Narembeen
Health Services Board

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 Narembeen Health Services Board 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

Narembeen Health Service
Ada St
NAREMBEEN WA 6369

PO Box 248
NAREMBEEN WA 6369

☎ *(08) 9064 7324*
℻ *(08) 9064 7028*
✉ narembeen.hospital@health.wa.gov.au

Mission Statement

Our Mission
To detect and treat illness and injury for the people of Western Australia.

Broad Objectives

The objectives of the Narembeen Health Services Board are:

- To provide accessible hospital care to those who require it and to provide these services according to recognised standards of quality and in a way that is acceptable to the community.

Enabling Legislation

The Narembeen Health Services Board 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 Narembeen 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 Narembeen 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 Narembeen Health Services Board, 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.

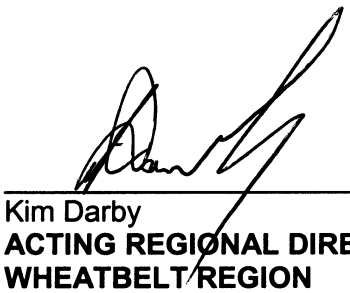
Such processes include:

- The availability of a *Human Resource Manual*, which addresses relevant aspects of the Public Sector Management Act. This manual was developed in April and May 1999 and endorsed by the Board of Management. The manual is available to all staff upon request.
- The Eastern Wheatbelt Health Service has a system of internal audit. Our Human Resource department regularly undertakes internal audits and process checks.
- Narembeen Hospital has adopted a number of checklists pertaining to relevant Standards. These are used as a form of self-assessment.
- The *Code of Conduct* was adopted as part of the endorsement of the HR Manual, however the Board of Management is in the process of adopting a *Code of Conduct* for Board Members.
- The *Code of Conduct* for staff is distributed to all new employees upon appointment and was distributed to existing staff following endorsement by the Board.
- Staff can report misconduct via the process documented in the policy.

The applications made for reporting 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 Narembeen Health Services Board 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 Narembeen Health Services Board published in accordance with Section 175ZE of the *Electoral Act 1907*.

CLASS OF EXPENDITURE	1999/2000 $	2000/2001 $	2001/2002 $
Advertising Agencies	–	–	–
Market Research Organisations	–	–	–
Polling Organisations	–	–	–
Direct Mail Organisations	–	–	–
Media Advertising Organisations	–	–	–
TOTAL	**$0.00**	**$0.00**	**$0.00**

Advertising expenditure related to advertising positions vacant and public tenders amounted to $912.

Freedom of Information Act 1992

The Narembeen Health Services Board did not receive any formal applications under the Freedom of Information guidelines during 2001/2002.

Formal applications are defined as requests which:

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

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

The types of documents held by the Narembeen Health Service include:

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

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

Information Coordinator
Narembeen Health Service
PO Box 248
NAREMBEEN WA 6369

☎ *(08) 9064 7234*

Narembeen Health Service

Key Operations and Achievements

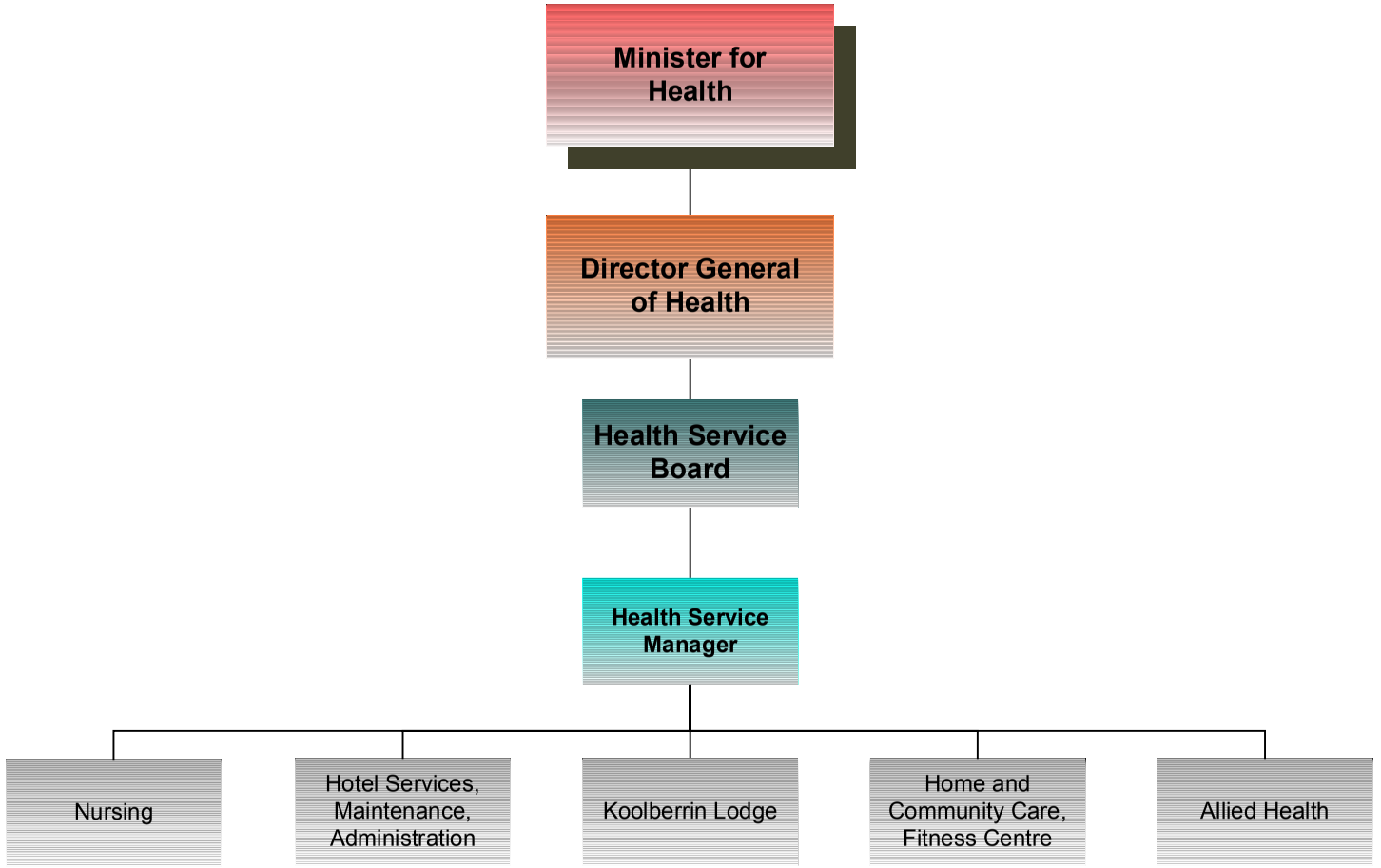
- The government resolved to abolish Health Service boards with the expectation that it will bring improvements in efficiency.
- The overall activity levels of Narembeen Health Services Board remained fairly constant and services were maintained as previously reported.

Major Capital Projects

The Narembeen Health Services Board did not complete or make progress on any major capital projects during 2001/2002.

Management Structure

Organisational Chart



Accountable Authority

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

Name	Position	Term of Office Expires
M. Cowan	Chairperson	30 September 2003
C. Arnold	Deputy Chairperson	30 September 2003
S. Smith	Member	30 September 2002
T. Cheetham	Member	30 September 2002
H. Cowan	Member	30 September 2002
J. McCutcheon	Member	30 September 2002
D. Pollard	Member	30 September 2002
D. Hunter	Member	30 September 2003
L. Yeomans	Member	30 September 2002

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

Area of Responsibility	Title	Name	Basis of Appointment
District and Corporate Management	General Manager	Gerry Burns	Permanent
Health Service Management and Director of Nursing Services	Health Service Manager/Director of Nursing	Wendy Hooper	Permanent
Medical Services	General Practitioner	Dr P Lines	Private Practice

Pecuniary Interests

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

Demography

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

- Narembeen Shire

The following table shows population figures for the local authority:

LOCAL AUTHORITY	Population as at 1996*	Population as at 2001*	Projected Population as at 2006*
Narembeen Shire	1038	961	999

*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*.

Narembeen has a stable population. As elsewhere in Western Australia, the trend is towards an ageing population. Significant numbers of senior citizens are remaining or returning to the area for the safer and more relaxed lifestyle offered by the Narembeen community. This is the most significant trend that will impact on the delivery of health services.

The Narembeen Health Service is well placed to meet the challenges these trends pose especially with the MPS enabling a more comprehensive and coordinated approach to service provision.

Available Services

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

Direct Patient Services
Accident and Emergency
Acute Medical
Antenatal and Postnatal Care
Extended Care Services
Hostel Care
Level II Surgical Services
Nursing Home Type Care
Paediatrics
Palliative Care
Respite Care

Medical Support Services
Allied Health Assistants
Mental Health Service (regional service)
Occupational Therapy (district-wide service)
Pathology (daily transfer to Perth or Merredin)
Physiotherapy (visiting private practitioner)
Podiatry (visiting private practitioner)
Speech Pathology (district service)
X Ray and Ultrasound (Merredin)
X-Ray Operator Facility

Community Services
Aged Care Councillors
Extended Care / HACC Laundry Service
HACC Coordination and Staffing
Health and Fitness Centre / Gymnasium
Meals on Wheels

Other Support Services
Health Promotion
Medical Records

Specialist Services
None

Other Services
None

Disability Services

Our Policy
The Narembeen 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 Narembeen 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.

- Hospital facilities have been audited to ensure that they meet the standards of the Disability Services Plan.
- All Home and Community Care and extended care patients are assessed for home help requirements.
- Home aids are provided and will continue to be provided to those in need.
- Disabilities services are represented on the hospital Consultative Committee.
- Copies of the *Disability Services Act* are available for all staff to read.

Outcome 2: Access to buildings and facilities is improved.

- All new projects and activities undertaken through the Multi Purpose Service address the Disability Services Plan.
- Any areas of deficit have been addressed therefore improving access.

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

- Narembeen Health Services Board utilises a disabilities plan developed within the Eastern Wheatbelt Health Services, which complies with the *Disability Services Act*.
- Narembeen Health Services Board also has a Customer Charter which provides information to the public in a format which meets the communication needs of people with disabilities.

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

- All staff are aware of the special needs of people with disabilities and act appropriately when delivering services and providing advice.
- Regular reassessment of community needs is undertaken.

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

- Our Customer Charter provides all members of the Public with information on how to lodge a grievance.
- The community also has the opportunity to participate in public consultations and decision making processes.

Future Direction
The Narembeen 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 Narembeen 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 Narembeen Health Service operates in conjunction with the *Western Australian Government Language Services Policy*.

No specific action was undertaken in this financial year.

Youth Services

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

The Narembeen 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

No specific programs where undertaken in this financial year.

Employee Profile

The following table shows the number of full-time equivalent staff employed by the Narembeen Health Services Board:

CATEGORY	1999/2000	2000/2001	2001/2002
Nursing Services	10.90	10.15	10.41
Administration and Clerical*	2.55	2.15	2.33
Medical Support*	–	–	–
Hotel Services*	–	–	–
Maintenance	0.50	0.50	0.40
Medical (salaried)	–	–	–
Other	10.30	10.77	9.91
TOTAL	**23.75**	**23.57**	**23.05**

*Note these categories include the following:

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

Recruitment Practices

Narembeen Health Service has continued to recruit nursing staff as opportunities present. The acute shortage of Registered Nurses presently being felt by all hospitals is impacting upon our ability to recruit staff and our dependence on Perth based Nursing Agencies. The Eastern Wheatbelt Health Service has successfully commenced a graduate Nurse Program. We are hoping this will result in increased permanent staff numbers. Appreciation must also be stated to local staff members who maintain the flexibility to ensure that we are always adequately staffed.

Staff Development

Narembeen Health Service has a staff development policy in place, which was endorsed by the Board and accepted by staff. The policy encourages and assists staff to maintain and enhance their skills and knowledge through external study courses whilst maintaining a very active in-service program supported and reinforced by the General Practitioner and our Consultative Committee.

Industrial Relations Issues

No issues of significance relating to industrial relations occurred during the reporting period.

Workers' Compensation and Rehabilitation

The following table shows the number of workers' compensation claims made through the Narembeen Health Services Board:

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

*Note these categories include the following:

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

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 Narembeen 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 Narembeen Health Service aims to promote equal opportunity for all persons, according to the *Equal Opportunity Act 1984*. This goal is achieved through activities and programs run on behalf of the following outcomes:

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

- The EEO is an integral part of the Consultative Committee.
- All recruitment and selection processes embrace the principles of EEO.
- All Job Description Forms include awareness of EEO as a desirable criterion.
- Harassment and grievance resolution policies are in progress.
- EEO principles are written into the hospital's orientation manual.

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

- There have been no Equal Employment Opportunities grievances received in 2001/2002.

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

- Employment practices recognise, and where appropriate, include measures intended to achieve equality of opportunity for people from EEO target groups.
- The administration of the Narembeen Health Services Board complies with the Public Sector Standards in Human Resource Management, the *Code of Ethics* and our *Code of Conduct*. Procedures are in place which are designed to ensure such compliance and appropriate internal checks to satisfy that the statement made above is correct.

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 Narembeen Health Services Board 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	Implemented

Marketing

Community awareness of the services available and offered by the Health Service was achieved through the following activities:

- Articles printed in the local newspaper listing the activities available through the hospital.
- An active Health Promotions Campaign.
- Our Customer Charter.
- The distribution of our staff recruitment brochure.
- Participation in the Eastern Wheatbelt Health Service web site.

Narembeen Health Service has a high profile within the Narembeen community. It is extremely well supported and respected by the members of our community. All fundraising and other activities conducted by and for the hospitals are well supported and backed by the community.

The Narembeen Health Services Board makes available a great deal of literature for the public. We provide mostly pamphlet information obtained from the Department of Health.

Health Promotion activities are all advertised in the local *Fencepost*. Details of hospital-related activities and events pertaining to the operation of the Narembeen Health Service are also published in this local newsletter on a needs basis.

Publications

Narembeen Health Service has a Customer Charter as well as recruitment brochures outlining the services we offer to the community and the philosophy behind their delivery.

We have also participated in the development of a web site for the Eastern Wheatbelt Health Service.

Research and Development

The Narembeen Health Services Board carried out no major research and development programs during 2001/2002.

Evaluations

The Narembeen Health Services Board carried out no major evaluations during 2001/2002.

Risk Management

Our Policy

The Narembeen Health Services Board, in conjunction with other sites across the Eastern Wheatbelt 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:

- Narembeen Health Service has an active Consultative Committee, which reviews all aspects of workplace activity. One of the major roles of this committee is to identify hazards, bring them to the attention of management and to ensure the necessary changes are brought about to ensure safety in the workplace.

Future Direction

The Narembeen Health Services Board will continue to review its risk management and quality improvement processes in keeping with the above policy.

Internal Audit Controls

The Narembeen Health Services Board has established a system of internal controls as a means of providing reasonable assurance that assets are safeguarded, proper accounting records are maintained, and financial information is reliable.

An audit committee is established to oversee the operation of internal audit functions and to ensure that management addresses any findings made by the Health Services internal and external audit.

A number of audits were conducted of Narembeen Health Services Board this financial year. One was conducted by the Office of the Auditor General and the other outsourced to Stanton Partners. The following are the actions undertaken to address significant findings of both.

Stanton Partners were contracted to undertake an internal audit of Narembeen Health Services in the 2001/2002 period. Their audit observations ranged from Minor to Moderate. This indicates that few areas were of critical importance. All recommendations of the audit have been taken on board and addressed by the Board of Management in conjunction with the Health Service Manager. An action plan has been compiled to address the same.

Waste Paper Recycling

Our Waste Management Policy was developed in cooperation with the Narembeen Shire Council and is reviewed regularly. Narembeen Health Service recycles paper waste through a local paper brick producer and has a number of recycling practices in place to greatly reduce the amount of waste requiring disposal.

Pricing Policy

The Narembeen Health Services Board 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.

AUDITOR GENERAL

To the Parliament of Western Australia

NAREMBEEN HEALTH SERVICES BOARD
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Scope

I have audited the key effectiveness and efficiency performance indicators of the Narembeen Health Services Board 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 Narembeen Health Services 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, 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 Narembeen Health Services Board 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

NAREMBEEN HEALTH SERVICES BOARD

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 Narembeen Health Services Board for the year ended June 30, 2002 by February 28, 2003.

Whilst the Minister for Health granted the Narembeen Health Services Board 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.

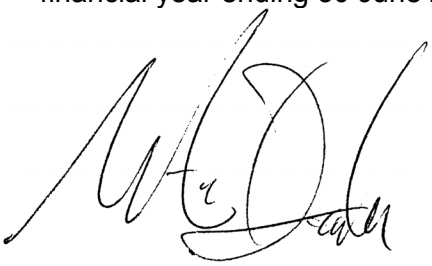
It is anticipated that the opinions will be issued by March 31, 2003.

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

NAREMBEEN HEALTH SERVICES BOARD
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 Narembeen Health Services Board and fairly represent the performance of the Health Services Board for the financial year ending 30 June 2002.



Mike Daube
ACCOUNTABLE AUTHORITY
Director General of Health

November 2002

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Background

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

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

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

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

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

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

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

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

Output 1: *Prevention and Promotion*

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

Output 2: *Diagnosis and Treatment*

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

Output 3: *Continuing Care*

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

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

General Approach

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

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

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

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

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

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

Comparative Results

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

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

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

Output Measures

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

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

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

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

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

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

Assessing the Performance of the Health Service

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

Glossary of Terms

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

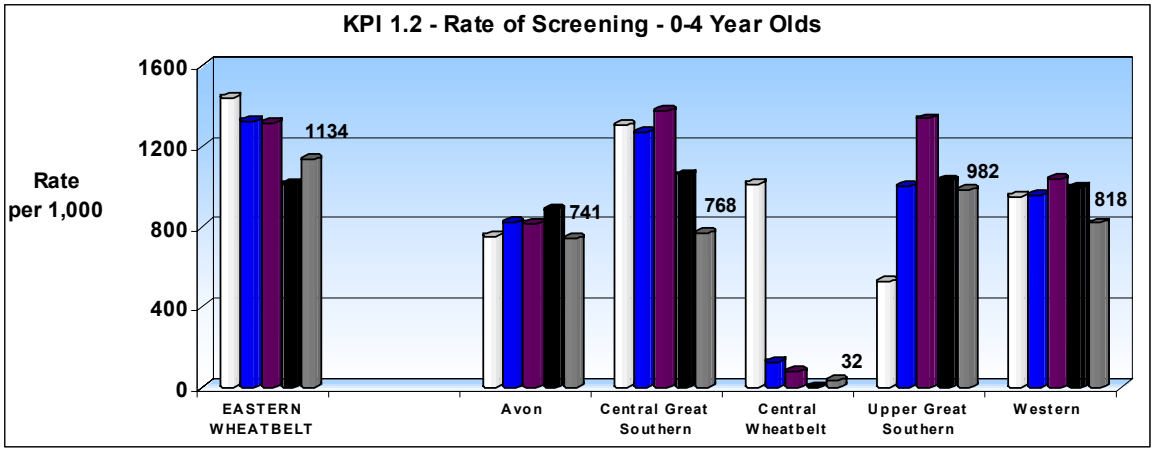
RATE OF SCREENING IN CHILDREN	KPI 1.2

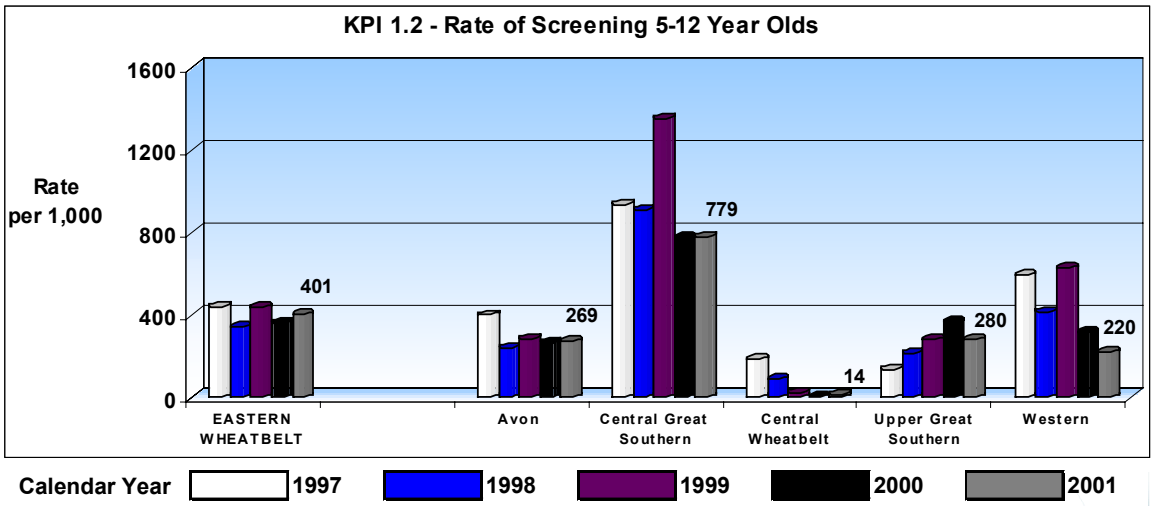
The community sets a very high priority on ensuring that the health and well being of children are safeguarded. Screening programs designed to detect disability and disease in the early stages of childhood development can prevent long-term disability. These programs not only restore children to good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

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

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

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





RATE OF CHILDHOOD IMMUNISATION	KPI 1.5

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

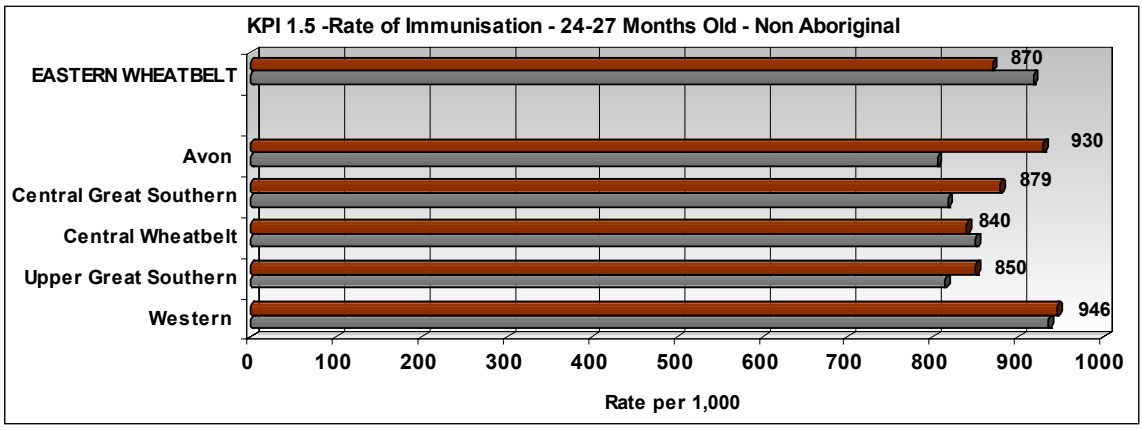
Without access to immunisation for children the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death.

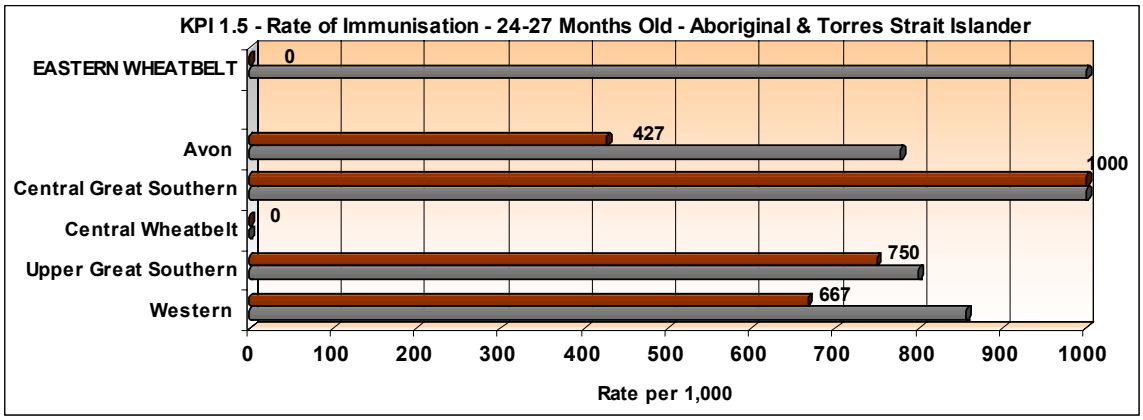
This indicator measures the rate of immunisation against particular diseases, by age group, of the resident child population in the catchment for the Health Service.

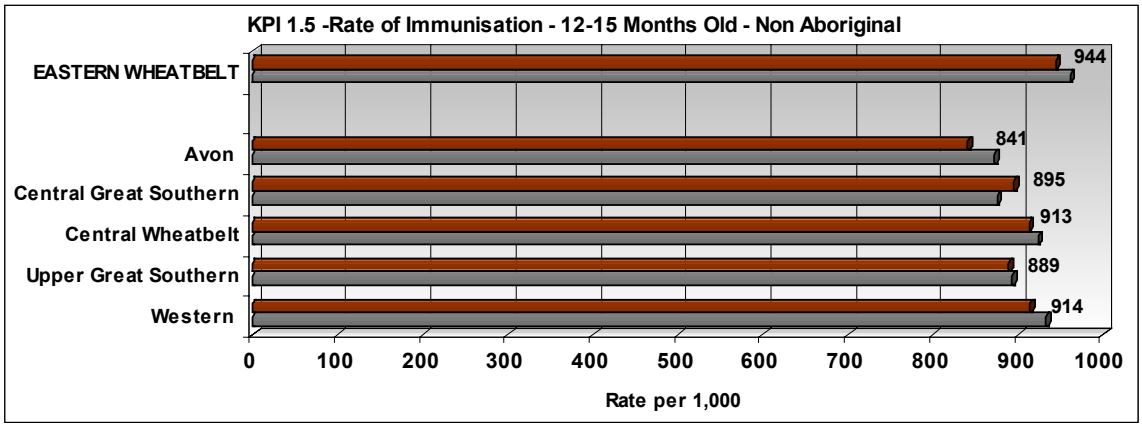
In calculating the rate of Immunisation, the number of Immunisations refer to the number of children who were fully vaccinated in accordance with the National Health and Medical Research Council (NH&MRC) standard vaccination schedule.

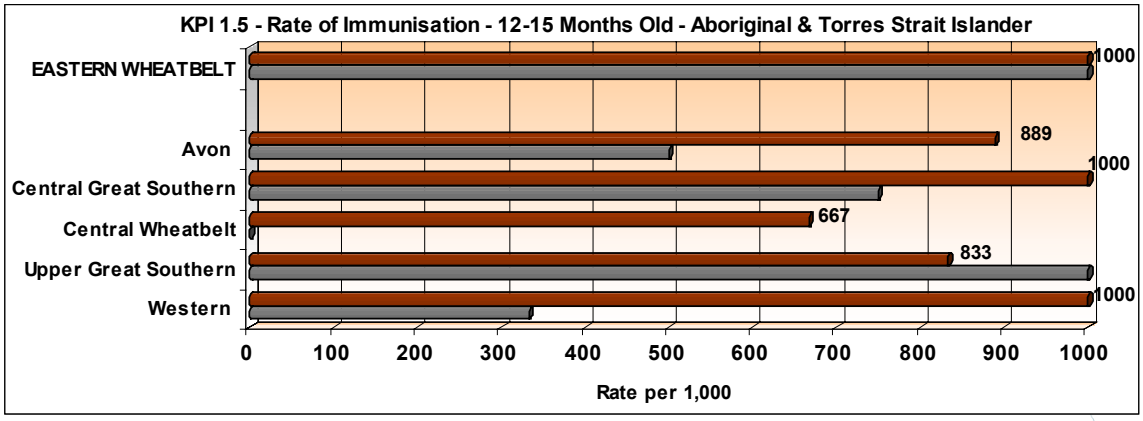
All infants born after May 2000 (but not before) were to be vaccinated against Hepatitis B at birth and again at 12 months. This effectively created 2 classes of immunised infants in that age group (12-15 months). It also means that there will be some discrepancies with the 24-27 month age group of the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

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 -Rate of 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 - Rate of 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


KPI 1.5 -Rate of 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 - Rate of 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

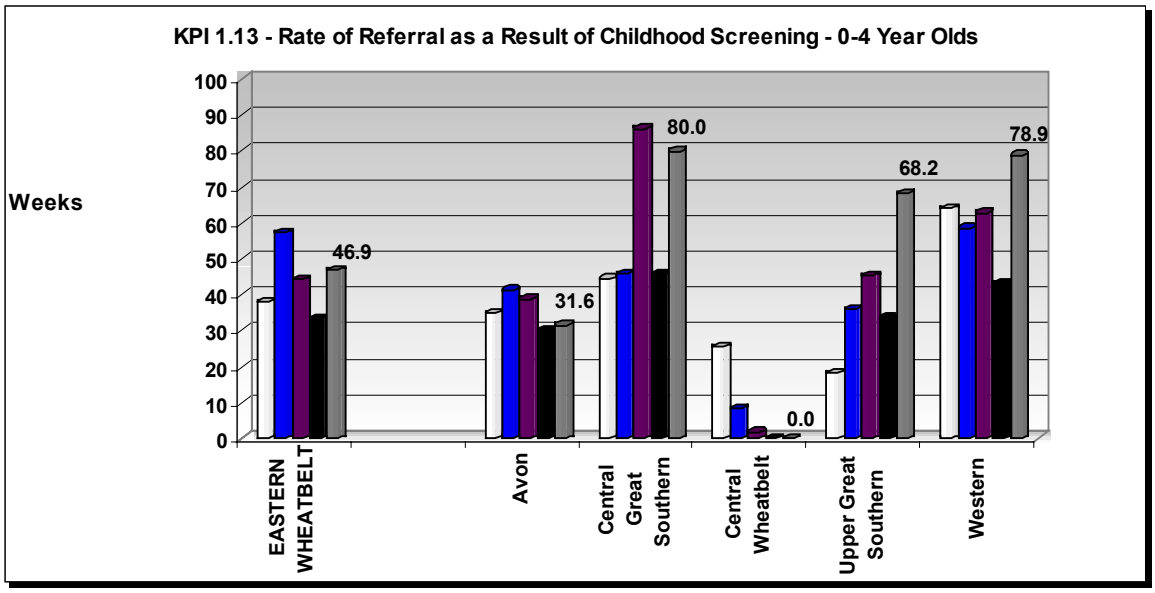

Calendar Year
2001
2002

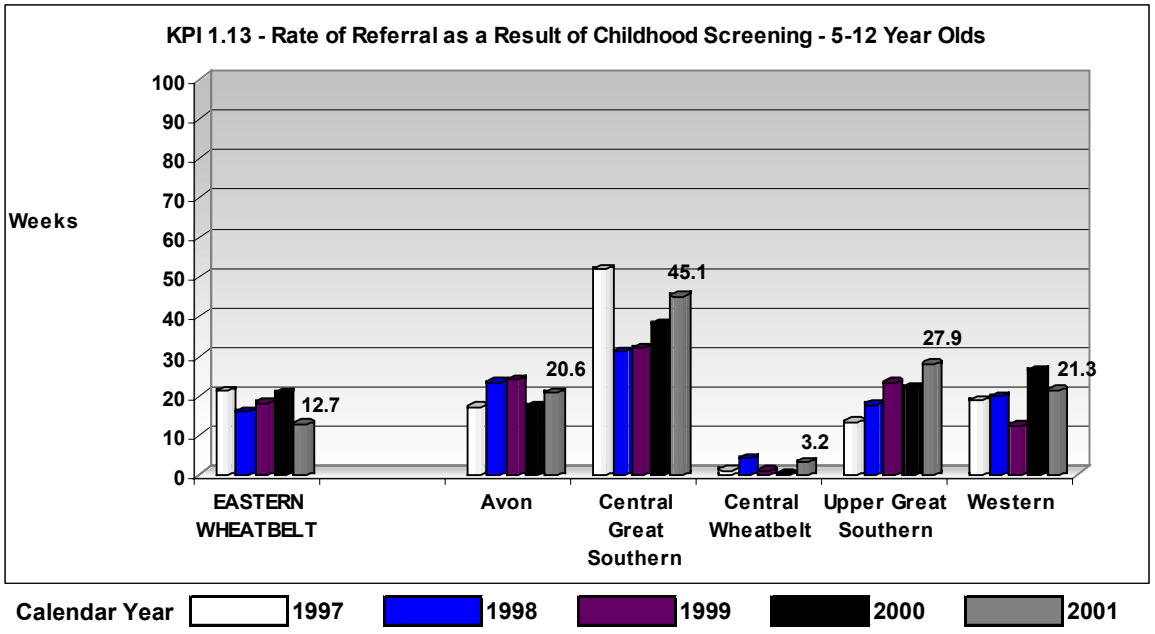
RATE OF REFERRAL AS A RESULT OF CHILDHOOD SCREENING SCHEDULE	KPI 1.13

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.



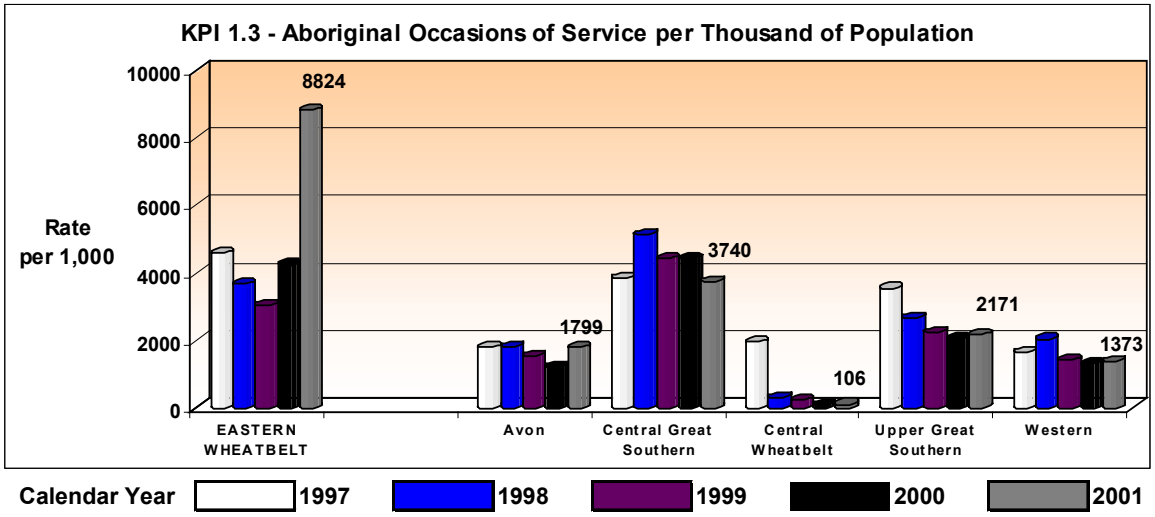


RATE OF SERVICE PROVISION BY COMMUNITY HEALTH STAFF TO ABORIGINAL PEOPLE	KPI 1.3

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.



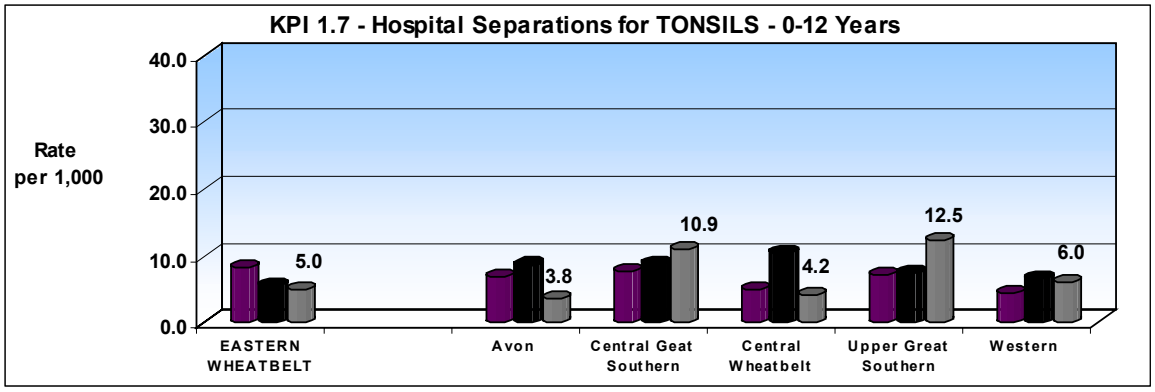
HOSPITAL SEPARATIONS FOR TONSILLECTOMIES & GROMMETS — KPI 1.7

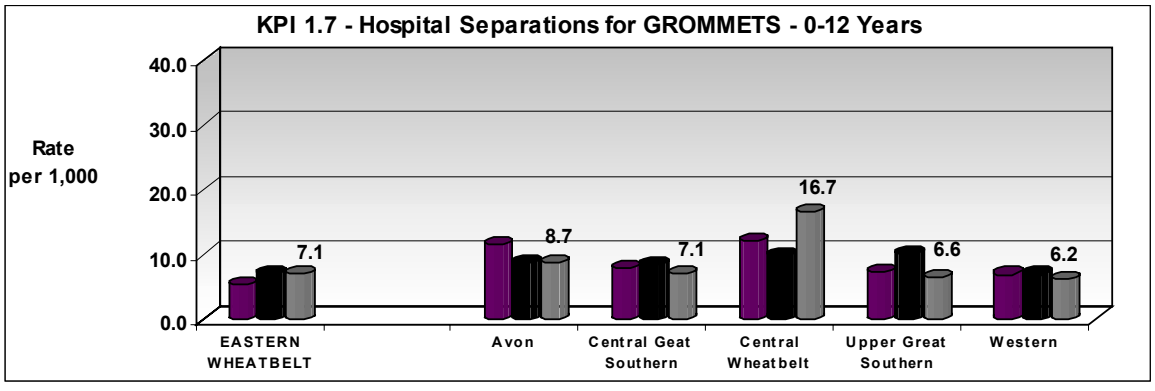
Current evidence suggests many tonsillectomies and grommet insertions are unnecessary and 'watchful waiting' and presurgery testing may be effective in reducing inappropriate surgery.

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

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

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





Calendar Year 1999 2000 2001

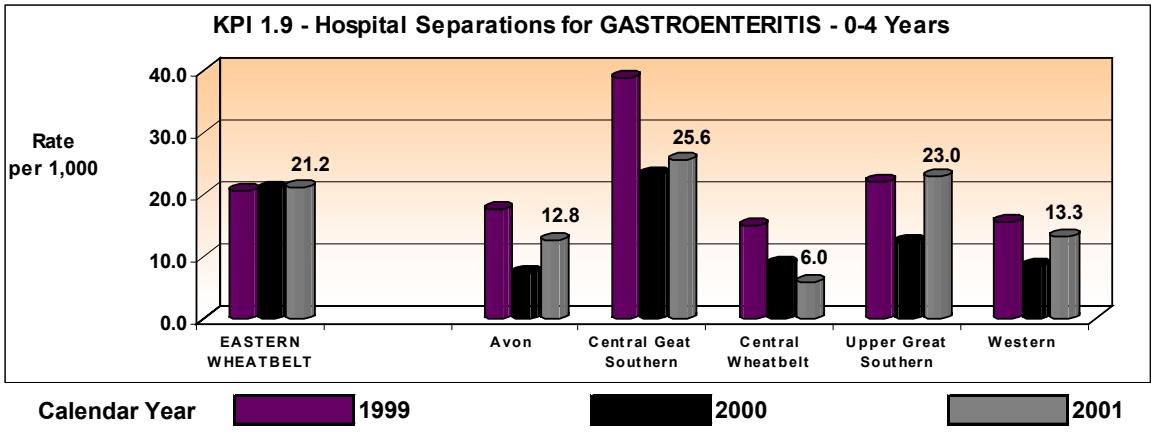
HOSPITAL SEPARATIONS FOR GASTROENTERITIS IN CHILDREN | KPI 1.9

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

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

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

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



HOSPITAL SEPARATIONS FOR RESPIRATORY CONDITIONS — KPI 1.10

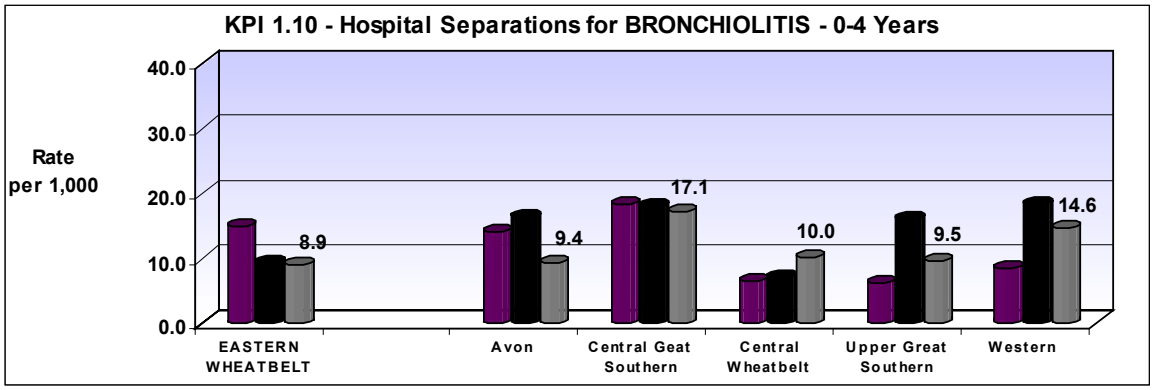
Respiratory illness is one of the most common reasons for hospital admission in children and young adults. Improved primary health and community health strategies, such as health monitoring, education and risk prevention can assist in reducing the incidence and prevalence of conditions such as acute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

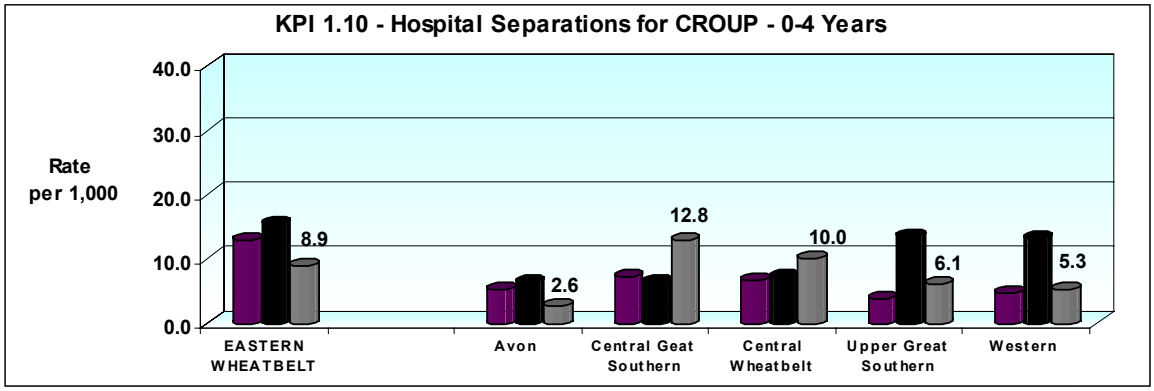
Improved primary management will reflect a decrease in the number of admissions for these conditions. Comparison of the rate of hospitalisation for respiratory illness with other comparable areas can help identify those areas where improvements in primary care could be necessary.

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

Croup
The graph shows individuals aged 0-4. Of those individuals aged 5-12, only 3 were hospitalised this year, a rate of 2 per thousand. Of those individuals aged 13-18, none were admitted 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

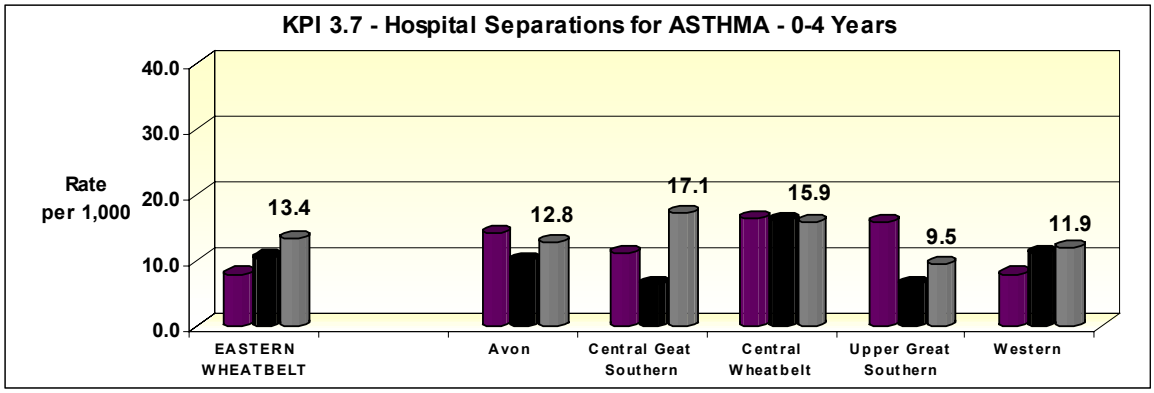
Hospitalisation for Respiratory Conditions like Bronchitis, Croup would generally include patients who have asthma. However, because of its importance as a condition in WA, hospitalisation for acute Asthma also reported separately to provide a more exact view of Asthma hospitalisation.

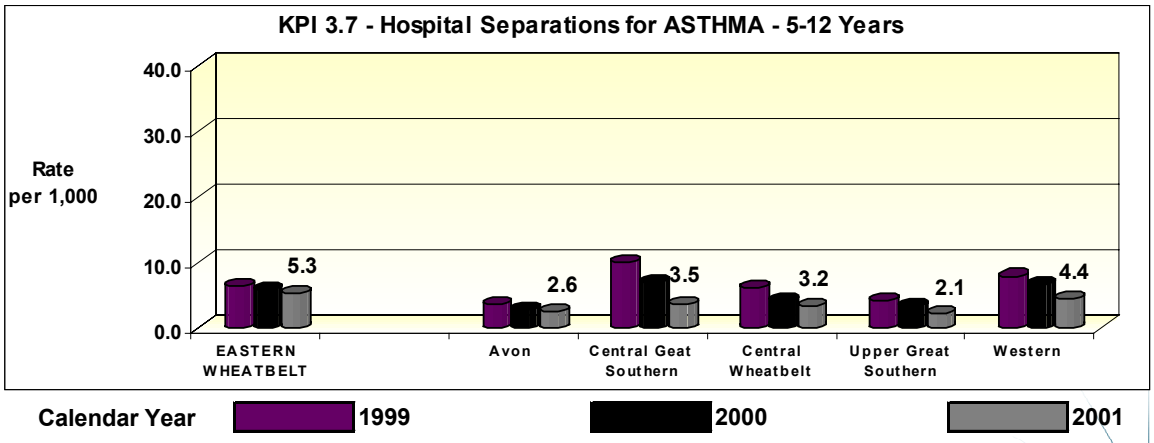
Hospitalisation for Asthma is part of managing this chronic condition. It is being reported in Output 1, instead of Output 3, in order to highlight the focus on measuring the effectiveness of Prevention and Promotion services for the condition.

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

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

The graphs show individuals aged 0-4 and 5-12. 7 individuals aged 13-18 at a rate of 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.

EMERGENCY DEPARTMENT WAITING TIMES	KPI 2.18

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

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

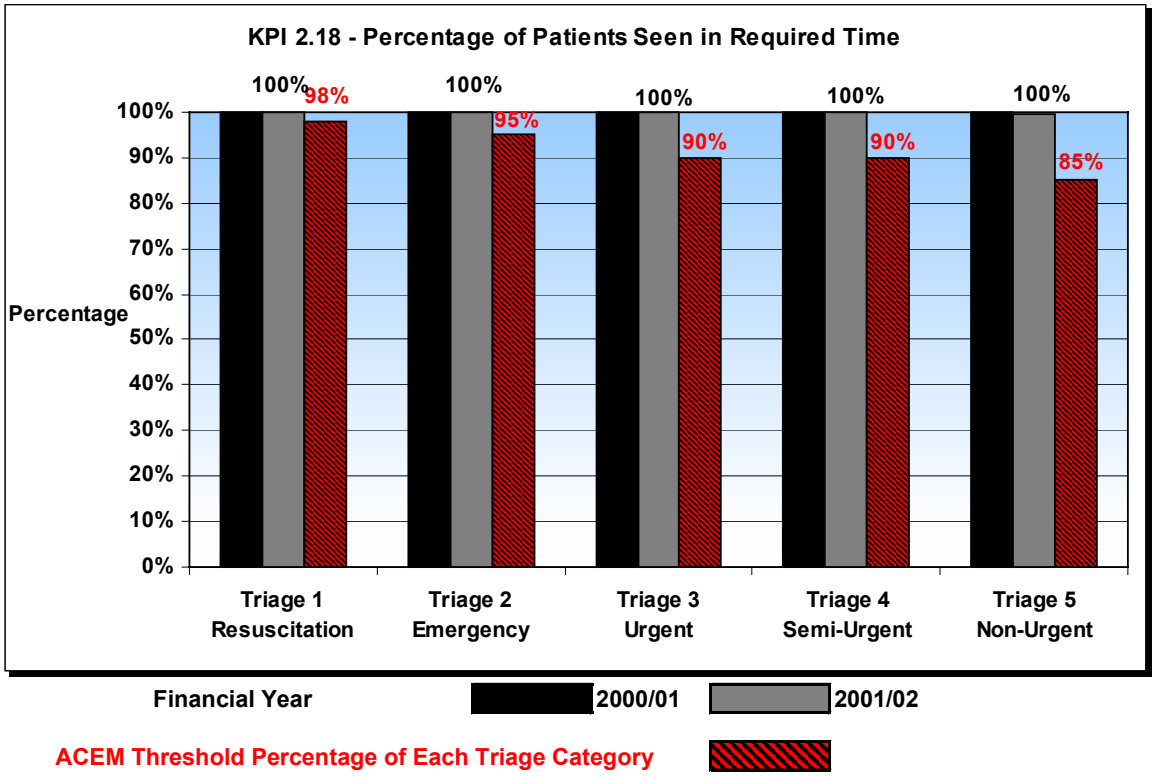
Furthermore, in small health care units, measuring waiting times has either not been regularly performed or the information systems in place collectively pool the data for all health care professionals attending patients in each of the triage categories.

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

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

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

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

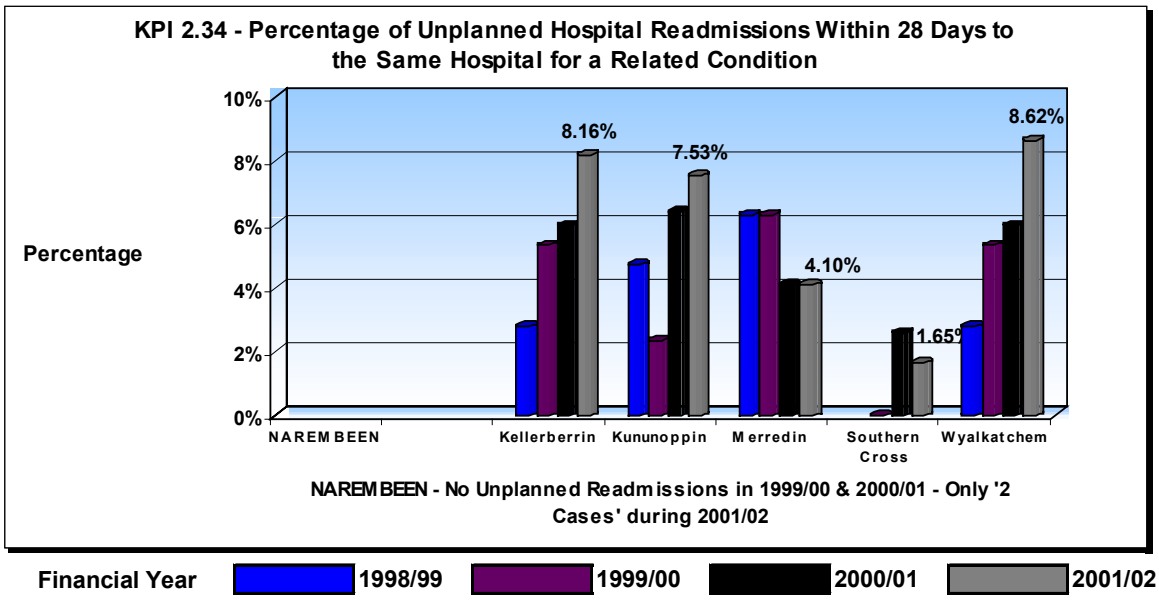

KPI 2.18 - Percentage of Patients Seen in Required Time
Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
98%
100%
95%
100%
90%
100%
90%
100%
85%
Triage 1 Resuscitation
Triage 2 Emergency
Triage 3 Urgent
Triage 4 Semi-Urgent
Triage 5 Non-Urgent
Financial Year
2000/01
2001/02
ACEM Threshold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

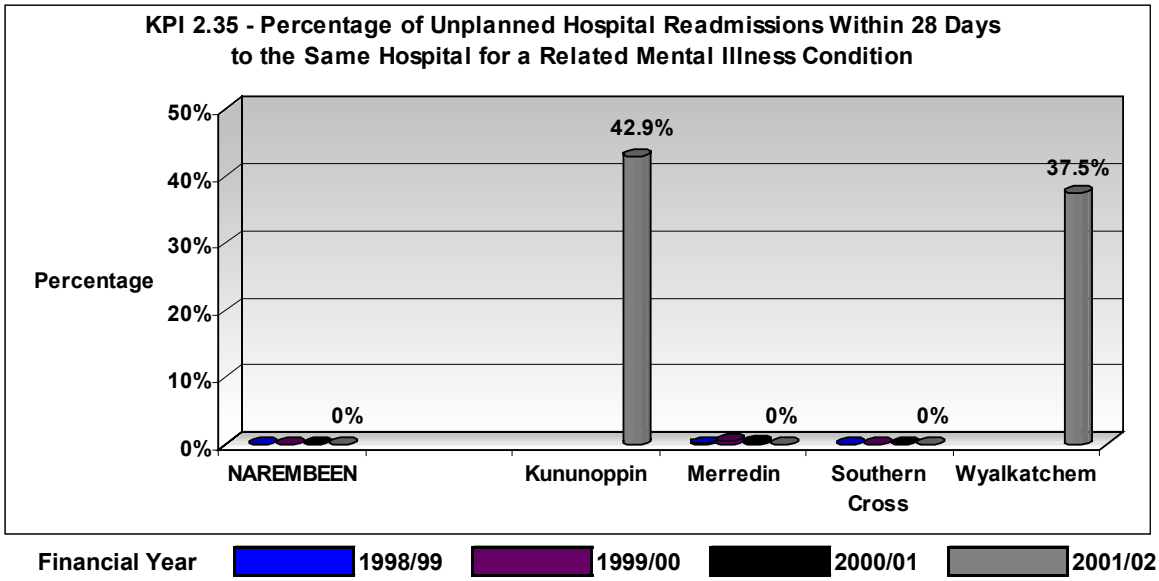


UNPLANNED HOSPITAL READMISSIONS WITHIN 28 DAYS TO THE SAME HOSPITAL FOR TREATMENT AND CARE FOR A RELATED MENTAL HEALTH ILLNESS	KPI 2.35

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.

There were no admissions of this type at Narembeen.

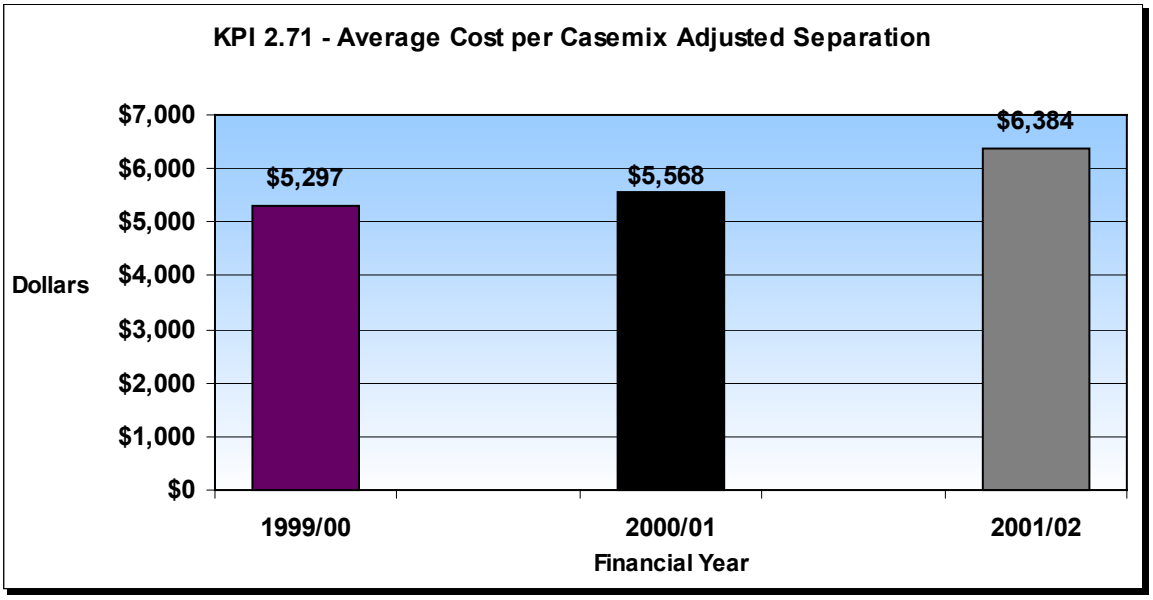


AVERAGE COST PER CASEMIX ADJUSTED SEPARATION FOR RURAL NON-TEACHING HOSPITALS	KPI 2.71

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.

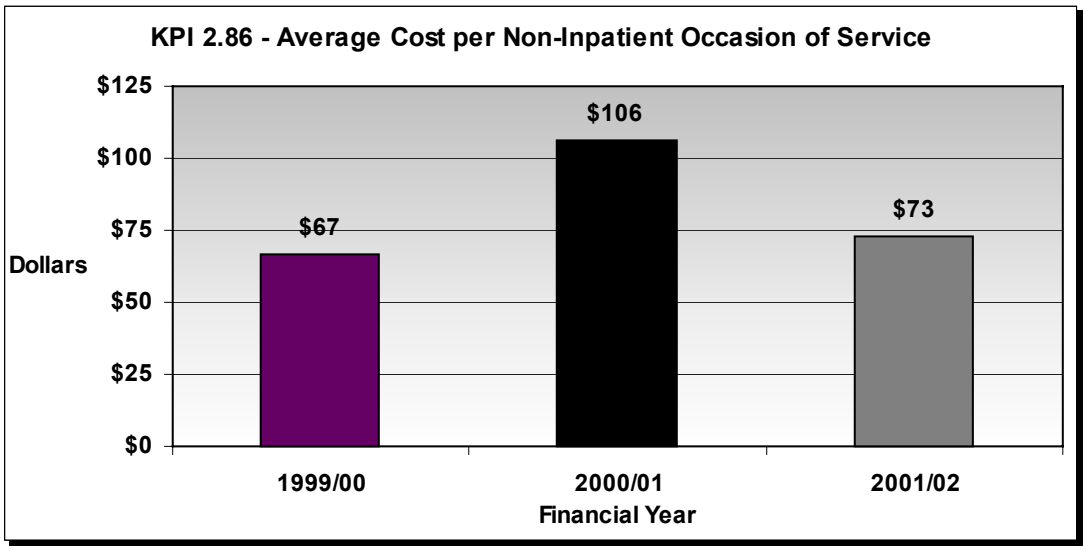


AVERAGE COST PER NON-INPATIENT OCCASION OF SERVICE	KPI 2.86

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.

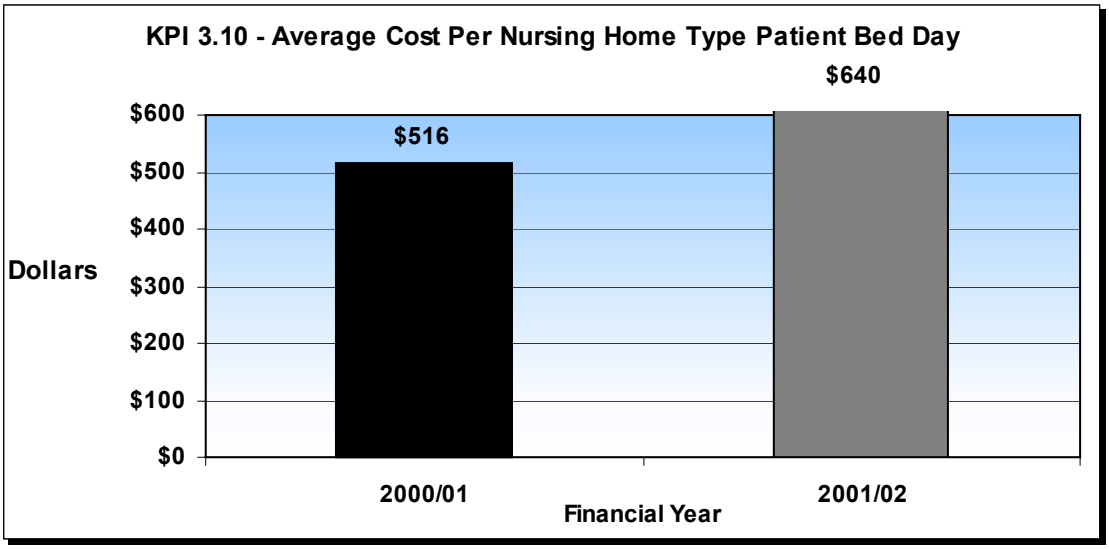
There were three individuals who were admitted as Nursing Home Type Patients during this financial year with an average bed day of 4.42.

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.

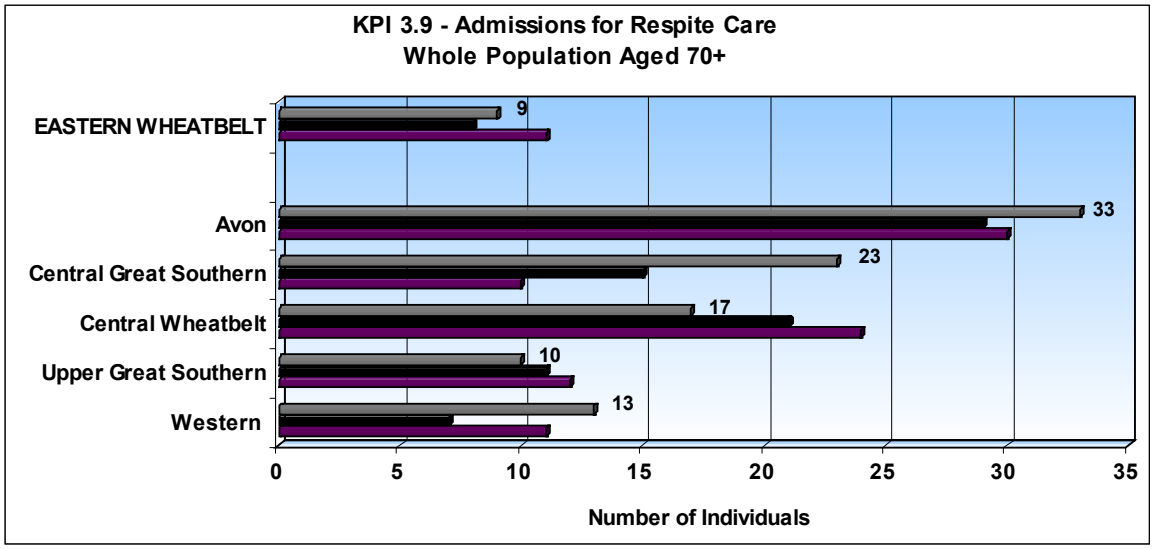


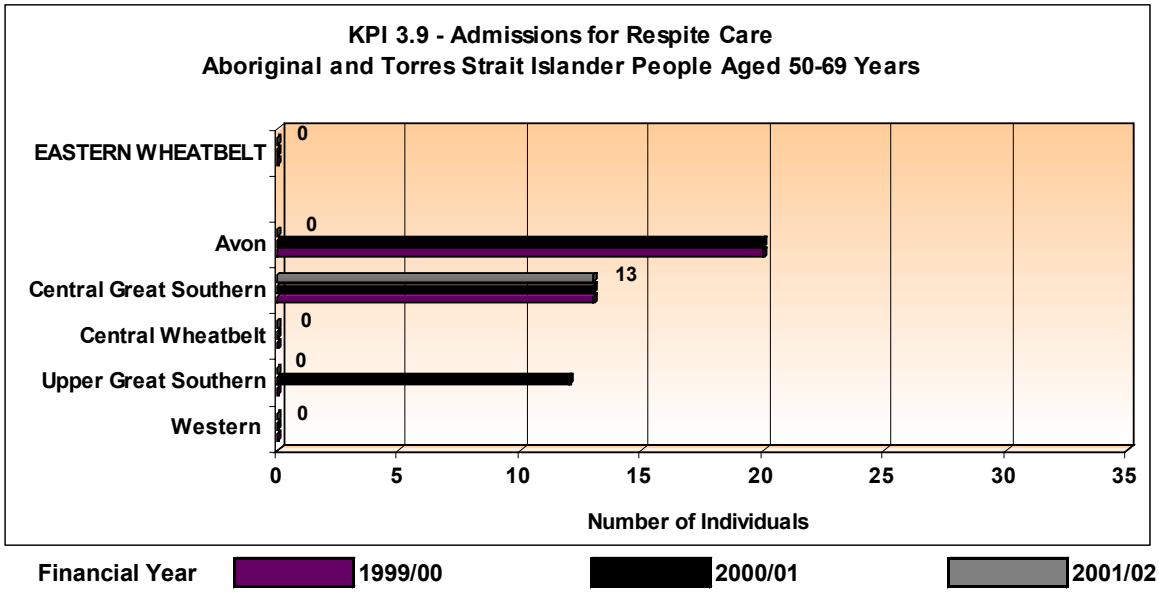
NUMBER OF INDIVIDUALS WITHIN TARGETED AGE GROUP ADMITTED FOR RESPITE CARE	KPI 3.9

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

NAREMBEEN HEALTH SERVICES BOARD
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

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

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

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

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

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

Narembeen Health Services Board
Financial Statements for the year ended June 30, 2002

Audit Opinion
In my opinion,

(i) the controls exercised by the Narembeen Health Services Board 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

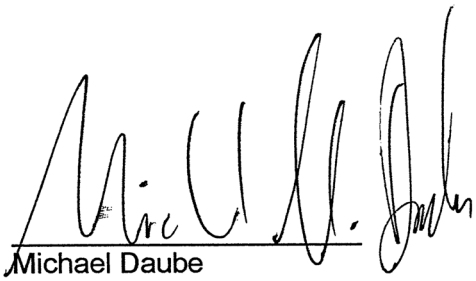
(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting 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

CERTIFICATION OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2002

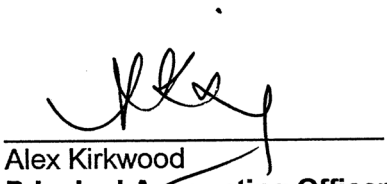
The accompanying financial statements of the Narembeen Health Services Board have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2002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

30 August 2002



Alex Kirkwood
Principal Accounting Officer
Narembeen Health Services
Board

30 August 2002

Statement of Financial Performance
For the year ended 30 June 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		1,056,162	969,389
Fees for visiting medical practitioners		30,293	34,587
Superannuation expense		66,450	71,868
Patient support costs	3	146,547	162,157
Patient transport costs		19,872	14,488
Repairs, maintenance and consumable equipment expense		56,847	129,884
Depreciation expense	4	62,719	65,611
Net loss on disposal of non-current assets	5	930	449
Capital user charge	6	137,653	0
Other expenses from ordinary activities	7	64,938	77,225
Total cost of services		1,642,411	1,525,658
Revenues from Ordinary Activities			
Patient charges	8	248,969	234,013
Donations revenue	9	3,528	2,379
Interest revenue		1,501	6,070
Other revenues from ordinary activities	10	25,893	38,512
Total revenues from ordinary activities		279,891	280,974
NET COST OF SERVICES		**1,362,520**	**1,244,684**
Revenues from Government			
Output appropriations	11	1,360,153	1,011,150
Capital appropriations	11	0	61,454
Liabilities assumed by the Treasurer	12	0	71,868
Resources received free of charge	13	6,500	5,250
Total revenues from government		1,366,653	1,149,722
Change in net assets		**4,133**	**(94,962)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**4,133**	**(94,962)**

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	608	10,121
Restricted cash assets	15	18,753	18,115
Receivables	16	31,368	21,842
Inventories	18	13,945	17,810
Prepayments		0	962
Total current assets		64,674	68,850
NON-CURRENT ASSETS			
Amounts receivable for outputs	17	68,600	0
Property, plant and equipment	19	1,599,209	1,646,517
Total non-current assets		1,667,809	1,646,517
Total assets		**1,732,483**	**1,715,367**
CURRENT LIABILITIES			
Payables		24,490	29,417
Accrued salaries	20	18,402	15,206
Provisions	21	146,718	123,011
Total current liabilities		189,610	167,634
NON-CURRENT LIABILITIES			
Provisions	21	31,364	40,357
Total non-current liabilities		31,364	40,357
Total liabilities		**220,974**	**207,991**
Net Assets		**1,511,509**	**1,507,376**
EQUITY			
Accumulated surplus / (deficiency)	22	1,511,509	1,507,376
Total Equity		**1,511,509**	**1,507,376**

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	23(c)	1,153,900	1,011,150
Net cash provided by Government		1,153,900	1,011,150
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(371,526)	(353,033)
Employee costs		(1,045,059)	(947,608)
GST payments on purchases		(40,301)	(29,761)
Receipts			
Receipts from customers		240,415	241,309
Donations		3,528	2,379
Interest received		1,501	6,067
GST receipts on sales		940	864
GST receipts from taxation authority		38,478	26,111
Other receipts		25,591	39,902
Net cash (used in) / provided by operating activities	23(b)	(1,146,433)	(1,013,770)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(16,342)	(50,374)
Net cash (used in) / provided by investing activities		(16,342)	(50,374)
Net increase / (decrease) in cash held		(8,875)	(52,994)
Cash assets at the beginning of the reporting period		28,236	81,230
Cash assets at the end of the reporting period	23(a)	19,361	28,236

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

Note 1 SIGNIFICANT ACCOUNTING POLICIES

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

(a) General Statement

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

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

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

(b) Output Appropriations

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

(c) Contributed Equity

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

(d) Acquisition of Assets

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

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

(e) Valuation of Non-Current Assets

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

i) Land and Non-Clinical Buildings

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

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

Recent valuations on this basis are equivalent to fair value.

ii) Clinical Buildings

The valuations of clinical buildings (eg hospitals) have been carried out at five yearly intervals by the Department of Health in conjunction with the Department of Housing and Works using "as constructed" drawings. The clinical buildings are valued at "Replacement Capital Value", which is defined as the cost to replace buildings constructed at

current building costs with current materials on a greenfield site. All building costs are Perth based and include elements of electrical, mechanical and plumbing services. Loose and free standing furniture and equipment together with specialised medical equipment are excluded from this valuation. Buildings are depreciated using weighted average age to determine the net carrying values. Recent valuations on this basis are equivalent to fair value.

(f) Depreciation of Non-current Assets

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

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

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

(g) Leases

The Health Service has no operating lease arrangements for buildings or office equipment. The sole operating lease is for a motor vehicle. 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.

Collectability of receivables is reviewed on an ongoing basis. A provision for doubtful debts is raised where some doubts as to collection exists.

(j) Inventories

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

(k) Payables

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

(l) Accrued Salaries

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

(m) Provisions

Employee Entitlements

i) Annual and Long Service Leave

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

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

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

ii) Superannuation

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

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

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

(n) Revenue Recognition

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

(o) Grants and Other Contributions Revenue

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

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

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

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

(q) Comparative Figures

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

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

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

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

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

Opening Balance	4,027	6,229
Add Receipts		
- Patient Deposits	38,504	65,124
- Interest	0	4
	42,531	71,357
Less Payments		
- Patient Withdrawals	36,516	67,330
Closing Balance	6,015	4,027

Note 3 Patient support costs

Medical supplies and services	24,374	28,054
Domestic charges	25,988	29,233
Fuel, light and power	36,543	41,378
Food supplies	39,353	42,979
Purchase of external services	20,289	20,513
	146,547	162,157

		2001/02 $	2000/01 $
Note 4	**Depreciation expense**		
	Buildings	45,210	46,545
	Computer equipment and software	1,866	2,180
	Furniture and fittings	4,838	4,402
	Other mobile plant	118	139
	Other plant and equipment	10,687	12,345
		62,719	65,611
Note 5	**Net profit / (loss) on disposal of non-current assets**		
a)	**Proceeds from sale of non-current assets**		
	Gross proceeds from sale of non-current assets	0	0
b)	**Profit / (Loss) on disposal of non-current assets:**		
	Computer equipment and software	(604)	0
	Furniture and fittings	(164)	0
	Other plant and equipment	(162)	(449)
		(930)	(449)
Note 6	**Capital user charge**		
		137,653	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	18,691	20,716
	Other employee expenses	756	3,210
	Motor vehicle expenses	3,552	9,409
	Insurance	6,328	5,735
	Communications	11,489	10,691
	Printing and stationery	2,526	3,766
	Rental of property	0	1,200
	Audit fees - external	12,326	7,988
	Other	9,270	14,510
		64,938	77,225
Note 8	**Patient charges**		
	Inpatient charges	247,841	233,737
	Outpatient charges	1,128	276
		248,969	234,013
Note 9	**Donations revenue**		
	General public contributions	1,328	2,379
	Specific contribution from Hospital Tennis Day for purchase of a bed	2,200	0
		3,528	2,379
Note 10	**Other revenues from ordinary activities**		
	Rent from properties	0	2,034
	Boarders' accommodation	150	37
	Recoveries	16,087	27,362
	Use of hospital facilities	3,190	2,287
	Other	6,466	6,792
		25,893	38,512

	2001/02 $	2000/01 $
Note 11 Government appropriations		
Output appropriations (I)	1,360,153	1,011,150
Capital appropriations (II)	0	61,454
	1,360,153	1,072,604

(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	71,868

The change in funding arrangement for the Gold State Superannuation Scheme and the West State Superannuation Scheme has resulted in the decrease in Liabilities assumed by Treasurer' (Refer note 1 (m)(II))

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	6,500	5,250

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	250	216
Cash at bank - general	358	9,905
	608	10,121
Note 15 Restricted cash assets		
Cash assets held for specific purposes		
Cash at bank	8,753	8,115
Term deposits and bank bills	10,000	10,000
	18,753	18,115

Restricted assets are assets, the uses of which are restricted, by specific legal or other externally imposed requirements. These funds relate to donations received for the purchase of assets.

Note 16 Receivables		
Patient fee debtors	19,862	13,295
GST receivable	4,292	2,802
Other receivables	7,214	5,745
	31,368	21,842
Less: Provision for doubtful debts	0	0
	31,368	21,842
Note 17 Amounts receivable for outputs		
Non-current	68,600	0

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

Note 18 Inventories	2001/02 $	2000/01 $
Supply stores - at cost	11,628	9,630
Pharmaceutical stores - at cost	1,572	7,784
Engineering stores - at cost	745	396
	13,945	17,810

Note 19 Property, plant and equipment

Land		
At valuation - 1999 (ii)	11,500	11,500
	11,500	11,500
Buildings		
Clinical:		
At cost (i)	435,697	435,697
Accumulated depreciation	(72,855)	(61,633)
	362,842	374,064
At valuation -1999 (ii)	3,290,000	3,290,000
Accumulated depreciation	(2,191,047)	(2,157,059)
	1,098,953	1,132,941
Computer equipment and software		
At cost	9,640	13,030
Accumulated depreciation	(5,819)	(6,739)
	3,821	6,291
Furniture and fittings		
At cost	64,697	64,330
Accumulated depreciation	(24,331)	(21,629)
	40,366	42,701
Other mobile plant		
At cost	2,094	2,094
Accumulated depreciation	(1,423)	(1,305)
	671	789
Other plant and equipment		
At cost	147,654	141,480
Accumulated depreciation	(66,598)	(63,249)
	81,056	78,231
Total of property, plant and equipment	1,599,209	1,646,517

Land and buildings

(i) Clinical buildings are yet to revalued and are carried at their cost of acquisition.
(ii) Land and clinical buildings are yet to be revalued at fair value and are carried at revalued amounts determined prior to the beginning of the current progressive revaluation.

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	13,674	50,374
Paid as cash by the Health Service from other funding sources	2,668	0
Gross payments for purchases of non-current assets	16,342	50,374

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	11,500
Carrying amount at end of year	11,500
Buildings	
Carrying amount at start of year	1,507,005
Depreciation	(45,210)
Carrying amount at end of year	1,461,795
Computer equipment and software	
Carrying amount at start of year	6,291
Disposals	(604)
Depreciation	(1,866)
Carrying amount at end of year	3,821
Furniture and fittings	
Carrying amount at start of year	42,701
Additions	2,668
Disposals	(165)
Depreciation	(4,838)
Carrying amount at end of year	40,366
Other mobile plant	
Carrying amount at start of year	789
Depreciation	(118)
Carrying amount at end of year	671
Other plant and equipment	
Carrying amount at start of year	78,231
Additions	13,674
Disposals	(162)
Depreciation	(10,687)
Carrying amount at end of year	81,056

Note 20 Accrued salaries	2001/02 $	2000/01 $
Amounts owing for:	18,402	15,206
Nursing staff		
7 days from 23 June to 30 June 2002		
(2001: 6 days from 24 June to 30 June 2001)		
Non-nursing staff		
7 days from 23 June to 30 June 2002		
(2001: 6 days from 24 June to 30 June 2001)		

Note 21 Provisions

Current liabilities:		
Annual leave	125,015	108,346
Long service leave	21,703	14,665
	146,718	123,011
Non-current liabilities:		
Long service leave	31,364	40,357
	31,364	40,357
Total employee entitlements	178,082	163,368

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 Accumulated surplus / (deficiency)	2001/02 $	2000/01 $
Balance at beginning of the year	1,507,376	1,602,338
Change in net assets	4,133	(94,962)
Balance at end of the year	1,511,509	1,507,376

Note 23 Notes to the statement of cash flows

a) **Reconciliation of cash**

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

Cash assets (Refer note 14)	608	10,121
Restricted cash assets (Refer note15)	18,753	18,115
	19,361	28,236

b) **Reconciliation of net cash flows used in operating activities to net cost of services**

Net cash used in operating activities (Statement of Cash Flows)	(1,146,433)	(1,013,770)
Increase / (decrease) in assets:		
GST receivable	1,490	2,758
Other receivables	8,036	(11,114)
Inventories	(3,865)	(355)
Prepayments	(962)	962
Decrease / (increase) in liabilities:		
Payables	4,927	(11,400)
Accrued salaries	(3,196)	(2,898)
Provisions	(14,714)	(4,235)
Non-cash items:		
Depreciation expense	(62,719)	(65,611)
Profit / (loss) from disposal of non-current assets	(930)	(449)
Capital user charge paid by Department of Health	(137,653)	0
Other expenses paid by Department of Health	6,500	5,250
Superannuation liabilities assumed by the Treasurer	0	(71,868)
Resources received free of charge	(6,500)	(5,250)
Other	(6,501)	66,704
Net cost of services (Statement of Financial Performance)	(1,362,520)	(1,244,684)

c) **Notional cash flows**

Output appropriations as per Statement of Financial Performance	1,360,153	1,011,150
Capital appropriations as per Statement of Financial Performance	0	61,454
	1,360,153	1,072,604
Less notional cash flows:		
Items paid directly by the Department of Health for the Health Service and are therefore not included in the Statement of Cash Flows:		
Capital user charge	(137,653)	0
Capital subsidy	0	0
Other non cash adjustments to output appropriations	(68,600)	(61,454)
	(206,253)	(61,454)
Output appropriations as per Statement of Cash Flows	1,153,900	1,011,150

Note 24 Revenue, public and other property written off or presented as gifts

a) Revenue and debts written off.	0	224
b) Public and other property written off.	0	0

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

c) Gifts of public property provided by the Health Service.	0	0

Note 25 Remuneration of members of the accountable authority and senior officers

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

	2001/02	2000/01
$20 000 - $30 000	1	0
$30 001 - $40 000	0	2
$40 001 - $50 000	1	0
Total	2	2

	$	$
The total remuneration of senior officers is:	63,207	68,906

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

Note 26 Explanatory statement

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

	2001/02 $	2000/01 $	Variation $
Expenditure			
Fees for visiting medical officers Reduction in outpatients occasions of service.	30,293	34,587	(4,294)
Patient transport costs Increase number of PATS claims this year.	19,872	14,488	5,384
Repairs maintenance & consumable equipment expense Worksafe compliance, A&E upgrade/WIP in prior year.	56,847	129,884	(73,037)
Capital user charge Newly introduced under capital appropriation policy.	137,653	0	137,653
Other expense from ordinary activities Reduced expenditure due to tighter fiscal management.	64,938	77,225	(12,827)
Revenues			
Patient charges Increase in patient charge rates.	248,969	234,013	14,956
Donations revenue Increase donations from the public.	3,528	2,379	1,149
Interest revenue Reduced level of funds held in bank accounts.	1,501	6,067	(4,566)
Other revenues from ordinary activities Reduced recoveries from hostel expenses.	25,893	38,512	(12,619)
Output appropriations Introduction of capital user charges.	1,360,153	1,011,150	349,003
Capital appropriations Accident & emergency upgrade and worksafe compliance in prior year.	0	61,454	(61,454)
Liabilities assumed by Treasurer Change in funding arrangements for superannuation.	0	71,868	(71,868)
Resources received free of charge Increase in nominal fee for services.	6,500	5,250	1,250

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

	2001/02 Actual $	2001/02 Estimate $	Variation $
Expenditure			
Fees for visiting medical officers Overestimation.	30,293	45,000	(14,707)
Superannuation Use of agency reduces superannuation commitments.	66,450	74,000	(7,550)
Indirect patient support costs Overestimation.	19,872	46,000	(26,128)
Repairs maintenance & consumable equipment expense Insufficient funds to purchase additional items of equipment.	56,847	95,000	(38,153)
Other expense from ordinary activities Reduced expenditure due to tighter fiscal management.	64,938	88,000	(23,062)
Revenues			
Patient charges Increase in patient activity / private NHTP.	248,969	230,000	18,969
Donations revenue Increase donations from the public.	3,528	2,000	1,528
Interest revenue Reduced level of funds held in bank accounts.	1,501	6,000	4,499
Other revenues from ordinary activities Reduced recoveries from hostel expenses.	25,893	37,000	11,107
Hospital Fund - recurrent appropriations Introduction of capital appropriation and capital user charges.	1,360,153	1,183,000	177,153

Note 27 Commitments for Expenditure

	2001/02 $	2000/01 $
a) **Operating lease commitments:** Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	6,940	3,638
Later than one year, and not later than five years	4,626	11,508
	11,566	15,146

These commitments are all inclusive of GST.

Note 28 Contingent liabilities

At the reporting date, the Health Service is not aware of any contingent liabilities as at June 30 this year.

Note 29 Events occurring after reporting date

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

Note 30 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 31 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 32 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	2.3%	1	0	0	0	0	1
Restricted cash assets	4.2%	9	10	0	0	0	19
Receivables		0	0	0	0	31	31
		10	10	0	0	31	51
Financial Liabilities							
Payables		0	0	0	0	24	24
Net financial assets / (liabilities)		10	10	0	0	7	27
As at 30th June 2001							
Financial Assets							
Cash assets	2.8%	10	0	0	0	0	10
Restricted cash assets	0.0%	18	0	0	0	0	18
Receivables		0	0	0	0	22	22
		28	0	0	0	22	50
Financial Liabilities							
Payables		0	0	0	0	29	29
Net financial assets / (liabilities)		28	0	0	0	(7)	21

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 33 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	53	48	422	388	581	533	1,056	969
Fees for visiting medical practitioners	2	2	12	14	17	19	30	35
Superannuation expense	3	4	27	29	37	40	66	72
Patient support costs	7	8	59	65	81	89	147	162
Patient transport costs	1	1	8	6	11	8	20	14
Repairs, maintenance and consumable equipment expense	3	6	23	52	31	71	57	130
Depreciation expense	3	3	25	26	34	36	63	66
Net loss on disposal of non-current assets	0	0	0	0	1	0	1	0
Capital user charge	7	0	55	0	76	0	138	0
Other expenses from ordinary activities	3	4	26	31	36	42	65	77
Total cost of services	82	76	657	610	903	839	1,642	1,526
Revenues from Ordinary Activities								
Patient charges	12	12	100	94	137	129	249	234
Donations revenue	0	0	1	1	2	1	4	2
Interest revenue	0	0	1	2	1	3	2	6
Other revenues from ordinary activities	1	2	10	15	14	21	26	39
Total revenues from ordinary activities	14	14	112	112	154	155	280	281
NET COST OF SERVICES	**68**	**62**	**545**	**498**	**749**	**685**	**1,363**	**1,245**
Revenues from Government								
Output appropriations	68	51	544	404	748	556	1,360	1,011
Capital appropriations	0	3	0	25	0	34	0	61
Liabilities assumed by the Treasurer	0	4	0	29	0	40	0	72
Resources received free of charge	0	0	3	2	4	3	7	5
Total revenues from government	68	57	547	460	752	632	1,367	1,150
Change in net assets	**0**	**(5)**	**2**	**(38)**	**2**	**(52)**	**4**	**(95)**

Note 33 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).