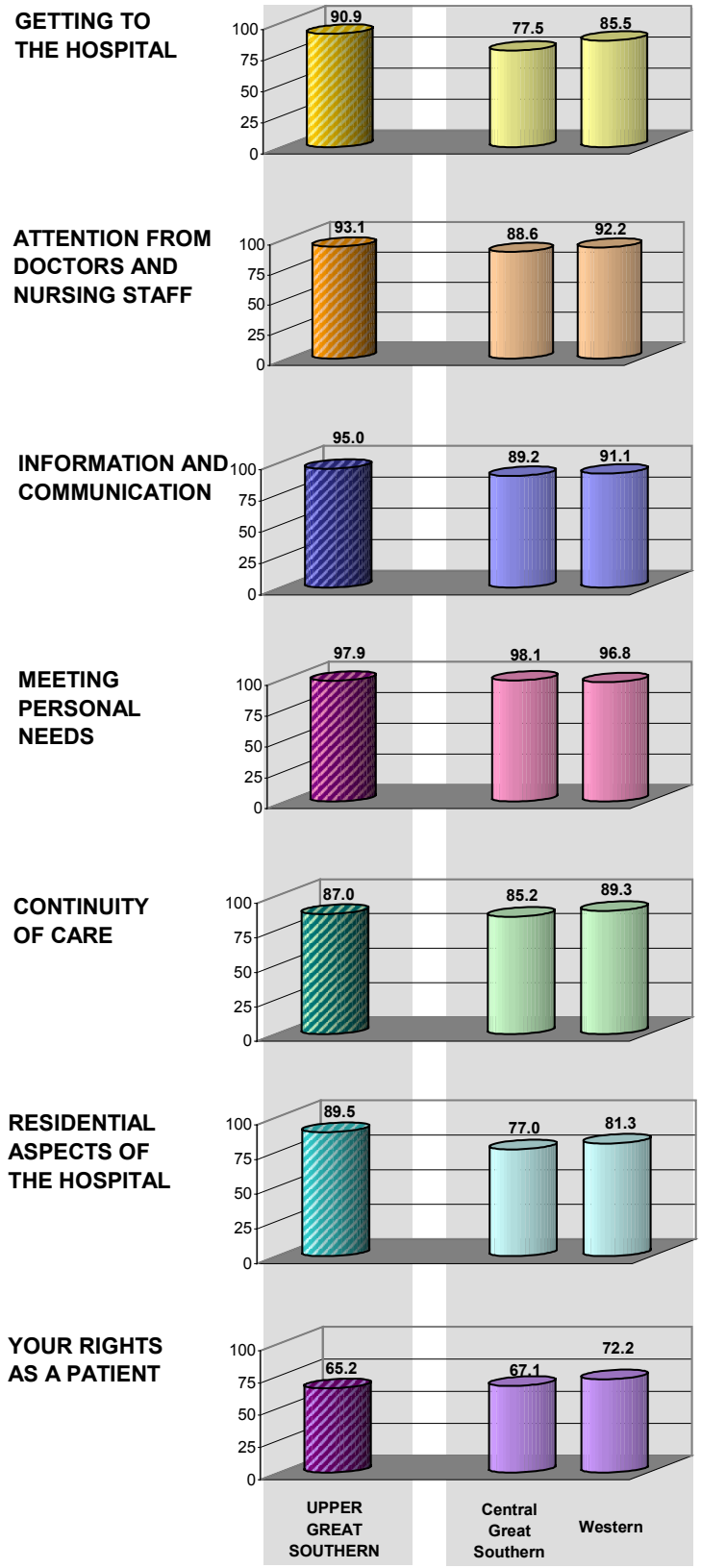
Favourable satisfaction ratings have been associated with favourable health outcomes. In addition, if a patient's perception of health service provision is favourable they will be more likely to seek timely help, assistance or treatment. The Department of Health has produced Client Satisfaction Survey 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 53) of this report.

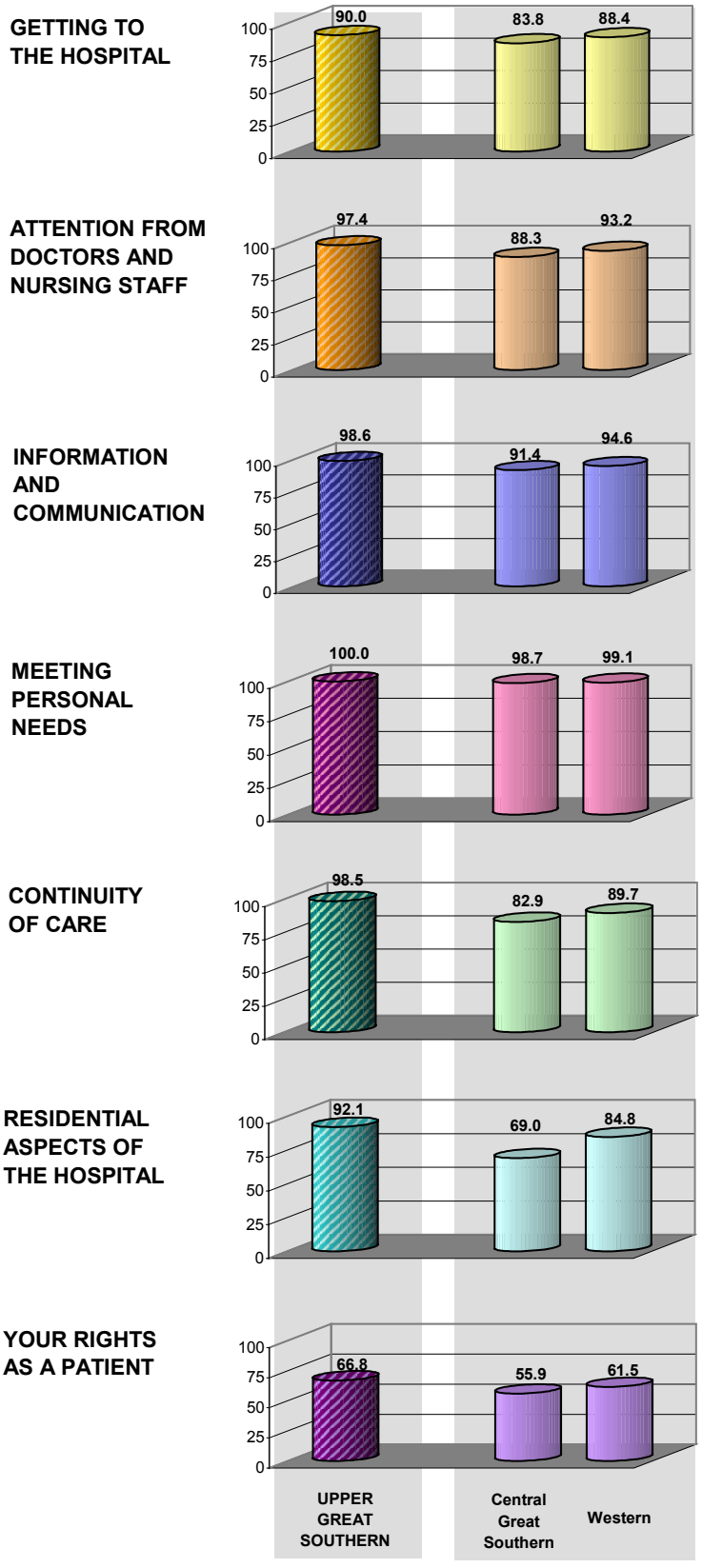
KPI 2.2: SAMEDAY PATIENTS — RURAL



KPI 2.2: EMERGENCY PATIENTS — RURAL



KPI 2.2: OUTPATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

UPPER GREAT SOUTHERN HEALTH SERVICE
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

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

The Board 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 Upper Great Southern 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 Upper Great Southern 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 7, 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

UPPER GREAT SOUTHERN 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 Upper Great Southern Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Upper Great Southern 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.

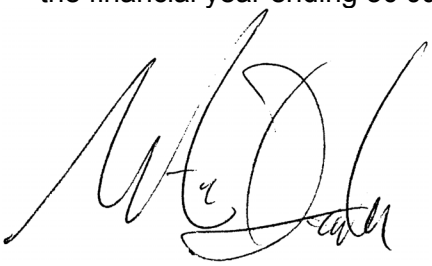
It is anticipated that the opinions will be issued by March 31, 2003.

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

UPPER GREAT SOUTHERN 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 Upper Great Southern 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

Table of Contents

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.

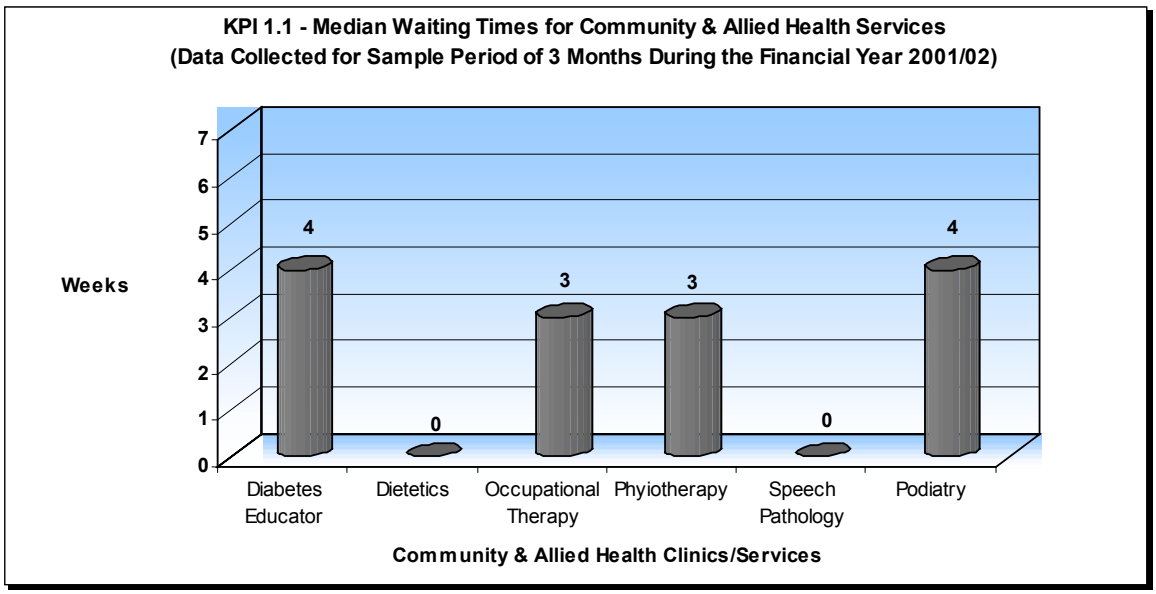
Access to health services are provided on the basis of clinical need but situations where clients are waiting longer than the average may reflect sub-optimal practices or under-resourcing within the organisation.

This indicator measures the median (middlemost) waiting time in days 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.

The waiting times reported for each service are affected by the level of demand for the service and the availability of the specialist staff who provide the service. During 2001/2002 the Health Service experienced difficulty in filling vacant speech pathology and occupational therapy positions, resulting in an increased waiting period for this service.

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.



RATE OF SCREENING IN CHILDREN	KPI 1.2

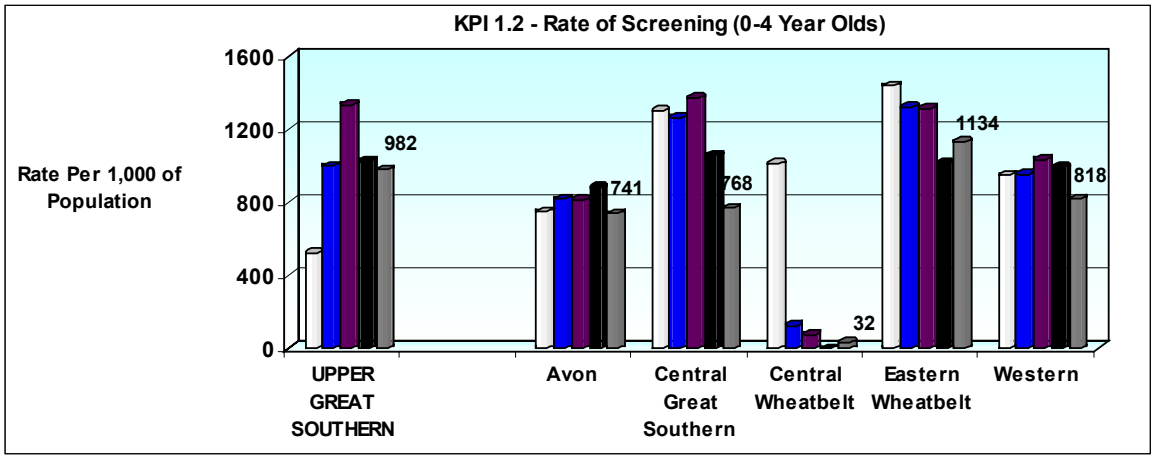
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good 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.

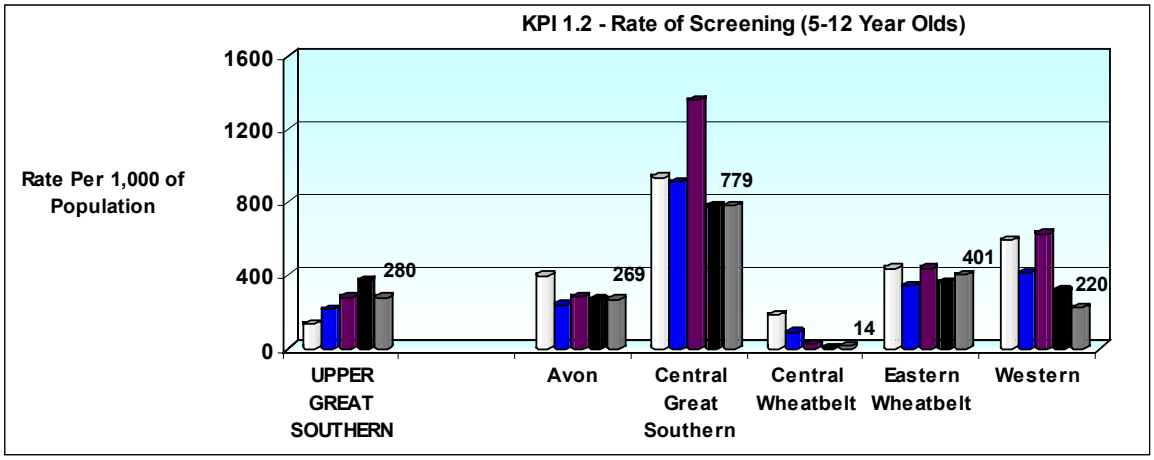
The consequences of any illness or disability not detected by routine screening programs for children are more likely to be permanently disabling or even contribute to their premature death.

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.

This year's results are comparable to last years.

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
1997 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.

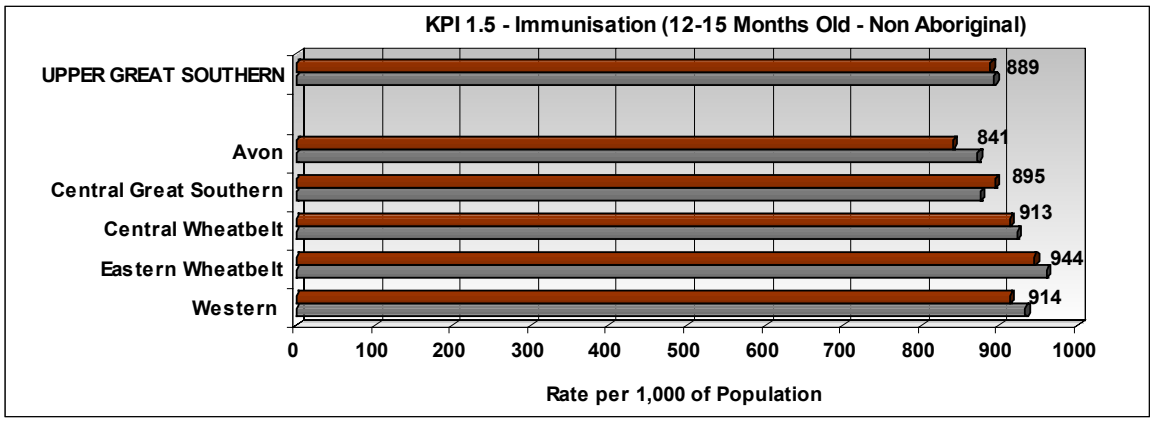
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

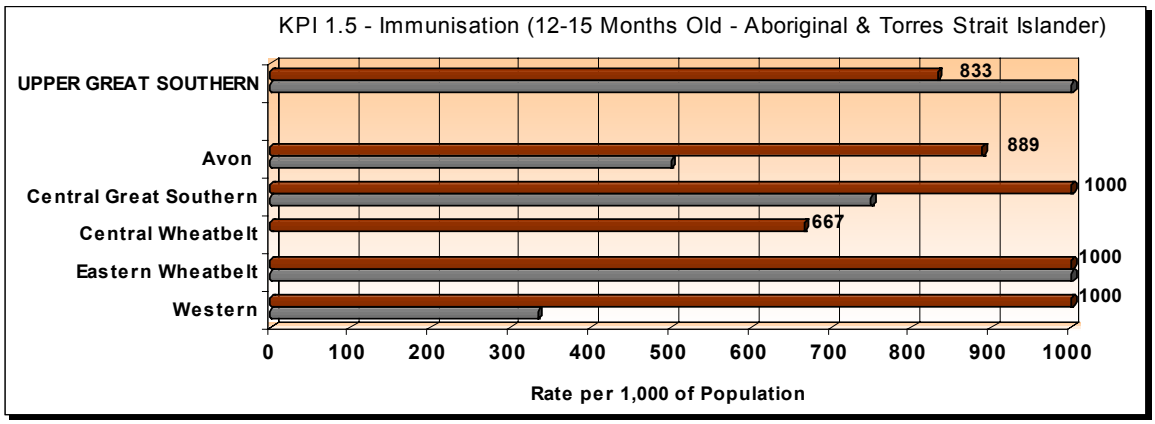
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

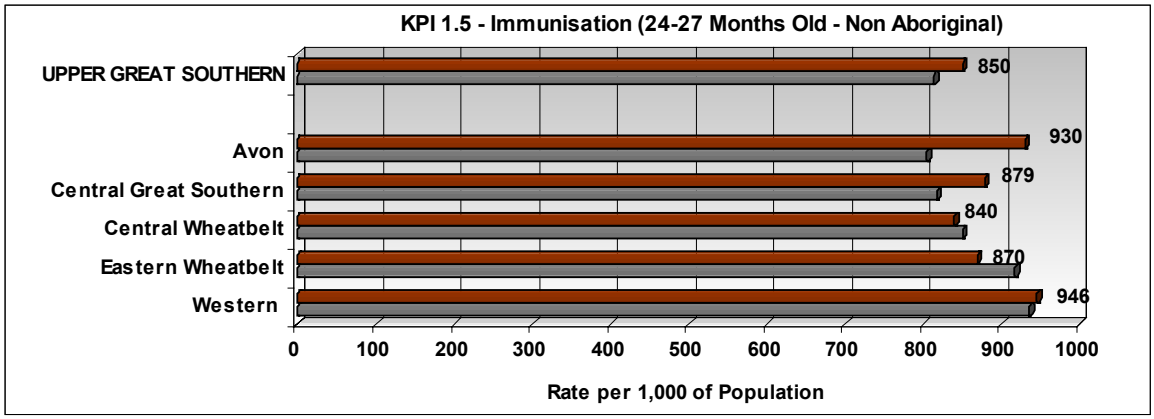
Year comparison with the state average would indicate continued commitment to the immunisation program within the UGSHS.

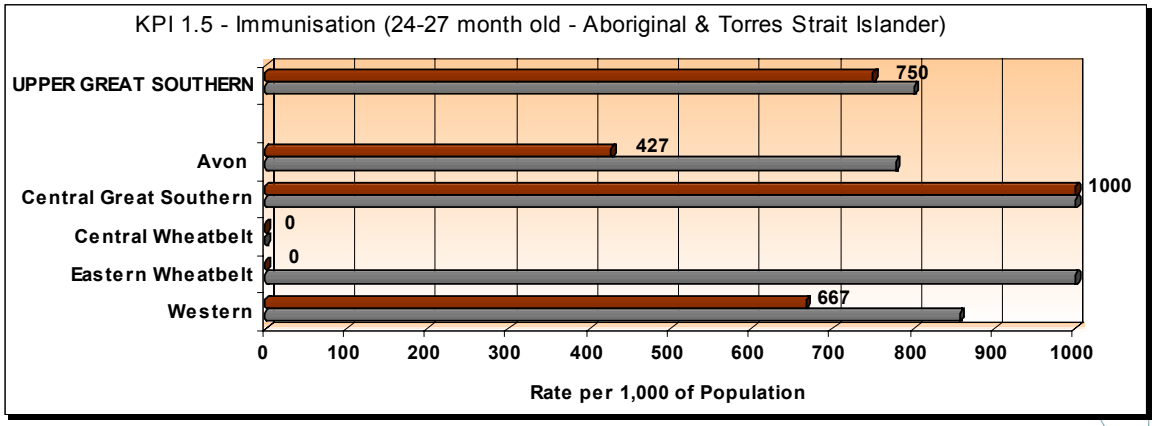
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

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

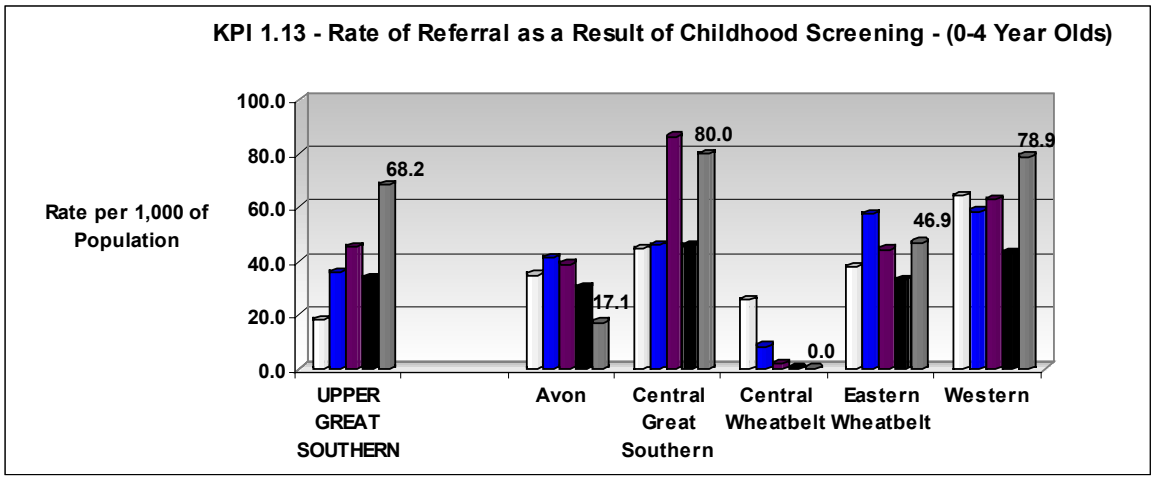
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only to restore children to good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

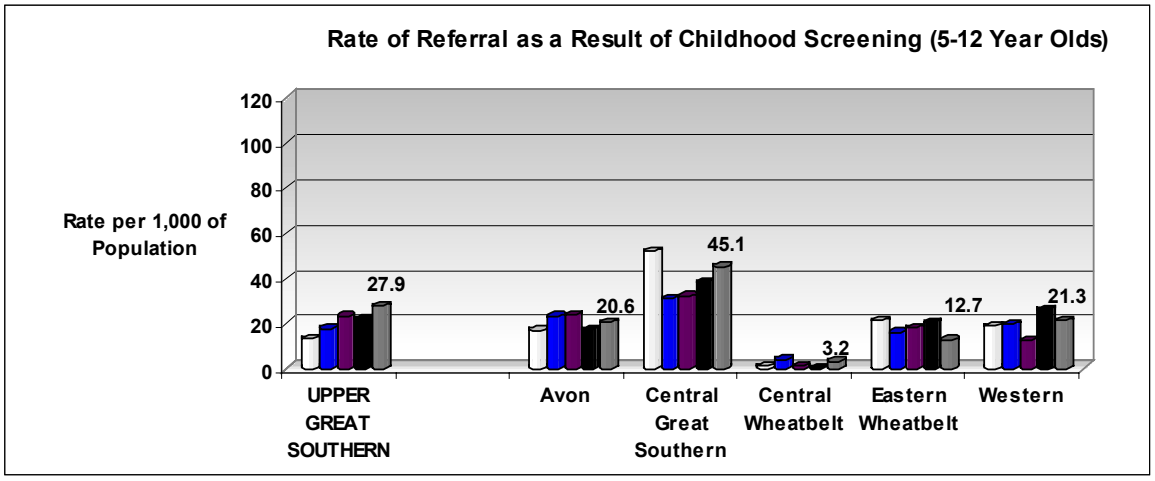
The State promotes a program of health monitoring at specific intervals in the period from birth to adolescence in accordance with the National Health and Medical Research Council's (NH&MRC) Minimum Screening Schedule. This program includes appropriate referral for children needing further assessment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

For this financial year, in the 0-4 years, there has been a 48% increase in the referral rate. For the 5-12 years the increase has been 15%.

This compares to the rural figures which show increases of 40.8% for the 0-4 years and 27% for 5-12 years.





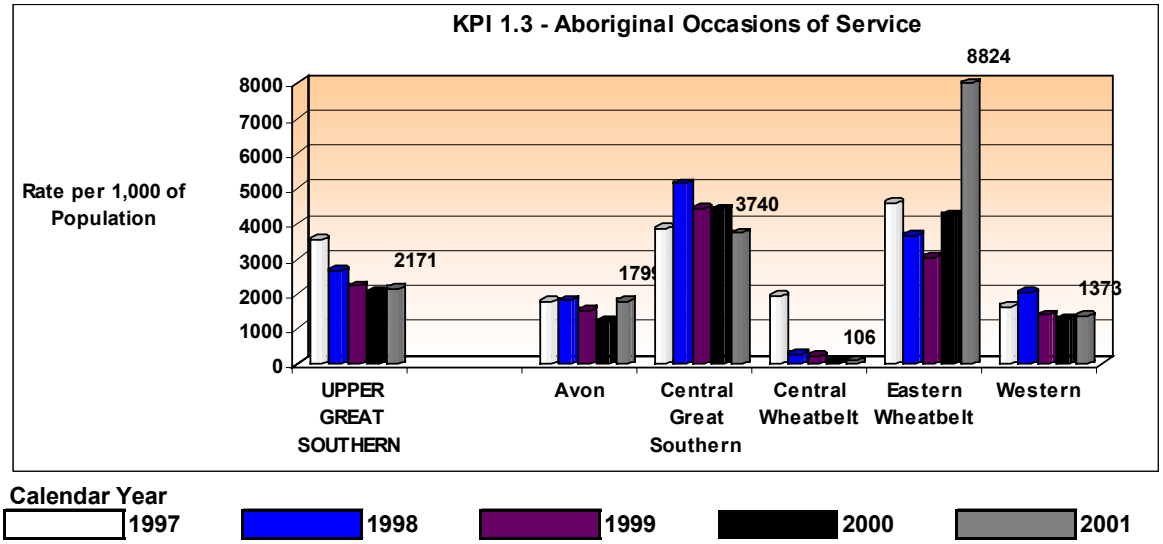
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

The lower standard of health experienced by the Aboriginal population 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.

This indicator measures the rate of provision of service per thousand members of this special needs group in the catchment area of the health service.



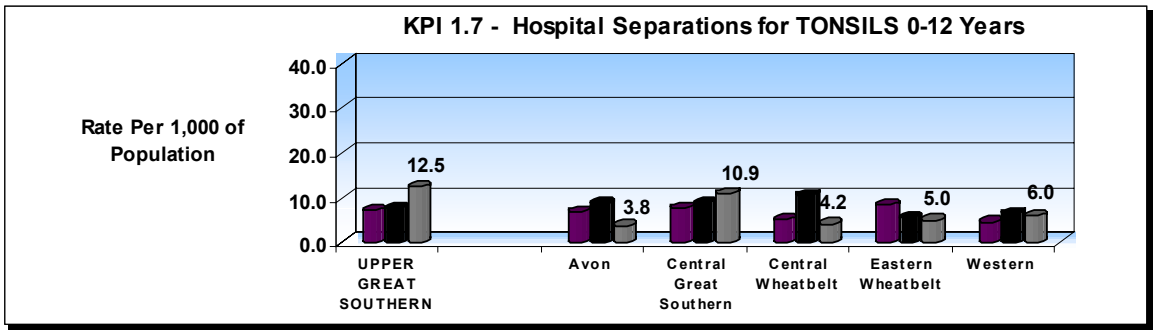
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

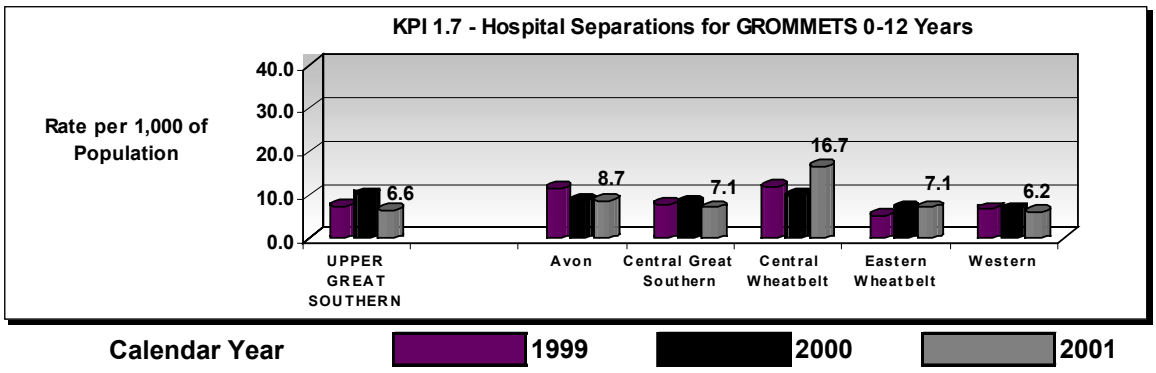
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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.





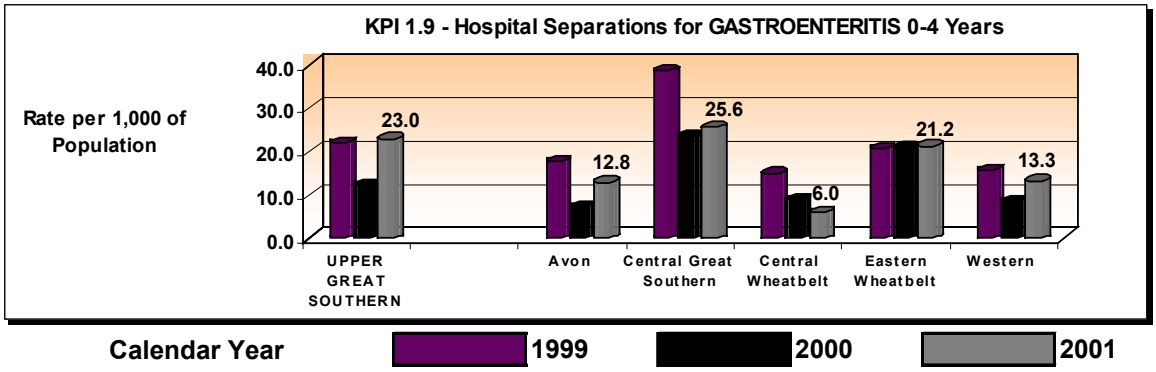
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN — KPI 1.9

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

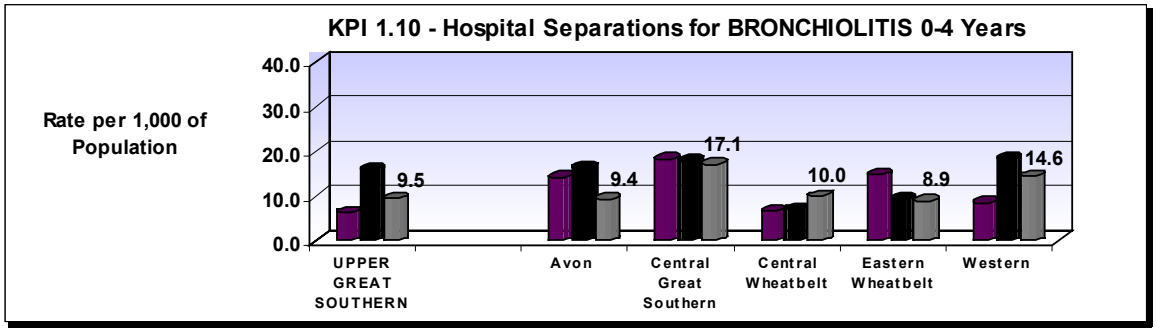
The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 2 were hospitalised this year, a rate of 0.4 per thousand and of those aged 13-18, none were hospitalised.

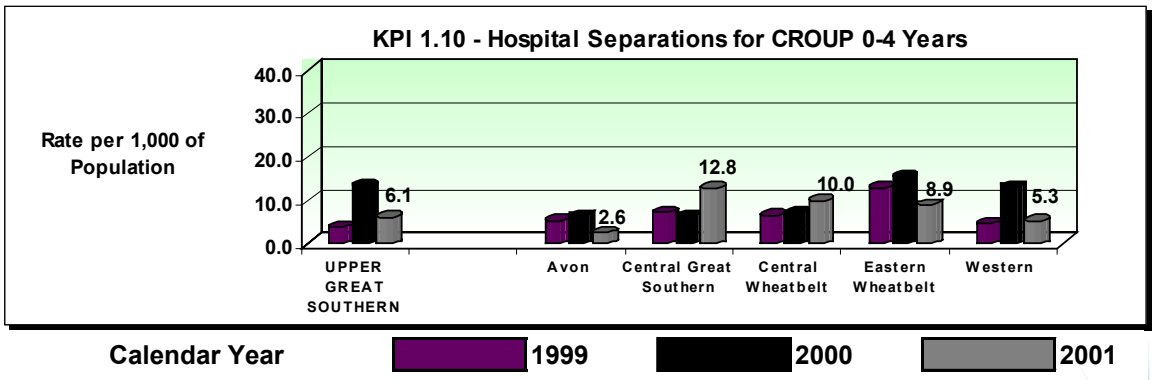
Croup

The graph shows those individuals aged 0-4. Of those individuals aged 5-12, only 2 were hospitalised this year, a rate of 0.8 per thousand and none aged 13-18 were hospitalised.

Acute Bronchitis

Only 3 individuals aged 0-4 at a rate of 2 per thousand were hospitalised this year, with 1 individual being admitted aged 5-12 at a rate of 0.4 per thousand with 1 individual aged 13-18 years being admitted at a rate of 0.7 per thousand.





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.

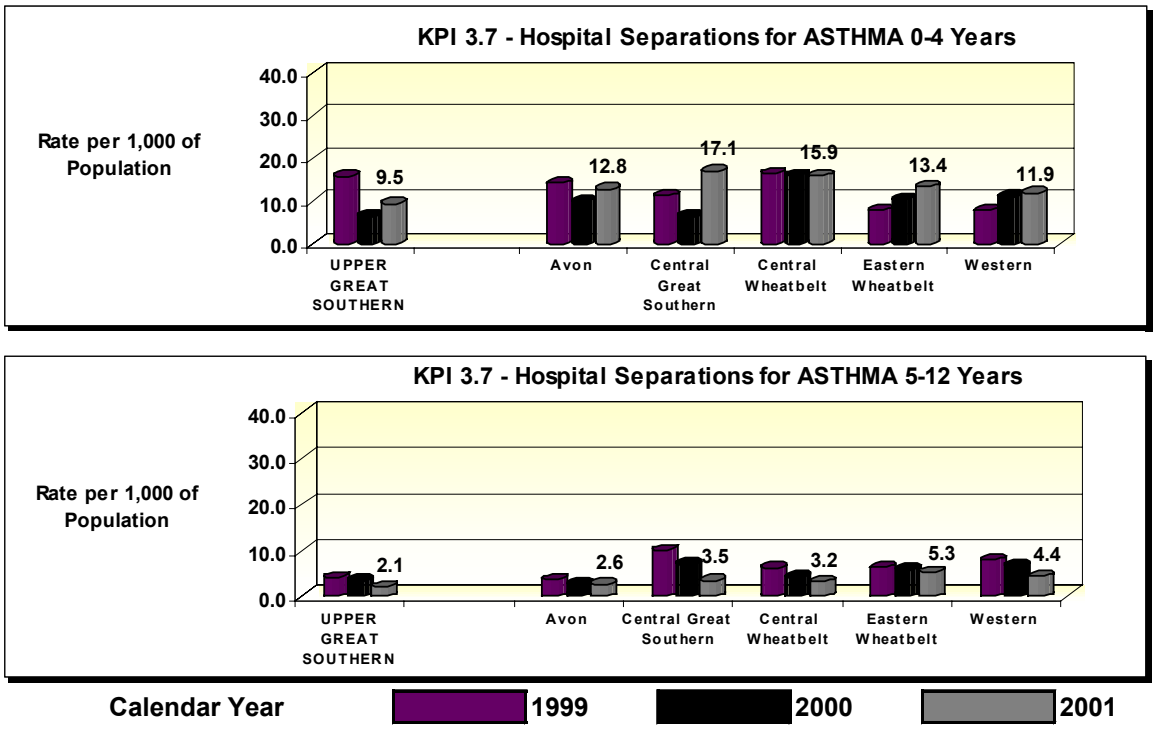
The number of patients who are admitted to hospital per 1,000 population for treatment of Asthma may be an indication of improved primary care or community health strategies - for example, health education.

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. 7 individuals aged 13-18 at a rate of 4.7 per thousand were hospitalised this year, with 5 individuals being admitted aged 19-34 at a rate of 1.4 per thousand and 29 individuals aged 35 years and over at a rate of 3 per thousand.

Individual management regimes initiated by community health clinicians and medical practitioners have enabled many parents to assist in the control of their children's asthma within the home environment.

This year's results are comparable to last years.

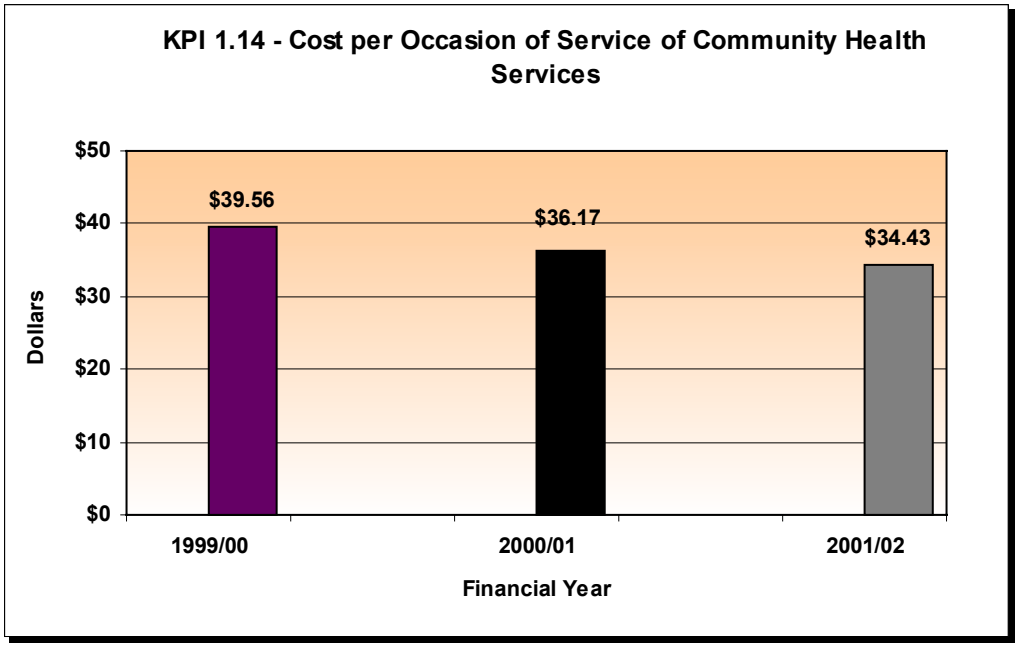


COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

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.



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.

The Upper Great Southern reports an overall satisfaction score of 92 for same-day patients, 88 for emergency patients and 92 for outpatients for this financial year with standard errors of 0.55, 1.19 and 1.16 respectively on a 95% confidence interval. The estimated populations of individuals surveyed were 747 Same-Day patients, 6228 Emergency Services Patients and 2060 Outpatients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Same-day Patients	194	120	62%
Emergency Patients – Centrally Administered	99	34	34%
Emergency Patients – Hospital Administered	266	59	22%
Outpatients – Centrally Administered	45	17	38%
Outpatients – Hospital Administered	170	30	18%

ELECTIVE SURGERY WAITING TIMES FOR PUBLIC PATIENTS — KPI 2.14

Access to health services must be provided on the basis of clinical need and if an organisation has large numbers of patients waiting for long periods of time for elective surgery, this may reflect sub-optimal practices, the non-availability of specialist staff or a lack of resources.

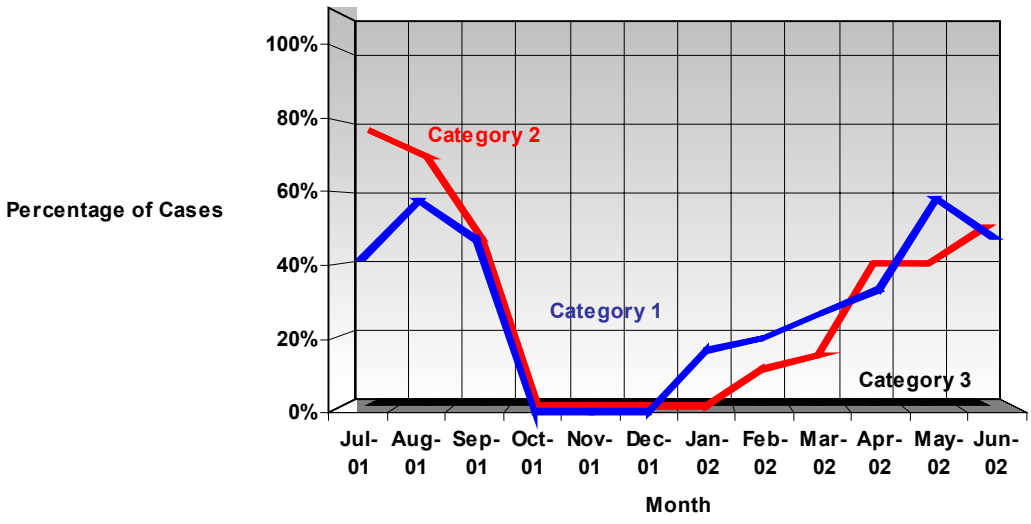
All patients who are referred for elective surgery must be classified by senior medical staff into one of the three following admission categories:

Category 1	Urgent	Admission desired within 30 days
Category 2	Semi-Urgent	Admission desired within 90 days
Category 3	Routine	Admission desirable within 365 days

This indicator measures the percentage of cases on an elective surgery waiting list which were not admitted within the appropriate time frame based on an assessment of their clinical need.

Waiting time fluctuations are related to seasonal variances such as seeding, harvesting and Christmas. Often clients choose to reschedule procedures due to these external pressures.

KPI 2.14 - Elective Surgery Waiting Times for Public Patients



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.

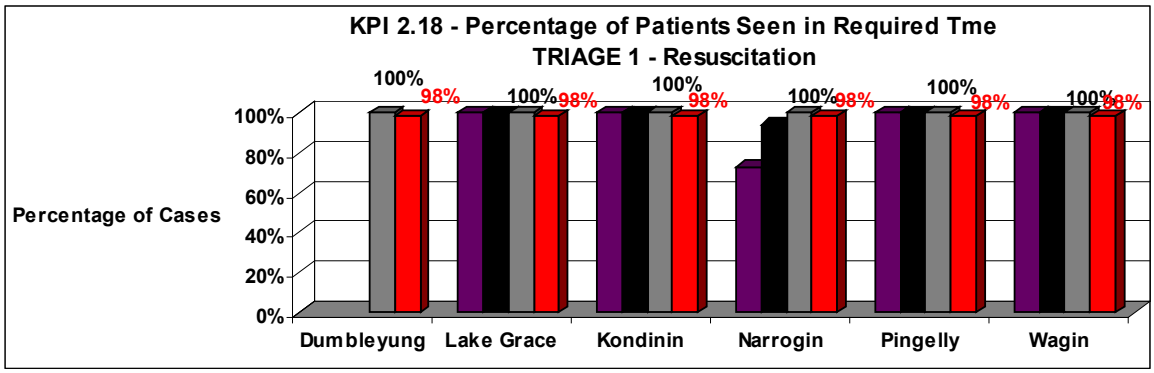
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

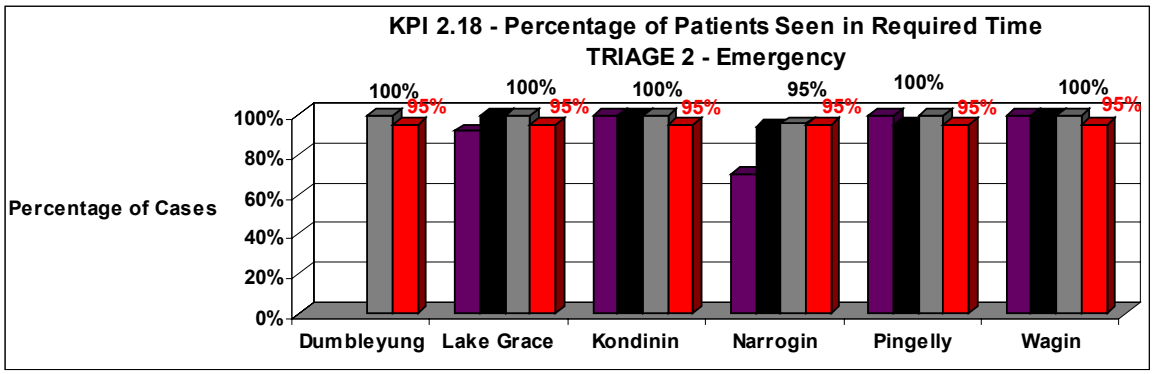
When patients first enter an Emergency Department, they are assessed by nursing staff and allocated a triage code between 1 and 5 that indicates their urgency. This code provides an indication of how quickly patients should be reviewed by medical staff. In rural areas however, where a medical practitioner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

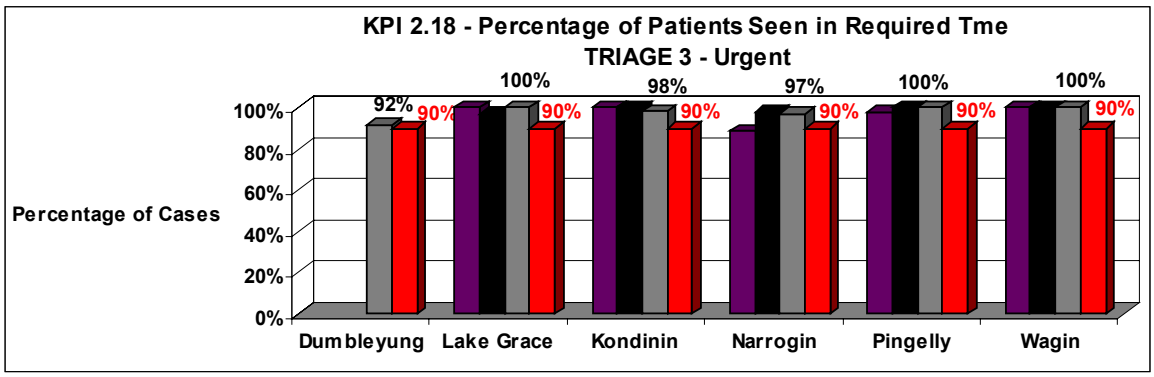
Data relevant to this indicator should be linked to data on the transfer of patients to other health care units, for example, larger hospitals and tertiary metropolitan centres.

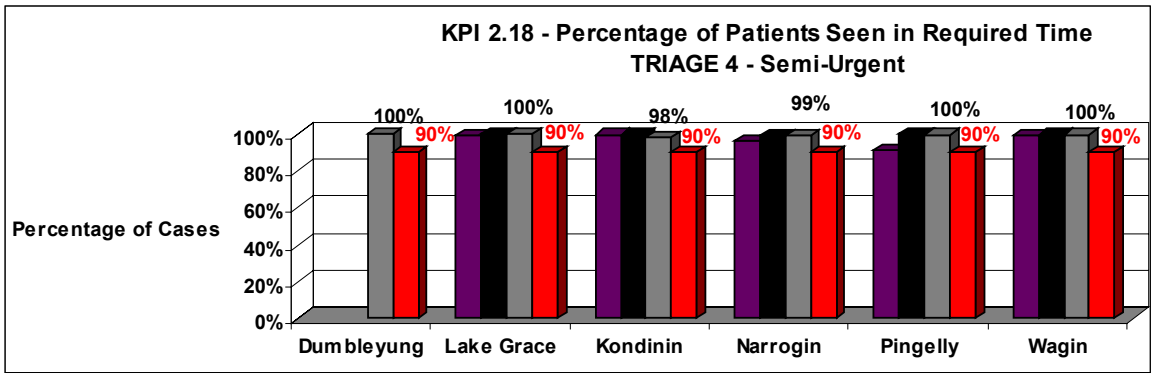
This indicator assesses what percentage of patients in each triage category were seen within the time periods recommended by the Australasian College for Emergency Medicine (ACEM) – in rural areas, this may include for example, telephone advice given by GP.

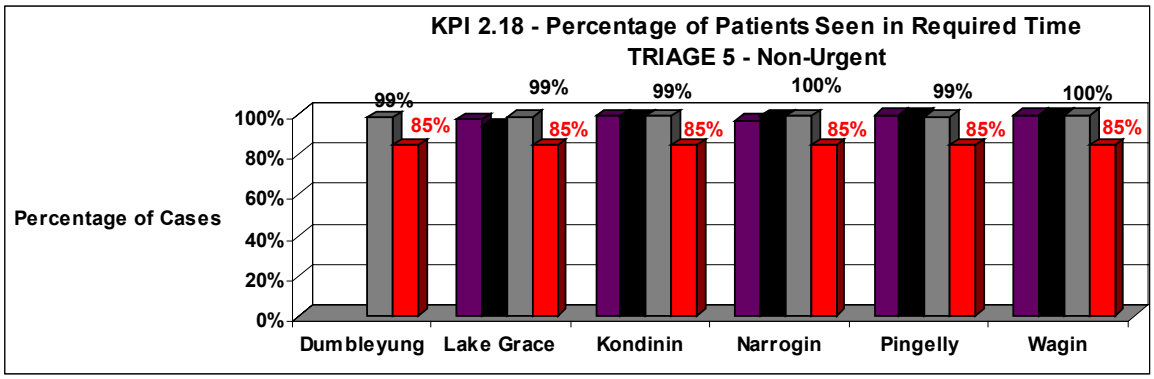
TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage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


KPI 2.18 - Percentage of Patients Seen in Required Tme
TRIAGE 1 - Resuscitation
Percentage of Cases
100%
80%
60%
40%
20%
0%
Dumbleyung
Lake Grace
Kondinin
Narrogin
Pingelly
Wagin
100%
98%


KPI 2.18 - Percentage of Patients Seen in Required Time
TRIAGE 2 - Emergency
Percentage of Cases
100%
80%
60%
40%
20%
0%
Dumbleyung
Lake Grace
Kondinin
Narrogin
Pingelly
Wagin
100%
95%


KPI 2.18 - Percentage of Patients Seen in Required Tme
TRIAGE 3 - Urgent
Percentage of Cases
100%
80%
60%
40%
20%
0%
Dumbleyung
Lake Grace
Kondinin
Narrogin
Pingelly
Wagin
92%
90%
100%
98%
97%



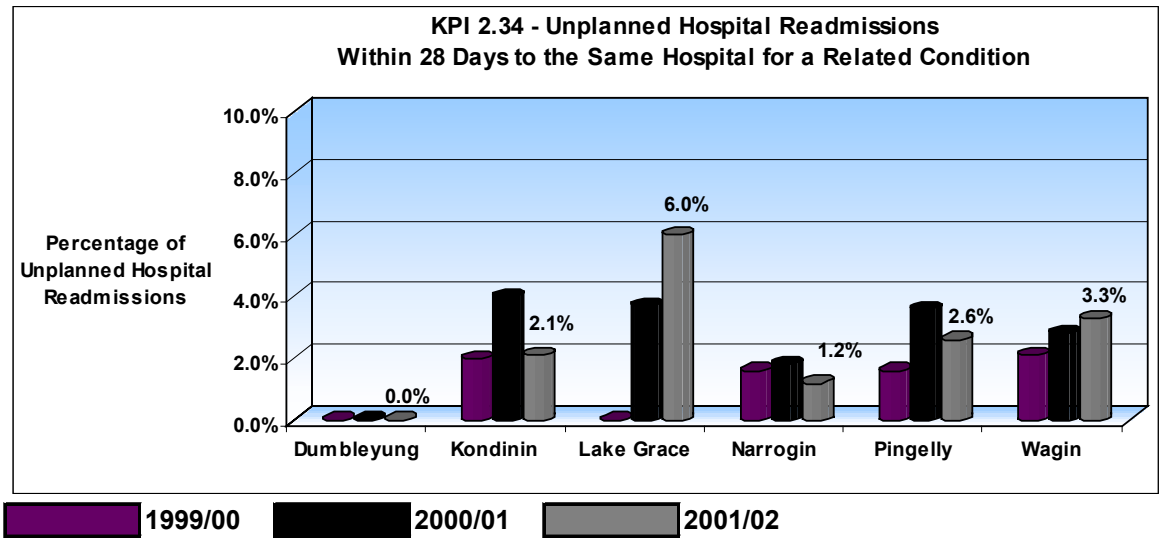


Financial Year
1999/00 2000/01 2001/02 ACEM Threshold Percentage for Each Category

UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR A RELATED CONDITION	KPI 2.34

Good medical and/or surgical intervention together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. Unplanned readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

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

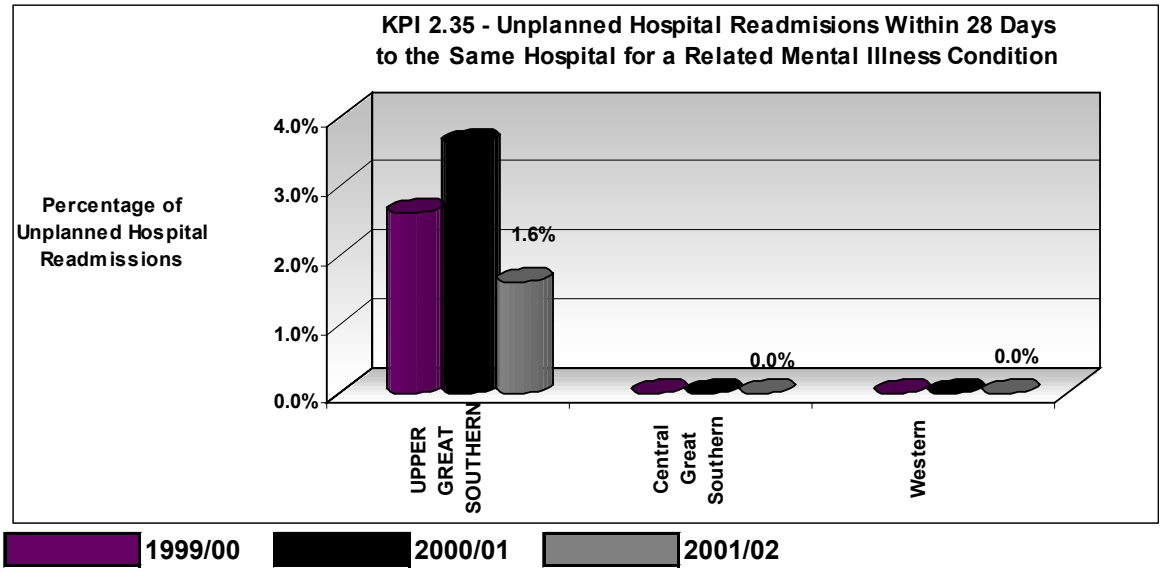


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

Readmissions to hospital within 28 days is an indicator of the effectiveness of hospital treatment and discharge planning, but may also reflect post-discharge treatment and care. The treatment and care needs of different age groups may be quite different. Readmission rates for these different age groups may provide a measure of the effectiveness of services in addressing these needs.

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

The low patient numbers means that the result is not significant.



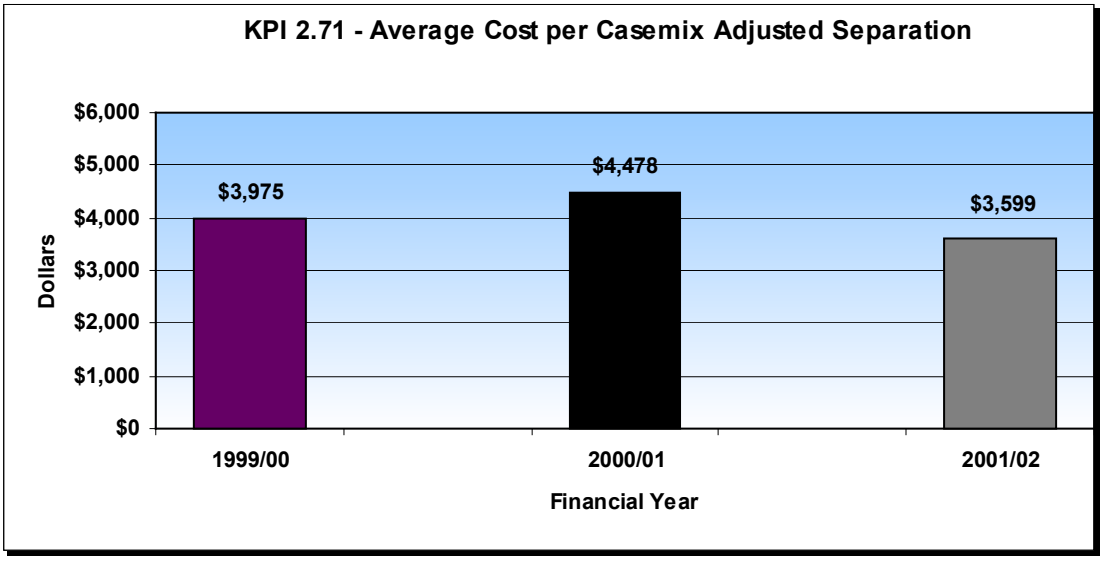
AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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.

The average cost per case-mix adjusted separation is an average of Dumbleyung, Narrogin, Pingelly, Kondinin and Wagin hospitals' performance.



AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

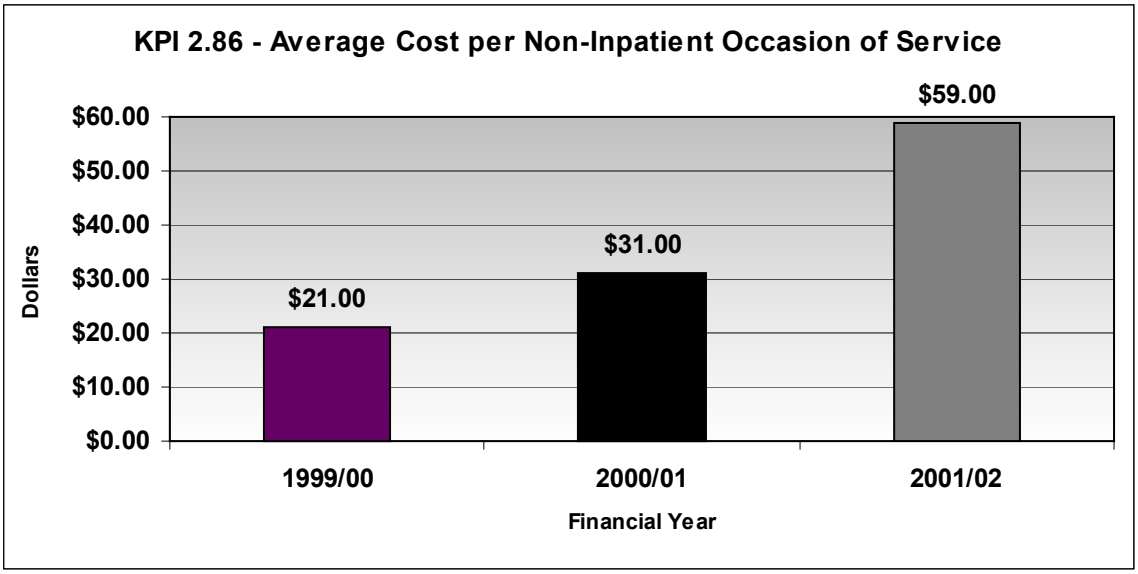
The effective use of hospital resources can help minimise the overall costs of providing health care or can provide for more patients to be treated for the same cost.

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.

Data reported in 1999/2000 and 2000/01 included the cost of non-inpatient occasions of service in nursing posts. Nursing post data has not been included in this KPI for this year.

The average cost per non-inpatient occasion of service is an average of Dumbleyung, Narrogin, Pingelly, Kondinin and Wagin hospitals' performance.

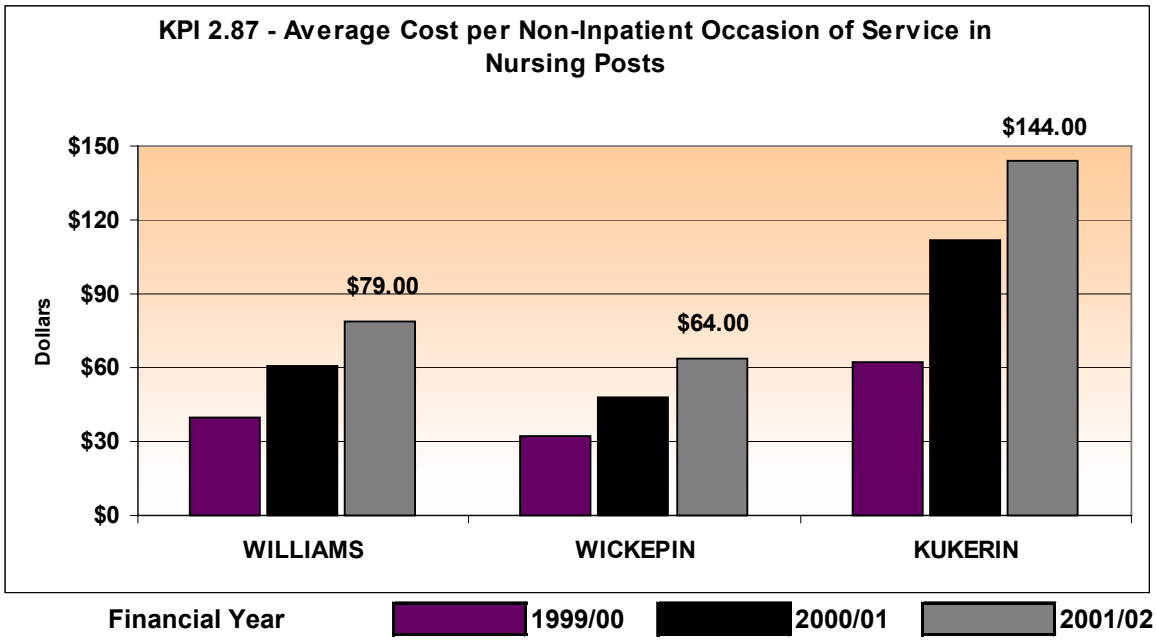


AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE IN NURSING POSTS	KPI 2.87

The effective use of Nursing Post 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 nursing posts may indicate the inefficient use of resources.

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



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 AGED CARE ASSESSMENT TEAM (ACAT) ASSESSMENTS WITHIN TARGETED AGE GROUPS PER 1,000 POPULATION NUMBER OF FIRST ACAT ASSESSMENTS WITHIN TARGETED AGE GROUPS PER 1,000 POPULATION	KPI 3.2 3.3

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

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

This indicator measures the extent to which people within the targeted age groups are assessed by Aged Care Assessment Teams. This is a measure of the extent to which elderly people's support needs are assessed and, where required, Care Plans developed to ensure that they receive the support they require. Care Plans aim to maintain elderly people in their own homes and communities for as long as possible.

Results are reported for the whole population aged 70+ years and for Aboriginal and Torres Strait Islander people aged 50-69 years.

The total number of assessments performed are shown in the first graph, with the number of *first* assessments performed shown in the second graph.*

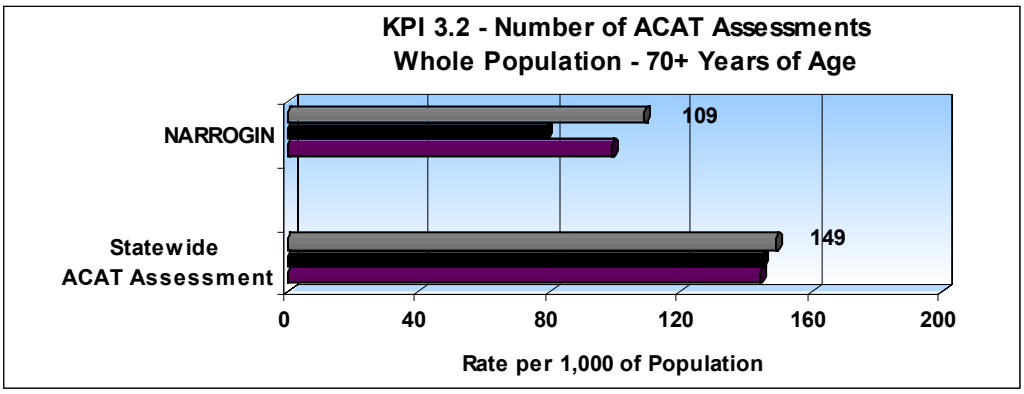
These results compare with the statewide results however care should be taken in interpreting results due to the small sample size.

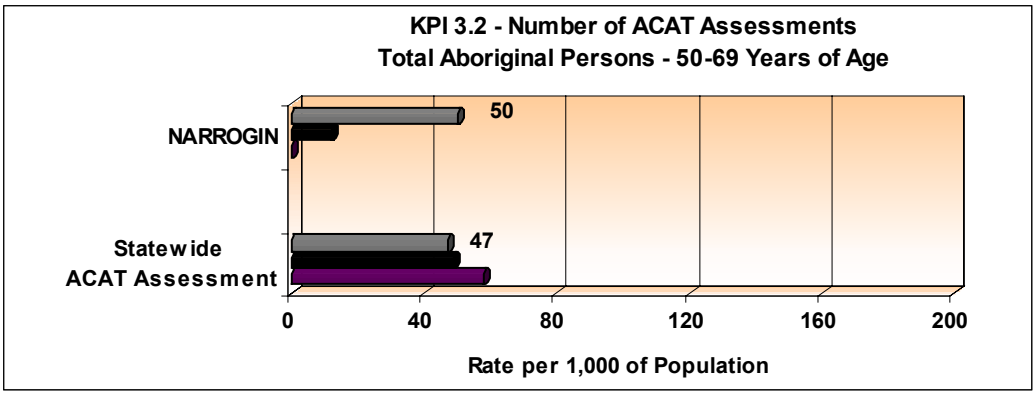
Note: 2001 is the latest year of available data.

*Notes:

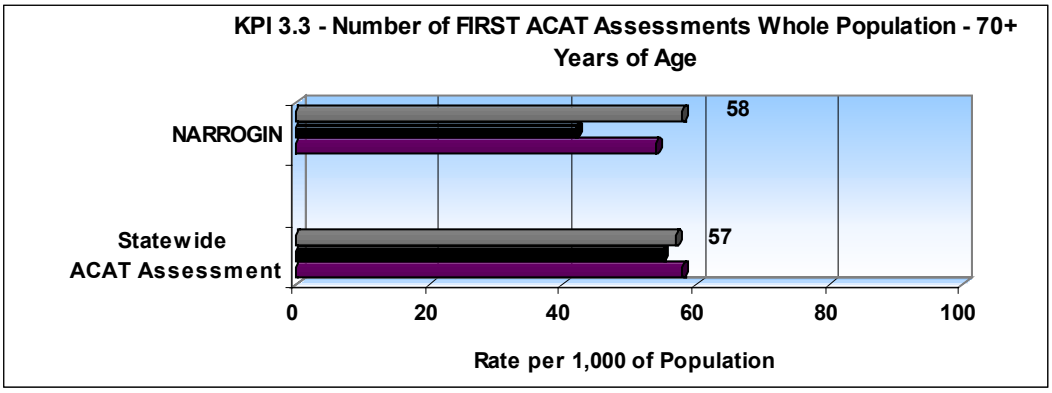
Estimate of the target population (ie, 70+ years) is obtained from the Estimated Resident Population report released by the ABS for the appropriate year (Catalogue No. 3203.5).
Estimate of the number of Aboriginal and Torres Strait Islander people aged 50-69 years is obtained from Epidemiology & Analytical Services, Health Information Centre.

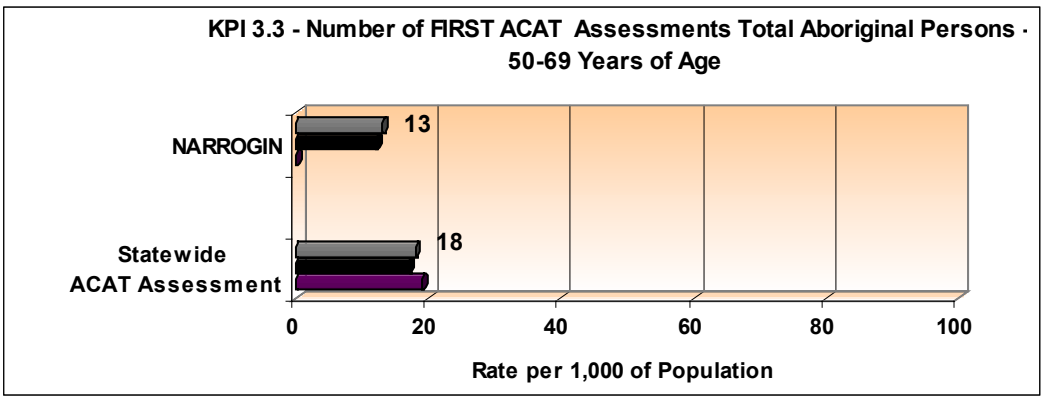
ACAT assessments within targeted age groups





FIRST ACAT assessments within targeted age groups





NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUPS ADMITTED AS A NURSING HOME TYPE PATIENT AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.5 KPI 3.10

Number of Individuals Admitted as a Nursing Home Type Patient

Some people with chronic illness and disability who are not able to be cared for at home even with regular respite care and/or with the support services provided by Home and Community Care (HACC), may need long-term residential care. This care is provided in an acute hospital where beds/funds have been allocated for this type of long-term residential care.

A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. The aim of the services and care is not only to allow the individual to maintain the greatest possible level of independence at the best possible level of health that can be practically achieved, but that these services and care are provided in a home-like environment.

This indicator measures the extent to which people within the targeted age groups are admitted as a Nursing Home Type Patient. The number of individuals within the targeted age group, i.e. 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 Nursing Home Type care in the Health Service.

Dumbleyung District Memorial Hospital had a total of ten Nursing Home Type Patients with an average of 4.8 bed days. At Kondinin District Hospital there were two Nursing Home Type Patients admitted with an average of 2.5 bed days. Lake Grace District Hospital had a total of two Nursing Home Type Patients with an average of 2.4 bed days. One Nursing Home Type Patient was admitted to Narrogin Regional Hospital with an average of less than one bed day. There were five Nursing Home Type Patients admitted to Pingelly District Hospital with an average bed day of 2.6. There were four Nursing Home Type Patients admitted at Wagin District Hospital with an average of 6 bed days.

Average Cost per Nursing Home Type Patient Bed Day

A Nursing Home Type Patient (NHTP) is an individual who because of a need for 24-hour medical and nursing supervision and/or services, requires long-term residential care. This indicator measures the cost per NHTP bed day.

The effective use of hospital resources can help to minimise the overall cost of providing health care or can provide for more patients to be treated at the same cost. Higher costs in providing care for NHTPs compared to providing the same service in another health service may indicate the inefficient use of resources.

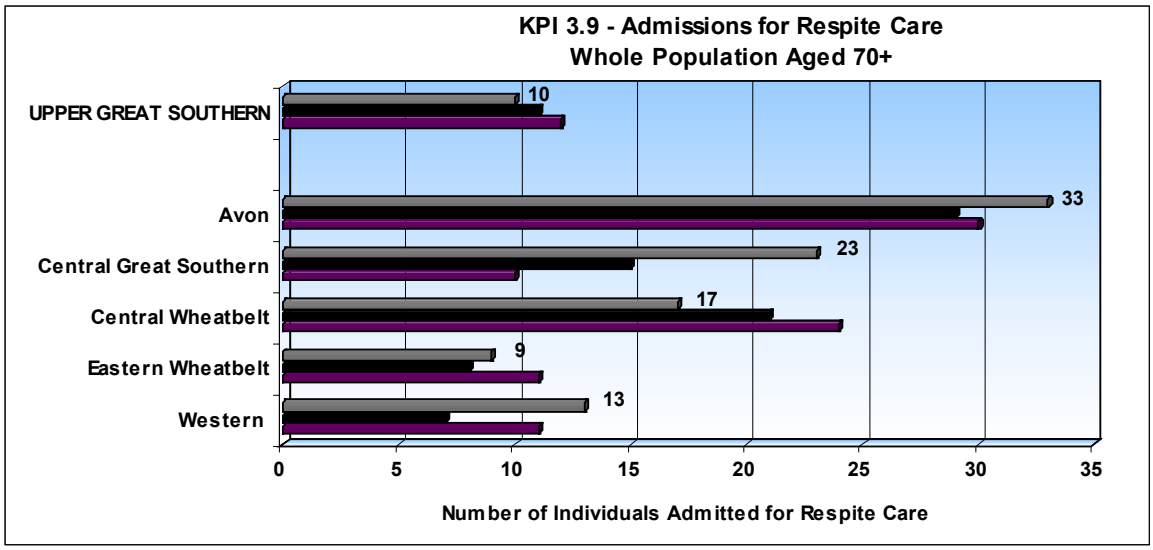
The average cost per Nursing Home Type Patient for the Upper Great Southern Health Service for the year 2001/02 is $578.00.

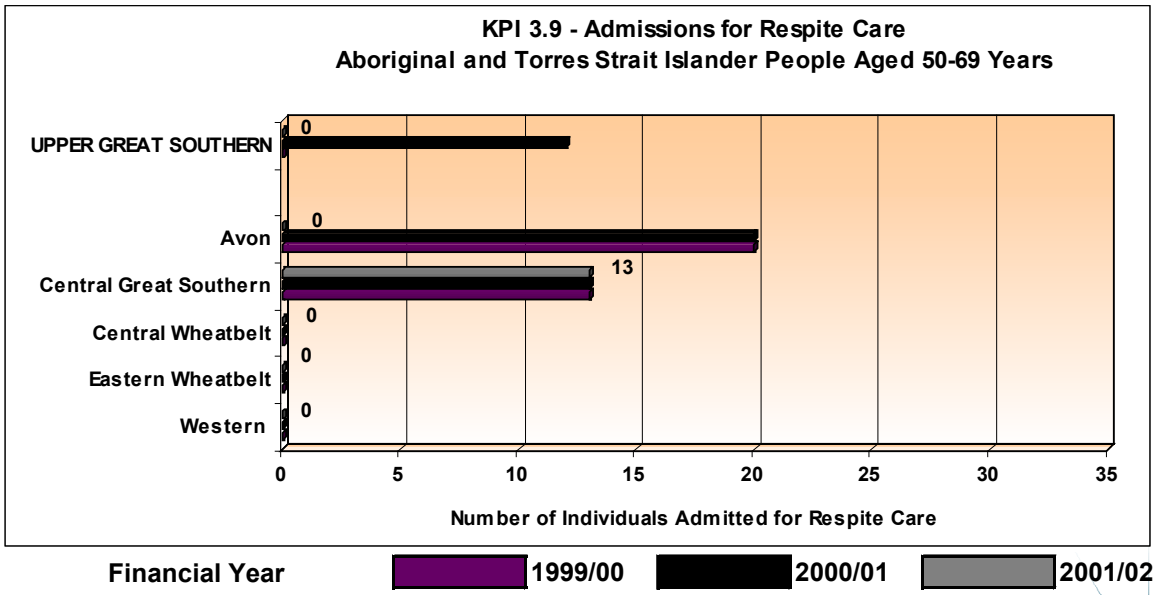
NB: This is the first year this KPI has been reported. Over time, the indicator will be refined so that there is clearer differentiation between the cost of the different care types treated within hospitals.

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 50-69 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.





AUDITOR GENERAL

To the Parliament of Western Australia

UPPER GREAT SOUTHERN HEALTH SERVICE
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Scope

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

The Board 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 Board.

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

Upper Great Southern Health Service
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Upper Great Southern 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, 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.

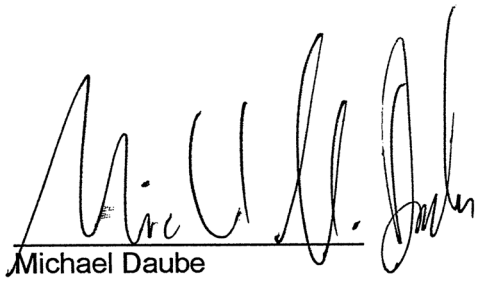
D D R PEARSON
AUDITOR GENERAL
March 7, 2003

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

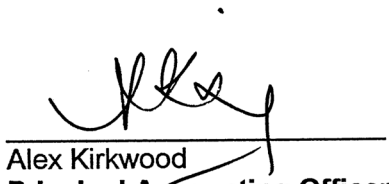
The accompanying financial statements of the Upper Great Southern Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Upper Great Southern
Health Service

30 August 2002

Statement of Financial Performance
For the year ended 30 June 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		12,225,224	11,059,436
Fees for visiting medical practitioners		1,642,201	1,254,579
Superannuation expense		969,412	938,851
Patient support costs	3	1,494,988	1,422,291
Patient transport costs		237,242	205,201
Borrowing costs expense		0	84,231
Repairs, maintenance and consumable equipment expense		974,542	1,147,470
Depreciation expense	4	786,765	718,207
Net loss on disposal of non-current assets	5	77,018	314,242
Asset revaluation decrement	24	133,170	950,573
Capital user charge	6	1,292,478	0
Other expenses from ordinary activities	7	1,264,824	1,241,423
Total cost of services		21,097,864	19,336,504
Revenues from Ordinary Activities			
Patient charges	8	1,426,821	1,197,804
Commonwealth grants and contributions	9	93,170	154,808
Donations revenue	10	5,754	8,829
Interest revenue		1,033	1,611
Other revenues from ordinary activities	11	541,979	555,809
Total revenues from ordinary activities		2,068,757	1,918,861
NET COST OF SERVICES		**19,029,107**	**17,417,643**
Revenues from Government			
Output appropriations	12	18,087,249	14,799,880
Capital appropriations	12	0	3,441,068
Liabilities assumed by the Treasurer	13	10,271	783,909
Resources received free of charge	14	33,000	63,617
Total revenues from government		18,130,520	19,088,474
Change in net assets		**(898,587)**	**1,670,831**
Net increase / (decrease) in asset revaluation reserve	24	0	(9,340)
Total revenues, expenses and valuation adjustments recognised directly in equity		0	(9,340)
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(898,587)**	**1,661,491**

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	15	286,963	134,859
Receivables	16	397,636	294,505
Inventories	18	140,685	121,438
Prepayments		7,771	16,158
Total current assets		833,055	566,960
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	751,100	0
Property, plant and equipment	19	21,227,603	16,978,327
Construction works in progress		62,848	2,378,041
Total non-current assets		22,041,551	19,356,368
Total assets		**22,874,606**	**19,923,328**
CURRENT LIABILITIES			
Payables		728,003	365,838
Accrued salaries	21	266,801	185,091
Provisions	22	2,006,211	1,757,696
Total current liabilities		3,001,015	2,308,625
NON-CURRENT LIABILITIES			
Provisions	22	1,584,451	1,612,057
Total non-current liabilities		1,584,451	1,612,057
Total liabilities		**4,585,466**	**3,920,682**
Net Assets		**18,289,140**	**16,002,646**
EQUITY			
Contributed equity	23	16,505,828	13,320,748
Accumulated surplus / (deficiency)	25	1,783,312	2,681,898
Total Equity		**18,289,140**	**16,002,646**

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

Statement of Cash Flows
For the year ended 30 June 2002

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Output appropriations	26(c)	16,043,671	13,938,111
Capital contributions (2000/01 appropriation)	26(c)	383,411	0
Net cash provided by Government		16,427,082	13,938,111
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(6,060,116)	(5,133,130)
Employee costs		(11,883,995)	(10,866,596)
GST payments on purchases		(535,535)	(449,790)
Receipts			
Receipts from customers		1,353,353	1,214,773
Commonwealth grants and contributions		93,061	154,808
Donations		1,751	8,829
Interest received		1,033	1,611
GST receipts on sales		52,611	34,244
GST receipts from taxation authority		465,212	380,891
Other receipts		529,426	542,191
Net cash (used in) / provided by operating activities	26(b)	(15,983,199)	(14,112,169)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(292,397)	(467,965)
Proceeds from sale of non-current assets	5	618	0
Net cash (used in) / provided by investing activities		(291,779)	(467,965)
Net increase / (decrease) in cash held		152,104	(642,023)
Cash assets at the beginning of the reporting period		134,859	776,882
Cash assets at the end of the reporting period	26(a)	286,963	134,859

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
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.		
The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	3,136	5,135
Add Receipts		
- Patient Deposits	4,455	4,708
- Interest	0	19
	7,591	9,862
Less Payments		
- Patient Withdrawals	2,049	6,678
- Interest / Charges	115	48
Closing Balance	5,427	3,136
Note 3 Patient support costs		
Medical supplies and services	554,871	489,297
Domestic charges	152,672	164,741
Fuel, light and power	399,106	427,740
Food supplies	280,083	271,467
Purchase of external services	108,256	69,046
	1,494,988	1,422,291
Note 4 Depreciation expense		
Buildings	533,884	467,742
Computer equipment and software	56,866	61,532
Furniture and fittings	32,125	32,485
Plant and equipment	163,890	156,448
	786,765	718,207
Note 5 Net profit / (loss) on disposal of non-current assets		
a) **Proceeds from sale of non-current assets**		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash by the Health Service	618	0
Gross proceeds from sale of non-current assets	618	0
b) **Profit / (Loss) on disposal of non-current assets:**		
Land and buildings	0	(135,735)
Computer equipment and software	(24,461)	(40,974)
Furniture and fittings	(13,996)	(46,819)
Plant and equipment	(38,561)	(90,714)
	(77,018)	(314,242)
Note 6 Capital user charge		
	1,292,478	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.		

Note 7 Other expenses from ordinary activities	2001/02 $	2000/01 $
Workers compensation insurance	265,418	131,968
Other employee expenses	133,882	144,701
Motor vehicle expenses	161,182	154,558
Insurance	61,300	68,731
Communications	155,906	194,749
Printing and stationery	89,584	89,514
Rental of property	20,369	12,375
Audit fees - external	33,000	37,088
Bad and doubtful debts expense	17,425	5,680
Other	326,758	402,059
	1,264,824	1,241,423

Note 8 Patient charges		
Inpatient charges	1,416,743	1,188,140
Outpatient charges	10,078	9,664
	1,426,821	1,197,804

Note 9 Commonwealth grants and contributions		
CACP Funding	30,442	52,023
Primary Health Development Fund	25,788	0
Community Aid & Equipment Program	25,000	0
Grant for HACC	6,100	9,362
HHCS Payments	0	18,156
Project Officer Salary	0	25,000
Community Consultant Grant	0	20,000
Community Donation For Residence Kukerin	0	25,000
Other Grants	5,840	5,266
	93,170	154,808

Note 10 Donations revenue		
General public contributions	5,754	8,829

Note 11 Other revenues from ordinary activities		
Rent from properties	43,178	37,182
Boarders' accommodation	1,332	15,986
Recoveries	326,536	310,928
Use of hospital facilities	105,960	146,688
Other	64,973	45,025
	541,979	555,809

Note 12 Government appropriations		
Output appropriations (I)	18,087,249	14,799,880
Capital appropriations (II)	0	3,441,068
	18,087,249	18,240,948

(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 13 Liabilities assumed by the Treasurer		
Superannuation	10,271	783,909

Note 14 Resources received free of charge	2001/02 $	2000/01 $
Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
Office of the Auditor General		
- Audit services	33,000	35,000
Other		
- Purchase of Equipment	0	28,617
	33,000	63,617

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 15 Cash assets		
Cash on hand	1,140	3,800
Cash at bank - general	214,422	54,130
Cash at bank / Short term bank deposits - donations	71,401	76,929
	286,963	134,859

Note 16 Receivables		
Patient fee debtors	201,430	105,999
GST receivable	84,495	37,573
Other receivables	146,504	177,321
	432,429	320,893
Less: Provision for doubtful debts	(34,793)	(26,388)
	397,636	294,505

Note 17 Amounts receivable for outputs		
Current	0	0
Non-current	751,100	0
	751,100	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 18 Inventories		
Supply stores - at cost	54,850	51,477
Pharmaceutical stores - at cost	49,835	64,661
Engineering stores - at cost	36,000	5,300
	140,685	121,438

Note 19 Property, plant and equipment	2001/02 $	2000/01 $
Land		
At cost (i)	218,500	218,500
At fair value (ii)	93,350	100,900
	311,850	319,400
Buildings		
Clinical:		
At cost (i)	5,096,865	1,200,967
Accumulated depreciation	(94,040)	(13,045)
	5,002,825	1,187,922
At fair value (ii)	35,555,598	36,220,000
Accumulated depreciation	(25,649,052)	(30,017,086)
	9,906,546	6,202,914
At valuation - 30 June 2000 (iii)	7,225,000	0
At valuation - 30 June 1999 (iii)	6,041,000	6,041,000
At valuation - 30 June 1998 and before (iii)	0	5,684,241
Accumulated depreciation	(9,384,009)	(4,253,357)
	3,881,991	7,471,884
Non-Clinical:		
At cost (i)	108,000	198,185
Accumulated depreciation	(25,887)	(24,179)
	82,113	174,006
At fair value (ii)	262,000	50,000
Accumulated depreciation	(1,486)	0
	260,514	50,000
At valuation - 30 June 1999 (iii)	109,000	109,000
At valuation - 30 June 1998 and before (iii)	0	52,000
Accumulated depreciation	(26,120)	(34,822)
	82,880	126,178
Computer equipment and software		
At cost	412,564	517,537
Accumulated depreciation	(221,930)	(306,662)
	190,634	210,875
Furniture and fittings		
At cost	724,877	665,737
Accumulated depreciation	(365,931)	(403,518)
	358,946	262,219
Plant and equipment		
At cost	2,045,192	1,801,178
Accumulated depreciation	(895,888)	(828,249)
	1,149,304	972,929
Total of property, plant and equipment	21,227,603	16,978,327

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to be 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 capital contributions	292,397	467,965
Paid by the Department of Health	2,708,246	1,052,543
Gross payments for purchases of non-current assets	3,000,643	1,520,508

Note 19 Property, plant and equipment - continued

Reconciliations

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

	2001/02 $
Land	
Carrying amount at start of year	319,400
Revaluation increments / (decrements)	(7,550)
Carrying amount at end of year	311,850
Buildings	
Carrying amount at start of year	15,212,904
Additions	4,663,469
Revaluation increments / (decrements)	(125,620)
Depreciation	(533,884)
Carrying amount at end of year	19,216,869
Computer equipment and software	
Carrying amount at start of year	210,875
Additions	61,086
Disposals	(24,461)
Depreciation	(56,866)
Carrying amount at end of year	190,634
Furniture and fittings	
Carrying amount at start of year	262,219
Additions	143,321
Disposals	(14,469)
Depreciation	(32,125)
Carrying amount at end of year	358,946
Plant and equipment	
Carrying amount at start of year	972,929
Additions	378,971
Disposals	(38,706)
Depreciation	(163,890)
Carrying amount at end of year	1,149,304

Note 20 Interest-bearing liabilities	2001/02 $	2000/01 $
Department of Treasury and Finance loans		
Balance at beginning of year	0	887,001
Less repayments this year	0	(887,001)
Balance at end of year	0	0

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

Note 21 Accrued salaries

Amounts owing for All Staff: 7 days from 23 June to 30 June 2002	266,801	185,091

Note 22 Provisions	2001/02 $	2000/01 $
Current liabilities:		
Annual leave	1,519,140	1,373,498
Long service leave	396,638	325,313
Superannuation	90,433	58,885
	2,006,211	1,757,696
Non-current liabilities:		
Long service leave	492,913	486,141
Superannuation	1,091,538	1,125,916
	1,584,451	1,612,057
Total employee entitlements	3,590,662	3,369,753

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

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

Note 23 Contributed equity

Balance at beginning of the year	13,320,748	13,320,748
Capital contributions (i)	3,185,080	0
Balance at end of the year	16,505,828	13,320,748

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 24 Asset revaluation reserve

Balance at beginning of the year	0	9,340
Net revaluation increments / (decrements) :		
Land	0	(1,700)
Buildings	0	(7,640)
Balance at end of the year	0	0
Asset revaluation decrements recognised as an expense (iii):		
Land	7,550	4,600
Buildings	125,620	945,973
	133,170	950,573

(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 25 Accumulated surplus / (deficiency)

Balance at beginning of the year	2,681,898	1,011,067
Change in net assets	(898,587)	1,670,831
Balance at end of the year	1,783,311	2,681,898

Note 26 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 15)	286,963	134,859
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)	(15,983,199)	(14,112,169)
Increase / (decrease) in assets:		
GST receivable	46,922	35,536
Other receivables	64,614	(20,321)
Inventories	19,247	5,188
Prepayments	(8,387)	11,649
Decrease / (increase) in liabilities:		
Doubtful debts provision	(8,405)	(1,821)
Payables	(362,165)	(38,255)
Accrued salaries	(81,710)	(35,221)
Provisions	(220,909)	(223,243)
Non-cash items:		
Depreciation expense	(786,765)	(718,207)
Profit / (loss) from disposal of non-current assets	(77,018)	(314,242)
Interest paid by Department of Health	0	(84,231)
Capital user charge paid by Department of Health	(1,292,478)	0
Asset revaluation decrements	(133,170)	(950,573)
Superannuation liabilities assumed by the Treasurer	(10,271)	(783,909)
Resources received free of charge	(33,000)	(63,617)
Other	(162,413)	(124,207)
Net cost of services (Statement of Financial Performance)	(19,029,107)	(17,417,643)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	18,087,249	14,799,880
Capital appropriations as per Statement of Financial Performance	0	3,441,068
Capital appropriations credited directly to Contributed Equity	3,185,080	0
	21,272,329	18,240,948
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to Department of Treasury & Finance	0	(84,231)
Repayment of interest-bearing liabilities to Department of Treasury & Finance	0	(887,001)
Capital user charge	(1,292,478)	0
Capital subsidy	(2,801,669)	(3,331,605)
Less non-cash component of output appropriations (Refer Note 17)	(751,100)	0
	(4,845,247)	(4,302,837)
Net Cash Provided by Government as per Statement of Cash Flows	16,427,082	13,938,111

Note 27 Revenue, public and other property written off or presented as gifts		
Revenue and debts written off.	9,020	7,237

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

Note 28 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
$20,001 - $30,000	1	1
$30,001 - $40,000	3	0
$40,001 - $50,000	1	1
$50,001 - $60,000	3	2
$60,001 - $70,000	1	2
$70,001 - $80,000	1	0
$80,001 - $90,000	1	0
$90,001 - $100,000	1	3
$100,001 - $110,000	0	1
$110,001 - $120,000	1	0
Total	13	10

	$	$
The total remuneration of senior officers is:	767,633	677,310

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).

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

	2001/02	2000/01
Members of the Accountable Authority	0	0
Senior officers other than members of the Accountable Authority	0	0
	0	0

Note 29 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% and $10,000.

	2001/02 $	2000/01 $	Variation %	Variation $
Expenses from Ordinary Activities				
Salaries and wages Increases in wages across several awards together with agency nursing cost increases and redundancy payments.	12,225,224	11,059,436	10.54%	1,165,788
Visiting medical practitioners Increased costs associated with new agreement and backpay.	1,642,201	1,254,579	30.90%	387,622
Superannuation Increased costs associated with higher base salary and wages.	969,412	938,851	3.26%	30,561
Patient support costs Increased expenditure associated with drugs and patient appliances.	1,494,988	1,422,291	5.11%	72,697
Patient transport Increased PATS claims relating to patient diagnosis, the Health Service cannot control expenditure in this area.	237,242	205,201	15.61%	32,041
Borrowing costs expense A reduction in the loan principle resulted in decreased expense this year. Loan has been paid out.	0	84,231	(100.00%)	(84,231)
Repairs, maintenance and consumable equipment Decreased expenditure in this area relates to an decrease in capital subsidy - repairs & maintenance program.	974,542	1,147,470	(15.07%)	(172,928)
Depreciation and amortisation Increase in this area due capitalisation of Narrogin Hospital's upgrade project.	786,765	718,207	9.55%	68,558

	2001/02 $	2000/01 $	Variation %	Variation $
Note 29 Explanatory statement (continued)				
Net loss from disposal of non-current assets Decrease in this area due mainly to a prior year exceptionally high costs associated with unlocated assets and written-off of assets < $1,000	77,018	314,242	(75.49%)	(237,224)
Asset revaluation decrement Decrease due to revaluation of Lake Grace, Kukerin and Dumbleyung land and buildings.	133,170	950,573	(85.99%)	(817,403)
Other expenses from ordinary activities Increased costs of workers compensation insurance.	1,264,824	1,241,423	1.89%	23,401
Revenues from Ordinary Activities				
Patient charges Increase in revenue due to an increase in private patients. Health Service development of incentives to encourage use of private health insurance cover.	1,426,821	1,197,804	19.12%	229,017
Commonwealth grants and contributions MPS and HACC funding shifted to recurrent appropriations in the current financial year.	93,170	154,808	(39.82%)	(61,638)
Donations revenue	5,754	8,829	(34.83%)	(3,075)
Interest revenue	1,033	1,611	(35.88%)	(578)
Other revenues from ordinary activities The Health Service is unable to control revenue received from items such as rent, meals and use of facilities.	541,979	555,809	(2.49%)	(13,830)
Revenues from Government				
Output appropriations Increase related to new allowances for non cash appropriations for capital user charges, depreciation and employee entitlements. Additional funding for superannuation.	18,087,249	14,799,880	22.21%	3,287,369
Capital appropriations Decrease due to change in accounting policy. Capital appropriations now treated as owners contributed equity	0	3,441,068	(100.00%)	(3,441,068)
Liabilities assumed by the Treasurer A decrease due to funding of superannuation through output appropriations.	10,271	783,909	(98.69%)	(773,638)
Resources received free of charge Decrease in assets transferred.	33,000	63,617	(48.13%)	(30,617)

b) **Significant variations between estimates and actual results for the financial year.**
Section 42 of the Financial Administration and Audit Act requires the Health Service to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget and $10,000.

	2000/2001 Actuals ($000's)	2000/2001 Estimates ($000's)	Variance %	Variation ($000's)
Operating Expenses				
Salaries and Wages	12,225	11,549	5.86%	676
Other Goods and Services Decreases due to lower than expected wage increases.	8,873	8,040	10.36%	833
Total Operating Expenses	**21,098**	**19,589**	**7.70%**	**1,509**
Revenues From Services MPS and HACC funding shifted to recurrent appropriation in the current financial year. This shift not anticipated at the time of the estimates preparation.	**2,069**	**1,927**	**7.36%**	**142**
Net Cost Of Services	**19,029**	**17,662**	**7.74%**	**1,367**

Note 30 Commitments for Expenditure	2001/02 $	2000/01 $
a) **Capital expenditure commitments**		
Capital expenditure commitments contracted for at reporting date are payable:		
Within one year	0	2,122,000
b) **Operating lease commitments:**		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	141,794	32,793
Later than one year, and not later than five years	45,057	10,601
Later than five years	0	0
	186,851	43,394
c) **Other expenditure commitments:**		
Within one year	0	0

These commitments are all inclusive of GST.

Note 31 Contingent liabilities

At the reporting date, the Health Service has a potential liability estimated at $150,000 plus costs of $20,000 relating to a case before the equal opportunity commission.

Note 32 Events occurring after reporting date

The Upper Great Southern 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 33 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 34 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 35 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%	286	0	0	0	1	287
Receivables		0	0	0	0	398	398
		286	0	0	0	399	685
Financial Liabilities							
Payables		0	0	0	0	728	728
Net financial assets / (liabilities)		286	0	0	0	(329)	(43)
As at 30th June 2001							
Financial Assets							
Cash assets	0.0%	131	0	0	0	4	135
Receivables		0	0	0	0	295	295
		131	0	0	0	299	430
Financial Liabilities							
Payables		0	0	0	0	366	366
Net financial assets / (liabilities)		131	0	0	0	(67)	64

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 36 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	734	995	10,147	8,737	1,345	1,327	12,225	11,059
Fees for visiting medical practitioners	99	113	1,363	991	181	151	1,642	1,255
Superannuation expense	58	84	805	742	107	113	969	939
Patient support costs	90	128	1,241	1,124	164	171	1,495	1,422
Patient transport costs	14	18	197	162	26	25	237	205
Borrowing costs expense	0	8	0	67	0	10	0	84
Repairs, maintenance and consumable equipment expense	58	103	809	907	107	138	975	1,147
Depreciation expense	47	65	653	567	87	86	787	718
Net loss on disposal of non-current assets	5	28	64	248	8	38	77	314
Asset revaluation decrement	8	86	111	751	15	114	133	951
Capital user charge	78	0	1,073	0	142	0	1,292	0
Other expenses from ordinary activities	76	112	1,050	981	139	149	1,265	1,241
Total cost of services	1,266	1,740	17,511	15,276	2,321	2,320	21,098	19,337
Revenues from Ordinary Activities								
Patient charges	86	108	1,184	946	157	144	1,427	1,198
Commonwealth grants and contributions	6	14	77	122	10	19	93	155
Donations revenue	0	1	5	7	1	1	6	9
Interest revenue	0	0	1	1	0	0	1	2
Other revenues from ordinary activities	33	50	450	439	60	67	542	556
Total revenues from ordinary activities	124	173	1,717	1,516	228	230	2,069	1,919
NET COST OF SERVICES	**1,142**	**1,568**	**15,794**	**13,760**	**2,093**	**2,090**	**19,029**	**17,418**
Revenues from Government								
Output appropriations	1,085	1,332	15,012	11,692	1,990	1,776	18,087	14,800
Capital appropriations	0	310	0	2,718	0	413	0	3,441
Liabilities assumed by the Treasurer	1	71	9	619	1	94	10	784
Resources received free of charge	2	6	27	50	4	8	33	64
Total revenues from government	1,088	1,718	15,048	15,080	1,994	2,291	18,131	19,088
Change in net assets	**(54)**	**150**	**(746)**	**1,320**	**(99)**	**200**	**(899)**	**1,671**

Note 36 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).