Dundas 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 Dundas Health Service for the year ended 30 June 2002.

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

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

ANNUAL REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mike Daube
DIRECTOR GENERAL

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Address and Location

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✉ Lynette.Brennan@health.wa.gov.au

Mission Statement

Our Mission
To work together with the local community to reach for the best possible health for all.

Broad Objectives

The objectives of the Dundas Health Service are:

- To provide accessible hospital care to those who require it.
- To provide health services according to recognised standards of quality, in a way that is acceptable to members of the public.

Enabling Legislation

The Dundas 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 Dundas Health Service, the Board of Management is responsible to the Minister for Health, Hon. R. C. Kucera APM MLA, for the general administration of the Health Service.

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

Ministerial Directives

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

Submission of Annual Report

Approval was sought under the *Financial Administration and Audit Act 1985* to extend the Dundas 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 Dundas 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:

- Reviewing all policies and procedures relating to the standards and ethical codes outlined above during 2001/2002.
- Successfully passing the Australian Council on HealthCare Standards review in April 2002.

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

Bronwen Scott
ACTING REGIONAL DIRECTOR
GOLDFIELDS SOUTH-EAST HEALTH REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

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

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies — Marketforce Productions	1,136.00	10,797.00	15,279.00
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$1,136.00**	**$10,797.00**	**$15,279.00**

Freedom of Information Act 1992

The Dundas Health Service received and dealt with no formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

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

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

The types of documents held by the Health Service include:

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

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

Information Coordinator
Dundas Health Service
Talbot St
NORSEMAN WA 6443

☎ *(08) 9039 1100*

Dundas Health Service

Key Operations and Achievements

- Expanding primary health care programs.
- Completing an upgrade to the Norseman District Hospital.
- Being surveyed by the Australian Council on HealthCare Standards.
- Establishing a Multi Purpose Service delivery plan for the next three years.
- Increasing respite care services.
- Developing plans to increase the use of telehealth technology.
- Improving the range of specialised medical services that visit Norseman.

Improvements to Primary Health Care Programs

An increase in staffing hours at the Norseman Community Health service has resulted in expansions to primary health care programs. A diabetic review, male Aboriginal health days, and public health checks have all occurred during 2001/2002. All staff have volunteered their time to be involved in these programs.

Upgrading the Norseman District Hospital

The upgrade to the Norseman District Hospital was completed in December 2001. The Hospital and aged care areas are now comfortably furnished thanks to support from local fundraisers. Home and Community Care, and aged care services are now on-site at the Hospital.

Involvement in ACHS Survey

The Health Service was surveyed by ACHS on 29 April 2002 with predictions of successful results. Staff and community efforts were vital in achieving successful results under the survey.

Establishing a Multi Purpose Service Delivery Plan

The Health Service's MPS delivery plan for the next three years has been established over the past six months. The Health Service is seeking extra funding for health promotion, staff development, Aboriginal health and allied health services as part of the plan.

Increase in Respite Care

There has been an increase in respite care since the completion of the Hospital upgrade. All services such as nursing and social wellbeing continue to be administered in-home.

Plans to Increase Telehealth

Plans to increase the use of telehealth have been established at the Health Service, especially in the field of allied health. Telehealth is the use of electronic information and telecommunications technology to support long-distance clinical health care, patient and professional health-related education. Mental health services in operation at Norseman have successfully used telehealth for some time.

Improving Specialised Medical Services

A physician and paediatrician are now visiting Norseman on a regular basis.

Major Capital Projects

Projects Completed during the Year

PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Multi Purpose Service Upgrade to the Norseman District Hospital	$940,620.00	$1,000,000.00

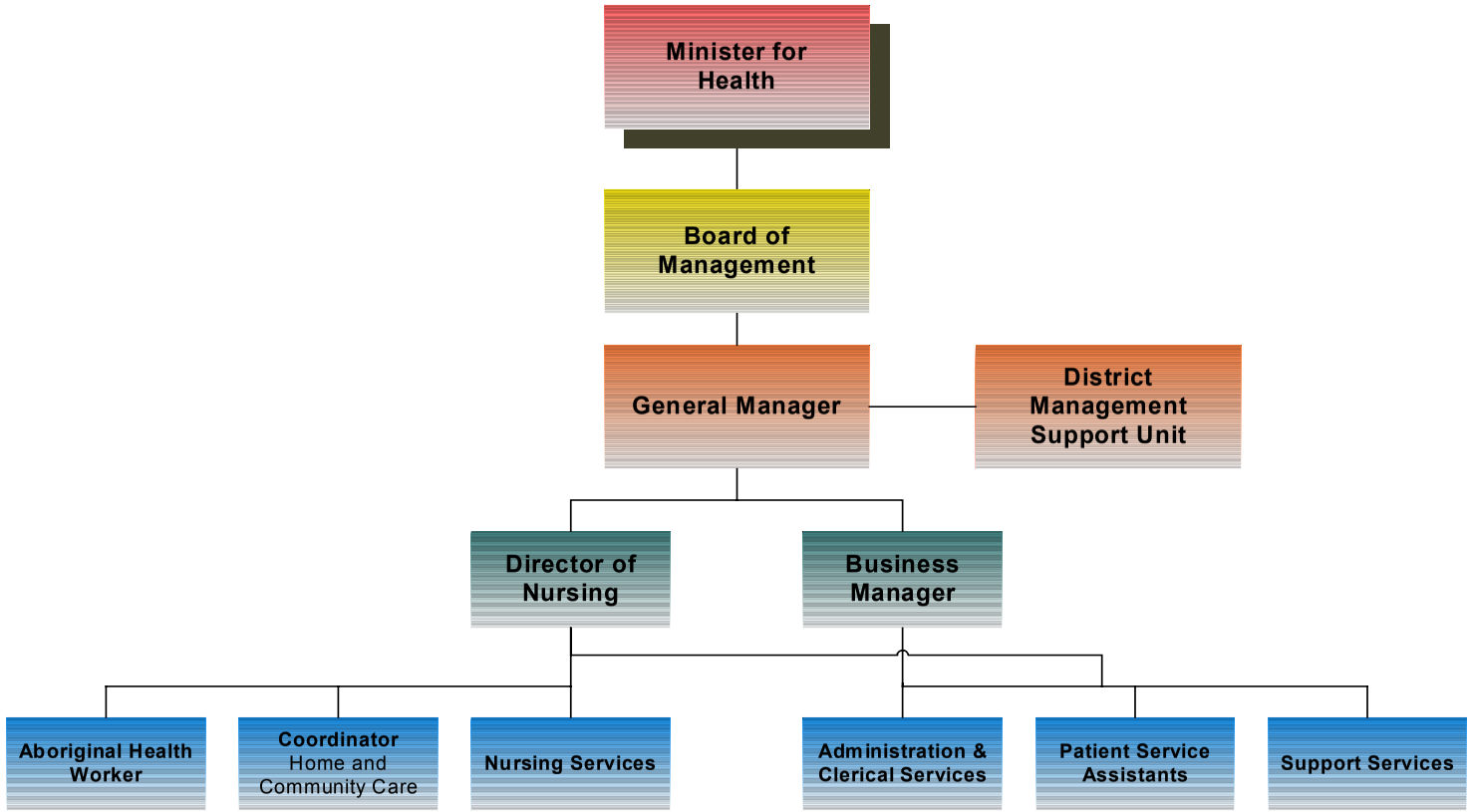
The upgrade to the Norseman District Hospital was completed in December 2001. The Hospital and aged care areas have been refurbished, and the Home and Community Care, and aged care services are now on-site at the Hospital.

Projects in Progress

The Dundas Health Service does not have any major capital projects in progress as at 30 June 2002.

Management Structure

Organisational Chart



Accountable Authority

The Dundas 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
Evelyn Reid	Chairperson	30 June 2002
John Smith	Deputy Chairperson	30 June 2002
James Clark	Member	30 June 2002
Edward Dimer	Member	30 June 2002
Patrick Hogan	Member	30 June 2002
Janice Stace	Member	30 June 2002

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

Area of Responsibility	Title	Name	Basis of Appointment
Health Service Corporate Management	General Manager	Mark Edgar	Permanent
Nursing Services	Director of Nursing	Chris Haar	Permanent
Administration/Support Services	Business Manager	Lyn Brennan	Contract
Medical Services	Director of Medical Services	Dr Emad Omar El-Taweel	Contract

Pecuniary Interests

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

Demography

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

- Dundas Shire

The following table shows population figures for the local authority within the Health Service:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Dundas Shire	1652	1247	1700

*Data sources:

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

ABS 2001, *Population Estimates by Age, Sex and Statistical Local Area, WA*, Cat. No. 3235.5.

Ministry of Planning 2000, *Population Projections by Age, Sex and Local Government Area, WA*.

The Dundas Shire covers an area of approximately 93,179 square kilometres. The climate for the region is classed as semi-arid with an average rainfall of 279 mm.

The Dundas Health Service is the major health service provider within the shire, with a nursing post situated 700 kilometres away at Eucla.

Norseman was established as a mining town in the nineteenth century with mining still remaining the main industry for the region. The large area to the east of Norseman is semi-arid pastoral land made up of sheep stations and a number of roadhouses situated along the Eyre Highway.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Extended Care Services
Outpatient Services
Paediatric
Permanent Care
Respite Care

Medical Support Services
Dietetics
Occupational Therapy
Pharmacy
Physiotherapy
Podiatry
Social Work
Speech Pathology
X-ray (Limited)

Community Services
Aboriginal Health Worker
Child Development
Day Care Centre
Home and Community Care
Home Care
Immunisation
Meals on Wheels
Primary Health Care

Other Support Services
Financial Services
Health Promotion
Hotel Services
Medical Records

Specialist Services
None

Other Services
None

Disability Services

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

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

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

- An extended care nurse is employed by the Health Service to ensure the needs of the aged and people with disabilities are met, and to act as a liaison with other external health services.

Outcome 2: Access to buildings and facilities is improved.

- Health Service buildings were recently upgraded to improve means of access for the aged and people with disabilities. These improvements include adding access ramps to entrances at the Norseman District Hospital.

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

- The Health Service has its own Customer Service Charter available for public access.
- Information booklets and other data on health services is made available to the community through the local media.
- Health Service information is not available in any formats specifically designed for people with disabilities.

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

- All Health Service staff receive regular training and updates on services required by people with disabilities.

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

- All patients are surveyed on an annual basis to monitor satisfaction levels regarding health services.
- People with disabilities are informed of grievance mechanisms, and are included in all decision-making processes conducted by the Health Service.

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

Cultural Diversity and Language Services

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

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

- The Health Service has access to a telephone interpreter service when it is required.
- Local community members are contacted to assist in some cases where further interpretative services are necessary such as in translating various Aboriginal languages.

An Aboriginal health worker is employed to assist with the Indigenous population.

Youth Services

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

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

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

Programs and Initiatives
The Health Service works closely with the Dundas Shire Council and other liaison committees to coordinate the following youth programs:

- Having the local community health nurse introduce students to many varied youth programs during the adolescents' first year at high school.
- Participating in work experience programs for young people designed to encourage post-school employment.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	10.80	9.15	9.65
Administration and Clerical*	2.66	3.85	4.49
Medical Support*	–	–	–
Hotel Services*	11.21	8.43	9.29
Maintenance	–	–	–
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**24.67**	**21.43**	**23.43**

*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 Dundas Health Service aims to provide flexible working conditions to attract staff to the area. Vacancies are advertised according to the *Public Sector Management Act 1994*.

Staff Development

Developmental training is provided for both clinical and non-clinical staff, with the majority of training programs available in-service. The Dundas Health Service also subscribes to a number of journals, which provide information that assists with in-service training.

The Health Service has access to both telehealth and Westlink facilities for training purposes.

Industrial Relations Issues

There was no industrial action taken within the Dundas Health Service during 2001/2002.

Workers' Compensation and Rehabilitation

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	0	0	0
Administration and Clerical*	0	0	0
Medical Support*	0	0	0
Hotel Services*	0	2	0
Maintenance	0	0	0
Medical (salaried)	0	0	0
Other	0	0	0
TOTAL	**0**	**2**	**0**

*Note these categories include the following:

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

The Health Service has an Occupational Safety and Health manual that is used by all staff. Regular in-service training is also provided to ensure all staff are aware of OSH issues. Workplace safety inspections are regularly conducted.

A staff orientation manual was produced for all new employees, and is distributed as part of the induction process.

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 Dundas 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.

- Health Service employees come from many diverse backgrounds, with staff including members from the Aboriginal community, and both male and female persons.
- There have been no incidents or disputes relating to racial or sexual harassment during 2001/2002.
- All new employees are briefed on Health Service policies relating to racial and sexual EEO matters.

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

- The Health Service follows EEO Guidelines for matters concerning discrimination practices.
- Aboriginal positions are advertised according to Section 50(d) of the *Equal Opportunity Act 1984*.

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

- The Health Service endeavours to employ staff following the guidelines set out in the *Equal Opportunity Act 1984*. Employment practices take into account the widely diverse population within Norseman given the predominance of mining activity in the local area.

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 Dundas Health Service has been able to meet these goals:

Plan or Process	Level of Achievement
EEO Management Plan	Implemented and reviewed in 2001/2002
Organisational plans reflect EEO	Implemented and reviewed in 2001/2002
Policies and procedures encompass EEO requirements	Implemented and reviewed in 2001/2002
Established EEO contact officers	Implemented
Training and staff awareness programs	Implemented
Diversity	Implemented

Marketing

Public awareness of the Dundas Health Service was raised through the following activities:

- Running promotional health advertising in *Norseman Today*.
- Conducting health awareness talks at the Norseman High School.
- Running promotions on behalf of Community Health and Home and Community Care services.
- Producing an information booklet available for patients of the Norseman District Hospital.
- Revising the Customer Service Charter and distributing the document throughout the local community.
- Holding a Hospital Open Day in December 2001.

Publications

The Customer Service Charter for the Dundas Health Service was revised during 2001/2002, and made available to the local community. The charter outlines hospital and community services, and Health Service commitments and standards.

The local newspaper, *Norseman Today*, is used to regularly advertise programs and activities run by the Health Service.

Research and Development

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

Evaluations

The Dundas Health Service is required to evaluate and keep abreast of community needs given its Multi Purpose Service status. All aspects of health and service delivery are surveyed annually as a result. This evaluation process is conducted to determine new outcomes and programs needed within the Health Service, and to determine what actions are required to instigate them.

The following evaluations were conducted during 2001/2002:

Community Survey
Surveys were distributed to the local community during 2001/2002 to identify unaddressed needs regarding the provision of health services. The Health Service will use the survey results to introduce new health programs targeted towards the community, and will continue to evaluate these programs on an annual basis.

Allied Health
An evaluation was conducted to determine the viability of introducing previously unavailable allied health services into the district. These areas included podiatry, occupational health, physiotherapy and dietetics.

The Health Service was able to negotiate the following:

- For a podiatrist to visit Norseman on a monthly basis.
- For an occupational therapist, dietician and physiotherapist to be contracted through the Esperance Health Service for regular visits.
- To employ a therapy assistant.

Community Health
The aim of an evaluation into community health was to increase the number of hours that primary health services were available for public access. The Health Service was able to commit more hours through the community health nurse, and to provide educational services in a greater number of primary health areas.

Aged Care
The purpose of the evaluation into aged care services was to assist the elderly in remaining in their own homes, and to provide them with the assistance to do so.

The Health Service was able to take the following actions:

- Providing transport for people with disabilities.
- Providing in-home care for individual patients.
- Increasing extended care nursing hours.
- Providing Meals on Wheels services.

Aboriginal Health
The evaluation on Aboriginal health aimed to identify Indigenous community needs taking into account issues of cultural difference. The Health Service sought to employ both male and female Aboriginal health workers to work alongside Indigenous families situated in the district.

The Health Service was able to take the following actions:

- Employing a female Aboriginal health worker.
- Educating current staff about cultural differences.
- Introducing a male Aboriginal health worker to the district through the Kalgoorlie–Boulder Public and Community Health Services.

Risk Management

Our Policy
The Dundas 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
The Health Service has an established risk management committee that ensures the following strategies are implemented:

- Surveys are conducted to determine future priorities for the planning of risk management activities.
- All Health Service staff are made aware of the benefits of risk management, and ongoing hazard education is provided for employees.
- Risk procedures are reviewed, performance targets are set and progress is monitored where it is considered necessary.
- Controls are introduced that reduce the chance of undesired events occurring.
- Risks are reduced by not engaging in activities likely to generate them.
- To have contingency plans and recovery procedures in place that reduce the likely impact of undesired events.
- Certain levels of risk are accepted in instances where other options are impractical or uneconomical.

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 Dundas 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. An audit committee oversees the operation of internal audit functions, and ensures management addresses any findings arising from internal and external audit reports.

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

Waste Paper Recycling

Waste paper is re-used for fax machines and as note pads, or is shredded and used as compost for the gardens at the Norseman District Hospital.

No records were kept of the amount of waste paper recycled in this manner during 2001/2002.

Pricing Policy

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

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

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

AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope

I have audited the key effectiveness and efficiency performance indicators of the Dundas 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 Dundas 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 Dundas Health Service are relevant and appropriate for assisting users to assess the Health Service's performance and fairly represent the indicated performance for the year ended June 30, 2002.

D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

AUDITOR GENERAL

INTERIM REPORT

To the Parliament of Western Australia

DUNDAS 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 Dundas Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Dundas 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.

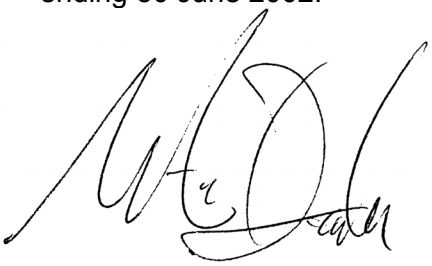
It is anticipated that the opinions will be issued by March 31, 2003.

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

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



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

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Background

The Performance Indicators reported in the following pages address the extent to which the strategies and activities of the Health Service have contributed to the required health outcomes and outputs, viz.,

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

Output 1 - Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability, premature death and the extent and impact of drug abuse.

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

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

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

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

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

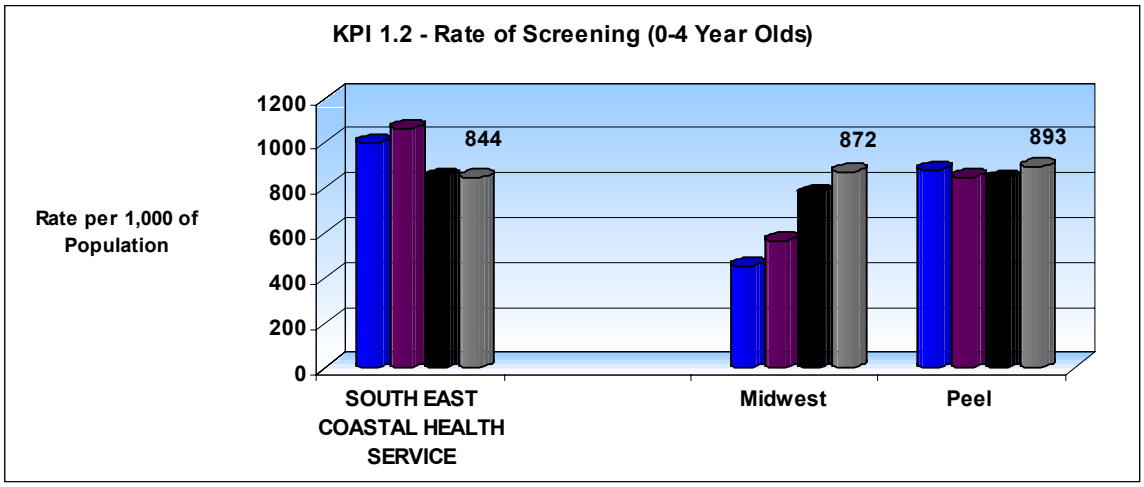
RATE OF SCREENING IN CHILDREN	KPI 1.2

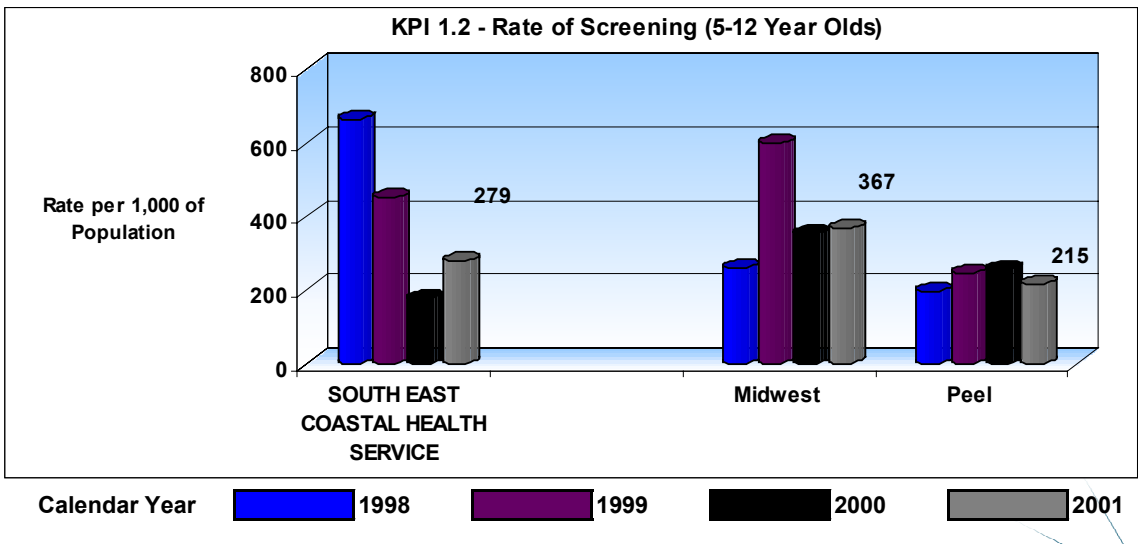
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

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





RATE OF CHILDHOOD IMMUNISATION	KPI 1.5

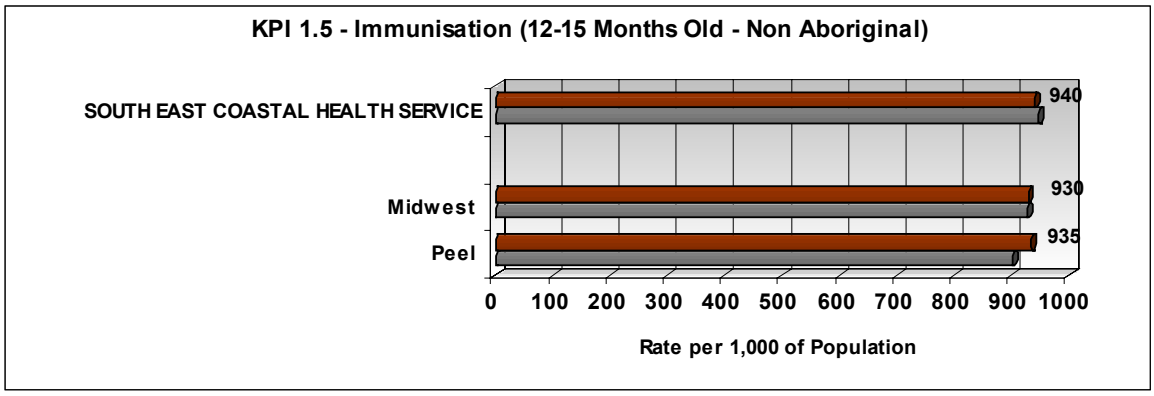
Vaccine preventable diseases are associated with considerable morbidity and mortality, and vaccination is effective in reducing the incidence of these diseases in the community. Through this adoption of the National Immunisation Schedule, health system effectiveness in providing vaccination coverage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

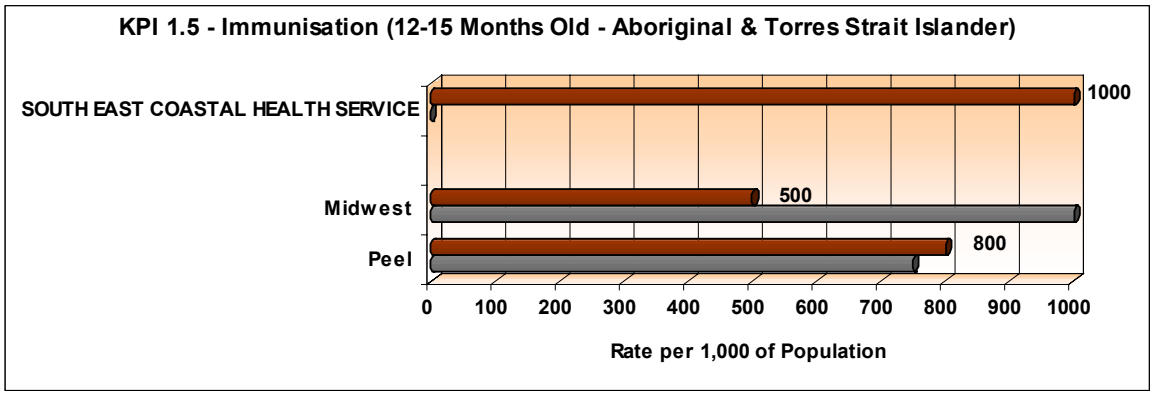
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

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

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

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


KPI 1.5 - Immunisation (12-15 Months Old - Non Aboriginal)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
940
930
935
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
1000
500
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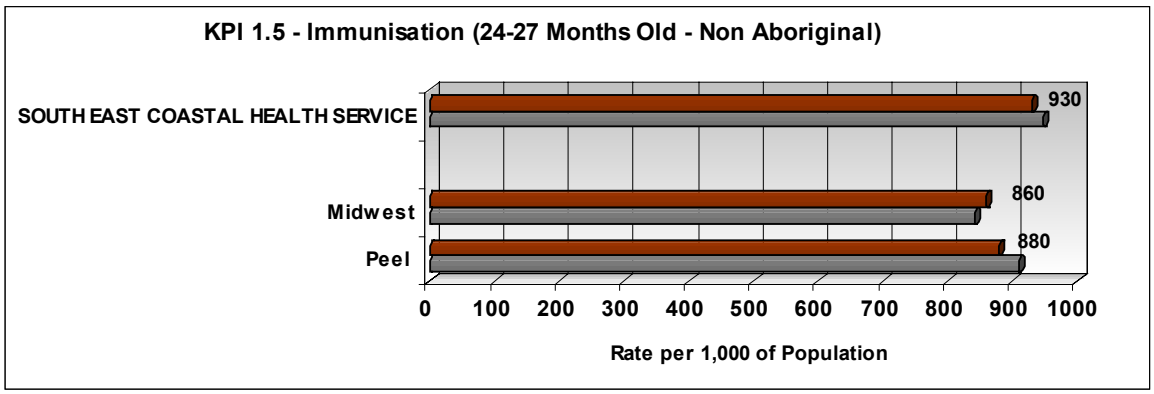
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Non Aboriginal)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
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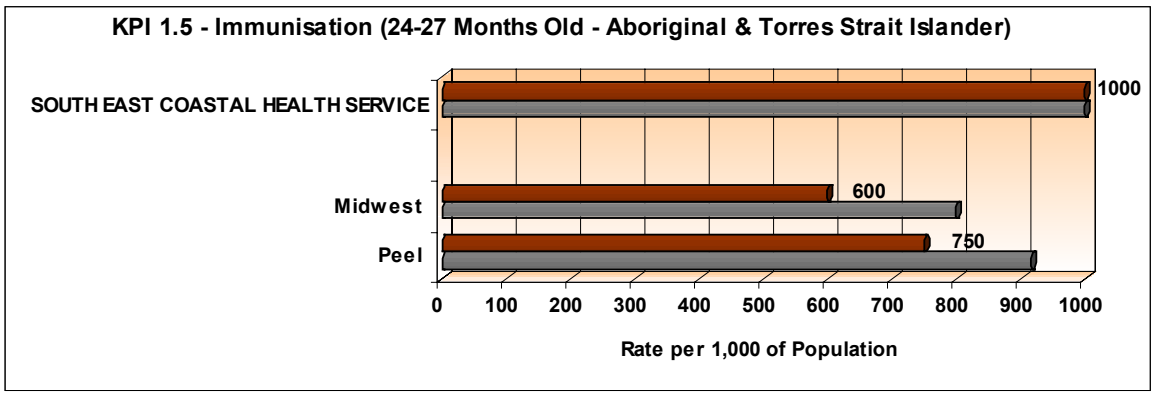
Rate per 1,000 of Population


KPI 1.5 - Immunisation (24-27 Months Old - Aboriginal & Torres Strait Islander)
SOUTH EAST COASTAL HEALTH SERVICE
Midwest
Peel
1000
600
750
0 100 200 300 400 500 600 700 800 900 1000
Rate per 1,000 of Population


Calendar Year
2001
2002

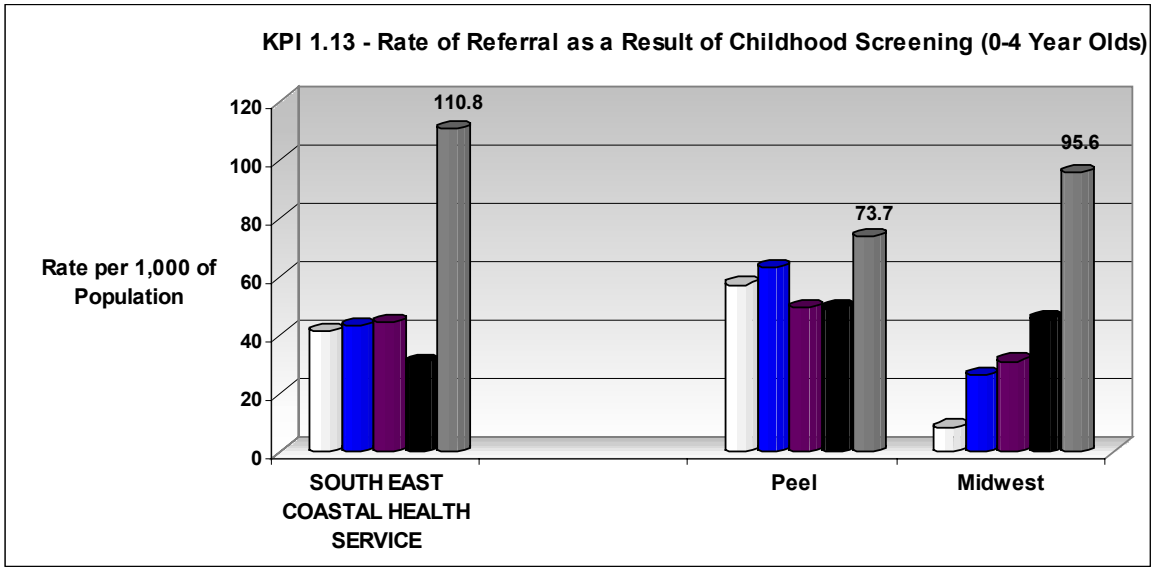
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

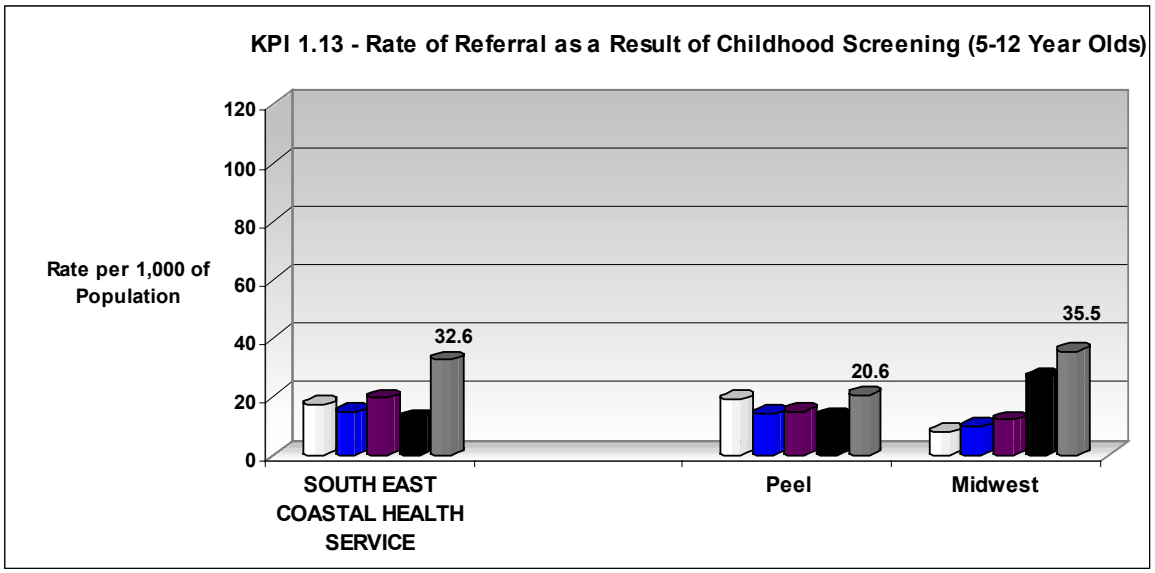
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. It is important not only to restore them to good health when they become ill but also to maintain a state of 'wellness' that allows them to develop to full potential.

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.

There was a significant improvement in the rate of referral as a result of childhood screening this year. This is in part due to the introduction of a new speech pathology screening program for Community Health Nurses.





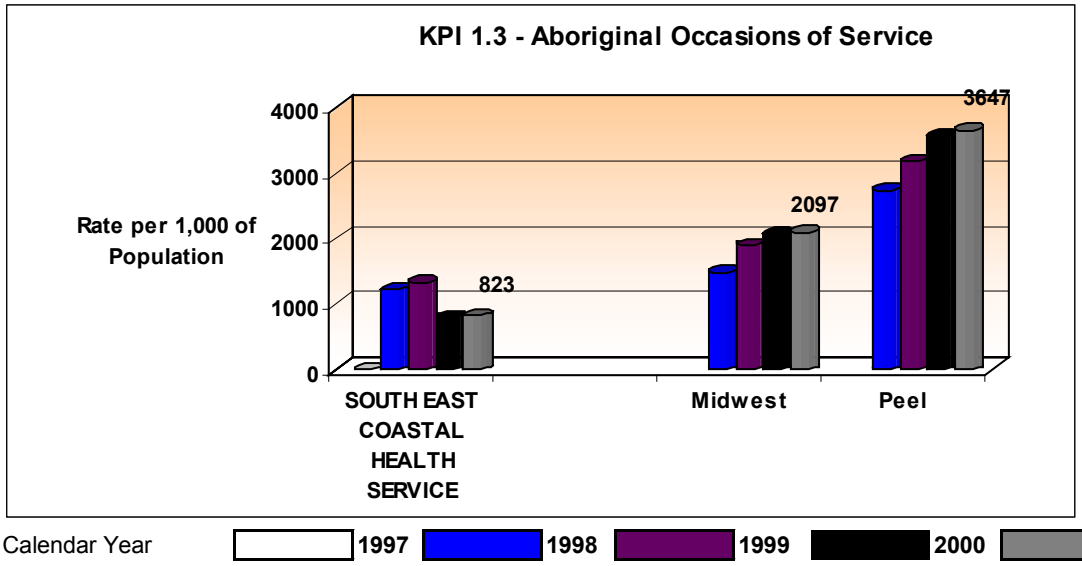
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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

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

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

The slight fall in the rate ratio of Aboriginal to non Aboriginal people may be due to a vacancy in the Aboriginal Health worker position.



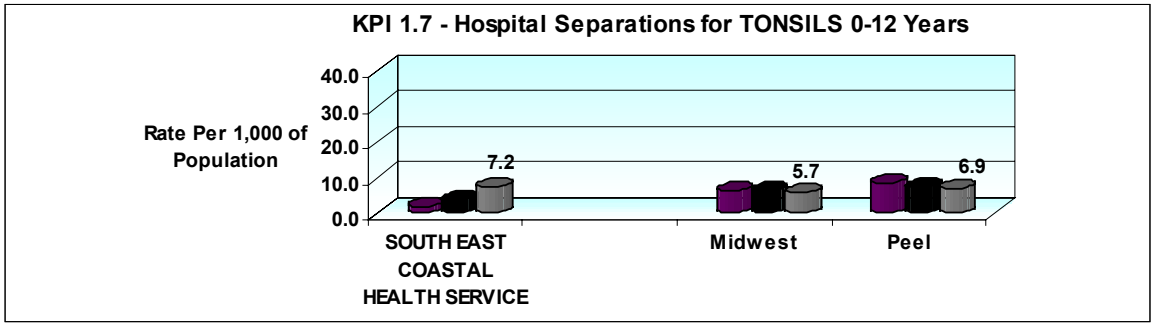
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

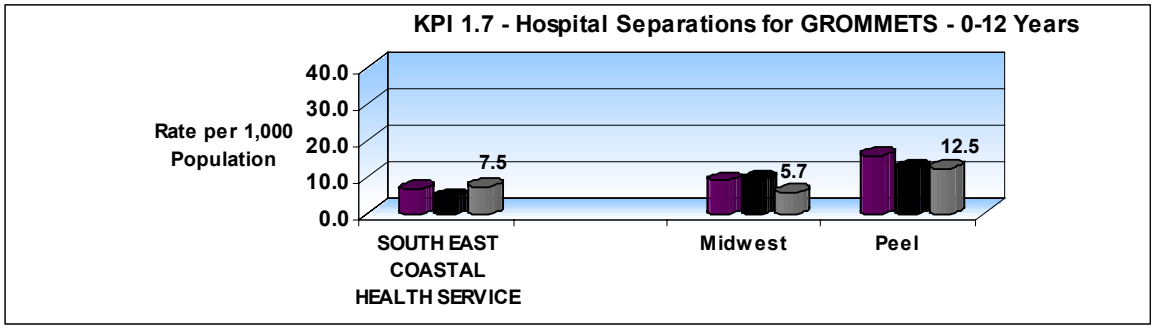
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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.





Calendar Year 1999 2000 2001

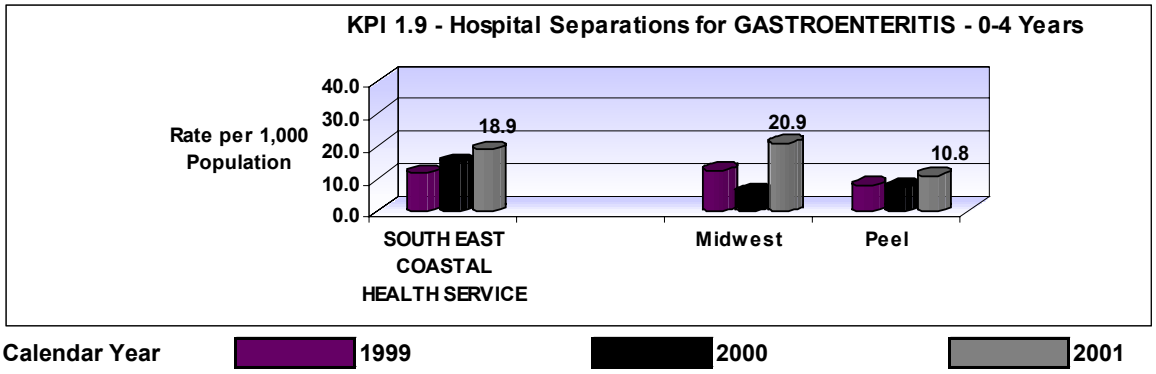
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

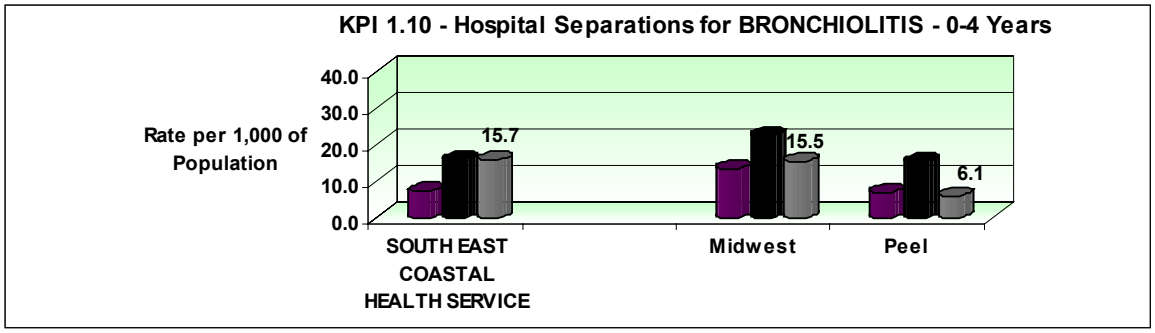
The graph shows individuals aged 0-4. Of those individuals aged 5-12 and 13-18, none were hospitalised this year.

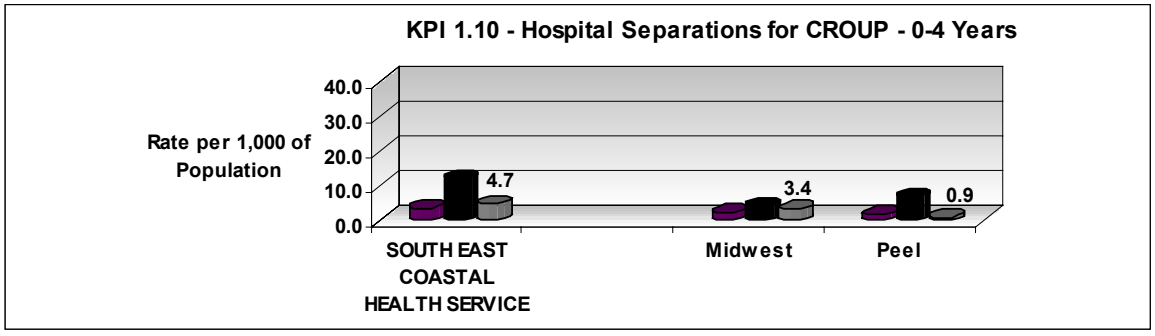
Croup

The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 3 were hospitalised this year, a rate of 1.8 per thousand. Of those individuals aged 13-18, none were hospitalised this year.

Acute Bronchitis

9 individuals aged 0-4 at a rate of 7.1 per thousand were hospitalised this year and no individuals were admitted aged 5-12 or 13-18.





Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

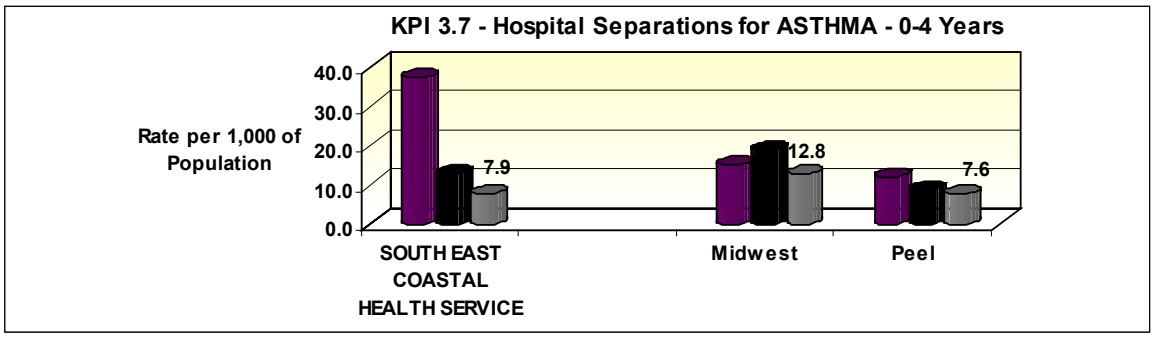
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

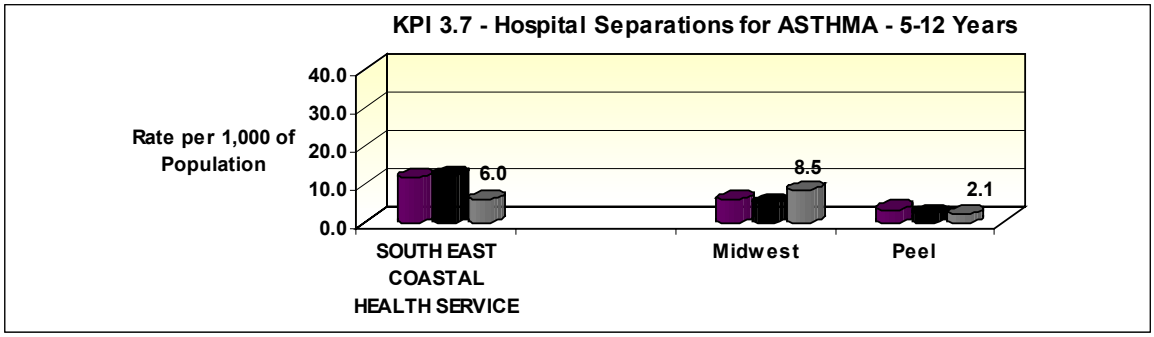
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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

It is important to note however, that other factors - such as allergic and climatic responses for example - may influence the number of people hospitalised with Asthma. This condition is one which has a high number of patients treated either in hospital or in the community. It would be expected that hospital admissions for Asthma may decrease as performance and quality of service increases thus indicating an improvement in the quality of life of people with a chronic illness.

The graphs show individuals aged 0-4 and 5-12. 5 individuals aged 13-18 at a rate of 3.8 per thousand were hospitalised this year, with 5 individuals being admitted aged 19-34 at a rate of 1.5 per thousand and 17 individuals aged 35 years and over at a rate of 2.1 per thousand.





Calendar Year 1999 2000 2001

COST PER OCCASION OF SERVICE OF COMMUNITY HEALTH SERVICE	KPI 1.14

Community health occasions of service measure the provision of primary and community health services undertaken by a range of health service professionals in a community setting, with a focus on improving the overall health of the State population. Child health nursing, clinical psychology, occupational and speech therapy are some examples of the types of community-based services provided under this Indicator. It provides a measure of, on average, how cost effective these activities are over time.

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

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

The cost of providing community health services in the South East Coastal Health Service has risen slightly in the past year. The Health Service has expanded the range of services offered to include more expensive professional services. The Health Service also experiences a disadvantage due to remoteness from Perth. Freight and transport charges contribute to increased overall costs.

HEALTH SERVICE	COST PER OCCASION OF COMMUNITY HEALTH SERVICE
South East Coastal	$75.40

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.

EMERGENCY DEPARTMENT WAITING TIMES	KPI 2.18

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

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

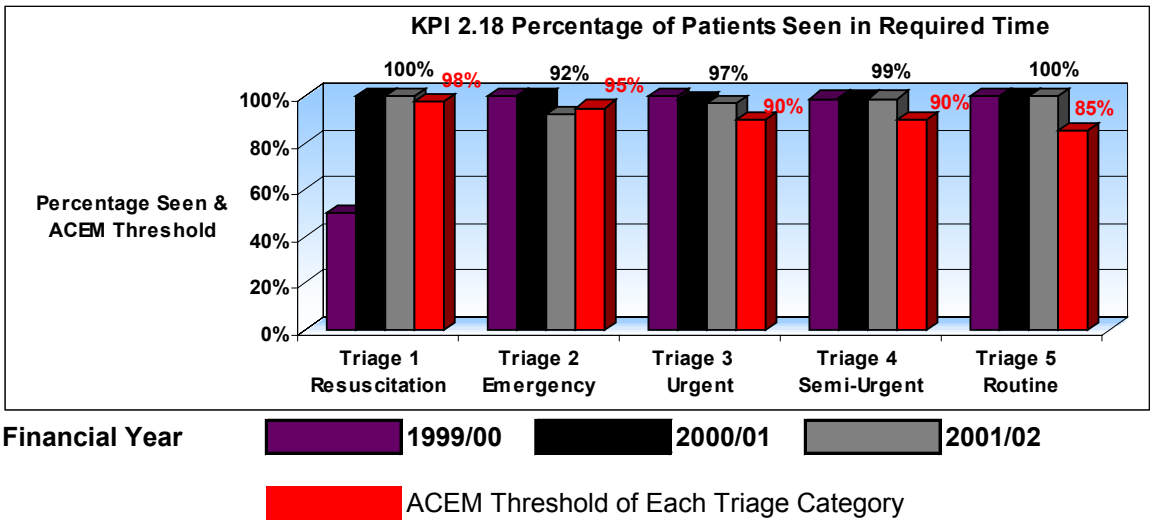
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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

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

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

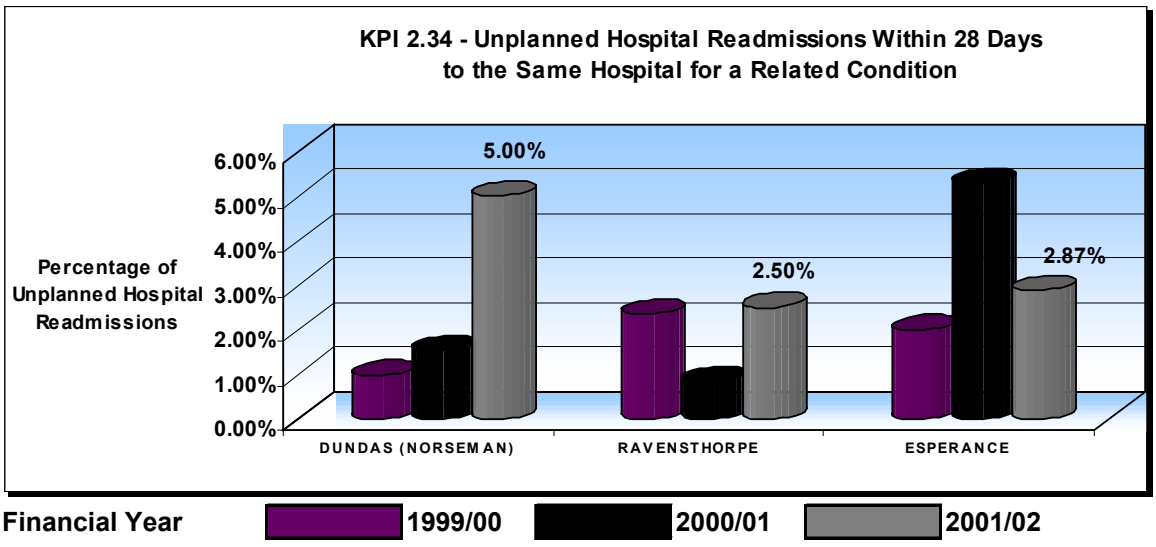
TRIAGE CATEGORY	TYPE OF PATIENT	REQUIRED TIME TO BE FIRST SEEN (By Practitioner)	ACEM THRESHOLD FOR PERCENTAGE SEEN WITHIN REQUIRED TIME
Triage 1	Resuscitation	Immediately	98%
Triage 2	Emergency	Within 10 Minutes	95%
Triage 3	Urgent	Within 30 Minutes	90%
Triage 4	Semi-Urgent	Within 60 Minutes	90%
Triage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


KPI 2.18 Percentage of Patients Seen in Required Time
Percentage Seen & ACEM Threshold
100%
80%
60%
40%
20%
0%
100%
98%
92%
95%
97%
90%
99%
90%
100%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Routine
Financial Year
1999/00
2000/01
2001/02
ACEM Threshold of Each Triage 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.

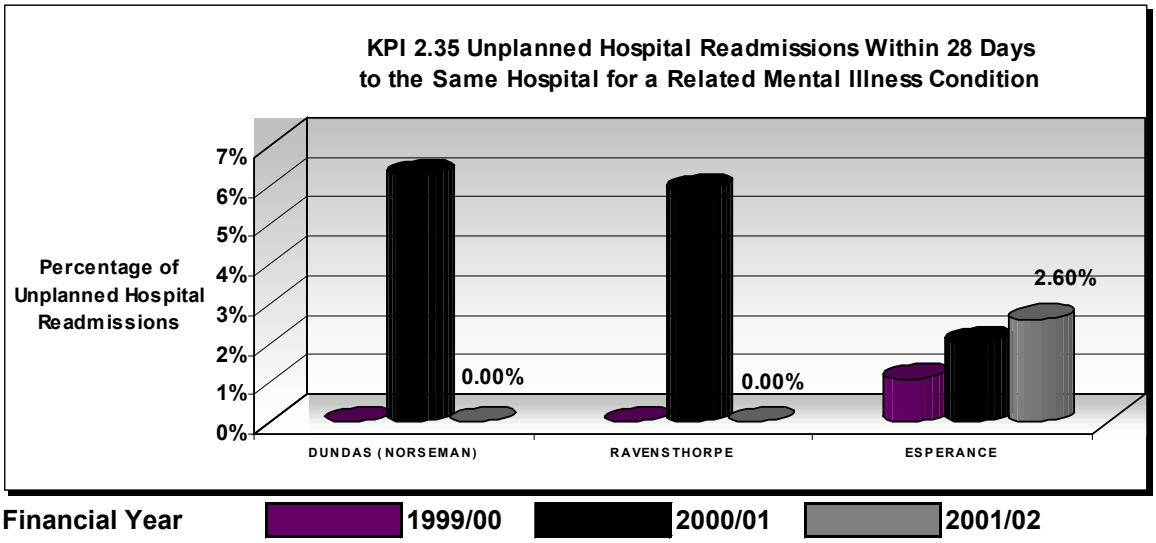


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

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 Health Service has not experienced any re-admissions in this category this year.



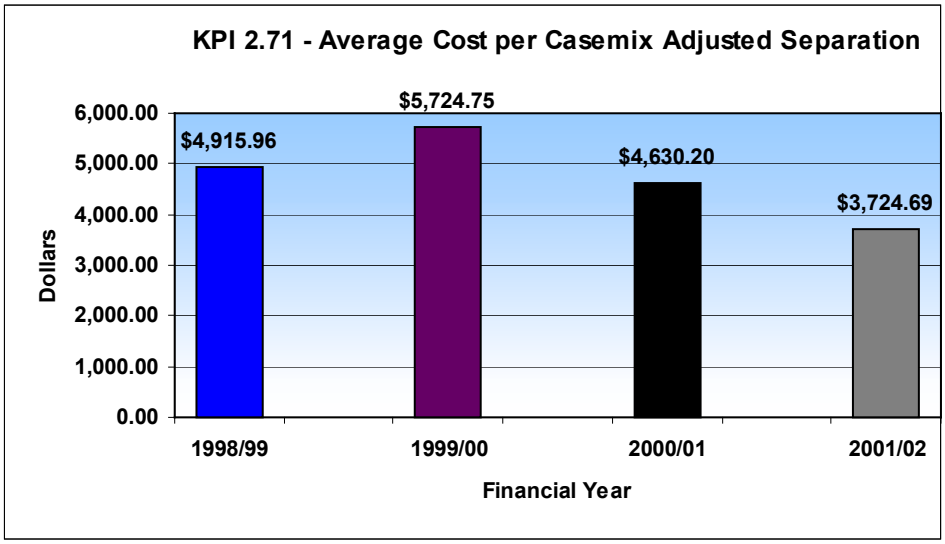
AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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 and is presented using CPI adjusted costs.

The cost of providing inpatient care has fallen over the past three years. The hospital has worked hard to contain costs and to provide services in an efficient manner.



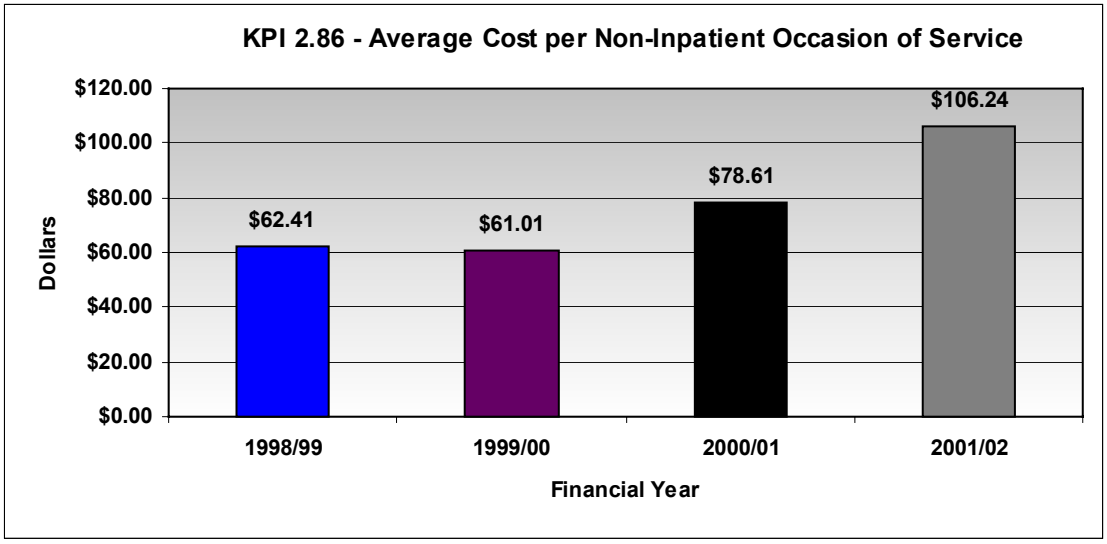
AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE — KPI 2.86

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 and is presented using CPI adjusted costs.

The cost per occasion of service has risen significantly in the last two years. The town has not had the service of a doctor for some time and so patient numbers are reduced. We are still required to maintain availability of outpatient service and do not enjoy the economies of scale available in other places.



KPI 3.7 : Hospital separations for Asthma

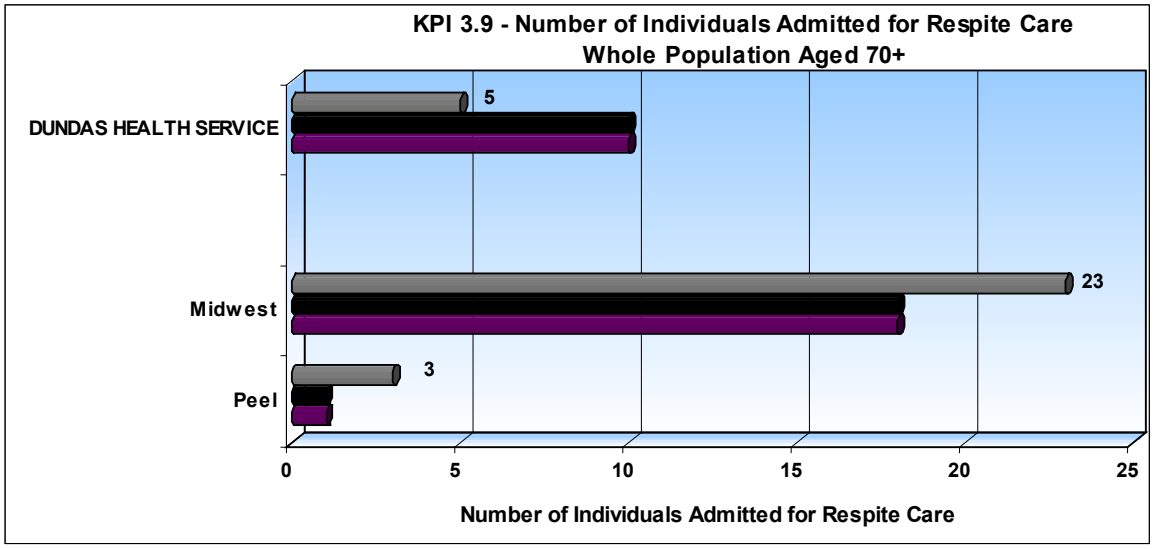
Hospitalisation for acute Asthma is part of managing chronic conditions. The indicator has been moved to Output 1 from Output 3 in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

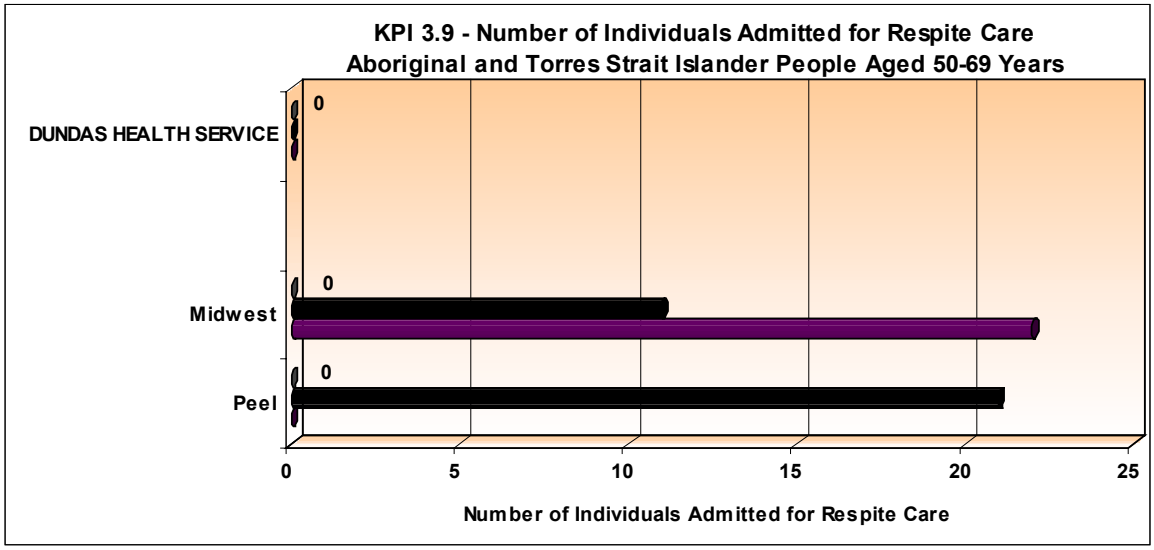
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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

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

The Health Service maintains a comprehensive extended care service, which supports people in need of care in the home. The relatively low rate of admission for respite care is a testimony to the success of this service. There were no admissions for respite care for Aboriginals aged 50-69 during the previous three years.





AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope

I have audited the accounts and financial statements of the Dundas 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

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

Audit Opinion
In my opinion,

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

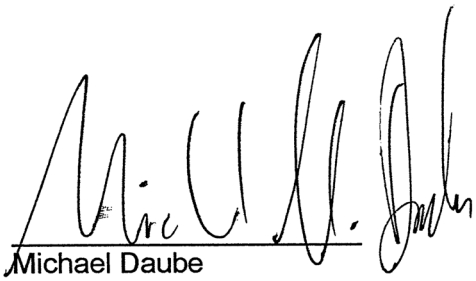
(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Health Service at June 30, 2002 and its financial performance and its cash flows for the year then ended.

D D R PEARSON
AUDITOR GENERAL
March 14, 2003

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

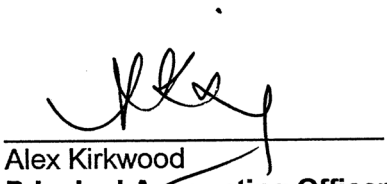
The accompanying financial statements of the Dundas Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Dundas 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		1,025,429	1,050,882
Fees for visiting medical practitioners		21,575	42,320
Superannuation expense		68,500	66,929
Patient support costs	3	137,830	158,131
Patient transport costs		69,368	58,697
Repairs, maintenance and consumable equipment expense		79,902	50,969
Depreciation expense	4	92,717	83,706
Net loss on disposal of non-current assets	5	0	37,465
Capital user charge	6	157,295	0
Other expenses from ordinary activities	7	106,851	148,177
Total cost of services		1,759,467	1,697,276
Revenues from Ordinary Activities			
Patient charges	8	6,862	24,994
Donations revenue	10	1,850	0
Net profit on disposal of non-current assets	5	52	0
Interest revenue		64	3,550
Other revenues from ordinary activities	11	29,937	35,777
Total revenues from ordinary activities		38,765	64,321
NET COST OF SERVICES		**1,720,702**	**1,632,955**
Revenues from Government			
Output appropriations	12	1,760,755	1,336,132
Capital appropriations	12	0	698,557
Liabilities assumed by the Treasurer	13	0	66,929
Resources received free of charge	14	7,000	6,250
Total revenues from government		1,767,755	2,107,868
Change in net assets		**47,053**	**474,913**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**47,053**	**474,913**

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	44,513	6,767
Receivables	16	5,384	9,448
Inventories	18	13,288	12,854
Prepayments		519	148
Total current assets		63,704	29,217
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	86,800	0
Property, plant and equipment	19	2,842,404	1,789,436
Construction works in progress		0	692,908
Total non-current assets		2,929,204	2,482,344
Total assets		**2,992,908**	**2,511,561**
CURRENT LIABILITIES			
Payables		31,388	92,085
Accrued salaries	22	53,748	15,562
Provisions	23	104,909	122,856
Total current liabilities		190,045	230,503
NON-CURRENT LIABILITIES			
Provisions	23	24,563	22,652
Total non-current liabilities		24,563	22,652
Total liabilities		**214,608**	**253,155**
Net Assets		**2,778,300**	**2,258,406**
EQUITY			
Contributed equity	24	472,840	0
Accumulated surplus / (deficiency)	25	2,305,460	2,258,406
Total Equity		**2,778,300**	**2,258,406**

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)	1,516,660	1,336,132
Capital contributions (2000/01 appropriation)	26(c)	0	0
Net cash provided by Government		1,516,660	1,336,132
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(507,333)	(402,930)
Employee costs		(1,007,099)	(1,056,666)
GST payments on purchases		(38,020)	(40,347)
Receipts			
Receipts from customers		9,149	26,314
Donations		1,850	0
Interest received		64	3,550
GST receipts on sales		168	422
GST receipts from taxation authority		37,341	38,418
Other receipts		29,979	35,716
Net cash (used in) / provided by operating activities	26(b)	(1,473,901)	(1,395,523)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(7,813)	(29,028)
Proceeds from sale of non-current assets	5	2,800	0
Net cash (used in) / provided by investing activities		(5,013)	(29,028)
Net increase / (decrease) in cash held		37,746	(88,419)
Cash assets at the beginning of the reporting period		6,767	95,186
Cash assets at the end of the reporting period	26(a)	44,513	6,767

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 fair value. Fair value is the amount for which an asset could be exchanged, between knowledgeable, willing parties in an arm's length transaction.

i) Land and Non-Clinical Buildings

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

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

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

(f) Depreciation of Non-current Assets

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

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

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

(g) Leases

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

The Health Service has no contractual obligations under finance leases.

(h) Cash

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

(i) Receivables

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

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

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

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

(m) Interest-bearing liabilities

No interest bearing liabilities

(n) 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).

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.

(o) Revenue Recognition

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

(p) Grants and Other Contributions Revenue

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

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

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

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

(r) Comparative Figures

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

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

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

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

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

Opening Balance	195	337
Add Receipts		
- Patient Deposits	355	435
	550	772
Less Payments		
- Patient Withdrawals	405	555
- Interest / Charges	0	22
Closing Balance	145	195

		2001/02 $	2000/01 $
Note 3	**Patient support costs**		
	Medical supplies and services	32,715	35,058
	Domestic charges	7,504	17,365
	Fuel, light and power	56,778	70,636
	Food supplies	19,089	23,875
	Purchase of external services	21,744	11,197
		137,830	158,131
Note 4	**Depreciation expense**		
	Buildings	64,748	48,784
	Computer equipment and software	3,950	5,720
	Furniture and fittings	5,857	7,539
	Motor vehicles	5,957	9,537
	Other plant and equipment	12,205	12,126
		92,717	83,706
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	2,800	0
	Gross proceeds from sale of non-current assets	2,800	0
b)	**Profit / (Loss) on disposal of non-current assets:**		
	Computer equipment and software	0	(2,376)
	Furniture and fittings	0	(16,154)
	Other plant and equipment	52	(18,935)
		52	(37,465)
Note 6	**Capital user charge**		
		157,295	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**		
	Workers compensation insurance	23,679	20,356
	Other employee expenses	9,431	12,315
	Motor vehicle expenses	22,525	18,470
	Communications	13,459	32,482
	Printing and stationery	8,309	8,815
	Audit fees - external	7,000	10,710
	Other	22,448	45,029
		106,851	148,177
Note 8	**Patient charges**		
	Inpatient charges	3,596	18,973
	Outpatient charges	3,266	6,021
		6,862	24,994
Note 9	**Commonwealth grants and contributions**		

Dundas Health Service did not receive any Commonwealth grants or contributions.

Note 10	**Donations revenue**		
	General public contributions	1,850	0

	2001/02 $	2000/01 $
Note 11 Other revenues from ordinary activities		
Recoveries	24,738	29,252
Use of hospital facilities	466	1,916
Other	4,733	4,609
	29,937	35,777
Note 12 Government appropriations		
Output appropriations (I)	1,760,755	1,336,132
Capital appropriations (II)	0	698,557
	1,760,755	2,034,689

(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	0	66,929
Note 14 Resources received free of charge		

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

Office of the Auditor General		
- Audit services	7,000	6,250
Note 15 Cash assets		
Cash on hand	325	325
Cash at bank - general	39,275	1,877
Cash at bank - donations	4,913	4,565
	44,513	6,767
Note 16 Receivables		
Patient fee debtors	374	2,501
GST receivable	3,656	6,735
Other receivables	1,354	212
	5,384	9,448
Note 17 Amounts receivable for outputs		
Non-current	86,800	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	8,708	7,479
Pharmaceutical stores - at cost	4,580	5,375
	13,288	12,854

Note 19 Property, plant and equipment	2001/02 $	2000/01 $
Land		
At valuation - 30 June 2000 (iii)	21,000	21,000
Buildings		
Clinical:		
At cost (i)	1,140,620	0
Accumulated depreciation	(17,016)	0
	1,123,604	0
At valuation - 30 June 2000 (iii)	4,326,821	4,326,821
Accumulated depreciation	(2,786,547)	(2,738,815)
	1,540,274	1,588,006
Computer equipment and software		
At cost	38,102	38,102
Accumulated depreciation	(28,890)	(24,940)
	9,212	13,162
Furniture and fittings		
At cost	92,618	92,618
Accumulated depreciation	(41,685)	(35,828)
	50,933	56,790
Motor vehicles		
At cost	52,000	52,000
Accumulated depreciation	(42,073)	(36,116)
	9,927	15,884
Other plant and equipment		
At cost	205,225	205,356
Accumulated depreciation	(117,771)	(110,762)
	87,454	94,594
Total of property, plant and equipment	2,842,404	1,789,436

Land and buildings

(i) Land, clinical buildings and non-clinical buildings that are yet to revalued are carried at their cost of acquisition.

(ii) Land, clinical buildings and non-clinical buildings have been subject to a recent revaluation and are carried at their fair value.

(iii) Land, clinical buildings and non-clinical buildings are yet to be revalued at fair value.

Payments for non-current assets

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

Paid as cash by the Health Service from output appropriations	7,813	29,028
Paid by the Department of Health	1,140,620	6,821
Gross payments for purchases of non-current assets	1,148,433	35,849

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	21,000
Buildings	
Carrying amount at start of year	1,588,006
Additions	1,140,620
Depreciation	(64,748)
Carrying amount at end of year	2,663,878

Note 19 Property, plant and equipment - reconciliations continued	2001/02 $
Computer equipment and software	
Carrying amount at start of year	13,162
Depreciation	(3,950)
Carrying amount at end of year	9,212
Furniture and fittings	
Carrying amount at start of year	56,790
Depreciation	(5,857)
Carrying amount at end of year	50,933
Motor vehicles	
Carrying amount at start of year	15,884
Depreciation	(5,957)
Carrying amount at end of year	9,927
Other plant and equipment	
Carrying amount at start of year	94,594
Additions	5,065
Depreciation	(12,205)
Carrying amount at end of year	87,454

Note 20 Interest-bearing liabilities

Dundas Health Service has no interest bearing liabilites.

Note 21 Lease liabilities

Dundas Health Service has no lease liabilities

Note 22 Accrued salaries	2001/02 $	2000/01 $
Amounts owing for:	53,748	15,562
Nursing staff		
7 days from 23 June to 30 June 2002		
(2001: 6 days from 24 June to 30 June 2001)		
Non-nursing staff		
7 days from 23 June to 30 June 2002		
(2001: 6 days from 24 June to 30 June 2001)		

Note 23 Provisions

Current liabilities:		
Annual leave	85,682	103,538
Long service leave	17,670	19,318
Superannuation	1,557	0
	104,909	122,856
Non-current liabilities:		
Long service leave	24,563	22,652
Total employee entitlements	129,472	145,508

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 24 Contributed equity

Balance at beginning of the year	0	0
Capital contributions (i)	472,840	0
Balance at end of the year	472,840	0

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

Note 25 Accumulated surplus / (deficiency)	2001/02 $	2000/01 $
Balance at beginning of the year	2,258,406	1,783,493
Change in net assets	47,053	474,913
Balance at end of the year	2,305,459	2,258,406

Note 26 Notes to the statement of cash flows

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)	44,513	6,767

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)	(1,473,901)	(1,395,523)
Increase / (decrease) in assets:		
GST receivable	(3,079)	6,735
Other receivables	(985)	(1,333)
Inventories	434	2,505
Prepayments	371	138
Decrease / (increase) in liabilities:		
Doubtful debts provision	0	90
Payables	60,697	(70,043)
Accrued salaries	(38,186)	(2,456)
Provisions	16,036	21,283
Non-cash items:		
Depreciation expense	(92,717)	(83,706)
Profit / (loss) from disposal of non-current assets	52	(37,465)
Capital user charge paid by Department of Health	(157,295)	0
Superannuation liabilities assumed by the Treasurer	0	(66,929)
Resources received free of charge	(7,000)	(6,250)
Other	(25,129)	(1)
Net cost of services (Statement of Financial Performance)	(1,720,702)	(1,632,955)

c) **Notional cash flows**

Output appropriations as per Statement of Financial Performance	1,760,755	1,336,132
Capital appropriations as per Statement of Financial Performance	0	698,557
Capital appropriations credited directly to Contributed Equity	472,840	0
	2,233,595	2,034,689
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Capital user charge	(157,295)	0
Other non cash adjustments to output appropriations	(559,640)	(698,557)
	(716,935)	(698,557)
Output appropriations as per Statement of Cash Flows	1,516,660	1,336,132

Note 27 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	0	871

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
$40,001 - $50,000	1	1
$50,001 - $60,000	0	0
$60,001 - $70,000	1	0
$70,001 - $80,000	0	0
$80,001 - $90,000	0	1
Total	2	2

	$	$
The total remuneration of senior officers is:	113,012	137,451

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).

	$	$
Senior officers other than members of the Accountable Authority	8,921	8,182
	8,921	8,182

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%.

	2001/02 $	2000/01 $	Variation $
Expenditure			
Fees for visiting medical practitioners	21,575	42,320	(20,745)
Patient transport costs	69,368	58,697	10,671
Repairs, maintenance, consumable equipment expense	79,902	50,969	28,933
Net loss on disposal of non current assets	0	37,465	(37,465)
Other expenses from ordinary activities	106,851	148,177	(41,326)

Fees to visiting medical officers decreased due to no permanent medical practitioner resulting in low activity.

Patient Transport increased due to higher usage of patients travel scheme.

Repairs and maintenance increased due to payment for electrical upgrade in Hospital

Nett loss on disposal of assets decreased due no significant write offs for financial year

Other expenses decreased due to installation of ISDN line for modems, decrease in advertising due to permanent staff

Revenue			
Patient charges	6,862	24,994	(18,132)
Donations revenue	1,850	0	1,850

Patient charges decreased due to no nursing home type patients

Donations received for this financial year

Note 29 Explanatory statement - continued

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

	2001/02 Actual $	2001/02 Estimate $	Variation $
Visiting medical practitioners	21,575	40,000	(18,425)
Repairs maintenance, consumable equipment expense	79,902	30,000	49,902
Other expenses from ordinary activities	106,851	148,000	(41,149)

Visiting medical practitioners estimation higher due to no permanent officer

Repairs and maintenance estimation lower due to unforseen payment of electrical upgrade

Other expenses estimation higher due to decrease in advertising and installation of ISDN line

Note 30 Commitments for Expenditure

Dundas Health Service has no commitments for expenditure.

Note 31 Contingent liabilities

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

Note 32 Events occurring after reporting date

The Dundas Health Service ceased to exist as a legal entity as at 1 July 2002. The health service was 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

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

Note 34 Affiliated bodies

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	Fixed interest rate maturities: 1 to 5 years $000	Fixed interest rate maturities: Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.0%	43	0	0	0	2	45
Receivables	0.0%	0	0	0	0	5	5
		43	0	0	0	7	50
Financial Liabilities							
Payables	0.0%	0	0	0	0	31	31
Net financial assets / (liabilities)		43	0	0	0	(24)	19
As at 30th June 2001							
Financial Assets							
Cash assets	0.0%	5	0	0	0	2	7
Receivables		0	0	0	0	9	9
		5	0	0	0	11	16
Financial Liabilities							
Payables	0.0%	0	0	0	0	92	92
Net financial assets / (liabilities)		5	0	0	0	(81)	(76)

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	65	64	960	987	0	0	1,025	1,051
Fees for visiting medical practitioners	0	0	22	42	0	0	22	42
Superannuation expense	5	6	63	61	0	0	68	67
Patient support costs	0	2	138	156	0	0	138	158
Patient transport costs	0	0	69	59	0	0	69	59
Repairs, maintenance and consumable equipment expense	0	6	80	45	0	0	80	51
Depreciation expense	1	1	92	83	0	0	93	84
Net loss on disposal of non-current assets	0	0	0	37	0	0	0	37
Capital user charge	0	0	157	0	0	0	157	0
Other expenses from ordinary activities	1	1	107	147	0	0	108	148
Total cost of services	72	80	1,688	1,617	0	0	1,760	1,697
Revenues from Ordinary Activities								
Patient charges	0	0	7	25	0	0	7	25
Donations revenue	0	0	2	0	0	0	2	0
Interest revenue	0	0	0	4	0	0	0	4
Other revenues from ordinary activities	0	0	30	36	0	0	30	36
Total revenues from ordinary activities	0	0	39	65	0	0	39	65
NET COST OF SERVICES	**72**	**80**	**1,649**	**1,552**	**0**	**0**	**1,721**	**1,632**
Revenues from Government								
Output appropriations	75	74	1,686	1,263	0	0	1,761	1,337
Capital appropriations	0	0	0	699	0	0	0	699
Liabilities assumed by the Treasurer	0	6	0	61	0	0	0	67
Resources received free of charge	0	0	7	6	0	0	7	6
Total revenues from government	75	80	1,693	2,029	0	0	1,768	2,109
Change in net assets	**3**	**0**	**44**	**477**	**0**	**0**	**47**	**477**

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).