Merredin 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 Merredin 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

Merredin Health Service
cnr Kitchener Rd and South Ave
MERREDIN WA 6415

PO Box 241
MERREDIN WA 6415

☎ *(08) 9041 1411*
(08) 9041 2282
www.wheatbeltwa.com/ewhs

Mission Statement

Our Mission
To develop and provide a high standard of accessible and relevant health care services to facilitate the maintenance and progressive improvement in the health status of the community.

Broad Objectives

The objectives of the Merredin Health Service are:

- To provide inpatient, outpatient, residential and continuing care services to the Merredin community.
- To provide a range of medical, surgical, diagnostic, nursing and allied health professionals to deliver services consistent with the Health Service's role and function and the community's expectations, within the resources available.
- To develop and maintain an appropriate physical environment to support the patient care services.
- To promote the ongoing development of employees.
- To monitor and review the quality, appropriateness, effectiveness and efficiency of the services provided in accordance with current health industry standards.

Enabling Legislation

The Merredin 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 Merredin 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 Merredin 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 Merredin 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:

- The development of human resource management policies and procedures to support all Public Sector Standards relating to Human Resource Management which are available via the Eastern Wheatbelt Health Service intranet site.
- The provision of *Code of Conduct* and *Code of Ethics* training for employees of the Health Service.
- Compliance testing is undertaken by the EWHS Human Resource Manager using the self-assessment guidelines provided by the Office of the Public Sector Standards Commissioner. However, due to resource constraints this did not occur during 2001/2002. A formal review of the EWHS by the Public Sector Standards Commission was last undertaken in 1998/99.

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

Kim Darby
ACTING REGIONAL DIRECTOR
WHEATBELT REGION
December 2002

Advertising and Sponsorship — Electoral Act 1907

The following table lists the expenditure on advertising and sponsorship made by the Merredin 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	6,927.00	1,329.00	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$6,927.00**	**$1,329.00**	**$0.00**

Freedom of Information Act 1992

The Merredin Health Service received and dealt with two 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:

Health Service Manager
Merredin Health Service
PO Box 241
MERREDIN WA 6415

☎ *(08) 9041 1411*

Merredin Health Service

Key Operations and Achievements

- All key acute program services other than obstetric services were maintained.
- There continues to be an increasing demand for permanent residential care services.
- Allied health services were maintained.
- Improvements are being made to employee accommodation to assist in recruitment of new staff.
- Fire safety services within the Merredin Health Service were upgraded.
- The air-conditioning plant upgrade was completed.
- The Merredin Health Service Board was disbanded.

Key Acute Program Services Maintained

The acute inpatient bed average increased from 6.22 in 2000/2001 to 7.80 in 2001/2002. All key acute program services, other than obstetric services, were maintained by the Merredin Health Service for the 2001/2002 period including 24-hour emergency services, medical and elective surgical services, paediatric services and visiting specialist operating and consulting services. The Health Service was unable to provide obstetric services from January 2002 due to the non-availability of local medical obstetric services.

Increasing Demand for Permanent Residential Care

The level of residential and respite care services provided increased significantly in 2001/2002 to a bed average of 8.65. There continues to be an increasing demand for permanent residential care services which cannot be fully met within the available residential care accommodation options, resulting in a growing number of people being accommodated in acute hospital beds until nursing home beds become available.

Allied Health Services Maintained

Allied health services were maintained throughout the 2001/2002 period in the areas of physiotherapy, medical imaging, including weekly ultrasonography services and speech pathology.

Employee Accommodation Improvements

The progressive development of two two-bedroom units which are due to be completed by the end of July 2002, will assist to expand the employee accommodation options available. The provision of a high standard of employee accommodation has been identified for many years as a key requirement for the recruitment and retention of clinical employees including multi-skilled nursing staff and allied health professionals.

Fire Safety Services

The fire safety services within the Merredin Health Service were upgraded during 2001/2002.

Air Conditioning Plant Upgrade

The final stage of the Merredin Health Service air-conditioning plant upgrade was completed in 2001/2002.

Merredin Health Service Board Disbanded
As at 30 June 2002, the Accountable Authority for the 2001/2002 period, the Merredin Health Service Board, in conjunction with other rural health service boards, was disbanded. From 1 July 2002 the Western Australian Country Health Service was implemented. Within the WA County Health Service model the Merredin Health Service has been incorporated into the Wheatbelt administrative region which is one of six new regions created to coordinate rural health service delivery, in addition to the existing South West Health Service. At the time of reporting the Wheatbelt region is managed by the Acting Regional Director, Kim Darby, who reports directly to the Executive Director of WA Country Health Services.

Major Capital Projects

Projects Completed during the Year

PROJECT DESCRIPTION	Actual Total Cost	Estimated Total Cost
Air Conditioning Upgrade — Stage 3	$139,558.00	$139,558.00

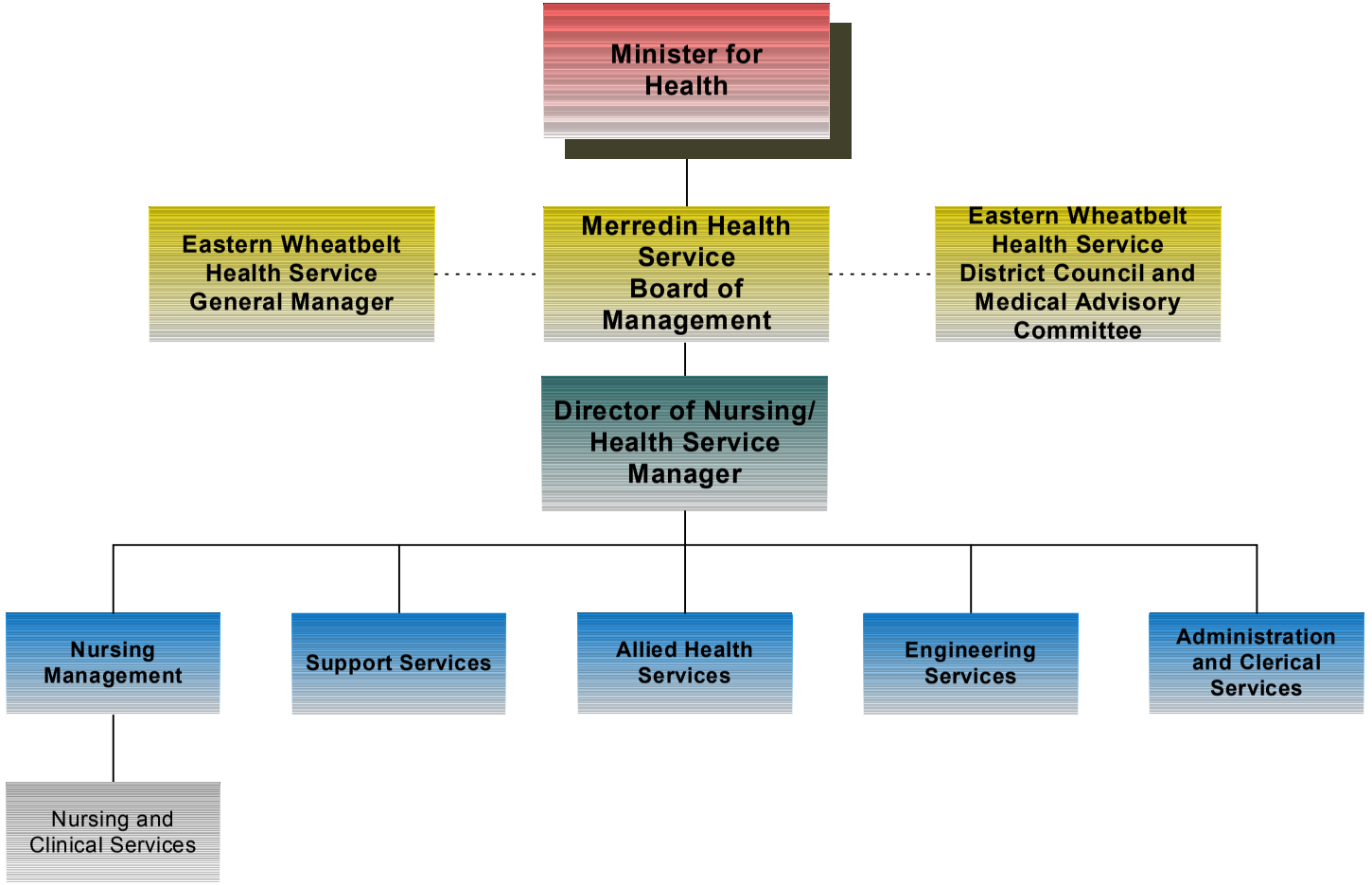
The Air Conditioning Upgrade project — Stage 3 was completed in accordance with the 2000/2001 estimated cost.

Projects in Progress

PROJECT DESCRIPTION	Expected Year of Completion	Estimated Cost to Complete	Estimated Total Cost
Employee Accommodation	**2002/2003**	$162,351.00	$306,050.00

Management Structure

Organisational Chart



Accountable Authority

The Merredin 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
Kevin Tengvall	Chairperson	31 December2002
Colin Chapman	Acting Deputy Chairperson	31 December 2002
Russell Crook Board	Member	30 September 2003
Michael Dorizzi	Member	31 December 2002
George Hayden	Member	31 December 2002
Margret Krone	Member	30 September 2003
Francis Marley	Member	30 September 2003
Lesley Snell	Member	31 December 2002

The Finance Committee was an appointed subcommittee of the Merredin Health Service Board. Appointment to this position occurred via nomination by members of the Merredin Health Service Board.

Finance Committee Members:
Colin Chapman
Russell Crook
Mike Dorizzi
Margret Krone
Kevin Tengvall

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

Senior Officers

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

Area of Responsibility	Title	Name	Basis of Appointment
Health Service Management	Director of Nursing/Health Service Manager	Elisabeth Gotts	Permanent
Nursing	Director of Nursing/Health Service Manager	Elisabeth Gotts	Permanent

For the 2001/2002 period, the Director of Nursing/Health Service Manager was nominated by the Merredin Health Service Board as the Principal Accounting Officer for the Merredin District Hospital.

Pecuniary Interests

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

Demography

The Merredin Health Service delivers services to communities covered by the following local authorities:

- Merredin Shire
- Nungarin Shire
- Westonia Shire

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

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Merredin Shire	3738	3734	3699
Nungarin Shire	287	276	312
Westonia Shire	308	251	320

*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*.

Merredin is predominantly a rural economy, with some light manufacturing industry based locally which primarily serves the needs of the farming and mining industries.

Merredin's strategic location on the Great Eastern Highway and as the largest town between Northam and Kalgoorlie ensures it is a suitable district base for some government departments. Merredin also serves as a centre for many retail and commercial services for both local and outlying towns and districts.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Inpatient Palliative Care Services
Nursing Home Type Care Services
Paediatric
Respite Care Services
Visiting Specialist General Surgery including consulting and surgical services
Visiting Specialist Gynaecological including consulting and surgical services
Visiting Specialist Orthopaedics including consulting and surgical services

Medical Support Services
Medical Imaging
Physiotherapy — contracted out
Speech Pathology
Ultrasonography — contracted out

Community Services
Community Catering and Meals on Wheels
Community Linen and Laundering
Home Aids and Equipment Loan

Other Support Services
Health Promotion
Home Modifications
Medical Records
Patient Support Services

Disability Services

Our Policy
The Merredin 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.

- Existing health service facilities incorporate the essential requirements to ensure they meet the needs of people with disabilities. The customer evaluation process for the range of services provided requests comment on the accessibility of services for people with disabilities. The Merredin Health Service will continue to encourage specific community liaison and input into identifying gaps in services and disability service issues.

Outcome 2: Access to buildings and facilities is improved.

- There has been no specific facility development or redevelopment during the 2001/2002 period. However, all planning for remodelling and future development of the Merredin Health Service facilities will incorporate appropriate standards to ensure that people with disabilities are able to access all services.

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

- Where appropriate, brochures and information sheets have been developed with black printing on a white background to enhance readability. Brochures advising of the type and range of services available through the Merredin Health Service and how these services can be accessed, are distributed throughout the Health Service and at medical centres.

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

- All staff are informed of and understand the needs of people with disabilities and apply that knowledge when delivering advice and services. The Disability Service Commission video *Getting There* is made available to all employees to increase employee awareness of disability service issues. Selection criteria for all positions include the requirement for the applicants and employees to be aware of disability service issues that may affect users of their service.

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

- The Client Evaluation survey form is used to seek specific feedback from patients on all areas of the Merredin Health Service and a complaint mechanism which requires formal review and reporting of all complaints is in place. In recent years any major redevelopment projects such as the Nursing Home and Respite Care wing have incorporated input from a range of community groups including those representing people with disabilities.

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 Merredin 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 recognises there are a significant number of people in the Western Australian community whose level of English may be a barrier to accessing appropriate health services or communicating effectively with health service providers.
- The Health Service is committed to using strategies to inform eligible clients of services and their entitlements and how they can obtain them. Health Service employees are aware of the process to access a range of qualified service providers to assist clients where language is a barrier to providing an acceptable level of service including translating and interpreting services, interpreting services for Indigenous languages and Auslan.
- Wherever possible multilingual information brochures are also made available on a range of health issues and these are distributed throughout the Health Service.

Youth Services

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

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

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

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

- The Health Service works on an ongoing basis with other government and non-government agencies to provide the most effective health services for young people within their local community. These health services may take the form of education on general health and wellbeing, treatment of injury and disease, identification of those young people at risk due to engaging in high-risk behaviours and the implementation of education strategies to minimise risk and self-harm.
- The Merredin Health Service participates actively in providing positive work experience opportunities in a range of health-related employment options including administration and business, clinical specialties including nursing, physiotherapy, medical imaging and speech therapy, support services areas including catering, cleaning, laundering and facility maintenance.
- The Health Service works to improve the health and wellbeing of young people by the provision of accessible health services.

Employee Profile

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

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	18.1	18.9	17.6
Administration and Clerical*	5.2	5.8	6.7
Medical Support*	1.3	2.2	2.9
Hotel Services*	13.8	15.5	16.0
Maintenance	1.0	1.0	1.0
Medical (salaried)	–	–	–
Other	–	–	–
TOTAL	**39.4**	**43.4**	**44.2**

*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 Merredin Health Service acknowledges that the employees of the Health Service are its greatest resource and that they are the most significant factor in dictating the effectiveness, efficiency and the quality of all services provided by the Health Service.

Despite a significant increase in inpatient activity, nursing service FTEs decreased by 1.3 in the 2001/2002 year due to the limited availability of permanent and agency nursing staff. The restricted availability of both permanent and locum nursing staff resulted in a reduction in the allocation of nursing management and professional development hours to enable clinical requirements to be met as a first priority.

Administrative service FTEs increased by 0.9 due to the additional administration workload associated with the introduction and maintenance of the Health Care and Related Information Systems Supply module and the general increase in administrative reporting requirements.

Medical support FTEs increased by 0.7 during 2001/2002 as result of the recruitment of allied health therapy assistants to assist with the provision of paediatric speech pathology services and therapy activities for residential care clients.

Support service FTEs increased by 0.5 FTE due to the additional patient support services required to maintain the increased patient activity levels and the ten-bed nursing home and respite care wing.

Recruitment Practices

All 2001/2002 recruitment activities were undertaken in accordance with the Public Sector Standards in Human Resources Management.

The Merredin Health Service continues to find it extremely difficult to fill specialised clinical nursing positions on a permanent or longer-term contract basis, in common with the majority of isolated or remote small rural hospitals not on the coastal strip. This affects positions which require experienced nurses with emergency, midwifery or peri-operative nursing skills.

Recruitment strategies, including the use of recruitment agencies and overseas sponsorship agreements, have met with limited success in the 2001/2002 period. Recruitment agencies have indicated there is now only a very small number of overseas-based nurses interested in rural sponsorship arrangements due to the availability of these arrangements in metropolitan and larger regional centres.

In order to maintain service provision in line with the delineated role of the Merredin Health Service, agency and short-term nursing staff have been employed when available throughout the period. The inability to recruit a range of multi-skilled nursing staff will continue to impact adversely on the Merredin Health Service's ability to provide or expand some procedural services including obstetrics and peri-operative services.

The total cost of employing agency nurses during the 2001/2002 period is estimated at $346,500, compared with $448,000 in the 2000/2001 period. The reduction in agency costs has been brought about by two key factors — the reduced availability of agency staff, due to the number of health services now competing for these services, and the implementation of the Eastern Wheatbelt Health Service Graduate Nurse Program.

Staff Development

Staff training and development play a key role in Merredin Health Service's commitment to provide high quality health care. Every opportunity is taken to ensure employees receive a high level of orientation, education and training in functions they are likely to perform.

An estimated $18,600 was expended on staff training for the 2001/2002 period which is approximately 0.9 per cent of the total salaries and wages expenditure and 0.5 per cent of the total expenditure for the period. This figure is reduced from previous years due to the reduced number of permanent clinical employees because of the difficulties in recruiting permanent nursing staff.

Industrial Relations Issues

No major industrial disputes occurred during 2001/2002 and this is consistent with past trends. All efforts are made to ensure employees are kept informed of any pending change that would impact on their work lives and staff participation in decision making is actively sought and encouraged and generally achieved.

Workers' Compensation and Rehabilitation

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

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

*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.

Prevention and Rehabilitation

Merredin Health Service continues to develop its Occupational Safety and Health systems in order to provide a safe and healthy working environment for all patients, visitors and employees.

A key focus of the Merredin Health Service District Hospital Occupational Safety and Health committee is the instigation and development of appropriate occupational health and safety guidelines and the education of employees in relation to safe practice in the workplace.

An extensive rehabilitation program was developed and further progressed in conjunction with a rehabilitation provider for a specific employee during the 2001/2002 period, but this met with very limited success.

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 Merredin 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 people, according to the *Equal Opportunity Act 1984*. This goal is achieved through activities and programs run on behalf of the following outcomes:

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

- The Health Service recognises its responsibilities under the *Equal Employment Opportunity Act 1984* and is committed to a policy of equal opportunity and diversity in the workplace. During the 2001/2002 period, training related to the Health Service's *Code of Conduct* and the Public Sector *Code of Ethics* was again provided for employees. The organisation has four employees who undertake the role of EEO contact officer and have received training in this area. There have been no reported cases of racial or sexual harassment during the 2001/2002 period.

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

- The Health Service promotes a workplace that is free from employment practices that are biased or discriminate unlawfully against employees or potential employees. The Merredin Health Service policies and management processes incorporate EEO standards. All recruitment and retention processes are based on Western Australian government Public Sector Standards. There have been no reported breaches of the relevant Public Sector Standards during the 2001/2002 period.

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

- Women continue to comprise the great majority of the Health Service workforce and undertake a range of employment within the workplace including financial and human resources management, supervisory, clinical, administrative and patient support roles. The number of Aboriginal or Torres Strait Islander employees, employees from a non-English speaking background and employees with disabilities is unable to be determined as employees are not required to provide this information.

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 Merredin Health Service has been able to meet these goals:

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

Marketing

Community awareness of the Merredin Health Service was achieved through the following activities in the 2001/2002 period:

- Representation by Merredin Health Service Board members and employees on a range of local and wider community groups including the Health Forum group, the Eastern Wheatbelt Health Service District Council, Merredin Hospital Auxiliary and the Merredin Local Emergency Management Advisory Committee.

- The development and distribution of newsletters and brochures on the range of services provided by the Merredin Health Service and how these services can be accessed.

- Consumer complaints or suggestions are considered in a positive manner and approached as an opportunity to assess and facilitate the improvement and development of services and care, in line with contemporary health standards.

Publications

The Merredin Health Service has developed a range of brochures and these are distributed widely within the Merredin District Hospital and relevant district localities. These brochures include information on the range of services provided and how these services can be accessed. These include the Customer Charter, Strategic Plan, Compliments and Complaints Feedback, Freedom of Information — Information Statement, Inpatient Services, Emergency Department Services and Surgical Services.

Copies of these brochures may be obtained by contacting:

Health Service Manager
Merredin District Hospital
PO Box 241
MERREDIN WA 6415

☎ *(08) 9041 1411*

Research and Development

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

Evaluations

The Merredin Health Service acknowledges the requirement of the Circular to Ministers No. 37/94, which identifies the Western Australian Government strategy for the ongoing review of public sector programs.

In 2001/2002 the Merredin Health Service business operations were audited by an external agency contracted by the Department of Health to determine compliance with government standards and reporting for accountable authorities. Additionally the Office of the Auditor General contracted services to review the Merredin Health Service Financial Statements and Key Performance Indicator reports to Government from the previous financial year.

In December 2001 the Merredin Health Service's four-year accreditation status with the Australian Council on HealthCare Standards lapsed due to a lack of human and financial resources to maintain the formal evaluation process.

Internal Audit Program

Purpose
To determine compliance with established policies, procedures and legislation, reliability and integrity of information, adequacy of control over the safeguarding of assets, the accomplishment of specified goals and objectives and that reported information is provided in the correct format.

Main Outcomes
Quality Management Control was rated as 'satisfactory.' Trends in Quality of Management Control were rated as 'better'. Overall Risk Exposure was rated as 'low'.

Action Taken or Proposed
Address issues identified for further review.

Risk Management

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

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

- The Merredin Health Service actively participated in the review and development of the Eastern Wheatbelt Health Service Risk Management Plan and policies.
- An action plan has been developed to progress the implementation of identified strategies to assist with risk minimisation throughout the district.

Internal Audit Controls

The Merredin 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.

Waste Paper Recycling

Due to Merredin Health Service's location in a relatively remote rural community 260 kilometres from Perth, it continues to be uneconomical to transport used paper and other products to a Perth contractor for recycling. Merredin Health Service does not produce enough waste paper or other products suitable for recycling to make it feasible or viable to pay the transport costs involved in transferring waste to Perth for recycling.

Where possible and practical the hospital uses recycled products and recycles appropriate paper products for 'in-house' use. The Health Service also uses shredded waste paper for garden composting purposes.

Pricing Policy

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

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

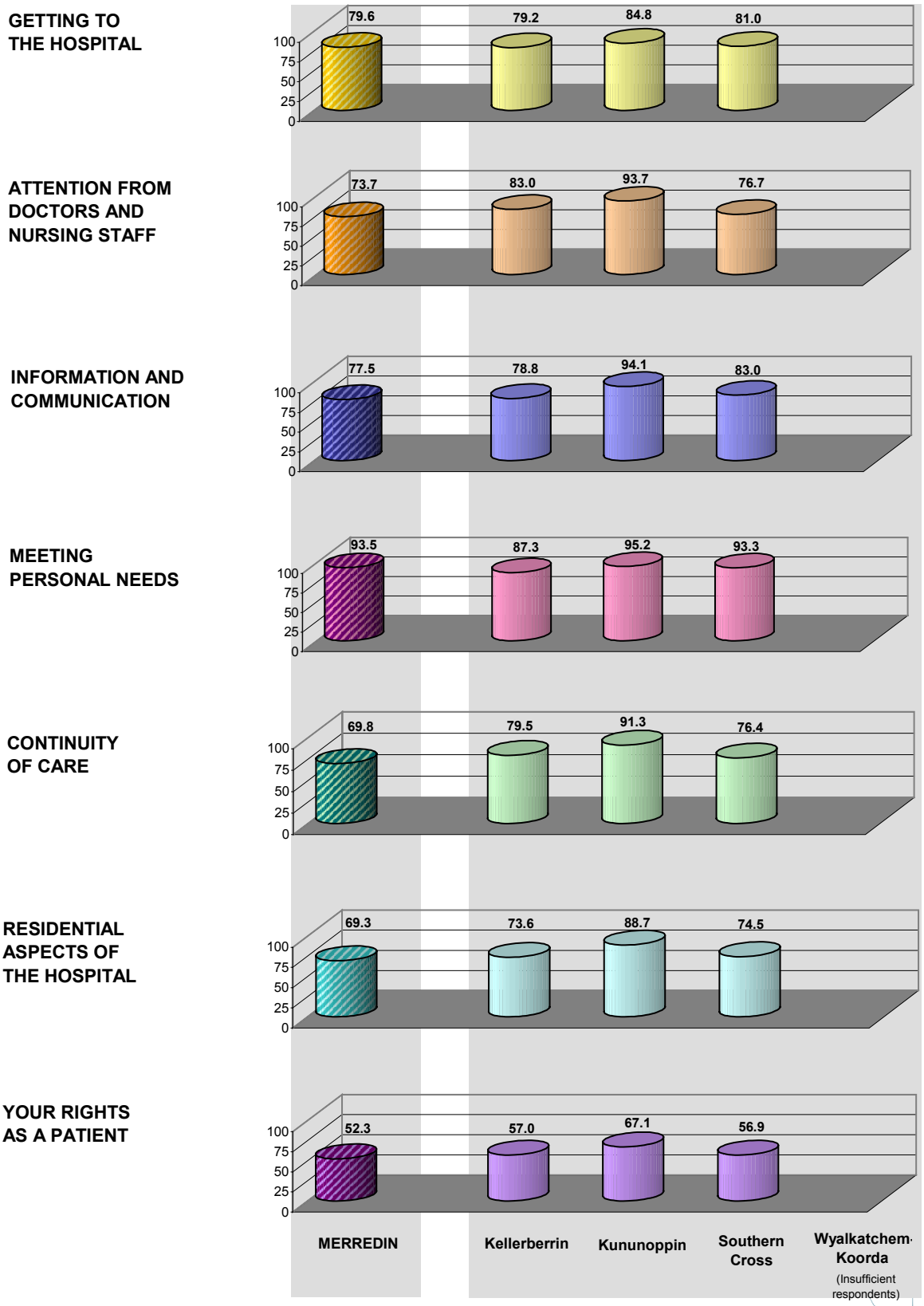
No fees are raised against registered public and private outpatients of the hospital.

Client Satisfaction Surveys

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

Each year a number of client groups are selected to answer questions about their experiences within the health system. The survey process is managed by the Department of Health with questionnaires being posted to patients during a specified survey period. Details of the responses to individual questions are shown below and audited aggregate results of these surveys are shown in the Key Performance Indicator section (page 43) of this report.

KPI 2.2: EMERGENCY PATIENTS — RURAL



AUDITOR GENERAL

To the Parliament of Western Australia

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

Scope

I have audited the key effectiveness and efficiency performance indicators of the Merredin 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 Merredin 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 Merredin 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 21, 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

MERREDIN 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 Merredin Health Service for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Merredin 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.

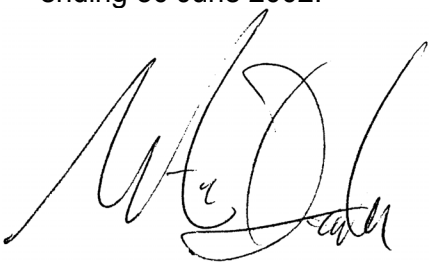
It is anticipated that the opinions will be issued by March 31, 2003.

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

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



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

Table of Contents

Background

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

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

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

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

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

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

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

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

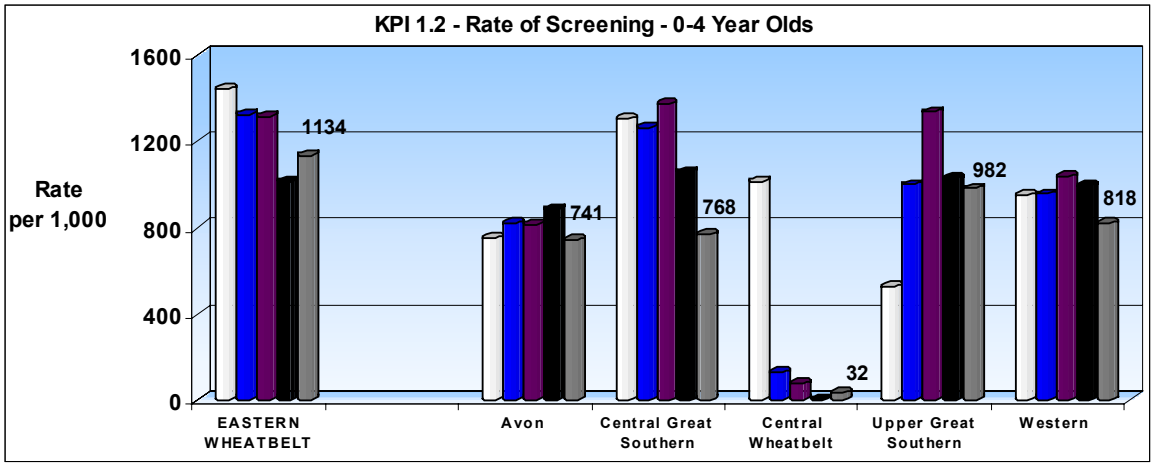
RATE OF SCREENING IN CHILDREN	KPI 1.2

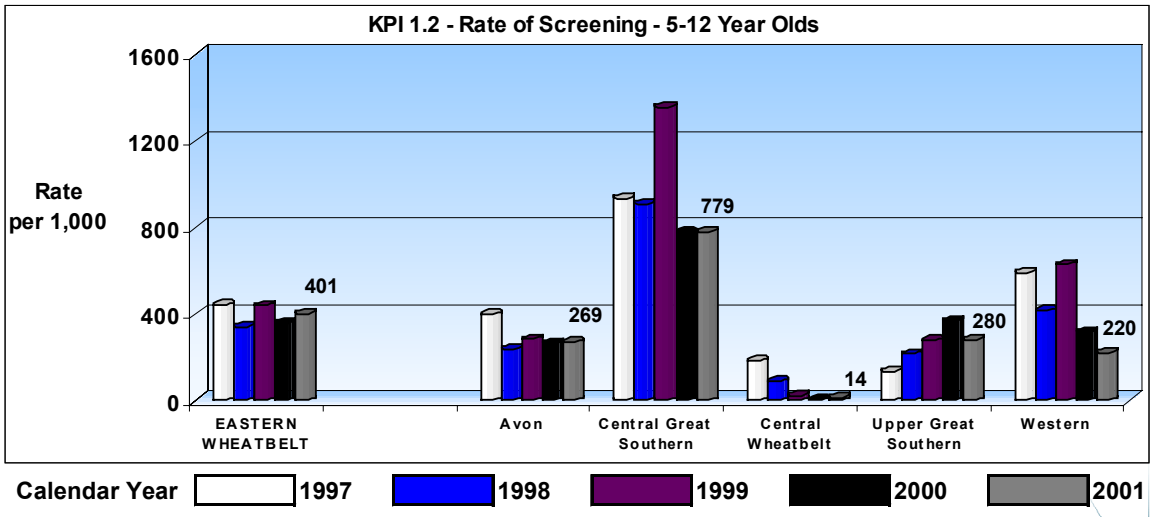
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

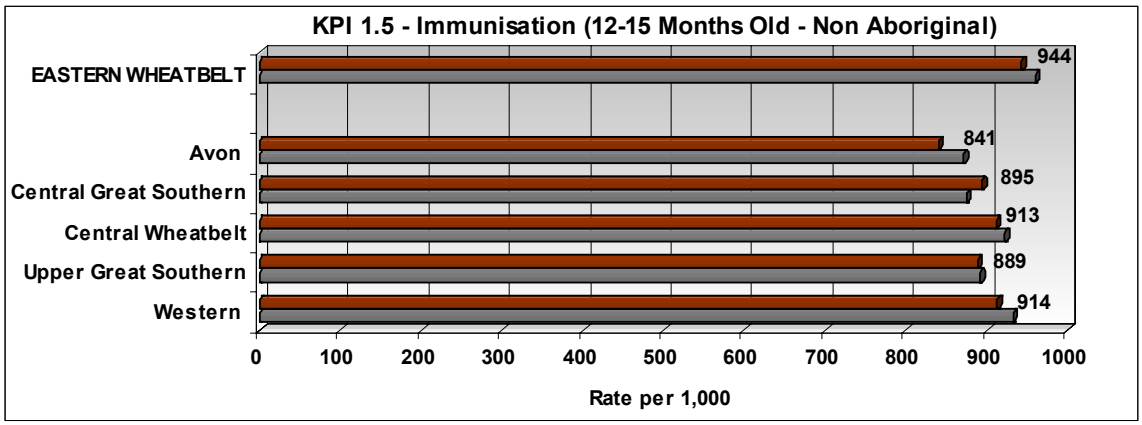
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

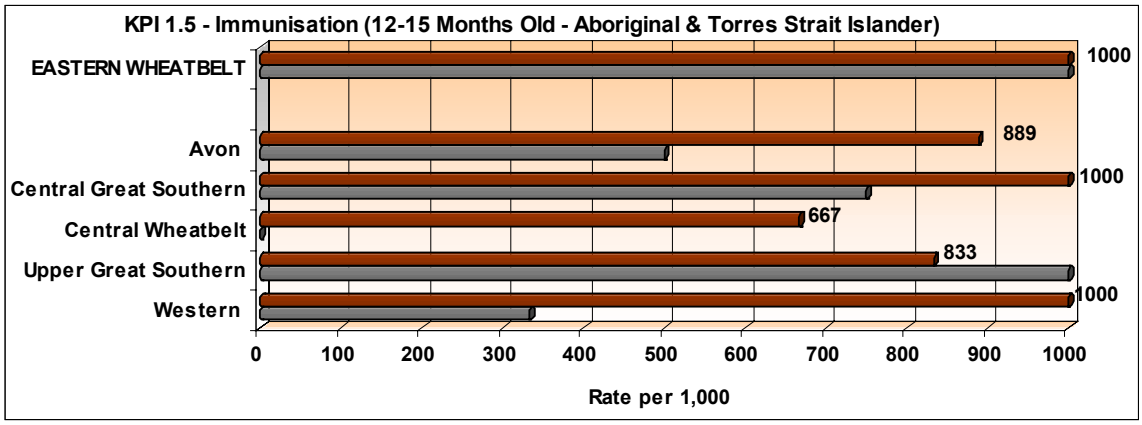
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

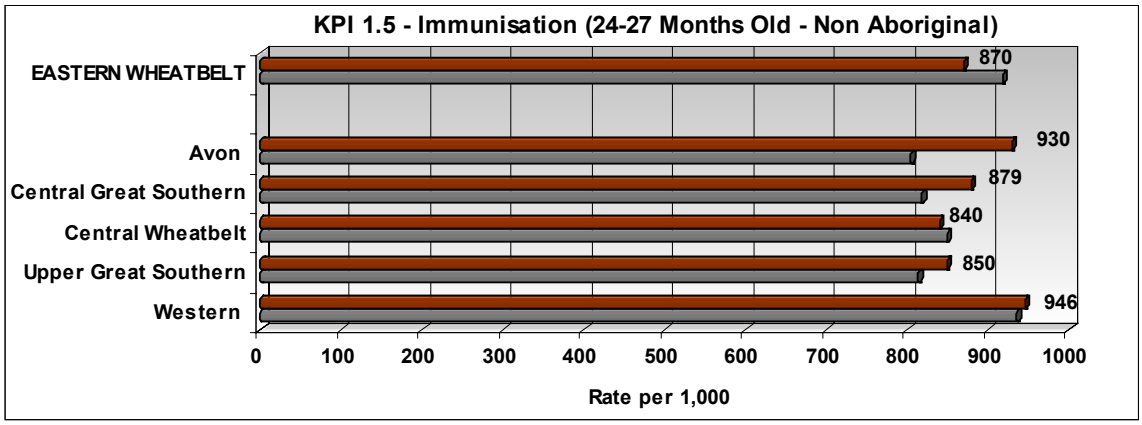
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

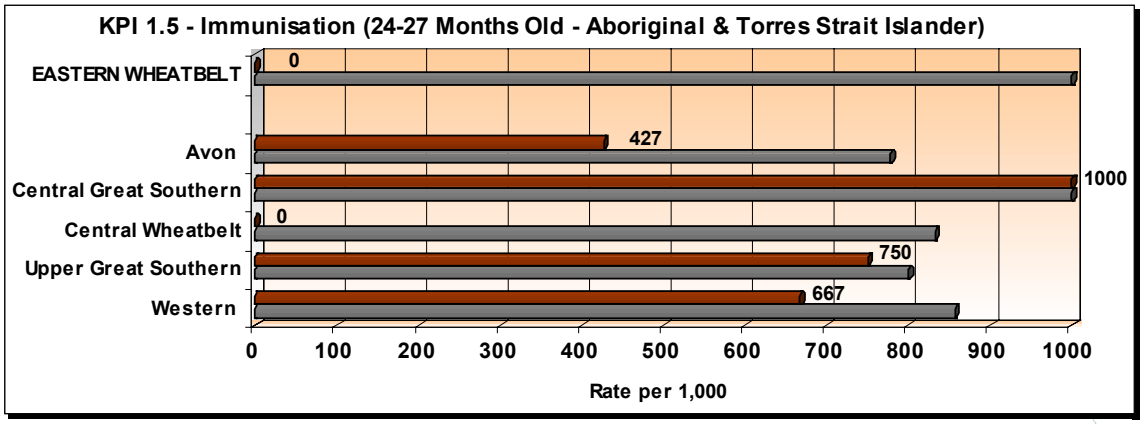
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the 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.

There were no Aboriginal or Torres Strait Islander children in the 24 to 27 month age group cohort reported for the collection period of March 2002.


KPI 1.5 - Immunisation (12-15 Months Old - Non Aboriginal)
EASTERN WHEATBELT
Avon
Central Great Southern
Central Wheatbelt
Upper Great Southern
Western
944
841
895
913
889
914
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000


KPI 1.5 - Immunisation (12-15 Months Old - Aboriginal & Torres Strait Islander)
EASTERN WHEATBELT
Avon
Central Great Southern
Central Wheatbelt
Upper Great Southern
Western
1000
889
1000
667
833
1000
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000


KPI 1.5 - Immunisation (24-27 Months Old - Non Aboriginal)
EASTERN WHEATBELT
Avon
Central Great Southern
Central Wheatbelt
Upper Great Southern
Western
870
930
879
840
850
946
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000


KPI 1.5 - Immunisation (24-27 Months Old - Aboriginal & Torres Strait Islander)
EASTERN WHEATBELT
Avon
Central Great Southern
Central Wheatbelt
Upper Great Southern
Western
0
427
1000
0
750
667
0
100
200
300
400
500
600
700
800
900
1000
Rate per 1,000

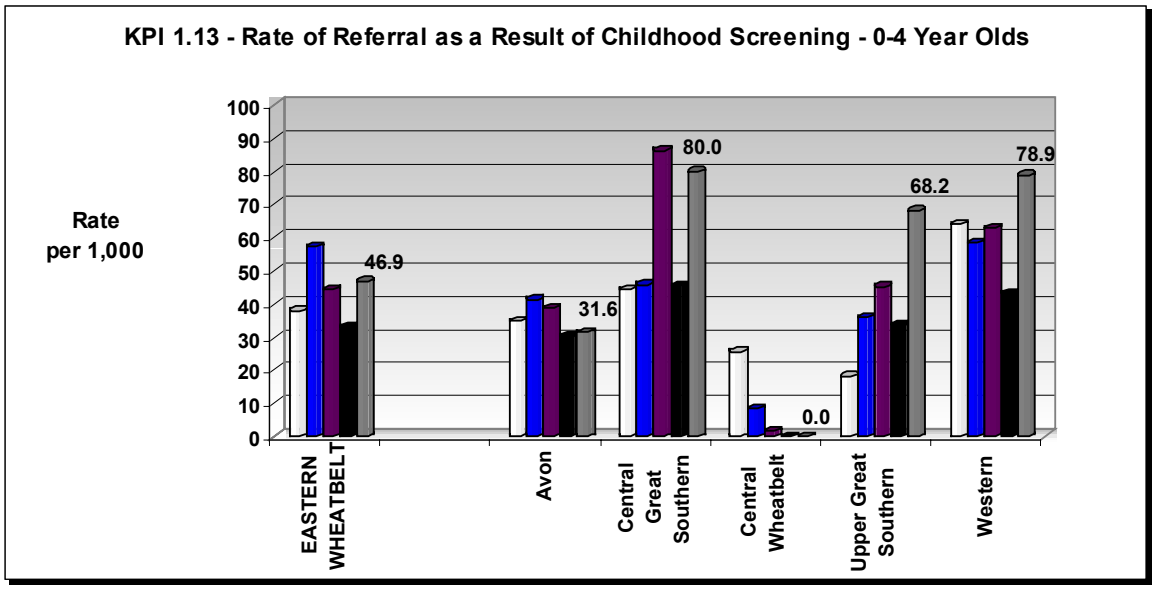

Calendar Year
2001
2002

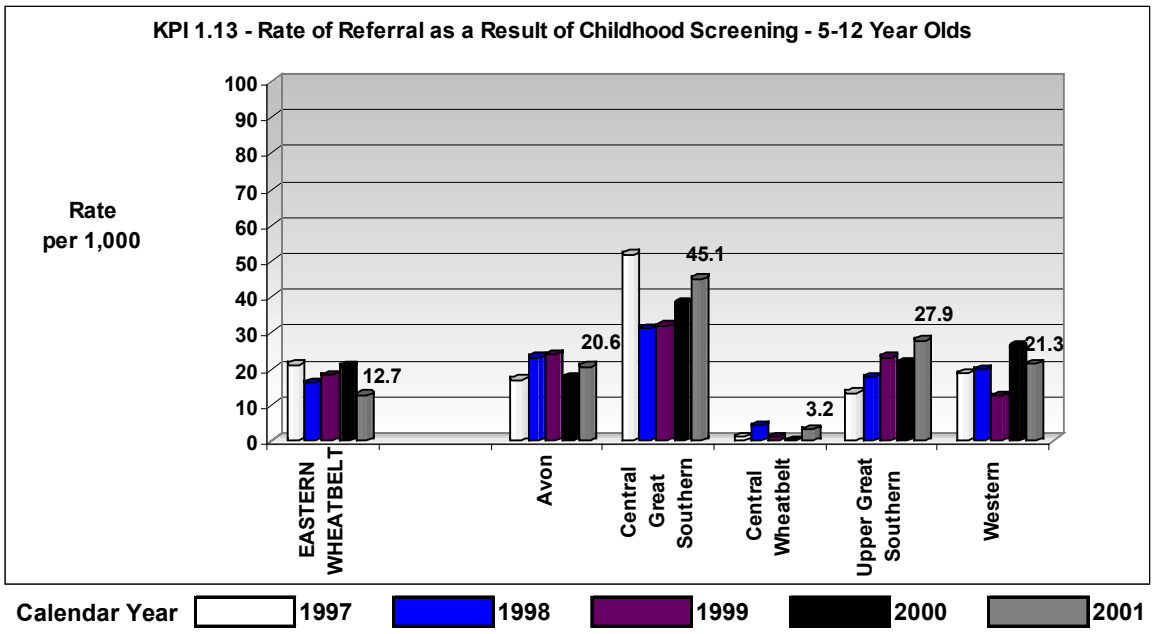
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

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.





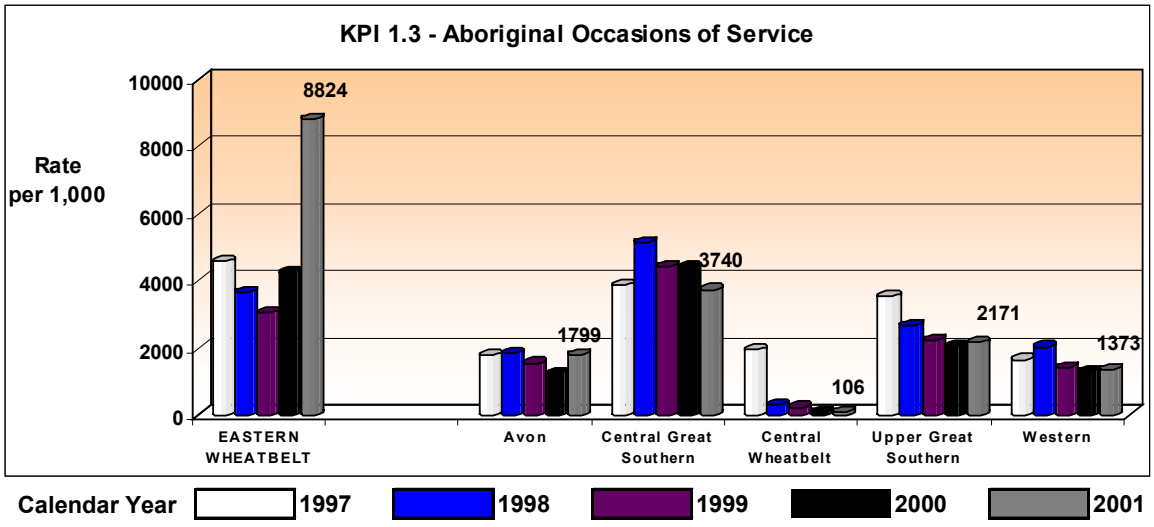
RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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.

Note: There is no Aboriginal Health Service but one Aboriginal health worker is employed on a part-time basis within the community health service.



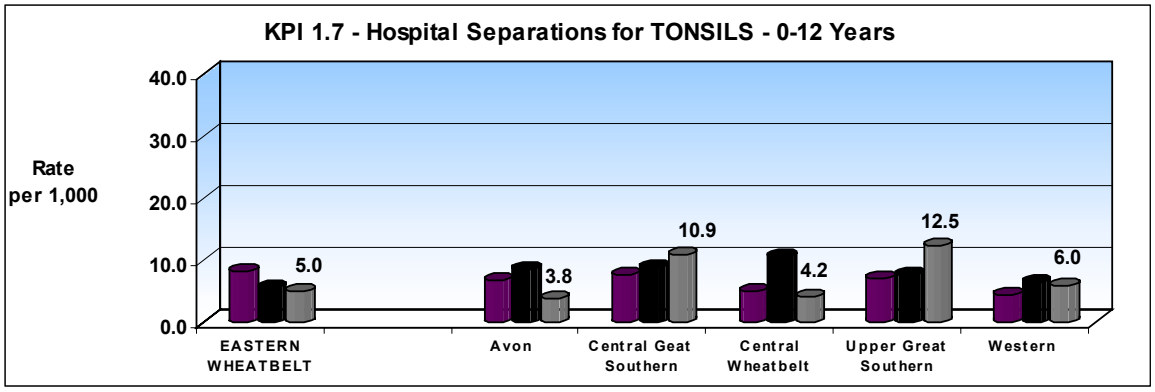
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

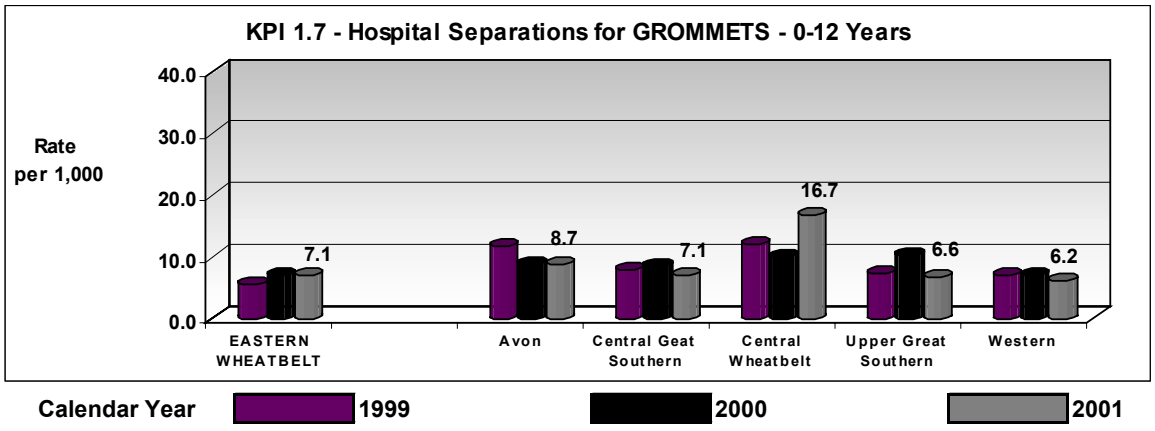
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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

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

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





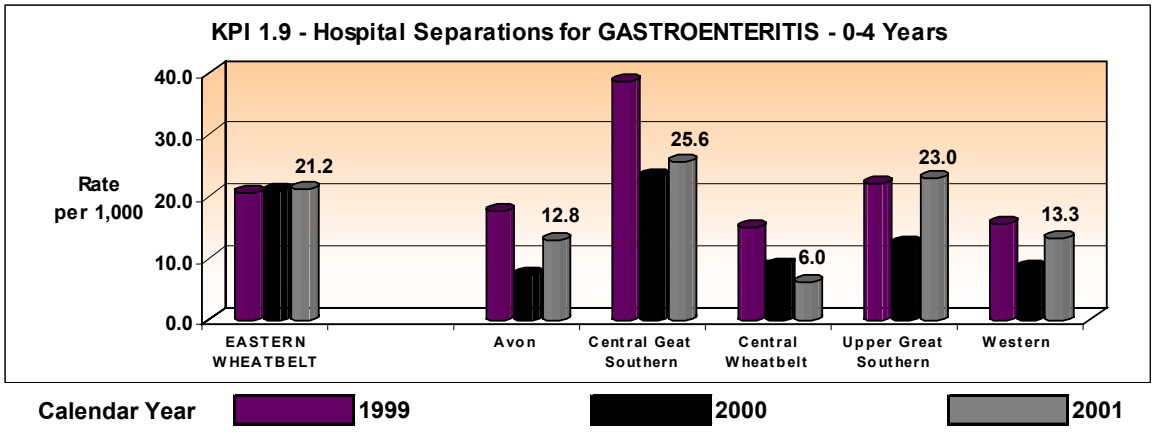
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

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

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

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



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS — KPI 1.10

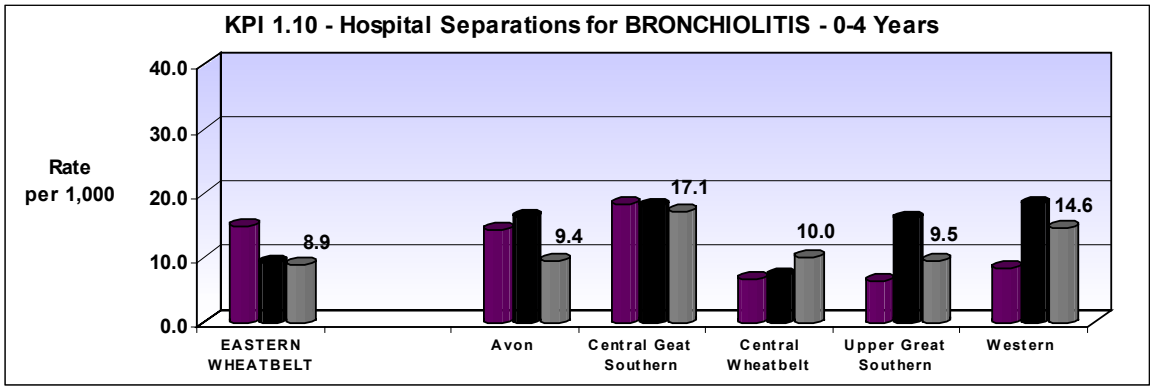
Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute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

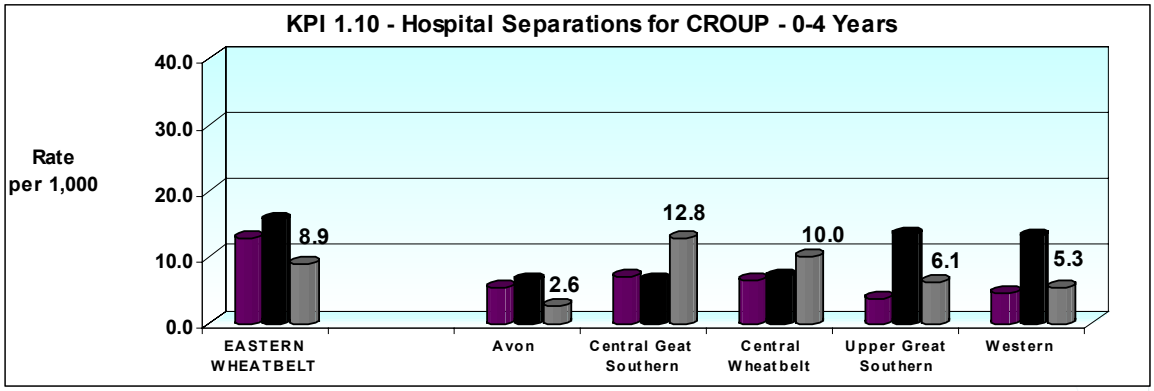
Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

Bronchiolitis
The graph shows individuals aged 0-4. Of those 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 2 per thousand. Of those aged 13-18, none were hospitalised this year.

Acute Bronchitis
Only 2 individuals aged 0-4 at a rate of 2.2 per thousand were hospitalised this year, with 3 individuals being admitted aged 5-12 at a rate of 2 per thousand and no individuals aged 13-18 years being admitted.





Calendar Year 1999 2000 2001

HOSPITAL ADMISSIONS FOR ASTHMA	KPI 3.7

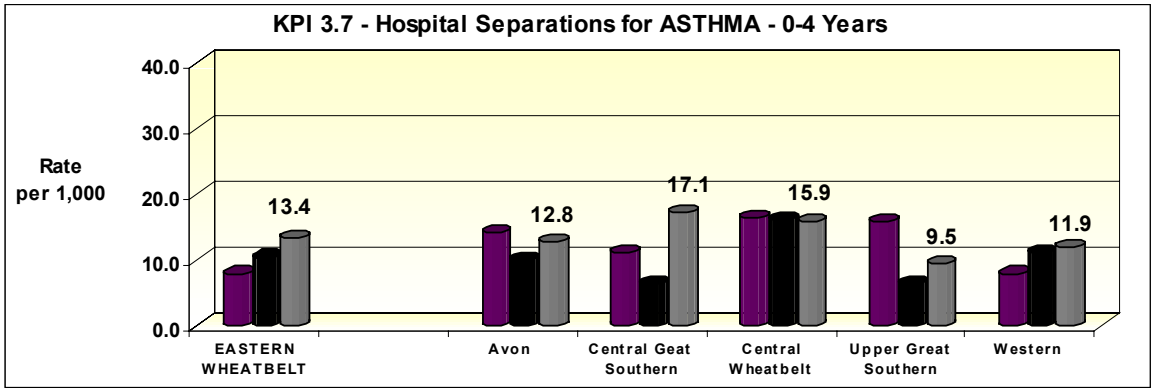
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

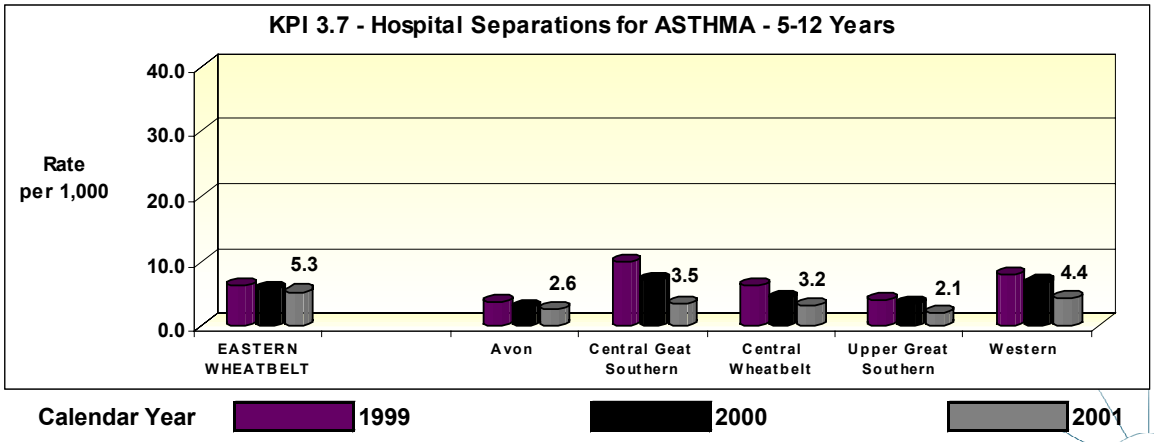
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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

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

The graphs show individuals aged 0-4 and 5-12. 7 individuals aged 13-18 at a rate of 9.2 per thousand were hospitalised this year, with 8 individuals being admitted aged 19-34 at a rate of 3.3 per thousand and 20 individuals aged 35 years and over at a rate of 3.5 per thousand.





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.

HEALTH SERVICE	COST PER OCCASION OF COMMUNITY HEALTH SERVICE
Eastern Wheatbelt Health Service	$24.94

NOTE:

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

CLIENT SATISFACTION	KPI 2.2

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

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

The Merredin District Hospital reports on overall patient satisfaction score of 74 for emergency patients with a standard error of 3.4 on a confidence interval of 95%. The estimated population of individuals surveyed was 2640 emergency department patients.

The table below shows the response rate by patient type.

SURVEY QUESTIONNAIRES			
PATIENT TYPE	**NUMBER SENT**	**NUMBER RETURNED**	**RESPONSE RATE**
Emergency Patients	57	22	39%

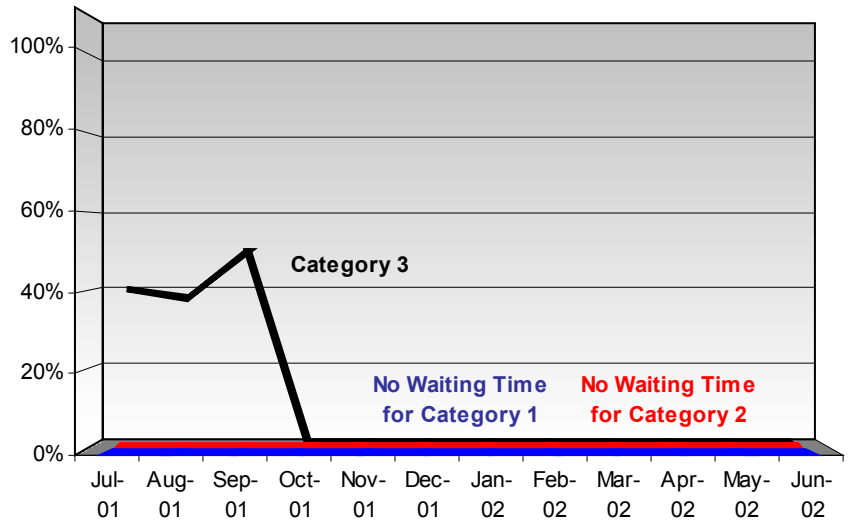
ELECTIVE SURGERY WAITING TIMES FOR PUBLIC PATIENTS — KPI 2.14

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

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

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

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



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.

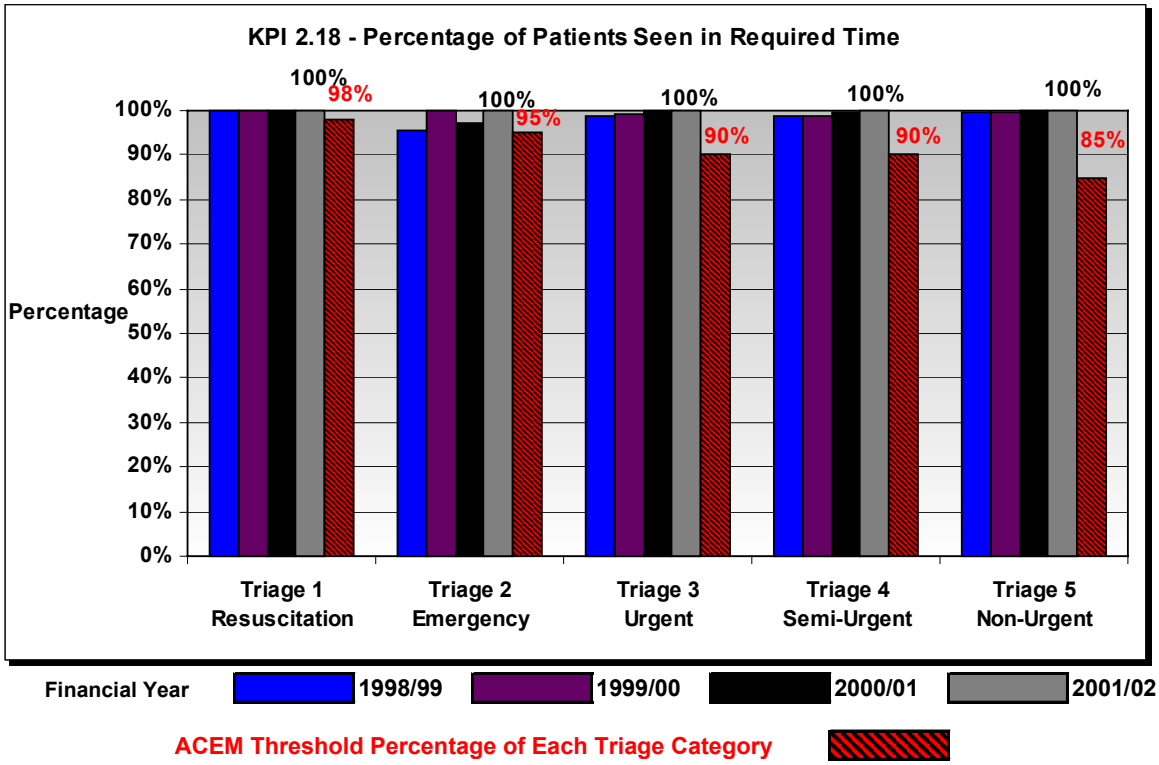
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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's.

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%

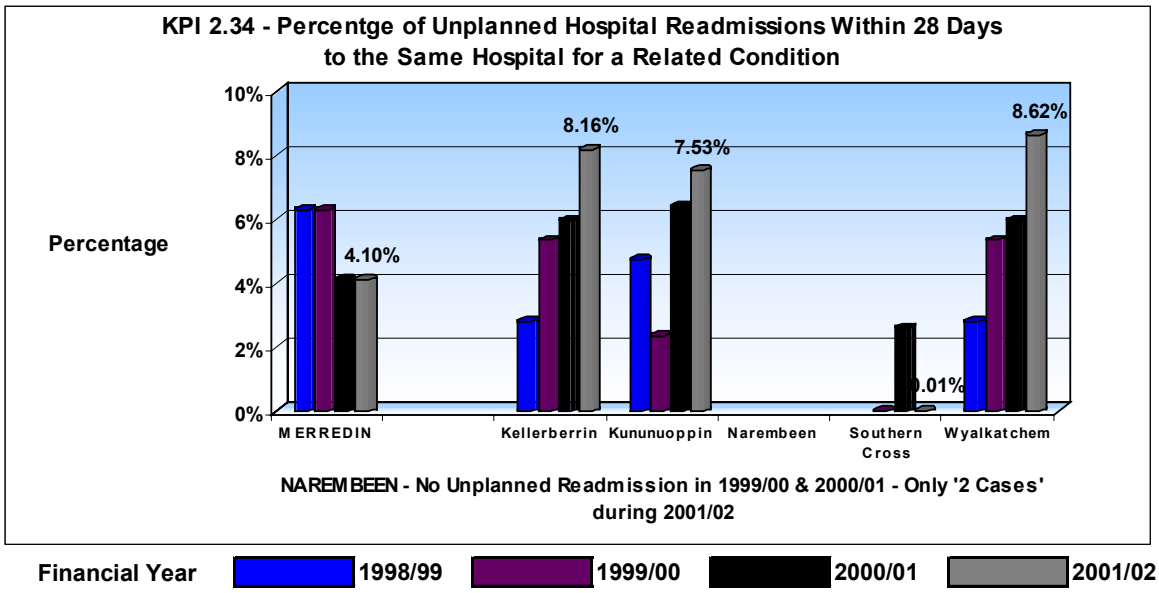

KPI 2.18 - Percentage of Patients Seen in Required Time
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
98%
100%
95%
100%
90%
100%
90%
100%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Non-Urgent
Financial Year
1998/99
1999/00
2000/01
2001/02
ACEM Threshold Percentage 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.

2001/02 data is from a three-month time period only. All previous data is from a twelve month time period.

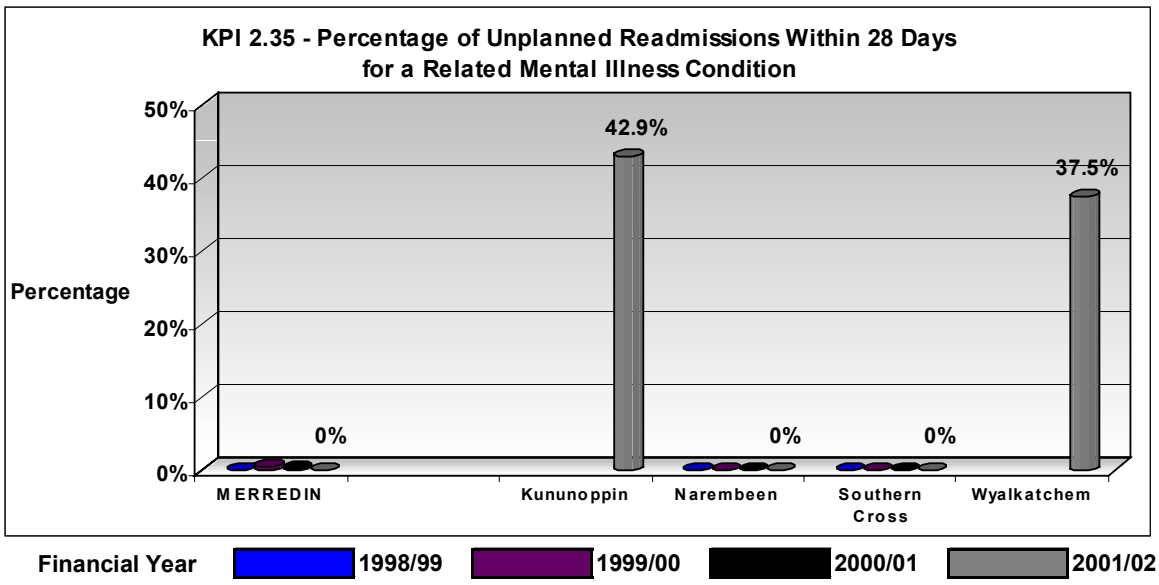


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

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.

Merredin District Hospital had no unplanned hospital readmissions within 28 days for treatment and care for a related mental health illness this financial year.

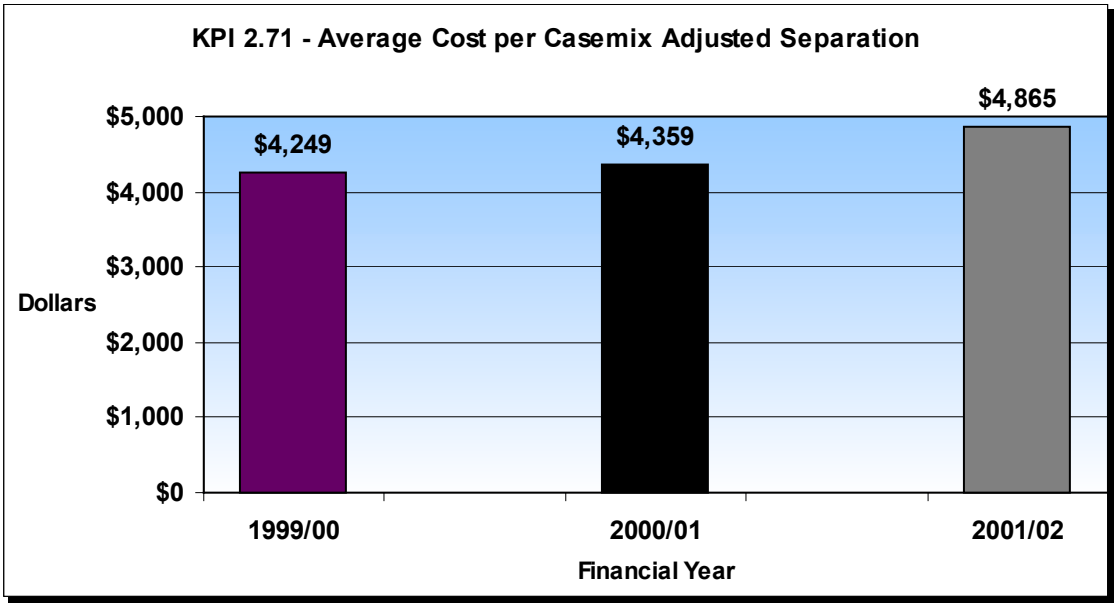


AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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.

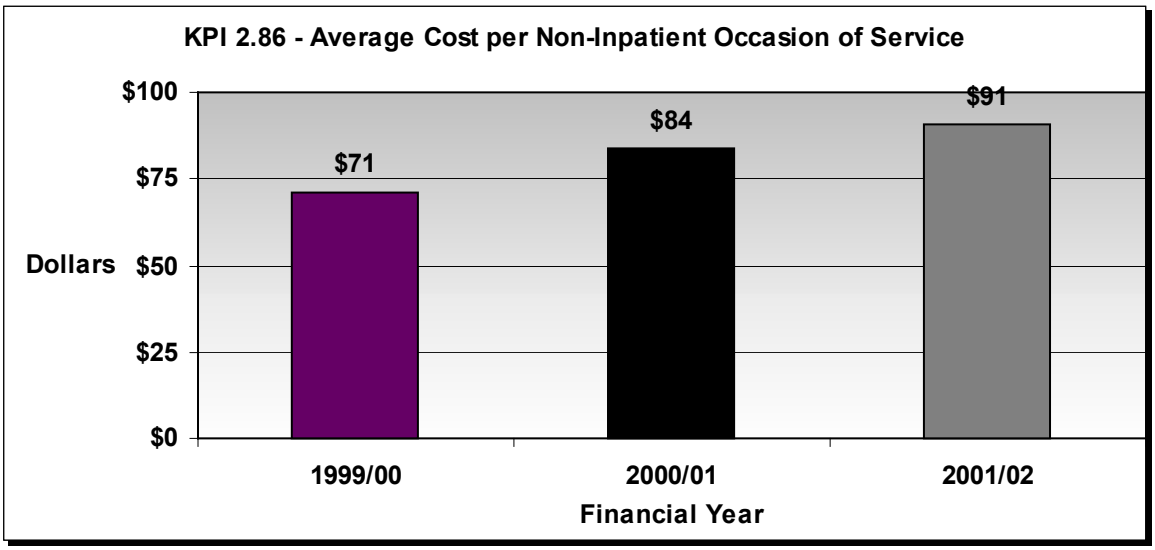


AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.



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 GROUPS ADMITTED AS A NURSING HOME TYPE PATIENT AVERAGE COST PER NURSING HOME TYPE PATIENT BED DAY	KPI 3.5 KPI 3.10

Number of Individuals Admitted as a Nursing Home Type Patient

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

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

This indicator measures the extent to which people within the targeted age groups are admitted as a Nursing Home Type Patient. The number of individuals within the targeted age group, i.e. 70 years and over for non Aboriginal patients and 50-69 years for Aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Nursing Home Type care in the Health Service.

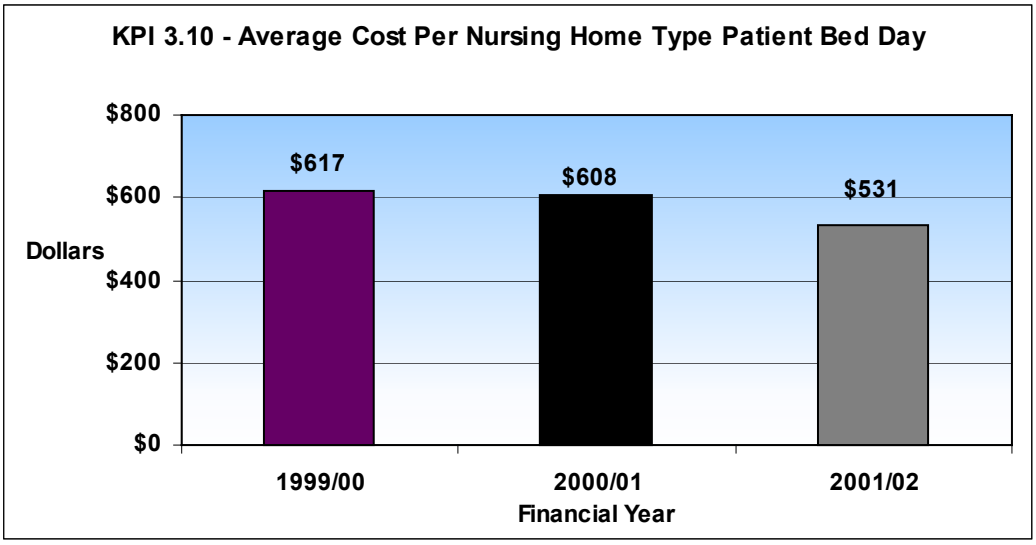
There were 41 Nursing Home Type Patient admissions for nine individuals aged over 70 years during 2001/2002 with a bed day average of 8.7. There were no Aboriginal patients aged between 50-69 admitted as Nursing Home Type Patients.

Average Cost per Nursing Home Type Patient Bed Day

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

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

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

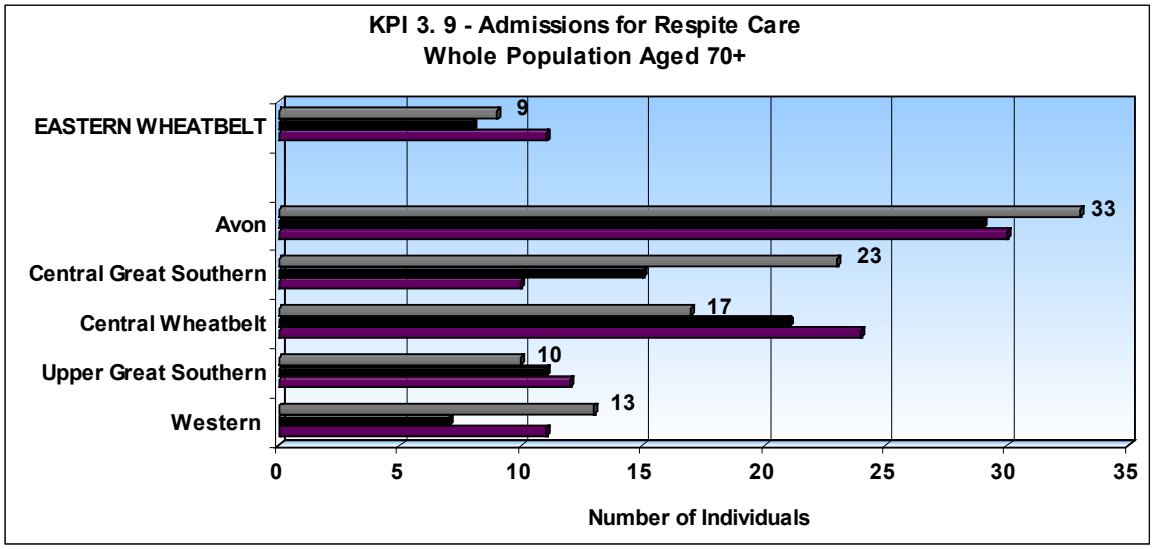


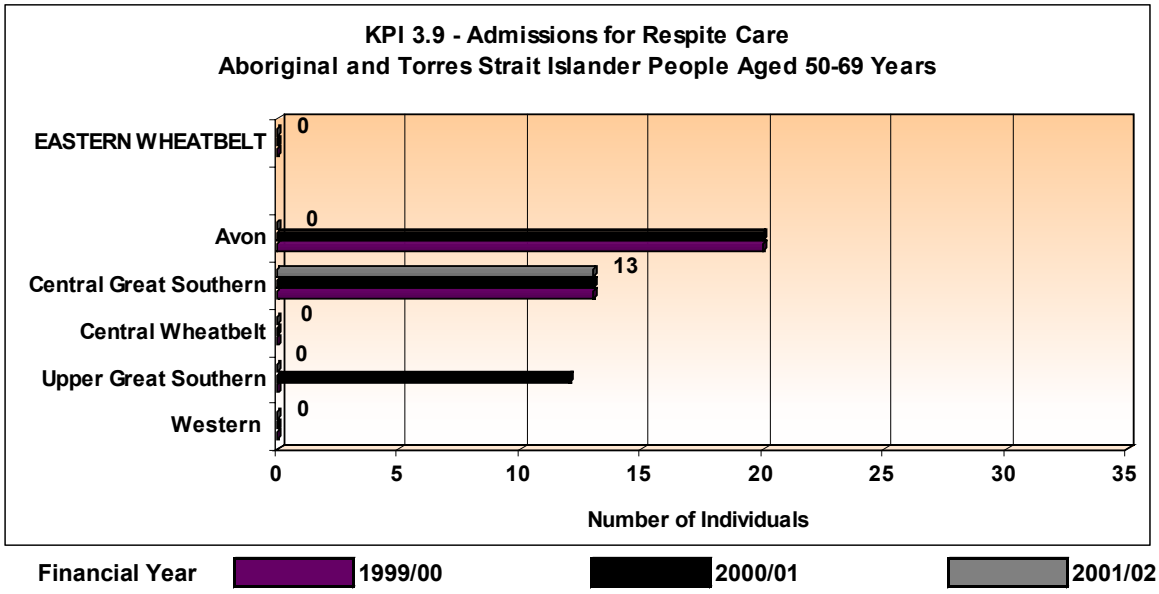
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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

The number of individuals within the targeted age group, ie. 70 years and over for non aboriginal patients and 50-69 years for aboriginal patients, is measured against the total population in the catchment area. This shows the proportion of the eligible population that receives Respite Care in the Health Service.

The catchment area for this KPI is the Eastern Wheatbelt. There were no Aboriginal or Torres Strait Islander people within the targeted age group admitted for respite care this year.





AUDITOR GENERAL

To the Parliament of Western Australia

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

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

The Board is 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

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

Audit Opinion
In my opinion,

(i) the controls exercised by the Merredin 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.

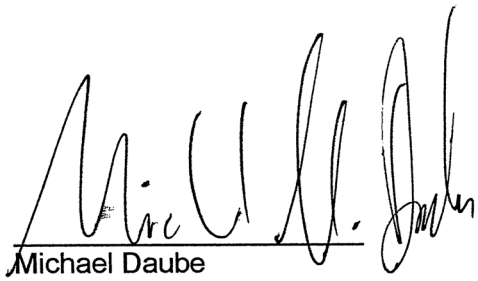
D D R PEARSON
AUDITOR GENERAL
March 21, 2003

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

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

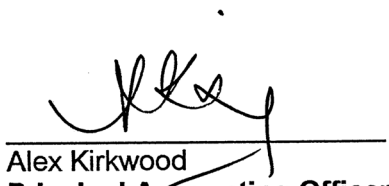
The accompanying financial statements of the Merredin Health Service have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002 and the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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Merredin 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		2,110,396	2,035,926
Fees for visiting medical practitioners		181,770	299,549
Superannuation expense		135,660	121,801
Patient support costs	3	509,891	510,766
Patient transport costs		109,300	94,049
Borrowing costs expense		49,533	58,205
Repairs, maintenance and consumable equipment expense		186,068	232,071
Depreciation expense	4	184,244	181,317
Net loss on disposal of non-current assets	5	13,815	3,783
Asset revaluation decrement	23	210,059	0
Capital user charge	6	271,723	0
Other expenses from ordinary activities	7	243,768	444,098
Total cost of services		4,206,227	3,981,565
Revenues from Ordinary Activities			
Patient charges	8	252,983	160,242
Donations revenue	9	100	2,650
Interest revenue		21	83
Other revenues from ordinary activities	10	130,998	116,128
Total revenues from ordinary activities		384,102	279,103
NET COST OF SERVICES		**3,822,125**	**3,702,462**
Revenues from Government			
Output appropriations	11	3,727,066	3,127,392
Capital appropriations	11	0	543,914
Liabilities assumed by the Treasurer	12	0	114,625
Resources received free of charge	13	10,000	33,750
Total revenues from government		3,737,066	3,819,681
Change in net assets		**(85,059)**	**117,219**
Net increase / (decrease) in asset revaluation reserve	23	2,900	0
Total revenues, expenses and valuation adjustments recognised directly in equity		2,900	0
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(82,159)**	**117,219**

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

Statement of Financial Position
As at 30th June 2002

	Note	2001/02 $	2000/01 $
CURRENT ASSETS			
Cash assets	14	123,782	15,835
Receivables	15	90,041	66,267
Inventories	17	58,191	43,988
Prepayments		1,066	1,609
Total current assets		273,080	127,699
NON-CURRENT ASSETS			
Amounts receivable for outputs	16	185,400	0
Property, plant and equipment	18	4,597,523	4,656,308
Total non-current assets		4,782,923	4,656,308
Total assets		**5,056,003**	**4,784,007**
CURRENT LIABILITIES			
Payables		86,970	185,965
Interest-bearing liabilities	19	34,903	33,048
Accrued salaries	20	78,259	29,122
Provisions	21	319,581	278,405
Total current liabilities		519,713	526,540
NON-CURRENT LIABILITIES			
Interest-bearing liabilities	19	846,408	882,398
Provisions	21	85,916	94,884
Total non-current liabilities		932,324	977,282
Total liabilities		**1,452,037**	**1,503,822**
Net Assets		**3,603,966**	**3,280,185**
EQUITY			
Contributed equity	22	405,940	0
Asset revaluation reserve	23	2,900	0
Accumulated surplus / (deficiency)	24	3,195,126	3,280,185
Total Equity		**3,603,966**	**3,280,185**

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	25(c)	3,418,378	3,036,067
Capital contributions (2000/01 appropriation)	25(c)	0	26,000
Net cash provided by Government		3,418,378	3,062,067
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(1,441,208)	(1,401,301)
Employee costs		(2,042,507)	(1,931,559)
GST payments on purchases		(154,073)	(139,829)
Receipts			
Receipts from customers		240,644	157,063
Donations		100	2,650
Interest received		21	83
GST receipts on sales		11,236	8,881
GST receipts from taxation authority		144,871	115,673
Other receipts		118,146	113,737
Net cash (used in) / provided by operating activities	25(b)	(3,122,770)	(3,074,602)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	18	(187,661)	(32,123)
Net cash (used in) / provided by investing activities		(187,661)	(32,123)
Net increase / (decrease) in cash held		107,947	(44,658)
Cash assets at the beginning of the reporting period		15,835	60,493
Cash assets at the end of the reporting period	25(a)	123,782	15,835

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

Note 1 Significant Accounting Policies

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

(a) General Statement

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

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

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

(b) Output Appropriations

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

(c) Contributed Equity

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

(d) Acquisition of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

(e) Valuation of Non-Current Assets

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

i) Land and Non-Clinical Buildings

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

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at current building costs with current materials on a greenfield site. All building costs are Perth based and include

elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

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

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

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

(g) Leases

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

The Health Service has no contractual obligations under finance leases.

(h) Cash

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

(i) Receivables

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

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

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

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

(m) Interest-bearing liabilities

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

(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).

The liability for future payments under the Pension Scheme are provided for at reporting date.

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

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

The note disclosure required by paragraph 51(e) of AAS30 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Health Service. Accordingly, deriving the information for the Health Service is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

iii) Deferred Salary Scheme

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

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

(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.

	2001/02 $	2000/01 $
Note 2 Administered trust accounts		
Funds held in these trust accounts are not controlled by the Health Service and are therefore not recognised in the financial statements.		
a) The Health Service administers a trust account for the purpose of holding patients' private moneys.		
A summary of the transactions for this trust account is as follows:		
Opening Balance	170	170
Add Receipts		
- Patient Deposits	29	0
	199	170
Less Payments		
- Patient Withdrawals	165	0
Closing Balance	34	170
Note 3 Patient support costs		
Medical supplies and services	144,430	132,592
Domestic charges	33,839	47,330
Fuel, light and power	117,052	130,598
Food supplies	73,720	66,975
Purchase of external services	140,850	133,271
	509,891	510,766
Note 4 Depreciation expense		
Buildings	127,157	125,103
Computer equipment and software	6,616	9,274
Furniture and fittings	11,456	11,010
Other plant and equipment	39,015	35,930
	184,244	181,317
Note 5 Net profit / (loss) on disposal of non-current assets		
Profit / (Loss) on disposal of non-current assets:		
Computer equipment and software	(2,252)	(2,698)
Furniture and fittings	(2,087)	(617)
Other plant and equipment	(9,476)	(468)
	(13,815)	(3,783)
Note 6 Capital user charge		
	271,723	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	33,684	36,656
Other employee expenses	49,817	63,763
Motor vehicle expenses	9,260	13,088
Insurance	12,161	11,838
Communications	35,779	40,590
Printing and stationery	15,734	14,013
Rental of property	7,526	11,964
Audit fees - external	20,928	15,475
Bad and doubtful debts expense	(1,622)	(1)
Other	60,501	236,712
	243,768	444,098
Note 8 Patient charges		
Inpatient charges	251,865	154,024
Outpatient charges	1,118	6,218
	252,983	160,242

	2001/02 $	2000/01 $
Note 9 Donations revenue		
General public contributions	100	2,650
Note 10 Other revenues from ordinary activities		
Rent from properties	14,490	17,050
Recoveries	49,006	39,425
Use of hospital facilities	67,287	59,653
Other	215	0
	130,998	116,128
Note 11 Government appropriations		
Output appropriations (I)	3,727,066	3,127,392
Capital appropriations (II)	0	543,914
	3,727,066	3,671,306

(I) Output appropriations are accrual amounts as from 1 July 2001, reflecting the full price paid for outputs purchased by the Government. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.

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

Note 12 Liabilities assumed by the Treasurer		
Superannuation	0	114,625
Note 13 Resources received free of charge		

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

Office of the Auditor General		
- Audit services	10,000	10,000
DOH		
- 7 x Computers & 1 Defibrillator Supplied	0	23,750
	10,000	33,750

Where assets or services have been received free of charge or for nominal consideration, the Health Service recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

Note 14 Cash assets		
Cash on hand	5,250	5,250
Cash at bank - general	108,033	207
Cash at bank - donations	10,499	10,378
	123,782	15,835
Note 15 Receivables		
Patient fee debtors	46,976	29,572
GST receivable	13,598	17,858
Other receivables	29,467	20,459
	90,041	67,889
Less: Provision for doubtful debts	0	(1,622)
	90,041	66,267

Note 16 Amounts receivable for outputs	2001/02 $	2000/01 $
Non-current	185,400	0

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

Note 17 Inventories

Supply stores - at cost	26,731	19,246
Pharmaceutical stores - at cost	27,174	19,108
Engineering stores - at cost	4,286	5,634
	58,191	43,988

Note 18 Property, plant and equipment

Land		
At valuation - 30June 2002 (ii)	18,000	15,100
	18,000	15,100
Buildings		
Clinical:		
At cost (i)	0	1,055,027
Accumulated depreciation	0	(42,749)
	0	1,012,278
At valuation - 30 June 2002 (ii)	11,575,000	9,767,223
Accumulated depreciation	(7,589,052)	(6,553,595)
	3,985,948	3,213,628
Non-Clinical:		
At valuation - 30 June 2002 (ii)	186,000	0
Accumulated depreciation	0	0
	186,000	0
Computer equipment and software		
At cost	37,618	52,863
Accumulated depreciation	(22,338)	(32,251)
	15,280	20,612
Furniture and fittings		
At cost	206,108	187,698
Accumulated depreciation	(88,619)	(81,668)
	117,489	106,030
Other plant and equipment		
At cost	655,622	662,782
Accumulated depreciation	(380,816)	(374,122)
	274,806	288,660
Total of property, plant and equipment	4,597,523	4,656,308

Land and buildings

(i) 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. The valuation was undertaken by the Valuer General and was dated 1 July 2001. The valuation has been based on a combination of current use and the improved vale of the land.

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	40,159	32,123
Paid as cash by the Health Service from capital contributions	147,502	0
Paid by the Department of Health	161,045	1,105,500
Gross payments for purchases of non-current assets	348,706	1,137,623

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	15,100
Revaluation increments / (decrements)	2,900
Carrying amount at end of year	18,000
Buildings	
Carrying amount at start of year	4,225,906
Additions	283,258
Revaluation increments / (decrements)	(210,059)
Depreciation	(127,157)
Carrying amount at end of year	4,171,948
Computer equipment and software	
Carrying amount at start of year	20,612
Additions	3,536
Disposals	(2,252)
Depreciation	(6,616)
Carrying amount at end of year	15,280
Furniture and fittings	
Carrying amount at start of year	106,030
Additions	27,275
Disposals	(4,360)
Depreciation	(11,456)
Carrying amount at end of year	117,489
Other plant and equipment	
Carrying amount at start of year	288,660
Additions	34,637
Disposals	(9,476)
Depreciation	(39,015)
Carrying amount at end of year	274,806

Note 19 Interest-bearing liabilities	2001/02 $	2000/01 $
a) **Western Australian Treasury Corporation (WATC) loans**		
Balance at beginning of year	915,446	948,565
Less repayments this year	(34,135)	(33,119)
Balance at end of year	881,311	915,446
Amount repayable within the next 12 months	34,903	33,048
Amount repayable after 12 months	846,408	882,398
Balance at end of year	881,311	915,446

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

Total interest-bearing liabilities:		
Balance at beginning of year	915,446	948,565
New loans this year	0	0
Less repayments this year	(34,135)	(33,119)
Balance at end of year	881,311	915,446
Amount repayable within the next 12 months	34,903	33,048
Amount repayable after 12 months	846,408	882,398
Balance at end of year	881,311	915,446

Note 20 Accrued salaries		
Amounts owing for:	78,259	29,122
Nursing staff		
7 days from 24 June to 30 June 2002		
(2001: 6 days from 25 June to 30 June 2001)		
Non-nursing staff		
5 days from 25 June to 28 June 2002		
(2001: 5 days from 25 June to 30 June 2001)		

Note 21 Provisions	2001/02 $	2000/01 $
Current liabilities:		
Annual leave	246,514	232,416
Long service leave	70,074	42,942
Superannuation	2,993	3,047
	319,581	278,405
Non-current liabilities:		
Long service leave	54,343	62,738
Superannuation	31,573	32,146
	85,916	94,884
Total employee entitlements	405,497	373,289

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 22 Contributed equity

Balance at beginning of the year	0	0
Capital contributions (i)	405,940	0
Balance at end of the year	405,940	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 23 Asset revaluation reserve

Balance at beginning of the year	0	0
Net revaluation increments / (decrements) :		
Land	2,900	0
Balance at end of the year	2,900	0
Asset revaluation decrements recognised as an expense (iii):		
Buildings	210,059	0
	210,059	0

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

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

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

Note 24 Accumulated surplus / (deficiency)

Balance at beginning of the year	3,280,185	3,162,966
Change in net assets	(85,059)	117,219
Balance at end of the year	3,195,126	3,280,185

Note 25 Notes to the statement of cash flows	2001/02 $	2000/01 $
a) **Reconciliation of cash**		
Cash assets at the end of the reporting period as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
Cash assets (Refer note 14)	123,782	15,835
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)	(3,122,770)	(3,074,602)
Increase / (decrease) in assets:		
GST receivable	(4,260)	17,858
Other receivables	26,413	(3,197)
Inventories	14,203	(10,028)
Prepayments	(543)	1,236
Decrease / (increase) in liabilities:		
Doubtful debts provision	1,622	1
Payables	98,995	(75,749)
Accrued salaries	(49,137)	(6,260)
Provisions	(32,208)	(72,956)
Non-cash items:		
Depreciation expense	(184,244)	(181,317)
Profit / (loss) from disposal of non-current assets	(13,815)	(3,783)
Interest paid by Department of Health	(49,533)	(58,205)
Capital user charge paid by Department of Health	(271,723)	0
Asset revaluation decrements	(210,059)	0
Superannuation liabilities assumed by the Treasurer	0	(114,625)
Resources received free of charge	(10,000)	(33,750)
Other	(15,066)	(87,085)
Net cost of services (Statement of Financial Performance)	(3,822,125)	(3,702,462)
c) **Notional cash flows**		
Output appropriations as per Statement of Financial Performance	3,727,066	3,127,392
Capital appropriations as per Statement of Financial Performance	0	543,914
Capital appropriations credited directly to Contributed Equity	405,941	0
	4,133,007	3,671,306
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Interest paid to WA Treasury Corporation	(49,533)	(58,205)
Repayment of interest-bearing liabilities to WA Treasury Corporation	(34,135)	(33,119)
Capital user charge	(271,723)	0
Capital injection funding	(173,838)	(517,915)
Amt Receivable for Outputs	(185,400)	0
	(714,629)	(609,239)
Output appropriations as per Statement of Cash Flows	3,418,378	3,062,067

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

Remuneration of senior officers

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

	2001/02	2000/01
$110,001 - $120,000	1	1
Total	1	1

	$	$
The total remuneration of senior officers is:	119,138	118,752

The superannuation included here represents the superannuation expense incurred by the Health Service in respect of the Senior Officer.

Note 27 Explanatory statement

a) **Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.**
Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10% or $100,000.

	2001/02 $	2000/01 $	Variation $	Variation %
Expenses from Ordinary Activities				
Employee expenses	2,110,396	2,035,926	74,470	3.7%
Fees for visiting medical practitioners	181,770	299,549	(117,779)	(39.3%)
The private / public ratio has increased this year, with less public patients seen by the VMO's, with costs decreasing in this area. Also a reduction in procedural activities and medical emergency services due to limited availability of some medical services.				
Superannuation expense	135,660	121,801	13,859	11.4%
Slight increase in expense is aligned to the increase in employee expenses for the current year.				
Patient support costs	509,891	510,766	(875)	(0.2%)
Patient transport costs	109,300	94,049	15,251	16.2%
An increase in patient transfers due to unavailability of medical services.				
Borrowing costs expense	49,533	58,205	(8,672)	(14.9%)
Decrease is due to the decrease in loan principal from prior years.				
Repairs, maintenance and consumable equipment expense	186,068	232,071	(46,003)	(19.8%)
Due to budgetary constraints discretionary expenditure on equipment replacement and repairs & maintenance decreased in the current financial year.				
Depreciation expense	184,244	181,317	2,927	1.6%
Net loss on disposal of non-current assets	13,815	3,783	10,032	265.2%
Obsolete assets taken off of asset register has resulted in a loss on disposal for the current financial year.				
Asset revaluation decrement	210,059	0	210,059	
Revaluation of land & buildings as at 30 June 2002.				
Capital user charge	271,723	0	271,723	
The capital user charge is included in the financial statements for the first time in the current financial year.				
Other expenses from ordinary activities	243,768	444,098	(200,330)	(45.1%)
Decrease in this area is due mainly to the cessation of transfer of payments to MPS Hostel and MPS HACC and a decrease in Travel costs associated with agency nursing staff.				
Revenues from Ordinary Activities				
Patient charges	252,983	160,242	92,741	57.9%
A change to the private / public mix has resulted in increased revenue collections for patient fees and charges along with significant increase in occupied bed days.				
Donations revenue	100	2,650	(2,550)	(96.2%)
A decrease in public donations in the current year.				
Interest revenue	21	83	(62)	(74.7%)
Other revenues from ordinary activities	130,998	116,128	14,870	12.8%
An increase in revenue collections for services to other health units and use of facilities has resulted in increased revenue in this area.				

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 or $100,000.

	2001/02 Actual $000's	2001/02 Estimate $000's	Variation $000's	Variation %
Expenses from Ordinary Activities				
Employee expenses	2,110.4	2,120.0	(9.6)	(0.5%)
Fees for visiting medical practitioners	181.8	320.0	(138.2)	(43.2%)
A change to the private / public ratio has resulted in a decrease in expected VMO fees in the current financial year.				
Superannuation expense	135.7	135.0	0.7	0.5%
Patient support costs	509.9	520.0	(10.1)	(1.9%)
Patient transport costs	109.3	115.0	(5.7)	(5.0%)
Borrowing costs expense	49.5	53.0	(3.5)	(6.5%)
Repairs, maintenance and consumable equipment expense	186.1	480.0	(293.9)	(61.2%)
Due to budgetary constraints discretionary expenditure on equipment replacement and repairs & maintenance was less than anticipated in the current financial year.				
Depreciation expense	184.2	175.0	9.2	5.3%
Net loss on disposal of non-current assets	13.8	1.0	12.8	1281.5%
Obsolete assets taken off of asset register has resulted in a loss on disposal for the current financial year.				
Asset revaluation decrement	210.1	0.0	210.1	
Revaluation of land & buildings as at 30 June 2002.				
Capital user charge	271.7	0.0	271.7	
The capital user charge is included in the financial statements for the first time in the current financial year.				
Other expenses from ordinary activities	243.8	440.0	(196.2)	(44.6%)
Decrease in this area is due mainly to the cessation of transfer of payments to MPS Hostel and MPS HACC and a decrease in travel costs associated with agency nursing staff.				
Revenues from Ordinary Activities				
Patient charges	253.0	180.0	73.0	40.5%
A change to the private / public mix has resulted in increased revenue collections for patient fees and charges along with significant increase in occupied bed days.				
Donations revenue	0.1	2.0	(1.9)	(95.0%)
A decrease in public donations in the current year.				
Other revenues from ordinary activities	131.0	118.0	13.0	11.0%
An increase in revenue collections for services to other health units and use of facilities has resulted in increased revenue in this area.				
Revenues from Government				
Output appropriations	3,727.1	3,600.0	127.1	3.5%
Greater than anticipated SR & E funding resulted in the increase in this area.				
Capital appropriations	0.0	213.0	(213.0)	(100.0%)
Capital injection funding included as equity this financial year, whereas in prior years it was included in revenue.				
Resources received free of charge	10.0	36.0	(26.0)	(72.2%)
No assets purchased by the DOH in the current financial year.				

Note 28 Commitments for Expenditure	2001/02 $	2000/01 $
Operating lease commitments:		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	19,309	24,330
Later than one year, and not later than five years	5,016	17,923
	24,325	42,253

Note 29 Contingent liabilities

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

Note 30 Events occurring after reporting date

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

Note 31 Related bodies

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

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

Note 32 Affiliated bodies

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

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

Note 33 Financial instruments

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

	Weighted average effective interest rate %	Variable interest rate $000	Fixed interest rate maturities: Less than 1 year $000	1 to 5 years $000	Over 5 years $000	Non interest bearing $000	Total $000
As at 30th June 2002							
Financial Assets							
Cash assets	0.0%	119.0	0.0	0.0	0.0	5.0	124.0
Receivables		0.0	0.0	0.0	0.0	90.0	90.0
		119.0	0.0	0.0	0.0	95.0	214.0
Financial Liabilities							
Payables		0.0	0.0	0.0	0.0	87.0	87.0
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0.0	33.7	142.6	705.0	0.0	881.3
		0.0	33.7	142.6	705.0	87.0	968.3
Net financial assets / (liabilities)		119.0	(33.7)	(142.6)	(705.0)	8.0	(754.3)
As at 30th June 2001							
Financial Assets							
Cash assets	5.9%	11.0	0.0	0.0	0.0	5.0	16.0
Receivables		0.0	0.0	0.0	0.0	66.0	66.0
		11.0	0.0	0.0	0.0	71.0	82.0
Financial Liabilities							
Payables		0.0	0.0	0.0	0.0	186.0	186.0
Interest-bearing liabilities							
- W A Treasury Corporation	5.7%	0.0	33.0	140.0	742.0	0.0	915.0
		0.0	33.0	140.0	742.0	186.0	1,101.0
Net financial assets / (liabilities)		11.0	(33.0)	(140.0)	(742.0)	(115.0)	(1,019.0)

b) **Credit risk exposure**
All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. In respect of other financial assets, the carrying amounts represent the Health Service's maximum exposure to credit risk in relation to those assets.

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

Note 34 Output information

	Prevention & Promotion		Diagnosis & Treatment		Continuing Care		Total	
	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01	2001/02	2000/01
COST OF SERVICES	$000	$000	$000	$000	$000	$000	$000	$000
Expenses from Ordinary Activities								
Employee expenses	0.0	0.0	1,798.1	1,734.6	312.3	301.3	2,110.4	2,035.9
Fees for visiting medical practitioners	0.0	0.0	154.9	255.2	26.9	44.3	181.8	299.5
Superannuation expense	0.0	0.0	115.6	103.8	20.1	18.0	135.7	121.8
Patient support costs	0.0	0.0	434.4	435.2	75.5	75.6	509.9	510.8
Patient transport costs	0.0	0.0	93.1	80.1	16.2	13.9	109.3	94.0
Borrowing costs expense	0.0	0.0	42.2	49.6	7.3	8.6	49.5	58.2
Repairs, maintenance and consumable equipment expense	0.0	0.0	158.5	197.7	27.5	34.3	186.1	232.1
Depreciation expense	0.0	0.0	157.0	154.5	27.3	26.8	184.2	181.3
Net loss on disposal of non-current assets	0.0	0.0	11.8	3.2	2.0	0.6	13.8	3.8
Asset revaluation decrement	0.0	0.0	179.0	0.0	31.1	0.0	210.1	0.0
Capital user charge	0.0	0.0	231.5	0.0	40.2	0.0	271.7	0.0
Other expenses from ordinary activities	0.0	0.0	207.7	378.4	36.1	65.7	243.8	444.1
Total cost of services	0.0	0.0	3,583.7	3,392.3	622.5	589.3	4,206.2	3,981.6
Revenues from Ordinary Activities								
Patient charges	0.0	0.0	215.5	136.5	37.4	23.7	253.0	160.2
Donations revenue	0.0	0.0	0.1	2.3	0.0	0.4	0.1	2.7
Interest revenue	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Other revenues from ordinary activities	0.0	0.0	111.6	98.9	19.4	17.2	131.0	116.1
Total revenues from ordinary activities	0.0	0.0	327.3	237.8	56.8	41.3	384.1	279.1
NET COST OF SERVICES	**0.0**	**0.0**	**3,256.5**	**3,154.5**	**565.7**	**548.0**	**3,822.1**	**3,702.5**
Revenues from Government								
Output appropriations	0.0	0.0	3,175.5	2,664.5	551.6	462.9	3,727.1	3,127.4
Capital appropriations	0.0	0.0	0.0	463.4	0.0	80.5	0.0	543.9
Liabilities assumed by the Treasurer	0.0	0.0	0.0	97.7	0.0	17.0	0.0	114.6
Resources received free of charge	0.0	0.0	8.5	28.8	1.5	5.0	10.0	33.8
Total revenues from government	0.0	0.0	3,184.0	3,254.4	553.1	565.3	3,737.1	3,819.7
Change in net assets	**0.0**	**0.0**	**(72.5)**	**99.9**	**(12.6)**	**17.3**	**(85.1)**	**117.2**

Note 34 Output information (continued)

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

Prevention and Promotion
Prevention and promotion services aim to improve the health of Western Australians by reducing the incidence of preventable disease, injury, disability and premature death. Services provided in this output include community health services; screening services; communicable disease management; health regulation and control; and community information and education.

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

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

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

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

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

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

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

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

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

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

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

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