ACCOUNTING MANUAL

FOR

PUBLIC HEALTH ORGANISATIONS

DEPARTMENT OF HEALTH

ACCOUNTING MANUAL FOR PUBLIC HEALTH ORGANISATIONS

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FOREWORD

This Manual has been extensively revised and is to be read in conjunction with the amended Accounts & Audit Determination for Area Health Services and Public Hospitals. The revisions in both publications take into account the policy and procedural changes arising from the introduction of district health services and other legislative changes, particularly to the ***Public Hospitals Act 1929***, and are designed to set out financial, accounting and audit policy and procedures applicable to area health services, district health services and public hospitals.

This Manual makes frequent reference to the Accounts & Audit Determination and should be considered as a procedure manual which outlines in greater detail some of the matters contained, or gives practical guidance in respect of matters referred to in that Determination. As such, any matter raised in this Manual should be considered as having the same force as that given in the Determination and not as an alternative. Should there be any apparent inconsistency in respect of any issue common to both publications the Accounts & Audit Determination takes precedence over the Accounting Manual. Terms used in the Accounting Manual have the same meaning as those defined in the Accounts & Audit Determination.

All administrators of health organisations are required to know and ensure observance of the requirements of the Accounts & Audit Determination in respect of accounting and audit policy. This Manual elaborates in specific instances upon that Determination and together they reflect current policy and procedures of the Department of Health, NSW and outline the practices which are to be followed by a health organisation as a condition of receiving subsidy from the Department.

As such, this Manual outlines the responsibilities of a health organisation in receipt of subsidy from the Department which are current at the date of publication. Official amendments will be issued from time to time to cause it to accurately reflect those further pronouncements or requirements which are contained in any relevant circular issued by the Department subsequent to the publication of this Manual, and each health organisation should ensure that it is revised in accordance with official amendments issued for that purpose. Further, suggestions for future amendments may be submitted by users of this Manual through appropriate channels, i.e. area health services and district health services, to the Department's Audit Branch.

Accrual Accounting

The content of the Department's Accrual Accounting Standards and Procedure Manual is now incorporated in this Manual as a complete section with amendments being made to the general Manual content to reflect the accrual accounting requirements.

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INTRODUCTION

As laid down in the Accounts & Audit Determination for Area Health Services and Public Hospitals, a health organisation shall keep accounting records and maintain suitable accounts by manual or electronic means to ensure that:

(i) its financial affairs are accurately and reliably recorded;
(ii) that reports can be prepared which reliably present the affairs and operations of a health organisation; and
(iii) allow the reports required by the Department to be presented in the required form, facilitating a common presentation across health services generally.

Because a health organisation receives a very significant proportion of its funding from the State Government it has an obligation to maintain accounting records and systems of control which are at least similar to the accounting systems and controls which are laid down in the Treasurer's Directions issued under the ***Public Finance and Audit Act 1983***.

This Manual outlines the minimum standard required of a health organisation in receipt of Government Cash Payments (both recurrent and capital) and applies the requirements of the Treasurer's Directions to health organisations generally where they are appropriate to such organisations.

In this respect, the Accounts & Audit Determination identifies responsibility as follows:

"The Board of Directors (where applicable) and the Chief Executive, or equivalent, of a public health organisation shall be responsible to ensure:

(i) the proper performance of its accounting procedures including the adequacy of its internal controls;
(ii) the accuracy of its accounting, financial and other records;
(iii) the proper compilation and accuracy of its statistical records; and
(iv) the due observance of the directions and requirements of the Director-General and the Department

as laid down in this Determination and in circulars and directives issued by the Minister, the Director-General and the Department."

DISTINGUISHING BETWEEN FUNDS

A health organisation is required by the Accounts & Audit Determination to distinguish between its General Fund and its Special Purposes and Trust Fund, having adequate accounting and associated records which allow it to accurately and reliably record the affairs of each fund and clearly distinguish the affairs of one from the other.

Expenditures on Mental Health, Aboriginal Health and Community Health programs must be maintained in real terms, at least at the level of 1998/99 annual budgets. Any reductions to those budgets can only occur with the Department's approval.

Accrual Accounting

A health organisation that has been directed by the Department to introduce accrual accounting on or after 1 July 1990, shall keep its accounts, prepare its financial statements and report in accordance with the provisions of the Accrual Accounting Standards and Procedure Section of this Manual.

In any instance where a provision of the Accrual Accounting Standards and Procedure Section differs from a provision of the Accounts & Audit Determination or a provision of the Accounting Manual for Area Health Services and Public Hospitals regarding accounting, the provision of the Accrual Accounting Standards and Procedure Section prevails.

General Fund

Accounting records shall be maintained on the double entry system of accounting, using ledger accounts and subsidiary ledger accounts, and journals to accurately and reliably record the financial operations and affairs of the health organisation.

Special Purposes and Trust Fund

The accounting records of the Special Purposes and Trust Fund are to comply with the requirements of the Accrual Accounting Standards and Procedures Section.

TREASURY MANAGED FUND

It is compulsory for all Budget Sector Departments, including the Department of Health, to belong to the Treasury Managed Fund and to have the Fund undertake claims management. Any consultancies which are aimed at setting up individual Area or District/Hospital Managed Funds or which offer claims management should **not** therefore be entertained.

Where approval is obtained from the Department health organisations are permitted to establish a cash reserve against possible future managed fund deficits within the General Fund.

Declaration of dividend and payment should be at same time. However, if cash follows at a later date GIO is to be recognised as banker. No change is to be effected.

The Department of Health operates under Treasury direction a managed fund approach to all income policies for the NSW public hospital system.

Such policies cover:
(i) Cash in Transit;
(ii) Fidelity Guarantee (in respect of all employees);
(iii) Fire and Other Perils (in respect of hospital buildings and contents);
(iv) Personal Accident (in respect of hospital board directors);
(v) Personal Accident (in respect of voluntary workers);
(vi) Public Liability;
(vii) Workers' Compensation.
(viii) Motor Vehicles (comprehensive)

Area Health Services, District Health Services and Public Hospitals shall:

(i) comply with directions issued by the Department of Health from time to time concerning the operation of the managed fund including requirements in respect of:
- the insured component
- the managed fund component

(ii) ensure sound risk management policies are adopted.
(iii) comply with requests issued by the Fund Manager (GIO from 1.7.89) including the use of on-line computer processing requirements on claims processing.

In this regard, the Chief Executive Officer, must be satisfied that each such group's activities are bone fide health related.

However, to reduce potential liability to the centrally held Public Liability Managed Fund, such groups should be encouraged to take independent public liability insurance if at all possible.

Whilst the Public Liability Managed Fund has been retained centrally, it is the responsibility of all Chief Executive Officers to ensure that effective risk management procedures are applied to the area of liability and deficits, if any, must be met from within the Departments' allocation.

Chief Executive Officers should insist that non health related groups who wish to use hospital facilities have adequate public liability insurance coverage, prior to such use being approved.

LEDGER ACCOUNTS

Ledger accounts shall be classified to provide at minimum monthly, quarterly and annual reports required by the Department and those other reports required by external agencies. The Chart of Accounts may be expanded to suit local needs, provided the health organisation is able to supply its financial information in the form required by the Department of Health, NSW.

JOURNALS

The following journals shall be used:

General Journal (with appropriate narrations for each entry);
Fees Journal;
Cash Receipts Journal;
Cash Payments Journal;

Where appropriate, an electronic interface may be used between the General Ledger and subsidiary accounting systems to replace the manual preparation of Fees Journals, Cash Receipts Journal and Cash Payments Journals.

Other subsidiary journals as required may be used to ensure that the financial affairs of a health organisation are accurately and reliably recorded.

The receipts and payments accounts of a health organisation shall have provision for dissection in accordance with the prescribed Chart of Accounts and be updated regularly, showing all receipts and payments and amounts deposited in the bank. These accounts shall be reconciled with official records maintained by the bank or financial institution (i.e. bank statement, certificate, passbook etc.) at the end of each month and particulars of the reconciliation shall be:

(i) recorded or appended in an appropriate section of the Cash Records;
(ii) signed by the person preparing the reconciliation;
(iii) checked and signed by the supervisor of the person who prepared the reconciliation.

REGISTERS

The following registers shall be used in respect of the General Fund:

Register of Accountable Records;
Stores Register;
Commitments Register;
Assets Register;
Motor Vehicle Register;

and other registers as are required to ensure that the financial affairs of a health organisation are accurately and reliably recorded.

Register of Accountable Records

Accountable records are documents, records or registers which relate to the ordering, payment, receipting or recording of moneys and/or assets identified by serial numbers or other specific reference, and include: Admission Forms (A1 Forms)/Patient Fees Record Cards, Cabcharge Vouchers, Cheques (Computer/Manual), Meal Tickets, Purchase Order Books, Receipts.

A health organisation shall maintain a record of all accountable forms and records held unissued in stock, in use, or used or cancelled. The register shall be a bound volume with numbered pages and shall show particulars of the accountable records, such as: serial numbers; the date of issue; the person to whom the documents were issued; the location where they are to be used, the date when the volume was returned as used or to be cancelled etc., and the signature/initials of the persons issuing and receiving the documents.

Stores Register

The Stores Register shall record (on stock cards or on an electronic medium) the receipt and issue of stores, and be supported by an adequate system of internal control to ensure that such assets are adequately safeguarded.

The register shall provide for appropriate controls over all goods received and issued from the store.

Stock records should show:

(a) **Goods Received:**
Date of Delivery
Description of Goods
Quantity Received
Storage Centre
Initials of Receiving Officer

(b) **Goods Issued:**
Date of Issue
Particulars of Requisition (Requisition order no.)
Description of Goods
Quantity Issued
Initials of Issuing Officer
Initials of Receiving Officer

A separate register may be kept where the volume of issues justifies a separate register for certain stores items. Supplies of Drugs, both into and out of store should be separately controlled (by the pharmacist) in compliance with the Purchasing and Storekeeping Procedure Manual for Area Health Services and Public Hospitals. The provisions of that Manual should also be observed in respect of Receipt and Custody of Stores.

Commitments Register

The Department of Health, NSW required the introduction of a formal commitments register (either manual or electronic) within each health organisation from 1 July 1988, with a view to facilitating:

- greater accountability at the “cost centre”, or point of order;

- more accurate recording and reporting of the financial situation;
- earlier detection of budgetary problems;
- greater precision in management's assessment of the availability of funds and the appropriateness of further expenditure; and
- assistance in the future introduction of accrual accounting.

General Requirements

Commitment registers are to be maintained in respect of funding for individual programs, e.g. 2.3 "Support for Area Health Services and Public Hospitals", 2.8 "Services Mainly for the Psychiatrically Ill", etc.

Details of commitments must be maintained, at a minimum, for the following line items in respect of each program:

- Goods and Services; and
- RMR (Repairs, Maintenance & Replacements)

Individual health organisations may wish to dissect the above line items into sub-headings, dissect the register for a program into various departments, or establish commitment records for the other line items.

The register may be comprehensive, or a consolidation of subsidiary registers introduced in any section of a health organisation which raises requisitions/orders and processes invoices - e.g. store, pharmacy, catering, engineering, etc. Consolidation is essential in order to ensure that all commitments, whether they be general orders through the store or direct purchases by other sections, are recorded in respect of the health organisation as a whole.

Procedures

1. The source document for the commitment register system is the official purchase order.
2. A commitments register should be updated progressively during each reporting period as orders are placed for the supply of goods and services.
3. When the invoice from the supplier relating to each order (commitment) is paid, the commitment in the register should be identified as discharged, by a recording of the appropriate information.
4. Provision will need to be made to account for commitments of a standing nature where no order is placed, e.g. utility charges such as rates, electricity charges, etc.
5. Where an order is not costed, an accurate estimate of the cost incurred should be made and recorded.
6. Appropriate procedures will need to be applied to accurately record the relevant details where an order is only partially filled.
7. The commitment register should be added at the end of each period to obtain the value of outstanding commitments on a period and year-to-date basis (i.e. total commitments to date less invoices processed and other goods/services provided which are as yet unpaid).
8. The results as obtained in point 7. above, along with the year-to-date actual expenditure, should then be used in assessing the current position and end of year projected results.

Relevant details of such commitments are also required to be incorporated in the annual reports to be furnished by a health organisation.

Commitment registers should be used as a management tool to permit financial assessment of current and projected results. They must be properly maintained and be readily available for audit and inspection purposes. A health organisation will be held fully accountable for any commitments entered into which cannot be encompassed within the budget allocations.

Assets Register

A health organisation shall appoint an officer(s) who is responsible to maintain an assets register/s as an accountable document. It shall be registered in the Register of Accountable Records at the time of issue and each page shall be numbered to allow for identification of all items and ensure accountability.

If the assets register is maintained by an electronic data process, controls should apply to ensure that:
(a) relevant particulars to identify it are recorded in the Register of Accountable Records;
(b) records cannot be made, altered or deleted by an officer who is not authorised to do so; and
(c) an audit trail is maintained in respect of every authorised entry, alteration or deletion, and supported by documentation which is readily accessible for verification or review.

An assets register software package has been prepared as an interface with the Department's Hosfin system and is an integral component of the ORACLE Financials package. Health organisations using other processing systems shall ensure that, as a minimum requirement, the alternative system provides the information and control available under the Hosfin or ORACLE systems.

The officer(s) maintaining the assets register(s) shall be an officer other than the person responsible for:
(a) maintaining the Register of Accountable Records; or
(b) custody of assets.

The assets register shall contain a section for condemnings or disposal of assets, to include particulars of the reasons for and the names of the officers approving the disposal of any asset.

Receipt of Assets

A health organisation shall institute controls to ensure that delivery of assets is accepted only by persons authorised to take delivery of such items and written evidence of the receipt of assets should be provided by the authorised officer in one of the following ways:
(a) The authorised officer may personally certify the receipt of the goods, if the delivery complies with the official order.
(b) If an order is only part delivered, delivery should be acknowledged on a delivery docket or invoice.

The evidence of delivery shall then be forwarded promptly to the ordering section where the official order shall be noted to record details of delivery and the evidence of delivery shall be attached to the payment voucher copy of the official order or a separate payment voucher and forwarded to the payments section for processing and eventual payment to the supplier.

In regard to a non-current asset a copy of the order form with the relevant particulars describing the assets acquired shall be forwarded to the officer in charge of maintaining the assets register.

A health organisation receiving donated assets shall provide a donation advice to the donor (such as a letter from the chief executive officer) and a copy of this advice together with the relevant particulars describing the donation shall be submitted to the officer in charge of maintaining the assets register.

Recording Non-Current Assets

All accountable items are to be recorded in the Assets Register. These accountable items are assets having a purchase cost in excess of $5,000 and a life expectancy of more than two years.

Attractive items which do not satisfy the above life expectancy/cost criteria are to be recorded for safekeeping purposes only and such items are not to be assigned a monetary value which is taken up in the financial statements.

These items include automatic data processing and ancillary machines, expensive trade equipment such as circular saws etc., word processors, typewriters, bookkeeping or adding machines, calculating machines costing more than $200, safes, copiers, dictating machines, works of art, technical equipment which is subject to wear and tear and eventual replacement; and

Entries in the assets register shall include relevant particulars sufficient to identify:
(a) the assets (such as general description, make, model, serial number, cost, supplier);
(b) its place of location;
(c) the officer responsible for its custody (who shall be required to confirm in writing that the asset has been taken into custody).

If an asset is donated or a "second-hand" item is purchased, a special note to this effect shall also be recorded along with a brief description of its condition.

A health organisation may organise its assets register(s) in a manner which best suits its administrative needs provided that sufficient records are maintained to identify all non-current assets which shall be registered and that particulars of all registers are recorded in the Register of Accountable Records.

Identification of Non-Current Assets

The chief executive officer of a health organisation shall ensure that non-current assets other than real property or buildings are either engraved or stamped (unless the nature of the item renders marking an impracticable action) at the earliest practicable date with:
(a) the name of the health organisation; and
(b) some identification which identifies the item in the assets register,

to discourage theft, or for easier identification if the goods are subsequently recovered by authorities after being stolen.

Stocktaking

In carrying out stocktakes or sightings, regardless of the system used, the following principles appropriate to stocktakes should, to the extent practicable, be observed:
(a) Stocktaking lists are to be compiled by an officer nominated by the chief executive officer and retained for 2 years after audit. Where practicable this should be a person other than the person who has custody of the equipment.

(b) Whereas a stocktake of accountable items will normally be conducted so as to sight each item once every 12 months, it is desirable that "Pool" or "Common User Items", and items which are "highly attractive", are recorded in a register when issued to staff and returned to store.

(c) When a stocktake reveals a substantial discrepancy, e.g. loss of an asset recorded in the assets register, an officer is to be nominated by the chief executive officer to conduct an appropriate investigation prior to giving a written report of discrepancies. He/she should also report the action taken to locate missing items in a brief report, which when accepted by the chief executive officer, or delegated officer, is to be attached to a record of condemnings or filed separately.

(d) The chief executive officer, or delegated officer, is to determine the appropriate action to be taken in light of the investigation conducted as in (c), taking into account the following:
   i) Should theft or malpractice be suspected, the matter is to be reported to the police.
   ii) Should the loss be caused by carelessness or disregard of procedures, appropriate corrective action is to be taken about the cause of the loss.

(e) If the chief executive officer, or delegated officer, is satisfied that any missing item cannot be recovered and that appropriate action has been taken regarding (d), action to write-off the item and adjust the equipment register is to be considered.

(f) Following full investigation of any discrepancies and approval of any write-off action:
   i) A certificate signed by the chief executive officer, or delegated officer, is to be prepared and secured in the relevant assets register.
   ii) Equipment registers are to be adjusted and signed by officers authorised to maintain the assets register.
   iii) An appropriate entry shall be made in the section for condemnings and signed by the same two officers (whenever possible) who adjusted the records in the assets register.
   iv) Ledgers will be adjusted to write off the asset value. In the case of plant and equipment this will be by means of the accumulated depreciation to date and, secondly, the loss which is equivalent to the written down value of that asset.

Write-off and Adjustment of Stocktaking

The CE of an area health service and Royal Alexandra Hospital for Children, or delegate, can approve the write-off of stocktaking discrepancies and adjustment of equipment/asset registers and other inventory records etc. If delegated, annual advice is to be provided to the CE, or delegate) on the level of write-offs and where material corrective action has been undertaken or is proposed.

The CE, or delegate, in delegating the write-off authority is also responsible for determining conditions, if any, that apply in the exercise of any delegation, e.g. $ value limits for write-offs to certain levels of officers.

ALTERNATIVE STOCKTAKING

The following suggestions may be of assistance in carrying out stocktakes or sightings with the agreement of external audit.

(a) In lieu of annual stocktakes stocktaking can be performed on a staged approach throughout the year so as to minimise interference with clinical programs and enable the financial reports to be prepared without undue involvement at year end, e.g.
   i) some areas being covered each month or in particular months;
   ii) some areas being covered during a progressive stocktake;
   iii) some areas being covered during periods of quieter activity.

(b) Consideration should always be given to programming stocktaking activities so that they occur at times when the staff involved are not under peak pressure from other workload demands.

(c) Where practicable Internal Audit should also witness major stocktakes performed and ensure adequate workpapers/documentation is retained in order that external auditors can clearly evaluate the extent of reliance they may place on the work performed.

Motor Vehicle Register

A separate motor vehicle register is to be maintained in accordance with the detailed requirements and procedures contained in the Purchasing and Supply Manual.

CORRECTION OF ERRORS

Erasures, overwriting of figures or words or the use of correction fluid shall not be permitted in any books of account or of record. Where corrections are necessary, the incorrect word or figure shall be ruled through in ink, and the correction substituted and initialled by the employee making it in any source documents, books of account or of record.

RETENTION OF RECORDS

Records are to be retained in accordance with the undermentioned "General Disposal Authorities" obtainable from the State Records Office:

- Personnel Records - General Disposal Authority 12
- Administrative Records - General Disposal Authority 2
- Financial & Accounting Records - General Disposal Authority 7
- Administrative Records – General Retention & Disposal Authority 21

RETENTION AND DISPOSAL OF RECORDS ON THE CLOSURE OF HEALTH ORGANISATIONS (PD2005_282)

The following instructions have been produced to clarify responsibilities concerning records management on closure of health organisations. Some general information is given, along with responsibilities for closures and the recording process that is to be followed.

Accounting, Medical, Personnel, Administrative and Electronic Records are dealt with individually as procedures vary slightly between each record group. Subsequent to the closure of a health organisation the procedures as specified in this document are to be followed in respect to the functional groups indicated.

Enquiries should be directed to the Records Management Supervisor, Records Management Centre, Central Administration, Department of Health on (02) 9391 9076.

1. GENERAL

The procedures set out in this document are to be followed in respect of public records. These are defined in Section 3 (1) ***State Records Act 1998*** as:

> "*Record means any document or other source of information complied, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means."*

This is a wide definition which encompasses the more modern kinds of records, including those on microform and on machine readable computer tapes, disks, optical disks, etc.

2. RESPONSIBILITY FOR CLOSURES

2.1 Area Health Services

Area Health Services are to be responsible for the storage of records and the undertaking of disposal action in respect to hospitals etc. under their administration.

2.2 Department of Health, Central Administration

Department of Health, Central Administration is to be responsible for the storage of records and the undertaking of disposal action in respect to the Department of Health administrative units, statutory health corporations under the *Health Services Act 1997*.

2.3 Governing Bodies

Governing bodies, e.g. Homes of Peace, are to be responsible for the storage of records and the undertaking of disposal action in respect to organisations under their auspices.

3. MANAGEMENT OF CLOSURES

3.1 Recording Procedures

Each responsible area is to create a file that incorporates details of:
- records or documents destroyed;
- documents retained;
- documents transferred to other locations;
- details of officers who undertook closures.

3.2 Confidentiality

All records are to be securely stored with confidentiality ensured.

3.3 Storage Procedures

All records are to be boxed and comprehensively listed in accordance with the Government Records Repository standards. These are set out in their publication "Procedures For Using The Government Records Repository".

4. ACCOUNTING RECORDS

Officers from the health organisation in conjunction with an officer from the Area Health Service or Central Administration will undertake the following activities.

4.1 Accountable Records

4.1.1 Records held are to be checked against the accountable books register.

4.1.2 A schedule of documents that cannot be located is to be prepared. Local health organisation management should endeavour to locate the documents. If unlocatable the local health organisation management is to obtain approval from the appropriate Area Health Service, or Central Administration for the adjustment of the records etc.

4.2 Retention/Disposal Procedures

4.2.1 Mark retention periods on used documents with the documents being boxed and listed in accordance with the Government Records Repository standards. These are set out in their publication "Procedures For Using The Government Records Repository".

4.2.2 Destroy all documents that are unused.

4.2.3 As an alternative to destruction unused documents may be transferred to another health organisation subject to letters of transfer and receipt being obtained specifying details of documents transferred, eg receipt numbers of receipt books etc.

4.2.4 Destroy or make void unused portions of partially used documents.

4.2.5 Destroy documents that have reached the periods indicated in the retention schedules specified in the State Records Office General Disposal Authority 7 - Financial and Accounting Records.

4.3 Destruction of Records

The destruction of documents is to be performed by a representative from the health organisation in conjunction with an officer from either the Area Health Service, District Health Service, or Central Administration. **Destruction is to be done by either shredding or burning.** The accountable books register is to be noted with the destruction date and officers' signatures.

5. MEDICAL RECORDS

Officers from the health organisation will undertake the following activities.

5.1 Retention/Disposal Procedures

5.1.1 Destroy or make void unused portions of partially used documents.

5.1.2 Destroy all documents that are unused.

5.1.3 As an alternative to destruction unused documents may be transferred to another health organisation subject to letters of transfer and receipt being obtained specifying details of documents transferred.

5.1.4 Destroy or make void unused portions of partially used documents.

5.1.5 Destroy documents that are beyond the periods indicated in the retention schedules specified in the Patient Matters Manual for Area Health Services and Public Hospitals.

5.2 Destruction of Records

The destruction of documents is to be performed by a representative from the health organisation in conjunction with an officer from either the Area Health Service or Central Administration. **Destruction is to be done by either shredding or burning.**

6. PERSONNEL RECORDS

Officers of the health organisation will undertake the following activities.

6.1 Retention/Disposal Procedures

6.1.1 Mark retention periods on used documents with the documents being boxed and listed in accordance with the Government Records Repository standards. These are set out in their publication "Procedures For Using The Government Records Repository".

6.1.2 Destroy all documents that are unused.

6.1.3 As an alternative to destruction unused documents may be transferred to another health organisation subject to letters of transfer and receipt being obtained specifying details of documents transferred.

6.1.4 Destroy or make void unused portions of partially used documents.

6.1.5 Destroy documents that are beyond the periods indicated in the General Disposal Authority 3 - Personnel Records issued by the State Records Office.

6.2 Destruction of Records

The destruction of documents is to be performed by a representative from the health organisation in conjunction with an officer from either the Area Health Service or Central Administration. **Destruction is to be done by either shredding or burning.**

7. ADMINISTRATIVE RECORDS

Officers of the health organisation will undertake the following activities.

7.1 Retention/Disposal

7.1.1 Mark retention periods on used documents with the documents being boxed and listed in accordance with the Government Records Repository standards. These are set out in their publication "Procedures For Using The Government Records Repository".

7.1.2 Destroy all documents that are unused.

7.1.3 As an alternative to destruction unused documents may be transferred to another health organisation subject to letters of transfer and receipt being obtained specifying details of documents transferred.

7.1.4 Destroy or make void unused portions of partly used documents.

7.1.5 Destroy documents that are beyond the periods indicated in the Disposal Authority 2 - Administrative Records issued by the State Records Office.

7.2 Destruction of Records

The destruction of documents is to be performed by a representative from the health organisation in conjunction with an officer from either the Area Health Service or Central Administration. **Destruction is to be done by either shredding or burning.**

8. ELECTRONIC RECORDS

Computer disks, tapes, optical disks and all other forms of data storage media which are no longer required can be disposed of by the following means.

8.1 Disks

8.1.1 Disks may be physically destroyed so that they are unusable by burning or mutilation (cutting in half, shredding etc.). Both means are to ensure that disks are totally unreadable.

8.2 Recycling of Magnetic Disks

8.2.1 Disks may be wiped of all data by using a disk wipe utility program such as Norton "Wipeinfo". These programs overwrite the data on each disk in such a way that it may not be reconstructed at a later date.

8.2.2 Disks may be wiped of all data by using a bulk eraser which destroys the data. The Bulk Eraser uses a strong magnetic field to randomise or scramble the magnetic particles on each disk preventing the data being reconstructed.

8.3 Optical Disks

8.3.1 Optical read only laser disk cannot be recycled. Read/Write optical disk can be treated as read only as there appear to be no utilities to wipe them currently available.

8.4 Magnetic Tapes

8.4.1 Magnetic tapes (of any type) can be bulk erased as with magnetic disks and then reused.

8.5 Disposal of Microcomputers

Microcomputers disposed of by sale, trade-in, or relocation should be treated as follows.

8.5.1 All data of a financial nature should be backed-up after all processing of data and production of reports to end period. The back-ups should then be stored as per retention period applicable and previous instructions.

8.5.2 The Hard Disk should be reformatted by using the MS-DOS FDisk, Norton "Wipeinfo", or other such disk erase utility. The disks should be left with only the operating system installed and any other software that may be installed as part of the disposal.

Financial Procedures for the Operation of Residences (Group Homes)

It is the responsibility of the Chief Executive, or delegate, to ensure that responsible persons in control of all personnel having custody, management or control of House or resident funds and/or property are familiar with the relevant sections of the Accounts & Audit Determination and other instructions issued by the Department applicable to their duties.

The following conditions should be applied to the administration of residences (Group Homes) operated by health organisations.

1. Managing House Finances

For the purpose of managing house finances an account is to be opened for each residence or for a group of residences. The account in each case should be titled "....House Operating Account", should be opened at a local bank or building society and be operated using two signatures on cheques or withdrawals. These signatories are to be staff who work in or are associated with the particular residence.

In the case of houses operated by health organisations the approval of the respective CE, or delegate, needs to be obtained to the opening of such accounts.

The following basic procedures, at least, must be observed by staff in respect of the House Operating Account:

- A simple cash book (Appendix I) showing receipts and payments is to be maintained. All payments (including petty cash) are to be supported by documentation which is to be filed and held for audit/inspection.
- All major domestic items costing more than $30 must be paid for by cheque and the dockets/receipts retained on file.
- A receipt book (numbered receipts) is to be maintained and receipt numbers are to be listed in the cash book.
- Banking is to be carried out regularly and at least weekly. When receipts exceed $50 banking must be done that day.
- A petty cash float (max. $200) will need to be established. The float must be balanced at least weekly. The maximum amount payable from petty cash is $30 per item.
- The cheque book and petty cash float are to be kept in a secure place with access restricted to person/s responsible.
- The Operating Account is to be reconciled monthly and the reconciliation, signed by any two cheque signatories, maintained in the cash book or some other permanent record. A financial statement (Appendix II) of operations for the month and year to date of the House Operating Account for each residence must be presented each month to the CE. At least every three months the accounts are to be examined and the financial statement is to be signed by the CE.
- Any excess of receipts over payments for any residence is to be held in that residence's House Operating Account for operating contingencies and the purchase of special items as decided upon by the residents. It is the responsibility of the health organisation to ensure that staff involved with purchases from House Operating Accounts are aware of the limits of their authority. Any purchase of major items (television, washing machine, stereo) must be authorised by persons holding a specific delegation by the health organisation as required by the Accounts & Audit Determination.
- While it is expected that residences will be self-supporting there may be instances where this is not the case, e.g. residents are children. In such a case it will be necessary for subsidy to be paid by the health organisation to the House Operating Account.

  Health organisation subsidies for funding shortfalls should be paid monthly/ quarterly in advance and should be based upon a written claim, signed by the CE, showing details of estimated receipts and payments, as well as details of cash on hand for the period in respect of which the subsidy is to apply.

  The total of such subsidies is to be clearly and separately identified in the residence's financial statements.

2. Residents' Finances

a. The residents should be assisted to handle their finances in a manner typical of an ordinary citizen. Staff should determine on an individual basis the level of assistance required and such assistance should be undertaken in such a way as to educate the resident in the management of his or her personal finances.

b. A savings account should be established for each resident in his/her name. Where in the opinion of the staff members and the resident or his/her representative the resident needs the protection, the withdrawal authority must stipulate the signature of both the resident and a responsible staff member, or, in the case of a resident who cannot sign on his/her own behalf, the signatures of two responsible staff members or the signature/s of nominated representative/s. Appropriate arrangements will need to be made with banks, building societies, etc., in accordance with these procedures. It is stressed that for the protection of staff and residents that where such assistance is necessary that efforts must be made to involve relatives and/or citizen advocates.

c. Where a resident is responsible for regular outgoings (mortgage payments, rent, maintenance payments, etc.) and these payments are of a set amount, it may be appropriate for arrangements to be made with the chosen financial institution to remit regular payments on the resident's behalf. This arrangement must of course be with the consent of the resident or his/her representative/s.

d. Where the resident draws upon his/her account, the responsible staff member should, as far as possible, ensure a record is maintained of the item or purpose for which the amount is withdrawn. This procedure is essential where staff members sign on behalf of residents.

e. Where the resident has an inheritance or savings in excess of $2,000 the following options should be considered:
   i. Where the resident formally gives consent, the services of a qualified professional (e.g. accountant, stockbroker) may be engaged, and/or;
   ii. The funds are to be invested in accordance with the *Public Authorities (Financial Arrangements) Act 1987* which is considered by the Department of Health to comply with the requirements of the *Trustee Amendment (Discretionary Investments) Act 1997*. Information regarding organisations with whom funds can be invested in accordance with this Act is shown separately within this Manual (see Investments).
   iii. Application can be made under the *Protected Estates Act 1983*, for the Protective Commissioner to manage the affairs of the resident. Such application should seek to have the funds for investment managed by the Protective Commissioner and for delegation to be granted for the resident's current account to continue to be administered by the staff members or resident's representative/s.

f. The residential staff should keep a register of all property entrusted to them by, or on behalf of, each resident. The register should detail the value, description, identification, date of purchase and disposal of any such property. When the property is returned to the resident, his/her signature should be obtained to verify the transfer of responsibility. If the resident is unable to sign, the transfer should be witnessed by a responsible person and signatures of the person handing over the property and the witness obtained. Property so held by the staff should be kept in a secure place with access limited to authorised staff. A small safe may need to be acquired for this purpose.

3. General

a. Board and Lodging

Charges for board and lodging are only to be applied to the personal income of residents. Charges are to be two-thirds of the invalid pension plus eighty per cent of the supplementary assistance rate.

If a pensioner client is not in receipt of supplementary assistance, arrangements should be made for application.

The maximum charge applicable relates to pensioners and non-pensioners. The rate to be charged is two-thirds of personal income to this maximum.

The rental component of the board and lodging charge is to be thirty per cent of the charges made.

b. Payment of Rental

Group homes may be established under a variety of arrangements. In some cases, houses may be specifically purchased, in other cases leased commercially or from the Housing Commission and in other cases existing Department of Health housing utilised.

For simplicity of operation, rental is to be paid from the operating account of each house on the basis previously established (30% of charges) to the health organisation. Responsibility for payment of rental, rates, mortgage payments, etc., if applicable, will then rest with the health organisation.

Payment of rent from the House Accounts is to be made to the health organisation every month. The health organisation concerned should then clear the rental monthly unless the lease specifies some other period. Where houses are controlled/owned by an Area the money may be utilised as "User Charges" revenue.

c. Payment for Food and Miscellaneous Items

Food is to be purchased from funds held in the House Operating Account and as far as practicable it is to be part of the training of residents to involve them in purchasing of daily and weekly requirements.

As part of the program residents are to be taken to shopping centres and taught how to purchase such requirements. This may involve payment by cheque or cash. Where cash is involved the following procedures are to be followed:

- A cheque drawn on the Operating Account is "opened" and cashed;
- Residents are taken shopping and make purchases and pay cashier in cash;
- The shopping cash register strip of purchases is filed with a covering voucher indicating the amount involved;
- Any excess cash is receipted and banked the receipt being filed with the voucher and shopping strip.

Where deliveries are made (milk, bread, etc.) and are paid by cheque, residents should be made aware of these operating costs and generally trained in the operation of the house. A similar system should apply with the payment of service accounts, viz. gas, electricity.

Documents supporting payments should be filed in cheque number order and held for audit/inspection.

d. Asset Registers

Asset Registers must be maintained and are to include:

- A record of plant, machinery, motor vehicles, tools, furniture, office equipment, scientific apparatus, books and appliances;
- A record of books issued on loan;
- A suitable register for all works of art.

In assigning values for inclusion in financial statements the record required to be maintained shall apply to items costing more than $5,000 with a useful life of more than two years. However, the following attractive items are also to be recorded:

- Computer and Ancillary Equipment
- Typewriters
- Calculators, Adding Machines, etc. costing more than $200
- Safes
- Technical Equipment, Instruments, Cameras, etc.
- Audio and Video Recording Machines
- Works of Art
- Any other items considered by the CE or by the delegated officer to be at risk of loss by misappropriation.

Any items acquired from House Funds which qualify as reportable assets in the financial statements need to be recognised as Area revenues (Donations/ Industry Contributions). Such revenues would however, not normally be expected.

Administrative control shall be kept of the usage rates of all items exempted from being recorded as plant. Requisitions for unrecorded items shall be supported by a statement of the reasons for procurement, and where appropriate, the date and quantity of the last supply. The approving officer should be satisfied of the need for the quantity requisitioned. All "unrecorded plant items" shall be entered in a Goods Inward Book or other appropriate record as received.

Where it is considered by the health organisation or by an officer with authority delegated by the CE that there is no significant risk, certification of this should be made in writing and retained on file and thereafter the maintenance of plant records for office furniture (including tables, chairs, document trays, lockers, cupboards, filing cabinets, floor coverings, etc.) may be discontinued.

Stores shall, upon receipt and if practicable, be stamped, impressed or otherwise marked in an indelible manner with the mark of the health organisation or department and once so stamped, impressed or otherwise marked, if to be disposed of other than by health organisation or departmental use shall be further marked to show that ownership by the health organisation has ceased.

For each items of plant (except exempted items) the following shall be recorded:

- Date of Receipt
- Purchase Price
- Location
- Serial or other distinguishing number, identification marks, brands or machine numbers
- List of Accessories
- Provision for entry of disposal details
- Any other relevant particulars.

When stores are transferred from a house to another centre without a charge being made for their value, a transfer advice giving full details shall be completed in triplicate and the original and duplicate shall be sent to the receiving officer who shall on receipt of the stores sign the original and return it to the despatching officer.

Registers should be checked against physical items at least annually and a return showing any discrepancies must be submitted to the CE, or delegate. Any adjustment requires the formal approval of the CE, or delegate.

Procedures with Receipting and Banking

Appendix (III) sets out some general accounting procedures for the assistance of staff involved in the operation of these houses.

Audit Requirements

All residences (group homes) are to be subject to review by Area Health Service internal auditors and Department of Health Inspectors/Auditors. The operation of the residences/group homes is also to be brought to the attention of appointed Area Health Service/Hospital external auditors.

APPENDIX I

HOUSE OPERATING ACCOUNT

CASH BOOK														
RECEIPTS								PAYMENTS						
DATE	RECEIPT NO	NAME & PARTICULARS	PERIOD	RENT	FOOD	MISC	BANK	DATE	PARTICULARS	CHQ	RENT	FOOD	MISC	TOTAL
		Balance b/fwd		-	297.00	328	625	26/1/86	St.George Hosp	1	142			142
24/1/86	1	J.Jones - B & L	20-26/1	28.40	37.60	5.0	71	26/1/86	Food	2		216		216
26/1	2	Repay - food			15.00		15	"	Phone - Telecom	3			105	105
"	3	J.Smith - B & L	"	28.40	37.60	5.0	71	"	SCC - Electric	4			223	223
"	4	B.Black - B & L	"	28.40	37.60	5.0	71		Balance c/fwd	-		284	25	309
"	5	S.Slack - B & L	"	28.40	37.60	5.0	71							
"	6	B.Green - B & L	"	28.40	37.60	5.0	71							
				142.00	500.00	353	995				142	500	353	995

APPENDIX II

FINANCIAL STATEMENT OF HOUSE OPERATING ACCOUNT

FOR MONTH ENDED.....

Balance of Funds at commencement			xxx	
Add:	Receipts			
	Accommodation charges	xxx		
	Other (give details)	xxx		
				xxx
Total Receipts			xxx	
Less:	Payments	xxx		
	Rent	xxx		
	Food	xxx		
	Electricity/Gas	xxx		
	Other (give details)	xxx		
Total Payments			xxx	
Balance of Funds			xxx	
Balance as per bank statement			xxx	
Add: Outstanding deposits			xxx	
				xxx
Less: Unpresented cheques				
				xxx
				xxx

Signed: .....
House Manager

APPENDIX III

GENERAL PROCEDURES WITH RECEIPTING AND BANKING

1. Variation of Signatures on House Operating Account

a. Approval of the Area Health Service and Department of Health must be obtained to a change in signatories to the account and this formal approval must be held on file.
b. Forms for variation of signature on banking accounts are obtained from the bank. Subject to the necessary approval being obtained they should be completed and lodged with the bank.

2. Stoppage of Payment of Cheques and Issue of Replacement Cheques

a. Where it is necessary to stop payment on a cheque the bank should be immediately notified.
b. The bank form for stoppage of cheques should be completed by officers having authority to stop payment on cheques.
c. An appropriate notation must be made against the related entry in the cash book and noted on the payment voucher.
d. The bank form where acknowledged by the bank should be filed with the payment voucher.
e. Before any replacement cheque is issued an adequate check must be made to ensure that the original cheque has not been paid by the bank and that the stoppage of payment has been effected.
f. Particulars relating to each stopped cheque should be recorded in a "Stopped Cheque Register" kept for that purpose. The following particulars should be entered:

    - details of stopped cheque, reason for stoppage, confirmation of stoppage, authorisation to replace cheque and details of replacement cheque.

3. Opening of Cheques

Cheques will need to be "opened" to obtain cash for regular shopping (groceries). Also there may be occasions where the payee requests that the cheque be opened.

Where a cheque is opened at a payee's request his/her identity must be established and endorsement of the payee obtained on the cheque. Acquittances must be obtained for all opened cheques and a Record of Cheques Opened be maintained in which is recorded the cheque number, reason for payment and the cheque signatories.

4. Dishonoured Cheques

A cheque dishonoured after lodgement to a House Operating Account will be debited by the bank to the account. A corresponding entry will need to be made in the cash book.

On receipt of advice that a cheque has been dishonoured, except in cases of omitted or incorrect endorsement which can be rectified, communication immediately with the drawer of the cheque with a view to the correction of the irregularity or to obtaining a fresh remittance should be instigated. Such fresh remittance should be either cash or bank cheque.

The Area Health Service and Department of Health are to be advised of any dishonoured cheques.

5. Stale Cheques

Cheques unpresented for six months are to be followed up and, if necessary, stop payments effected and replacements issued. Cheques are to be staled after fifteen months.

6. Receipts

A receipt is an official acknowledgement of moneys received and must be written in each case. The person receiving the money is responsible to ensure that all such money is banked.

All receipts must be drawn on official forms provided for the purpose and must be typewritten, written in ink or indelible pencil and must be signed by an authorised officer. Receipts drawn in error and cancelled must be securely held. A short explanation is to be made on each cancelled receipt including the number of any receipt issued in lieu.

Official receipt forms are not to be used for any purpose other than the original acknowledgement of the receipt of moneys. Duplicate receipts are not to be issued. A letter may be furnished, if necessary, giving particulars of the receipt originally issued.

Where one person's cheque is received in payment of an amount due by another person the name of the drawer of such cheque is also to be entered on the receipt and receipt butt or carbon copy of the receipt.

Under no circumstances is change to be given on a cheque.

Receipts should only be mailed where the payer has specifically requested a receipt.

7. Handling of Remittances

All cheques, bank drafts, money orders or postal orders received shall be crossed "Not Negotiable" immediately on receipt.

All unidentifiable and surplus remittances are to be banked and then investigated. Any problem in this regard is to be reported to the Area Health Service and Department of Health.

8. Deposit Forms for Bank Accounts

Deposit forms showing all details of cheques deposited shall accompany all deposits to bank accounts. The bank will receipt the duplicate copy remaining in the deposit book. Where the account has been allocated a MICR account number, on encoded deposit slip, supplied by the bank is also to be completed and lodged with the deposit.

9. Payment by Cheque

a. It is the responsibility of each cheque-signing officer to establish that the amount of the cheque agrees with the amount due to the payee as shown on the vouchers, that it is drawn in favour of the payee as shown on the voucher, or is in accordance with his/her order and that the vouchers are certified and authorised.
b. Cheques are drawn against each voucher and the cheque numbers are recorded on the face of the voucher.
c. Spoilt cheques should be shown in the cash book to explain the break in continuity on the vouchers.
d. Cheques are to be drawn "to order" and crossed "Not Negotiable - Account Payee Only".
e. Amounts payable to be expressed in words and figures.

f. All cheques shall bear two signatures.
g. Any alterations on cheques must bear the full signature of the cheque signatures.

AUTHORISATION OF ENTITIES, CONTROL, FUNDRAISING AND ACCOUNTING
(PD2005_084)

It has recently come to the attention of the Department that several NSW public sector health organisations have become involved in the establishment of separate legal and financial entities in the form of a trustee company to raise donations and account for donations and investments outside the General Fund and the Special Purposes and Trust Fund of the health organisation and without the approval of the Minister for Health or the Director-General of Health.

The purpose of this Section is to bring to the attention of the boards and management of public sector health organisations the following:

- A health organisation is not to form a separate legal or financial entity, for example, a trust, a corporation or a foundation unless it has obtained the prior written authorisation of the Minister for Health and the Treasurer. Premier's Memorandum No. 91-2 "Guidelines for the Formation and Operation of Subsidiary Companies by Departments and Statutory Authorities" provides that separate legal and financial entities may only be established with the approval of the Minister and the Treasurer. The Guidelines have been included as accounting policy in the new Accounting Manual for Area Health Services and Public Hospitals and a copy of the Guidelines is hereunder. The Guidelines apply to the establishment of a separate legal and/or financial entity controlled by a health organisation. Applications for approval will be assessed against the criteria in the Guidelines.
- An authorised separate legal or financial entity is to be constituted in such a way that it is a controlled entity of the health organisation that proposes its formation.
- The Minister will not approve applications for the establishment by public sector health organisations of separate legal or financial entities formed for the purpose of raising donations or for fundraising.
- All donations and fundraising receipts and revenue whether obtained directly by a health organisation or from an external entity not subject to the control of a health organisation are to be brought to account within the Special Purposes and Trust Fund or the General Fund of the health organisation, as appropriate, in accordance with the relevant provisions of the Accounts and Audit Determination, the Accrual Accounting Standards and Procedures Manual, the Accounting Manual and the Revenue Standard applicable to the health organisation.
- Whilst fundraising for the purposes of a health organisation by an external entity not subject to its control is welcomed, it is important that an external entity can be clearly distinguished from the health organisation and that such an entity is not permitted to adopt or use the health organisation's name/s, address or logo as its own. Health organisation staff or resources should not be engaged for the purpose of undertaking fundraising activities for an external entity.
- The transactions of an authorised separate legal or financial entity are to be brought to account on an entity basis in such a way as to enable the assets, liabilities, residual equity, receipts, revenue, payments, expenses and expenditure of that entity to be separately brought to account for that entity and to be brought to account on consolidation, as a controlled entity, of the controlling health organisation within its consolidated General Fund and Special Purposes and Trust Fund financial statements.
- Each separate legal or financial entity subject to the control of a health organisation is to be identified by its title in the notes to the financial statements in the annual report of the health organisation.

- A health organisation has the same meaning as defined in the Accounts and Audit Determination for Area Health Services and Public Hospitals and it includes Area and District Health Services and public hospitals.
- Clause 4.1 of the Accounts and Audit Determination only provides for two funds for a health organisation being the General Fund and the Special Purposes and Trust Fund. Only approved separate legal and financial entities may maintain separate accounts outside these funds. The Department does not encourage the formation of a separate legal or financial entity and it will only support such a proposal in exceptional circumstances where strong justification exists.

The primary aim of this policy is to help ensure that donations and fundraising are accounted for as stated above and that a separate legal or financial entity formed by a health organisation is able to be controlled by and subject to the corporate governance of that health organisation.

FORMATION AND OPERATION OF PUBLIC SECTOR SUBSIDIARIES (Pr. Mem. 2006-02)

PM2006-02 rescinds PM91-02.

PM91-02 were issued at a time when it was becoming increasingly common for Government departments and statutory authorities to set up subsidiary companies, and amid concerns that the formation of these subsidiaries might result in some public sector activities being removed from Parliamentary scrutiny and usual accountability measures.

Although subsidiary companies have continued since that time to be used as a vehicle for conducting some government activities, it is important to reiterate the need to be circumspect when establishing and operating subsidiary companies, given their status as separate legal entities.

It is timely then, that these guidelines now be issued in an updated form.

The following guidelines apply to the establishment of subsidiaries by all public sector entities (including Departments and Ministers). The guidelines apply, as far as possible, to existing subsidiaries. The guidelines do not, however, apply to State Owned Corporations.

The guidelines are administrative requirements which should be met in addition to any legislative requirements.

Application of guidelines

These guidelines apply to all public sector entities (including Departments).

The guidelines apply, as far as possible, to existing public sector subsidiaries. Where these guidelines require that particular provisions be included in the constitution of a public sector subsidiary, existing public sector subsidiaries should, if necessary, take steps to amend their constitutions to comply with these guidelines.

The guidelines extend to public sector entities which are not otherwise subject to Ministerial control, **except that the guidelines do not apply to State Owned Corporations and their subsidiaries.**

If an entity is not otherwise subject to Ministerial control, a requirement in these guidelines to obtain the approval or agreement of, or to act in accordance with directions of, the Portfolio Minister should be read as a requirement to obtain the approval or agreement of, or to act in accordance with the directions of, the relevant parent body.

What is a "public sector subsidiary"?

In these guidelines "public sector subsidiary" follows the meaning of "subsidiary" given in the *Corporations Act 2001* (Cth), which is based on the concept of control.

A company in which one or more public sector entities holds shares will be a public sector subsidiary if it would be a subsidiary under the Corporations Act if those shares instead were held by a single corporation.

This means that a company will be a public sector subsidiary if one or more public sector entities alone or together:

(i) control the composition of the company's board;
(ii) are in a position to cast, or control the casting of, more than one-half of the maximum number of votes that might be cast at a general meeting of the first company; or
(iii) hold more than one-half of the company's issued share capital.

A company is also a public sector subsidiary if it is a subsidiary of a public sector subsidiary (as defined above).

Where more than one public sector entity holds shares in a public sector subsidiary then a reference in these guidelines to the "parent body" of that public sector subsidiary includes all of those entities.

Ministerial Responsibility

The Minister responsible for the parent body will also be the Minister responsible for the public sector subsidiaries of that parent body. In these guidelines that Minister is referred to as the Portfolio Minister. Note that a public sector subsidiary may have more than one Portfolio Minister, if it is jointly owned by more than one public sector entity.

PART I - APPROVALS

1. Requirement to Obtain Approval from the Portfolio Minister and the Treasurer

1.1 Before forming a public sector subsidiary or acquiring interests in a company which would result in that company becoming a public sector subsidiary, a public sector entity (including a public sector subsidiary) must obtain written approval from the Treasurer and, if the parent body is subject to Ministerial control, the Portfolio Minister.

1.2 Where two or more public sector entities propose together to establish a public sector subsidiary, they must separately seek the approval of their Portfolio Minister (if subject to Ministerial control) and jointly seek the Treasurer's approval.

2. Approval may be conditional

2.1 Approval for the establishment of a public sector subsidiary may be granted subject to conditions.

3. Approval of Premier may be required

3.1 Before granting approval, the Treasurer must inform The Cabinet Office that approval has been sought.

3.2 If the Treasurer, with the advice of The Cabinet Office, is of the view that the establishment of the public sector subsidiary may raise important public sector management and/or whole-of-government policy issues, the Treasurer will grant approval subject to the relevant parent body also obtaining approval from the Premier.

4. Circumstances in which approval may be granted

4.1 Approval for the establishment of a public sector subsidiary will not ordinarily be granted unless all of the following are demonstrated:

i. the company will pursue principally commercial objectives, will operate on a commercial basis and will be subject to the Commercial Policy Framework;

ii. the company will operate at least as efficiently as any comparable business, will comply with principles of competitive neutrality and will not enjoy the benefit of cross-subsidisation from other operations of the parent body;

iii. the establishment of the company will result in clearly identified efficiencies and/or other benefits which cannot be obtained without recourse to such a structure;

iv. the company will exhibit a sense of social responsibility by having regard to the interests of the community in which it operates;

v. the company will, where its activities affect the environment, conduct its operations in compliance with the principles of ecologically sustainable development contained in section 6(2) of the *Protection of the Environment Administration Act 1991*;

vi. the company will exhibit a sense of responsibility toward regional development and decentralisation in the way in which it operates;

vii. any industrial relations issues have been identified and a strategy formulated for dealing with them (including, where appropriate, following consultation with the Public Employment Office and the Minister for Industrial Relations); and

viii. the company, including its proposed constitution, complies with these guidelines.

4.2 Approval will not ordinarily be granted to budget-dependent general government sector agencies (ie. those agencies which depend on the Consolidated Fund for their operating income). Approval may only be granted to such agencies if they can demonstrate that, after having considered all available options (including the system of net appropriations), the establishment of a public sector subsidiary will create benefits which cannot be achieved in any other way.

5. Disposal of a public sector entity

5.1 A parent body must not dispose of an interest in a company which would result in that company ceasing to be a public sector subsidiary without the prior written approval of the Treasurer and the Portfolio Minister.

6. Tabling of documents in Parliament

6.1 The Portfolio Minister must table before each House of Parliament the following:

(a) the constitution of a public sector subsidiary within 14 sitting days of its having been established; and

(b) any change to the constitution of a public sector subsidiary within 14 sitting days of the date of the change.

6.2 Where two or more public entities have together established a public sector subsidiary, it is sufficient for the Portfolio Minister for one of the public sector entities to table the relevant documents.

PART II - RELATIONSHIP TO CROWN

7. Ability to act on behalf of the Crown

7.1 The constitution of a public sector subsidiary must specify any circumstances under which the subsidiary will be taken to act as an agent of the Crown. Otherwise, it must state that the company is not an agent of the Crown.

7.2 That provision of the constitution may not be modified without the written approval of the Treasurer and the Portfolio Minister.

8. Government guarantee

8.1 Public sector subsidiaries do not enjoy the benefit of an implied government guarantee.

8.2 Where, however, a public sector subsidiary is an 'authority' under section 3 of the *Public Authorities(Financial Arrangements) Act 1987*, section 22A of that Act confers an express government guarantee for certain types of financial accommodation.

8.3 The constitution of a public sector subsidiary must contain provisions to the effect that:
(a) the company does not enjoy the benefit of any implied government guarantee; and
(b) other than the guarantee provided under Section 22A of *the Public Authorities (Financial Arrangements) Act 1987* (if relevant), any guarantee which may be granted by the Government is to be expressly agreed in writing between the board, the shareholders and the Treasurer, and will (unless an exemption is agreed) be subject to the company paying to the Government a fee for the benefit of the agreed guarantee.

8.4 Those provisions of the constitution may not be modified without the written approval of the Treasurer and the Portfolio Minister.

9. No powers beyond those of parent body

9.1 The constitution of a public sector subsidiary must include an express restriction on the power of the company, so that its powers do not exceed the powers of the parent body. In particular, the constitution of a public sector company must prohibit the company from operating outside the State of New South Wales if the parent body does not have power to do so.

9.2 That provision of the constitution may not be modified without the written approval of the Treasurer and the Portfolio Minister.

PART III - CORPORATE STRUCTURE AND CORPORATE GOVERNANCE

10. Type of company

10.1 A public sector subsidiary should take the form of a company limited by shares. It should not take the form of a company limited by guarantee or an incorporated association.

11. Shareholders

11.1 If the parent body is a legal entity (such as a statutory authority) the shareholder of the public sector subsidiary should be the parent body itself. The parent body may nominate a Minister or one or more holders of senior management positions within the parent body also to be shareholders as nominees for the parent body.

11.2 In other cases, the parent body should nominate a Minister or one or more holders of senior management positions within the parent body to be shareholders as nominees for the Crown. The proposed nominee(s) must be approved by the Portfolio Minister.

11.3 The constitution of a public sector subsidiary must include provisions to the following effect:

(a) no person may become a shareholder without the approval of the Portfolio Minister;

(b) shareholders (other than the parent body) hold their shares in trust for the parent body or the Crown (as the case may be);

(c) shareholders (other than the parent body) must deal with their shares (including transferring them) as directed by the parent body;

(d) the Portfolio Minister may execute a transfer of shares on behalf of a shareholder, and a transfer of shares executed on behalf of the transferor by the Portfolio Minister is taken to be an effective transfer of shares by the transferor;

(e) if a shareholder holding a senior management position in the parent body ceases to hold that position they must immediately transfer their shares to the successor to that position (or such other person as the parent body may, with the approval of the Portfolio Minister, nominate) and, pending such a transfer, the shareholder continues to hold the shares in trust for the parent body or the Crown but may not exercise any voting or other rights attaching to the shares; and

(f) a shareholder may not sell or dispose of any shares (or interests in shares) to any person other than the parent body or a person approved by the Portfolio Minister.

12. Entrenchment of constitution

12.1 In addition to any other requirement imposed by these guidelines, the constitution of a public sector subsidiary whose parent body is subject to Ministerial control may not be modified except with the approval of the Portfolio Minister.

PART IV - COMMERCIAL POLICY FRAMEWORK AND FINANCIAL OVERSIGHT

13. Application of Commercial Policy Framework

13.1 Public sector subsidiaries formed to operate on a commercial basis will be subject to the Government's Commercial Policy Framework.

13.2 If the parent body of a public sector subsidiary is already subject to the Commercial Policy Framework, then the subsidiary will also be covered by the Framework. This means that the public sector subsidiary, its objectives, activities and performance targets must be separately identified and included in the parent body's Statement of Business Intent.

13.3 If the parent body is not itself subject to the Commercial Policy Framework, but the public sector subsidiary has been formed to operate on a commercial basis, then the parent body and the public sector subsidiary must seek Treasury's advice as to the specific policies and disciplines of the Framework which will apply.

14. Dividends

14.1 If a public sector subsidiary is wholly-owned, its constitution must include provisions:

(a) requiring it to declare and pay such dividends as may be directed by the Treasurer from time to time, and to submit accounting statements to the Treasurer for the purpose of determining the dividend payable; and

(b) requiring that all dividends be paid to the Treasurer on behalf of the State for payment into the Consolidated Fund.

14.2 If a public sector subsidiary is not wholly-owned, its constitution should set out a procedure, which has been approved by the Treasurer, for the determination and payment of dividends.

14.3 Generally, the procedure will require that dividends be of such amount and paid at such times and in such instalments as may be agreed between the shareholders and the board, after consultation with the Treasurer. If no agreement is reached, then the parent body may, with the concurrence of the Treasurer and by written notice to the board, determine the matter and the board must act in conformity with the determination.

14.4 Provisions of the constitution relating to dividends may not be modified without the Treasurer's approval.

15. Prohibition on disposal of main undertaking

15.1 The constitution of a public sector subsidiary must provide that the company may not dispose of its main undertaking without the approval of the Portfolio Minister.

15.2 Unless the Portfolio Minister agrees otherwise, the constitution of a public sector subsidiary company must also provide that the company may not acquire or dispose of fixed assets or investments which exceed ten percent of the total value of its assets or investments (as the case may be) without the prior approval of the Portfolio Minister.

16. Reporting requirements

16.1 In addition to all other statutory requirements, the annual reports of parent bodies must:

(a) identify each public sector subsidiary in which shares are held, and the number and percentage of shares held;
(b) include key figures for each public sector subsidiary (turnover, profit, assets) and their proportion to group totals;
(c) include a detailed statement of the objectives, activities and operations of each public sector subsidiary, the performance targets and measures for each public sector subsidiary and the accounts referred to above; and
(d) include a description of the nature and extent of any involvement in any other companies, joint ventures, partnerships, trusts or other such associations (whether incorporated or not).

17. Audits

17.1 All public sector subsidiaries are subject to audit by the Auditor General. Audits will be required to be undertaken irrespective of whether the company is a controlled entity of a department or statutory body required to be audited under the *Public Finance and Audit Act 1983*.

17.2 When an audit of a public sector subsidiary is required for any purpose (including for the purposes of the Corporations Act 2001 (Cth)) the company should arrange for the Auditor General to undertake the audit.

18. Liability to pay taxes

18.1 Public sector subsidiaries will be subject to all applicable State and local taxes, duties and charges.

18.2 Division 1AB of the *Income Tax Assessment Act 1997* (Cth) provides that a State and Territory Body (STB) is exempt from Commonwealth income tax. A STB is a company wholly-owned by a State or Territory Government or their authorities. As wholly-owned public sector subsidiaries are thus exempt from income tax, they should not register with the Australian Tax Office for income tax purposes. However, STBs are not exempt from the Goods and Services Tax (GST). Care must be taken when registering for GST that these companies do not also register for income tax.

18.3 Those public sector subsidiaries which are not required to pay Commonwealth income tax must have included in their constitution a provision to the effect that:

i. the company is to pay to the Treasurer, for payment into the Consolidated Fund, the equivalent of the amounts that would otherwise be payable for Commonwealth income tax ("tax-equivalent payments");
ii. the amount of tax-equivalent payments will be calculated by persons nominated by Treasury; and
iii. the Treasurer may grant an exemption from liability of tax-equivalent payments for specified periods or under specified conditions.

18.4 Where a parent body is currently under the national Tax Equivalent Regime or the NSW-based Tax Equivalent Regime, the public sector subsidiary will generally be covered by the same regime as its parent body under consolidation rules.

PRIVATE SECTOR FINANCING OF GOVERNMENT FACILITIES - BARTER TRANSACTIONS (PD2005_172)

In May 1999 the Treasury issued Circular TC99/04 which outlines the reporting and approval requirements for agencies intending to enter into barter transactions with the private sector.

The process requires the Treasurer's approval at two points:
1. Before proposals are sought from the private sector; and
2. Prior to signing a binding contract.

Area Health Services are advised to consider this procurement method in the acquisition of facilities or infrastructure required for the delivery of health services.

Area Health Services should seek in principle approval to proposals from the Department prior to discussing commercial and financial aspects of a transaction with the private sector.

Proposals recommended by an Area Health Service which involve building infrastructure should be directed to the Director, Capital & Asset Management Branch in the form of a detailed submission for consideration in the first instance.

The submission must include the following:
- Evidence that the proposal is consistent with the Area Health Service's strategic plan and the NSW Health Department's Corporate Plan.
- An economic and financial appraisal for all feasible options.
- A discussion of the probity issues, if any, associated with the proposal.
- Fully developed performance specifications for the proposal.
- A draft Call for Proposals.
- An account of consultation undertaken on inter-agency impacts.
- Assurance that adequate resourcing and a realistic implementation timetable is available for the contract.

Formal Treasury approvals to proposals will be facilitated through the Department on behalf of Area Health Services.

New South Wales
TREASURY

Treasury Circular

NSWTC 99/04
18 May 1999

PRIVATE SECTOR FINANCING OF GOVERNMENT FACILITIES – BARTER TRANSACTIONS

Summary:

This Circular outlines the reporting and approval requirements for agencies intending in the course of providing Government facilities to enter barter transactions with the private sector.

This Circular applies to SOCs, GTEs and General Government agencies. It should be read in conjunction with previously issued circulars TC95/15, TC98/4 and TC 98/7.

John Pierce
Secretary

Further Information: Contact Mr Danny Graham, Manager, Infrastructure Assessments
Tel: (02) 9228 3213 or fax (02) 9228 4041
NSW Treasury Internet : www.treasury.nsw.gov.au

6(1/01)

PRIVATE SECTOR FINANCING OF GOVERNMENT FACILITIES - BARTER TRANSACTIONS

Background:

Private sector involvement in financing provision of Government facilities may occur under:

- **"joint financing arrangement"** contracts approved by the Treasurer under the provisions of the *Public Authorities (Financial Arrangements) Act 1987* (PAFA Act) - BOO and BOOT schemes, the subject of:
  - TC 95/15 dealing with the provision of public infrastructure by the private sector; and
  - the associated "G*uidelines for Private Sector Participation in the Provision of Public Infrastructure"*.
- **long term leases**, the subject of:
  - TC 98/4 dealing with the approval of property development projects on Crown land supported by a precommitment to a Government floor space lease; and
  - TC 98/7 dealing with Structured Finance Transactions (other than leasing office accommodation); and
- **barter transactions**, the subject of this Circular.

Barter transactions are arrangement where the Government disposes of assets but does not receive a cash payment. Instead, it is provided with facilities or infrastructure of equivalent value. A barter transaction will generally place no long term obligation on the private sector party to service or maintain the asset exchanged. Therefore it is neither:

- a "joint financing arrangement" as defined in section 5A of the *PAFA Act 1987*; nor
- a long term operating or finance lease.

Examples of this type of transaction include the funding by a private sector party of the:

- construction of a new police station on a new site in return for title to the land upon which an existing old police station stands;
- refurbishment of a fire station on its current site with an area no longer needed for departmental purposes assigned to a private sector developer for commercial redevelopment; or,
- preservation of heritage assets together with the construction of parks and open space and a theatre arts complex at Walsh Bay in return for the granting of commercial and residential redevelopment opportunities.

Requirement to Report to Treasury:

Treasury has concerns about the legal, financial and accounting issues associated with barter transactions. Such transactions can involve complex contractual arrangements and the analysis of risk allocation between the parties often assumes a greater importance than it would in an outright disposal by sale or lease. It is important that the full ramifications of entry into a barter transaction are analysed in detail and well understood at an early stage.

Approval and Reporting Requirements:

SOCs and GTEs

For SOCs and GTEs barter transactions will be reported to Treasury and approved by the Treasurer as part of the approval of the annual Statements of Financial Performance. The disclosure of the barter transaction information listed below is now required to-be submitted to Treasury as part of the Statement of Financial Performance.

General Government Agencies

General Government agencies are to follow the reporting and approval process outlined below. Barter transactions are to be the subject of a competitive tender process. Direct negotiations will only be considered in exceptional circumstances.

Proposals for an agency to enter a barter transaction now require the Treasurer's approval at two key points.

1. Approval of the Treasurer before an agency seeks proposals from the private sector

The submissions to NSW Treasury for the Treasurer's approval must include the following information:

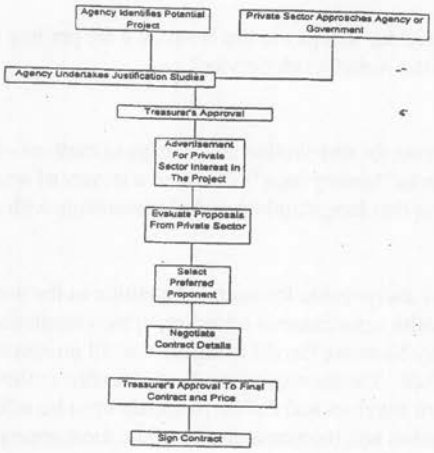
- evidence that the proposal is consistent with the agency's strategic plan;
- an economic and financial appraisal for all feasible options;
- an evaluation showing that there is value for money to Government from the proposal;
- a discussion of the probity issues, if any, associated with the proposal;
- fully developed performance specifications for the proposal;
- a draft Call for Proposals;
- an account of consultation undertaken on inter agency impacts; and
- assurance that adequate resourcing and a realistic implementation timetable is available for the contract.

2. Approval of the Treasurer to the final arrangements prior to signing a binding contract

In addition to a review of the-previously supplied information in light of the negotiations and variations to the proposal resulting therefrom, the following additional information should accompany the request for final authority to close the deal:

- the identification of all substantial land use planning, environmental and regulatory issues;
- a review of contingent liabilities of the proposal;
- a report of the proposed accounting treatment;
- a risk allocation schedule accompanied by a risk management plan; and,
- a copy of the contract to be signed.

APPROVAL PROCESS FOR BARTER TRANSACTIONS FOR GENERAL GOVERNMENT AGENCIES



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PROSECUTION POLICY AND GUIDELINES (PD2014_021)

PD2014_021 rescinds PD2007_002.

PURPOSE

This document describes in broad terms the prosecution policy of the NSW Ministry of Health. This policy replaces the Ministry's *Prosecution Policy and Guidelines PD2007_002*. Its primary purpose is to provide guidance to officers who conduct regulatory work within NSW Health, on the mandatory requirements needed to process and request a prosecution. It aids in standardising the regulatory process under Health legislation state-wide. It is freely available to members of the public and provides transparency in the process and procedures of the Ministry of Health's approval of prosecutions.

MANDATORY REQUIREMENTS

All prosecutions undertaken by the Ministry of Health or on behalf of the Ministry of Health under the *Public Health Act 2010*, the *Poisons and Therapeutic Goods Act 1966*, the *Smoke-free Environment Act 2000* and the *Public Health (Tobacco) Act 2008* (and the regulations made under those Acts) can only be initiated with the approval of the Secretary, the Chief Health Officer or the Director Legal and Regulatory Services and General Counsel of the Ministry of Health. Court attendance notices are only to be provided or issued by the Ministry of Health and are served by the Public Health Unit or Pharmaceutical Services Branch after approval to prosecute has been given.

IMPLEMENTATION

This policy is relevant to Public Health Unit Directors, Environmental Health Officers, Tobacco Compliance Officers, the Chief Pharmacist and Pharmaceutical Advisers.

The Chief Pharmacist and Public Health Unit Directors are responsible for ensuring that:

- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented Procedures are in place to support the Policy Directive.
- All documents required for the processing of a recommendation for prosecution must be submitted in a timely fashion well within the statutory limitation period for the relevant offence.
- The Procedures adopted in submitting a recommendation for prosecution are consistent with the steps outlined in this Policy Directive.

1. BACKGROUND

1.1 Introduction

This document describes in broad terms the prosecution policy of the NSW Ministry of Health and replaces the Ministry's Prosecution Policy and Guidelines PD2007_002. The policy will be reviewed from time to time to ensure that public health legislation continues to be applied in an efficient manner, whilst keeping abreast of changes within the legislation, the common law as well as changes in the attitudes of the community that may raise issues falling outside current practices and guidelines. The prosecution policy and guidelines in this document are informed by the Director of Public Prosecutions (NSW) Prosecution Policy.

1.2 Privacy

All information collected and retained for the purposes of regulatory work, including prosecutions, are to be retained, used and disclosed in accordance with the Information Protection Principles set out in the *Privacy and Personal Information Protection Act 1998* which apply to the collection, use, storage and disclosure of personal information. Personal information collected during an investigation for the purposes of enforcing public health legislation, such as, for example, private residential addresses and telephone numbers, must not be disclosed to third parties outside Health except in limited circumstances and with the approval of the Secretary NSW Health or the Director's representative.

1.3 Fraud and corruption

The Ministry of Health requires an organisational culture that promotes ethical behaviour which does not tolerate any acts of fraud or corruption. It is also important that officers remember when conducting regulation work that they not only must act ethically and impartially, they must also be seen to be acting in an ethical manner. Apart from the legal consequences of fraud and corruption for the officer involved, real or perceived improper acts have the potential to damage the Ministry's public image and reputation and undermine the purpose of the Ministry's regulatory work. Officers should ensure that they have read and understood the Ministry's Fraud Control Strategy PD2007_070.

2. PROSECUTIONS

2.1 The rationale for prosecuting

The principal role of the Ministry of Health through prosecutions is to promote public health, assist the court to arrive at the truth in relation to an alleged offence, and to do justice between the needs of the community and the accused person according to law and the dictates of fairness. Health prosecutions must also further the aims of NSW Health, which is, in part to ensure and monitor compliance with health legislation.

The resources available for the prosecution of breaches of health legislation are necessarily finite, and should therefore be concentrated on those cases most worthy of prosecution. Resources should not be wasted pursuing cases which do not advance the objects of the relevant legislation.

Not all breaches of health legislation will lead to prosecution, and some limited breaches of health legislation may be dealt with by way of penalty notice or caution. For guidance on the issue of penalty notices under health legislation refer to the Ministry's Penalty Notice and Caution Policy. When a breach occurs, consideration should be given to the issue of a warning notice. However, in cases where the breach presents a serious risk to public health and safety or where the issue of a warning notice is inappropriate and would be counterproductive to the promotion of public health, the circumstances may warrant the matter going before a court. For a list of indicators of where warning notices may not be appropriate please see sections 2.2 and 2.4 below.

Prosecution will only be considered when a prosecution is likely to promote the interests of public health, and where the prosecution is in the public interest. Whether the public interest requires a prosecution to be pursued will be a matter for the Secretary or delegate approving the prosecution to assess based on the provable facts and the whole of the surrounding circumstances. Factors which can properly be taken into account in deciding whether the public interest demands a protectoral proceeding will necessarily vary from case to case. Factors which are relevant to determining whether the public interest requires a prosecution are set out in section 2.2 below.

2.2 The decision to prosecute

The first factor to be considered in relation to any prosecution is whether the available evidence establishes a prima facie case. A prima facie case is one where there is admissible evidence available proving each and every element of the offence. However, merely establishing a prima facie case is insufficient. There must be a reasonable prospect of the conviction being secured. In this respect, consideration should be given to:

(i) The availability, competence and credibility of witnesses and the admissibility of such evidence.
(ii) Any defences open to the defendant, including, where applicable, the defence of due diligence.
(iii) Whether a prosecution is in the public interest.
(iv) Whether or not discretionary factors nevertheless dictate that the matter should not proceed in the public interest.
(v) Any other factors which could affect the likelihood or otherwise of a conviction.

Further, in considering whether a matter has a reasonable prospect of conviction, an evaluation of how strong the evidence is likely to be when presented in court is necessary, and consideration must be given to the credibility of the witnesses.

Factors, which alone, or in conjunction, arise for consideration in determining whether the public interest requires a prosecution include:

(i) The harm or potential harm to the health, safety and protection of the public caused by the offence.
(ii) The seriousness or triviality of the alleged offence, and whether the offence is of a technical nature only.
(iii) Whether any actual injury or damage has occurred to any person as a result of the alleged breach.
(iv) Any mitigating or aggravating circumstances.
(v) Any degree of culpability of the alleged offender in relation to the offence.
(vi) The availability of any alternatives to prosecution.
(vii) Whether the offender has been dealt with previously by warning notice or other non-prosecutorial means.
(viii) Whether the breach is a continuing offence.
(ix) The prevalence of the alleged offence and whether the needs of deterrence are specific in relation to the offender and/or general in relation to the community.
(x) The length of time since the alleged offence.
(xi) The length of time and expense of a court hearing.
(xii) The likely outcome in the event of a conviction having regard to the sentencing options available to the court.
(xiii) Any precedent which may be set by not instituting proceedings.
(xiv) The youth, age, maturity, intelligence, physical health, mental health or special disability or infirmity of the alleged offender or a witness.
(xiv) Whether proceedings are to be instituted against others arising out of the same incident.

A decision of whether to prosecute or not must not be influenced by:

- Any elements of discrimination against a person in relation to age, race, or nationality.
- Personal empathy or antipathy towards the offender.
- Possible financial advantage or disadvantage to the offender.
- The possible effect of decision on the personal or professional circumstances of the officers responsible for the prosecution.

2.3 Young offenders

Special considerations may apply to the prosecution of minors, as the prosecution of a minor is generally regarded as a severe measure. Whilst each situation must be assessed on its merits, frequently there will be a stronger case for dealing with a minor who breaches public health legislation by some means other than prosecution. However, the seriousness of the alleged offence, harm to the public generally and the conduct, character and general circumstances of the minor concerned may require that prosecution be undertaken. The public interest will not normally require the prosecution of a minor who is a first offender where the alleged offence is not a serious one.

2.4 Warning notices verses prosecution

The primary intent of public health legislation is to safeguard public health and safety and protect consumers. Warning notices can provide an effective and efficient way to deal with breaches of health legislation. They are a simple and expeditious means to achieve this intent without requiring the State to undertake the more lengthy and expensive path of prosecutions. Prosecution, however, also has an important role in ensuring general compliance throughout the community which cannot be achieved through the issue of warning notices alone.

A warning notice should only be served when it is apparent that an offence under health legislation has been committed and prosecution in the particular case is not indicated. A notice should be based on reliable evidence only and should only be served on an offender if there is sufficient evidence to make out a prima facie case against the offender.

Those establishments visited and found to breach after a number of complaints have been received from the public should not be issued with a warning notice. If a number of complaints have been received about an establishment from the public the establishment must be visited in the next round of compliance monitoring and investigated for consideration of prosecution if found to breach the legislation.

Prosecution action rather than a warning notice will be considered in the following circumstances:

(i) Where the breach relates to a serious compromise of health standards and is of such a nature as to amount to a serious threat to public health and safety.
(ii) Where the offender has already been subject to a prior warning notice issued by an officer of the NSW Health, Local Government or similar government authority for the same type of offence.
(iii) Where the offender has already been subject to a number of warning notices for different offences over the previous five years.
(iv) Where it is apparent that the offender was aware of the relevant legislation, but knowingly and recklessly disregarded the legislation.
(v) Where the offender has a conviction for a breach of the same or similar nature within the last five years.
(vi) Where the offence is for assaulting, obstructing, hindering an officer or offering a bribe.
(vii) Where the offender demonstrates a knowledge of the legislation but has been indifferent or negligent in its application.

If any of the above circumstances exist prosecution may be appropriate, provided that the issues of public interest are satisfied. Public interest considerations are set out at section 2.2 above.

Warning notices should be sent to or delivered to the offender as soon as practical after detection and investigation of the breach. Warning notices should include:

a. The exact nature of the alleged breach, including the relevant section and Act under which the breach occurred.

b. The time and date and place where the offence occurred.
c. An explanation of the purpose of the Warning Notice noting that non-compliance in the future may result in prosecution.
d. A statement that if the person is found to breach the legislation in the future a prosecution would be considered.
e. The name and telephone number of a contact officer.

It is inappropriate to issue warning notices for more than one simultaneous statutory breach. A person or company engaging in more than one offence at a time demonstrates a major compliance problem even though each breach in itself may be comparatively minor. Such a problem may need to be dealt with by a court. No more than one warning notice should be issued in relation to the same establishment within the period of 12- months unless a senior officer has approved the matter.

A person or establishment who has received a warning notice should be revisited to check compliance within 12 months of the issue of the warning notice. In the instance where the initial breach was revealed through compliance monitoring, then similar compliance monitoring methods should be adopted in the second round, and if a second breach for the same or a similar offence is revealed, a brief of evidence must be compiled and submitted to Legal Branch in accordance with the policy outlined in section below. It is also inappropriate to issue successive warning notices for a series of breaches for unrelated offences within a relatively short period of time. Breaches for a range of different offences identified through compliance monitoring over a relatively short period may demonstrate a major compliance problem even though each breach on their own may appear to be relatively minor.

2.5 Selecting the appropriate defendant

General considerations in selecting the appropriate defendant in a particular case are:
(i) Who is primarily responsible for the offence, that being who committed the act or who created the circumstances giving right to the alleged breach.
(ii) What was the role of the alleged offender.
(iii) The likely effectiveness of court orders against the proposed defendant.

The common law and public health legislation confer liabilities on legal entities as well as individuals. In respect of determining how corporate liability may arise the informant should bear in mind that where an employee, agent or officer of a corporation in the course of their employment commits an offence, proceedings may be instituted against the corporation. Another relevant factor to be considered is the existence of an effectively implemented compliance programme by the corporation, demonstrating due diligence on behalf of the corporation.

2.6 Content of requests for approval to prosecute

Requests for approval to prosecute should contain:
(i) Draft Court Attendance Notices for the offence.
(ii) Draft statements and documents in admissible form which prove every element of the offence.
(iv) Records of interview where appropriate.
(v) A company search where appropriate.
(vi) Copies of birth certificates or other government documents where appropriate.
(vii) Draft fact sheet.
(vi) Photographs where appropriate.
(viii) Copies of warning notices sent previously.
(ix) A separate sheet setting out any material relating to:

(i) Any potential defence which may be available to the defendant, and
(ii) The officer's observations and dealings with witnesses.

Requests recommending prosecution should be submitted in a timely fashion having regard to the limitation period for the relevant offence.

Prosecution is only to occur with the approval of the Secretary, the Chief Health Officer or the Director Legal and Regulatory Services and General Counsel of the Ministry of Health ('General Counsel'). All requests for prosecution approval should be forwarded to the Legal Branch via LegalMail@doh.health.nsw.gov.au after being endorsed by their Public Health Unit Directors or relevant senior officers. Where doubt exists over sufficiency of evidence or possible defences, advice is to be sought from the Legal Branch. When a request for prosecution is received by Legal Branch, a legal officer will assess the request and recommend whether a prosecution should be approved. In some cases further information may be required from the investigating officer before a recommendation can be made.

Court attendance notices are not to be issued in anticipation of approval being granted. Court attendance notices are only to be provided by the Ministry of Health and served by the Public Health Unit after approval to prosecute has been given.

2.7 Plea negotiation

A plea of guilty is a fact that is taken into account in mitigation of sentence. There are also obvious benefits to the criminal justice system resulting from a plea of guilty. The earlier a plea of guilty is entered is offered, the greater will be the benefit accruing to NSW Health, the accused and the court system.

Accepting a plea of guilty to fewer offences than those commenced, in full satisfaction of the charges laid requires the consent of the Secretary, the Chief Health Officer or the General Counsel of the Ministry of Health. In the event of a plea negotiation the following matters will be taken into consideration:

(i) Whether accepting a plea to a lesser number of offences reflects the essential criminality of the conduct.
(ii) The plea provides adequate scope for sentencing.
(ii) Whether the evidence available to support the prosecution case is weak in any particular respect.
(iii) The saving of cost and time, against the likely outcome of the matter if it proceeded to hearing.

A plea to a lesser number of offences will not be considered where its acceptance would produce a distortion of the facts and create an artificial basis for the sentencing, or where the accused intimates that he or she is not guilty of any offence.

2.8 Discontinuation of commenced proceedings

Once a decision has been made to prosecute, discontinuation of proceedings is only to occur with the approval of the Secretary, the Chief Health Officer or the General Counsel of the Ministry of Health. Discontinuation may occur where a change in circumstances is such as to undermine the basis of the initial decision to prosecute, for example, proof of action, against the wrong defendant, unavailability of key witnesses, or the demonstration of an available defence.

A matter may be discontinued with the approval of the Secretary, the Chief Health Officer or the General Counsel of the Ministry of Health at any time, either as a result of an internal assessment of the case, or an application from any interested party.

Any application to discontinue should be made through or by the General Counsel of the Ministry of Health and should include a detailed account of the grounds on which the application is based.

On receipt of an application, the case will be reviewed. A decision to discontinue will only be made where there is sufficient new evidence to undermine the original basis of the decision to prosecute, the key witnesses are unavailable or there is new evidence which demonstrates an available defence. All details of the relevant defences should be included in the application for discontinuation.

Reasons for not proceeding with the prosecution would not normally be given to the defendant.

2.9 Funding of undefended prosecutions

The cost of prosecuting undefended Local Court prosecutions initiated on the recommendation of a Public Health Unit, are to be funded by the Public Health Unit. The responsibility of court appearances is that of the informant or the officer in charge of the investigation until the matter is either finalised or legal assistance for the hearing has been approved by the General Counsel of the Ministry of Health.

2.10 Prosecutions requiring legal assistance

Defended matters or other matters where legal assistance is required are to be referred to the General Counsel of the Ministry of Health. Requests for legal assistance must include a brief of evidence (see section 2.6 above). Consideration of legal assistance will not be given unless this is provided.

The engagement of external legal representation will be funded by Population Health, Ministry of Health only if the legal representation is approved by the General Counsel.

Funding for legal assistance includes witness's expenses, subpoenas, transcripts, and costs of travel and accommodation. These costs are to be met by the Public Health Unit until the matter is finalised. If costs are awarded by the court in favour of NSW Health the prosecution fund will not be utilised. If costs are not awarded or the costs awarded do not cover all the expenses reimbursement will be made from the prosecution fund.

Once the matter has been forwarded to Legal Branch for assistance, the decision as to whom will provide that assistance is that of the General Counsel for the Ministry of Health, consistent with Department policy on the engagement of external legal services.

Once a prosecution is initiated, all court appearance work will be conducted by a member of the relevant investigative branch, or, until either a plea of not guilty is entered into by the defendant or until such time as the matter is taken over by legal representatives engaged by the Ministry.

On a plea of not guilty the investigative unit must refer the matter to Legal Branch at the earliest opportunity. General Counsel for the Ministry of Health (or their representative) will determine the type and manner of legal assistance required. Any necessary funding for a prosecution will generally be the responsibility of the branch or unit with administrative responsibility for the legislation under which the prosecution action is taken, unless special funding arrangements have been approved by the Chief Financial Officer in consultation with Legal Branch.

Noting the potential for costs orders, no court adjournments may be sought, or consented to, without the prior consent of the General Counsel for the Ministry of Health or their representative.

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1.	❑	❑	❑
	Notes:		
2.	❑	❑	❑
	Notes:		
3.	❑	❑	❑
	Notes:		
4.	❑	❑	❑
	Notes:		
5.	❑	❑	❑
	Notes:		
6.	❑	❑	❑
	Notes:		

SECTION TWO

RECEIPTING AND BANKING PROCEDURES

ISSUE OF RECEIPTS

POSTAL REMITTANCES

PATIENTS' MONEYS AND PROPERTY

BANKING OF MONEYS RECEIVED

STOPPAGE OF PAYMENT OF CHEQUES AND ISSUE OF REPLACEMENT CHEQUES

OPENING OF CHEQUES

MISAPPROPRIATED CHEQUES

DISHONOURED CHEQUES

"STALE" CHEQUES

STAMP DUTY ON CHEQUES DRAWN BY A HEALTH ORGANISATION

NSW FINANCIAL INSTITUTIONS DUTY

FEDERAL GOVERNMENT DEBITS TAX

TRUST FUND PROCEDURES MENTAL HEALTH ACT HOSPITALS

FINANCIAL MANAGEMENT ISSUES

- Bank Overdraft
- Finance Committees
- Audit Committee

FINANCIAL TRANSACTIONS ON BEHALF OF PATIENTS

DEFINITION OF RECEIPTS

RECEIPTS in respect of the General Fund are:

"the total of all monies received during the accounting period, unless specified as Special Purpose and Trust Fund by the Director-General of Health:

Special Purposes and Trust Fund Receipts shall include:

(a) Donations, legacies and bequests other than those designated as General Fund;
(b) Proceeds of fundraising activities (as defined in the Revenue Policy);
(c) Trust Funds held on behalf of third parties, i.e. patients and hospital auxiliaries;
(d) Private practice trust funds net of facilities charges;
(e) Other items as scheduled by the Director-General of Health (see Revenue Standard Section 3);
(f) Income earned on the above, apportioned and credited to the applicable account.

RECEIPTS - ISSUE, USAGE AND CUSTODY

Official receipt forms shall not be used for any purpose other than the original acknowledgement of the receipt of moneys. A receipt shall be issued on an official form provided for that purpose for each payment tendered to a health organisation and shall be signed by the cashier or other receiving officer. However, a receipt need not be issued for money paid directly to the bank account of the health organisation, provided that a record is entered in the cash book or cash receipts journal to acknowledge that direct credit. In computer generated receipt systems, controls are to be in place to safeguard the integrity of all receipts issued.

Receipts must be typewritten, written in ink or indelible pencil.

Where a manual receipting system is used, a carbon copy shall be made of each receipt at the time a receipt is prepared unless details of receipts issued are retained on a cash register strip. Where a computerised receipting system is used, a record of all receipts issued must be kept.

The receipt shall be given to the payer unless the payer advises that no receipt is required as another form of acquittance applies in respect of that payment. In this case, the receipt shall be retained in the receipt book or attached to the documents which accompanied the payment when it was received.

Cash register receipt strips and books of carbon copy receipts shall be retained for audit and review purposes for those periods nominated in the section dealing with Retention of Records in this Manual.

The receipt should identify the form of payment tendered (cash, cheque, credit card, money order etc.) and shall identify the debtor involved where payment is made by another person on behalf of a debtor.

Unused receipt books shall be adequately secured, and issued only to employees authorised to issue receipts. Issued receipt books shall be secured against misuse, by the persons to whom they are issued.

Adequate controls against misuse shall be implemented where cash registers are used, including maintenance of a daily reading book to record matching totals and appropriate monitoring of the work of the cashier by a supervising officer. The daily reading entries shall be initialled by the cashier and checked and initialled by the supervising officer.

Spoiled receipts shall be cancelled and the original retained in the receipt book attached to the copy, together with a brief explanation identifying the reason and the number of any receipt issued in lieu.

Corrections or alterations to a receipt shall be made only before the original is issued to the payer and should be initialled by the person preparing the receipt. A cashier shall cancel an altered receipt and issue another, rather than issue a receipt which is altered, unless the correction is of a minor nature.

Duplicate receipts shall not be issued. If a replacement is requested by a payer who has lost a receipt, the chief executive officer/general manager or delegate shall issue a letter identifying the original receipt and indicating the letter is issued in lieu of a replacement receipt.

Unless special arrangements have been approved by the chief executive officer or his delegate, payments tendered other than in cash and requiring payment of change to the payer shall not be accepted.

POSTAL REMITTANCES

Payments made by mail shall be receipted in the normal process, but unless the payer requests a receipt, no receipt shall be sent. The original should be attached to any supporting documentation for audit or review purposes.

All mail received by a health organisation shall be opened in the presence of two officers other than the cashier. Regard is to be had to privacy considerations of mail marked "Confidential" – see Privacy Manual for Health Information. Postal remittances other than cash shall be crossed and marked "not negotiable". Such remittances, together with postal remittances in the form of cash shall be entered in a remittance register, initialled by the officers involved and given to the cashier (along with the remittances) who shall issue a receipt for each remittance and record the relevant receipt number against each entry in the register and agree the total amount receipted with the total of remittances in the register and certify the receipting of all remittances in the register. A senior officer shall confirm the correctness of this certification.

A health organisation having an adjusted daily average of 120 or more may dispense with a remittance register, with the prior written approval of the chief executive officer/general manager (whichever is appropriate) if an alternative internal control has been instituted and is operating effectively.

If it is not possible to carry out some of the functions set out in this Manual in respect of postal remittances because there are insufficient staff to permit the required segregation of duties, the chief executive officer/general manager or delegate shall ensure that appropriate receipting and banking procedures are followed, and shall personally conduct appropriate random checks to confirm that those procedures are being followed.

Unidentifiable or surplus remittances shall be receipted and credited to a suspense account and dealt with in an appropriate way when enquiries have determined the intended purpose of the payer.

PATIENTS' MONEYS AND PROPERTY (See Appendix at the back of this section for policy and procedures re hospitals under the ***Mental Health Act 1990***.)

Patients should be encouraged not to bring money or valuables with them when being admitted to a health organisation. Where a health organisation is requested to provide safe custody for any money or valuables the following procedures are to apply:

1. **Admission**

   (a) **Cash and Valuable Belongings**

   If a health organisation receives for safe custody any money or property brought to the health organisation by a patient, the patient shall be given a receipt (A45), with particulars being recorded in the appropriate register (A46).

   Where a patient, for some reason, receives back only portion of the money and/or articles originally handed over for safekeeping, the following procedure is suggested where suitable adjustment cannot be made against the original entry:

   - Obtain patient's signature - or that of his/her properly authorised representative - in receipt of the whole of the money and valuables listed in the entry, and witness the signature.

   - Cancel the receipt form presented by the patient or representative.

   - Issue new receipt (A45) for the articles left in safekeeping, marking this receipt in space provided for "Ward" with the word "Office".

- Write in remarks column against original entry in Register the words "Part only - see new entry folio ..... Receipt No. .....".

At 30 June each year the Register should be ruled off, and all items not disposed of at that date should be re-entered below the ruled line against date 1 July of that year. A notation, "Transferred to Folio .....", should be entered in the signature column against the original or previous entry.

Unclaimed items should be regularly reviewed with the object of disposing of those being held unnecessarily, especially items received from persons who have subsequently ceased to be patients. A review should be made at least annually, after the unclaimed items have been brought forward at 1 July; more frequent reviews may be desirable in particular cases.

Health organisations are warned that legally they are in the position of bailee of the money and valuables entrusted to them for safekeeping, and are thereby expected to use that diligence in safeguarding the property as would be expected of a person of **commonsense**; they would be well advised not to bank any money without the consent of the patient or his/her accredited representative.

Where a patient's/client's money is banked a trust account is to be established within the Special Purposes and Trust Fund. Such trust account is to record all deposits/receipts and withdrawals/payment. A patient who has accumulated a large sum of money in a trust account should be encouraged, where appropriate, to withdraw the funds and place them in a bank or in an investment of the patient's/client's choice.

Where a patient/client requires an amount of cash a written authority for withdrawal by the patient/client is required. Under no circumstances is a withdrawal to be made from a patient's/client's trust account without the patient's/client's or authorised representative's written approval.

Where the patient/client has regular commitments (rent, rates, etc) and the patient/client is unable to make a payment personally the hospital or nursing home should obtain a "standing" authority for payment of such an account on behalf of the patient/client with a receipt for such payment being obtained wherever possible if paid by cheque and in every instance where a cash payment is made.

In respect to a trust account kept for a patient/client who is unable to sign for a transaction **and** where no **guardian** has been appointed, the patient/client is to place his/her (x) on the authority and this is to be witnessed by two officers from the hospital or nursing home. The officers so witnessing should be senior staff with at least one working in an area independent from the area (ward) in which the patient/client is located. The authority should state why the patient/client cannot sign and why the withdrawal is required.

Authorities for payment are to be held on a separate file for audit/inspection with a copy also being used as support documentation for the payment.

(b) **Property**

Items of clothing are not normally noted in the Valuables Register, however, the health organisation may if it so wishes maintain a separate record listing patient apparel indicating what is held in store and what is held by the patient. If a patient on admission has valuables on his/her person and wishes to retain them, the patient should be advised that no responsibility will be taken for those objects in the ward.

(c) **Money - Short Stay Patients**

Where property is received by the health organisation on the admission of a patient, and the same property is to be returned, e.g. the actual banknotes which were received from the patient, are to be returned to him/her on discharge, the health organisation is a bailee and it is under a duty to exercise care over the goods, i.e. by way of safe custody. No duty to invest is imposed.

Accordingly, in all cases where the patient's stay in a health organisation is anticipated to be less than one month, the following procedure should generally be adopted in respect of property/valuables:

- On admission and subject to the issue of a receipt (A45) to the patient, monies are to be sealed in an envelope marked with the patient's name,

amount and date of receipt then placed in a safe. If patient requests some or all of the funds held the register is to be noted accordingly and signed by the patient with the envelope also being amended and resealed. (See also 1[a].)

2. **Deceased or Discharged Patients**

(a) **Discharged**

On return to the patient (or someone properly authorised on his/her behalf) of valuables and money a signature in acknowledgement is to be obtained in the (A46) Register and witnessed by a member of the staff.

Where possible property (valuables) and monies held are to be released to patients on discharge.

If monies and valuables are not disbursed on discharge at least two follow-up letters (to last known address) are to be forwarded to the patient requesting a collection of property etc. If any money is involved, a cheque made out in the discharged patient's name may be forwarded to the last known address. Contact is also to be made to the Public Trustee's Office/Protective Office requesting advice as to whether they are responsible for the patient's affairs if the patient cannot be contacted.

b) **Release of Assets of Deceased Patients (**01/116)

Where a patient has died, public health organisations are required to make decisions concerning the release of assets.

1. Assets

For the purpose of this section, assets are either trust funds and/or cash and property held as bailee. Property may include personal items such as wallets, watches, clothing and jewellery.

2. Release of Assets generally

Unless one of the exceptions outlined below applies, the general rule is that no assets are to be released until the health organisation ("the organisation") is satisfied that formal requirements are met. This includes (i) Probate, Letters of Administration or a Certificate of Grant issued by the Court being sighted: (ii) the organisation being satisfied as to the identity of the legal personal representative (executor named in the will or administrator appointed by the court); and (iii) acknowledgement of receipt being obtained from the representative.

Outlined below are some circumstances where a departure from the general rule is warranted. 8(5/02)

3. Release of assets in certain circumstances

There is no requirement to sight Probate, Letters of Administration or a Certificate of Grant issued by the Court in the following circumstances. Individual cases need to be carefully considered before decisions are made about the release of assets.

a) Jointly owned assets

Where the health organisation is satisfied that assets are held in joint names with another person, the assets should be released to the surviving joint owner upon satisfactory proof of death and identity of the survivor as joint owner. A written acknowledgment from the surviving joint owner should be obtained which records the assets which are released, and the date that this occurs.

b) With Will (small estates less than $15,000)

Where the total value of an estate is under $15,000 in value, assets may be released to the executor upon production of:

i) Death Certificate; and
ii) certified copy of Will.

Before releasing the assets to the executor, confirmation in writing should be sought from the executor as to their identity and that the total value of the estate is under $15,000. The total value of the whole estate must be calculated, not just assets held by the health organisation. A detailed receipt from the executor must also be obtained.

c) No Will (release up to $5,000 provided conditions met)

Where the total value of assets held by a public health organisation is under $5,000 in value, assets (either trust funds or property) may be released to a person claiming to be entitled upon production of:

i) Evidence that establishes the person's relationship to the deceased (eg birth, marriage and death certificates);

ii) Signed statement that no other person has a claim upon the estate;

iii) Detailed receipt for all monies, chattels and documents released; and

iv) Indemnity from claimant approved by a senior officer of the health organisation (signed undertaking to repay in the event that there is another successful claim. A pro-forma undertaking is attached).

Health organisations are responsible for any reimbursement and/or damages in the event of a successful counter claim where the indemnity is not upheld.

4. Public Trustee's Office/Protective Commissioner/Guardianship Tribunal

Reasonable effort is to be made to contact the deceased patient's next of kin so that funds and property can be released. The Public Trustee's Office is also to be contacted requesting advice as to whether they are responsible for the deceased patient's affairs when it appears that there are no next of kin. Where an order for management of the patient's financial affairs has been made under the Protected Estates Act 1983 or the Guardianship Act 1987; the Office of the Protective

Commissioner or the Guardianship Tribunal is to be contacted. Section 247 of the Mental Health Act I990 requires that any funds in the trust account of a deceased patient whose affairs have been committed to the Protective Commissioner are to be paid to the Protective Commissioner.

5. Funeral Expenses

Apart from funeral expenses, no other transactions are to be made on a deceased patient's trust account. Where the affairs of the patient are not under the jurisdiction of the Protective Commissioner or the Public Trustee and where relatives have paid funeral expenses, then the relatives should be advised to apply for a recoup of funeral expenses. Such reimbursement is to be limited to the cost of the burial or the amount held in the deceased's trust account, whichever is the lesser. When dealing with reimbursement for funeral expenses, health organisations should obtain:

- written confirmation that funeral expenses have not been obtained from any other source;
- date and number of any receipt produced and the name of the Funeral Director. (A copy of the receipt, where possible, should be held on file.)

The amount reimbursed should be noted on the reverse of the receipt, which should be returned to the person arranging the funeral. The health organisation may pay the Funeral Director direct, but in this case the receipt should be held by the health organisation.

6. Unclaimed Money and Property

Section 133 of the Health Services Act 1997 makes provision for the establishment of Samaritan Funds. If after a period of twelve (12) months monies and property have not been claimed, the monies and realised value of property held are to be paid into the health organisation's Samaritan Fund (property is to be disposed of for a fair market value).

For More Information:	Public Trustee	02 9252 0523
	Protective Commissioner	02 9265 3131
	Legal Branch	02 9391 9616
	Guardianship Tribunal	02 9555 8500

UNDERTAKING AS TO RELEASE OF ASSETS

THIS UNDERTAKING IS MADE ON DAY OF 20__

I _____(Full Name) of

_____ (Address)

being the _____(specify relationship) of _____

_____(full name of deceased) hereby indemnify the

_____(full name of public health organisation) against all claims made by any other person in relation to the assets of the deceased ("the assets") which were held by the public health organisation and have been released to me.

The assets which I have received are_____(list all assets) having a total value of $_____

I confirm that to the best of my knowledge, no other persons have an entitlement to the assets.

I understand that in the event that another person makes a successful claim upon these assets, I must repay to the public health organisation the total value of the assets which have been released to me within two months of receiving written notice from the public health organisation.

Signed:

_____
Claimant

In the presence of:

_____ _____
Signature of Witness Nam e of Witness

(c) **Unclaimed Money and Property**
If after a period of twelve (12) months monies and property have not been claimed the monies and realised value of the property held are to be paid into the health organisation's Samaritan Fund (property is to be disposed or for a fair market value).

3. It is important to be aware that health organisations are legally in the position of bailee when money and/or valuables are entrusted to them by a patient for safekeeping and the same property is to be returned to the patient on discharge. Diligence and care must be exercised in the safeguarding of this property. All authorities given by patients etc. and any other records must be available for audit examination and must be retained in accordance with normal record retention requirements.

Health Service Internal Auditors and Inspectors are to examine the systems in force for the receipt, safeguarding and disbursement of patient monies and property. This is to include both compliance and substantive tests. Examination of money and valuables is to be conducted in the presence of an officer of the health organisation. If a patient has explicitly indicated, in writing, that no-one is to have access to monies or property lodged in a bailee situation then Internal Auditors and Inspectors etc. cannot have access to the items.

BANKING OF MONEYS RECEIVED

At the close of business each day (or at some other cut-off period authorised by the chief executive officer or his delegate) all moneys received shall be balanced and agreed with the total of all receipts issued for that day (or period). Particulars of the agreement shall be recorded in an appropriate place and initialled by the officer balancing the moneys and another authorised checking officer.

The Chief Executive Officer of a health organisation shall ensure that all individual locations of cash receipting are identified, checked regularly for proper accounting practices and internal controls including the use of only official receipt books.

All moneys received shall be deposited to the credit of an appropriate account daily, or at least weekly where the total received since the last banking is less than $400. In those locations with no banking facilities within a practicable distance the approval of the area health service Chief Executive Officer should be obtained to vary the frequency of banking. Prior to granting approval the Chief Executive Officer should ensure that the location has a secure area in which to hold funds for the period approved and that safety/security procedures are adequate.

Moneys shall be banked in the form in which they were received unless express approval has been given by the chief executive officer for an alternative procedure. In the event that an alternative procedure has been so approved, a note shall be made in the receipting or banking records to record the appropriate particulars.

No banking account is to be opened with any bank or other financial institution without the authorisation of the chief executive officer.

A health organisation shall submit its banking operations to tender at least every four years and it shall review its banking arrangements at yearly intervals at least, to ensure that it earns the most favourable return on its liquid funds after allowing for bank fees and charges and other costs and also allowing for the suitability and availability of banking services. However, a health organisation should not defer timely payment of its accounts in its desire to maximise returns on invested funds.

Particulars of the review and details of any Board decision shall be documented for review and audit purposes.

The New South Wales Treasury (Funds Management Section) can provide interest rate quotations or advice concerning investment of surplus funds. However, it is the responsibility of the CE of area health services and Royal Alexandra Hospital for Children to ensure that the investment of surplus funds complies with the terms of the ***Public Authorities (Financial Arrangements) Act 1987***.

Bank accounts shall be operated upon or closed only by officers duly authorised to do so by the CE, or delegate, of a health organisation, who shall also be responsible to approve any variation either in banking institution utilised or any cheque signing authority.

In a small hospital where only one cheque signatory is authorised to operate a banking account and that officer is to depart from employment before a replacement arrives, the authority to operate that account should be cancelled prior to the departure of that officer and revised upon the arrival of the replacement officer by the express authority of the CE, or delegate, of a public health organisation.

Separate bank accounts shall be operated in respect of the Special Purposes and Trust Fund and the General Fund.

A cash book or cash journals shall be kept in respect of each bank account and all receipts and payments relevant to each account shall be recorded in the respective cash book or journals.

At the close of each accounting cycle each cash book/journal shall be balanced and reconciled with its banking institution's official statement or pass sheets. Details of the reconciliation shall be recorded in or appended to the cash records, be signed by the officer preparing it and be checked and initialled by a supervisor as checking officer.

A reconciliation shall be made prior to the departure of an officer of all cash records for all bank accounts for which the officer concerned was responsible for maintaining and reconciling.

POSTING OF RECEIPTS

Receipts shall be classified according to appropriate programs and cost centres which are consistent with the ledger accounts as set out in the Chart of Accounts in this Manual and posted to the appropriate accounts in the General Ledger.

STOPPAGE OF PAYMENT OF CHEQUES AND ISSUE OF REPLACEMENT CHEQUES

Where payment of a cheque is to be stopped:

- Cheque signing officers having authority to stop payment shall use the usual stop payment form in correspondence with the bank.

- When payment is stopped the appropriate entry shall be made in the cash book and on the relevant payment voucher.

- Acknowledgements of receipt of the stop payment advices shall be obtained from the bank and attached to the relevant payment voucher.

- A replacement cheque shall not be issued before an adequate check has been made to ensure that the original cheque has not been paid by the bank and that the stoppage of payment has been effected.

- If, after the issue of a replacement cheque as outlined above both the original cheque and the replacement cheque are found to have been paid by the bank on which they were drawn, the bank shall be requested in writing to make good the amount of the original cheque (which had been stopped) and to institute its own recovery action.

- Particulars relating to each stopped cheque should be recorded in a Stopped Cheque Register kept for that purpose. The following particulars should be entered:

    - details of stopped cheque, reasons for stoppage, confirmation of stoppage, authorisation to replace cheque, details of replacement cheque.

OPENING OF CHEQUES (See also pages 4.7 to 4.8 re Payment of Moneys)

As a general rule, cheques shall not be:

1) "opened" (made payable to "bearer"); or

2) made payable to cash (e.g. payments for Salaries and Wages, Petty Cash). Prior to this occurring the payee must have first established his/her identity and endorsed the cheque. A health organisation shall maintain a "Register of Cheques Opened" which should contain the reason for opening a cheque and the signatures of the payee and the cheque signatories opening the cheque.

MISAPPROPRIATED CHEQUES

Prompt action shall be taken to stop payment of all lost or stolen cheques which have not been presented at the bank. Where such a cheque has been negotiated, recovery should be sought in the first instance from the collecting bank or, where desirable, from the person or firm who negotiated the cheque. If this action is not successful then the Board of Directors must be informed and appropriate action taken for recovery.

DISHONOURED CHEQUES

On receipt of advice that a cheque has been dishonoured, except in cases of omitted or incorrect endorsement which can be rectified, the drawer of the cheque(s) should be promptly contacted with a view to the correction of any irregularity or to obtaining a fresh remittance. This remittance should be made either in cash or by bank cheque.

All moneys so collected shall be lodged to the credit of the account to which the dishonoured cheques were debited, but no official receipt should be issued unless the original receipt has been cancelled and an appropriate entry is made in the cash records. If the payer requires an acknowledgement of receipt a letter should be provided by the chief executive officer, referring to the original receipt and the reason for issuing the letter.

STALE CHEQUES

A cheque unpresented for six months shall be followed-up and, if necessary, "stop payment" should be effected and a replacement issued. A cheque is to be "staled" if unpresented after fifteen months, by instituting stop payment procedures and insertion of a reversal entry in the cash records.

UNCLAIMED SALARIES AND WAGES (3.2.1.7)

Unpresented salaries cheques are to be paid initially to the Unclaimed Salaries and Wages Account (in the General Fund) after 30 days, and then processed in the prescribed manner for all unclaimed salaries and wages as listed hereunder.

DISPOSAL OF UNCLAIMED SALARIES AND WAGES

Any unclaimed salaries/wages are to be paid to the Unclaimed Salaries and Wages Account in the General Fund after 30 days.

Health organisations are required to comply with the law in respect of the disposal of unclaimed salaries and wages. These requirements are set out in the ***Industrial Relations Act 1996***, as amended, and are repeated below for information:

> "In every case where an employee has left the employment of an employer without being paid the full amount due to the employee in respect of the employment, and the employer has been unable, during a period of thirty days after the termination of employment, to make the payment because the location of the employee is unknown to the employer, and cannot with reasonable diligence be found, the employer must immediately after the expiration of that period, pay the full amount to the Treasury. A receipt issued on behalf of the Treasury for money so paid is sufficient discharge to an employer for the amount specified in the receipt.

Any employer who fails to comply with this subsection shall be liable to a penalty of up to 50 penalty units."

STAMP DUTY ON CHEQUES DRAWN BY A HEALTH ORGANISATION

Area Health Services and public hospitals are exempt from the payment of Stamp Duty and should use cheque forms which have been stamped "Duty Free".

The bank issuing the forms will arrange for the "Duty Free" stamping, but the health organisation will be required, when applying for a supply of "Exempt" cheques, to quote the Stamp Duty Office General Exemption Number 9, under which exemption is appropriate.

The same exemption applies to auxiliary organisations provided the whole of their efforts are directed solely towards the benefit of a local public hospital. Hospital auxiliaries should be informed accordingly. Where an auxiliary utilises an "S" Account with the Commonwealth Savings Bank, it will not be necessary for it to obtain specially stamped "Duty Free" forms, as such stamping is not required for this type of account.

STAMP DUTIES OFFICE - NEW SOUTH WALES FINANCIAL INSTITUTIONS DUTY - APPLICATION FOR EXEMPTION OF AN ACCOUNT IN ACCORDANCE WITH SECTION 98T OF THE *STAMP DUTIES ACT 1920*

The ***Stamp Duties (Financial Institutions Duty) Amendment Act 1982***, was assented to on 15 December 1982, and Regulations under the Act were published in the New South Wales Government Gazette on 24 December 1982.

Sections 98T and 98U of the ***Stamp Duties Act 1920***, provide for the establishment of an exempt account with a bank or with another person or class of persons specified in the Act or Regulations.

A regulation to the ***Stamp Duties Act 1920***, provides for the establishment of exempt bank accounts prescribed under Section 98U for a public hospital or a hospital that is carried on by an association or other body of persons otherwise than for purposes of profit or gain to the individual members of that association or other body.

All health organisations receiving State Government Subsidy are obliged to comply with these requirements.

FEDERAL GOVERNMENT DEBITS TAX TO BANK ACCOUNTS - EXEMPTIONS FOR STATE GOVERNMENT AND PUBLIC HOSPITAL BANK ACCOUNTS

The tax is levied on debits to cheque accounts held by the banks, and the banks have the statutory right to recover the tax from each customer who operates an account.

The legislative provisions for government exemptions are basically the same as those under the ***Stamp Duties (Financial Institutions Duty) Amendment Act 1982***, although they are not fully identical. Generally, the Australian Taxation Office adopts a similar approach to that relating to the Financial Institutions Duty in determining eligibility for exemption. Attention is drawn to Section 3(1) of the Federal Legislation which, broadly, allows debits to accounts operated by State departments and authorities, where they do not relate to the carrying on of a business, to be excluded from the tax. Where it is determined that debits to an account are exempt, the department or authority may apply to the Commissioner of Taxation for a certificate of exemption in terms of Section 11(1).

All area health services, districts, divisions, branches and ambulance services should examine their bank accounts in order to determine their liability under the ***Bank Account Debits Tax Administration Act 1982***, and attention is particularly drawn to Section 3 which defines those accounts for which debits may be excluded. After having identified which accounts may be exempted, applications for exemption forms should be completed for those accounts, and lodged with a branch of the Australian Taxation Office.

After exemptions have been granted by the Taxation Office, the original certificate in respect of each account will be issued to the bank with which the account is held, and a copy of the certificate will be forwarded to the applicant. It is important to note that an exemption certificate is required in respect of each individual account for which exemption is being sought. Application for exemption forms are available from Taxation Offices and banks.

SALES TAX

FOR SALES TAX PROVISIONS SEE PURCHASING AND SUPPLY MANUAL.

APPENDIX

HOSPITALS UNDER THE *MENTAL HEALTH ACT 1990* (PD2005_484)

(Reference to hospital in these procedures is to be taken as hospital as defined in the ***Mental Health Act 1990***)

The ***Mental Health Act 1990***, which commenced on 3 September 1990, incorporated a number of provisions relating to establishment and operation of trust funds, payment of interest, withdrawals from patients' accounts and related issues.

The following procedures have been developed to facilitate the operation of these provisions.

TRUST FUND PROCEDURES

1. Each hospital is to establish a Patient Trust Fund, an Interest Account and a Patient's Amenities Account in a bank or other financial institution authorised by the Chief Executive Officer of the area health service or health service.

2. A separate current account is to be maintained for each patient within the Patient's Trust Fund (245). The balance of all individual patient trust accounts must be reconciled monthly with a control account.

3. The receipting of patient monies is to be in accordance with procedures incorporated in this manual.

4. Withdrawals from the Patient Trust Fund are to be made in accordance with Attachment 1 (246).

5. Procedures to be followed for the disbursement of monies upon death or discharge of a patient are incorporated in this manual.

6. Monies in the Patient's Trust Fund, Patient's Amenities Account and Interest Account may be invested with the approval of the CE, or delegate, in accordance with the ***Public Authorities (Financial Arrangements) Act 1987*** which is considered by the Department of Health to comply with the requirements of the ***Trustee Amendment (Discretionary Investments) Act 1997.*** It is stressed that liquidity should be kept under review to ensure sufficient funds are available to provide for withdrawals (e.g. Patient discharged with a large trust account). At least once in each year a review is to be undertaken of the performance (individually and as a whole) of trust investments [S14A(4)]

7. Income from the investment of the Patient Trust Fund and any capital gain made on the realisation of the investment is to be paid into the Interest Account. There is to be paid out of the Interest Account:

   i) any loss incurred on the realisation of the investment of the Patient's Trust Fund; and

ii) a 5.25% management fee of the total funds held in the Interest Account at the time, and prior to, the disbursement of interest to individual patient accounts (249). The management fee is to be credited to the account "Other Receipts" in the General Fund under program 2.8.

8. Subsequent to making the payments referred to in 6 above hospitals are to distribute the funds of the Interest Account by crediting funds to each patient's account proportionally according to the daily average for the month of each patient's account. A memorandum ledger of interest due is to be kept on a monthly basis, with the actual crediting of interest to individual accounts being carried out at least quarterly (250).

9. Interest derived from investment of the Patient Amenities Account funds is to be credited to that account on the same basis as individual patient accounts. Expenditure in respect of the Patient Amenities Account is to be made in accordance with Attach 2.

Unless subject to an order under the *Protected Establishment Act*, patients' funds are not to be transferred to the Protection Office without the patients' consent.

EXPENDITURE FROM INDIVIDUAL PATIENT TRUST ACCOUNTS

Cash payments may be made up to an amount determined by the Executive Officer/Medical Superintendent. The amount may be exceeded in individual cases with the approval of the Executive Officer/Medical Superintendent, or any Medical Officer or Assistant Director of Nursing if the Executive Officer/Medical Superintendent permits. This applies also to patients taking their discharge, or proceeding on leave.

Cash withdrawals from the trust accounts may be made on a multiple cash Payments Form (PH.21) only where several payments are made in a particular ward. Single withdrawals are to be made using form PH.154 or other suitable form.

The withdrawal forms are to be sent to the General Office untotalled. The Multiple Cash Payments Form (PH.21) is to be signed in the space provided, by the Nurse in charge of the ward or Nurse Unit Manager.

After checking by the ledger-keeper as to the availability of funds, the ledger-keeper is to total the sheet, initial such total, and hand the sheet to the paying officer.

Hospitals should bear in mind that the balance of a Trust Account may include amounts credited from private cheques. Payment is not to be made on a private cheque for ten working days after the cheque has been deposited at the bank unless evidence is obtained from the bank that the cheque has been cleared.

Withdrawal forms which have been altered from a lower to a higher amount are not to be accepted.

Where the above instruction is not complied with, the forms are to be accepted as valid only in respect of the lower amount.

If an error is made on preparing the Multiple Cash Payments Form (PH.21) the incorrect entry should be completely ruled out and a correct entry made.

Single withdrawal forms (PH.154) should not be signed by the patient having received payment or witnessed to such payment **PRIOR** to the money actually being received. This section must be completed at the time of payment.

Any single withdrawal form (PH.154) so signed before actual payment is made is not to be accepted.

When indicating no cents a dash or "oo" will suffice.

The paying officer is not to sign as a witness to the payment.

Officers signing as a witness to a payment must sight that payment being made.

The maximum amount of money to be drawn on the Multiple Cash Payments Form (PH21) each week on behalf of a patient is $50 except for special purposes approved by the Executive Officer/Medical Superintendent. Amounts drawn must be commensurate with the amount available in the patients trust fund.

Patients capable of handling their own money should do so.

Patients who are unable to handle or are incapable of handling their money, after withdrawal has been authorised by a delegated officer, should have the money signed for by **two nurses** in the presence of the paying officer, using the rubber stamp "Patient unable/refuses/not available to sign". In each case, the patient must be informed if practicable that the Nurse Unit Manager or Nurse in Charge will be taking care of his/her money.

Where payment is not made to a patient, monies are to be paid back into the individual Trust Account through the Trust Account Receipt Book. The receipt number is to be shown against the patient's name on the PH 21.

Money drawn regularly from Trust for patients should not be used for clothing purchases, but for day to day comforts, goods or outings.

The times of payment to patients by the general office is a matter for determination by each hospital.

Patients are permitted to hold in the wards up to $50 generally and more in individual cases approved by the respective Executive Officer/Medical Superintendent.

Nurses in charge should not be expected to search patients but reliance should be placed upon their personal knowledge of any additional funds which patients may acquire. Should patients have such funds then cash withdrawals should not be made if monies held exceed $30.

CLOTHING PURCHASES

Cash withdrawals for clothing purchases are limited to $500 per patient in respect of those with mental and physical capacity sufficient to enable them to shop for themselves. Such withdrawals are to be authorised by the Executive Officer/Medical Superintendent.

Receipts are to be obtained for attachment to the withdrawal form (PH154), balances not expended are to be returned to the Trust Account with the Trust Account receipt being attached to the PH154 form. (Receipts are to agree with the total amount withdrawn.) PH154's are to be headed "CLOTHING PURCHASE" and held separate pending the supply of receipts.

Other purchases are to be effected through credit accounts using Sundry Purchases Voucher (PH.64) supported by sales dockets. A number of firms which do not operate credit accounts will provide pro-forma invoices for goods selected and the goods held pending payment. The purchases referred to in this paragraph will be paid by cheque only.

Hospitals may also purchase underwear and night attire on behalf of patients through State Contracts wherever savings may be made. These purchases would not include the payment of sales tax.

If possible, competitive prices should be obtained (and details held for audit/inspection) where contracts are not utilised, however, quality of products should be considered and not just the lowest price.

The hospital management is to review on a six monthly basis the costs and quantities of clothing purchases by wards.

CANTEEN PURCHASES

Generally, patients capable of handling their own money and who are mobile enough to shop for themselves should not be included on canteen lists. Personal shopping has a general therapeutic purpose for the patient, but there may be occasions when patients who are capable, do **themselves** request to be placed on canteen lists.

Only appropriate goods should be ordered from the canteen. The items ordered must be for personal use only and quantities of items restricted to such as can be reasonably used by that patient.

Items thought **not** reasonable or **not** suitable for canteen lists - unless specifically requested by capable patients, (things such as "Aeroguard", "fly spray", "Preen", "'Comfort' softener", "washing soap", "beverages", "bird seed" and "clothing" etc.) should not be included.

There will be times when certain items in the above categories may need to be considered. When this occurs, approval must be granted by the Assistant Director of Nursing. Ordering from the canteen should be commensurate with the patient's available funds/ability to pay.

Items ordered should be restricted to as short a time as appropriate, e.g., cigarettes - weekly, deodorants - monthly.

Purchases from the canteen on behalf of patients shall be made by using Patients' Trust Fund Canteen Purchases form (PH.64A).

Once the forms are prepared they must go the Assistant Director of Nursing for approval before being submitted to the Trust Officer in the general office for checking as to availability of funds by the ledger-keeper.

After checking, all forms will be sent to the Canteen for filling of orders.

The Canteen will insert the "Item Cost" and "Total Cost".

The form will be returned to the ward concerned with the goods for each patient.

Where the patient is capable, he/she must check each item against those ordered before signing for them. Where the patient is not capable, two nurses must be in attendance and the goods taken to the patient, and signed for by the two nurses using the "patient unable/refuses/unavailable to sign" stamp. Nurses must not sign the lists unless they actually see the goods.

Where patients require storage of their goods, they must be marked with the patient's name, or have boxes marked with name, stored separately and **issued only to the owner**.

Patients' private supplies are not to be used for the benefit of other patients or for general use in the ward.

If on checking goods delivered against the order, it is found that an item has been charged for but not received, the matter should be taken up with the Canteen immediately.

When the form has been signed and witnessed it is to be sent to the general office where it will be totalled.

All forms will be summarised and one cheque drawn for payment to the Canteen.

The costs for each individual patient are to be posted to the appropriate trust ledger card and the voucher number recorded on the card against the appropriate entry.

PURCHASE OF CHRISTMAS PRESENTS

When the hospital is arranging the purchase of Christmas presents for patients from their own funds, due regard is to be paid to the individual patients' needs or wants, while ensuring that purchases are kept within reasonable limits. Competitive prices are to be obtained before purchase and items purchased must be worthwhile.

Except where unplanned, "one-off" purchases are made, the Assistant Director of Nursing should submit a list of proposed purchases (with expected prices) to the Director of Administration Services, Deputy Assistant, or equivalent officer.

GROUP PURCHASES

Group purchases are those items purchased through the pooling of funds from individual Patients' Trust Accounts. There is no objection to the use of patients' accumulated funds being used for various purposes (see below), provided that the sums expended are shared equally by participating patients and that funds are not used to purchase items of equipment, pictures, crockery, rugs etc.

Items purchased from pooled money shall be used in the following ways:

(a) when purchasing for highly dependent patients e.g. shopping for small items such as sweets, ice cream, toiletries;
(b) for special outings and holidays.

Repairs and maintenance to any items of equipment previously purchased by group purchasing methods shall be paid from the hospital's operating funds.

Use may be made of the Government Supply Service contracts and the procedures prescribed in the Purchasing and Storekeeping Manual must be followed.

In respect of outings and holidays, use should be made of the NSW Government contract "Travel Agency" to arrange bookings etc. Group projects should be shared equally by participating patients.

Where group purchases are considered, general agreement must be sought from all patients participating (if they are capable of deciding).

PATIENTS WITHOUT FUNDS

Toiletries etc., can be obtained from the hospital store and should be ordered on form A15.

Comforts such as sweets, drinks, etc., can be requested from the **hospital auxiliary**, if one exists. There will be some other items, which are not stocked by the hospital store nor available from hospital finances, which can also be referred to the auxiliary.

Where patient's pension or other funds are handled by relatives or other persons outside the hospital, it is expected that the patient will be provided with adequate supplies of clothing, toiletries and of other comforts at regular intervals, commensurate with the amount available.

If the purchase of cigarettes and tobacco for indigent patients who are suffering undue hardship from the effects of withdrawal is considered necessary funds are to be provided from the General Fund.

ACCOUNTING PROCEDURES

In the case of small items purchased from pooled money the procedure as outlined in the section "Cash Held in Wards" should be followed.

In regard to expenditure on special outings and holidays the following procedures are to be followed:

If approved by the Executive Officer/Medical Superintendent, the ward is to submit Sundry Purchase Voucher (PH.64) giving details of proposed purchase, trip or outing. The approval is to be attached to PH.64 and retained for audit/inspection.

When cost is known, Cash Payment Voucher (PH.21) is to be prepared indicating sums to be charged to each patient. The PH.21 is to be attached to relevant Sundry Purchases Voucher (PH.64).

In the case of group outings and trips, payment should preferably be made by cheque. Where this is impracticable, the total sum involved is to be handed to the Nurse Unit Manager/Nurse-in-charge for disbursement.

The voucher is to be acquitted by those patients who are mentally capable of comprehending what is being asked of them, acknowledging receipt opposite their name of Cash Payments Voucher (PH 21). In respect of those patients who, in the opinion of the Executive Officer/Medical Superintendent, are incapable of comprehending or who, through some disability are unable to sign, the Executive Officer/Medical Superintendent is to furnish a certificate authorising the expenditure.

The certificate mentioned above is to be in the following terms and is to be affixed to the relevant PH.21:

> "I hereby authorise the withdrawal of the sums listed above in respect of those patients marked * totalling $..and certify that such withdrawals are necessary for the benefit, use of enjoyment of those patients."

Acquittances for patients in respect of whom a certificate has been given, are to be completed by the affixing of the rubber stamp "Patient unable/refuses/unavailable to sign".

The use of the rubber stamp referred to in the above paragraph is to be restricted to those patients who, in the opinion of the Ward Medical Officer are incapable of comprehending or who at the time through some disability are incapable of signing their name.

Care is to be taken to ensure that projects approved are "for the benefit, use or enjoyment" of the **contributing Patients**.

MISCELLANEOUS EXPENDITURE

From time to time requests are received for payments to be made from a patient's trust account in respect of:

- weekend leave care by relatives
- telephone accounts
- rates
- rent
- hospital fees
- drycleaning

N.B. except in the case of weekend leave, all accounts should be referred to the Protective Office where the affairs of the patient are under its control.

In the case of weekend leave care by relatives, a completed withdrawal form (PH.154) should be obtained from the patient before payment is made. This withdrawal form should indicate to whom payment is to be made, and payment should be made by cheque. In special circumstances, payment may be made by cash. Sufficient cash should in any event be provided to the patient for any journey expenses.

In regard to telephone accounts, rates and rent, signed authorities for such payments to be made at regular intervals should be obtained from the patients. These authorities should be filed for inspection by Audit Officers.

With regard to damage caused by patients to private or hospital property, no payments are to be made from patients' trust accounts and the matter is to be referred to Central Administration (Accounts Unit).

Any approval for such payment is to be filed for inspection.

In the case of hospital fees, patients' trust moneys cannot be applied towards outstanding fees **unless** authorities completed by patients have been obtained.

Patients should be encouraged to complete such authorities which should be filed for inspection.

In Mental Health Hospitals only, all authorities by patients to pay pension moneys to persons other than the pensioner must be authenticated by the Director of Administration, Deputy Assistant or equivalent. All current "standing" authorities are to be filed alphabetically (by name of patient) in the Administration Office safe.

These authorities are accounting records, and non-current authorities must be retained by the hospital for the same length of time as is prescribed for withdrawal forms.

In those cases where patients require clothing to be drycleaned privately the cost of such service is to be charged to their trust accounts. A written authority or a PH.154 should be submitted to the office.

PATIENTS' AMENITIES ACCOUNT

GENERAL

Section 251 of the ***Mental Health Act 1990*** states that there is to be paid into the Patients' Amenities Account such amounts as are received by the responsible person (Director-General) for the purpose of providing goods, services or amenities for the benefit, use or enjoyment of the patients of the hospital generally; and sub-amounts, or amounts of such class or description of amounts, as may be prescribed. The Act also indicates that there may be paid out of the Patients' Amenities Account, for the abovementioned purposes such amount as may be determined by the responsible person (Director-General).

Strict interpretation of the phrase "for the benefit, use or enjoyment generally" has become increasingly difficult, with most hospitals being well equipped with items which fit such strict interpretations. Items may be purchased which cover one ward or one area without the necessity of being for the benefit, use or enjoyment of **every** patient in the hospital. Management should ensure that funds from the Patients' Amenities Account, are, as far as possible, expended equitably between all the patients in the hospital.

Items which might be expected normally to be provided by the hospital, should not usually be acquired as a charge against the Patients' Amenities Account. Projects should be considered, however, having regard to the time interval, the urgency and the desirability of the project and the likelihood of hospital funds being or becoming available.

There must be a direct or immediate benefit, use or enjoyment accrued to patients from purchases although this does not debar others from gaining some benefit.

PURCHASING PROCEDURE

Items or services financed from the Patients' Amenities Account must be obtained using normal purchasing procedures as per the Purchasing and Storekeeping Manual.

OWNERSHIP

Articles purchased from the Patients' Amenities Account are the property of the hospital and are to be entered on inventories/asset registers where appropriate.

SURPLUS AND OBSOLETE ITEMS

When any item becomes surplus, obsolete or beyond repair, it shall be written off the inventory/asset register and disposed of in the same manner as that pertaining to other Area Health Service/hospital property, with any income from disposal of the item being paid to the credit of the Patients' Amenities Account.

ITEMS/AREAS OF EXPENDITURE

It is obviously impossible to provide a comprehensive list of items or services on which funds may be expended, but examples of areas in which such funds may be expended include:

- Recreation and sporting equipment for patients
- Bus hire to best advantage where Public Transport Commission does not provide regular services
- Launch hire (hospitals to make own arrangements)
- Hire of films
- Hire of dance band)
- Hire of an entertainer) (Hospitals to make their own arrangements)
- Books, periodicals for patients' library
- Prizes for games, sporting contests
- Newspapers
- Record/cassette players
- Tapes, records
- Playground equipment
- Christmas decorations, gifts, parties
- Organised holidays and/or outings
- Educational equipment for patients
- Billiard tables
- Music systems in wards
- Swim ming pools
- Barbecues, all types
- Indoor pots, hanging baskets, pot plants
- Pianos, pianolas

- Colour television
- Air conditioners
- Tennis courts
- Buses
- Provision of facilities not normally provided by the hospital, viz. shelter sheds, rest areas, recreational facilities (except recreation halls), etc.
- Provision of furniture, furnishings, pictures, posters, murals, equipment, floor coverings for facilities provided from Patients Amenities
- Engagement of persons on a sessional/contract basis to provide and conduct special programmes, the funds for which are not available from any other source and subject to the Executive Officer/Medical Superintendent being satisfied that the programme is of benefit to the patients involved
- Fish tanks and ponds
- Sweets
- Maintenance of equipment purchased for Patients' Amenities Account
- Alterations/additions to facilities provided from Patients' Amenities Account.

Examples of areas on which funds from the Patients' Amenities Account may clearly **not** be expended include:

- Purchase of items, goods, facilities for persons other than patients
- Construction of buildings (other than those specified in the approved list above)
- Maintenance/modification of buildings (except those purchased from Patient Amenities Account)
- Repair/maintenance of motor vehicles (except those purchased from Patient Amenities Account)
- Floor coverings, blinds, curtains, furniture (except for areas specified in the approved items)
- Upkeep of grounds, ground maintenance equipment
- Supplementing other accounts, e.g. Occupational Therapy and Industrial Therapy Units
- Electrical appliances repair or maintenance of such (apart from items included in the approved list)

LIMITATIONS OF EXPENDITURE

The Director-General has determined that the Chief Executive Officers of Area Health Services (unlimited) and the Executive Officer/Medical Superintendent hospitals ($10,000 per purchase) can expend funds from the Patients' Amenities Account for the benefit, use or enjoyment of the patients of the hospital generally.

Executive Officers/Medical Superintendents are authorised to approve for "supply and fix" or "supply and erect" jobs for any projects, subject to the above paragraph. The procedures set out in the Purchasing and Storekeeping Manual shall be followed.

FINANCIAL MANAGEMENT ISSUES

1. Bank Overdrafts

It is a breach of the Accounts & Audit Determination to have a bank overdraft without the authorisation of the Director-General. Overdrafts also accrue an interest charge and, therefore, increase the expenses of Health Services.

It is the responsibility of Health Service management to ensure that appropriate internal controls exist, including regular internal audit checks, to avoid bank overdrafts on any account (e.g., General Fund, Special Purpose and Trust) operated by the Service.

The Department will favourably consider the provision of cash advances to cover all or part of outstanding budget supplementations where confidence exists on the level of funding. These matters are to be raised as part of monthly finance reports or directly with Financial Management and Planning Branch.

Where a Health Service has liquidity problems, after taking into account outstanding budget supplementations, which may impact on the payment of salaries, wages and general creditors, the Health Service is to approach the General Manager, Finance and Commercial Services for a short term cash advance. Such approaches must be supported by a clear demonstration that your Service is highly proactive in:

- implementing budget strategies;
- aligning the cost of services to budget;
- revenue collection.

Further, all monthly narrative reports to the Department are to include a statement as follows:

> "*Bank Overdrafts*
>
> *During the month ending.....no bank statement identified a debit balance at any day's end during the month.".*

OR

> *"During the month ending.....the following bank account/s identified a debit balance at a day's end during the month and full details of the incident are attached, as follows:*
>
> *name of account*
> *days in debit*
> *amounts in debit*
> *reasons for the overdraft; and*
> *corrective action in place".*

Similar statements are to be provided as part of the monthly Finance Committee Report to the Board and, where an overdraft exists, this is to be specifically mentioned by the CEO to the Board.

2. Finance and Audit Committees

2.l Finance Committee

It has been noted that Finance Committees exist under various titles and, in some cases, are incorporated as part of monthly Board meetings (ie the Full Board is the Finance Committee).

The following "best practices" are commended to Health Services:

- Finance Committees should meet monthly;
- **if the Full Board fulfils the role of the Finance Committee, the Finance report must be received and discussed at each ordinary meeting of the Board (i.e., it must not be noted or deferred);**
- Area CEO's must attend all Finance Committee meetings, except where absent on approved leave;
- reports by management to the Finance Committee should include advice which reconciles the Finance Committee Report to monthly finance reports to the Health Department;
- Finance Committees should meet no later than 28 days after the end of each month to discuss that month's figures and Executive analysis;
- Finance Committees should primarily focus on the financial management of funds for which the Area is responsible. This focus should not be diminished by various committee titles and other agenda items;
- the Audit Committee should be separate to the Finance Committee;
- where the Finance Committee is a sub-committee of the Board, an Executive Summary report should be tabled at monthly Board meetings including matters of concern, key indicators and any exceptions to acceptable practices.
- letters to management from the Auditor General, Minister for Health, and the Health Department relating to significant financial matters should be tabled at the Finance Committee.

2.2 Audit Committee

Audit Committees must ensure that internal audit plans include an annual review of financial reporting. The review is to cover:

- a reconciliation of Department of Health allocations to those advised to Health Service units and Area provisions;
- statements issued to the Department and Finance Committee in respect of bank overdrafts;
- advice provided to the Department in respect of general creditors;
- the monthly conduct of Finance Committee meetings including Chief Executive Officer attendance;
- a comparison of monthly information provided to Finance Committees and the Department;
- issues raised by the Auditor General, contract auditors or the Department on the quality, timeliness and presentation of annual financial statements.

3. Monthly Finance Reports to Department

To ensure appropriate levels of accountability exist between Directors of Finance and Chief Executive Officers, internal controls are to be established which formalise the submission of the draft narrative reports to the Chief Executive Officer. This can be achieved by either a formal submission or co-signing the narrative report. It is expected that all monthly reports to the Department will be signed by the Chief Executive Officer or Acting Chief Executive Officer (in cases of leave).

NSW PUBLIC HEALTH SYSTEM EMPLOYEES CONDUCTING FINANCIAL TRANSACTIONS AND OR DEALING WITH MONEY/PROPERTY FOR PATIENTS/CLIENTS (PD2005_167)

This circular replaces circular 99/4 of 8 January 1999.

A NSW health system employee as a general rule should not become formally or informally involved in any transaction for or with a patient/client of the health system which involves dealing with cash, bank accounts, credit cards or property on behalf of a patient/client.

Whilst providing such services may assist and could be for the well being of the patient/ client, such practices could place the employee in an invidious position, possibly exposing them to criminal charges.

Where a patient/client requires such services, especially if they are in a home environment and cannot conduct such transactions themselves, a health system employee should discuss with the patient/client low risk alternatives and, with their consent:

1. contact relatives to undertake the service; or

2. contact other agencies that can assist in such matters (for example, Department of Community Services);

3. contact patient/client's bank etc. and advise of situation and make appropriate accountable arrangements;

4. utilise methods of an accountable nature (for example, a "not negotiable" cheque made payable to the appropriate payee).

Where the health employee is concerned that the patient/client may have impaired capacity to manage their financial affairs they are to make contact with the Guardianship Tribunal.

If it is absolutely necessary or unavoidable that a health system employee has to handle cash/property etc. on behalf of a patient/client they should:

1. have a witness (for example, a next door neighbour) be present and formally sign appropriate verification of the transaction; and

2. obtain a receipt/signed acknowledgement from the patient/client for the cash/property involved in the transaction.

Under no circumstances should an employee:

1. obtain the electronic or other PIN number for a bank account etc. of a patient/client or use a credit card of a patient/client. Apart from potentially being an illegal act this would also breach bank or other account conditions of use;

2. obtain or accept a power of attorney for a patient/client;

3. facilitate an arrangement whereby a friend, relative or business associate of the employee obtains a power of attorney for the patient/client.

4. accept cash from a patient/client in order to undertake any transaction on the client's behalf without the presence of an appropriate witness to the transaction request. The witness should formally verify transactions by signing.

Enquiries should be made with the Guardianship Tribunal if a person's financial affairs appear to need formal management. The Tribunal's enquiries service can give advice and information about the less restrictive alternatives to formal management that may be open in the circumstances of the particular case. If an employee considers that a patient/client has lost capacity to make personal or lifestyle decisions for themselves then contact should be made with the Guardianship Tribunal about the possible appointment of a guardian.

SECTION THREE

REVENUE

ACCOUNTING FOR FEES AND OTHER INCOME

REVENUE POLICY

REVENUE STANDARD

PATIENTS' FEES

DEPARTMENT OF HEALTH CAPITAL WORKS FUNDING

LOCAL FUNDS

SERVICES TO OTHER HOSPITALS AND ORGANISATIONS

ACCOMMODATION – HEALTH OWNED – REQUESTS FROM EXTERNAL ORGANISATIONS

PARTICIPATION AT EXTERNAL SEMINARS

OCCUPATIONAL AND THERAPY DEPARTMENTS - SALES TAX

TELEPHONE BOXES - ACCOUNTING FOR COLLECTIONS

INVESTMENT OF FUNDS

SUBPOENAS

AD-HOC FUNDING REQUESTS FROM EXTERNAL ORGANISATIONS

NSW HEALTH SYSTEM FEES AND CHARGES - IMPACT OF THE GOODS AND SERVICES TAX

CLINICAL TRAINING GRANTS FOR POSTGRADUATE YEAR ONE AND TWO MEDICAL OFFICERS

ACCOMMODATION – HEALTH OWNED – CONSIDERATION OF RENTAL/MARKET RENTAL ASSISTANCE GRANT

ACCOUNTING FOR FEES AND OTHER INCOME 3.2

REVENUE POLICY

The principal sources for Health Funding are:

Government
Patient fees and other revenue
Local initiatives
Donations, bequests, grants and contributions by hospital auxiliaries

The Government contribution is the largest representing in excess of 87% of the Health budget and one third of the State Budget. Commitment of Public Funds to this extent requires a high level of responsibility and accountability. Treatment of Health revenue in accordance with Statutory and Regulatory requirements is a condition of government cash payments.

Funding from other sources although marginal has a significance far greater than suggested by the monetary amount when measured in terms of community commitment, caring and dedication.

This policy is therefore formulated to promote the responsibility and accountability required by government while at the same time retaining sufficient flexibility to maintain a climate which encourages development of operational initiative through a system of rewards and protects the integrity of fundraising, donations and bequests which form part of the vital interaction between the hospital and the community.

All activities of health organisations subject to the provisions of the Accounts and Audit Determination for Area Health Services and Public Hospitals are to be accounted for through the General Fund unless specified as Special Purpose and Trust Fund by the Director General of Health.

The Special Purposes and Trust Fund shall contain funds from:

Donations, legacies and bequests other than those designated as General Fund

Proceeds of fundraising activities

Trust Funds held on behalf of third parties i.e. patients and hospital auxiliaries

Private practice trust funds

Other items as scheduled by the Director General of Health

Income earned on the above, apportioned and credited to the applicable account

All funds received or credited shall be accounted for in the General Fund with the exception of those approved for inclusion in Special Purpose and Trust Fund.

Definitions and guidelines for the operation of Revenue Policy are contained in the Revenue Standard.

The Health Budget is prepared in four segments:

1. Gross Operating Payments
2. Patients Fees Revenue
3. Other Revenue
4. Capital Works

It is recognised that the current downward trend in chargeable bed days is outside the control of the Health system. Accordingly the Department will underwrite the effect on Patient's Fees of reduced chargeable bed days by 100%.

Surpluses or deficiencies in meeting other revenue budgets will be borne 100% by the health organisation.

From 1 July 1993 subsidy (Government Cash Payments; GCP) has been provided on the basis of a Net Operating Cost system.

Gross Operating Payments - Revenue = Government Cash Payments

The policy enables health organisations to benefit immediately from revenue raising initiatives and permit use of additional revenue raised to be applied to the cost of raising that additional revenue or to any other local priority. GCP will be paid net of revenue which will be retained. Additional other revenue collections will permit a corresponding GOP budget adjustment. Shortfalls will produce a reduction in funds made available for expenditure. In the case of a decrease in Patient Fee Revenue due to a decline in the Public/Private Patient mix budget adjustments will be made to alleviate any possible liquidity problem.

REVENUE

Nett Appropriations were introduced to the public hospital system effective from 1 July 1993.

Patient Fees: Unfavourable variances that occur as a result of changes in Government policy or shifts in chargeable patients under existing Government policy will be supplemented.

The Department will effect adjustments in respect of related unfavourabilities.

Health organisations are not to benefit from any patients' fees favourabilities.

Other User & Other Income: 100% of favourable/unfavourable variances are to be absorbed by the area/hospital.

Charts of Accounts are to be structured to provide:

- Patients Fees
- Other User Charges
  - Facility charges
  - Meals and accommodation
  - Services to Other Hospitals/Organisations
  - other (includes rent, fees for medical records, pharmaceutical charges, car parking)
- Other Income
  - Interest - investments
  - Grants
- Donations and industry contributions

ACCOUNTING FOR FEES AND OTHER INCOME 3.4

REVENUE STANDARD

INTRODUCTION

This standard is an appendix to the Department of Health Revenue Policy and should be read in conjunction with it. It has been prepared from a number of sources including:

Reports of the 1991 Survey of Accounting Controls

The Revenue Standards Committee established by the Directors of Finance

Response to a Department request for information on Public Hospital Revenue - Accounting Arrangements dated 1 October 1991

Seminar on Accountability, Integrity, Control & Corruption, 5 June 1992

The Accounts and Audit Determination for Area Health Services and Public Hospitals

The Accounting Manual for Area Health Services and Public Hospitals

Circulars and Directions issued by the Department of Health

Classification of User Charges in the Public Sector - document issued by Treasury and revenue practices as promulgated by the Treasurer and Treasury from time to time.

Responses to the Revenue Standards Discussion Paper issued with the 1992/93 Allocation.

The purpose of the document is to achieve an improvement in the level of compliance with directions issued by the Department for the treatment of receipts. The document is in five principal parts:

1. **The Standard.** The Standard embodies the overall principle relating to treatment of revenue.

2. **Future Directions in Revenue Treatment.** Two major changes to the treatment of Other Revenue which have been negotiated with Treasury to ensure that local initiatives in obtaining additional revenue are appropriately rewarded and that maximum flexibility is achieved by permitting immediate use of all Other Revenue receipts.

3. **Statutory and Regulatory Requirements.** This section contains the principal Statutory and Regulatory requirements in relation to receipts and also details some of the most common exceptions.

4. **Correcting Errors of the Past.** This section contains details of the corrections needed to bring practices up to standard and the specific measures taken including negotiations with Treasury to facilitate the procedure.

5. **Examples of Compliance and Non Compliance.** This section cites a number of instances of non-compliant practices which were found in Areas and Hospitals during the course of the 1991 Survey of Accounting Controls.

The document is intended as an aid in receipt and revenue administration.

1. THE STANDARD

Receipts of all activities of health organisations subject to the provisions of the Accounts and Audit Determination for Area Health Services and Public Hospitals are to be accounted for through the General Fund unless scheduled as Special Purpose and Trust Fund by the Director General of Health.

2. FUTURE DIRECTIONS IN REVENUE TREATMENT

There has been concern expressed that the revenue system as it existed stifled initiative by failing to provide appropriate rewards for above budget performance. The following measures have been instituted to overcome this and to provide additional incentive.

2.1 Revised Revenue Incentive Scheme

The Revenue Incentive Scheme negotiated with Treasury which commenced 1 July 1992 provides that 100% of Other Revenue favourabilities will be returned to Areas and Regions. The object of this was to ensure that Areas and Regions received the full benefit of local initiatives taken to raise additional funds.

2.2 Revised Health Funding Model for Areas/Districts and Hospitals

The object of the model is to give public health organisations maximum flexibility with Other Revenue while ensuring that there is no financial penalty for a declining public/private patient mix.

The model provides for a full Net Cost of Services Budget. Adjustments for any decrease in patient fees due to a decline in the Public/Private Patient mix will be made to alleviate possible liquidity problems. All revenue will be retained by the public health organisation and subsidy will be paid net of Revenue. Additional other revenue collections will permit a corresponding increase in Total Expenses. On the other hand failure to achieve the Other Revenue Budget will generally require a corresponding reduction in Total Expenses.

The public health organisation will internally retain Revenue within the General Fund and apply as a source of increased expense or adjustment of balance sheet amounts. Revenue will not form part of remittances to the Department of Health. In addition shortfalls in Patients Fees will be adjusted on a quarterly basis.

The public health organisation will have the option of deciding on the nature of the Expense/Revenue adjustment required. That is whether they are a one off current year adjustment or a current year/annual adjustment or whether the amount is to be treated as a rollover at the end of year. Budget adjustments to effect this will be made in response to requests from public health organisations.

Significant matters arising from the adoption of the GCP Model

Details of staffing transferred from SP&T, Group Services/commercialisations etc. to the General Fund will need to be advised to the Department for inclusion in the staff profile.

3. STATUTORY AND REGULATORY REQUIREMENTS

In considering revenue practices, the following requirements must be observed and appreciated.

3.1 Statutory Basis of the Accounts and Audit Determination

The monies received by public health organisations are public monies. The Accounts and Audit Determination is the means by which the Government, through the Minister and the Director General, seeks to ensure proper accountabilities and controls of expenditure and administration of these public monies. The Determination is also intended to provide probity and equity in the administrative

procedures within Health organisations. Accordingly, public health organisations are required to undertake their obligations under the Determination with the same scrupulousness with which the Department of Health is required to undertake its obligations pursuant to the *Public Finance and Audit Act* and the Treasurer's Directions.

Compliance with the Accounts and Audit Determination has been determined by the Director-General, as delegate of the Minister, to be a condition of the Government Cash Payments received by public health organisations from the Consolidated Fund.

The Determination of course does not stand in isolation. The Determination provides for compliance with a range of Policy and Procedure Manuals, including the Accounting Manual, the Accrual Accounting Standards and Procedures Manual, the Purchasing and Storekeeping Manual, the Building and Equipment Manual, the Patients Fees Manual, and the Patients' Matters Manual.

3.2 Direction Contained in the 1991/1992 allocation letter to CEO'S and Regional Directors in respect of Accounting Practices

Departures from good accounting practices, bad internal control policies and a failure of management to observe proper practices will not be tolerated.

Accordingly Chief Executive Officers are to ensure that the requirements of the Accounts and Audit Determination are being observed and that sound internal control practices exist. In addition, Internal Auditors are, as part of audit programmes, to test check procedures to ensure compliance with the Accounts and Audit Determination and other accounting/financial policies issued by the Department.

Future departures from these principles will result in disciplinary action.

3.3 Accrual Accounting Standards and Procedures Section, Accounting Manual

Area Financial Statements are to be prepared in accordance with the requirements of the *Health Services Act 1997* and its regulations.

3.4 Accounts and Audit Determination - the definition of receipts is:

RECEIPTS in respect of the General Fund are:

> "the total of all monies received during the accounting period, unless specified as Special Purpose and Trust Fund by the Director-General of Health:
>
> The Special Purpose and Trust Fund shall be credited with:
> (a) Donations, legacies and bequests other than those designated as General Fund
> (b) Proceeds of fundraising activities (as defined in the Revenue Policy)
> (c) Trust Funds held on behalf of third parties i.e. patients and hospital auxiliaries.
> (d) Private practice trust funds net of facilities charges.
> (e) Other items as scheduled by the Director General of Health.
> (f) Income earned on the above, apportioned and credited to the applicable account.

3.5 Examples of Other Specific Exceptions

There are a number of specific exceptions in the treatment of General Fund receipts which include the following:

(a) **Accounting for Services within Area Health Services and to other Area Health Services or Public Hospitals.** In this case the Accounting Manual prescribes that receipts are to be credited against the particular expense account or accounts when payment is received. The Manual also states "No other income can be offset against expenditure without specific written approval of the Director-General of the Department of Health."

(b) **Direct recredits such as refunds, salary overpayment recredits, workers' compensation recredits, supplier refunds and rebates.**

(c) **Authorised Group Services/Commercialisations.** In this instance receipts are credited to the separate financial entity in accordance with Accounts and Audit Determination Section 6 and the Group Service Guidelines

Note: All group services and commercialisations are to be included in General Fund monthly reports as from 1 July 1993.

(d) **Public Hospital Charges for Prostheses.** Circular 93/32 is the most recent giving the list of prostheses charges. Revenue from these charges was, up until 30 June 1993, paid into a separately identifiable account within the Special Purposes and Trust Fund and used solely for the purchase of other prostheses.

Note: As from 1 July 1993 this item was brought back into the General Fund. Any balance remaining in the account was to be transferred to the

General Fund at 30 June 1993 and from that date revenue from Public Hospital Charges for Prostheses will be treated as General Fund User Charge Revenue.

(e) **Shoulder Splints and Crutches.** The Fees Procedures Manual section 4.64 requires that these are to be loaned free of any hiring charge to inpatients upon discharge but deposits are chargeable and should be paid into a suspense account from which refunds are to be made.

(f) **Brain Injury Rehabilitation Program.** As from 1 July 1993 this item was brought back into the General Fund. Any balance remaining in the account was to be transferred to the General Fund at 30 June 1993. From that date although overall accounting treatment and reporting requirements will be similar to the May 1991 letter, the receipts of the Brain Injury Rehabilitation Program will be treated as General Fund User Charge Revenue.

(g) **Superannuation.** Treatment of the collection and payment of employee contributions through the SP&T Fund in accordance with instructions contained in the Department's letter dated 21 February 1992. This exception was permitted to facilitate reconciliation of accounts with the State Authorities Superannuation Board.

Note: This practice was an interim measure only to facilitate a backlog reconciliation problem. The practice ceased as at 30 June 1993 and all funds will be returned to the General Fund at that date.

(h) ***Adoption Information Act* - Search Fees.** PD2010_050 states: An Information Source may charge a fee for disclosing information held by the Information Source. Information Sources should refer to PD2006_050 *Health Records and Medical/Clinical Reports - Charging Policy* in respect of the fees to be charged.

3.6 Summary

Directions, manuals, policy, procedures, regulations and rules exist to ensure a high standard of integrity and accountability in financial dealings, accounts and reports within the Health system. Failure to observe these requirements is a breach of the conditions of subsidy and could result in disciplinary action being taken against the responsible officer and a report of possible corrupt conduct to ICAC.

4. CORRECTING ERRORS OF THE PAST

It is the responsibility of the Area CEO, District General Managers and/or the Hospital CEO to ensure that a thorough investigation is carried out of General Fund records and SP&T Fund records to ensure that all incorrect practices are identified and suitable corrective action taken. In particular, where revenue which should have been credited to General Fund Revenue has either been diverted, understated or unrealised the credit due must be ascertained.

4.1 **Moratorium.** It is considered reasonable that some limit be placed on how far back adjustments need to be made. In the case of interest, patient fees and scheduled fees restitution is required back to 1 July 1988. This is the date which has already been applied to a number of Areas who had been found to withhold interest or who had devised schemes by which interest which should have been earned was either understated or unrealised. In the case of other types of revenue the moratorium date is 1 July 1990.

4.2 **Equity of Treatment.** The Revenue Standards Committee found that while some of the practices such as diversion of interest on the General Fund Account to the Special Purposes and Trust Fund Account were quite clear breaches of the rules, other breaches had arisen due to a change in circumstances such as a canteen which had formerly been run by voluntary labour evolving into an unauthorised commercialisation as the hospital gradually took over operational functions. It is the intention of the Department to treat each case fairly while at the same time ensuring future compliance with the rules. Correction in some cases will require adjustments for both Revenue and Expense and in other cases adjustment will be made for the Revenue Budget only.

4.3 **Patient Fees and other charges.** Apart from the exceptions stated in the definition of receipts and fees for services provided between health organisations all Patient Fees and other charges are General Fund Revenue. The only exceptions to this rule must have the written approval of the Director General of Health. Examples of schemes which have from time to time been given individual approval include deposits on crutches etc.

4.4 **Facilities Charges and Staff Specialist Trust Accounts.** It is essential that these accounts be kept strictly in accordance with Section 6 of the Accounting Manual for Area Health Services and Public Hospitals and issued Policy Documents. (See Chapter 6 Fees Procedures Manual.) It has been noted that in a number of cases the facility charge percentage of the scheduled fee is not in accordance with the Circulars. Action must be taken to correct any errors in these accounts. Health organisations are to deduct facility charges from fees collected on behalf of visiting diagnostic medical practitioners or salaried medical specialists (exercising rights of private practice) for the use of hospital facilities and/or staff. On a monthly basis facility charges are to be transferred to revenue as a first charge against the Private Practice Trust Fund.

4.5 **Rewards for Initiatives Taken.** Some Areas have expressed the concern that a return to revenue compliance may stifle initiative in those who are resourceful enough to create money making schemes for the Area. This can not be accepted as a valid excuse for non compliance and in future will not be tolerated particularly in view of successful negotiations with Treasury as a result of which Areas and Hospitals benefit from the return of 100% of Other Revenue favourabilities commencing 1 July 1992. In addition as from 1 July 1993 subsidy will be allocated on an NOC basis which will permit the retention of all other revenue enabling those who earn additional other revenue to obtain immediate benefit from the extra income.

4.6 **Unauthorised Group Services and Commercialisations.** The 1991 Survey found that some Areas/Regions had developed a means by which revenue due to the State was removed from the system and at the same time escaped the Departmental requirements relating to Group Services and Commercialisations. This could be by simply paying revenue into SP&T, as repayment to vote or a myriad of other schemes. Where the investigation of practices indicates schemes of this nature which exist without Departmental written approval, action should be taken to gain the necessary authority for continuation or the scheme should cease and action be taken to restore the situation to what it would have been without the unauthorised arrangement. In many cases restorations will not be a simple matter and consideration will need to be given to matters such as SP&T input and previous Departmental Guidelines. Details of departures from acceptable practice should be advised to the Department together with an assessment of the financial implications as soon as possible.

4.7 **Application of Special Purpose and Trust Funds.** Section 6 of the Accounting Manual prescribes the manner in which SP &T Accounts are to be operated. SP&T Funds are to be used strictly in accordance with the terms of the Trust or grant. They cannot acquire conditions more restrictive than those set by the donor. Until the purpose of the special purpose or trust is satisfied investment of the funds can only be in accordance with the terms specified or where none have been specified then in accordance with the provisions of the ***Public Authorities (Financial Arrangements) Act 1987*** which is considered by the Department of Health to comply with the requirements of the ***Trustee Amendment (Discretionary Investments) Act 1997.*** As a general rule, application of SP&T Funds in a manner permitted by the Special Purpose or Trust satisfies the Trust. For example where SP&T Funds have been used for maintenance on a building or for the purchase of equipment the trust is satisfied and the benefit has passed to the Area or Hospital. This is also the case where within the provisions of the special purpose or trust, constructions such as tennis courts or parking areas are built on Hospital land. Unless specific approval has been given by the Department or in the case of residences that are held for the purpose of SP&T Fund investment, revenue earned on assets or enhancement to assets provided from the application of SP&T Funds is General Fund Revenue.

4.8 **Contracting in.** Where excess capacity and resources in an Area or Hospital are used to provide services to organisations outside the NSW Public Health System the gross revenue from such operations is General Fund Revenue. Great care should taken when “contracting in”. This is to ensure that Treasury procedures are adhered to in respect of User Charge activities and in particular with regard to the concept of “the level playing field”. Treasury policy states that access to private sector clients is not available where goods or services in question are readily available in a competitive market environment except with the approval of the Minister for the Department and the Treasurer.

4.9 **Interest on Capital Works Accounts.** No authority exists under the Accounts and Audit Determination to divert Capital moneys or interest thereon to projects other than the specific project to which the original advance relates. It is understood that practices have developed which have seen a diversion of such moneys to various local capital works projects such as information technology and general Building and Equipment Accounts.

No corrective action is proposed on such diversions provided that the diversion was to other capital works projects and the moneys were expended prior to 30 June 1992.

As from 1 July 1992 all capital works accounts and interest thereon are to be accounted for through the General Fund. See Page 3.24 for full details re Capital Works Accounting Arrangements.

5. EXAMPLES OF COMPLIANCE AND NON COMPLIANCE

5.1 Patient Fees and other charges

Fees for hospital services provided to chargeable inpatients and non inpatients are collected and accounted for by the hospital in accordance with the policies and procedures described in the Fees Procedures Manual for Area Health Services and Public Hospitals. The 1991 Survey of Accounting Controls noted that there were instances where charges which should have been paid into the General Fund were diverted to the SP&T Fund. These included receipts from migrant x-rays, receipts from private hospitals for the treatment of patients in the public hospital and receipts from compensable patients for rehabilitation services. Notable exceptions which have been approved are the Brain Injury Program, receipts and expenditure for prostheses and deposits for shoulder splints, crutches, etc. (Refer also to paragraph 3.5.)

Unless specifically exempted by the Director General of the Department of Health charges for hospital services to patients are General Fund Revenue and must be collected and accounted for in accordance with the Fees Procedure Manual for Area Health Services and Public Hospitals.

5.2 Recredits

5.2.1 **Recredits in income against expenditure.** Apart from the exceptions listed in the definition of Receipts the only circumstances in which recredits of income against expenditure are allowed without the specific written approval of the Director-General of the Department of Health are in the case of refunds or rebates and in accounting for services within the Area Health Service to other Area Health Services or Public Hospitals. (Section 1 Accounting Manual for Area Health Services and Public Hospitals.) During the course of the 1991 Survey a number of unauthorised recredits to vote were found such as recredit to expenditure of canteen receipts.

With the exception of instances cited in 3.4 and 3.5 of this document income other than that generated for provision of services between Area Health Services offset against expenditure without specific written approval of the Director-General of the Department of Health.

5.2.2 **Recredits of income from the provision of infrastructure services to other service providers.** The rules as stated above take no account of the particular circumstances in which local hospitals provide services to other service providers such as nursing homes, and Hostels for the aged and disabled.

In future such services should be treated as separate entities with a separate matching revenue and expenditure budget within the General Fund. This may be on a hospital, Area or District basis.

5.2.3 **Lump sum returnable grants.** As a general rule all operations of an Area/District should be carried out through the General Fund. This has particular significance in relation to activities which employ staff, as staff employed outside the General Fund attract additional on-costs such as employer contribution to superannuation. Where research is funded in advance through a returnable grant from a third party and the donor is reluctant to have the grant paid into the General Fund the activity may continue to take place within the SP&T.

This concession should be seen as the exception rather than the rule and on no account is this treatment to be used for commercial transactions such as receipt of monies for Drug Testing and preparation of specialist videos where funds received are to be treated as General Fund Revenue.

5.3 Interest

5.3.1 **General Fund Interest.** As a condition of subsidy interest attributable to the investment of General Fund money was revenue returnable to the State up to 30 June 1993. This was the case since before the inception of the Area Health Boards and also with interest earned on revenue since the 1 July 1991. (With effect from July 1993 such revenue is retained by the health organisation as General Fund revenue.)

> Accounts and Audit Determination clause 4.17 states:
>
> "General Fund interest earned on a General Fund bank account (other than the Capital Works account) or invested General Fund money is to be credited to the General Fund as other revenue, and all General Fund bank charges are to be debited to Goods & Services."

Actions taken to divert interest from the General Fund constitute breaches of this requirement. Examples of breaches found during the course of the 1991 Survey of Accounting Controls include:

- Payment of General Fund Interest into the SP&T Fund either through the Bank Account or by transfer into the SP&T Bank Account.
- Payment of General Fund Interest into a Bank Account outside the system.

Both instances are a clear breach of the Accounts and Audit Determination, clause 4.17.

- Payment of SP&T Fund Accounts through the General Fund with subsequent reimbursement some days or weeks later.

The Accounts and Audit Determination clauses 4.2 and 4.3 require that accounts for the General Fund and the SP&T Fund be separately maintained. It is appreciated that difficulties may arise where computerised creditors and cheque payments systems exist. In such a case it may be permissible to draw cheques for payment of SP&T Accounts provided that reimbursement was made to the General Fund Bank Account from the SP&T on the same day.

- Transfer of General Fund Accounts to SP&T e.g. PAYE Tax deductions. The effect of this is to increase the interest earning potential of the SP&T Account to the detriment of the General Fund.

This is a clear breach of section 4 of the Accounts and Audit Determination Distinguishing Between Funds.

5.3.2 **Special Purposes and Trust Fund Interest**

Accounts and Audit Determination clause 4.22 states:

"Interest earned from the investment of Special Purpose and Trust Fund assets shall be apportioned to each respective account in a timely and equitable manner but not later than 30 June in each financial year."

All accounts in the SP&T Fund are essentially Trust Funds whether they were obtained by way of donation from a benefactor or through special or capital allocations from the Department or the Government. This position was confirmed in recent advice from the Crown Solicitor and the Attorney-General. It is clear from this advice that each account must receive an equitable share of the interest earned by the SP&T.

Practices which would not be considered to provide an equitable distribution include:

- Any scheme which treated one class of SP&T accounts in a manner unlike that used for other SP&T accounts e.g. payment of interest on Specialists' Trust Accounts at the going rate of say 10% less one i.e. 9%, while other SP&T accounts receive a share of the remainder.
- Any scheme which permitted debit balances to exist in the SP&T Fund.
- Any scheme which did not require interest to be paid on debit balances in the SP&T to compensate for the interest foregone by SP&T accounts with credit balances. (Whilst all senior financial officers have a clear personal responsibility to ensure no SP&T account goes into debit, it is noted, albeit reluctantly, that from time to time accounts go into debit. This is a most serious situation and should be monitored by the CE for area health services and Royal Alexandra Hospital for Children. However, all such accounts in debit must pay interest on such a balance.)
- Any scheme which excluded an account from receiving a just share of income.
- Any scheme which paid interest on only a portion of an account.
- Any scheme which did not make an equitable apportionment of interest over all SP&T funds with regard to the varying balances of those funds throughout the year.
- Any scheme which credited the interest related to one SP&T account into another account.

5.4 Accommodation and Property Income

5.4.1 **Relative Accommodation.** Accommodation provided to relatives and friends can be distinguished from that provided for inpatients on the basis that the service provided is limited and does not

include provision of nursing or medical services on the premises. There is a prescribed fee for this which includes meals and accommodation. **These charges are General Fund Revenue** and are not to be recredited to vote or paid into the SP&T Fund. Some Areas have expressed the view that adherence to this rule will place them at a disadvantage as their current arrangement provides them with a source of funds to meet costs and refurbishments which will be lost.

Receipts for accommodation provided are General Fund Revenue. The only exception is where land and buildings are part of a Trust or are held as an investment of the SP&T Fund in which case the receipts and all expenditure in relation to the property must be brought to account in the appropriate SP&T Fund Account (ref. page 2.70 Fees Procedure Manual).

5.4.2 **Staff Accommodation.** A number of hospitals have been treating revenue from this source as recredit to expenditure or crediting the amount to an SP&T Account.

Charges for Staff Accommodation should be in accordance with page 3.25 of the Accounting Manual and paid into the General Fund as Revenue except in instances where the residence is held as an investment of the SP&T Fund in which case the receipts and all expenditure in relation to the property must be brought to account in the appropriate SP&T Fund Account.

5.4.3 **Other Property Income.** Income earned from assets or activities which are not self contained or separate from the core activities of the operation of the health organisation is General Fund Revenue. Treasury have defined Government Service Activities in the case of Health as including:

> "Hospital bed day charges and incidental hospital charges (e.g. parking fees)."

Incidental hospital charges include parking fees, collections from telephones, rental of meeting rooms, halls, premises, advertising space income.

Treatment of this revenue as a recredit or diversion to the SP&T Fund is not permitted by the Accounts and Audit Determination.

5.5 **Meals on Wheels.** Receipts from meals on wheels are General Fund Receipts and must not be treated as recredits or diverted to the SP&T Fund. *Treatment of this revenue as a recredit or diversion to the SP&T Fund is not permitted by the Accounts and Audit Determination.*

5.6 **Half-Hearted Commercialisations.** During the course of the 1991 Survey of Accounting Controls a number of instances were found where units credited income from the profitable part of their operation to the SP&T Fund. For example some Staff Development Units charged for part of their services and had the proceeds of these services credited to an SP&T Fund Account with minimal or no expenditure debited to the account. Where the services were provided to operations within the Area or to other Areas or hospitals, fees received should be credited to the appropriate General Fund expenditure account which bore the cost of the service. Where fees are received from others such as private hospitals or other government organisations, the gross fees should be credited to General Fund Revenue. There are other examples of this type which generally have one feature in common, i.e. diversion of General Fund receipts to the SP&T Fund while expenses are met from Gross Operating Payments in the General Fund.

Treatment of this type of Revenue as a diversion to an SP&T Fund Account is not permitted and recredit may only occur as permitted by the Accounting Manual.

5.7 **Sponsorships.** In all cases sponsorships must be regarded most carefully before acceptance to ensure that they in no way compromise the organisation or the government. Sponsorships, scholarships, etc., which are offered in the process of tendering should be discouraged because they may be seen as unfair inducement by other tenderers, confuse the assessment process and are generally irrelevant to the purchase of the product involved. Full disclosure of sponsorships must be made to the CE for area health services and Royal Alexandra Hospital for Children and approval for their application should be contained in the Board Minutes with a clear indication if the sponsorship includes research, overseas travel or addressing seminars/ conferences. In instances where the sponsorship is to be applied to overseas travel the prior approval must be obtained from the Director-General except in respect to Staff Specialists approvals for which can be granted by the CE.

Area CEO's and Hospital CEO's must take great care to ensure that sponsorships do not compromise the organisation or the government. They must also ensure that sponsorships are not simply being used as a means of diverting refunds, rebates and other supplier credits from the General Fund.

See Section 9 for Sponsorship Principles.

5.8 **"Donations" from suppliers.** Where receipt of money from a supplier is in any way linked to the supply of goods it is General Fund money and in most cases should be treated as a recredit against the cost of purchase of the supplies. In cases where the "donation" is for rent of premises or advertising it is General Fund Revenue. Where the "donation" is consideration for trial of equipment or drugs etc this is also General Fund Revenue.

Area CEO's and Hospital CEO's must take care to ensure that "Donations" from suppliers do not compromise the organisation or the government. They must also ensure that donations are not simply being used as a means of diverting refunds, rebates and other supplier credits from the General Fund.

5.9 **Cremation Fees and similar types of receipts.** During the course of the 1991 Survey of Accounting Controls a number of instances were found where minor receipts such as cremation fees were credited to SP&T Accounts and utilised as source funding for items such as "Staff Education".

Treatment of this type of revenue as a recredit to expenditure or a diversion to the SP&T fund is not permitted by the Accounts and Audit Determination.

5.10 **Reserves created from the General Fund.** During the course of the 1991 Survey of Accounting Controls a number of instances were found where unit heads had created reserves in the SP&T Fund accounts by transferring funds from the General Fund or diverting revenue from the General Fund Revenue.

Diversion of General Funds to the SP&T Fund is not permitted without the specific written permission of the Director-General of the Department of Health.

5.11 **Teaching Hospital Grant.** Expenditure for this item is covered in the Gross Operating Payments funding to the Area and therefore the Teaching Hospital Grant must be accounted for as part of General Fund Revenue.

Retention of the Teaching Hospital Grant is a breach of the conditions of subsidy.

5.12 **Fundraising ventures and commercial activities.** The effort of many Areas and Hospitals in active fundraising is generally applauded for not only does this provide additional funds but it brings the community into closer contact with the work of the Area or Hospital. However during the course of the Survey in 1991 a number of schemes were drawn to attention which purported to be fundraising schemes but which were in fact commercial ventures involving use of government resources and or the lease of government land. An example of this was lease of hospital land for weekend markets. In this case the only contribution made by the stallholders was in the form of rent and there was no question of voluntary or community participation in the venture. In another example the entrance to a hospital was leased to a local Art Gallery in consideration of which an amount equivalent to a percentage of sales was paid. This was clearly a commercial proposition on the part of the Gallery.

Where the situation may become unclear is where there is a combination of hospital and voluntary work. For example a kiosk which is managed by an employee of the hospital but otherwise staffed by volunteers. In such a case it would be expected that the payment into the SP&T Fund would be net of the cost of employing the manager and any other costs incurred by the Hospital such as electricity. If the situation changed and a majority of persons operating the kiosk were hospital employees it would be expected that the hospital would review the situation.

Area CEO's and Hospital CEO's are required to carefully examine all fundraising schemes to ensure that they are bona fide and not just thinly disguised commercialisations using hospital resources with little or no voluntary or community input.

Receipts from fundraising or charitable undertakings may be accounted for as part of SP&T Funds. Receipts from ventures based on use of government resources with little or no community or voluntary input are not to be treated as fundraising ventures but as part of General Fund Revenue. In cases where receipts from fundraising or charitable undertakings are credited to the SP&T Funds all expenditure associated with the venture must also be charged against the account.

Generally speaking rental of government property and resources or revenue from commercial ventures is considered to be revenue and should be paid into the General Fund. Proceeds of genuine fundraising by volunteers, auxiliaries and benefactors which is community based may be paid into the SP&T Fund.

NOTE: Commercial activities such as lease of hospital entrances to Art Galleries and lease of vacant land for market days may continue to be undertaken in accordance with existing authority of Areas. The revenues from these activities would assist in achieving an over-budget situation for Other Revenue which could be used to meet local initiatives. Activities of this type should not be stifled simply because accounting is in the General Fund rather than the SP&T.

5.13 **Application of Moneys According to the Conditions Attaching to them.** During the course of the 1991 Survey instances were found where Areas had retained unexpended Capital Works grants and Special Purpose grants after the completion of the purpose of the grant. Pages 6.7 & 6.8 of the Accounting Manual cover this circumstance.

"In the case of unexpended balances of capital works grants or other grants from the Department of Health, the health organisation should refund the unexpended balance to the Department of Health NSW or obtain its approval for its expenditure on some other purpose."

PATIENTS' FEES

Fees for hospital services provided to chargeable inpatients and non-inpatients are collected by the hospital in accordance with the policies and procedures described in the Fees Procedures Manual for Area Health Services and Public Hospitals.

All fees charged to patients on the admission and account forms or other appropriate forms shall be posted to the respective debtor's account maintained in the respective subsidiary "debtors for patients' fees" ledger, and all fees received in respect of these debtors shall be posted to these accounts. This subsidiary ledger shall be comprised of:

1. A separate subsidiary ledger which shall be kept for each chargeable inpatient classification; and

2. A separate subsidiary ledger which shall be kept for each chargeable non-inpatient classification to provide for accounting disclosure and Department of Health reporting requirements.

A control account shall be maintained in respect of each subsidiary ledger and bulk charges and receipts in respect to patients' fees debtors by classification, shall be posted to the respective control account. Each control account shall be balanced with the accounts in the corresponding subsidiary ledger at the end of each accounting period in accordance with the provisions of the Accounts & Audit Determination.

All fees received shall be credited to the respective patients' fees receipts accounts, duly classified, and receipts shall be brought to account as fees received from patients in financial statements of the health organisation.

PATIENTS' FEES

A health organisation shall provide:

(a) free inpatient treatment and accommodation and free non-inpatient treatment as required by the Commonwealth Government for eligible persons and their dependants, provided that an election is not made by such inpatient for treatment by a medical practitioner other than a practitioner nominated by the health organisation; and

(b) free inpatient treatment and accommodation and free non-inpatient treatment as determined by the New South Wales Government and as directed by the Minister for Health.

A health organisation shall maintain, in respect of:

(a) each chargeable inpatient: a form of election, an admission and an accounting record in appropriate form, showing all necessary details including the patient's classification and period of stay in hospital. Admission, classification procedures and charging of fees shall be in accordance with directions and manuals issued by the Department.

(b) each registered non-inpatient: records in appropriate form of registrations, occasions of service and fees charged, if applicable. Procedures concerning registration, counting of occasions of service and charging of fees shall be in accordance with directions and procedures set out in manuals issued by the Department.

For each chargeable inpatient, an account for fees shall be issued showing all fees payable to the hospital. The account shall be issued:

(i) on the day of separation, or if this is not practicable, no later than seven days after the date of separation in respect of inpatients; and

(ii) on the day of providing a chargeable service or if this is not practicable, no later than seven days after the date of service, in respect of non-inpatients.

The Board shall ensure that appropriate follow-up action is taken with regard to all unpaid accounts, including legal action where appropriate.

Patients' fees charged shall not be postponed, remitted, reduced or written off as irrecoverable without the approval of the Board or Chief Executive of an area health service/ Royal Alexandra Hospital for Children, provided that the board or Chief Executive of an area health service/Royal Alexandra Hospital for Children may delegate authority to remit, postpone, reduce or write off a patient's account to:

(i) the Chief Executive Officer of a public health organisation, an amount up to $10,000; and

(ii) other employees of the public health organisation to an amount not exceeding that of the Chief Executive Officer.

Any such delegations are to be included in Board meeting minutes or in respect to area health services and Royal Alexandra Hospital for Children held on a separate delegations file.

Particulars shall be reported to the Board or Chief Executive of an area health service/Royal Alexandra Hospital for Children at the end of each accounting cycle on a schedule showing the number of accounts and the total of the fees remitted, reduced or written off by:

(i) the Chief Executive of a public health organisation;
(ii) other employees of the public health organisation delegated by the Board.

The Chief Executive Officer etc. shall ensure that an adequate audit trail is maintained to link the write off approval to each debtor's account.

The Patients' Fees Account will be comprised of charges as determined from time to time by the Department of Health for accommodation and treatment under the following categories:

Single (Hospital Doctor)
Shared

Single (Private Doctor)
Ineligible
Compensable

Veterans' Affairs

Nursing Home Type
(Hospital Doctor)

Nursing Home Type
(Own Doctor)

Day Only Patient

ACCOUNTING FOR FEES AND OTHER INCOME 3.18

The Department of Health requires particulars of fees charged to be disclosed in Annual Reports and accounts are to be kept which show the monthly fees raised or charged in each classification and which account for their discharge.

HEALTH DEPARTMENT CAPITAL WORKS FUNDING

Capital works allocations are credited to appropriately classified accounts in the General Fund.

Capital allocations are used to fund payments in respect of the following:

(A) payments for the acquisition or purchase of an asset being:

- (i) The provision and servicing of land including conveyancing.
- (ii) Land development not included in (i) above.
- (iii) The acquisition or construction of new or additional buildings including site preparation and other associated costs.
- (iv) The enlargement of, or extension to, existing buildings.
- (v) Replacement of an existing building on its site including demolition and site preparation.
- (vi) Replacement of an existing building on another site including its demolition and site preparation and redevelopment of the existing site.
- (vii) Alterations to buildings directly involved with additions to buildings or their service facilities.
- (viii) Original or additional service facilities incorporated in buildings or on site (including installation).
- (ix) (a) Original and additional items of equipment, furniture, furnishings and fittings associated with items (iii) to (vii) above.
  - (b) Original and additional items of equipment, vehicles, furniture, furnishings and fittings **not** associated with items (iii) to (vii) above.
- (x) Alterations to a part or all of a building and/or its service facilities which involve a change in functional use.

(B) payments for any of the following:

- (i) renovations to a building or part of a building costing more than $200,000 per project;
- (ii) additional works or services costing more than $200,000 per project; and
- (iii) replacement or additional equipment, plant, furniture, furnishings or fittings costing more than $200,000 per item.

Note: The above comments refer to the source of Government funding as opposed to the accounting treatment. Further reference should be made to the Accrual Accounting Standards and Procedures Manual (Section 8) for the treatment required.

Capital Works Program Structure

The Capital Works Program consists of 5 major programs (State Budget Programs):
- Public Hospitals
- Ambulance
- Community Health
- Miscellaneous Health
- Dental

These programs are further broken down into minor programs of individual projects, programs of works and annual provisions. The Public Hospitals major program is the most complicated and is broken down into:

- Hospital Projects
- Hospital Service Improvements
- Hospital Buildings Infrastructure
- Hospital Enhancement
- Technology Improvements
- Mental Health
- Legionnaires Disease
- Nurse Education
- Computers
- Annual Provisions

Minor programs consists of Specific item (SI) and/or Miscellaneous Item (MI) projects. SI projects are listed separately whilst MI projects are grouped under one MI project heading.

It is possible for minor programs to contain both SI or MI projects. This usually occurs when a project does not have a specific geographical location or when projects up to $3M have been grouped within a cohesive program (Hospital Building Infrastructure, Mental Health Programs, etc.).

An **SI Project** is a project where the estimated total cost is $500,000 or more.

An **MI Project** is a project where the estimated total cost is less than $500,000.

In the case of SI projects, a further distinction is made for Work in Progress (WIP) and New Works. New works are projects which are newly listed on the approved Capital Works Program, and generally have no previous years expenditure.

Capital Works - Accounting Arrangements

Capital Works payments from the Department are required to be credited to the General Fund.

The following procedural matters are brought to notice to ensure that adequate accounting records are maintained, accountability is clearly determinable and the interest derived is best utilised to meet capital works project priorities:

1. A separate bank account is to be maintained within the General Fund to account for all capital moneys received from the Department and the payments subsequently made therefrom unless local management is satisfied that it can adequately distinguish between funds and ensure due apportionment of interest.

All capital transactions funded by the Department shall be recorded in separate ledger accounts in the General Fund with the assets being duly capitalised in accordance with the provisions of the Accounts & Audit Determination and this Accounting Manual.

2. Interest derived on accounts is to be initially recognised as "Interest to Department of Health". Moneys are to be remitted to the Department by the sixth working day of the month following the credit to account with a debit being raised against "Interest to Department of Health".

3. All remittances are to be marked to the attention of the Manager, Accounts and clearly denote the nature of the remittance.

4. Each direct deposit/revenue remittance is to be supported by a return duly certified by the Director of Finance that all interest credited to the account has been lodged to the credit of the Department of Health.

The return should be faxed to Finance and Budget Branch on the day of deposit/remittance to the Department (refer item 2 above).

5. All bank charges incurred are to be apportioned equitably against the various Capital projects.

6. In those instances where a residue of capital allocations remains available from a previous year for a project not yet completed the amount involved is to be transferred to the General Fund - Capital Account.

7. In those instances where a residue of capital allocation remains available from a previous year for a project which has been completed, the amount involved plus due interest is to be repaid to the Department of Health in accordance with items 3 and 4.

   Interest held or accrued on unspent capital allocations for projects still in progress is also to be remitted to the Department in accordance with items 3 and 4 above.

8. Areas in receipt of Departmental Capital drawdowns are required to review the finality of projects with a view to ensuring that unneeded funds are returned to the Department in the year of grant. Only the net amount is to be recognised in the Operating Statement with repayment to be made by no later than 23 June.

   This action will largely obviate the need to report abnormal expenses in future years and will serve to ensure that the Department's record of Capital allocation agrees with the amounts recognised in Operating Statements.

9. Where material repayment of capital allocations is made other than in the year in which the money was provided by the Department the accounting treatment is as follows:

Debit Abnormal Expenses
Credit Bank

10. Capital moneys plus the interest thereon which are to be returned to the Department will be utilised to supplement the Capital Works Program in funding identified priority projects.

LOCAL FUNDS

Health organisations are able to contribute towards the cost of projects from their own funds. Conditions relating to the use of local funds are contained in the Accounts & Audit Determination. Moneys in the Public Contributions Trust Account shall not be expended without the prior approval of the Department for the:

i) acquisition and improvement of land;
ii) the construction of or additions to or renovations of buildings,

basically the Department's approval is required except for expenditure on the purchase of plant and equipment.

Local funds (Special Purpose) can be applied to either capital or revenue projects provided that the accounting procedures adhered to are consistent with those applicable to the source of funds involved, in each case. Local funds must only be expended in accordance with the terms and conditions of the trusts or purposes of those funds.

ACCOUNTING FOR SERVICES TO AREA HEALTH SERVICES OR PUBLIC HOSPITALS AND OTHER ORGANISATIONS

The General Fund of each health organisation must reflect the true income and expenditure position and therefore health organisations should charge other health organisations for services rendered. The health organisation providing the service and initially incurring the expense should credit the particular expense account or accounts when payment is received. The receiving health organisation should be recorded as a debtor when the charge is raised by the supplier.

The rate of charge for the service should be agreed between the participating health organisations and should have regard to staff involvement, use of materials, travelling time, use of vehicles etc. When agreement is reached the health organisations supplying and receiving the service should submit an application to the Department of Health for variation of their budgets apportioned under the various classifications of expenditure.

Formal accounts should be raised preferably on a monthly basis with the supplying health organisations dissecting the account into component parts, i.e. wages, travelling, materials etc. The health organisation receiving the service must debit the expense to the same expenditure heading as the supplier credits when the charge is raised. Where difficulties are experienced in apportioning the cost to appropriate expenditure the health organisations involved should jointly agree on a method of appropriation and advise the Department of the agreement when applying for a budget adjustment.

No other income can be offset against expenditure without specific written approval of the Director-General of the Department of Health.

ACCOMMODATION - HEALTH OWNED - REQUESTS FROM EXTERNAL ORGANISATIONS (PD2009_061)

PD2009_061 rescinds PD2008_049.

PURPOSE

Government policy now requires that market values be realised on the sale or lease (rental) of government assets. This means that if a non-controlled NSW Health entity is using a NSW Health building it must be charged market rent for that building. This policy allows for Non Government Organisation's (NGO's) a transitional arrangement. Previously Treasury approval was required if less than market value was to be charged. Where appropriate, NSW Health may consider making accommodation available for use by community/non government organisations or private entities where their services contribute to the provision of health services and programs consistent with the Government's public health priorities.

MANDATORY REQUIREMENTS

The key principles of this policy and attached procedures are to:

- Provide a management framework so that NSW Health Services can provide a consistent response to external organisations requesting Health accommodation assistance and, where appropriate, can consider the allocation of Health accommodation and/or land to meet such needs.
- Facilitate payment of market rent by external organisations for current or proposed leases or licences to occupy Health accommodation and/or land by arranging new grants or increasing existing grants to eligible NGO's to cover the rent where required.
- It is the funded NGO's responsibility to ensure that they have the capacity to meet the cost of rent within their grant allocation.
- Generally, when setting a rent for a funded NGO, consideration should be given to whether the rental being negotiated is related to a new rent request, an existing rent with no change to the existing rental arrangements or an existing rent with changed rental arrangements, eg. a request for new or refurbished accommodation.
- Principal rental arrangements will remain the same for existing leases or renewal of existing leases as per the existing lease conditions. For new accommodation, new lease or changed lease arrangements there must be capacity in NGO's grant to cover market rent.
- Formalise building maintenance, outgoings, insurance and related matters for non NSW Health entities that have approval to use NSW Health premises.

IMPLEMENTATION

In the context of this Policy, Health accommodation is considered to include buildings and other properties such as hospitals, ambulance stations, dwellings, vacant land etc. either owned or administered by NSW Department of Health, Health Administration Corporation, Area Health Services, Statutory Health Corporations (eg The Children's Hospital Westmead and Justice Health) and NSW Ambulance Service. In this Policy these Health organisations are referred to as Health Services.

All Health accommodation is to be provided at market value, in accordance with Government policy.

Where appropriate, consideration can be given to making Health accommodation available for use by organisations for the purpose of providing health services and programs consistent with the Government's public health priorities.

"External Organisation/s" refers not only to "not-for-profit" community organisations but also to semi commercial, educational, or any non government organisations (NGO's) or individuals (eg. doctor) seeking accommodation assistance for health related purposes and/or related services.

The procedures document for this policy includes procedures for assessing requests for accommodation assistance and determining an appropriate rental. It also provides details of relevant approvals to be obtained, the nature of a formal agreement between the health service and external organisation and covers transparency issues.

1. Surplus Health Accommodation

Treasurer's Direction 469.01 states that: "In the absence of specific approval to the contrary, market values should be realised on the sale or lease of Government assets." This is also confirmed in the Total Asset Management guidelines.

The charging of "peppercorn rentals", while beneficial to those organisations which have access to such accommodation effectively discriminates against other private and community-based organisations (and their clients) that do not enjoy this level of subsidy.

On this basis, the application of Treasurer's Direction 469.01 will produce a more appropriate outcome as it will provide greater financial transparency, promote competitive neutrality and ensure that a market return is earned on public health assets.

If surplus Health land or accommodation is identified for lease (or licence) it should be arranged on a commercial basis, i.e. in a competitive manner at market rent, assessed by the State Valuation Office, or its successor. Preference should be given to not for profit community organisations that provide health services and programs consistent with the Government's public health priorities.

2. Approaches from Organisations external to NSW Health for Health Accommodation Assistance

Where an external organisation requests Health accommodation assistance and provides services that are part of or complement Health's core business, NSW Health policy is that consideration of accommodating the organisation in surplus accommodation, if available, is appropriate.

If a specific Health property has been nominated or identified as being suitable for the external organisation, the request from the organisation should be referred to the Health Service that manages the property, for processing. If the organisation is seeking suitable Health accommodation within a geographic area covering a number of Area Health Services, the request should be referred to the Strategic Procurement and Business Development Branch within NSW Department of Health for assistance in identifying suitable premises. If suitable premises are identified, the Health Service that manages the property will have responsibility for the processing of the application.

Refer to *Delegation (A16, A19) Acquisition or Disposal of Land by Lease by Area Health Services or Statutory Health Corporations* of the Department's *Combined Delegations Manual* for the level of approval required for a health service to allow an external organisation to use a health property. The approving officer must be satisfied all the requirements of the policy are observed.

3. Lease Arrangements

All external bodies (current/future) are to have a formal lease agreement with the health service that reflects the following appropriate elements.

3.1 New Rent (ie future proposals or those subject to current discussion/negotiation)

Where an external organisation negotiates for office accommodation with a Health Service it is appropriate that the negotiations be conducted at arm's length using prevailing market rates for similar standard and size of office accommodation. Assessment of market rates can be sought from the State Valuation Office and such rates may be offset by capital improvements during the leasehold period if this is funded by the organisation.

3.2 Existing Rent – No Change in Accommodation Required

If a Health Service were to review the rent for an Organisation and wished to increase it to prevailing market rates, it is the Health Service's responsibility to ensure that if the organisation is a funded NGO it is not financially disadvantaged by this decision. This outcome could be achieved by grossing up the NGO grant to exactly offset the increase in rent. (NB Only applies to those NGO's to which explicit Ministerial approval is given to an annual funding grant.)

Approval to increase a grant to meet an increase in rental must be submitted to Finance Branch. It should be noted that in the event the NGO subsequently moves to alternative accommodation then the grant allocated to the NGO would be reduced by the grossed up factor, unless there is a pre-existing agreement between the NGO and the Health Service allowing for the retention in grant albeit it would be accommodated elsewhere.

Excluding NGO's all other external organisations should be subject to a rent review in accordance with this policy within 6 months of this policy.

3.3 Existing Rent – Change in Accommodation Required

Where an organisation (including NGO's) wishes to vary their current accommodation to either upgrade their accommodation, change its purpose or expand the accommodation required:

- The health service needs to assess the financial implications of such a proposal and funding sources;

  and

- The health service is to ensure that the organisation, as a result of an agreement pursuant to this proposal, is then charged market rent for all accommodation provided by the health service.

Where an NGO requests a change in the accommodation provided (eg change its purpose, expand the size) this request will be deemed to be a fundamental change to existing rental arrangements which will require a renegotiation of the terms of the rental agreement. Negotiations should be entered into between the parties to establish a new market rent that is commensurate with the changes in accommodation provided. Under these circumstances there is no requirement to gross up the NGO grant to offset the rent applicable to meet the changed accommodation needs of the NGO.

Where a health service requires an external organisation to be relocated it is to ensure the standard/size of the new accommodation is similar to that previously provided and if so existing rental charges should continue. If the relocation results in a superior standard and/or additional accommodation the health service with agreement of the organisation can negotiate an increase in rent up to market value.

4. Maintenance

Health Services are required to ensure that accommodation provided to external organisations is maintained at a reasonable standard to ensure the accommodation remains fit for its purpose.

Any decision to allow an external organisation to use Health Service premises should have a clear agreement on maintenance responsibility both internal and if relevant, external. Maintenance includes routine and emergency. In respect of external maintenance in exchange for market rental, health services are to be explicit in the health services responsibilities and that the lease agreement includes an external maintenance program over the period of the lease.

5. Outgoings

Any decision to allow an external organisation to use health service premises should have a clear agreement on all outgoings and the financial responsibility for costs. All outgoings should be defined to avoid any future confusion **and commercial principles should be applied to recoup outgoings**. Where such agreements do not exist, they should be developed immediately to reflect the current situation.

5.1 Insurance

Under no circumstances should the Health Service indemnify an organisation for insurance purposes. An organisation should effect all insurance for their risks. However as a Health Service is the ultimate owner of any building it allows an organisation to use the health service through the Treasury Managed Fund (TMF) [Health's insurers] will be covered for damage to the building shell under NSW Health policy (noting no cover will exist for an organisation's fittings, plant and equipment).

However, an organisation's assets and fit out costs within the building will require the organisation to have its own insurance cover.

It should be noted that the TMF would in no way cover any loss caused through the "negligence of the lessee" and that in the event that the building was damaged by/through the negligence of the lessee then there could be a situation where TMF may attempt to recover from the lessee or their insurer.

5.2 Car Parking

Any agreement must be clear in respect of car parking for staff and visitors to the external organisation. It needs to specify number of available spots, fees and location of where parking can/cannot occur and that a variation to any portion of the car parking component is at the discretion of the health service.

6. Renewal or Review of Existing Tenancies of Health Service Accommodation by External Organisations

In all future instances where external organisations are accommodated in Health Service accommodation they are to have a formal lease or licence with the rent to be reviewed to current market levels preferably every 3 years, but no more than every 5 years.

Where an external organisation (excluding NGO's) is currently paying a nominal or peppercorn rental, steps should be taken to undertake a rent review in accordance with this policy within 6 months of its publication date. The review should include an assessment of the need to continue providing the accommodation to the organisation in terms of the health services provided.

To ensure that NGOs are not financially disadvantaged by this decision, the grant allocated to the NGO could be grossed up in accordance with clause 3.1.2 of this policy.

Consideration should also be given, when market rental is calculated, to amortise the capital invested by the existing tenant over recent years.

If the tenant organisation is funded under the NGO Grant Program reviews are undertaken under that Program's guidelines. Termination clauses in the lease or licence agreement must allow the tenancy only to continue whilst funded and to be terminated if funding is discontinued.

7. Tenure/Tenancy Considerations

The following tenure/tenancy considerations should also be taken into account:

a. Lease/licence terms should not exceed 10 years, except where capital works are to be carried out at the cost of the tenant and the tenant must continue to use the Assets and Land for a certain length of time pursuant to a funding agreement;

b. Likelihood of future agency need (eg. affected by planned future redevelopment of a hospital);

c. Disposal consideration and timeframe (eg. site may need to be rezoned, part site required for use for a length of time etc.);

d. The granting of Health accommodation to an organisation and the terms offered may be influenced by a lack of alternative accommodation options in a particular locality where the services provided by the organisation are sought;

e. All organisations must hold and maintain public liability and other appropriate insurances for the use of the Health asset;

f. The lease/licence agreement should contain a clause to prevent organisations assigning, subletting or transferring their leasehold/licence interest in Health accommodation, to another entity, without the consent of NSW Health or the Minister. Approval to transfer such interest would only be granted in exceptional circumstances if a tenant organisation is paying less than market rental, as it would be in a position to obtain financial gain from the transfer.

g. A clause should be inserted in the lease/licence agreement to the effect that Health assumes no responsibility for finding alternative accommodation for the organisation in the event of termination of the agreement.

8. Acknowledgement/Reporting

Any charging of less than market rent should be made transparent by revealing the assessed market rent and the actual rent in the lease/licence agreement to enable the organisation to realise the benefit of the use of the Health premises.

All organisations which receive the benefit of Health accommodation at less than market rent should be required to acknowledge that benefit in all their relevant publications relating to the specific projects/services for which the Health accommodation is used eg. annual report and annual financial statements.

Any rental rebates provided to organisations (including retrospective arrangements) should also be identified in NSW Health's (NSW Department of Health and Health Services) Annual Reports under the heading "Land/Accommodation provided by the NSW Department of Health/respective Health Service at a Rebated Rent". The information to be reported is - name of external organisation, location of Health land/accommodation, market rental, actual rental, rental rebate and focus of external organisation.

9. Goods and Services Tax (GST)

If Health accommodation is provided by way of lease or rental, at less than 75% of market value, then the rental or lease payment will be GST-free, under section 38-250 of the Act. The GST implications should be checked in determining the appropriate rentals.

10. Non Health Related Organisations

Where a commercial or non health related or other Government agencies seek Health accommodation, consideration may still be given to the provision of Health accommodation on a full commercial and market value basis. Any proposals subject to consideration must satisfy this policy including the delegation requirements. The proposals need to ensure that the activities of such proponents are consistent with NSW Health's State Health Plan 2007.

11. Related Policies

- Treasurer's Direction 469.01 – market values should be realised on the sale or lease of Government assets, unless specific approval has been granted to the contrary.
- NSW Health Policy Directive PD2005_507 – Ad Hoc Requests for Funding - Organisations External to NSW Health.
- NSW Health Delegations Manual - Section 7.11 Ad Hoc Funding Requests
- NSW Health Delegations Manual - Section 7.27 Market Rental Assistance Grant

OCCUPATIONAL AND INDUSTRIAL THERAPY DEPARTMENTS - PAYMENT OF SALES TAX

Since 1 October 1969 goods manufactured and sold in Occupational and Industrial Therapy Departments of health organisations have been subject to payment of Commonwealth Sales Tax.

The Australian Taxation Office provides two different ways in which sales tax is paid:

- Health organisations selling goods valued at less than $1,400 per annum or who would pay sales tax of less than $100 per annum.

This group is not required to register as a manufacturer but sales tax must be paid on materials purchased for resale or from which articles are manufactured for sale.

- Health organisations selling goods to a value of $1,400 or more per annum.

This group must be registered with the Taxation Department as a manufacturer or wholesaler.

MULTI COIN TELEPHONE BOXES - ACCOUNTING FOR COLLECTIONS

Should a health organisation have a multi coin telephone unit which is cleared by the health organisation, the following procedure should be observed:

- All cash boxes should be cleared at regular intervals (at least once per week).
- Clearance and counting of proceeds should be carried out by two officers.
- A “telephone collections book” should be maintained, showing:
- date of clearance;
- amount cleared;
- signatures of the clearing and witnessing officers;
- particulars of internal receipts issued.
- As an additional internal control, it is preferable that the “telephone collections book” be reconciled against each telephone account received.
- The health organisation auditor’s attention should be drawn to this book for audit purposes.

INVESTMENT OF FUNDS

A. Public Authorities (Financial Arrangements) Act 1987 (PAFA)

The ***Public Authorities (Financial Arrangements) Act 1987*** (PAFA Act) provides the overarching legislative framework for the regulation of investment and borrowing functions of the Public Sector in New South Wales.

The Act prevails over other legislation and it provides the principal source of power to enter into financial arrangements.

Under the Act the Treasurer is given a central supervisory role in respect of the investment and liability management activities of the State.

ACCOUNTING FOR FEES AND OTHER INCOME 3.30

The PAFA Act was amended effective from 30 August 2000 and now covers entities that are included in Schedules 2 and 3 of the ***Public Finance and Audit Act 1983***, Ministers, State Owned Corporations and entities prescribed by regulations.

The investment powers under the PAFA Act range from Part 1 to Part 4.

Health Services included as entities under the regulations have been granted Part 1 investment with several accorded Part 2 powers based on specific approval by the Treasurer.

The following investments are authorised for an authority which may exercise Part 1 investment powers:

a. Deposits with a bank or the NSW Treasury Corporation (TCorp) and deposits with or withdrawable shares in a building society or credit union (not including certificates of deposit or other transferable securities);
b. Investment in an Hour-Glass investment facility of TCorp (being a facility under which TCorp accepts funds for investment by fund mangers approved by TCorp);
c. Such additional investments as are prescribed.

The following investments are authorised for an authority which may exercise Part 2 investment powers:

a. The investment powers described in Part 1;
b. Investment with, issued by, or guaranteed by, the Government of New South Wales or an eligible entity which is the Government of any other State or of the Commonwealth or of a Territory;
c. Bills of exchange that have been accepted by a bank, building society or credit union;
d. A loan to an eligible entity which is a dealer in the short-term money market and in relation to which, at the time the loan is made, the Reserve Bank of Australia stands as lender of last resort;
e. Certificates of deposit issued by a bank, building society or credit union;
f. Such additional investments as are prescribed.

Health Services seeking extension of investment powers must submit a business case for the proposed variation to the Department for endorsement by the Minister for Health prior to consideration by the Treasurer.

Health Services may seek approval (process outlined above) to engage a professional investment funds manager under Section 25 of ***PAFA Act*** to exercise the existing investment powers on its behalf.

All entities covered by the ***PAFA Act*** must comply with the requirements of the Act if they need to obtain financial accommodation. This means that before seeking any financial accommodation approval must be obtained from the Treasurer and Governor.

The following investment powers currently apply to NSW Health:

Part 2 Investment Powers
Health Administration Corporation
Central Sydney Area Health Service
Northern Sydney Area Health Service
Western Sydney Area Health Service
Royal Alexandra Hospital for Children (Children's Hospital Westmead)

Part 1 Investment Powers
All remaining Area Health Services

B. The Health Services Act 1997

The ***Health Services Act 1997***, provides vide sections 38 & 59 that the money held by the Health Service may be invested:

(a) in such manner as may be authorised by the *Public Authorities (Financial Arrangements) Act 1987****;***

(b) which should be deemed to be an investment that satisfies the prudent person test under the *Trustee Amendment (Discretionary Investments) Act 1997*; or

(c) if that Act does not confer power to invest money so held, in any manner authorised for the time being for the investment of trust funds and in any other manner approved by the Minister with the concurrence of the Treasurer.
Sections 38(2) and 59(2) of the *Health Services Act 1997* provide that the Health Service may, subject to any trust to the contrary, at any time dispose of any of its investments and apply the proceeds for the purposes of exercising its functions.

In respect of affiliated health organisations, trust funds are to be invested in accordance with the *Trustee Act 1925* and *Trustee Amendment (Discretionary Investments) Act 1997*.

SUBPOENAS (PD2010_065)

PD2010_065 rescinds PD2005_405.

PURPOSE

Outlines legislative provisions and procedures to be followed when the Department and public health organisations are required to produce documents in response to a subpoena.

MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place in order to make sure that subpoenas issued on the agency are complied with appropriately.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:

- The principles and requirements of this policy and attached procedures are applied, achieved and sustained.
- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive

Hospital Managers and Staff have responsibility to

- Understand the legislative requirements of a Subpoena.
- Provide only the documents which are requested under the schedule of the subpoena.
- To be aware of whether any claim for privilege over the documents can be applied and take appropriate action.

1. BACKGROUND

1.1 About this document

The Department and public health organisations are often required to produce documents on subpoena. This policy directive reflects current legislation and assists public health organisations to comply with subpoenas.

1.2 Key definitions

Subpoenaed Party means the person who the subpoena is addressed to.

Issuing Party means the person who has caused the subpoena to be issued, or that person's legal representative.

PHO means a public health organisation, or a part of a public health organisation

Patient also includes clients of PHOs.

Plaintiff is the person who has commenced the proceedings.

Defendant is the person against whom the action is brought by the Plaintiff.

Document includes
(a) any paper or other material on which there is writing,
(b) any paper or other material on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them; and
(c) any article or material from which sounds, images or writings are capable of being produced with or without the aid of any other article or device.

1.3 Legal and legislative framework

* *Children and Young Persons (Care and Protection) Act 1998*
* *Coroners Act 2009*
* *Commonwealth Service and Execution of Process Act 1992*
* *Criminal Procedure Act 1986*
* *Evidence Act 1995*
* *Health Administration Act 1982*
* *Interpretation Act 1987*
* Local Court Rules 2009
* Uniform Civil Procedure Rules 2005

2. INTRODUCTION

A subpoena is an order from a court or tribunal which directs someone that they must on a given date:

(i) produce to a court certain (existing) documents for use in legal proceedings;
(ii) attend a court on a particular date to be a witness in a hearing and give evidence; or
(iii) do both.

A subpoena can only be issued if legal proceedings have been commenced.

In some courts and tribunals subpoenas are called a "summons to produce documents", "Orders to Produce Documents," or "notices for non-party or third party production". In coronial matters, subpoenas may be called "section 53 Directions." The general principles that apply to these documents are the same.

A subpoena cannot be ignored. It must be dealt with promptly. Failure to comply with a subpoena is a serious matter. It can result in arrest and even being charged with contempt of court (failure to comply with a court order).

All PHOs should have designated officers to co-ordinate responses to subpoenas.

All subpoenas should be brought to the attention of the appropriate branch and the appropriate person within the PHO, for example the medico-legal officer or medical records officer, who should notify the chief executive officer or an executive officer of the PHO in particularly sensitive matters.

All subpoenas in matters in which a PHO, or a unit or employee of a PHO is a party must be brought to the attention of the solicitors acting on behalf of the PHO as soon as possible and certainly before any documents are forwarded to the court.

PART A - SUBPOENAS TO PRODUCE DOCUMENTS

PRELIMINARY ISSUES TO CONSIDER WHEN YOU RECEIVE A SUBPOENA

2.1 Who is the subpoena addressed to?

For a subpoena to be valid it must sufficiently identify the party in possession of the documents that have been subpoenaed. If a subpoena is defective in this regard, the PHO should promptly inform the issuing party in writing and return any conduct money provided. The letter should explain how the subpoena is defective and be copied to the Clerk or Registrar of the court.

If a subpoena is addressed, for example, to a particular hospital or community health service within a PHO only records held by that hospital or community health service need to be produced.

If a subpoena is addressed to the PHO (ie "X Area Health Service"), relevant records from all facilities within the PHO will need to be produced. If the subpoena is addressed to the PHO requesting all records relating to a particular patient, there are two options that can be considered:

(a) Contact the issuing party and ask the solicitor to nominate which facilities within the PHO they require records from. Ask for this to be confirmed in writing.

(b) Search all facilities within the PHO for records relating to the patient. If this needs to be done, a separate fee may be charged for each facility searched. The issuing party should be told that fees will be payable for each facility searched. It is not necessary for the issuing party to issue separate subpoenas each addressed to separate facilities within the PHO.

2.2 What if the PHO is a party to the proceedings?

If the subpoena lists the PHO or a unit of the PHO as a party to the proceedings, (for example as the Defendant) the subpoena should be referred to the solicitor who has been instructed to act for the PHO (or unit) in those proceedings. If no solicitor has been appointed to represent the PHO (or unit) in the proceedings, the executive officer (or delegate) of the PHO (or unit) should be notified so that a solicitor can be appointed.

If this occurs, that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

2.3 What if the subpoena relates to a coronial inquest?

A subpoena issued by the Coroner's Court needs to be signed by the Coroner or Assistant Coroner issuing it and provide a date and place where the document is to be produced. The Coroner may serve a subpoena by way of facsimile and is not required to provide conduct money.

The subpoena should be referred to the solicitor who has been instructed to represent the PHO's interests at the inquest, or in relation to the investigation. If no solicitor has been appointed, the relevant medical administrator should review the medical records of the deceased and an assessment should be made as to whether the executive officer (or delegate) of the PHO should be notified so that consideration can be given to instructing a solicitor to represent the PHO. It may be appropriate for the relevant medical administrator to also consider notifying the PHO risk manager and the Treasury Managed Fund of the incident, if they have not already been notified.

If the PHO decides to engage a solicitor that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

2.4 Has the subpoena been validly issued?

In most matters, subpoenas must be issued by a court or a tribunal. This means that they should include a court stamp or signature of a court officer.

In some Local Court proceedings, Police Officers and Public Officers, rather than the Local Court can issue subpoenas. These subpoenas do not need to be stamped. For more detail on these types of subpoenas, see section 1.9.

If you are uncertain about whether a subpoena has been validly issued, contact the court in which the proceedings have been commenced and ask for confirmation.

2.5 What are the proceedings about?

From reading the subpoena you will be able to ascertain whether it is a civil or criminal matter and the identities of the parties.

In criminal matters, one of the parties will usually be the Director of Public Prosecutions, (DPP), or 'Regina' or 'R'. It is also possible (but less common) that one of the parties in a criminal matter will be a government department with the power to prosecute offences, such as the Australian Taxation Office or the Environmental Protection Agency.

As well as looking at the names of the parties, subpoenas should state what court, and sometimes what division of the court the matter is to be heard in, which might help ascertain what the proceedings are about. For a description of common courts, see Appendix C.

2.6 Has the subpoena been served in time?

The subpoena should be served in sufficient time to allow the collection of documents and delivery to court. The subpoena will say on it that you need not comply with it if it is served after the due date. The due date will be not less than five working days prior to the return date (ie. the date that the documents are required by the court) unless the court that issued the subpoena has shortened the time for serving it. If the court has made an order to shorten the period in which you must comply, the subpoena will be marked accordingly.

If the subpoena is served after the due date and there is no note or endorsement on the subpoena from the court stating that the time for service has been shortened, then the subpoena need not be complied with. If the subpoena is not to be complied with, the Clerk or Registrar of the court should be contacted and advised in writing that the subpoena will not be complied with and reasons given. The issuing party (or their solicitor if named on the subpoena) should also be informed. The issuing party may then obtain a further return date, (an adjournment) so as to allow sufficient time for the documents to be collated.

Where the subpoena has been served in time, it may be possible to negotiate an extension of time within which to produce the documents with the issuing party. If the PHO has solicitors acting on its behalf in the matter, those solicitors may be able to negotiate an extension of time on behalf of the PHO. If the PHO has not engaged solicitors, the person responsible for responding to the subpoena can contact the issuing party negotiate an extension of time directly.

2.7 Does it make any difference if the subpoena is a facsimile or a photocopy?

As a general rule the original subpoena should be served to ensure it is authentic. Upon receipt of a facsimile the issuing party should be contacted. All reasonable steps should be taken to ensure that the original subpoena is served. This will protect the PHO from claims by patients that their privacy and confidentiality have been breached by the production of the documents without a valid subpoena.

However, this must be balanced against the requirements of the Uniform Civil Procedure Rules (UCPR) which applies to all NSW Courts, the NSW Industrial Relations Commission and the Dust Diseases Tribunal only. The UCPR states that despite the requirement that a subpoena must be served personally on the subpoenaed party, the subpoenaed party must comply with the requirements of a subpoena even if it has not been served personally, even if the subpoenaed party has by the last date of service for the subpoena, actual knowledge of the subpoena and its requirements.

Finally, the NSW Coroner's Court can serve a subpoena by way of facsimile. (S105 *Coroner's Act 2009*)

2.8 What is the date the subpoena must be complied with?

A failure to comply with a subpoena is a serious matter, the return date of each subpoena served on the PHO should be carefully noted as soon as it is received.

The Subpoena allows the PHO to produce documents by either attending the Court at the date, time and place specified and produce the subpoena or a copy of it and the documents or things to the court. Alternatively the PHO may deliver or send the subpoena and the documents or things requested in the schedule of the subpoena, via a courier or mail to the Registry at the address specified in the subpoena. If electing to send the documents or things via mail they should be received at the Court Registry at least 2 clear working days before the date specified in the subpoena for production.

As noted in paragraph 2.6 above, it may be possible to negotiate an extension of time within which to produce the documents with the solicitor or person who issued the subpoena. This should be done prior to the original return date.

2.9 What if the subpoena has been issued in a Local Court Criminal Matter or Children's Court proceedings?

Police Officers and a Prosecutor who is a Public Officer have the power to issue subpoenas in the following types of Local Court proceedings:

- Local Court criminal summary and committal hearings;
- Local Court Application Notice proceedings;
- Children's Court criminal proceedings;
- Apprehended Violence Proceedings.

Under the Criminal Procedure Act, ***prosecutor*** means the Director of Public Prosecutions or other person who institutes or is responsible for the conduct of a prosecution and includes (where the subject-matter or context allows or requires) an Australian legal practitioner representing the prosecutor.

Public Officer is defined as any of the following persons, if acting in an official capacity:

(a) an employee in the Public Service or the Police Service,

(b) an officer or employee of a statutory body representing the Crown,
(c) an employee of a council within the meaning of the *Local Government Act 1993*,
(d) an officer or employee of a livestock health and pest authority within the meaning of the *Rural Lands Protection Act 1998*,
(e) the Director of Public Prosecutions, Deputy Director of Public Prosecutions or Solicitor for Public Prosecutions

Subpoenas issued by police officers or a Prosecutor who is a public officer will not have been signed and dated by a registrar of the Local Court. They will not have a court stamp. They are still valid subpoenas and should be complied with. Except where the Court otherwise makes an order, it is not necessary for a police officer or a prosecutor who is a public officer to tender conduct money when serving a subpoena.

Any other party who issues and serves a subpoena on a party is required by section 224 of the Criminal Procedure Act 1986 to tender conduct money at the time of service for the reasonable expenses of the person in complying with the subpoena.

2.10 What if an interstate court issued the subpoena?

It is common for some hospitals in NSW to receive subpoenas issued by interstate courts. For example, hospitals in northern NSW often receive subpoenas issued by courts in Queensland.

The Commonwealth Service and Execution of Process Act allows for interstate subpoenas to be validly served in NSW. The general rule is that subpoenas served interstate should be served 14 days prior to the return date. This time can be shortened by the court that issues the subpoena, if a shorter time period is necessary in the interests of justice and there will be enough time for the subpoenaed party to comply without serious hardship or inconvenience.

PHOs are entitled to request that the original subpoena (or a copy of the original), rather than a faxed copy of the subpoena is served. They are also entitled to the usual amount of conduct money.

3. CONDUCT MONEY

3.1 What is conduct money?

Subpoena to Give Evidence

When a subpoena to give evidence is served on a person, the person named is not required to attend court unless conduct money has been handed or tendered to the named person a reasonable time before the date on which attendance is required. This means “an amount sufficient to meet the reasonable expenses” of the person named is paid or tendered at the time of service.

If there is a dispute about conduct money the named person should contact the person who has issued the subpoena and negotiate further conduct money. If no agreement has been reached, but some conduct money has been provided at the time the subpoena was served, the person should still attend the court on the date specified in the subpoena, but advise the court that the conduct money provided is not reasonable and seek an Order from the court that additional conduct money be paid by the person who issued the subpoena.

Subpoena to Produce Documents

When a subpoena is served on a person or corporation, the person named is not required to attend or produce any document or thing under the subpoena unless conduct money has been paid. This means an amount sufficient to meet the 'reasonable expenses' of the person named is paid or tendered at the time of service.

The court in the event of a dispute will determine what is 'reasonable' conduct money. In reaching a decision the court is likely to take into account NSW Health policy when determining what is reasonable.

The rates to be applied for servicing a subpoena are advised annually by NSW Health in an information bulletin titled *Health records and medical/clinical reports – rates*.

Even if original documents are being produced to court, the photocopying charge will still apply. It will cover the cost of copying the records so that the PHO can maintain a copy whilst the originals are removed.

If a subpoena asks for records relating to more than one patient, the PHO has the discretion to charge separate fees for each patient.

If a subpoena requires searches for records to be undertaken at more than one facility of the PHO, the PHO has the discretion to charge separate fees for each facility searched.

For subpoenas issued by Police Officers and Prosecutors who are Public Officers (as discussed in section 1.9), conduct money does not need to be paid.

There is also no requirement for the Victims Compensation Tribunal or the NSW Coroner's Court to tender conduct money if they are the issuing party.

3.2 What if the conduct money is inadequate?

If the conduct money is inadequate, the PHO representative should:

(i) Call the issuing party to inform him or her of your requirements.

(i) If there is still a refusal to provide conduct money, or you consider it insufficient, contact the issuing party and attempt to negotiate some compromise on the amount.

(ii) In the event that conduct money was not provided by the issuing party and/or the amount of conduct money is considered to be 'unreasonable' the PHO or solicitor acting on behalf of the PHO should advise the Court on the day the documents are produced to the Court and request the Court make an order to the issuing party that they pay conduct money and the amount of any reasonable loss or expense incurred in complying with the subpoena.

3.3 What if too much conduct money has been provided?

The PHO is entitled to retain the minimum amount of conduct money.

If more than the minimum amount is provided and the cost of producing the records is less than the amount provided, the records should be copied and delivered to the court and the excess conduct money should be refunded to the issuing party.

3.4 Are there any special procedures with respect to conduct money if the subpoena involves a lot of work?

If the record is lengthy, or will require a number of files to be searched or otherwise take up staff time so that it will cost more than the amount provided to produce the record, the issuing party should be contacted and advised of the estimated cost of compliance including staff time in searching and locating the relevant records, photocopy costs and mail or courier fees. Such contact may be by telephone but should be confirmed in writing.

In the event that the actual costs exceed the estimate, a further account should be raised against the issuing party.

If compliance with a subpoena involves a significant amount of work, consideration should be given to discussing with the issuing party whether they are prepared to narrow the scope of the subpoena. (See 5.1 of this Policy Directive)

3.5 Can the PHO keep the conduct money if it has no documents to produce?

If the PHO receives a subpoena, conducts searches for the records requested, and has no records to produce, it may retain the conduct money to cover the cost of conducting the searches, and the cost of writing to the Court explaining that it has no records to produce.

If the records have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

4. WHAT DOCUMENTS HAVE BEEN REQUESTED IN THE SUBPOENA?

4.1 How do I determine the scope of the subpoena?

The subpoena must be read very carefully to ascertain its breadth. This is critical because the PHO is under an obligation to produce only those documents covered by the description set out in the subpoena. A subpoena may call for the production of health and/or non-health related records. The applicable procedures are the same.

The next task is to undertake appropriate inquiries to determine whether the PHO is in possession of any records which fall within the scope of the subpoena, the likely location of the records and the number of files that may have to be searched.

Where files are located containing documents which fall within the scope of the subpoena, care should be taken to ensure that only those documents which fall within the subpoena are collated for the purposes of copying and production.

Documents that do not come within the scope of the subpoena should be removed from the medical record before it is copied and documents are sent to court. A clear record of which documents have and have not been produced and a copy of the subpoena should be kept by the PHO. This may involve keeping an additional copy of the records that were sent to the Court, if the records that were sent are a small extract from the medical record.

If the subpoena requests "*any records*" or "*all records*", this includes the entire file relating to the patient, including correspondence and x-rays, even if they are stored separately to the medical record. The definition of 'document' captures an electronic medical record or information contained on a computer file, such as photos and/or video.

Sometimes there may be letters from specialists who state that the letter should not be released to a third party without the consent of the author, contained within the clinical record of a patient whose records have been subpoenaed. If the letters are included in the clinical record which has requested in the schedule of the subpoena, the documents must be sent to Court. There is no need to obtain the permission of the specialist.

Only material specifically referred to in the subpoena should be collated.

Examples

Scenario: A patient, Sara X, attends Chester Public Hospital on 28/9/2000 after being sexually assaulted. There are several later attendances to the hospital over the next three months. Some of these admissions being for surgical procedures unrelated to the sexual assault.

Sara also visits the Chesterfield Sexual Assault Service, (a separate facility of the Chester Area Health Service, located in Main St, Chester) in relation to the sexual assault on 30/9/2000, and there are several sessions with a sexual assault counsellor Jenny K, after this initial presentation.

Some months later, the defence in a criminal trial decide to issue a subpoena to the Chester Area Health Service, seeking access to documents held on Sara X. Some of the requests they consider putting in the subpoena include:

"All notes relating to the visit by Sara X to the Chester Hospital on 28/7/2000"

The Hospital holds no records relating to an admission of Sara X on 28/7/2000. The hospital is not required to, nor should it volunteer any information in relation to other visits Sara X may have made to the Hospital.

"All notes of the visit by Sara X to the Chester Hospital on 28/9/2000"

The only records relevant to the subpoena are the actual notes which relate to the visit on 28/9/2000. No reference is made to other visits Sara X made to the Hospital, or the Community Health Centre at later dates, so these documents are not covered by the subpoena.

"All notes relating to the visit by Sara X to the Chester Hospital on 28/9/2000 or any time thereafter"

All notes included on Hospital records are covered, including notes on the unrelated surgical procedures. The subpoena does not, however, cover any records generated by the SAS. The SAS is a separate facility of the Area Health Service, and is located outside the hospital campus. As such, the AHS is not required to, nor should it volunteer any information on visits made by Sara X to the Chesterfield Sexual Assault Service. Had the SAS been located within the hospital campus, the result in this case would have been different.

"All notes and counselling records prepared by counsellor Mary G in relation to any counselling sessions conducted with Sara X."

The subpoena does not identify the records of a particular facility. As such, and as the subpoena is addressed directly to the Area Health Service, all AHS records should be checked, including those held by the SAS. Note, however, that the subpoena names a specific counsellor, and only requests her notes. Mary G did not see Sara X, so the AHS does not hold any records covered by the subpoena. The AHS is not obliged to inform the court that another counsellor saw Sara X.

"Any records, notes reports or any other written material held by any facility of the Chesterfield Area Health Service, including but not limited to the facilities at the Chester Hospital and the Chesterfield Sexual Assault Service relating to Sara X and dealing with an alleged sexual assault on 28/9/2000.

This is a more usual approach. The terms of the subpoena are broad, and clearly covers all the relevant documents held by the AHS on Sara X. The only documents not covered would be those dealing with the unrelated surgical procedures. Note however, the reference to "Chesterfield Area Health Service", when the actual legal entity is the "Chester Area Health Service". If the subpoena also wrongly names the AHS, arguments could be raised against complying with it.

4.2 What if the subpoena captures reports to Community Services (Department of Human Services)

Under section 29, Children and Young Persons (Care and Protection) Act 1988 risk of harm reports made to the Director General, Human Services, are not produced in response to a subpoena, summons or notice to produce (other than care proceedings in the Children's Court, or any appeal arising from those care proceedings).

Section 27(A) (7) of the Children and Young Persons (Care and Protection) Act 1988 provides that a referral by a mandatory reporter to their relevant Child Wellbeing Unit is also protected from production under Section 29 of the Act.

It is possible for a court or other body before which proceedings relating to the report are conducted to grant leave to a party or a witness to disclose the identity of the mandatory reporter if the court or other body is satisfied that the evidence is of critical importance in the proceedings and that failure to admit the evidence would prejudice the proper administration of justice. If a court or other body grants leave for this to occur reasons must be provided as to why leave is granted, and the court or body must ensure that the holder of the report is informed that evidence as to the identity of the person who made the report, or from which the identity of that person could be deduced, has been disclosed.

4.3 What if the subpoena captures sensitive records?

For medical records, the prime criterion of sensitivity is whether the patient would consider the data sensitive. Examples of sensitive records include: sexual assault, drug and alcohol, HIV/AIDS, domestic violence, genetic information, transgender status, mental health and records of children considered to be at risk and records containing information on other persons. Records relating to people or patients who are not directly involved in the legal proceedings can also be classified as sensitive. Examples include where genetic counselling or medical records contain information relating to persons other than the patient.

The fact that records are sensitive does not itself mean that privilege can be claimed over them, or that they do not need to be produced. If a subpoena requests sensitive records and there are no grounds for challenging the subpoena or claiming privilege (see section 5), the procedure set out in section 6.4 may be followed.

4.4 What if there are no documents?

If there are no records, a letter should be written to the court advising the court that there are no records to be produced. This letter should be copied to the issuing party. The conduct money may be retained.

However, if there are no records but there is evidence that there were relevant records that have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

A file note should be created outlining efforts made to find the relevant records. If records were destroyed in accordance with a disposal authority approved under the State Records Act 1998, a copy of the disposal authorisation should be included and the relevant disposal category cited.

5. ON WHAT GROUNDS CAN A SUBPOENA BE CHALLENGED?

5.1 The subpoena is too wide and/or oppressive

A subpoena may be set aside:

- where its terms are so wide and insufficiently precise that compliance (i.e. collation and production of documents) would impose an onerous obligation on the PHO; or
- where a subpoena is used for the purpose of "fishing" for information which a party hopes, but does not reasonably expect is in existence. This may apply particularly to broad requests for protocols and investigation documents.

Subpoenas which request the production of medical records relating to persons who are not parties to the proceedings, or which request records relating to multiple, unrelated patients may be an abuse of process or oppressive.

The subpoena may also be oppressive if it is not clear what documents are sought by a subpoena, or if it appears that the documents sought will have little, or no relevance to issues in the proceedings. The scope of a subpoena can be narrowed in two ways:

(i) by agreement with the issuing party; and
(ii) by successfully challenging the subpoena in court. (See section 6 of this Policy Directive)

If you believe that the scope of the subpoena is too broad and calls for documents to be produced which are demonstrably not relevant to the proceedings, an option available is to approach the issuing party with a view to seeking a compromise on the range of documents that are required. If a compromise is reached, written confirmation should be obtained from the issuing party.

If the issuing party refuses to negotiate the scope of the subpoena as is suggested above and you still wish to challenge a subpoena on the basis that it is an abuse of process or oppressive, you should consult your immediate manager, who may need to consult the PHO Executive, and obtain advice from the PHO's solicitors if appropriate.

You should be aware that where a subpoena is challenged unsuccessfully, the PHO may be liable to pay the court costs (associated with argument over the subpoena) of the party which issued the subpoena.

5.2 The subpoena is an abuse of process or lacks a legitimate forensic purpose

A subpoena that has been issued for reasons other than for the purpose of obtaining relevant evidence for the proceedings may be set aside.

In criminal matters, an accused person must have an objective basis for demonstrating a real possibility that the subpoenaed material would assist his or her defence. Only documents that have a legitimate forensic purpose need to be produced. Legal advice is recommended in order to argue that records have no legitimate forensic purpose.

5.3 Public interest immunity

Where the public interest that would be served by withholding certain documents is so strong that it overrides the public interest in the following of due process, a subpoena may be set aside. A challenge on this basis applies only to very limited types of documents and will usually only be available to documents which may affect national security, the workings of the NSW Cabinet or some other extraordinary public interest.

NB If you wish to challenge a subpoena on a public interest immunity basis, you should contact the Legal Branch on telephone (02) 9391 9606.

5.4 Client legal privilege

Client legal privilege can protect certain documents from being disclosed in court proceedings. This privilege applies to confidential communications between a client and another person, or between a lawyer acting for the client and another person, if the communication was for the dominant purpose of the client being provided with professional legal services relating to a court proceedings or an anticipated or pending court proceedings in which the client is or may be, or was or might have been, a party.

If a claim for legal professional privilege is contested, evidence will be required from the author of the documents and/or the person who requested that the document be created, that it meets this test; and/ or other investigations will need to be undertaken as to the document's dominant purpose. If a PHO wishes to claim client legal privilege over documents it has created for legal proceedings, the lawyer that the PHO instructs in those proceedings will be responsible for claiming the privilege.

5.5 Qualified Privilege

NSW qualified privilege legislation (Division 6B of the Health Administration Act) applies to approved quality assurance committees. It operates to prevent committee members and documents produced by the committee from being used in any legal proceedings.

Qualified privilege applies to records that are under the control of an approved quality assurance committee, or a member of an approved quality assurance committee and were created at the request of or solely for the purpose of the committee. If documents created by an approved quality assurance committee but have been disclosed to other units of the PHO, the privilege may be waived, however, if the committee has not waived privilege over the documents and a subpoena is received for these records, the PHO should write to the party who issued the subpoena and to the court stating that the records are protected by qualified privilege legislation and will not be produced.

If records relating to quality assurance activities and morbidity and mortality case reviews or committees are requested, the PHO Executive should be contacted to confirm whether the records are records created by an approved quality assurance committee.

In addition to approved quality assurance committees, the Minister has approved the following committees under section 23 of *Health Administration Act 1982*, to be specially approved committees.

- Special Committee Investigating Deaths Under Anesthesia
- Special Committee Investigating Deaths Associated with Surgery
- Maternal and Perinatal Committee
- Mental Health Sentinel Events Review Committee

These committees do not need to comply with subpoenas. If one of these committees is subpoenaed, it should not comply with the subpoena unless it has the approval of the Minister to do so, or the consent of the person from whom the information was obtained. A letter should be sent to the solicitor issuing the subpoena explaining the committee's special status and stating that records will not be produced.

5.6 Sexual Assault Communications Privilege

Records relating to the counselling of victims of sexual assault (protected confidences) may be protected from production if they are covered by sexual assault communications privilege. Sexual assault communications privilege can only be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs) in NSW Courts. The sexual assault communications privilege may also be claimed in NSW Courts in civil proceedings, in limited circumstances, usually when the privilege was granted in criminal proceedings. The privilege cannot be claimed in federal courts, such as the Family Court.

PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

See **Appendix A** for further detail about the privilege.

5.7 Professional Confidential Relationship Privilege

This privilege may apply to a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. The privilege can only be claimed in NSW courts. The privilege cannot be claimed in federal courts, such as the Family Court.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records. See **Appendix B** for further detail about the privilege.

6. PROCEDURES FOR RESPONDING TO A SUBPOENA

6.1 Should I notify anyone of the subpoena?

All subpoenas should be brought to the attention of the relevant person or branch within the PHO to whom the subpoena relates, for example the medical records department or, to medico-legal person or risk manager if the PHO has one. Subpoenas should also be brought to the attention of the CEO of the PHO if the subpoena requests sensitive information. In addition, the senior health care provider and the treating health care provider are to be advised (where possible) of subpoenas for health records, even if neither they nor the PHO are party to the proceedings.

Where a patient whose health record has been subpoenaed is not named on the subpoena as a party to the proceedings before the court, he or she should be notified by the PHO that the subpoena has been received and advised of the "return date" on the subpoena (i.e. the date the documents must be provided to the court) in sufficient time to allow the patient to arrange to attend the court if the patient wishes. Telephoning the patient, or writing to the patient's last known address is sufficient. A note should be made outlining measures taken to advise the patient of the subpoena.

NB If you have concerns about the scope of a subpoena you should consult your immediate manager who may need to consult the PHO Executive and obtain advice from the PHO's solicitors if appropriate.

6.2 Are photocopies sufficient or must originals be produced?

Documents can be provided to the Court by way of:
(a) a photocopy
(b) in PDF format on a CD-ROM or,
(c) in any other electronic form that the issuing party has indicated will be acceptable.

Unless a subpoena specifically requires the production of the original document, photocopies of the records or a CD-ROM should be provided. If the PHO is required to produce originals, it should ensure that a complete copy of the records remains with the PHO to ensure continuity of care.

6.3 What is the procedure for delivering subpoenaed documents to the court?

Documents produced under NSW subpoenas must be produced to the court at the address referred to in the subpoena and **not to** the issuing party. They should not be provided to the person who serves the subpoena, even if the matter is 'urgent'.

Documents produced on subpoena should be delivered to the Registrar or Clerk of the court in question. They should be:

(i) sealed in an envelope;
(ii) the PHO should allocate a unique number to the envelope from a register held by the PHO in which the name of the patient, the court to which the record is sent and the date of the hearing should be entered against the number;
(iii) a copy of the subpoena should be secured inside the envelope. (If the Court requires the original subpoena, the PHO should make a copy for its records.);
(iv) the PHO should keep a copy of the subpoena (and any original documents being sent to court with the subpoena); and
(v) the envelope should be delivered by hand by an employee of the PHO, registered post or courier not less than 2 clear working days before the return date specified in the subpoena.

On delivery, if practicable, a receipt should be obtained from the court which indicates the number of the record, the date the record was received at the court, the name of the court and the signature of the court official receiving the record.

If the PHO is a party to the proceedings in which the subpoena has been issued, or has sought legal advice in relation to the subpoena, the documents collated in response to the subpoena should be forwarded to the solicitor who is acting on behalf of the PHO. That solicitor will review the documents and arrange for them to be forwarded to the court on behalf of the PHO.

6.4 Can any additional precautions be taken for sensitive records?

A subpoena cannot be challenged merely because it requests sensitive records.

When responding to a subpoena that requests sensitive information, (and where there are no grounds for challenging the subpoena or claiming privilege over the documents), the following steps should be followed.

a. Contact the issuing party and ascertain why the information is required. It may be possible to negotiate with the issuing party to either exclude these records from production, or produce copies of the records with the names of the affected people deleted.

b. Request that the court limit access to the documents to certain people. For example, courts can give orders limiting access to the parties' legal representatives and independent experts on the condition that they give confidentiality undertakings. The responsibility for raising this issue rests with the subpoenaed party. A letter should be sent to the court setting out the concerns arising if the documents are provided in open court. The letter should not contain any sensitive information itself.

c. If sensitive records are to be produced, they could be placed in a separate envelope marked "sensitive", however, this is no guarantee that the Court will treat these records differently

7. PROCEDURES FOR CHALLENGING A SUBPOENA IN COURT

7.1 Subpoenas for records that are privileged (other than sexual assault and confidential communications privilege)

A solicitor's assistance will be necessary depending on the complexity of the case.

If a PHO decides to challenge a subpoena without legal representation the following procedures will apply:

(i) Follow 6.1 - should I notify anyone of the subpoena
(ii) Follow 6.3 - procedure for delivering subpoenaed documents to the court
(iii) Place the records which are to be produced in a sealed envelope.
Place any records over which a claim for privilege will be made in a separate envelope and mark the word "privileged" on the envelope.
(iv) Attach a copy of the subpoena to the outside of each envelope.
(v) Place the envelope(s) marked "privileged" inside another envelope and send to the court with a letter to the Registrar setting out:
(vi) (a) what type of privilege is claimed; and
(b) the reasons supporting the claim for privilege.
(vii) Consider attending in person on the return date, or instructing the PHO's solicitor to attend, in order to argue in support of the claim for privilege.

7.2 Steps to follow when a subpoena for sexual assault records or confidential communications records is received

7.2.1 Determine whether either privilege can be claimed in the proceedings

See Appendix A for a discussion of the types of proceedings in which sexual assault communications privilege can be claimed.

See Appendix B for a discussion of the types of proceedings in which it is possible to claim professional confidential relationship privilege.

7.2.2 Family Court subpoenas

Sexual assault communications privilege and professional confidential relationship privilege are created by NSW legislation. This means that they only apply in NSW courts. They do not apply in federal courts, such as the Family Court.

If you receive a Family Court subpoena requesting a patient's sexual assault counselling communications records and the subpoena was not issued by the patient or the patient's legal representative, and you are concerned about producing the records, although privilege cannot be claimed, you could consider treating the records as 'sensitive records' (see section 6.4).

Keep in mind that sexual assault communications records relating to children can be important evidence and highly relevant for the Family Court to have available when determining parenting orders for the care of a child.

7.2.3 Protected Confidence Notice

A protected confidence means a counselling communication that is made by a victim of a sexual assault. If the issuing party wants a document containing a protected confidence produced, they must give notice to the patient that production has been sought. Notice should also be given to the other parties. This is a requirement of the Criminal Procedure Act 1986.

This means that if the issuing party is aware that the documents sought contain protected confidences, the patient should have been made be aware that they can seek to appear in court on the return date to challenge the subpoena.

7.2.4 Determine whether the PHO should claim privilege on behalf of the patient

The following issues should be considered when deciding if the PHO should claim either sexual assault communications privilege or professional confidential relationships privilege:

- The views of the patient and whether the patient proposes to claim either privilege themselves;
- Whether harm is likely to occur to the patient if the material is disclosed.

7.2.5 The views of the patient

Sexual assault communications privilege and professional confidential relationships privilege belong to the patient.

When a subpoena requesting sexual assault counselling records or records of a protected confidence is received the PHO should contact the patient and inform them that the subpoena has been served. The PHO should then:

(a) explain nature of the privilege which may apply;
(b) ask the patient whether s/he will consent to waive the privilege. If so, a consent to waive the privilege should be obtained from the patient in writing;
(c) if the patient does not want to waive the privilege, advise the patient of the steps (if applicable) that the PHO is taking to claim the privilege on the patient's behalf.

If the patient chooses to waive the privilege, the documents must be produced to the court.

Reasonable attempts should be made to contact the patient if a subpoena for sexual assault counselling records is received. What constitutes reasonable steps will vary depending on the individual circumstances of the patient. If the file shows that there is a potential that the patient will suffer serious harm if the records are disclosed, taking reasonable steps to locate the patient may involve doing more than attempting to telephone the patient or writing a letter, such as contacting the police for assistance. If the patient cannot be contacted, the PHO should write a letter to the court explaining this, and noting that the records contain confidential counselling material. This letter should be sent to the court with the records.

In proceedings where the patient is represented, the PHO will meet its obligation by referring the matter to the patient's legal representative.

7.2.6 Whether harm is likely to occur to the patient of the material is disclosed

The treating counsellor (or, if that person is not available, another qualified professional) should review the file and form a preliminary view as to whether harm is likely to occur to the patient from disclosure.

This preliminary view will need to later be supported by the preparation of a harm statement or an affidavit. A harm statement or affidavit made by a professional with appropriate qualifications is an essential element to claiming the privilege. Before a decision is made to claim privilege, the professional/s involved should be comfortable they can adequately prepare a harm statement or affidavit for the court. If a decision is made to claim privilege, the most appropriate way to ensure the claim is argued effectively is for the PHO to obtain legal representation.

7.2.7 Instructions to be given to lawyers engaged by the PHO to argue a privilege claim

If the PHO decides to engage lawyers to argue a claim for privilege, a letter of instruction setting out the following should be sent to the lawyers. The letter should include the following information:

- When the subpoena is returnable (attach a copy of the subpoena);
- The nature of the documents held;
  The patient's views on disclosure;
  If the patient does not wish to waive the privilege, an indication that the PHO is of the view that harm will occur to the patient if the documents are released;
  The name and contact details of the other party/parties to the proceedings (or their legal representatives);
- If the matter is a criminal matter, the name and contact details for the police officer in charge of the criminal investigation;
- The name of appropriate contact officer at the PHO;
- The date that the hearing starts. This information can be obtained from the issuing party. The date that the hearing starts will usually be a date some time after the return date for the subpoena. This allows time for the return date for the subpoena to be adjourned by the court if the PHO wishes to put forward arguments objecting to disclosure. Where the subpoena is returnable at the start of the trial it is more difficult to negotiate additional time.
- Whether the documents have been subpoenaed before. This is important, as if the records were previously released, it will be more difficult to argue for their non-release in response to a later subpoena. Alternatively, the court may have prevented disclosure in earlier cases and made comments which may assist in arguing for non-disclosure in relation to the later subpoena.

7.2.8 The harm statement or affidavit

In order to support a claim for privilege, it is necessary for the patient or the PHO to provide the court with evidence about the nature and extent of the harm that the patient would suffer if the documents were disclosed. However, specific details about the patient should not be provided – to do this would negate the purpose for the privilege claim.

If the PHO has instructed a lawyer to argue the privilege, the lawyer will advise staff on whether affidavits, or harm statements, or a combination of both, are required, and will assist staff in preparing these documents.

If the PHO does not instruct a lawyer, it may consider asking staff to draft a harm statement. When drafting harm statements, keep in mind that they are likely to be read by all parties to the proceedings.

A professional with appropriate qualifications should prepare a harm statement. It should include:

(a) the qualifications and experience of the professional preparing the statement;
(b) the employed position of the professional at the time of preparing the statement;
(c) if the person preparing the statement is the treating counsellor, the statement should state this, and explain for how long the counselling relationship has been established;
(d) if the person is not the treating counsellor, the statement should state that fact. It should explain why the treating counsellor is not available to make the statement and state that the person who is preparing the statement has read all the relevant counselling notes;
(e) a statement that the counselling notes that have been subpoenaed were made in confidence and relate to the impact of alleged sexual assaults.
(f) a statement to the effect that the symptoms, concerns, and worries of the patient would be seriously aggravated if the contents of the documents were disclosed.
(g) if applicable, a statement to the effect that the patient expected the counselling records to remain confidential.
(h) a statement that the writer of the harm statement claims sexual assault communications privilege in respect of the records.

8. WHAT HAPPENS AFTER THE DOCUMENTS HAVE BEEN PRODUCED?

8.1 Who can see the documents after they have been produced to the court?

After documents have been produced to court, the court will make orders about who may access them. Usually, the parties to the proceedings and their legal representatives will be granted access to the documents.

If a patient's medical record has been produced to court, and the patient is also a party to the proceedings, his or her legal representative may ask for 'first access.' This means that the patient's legal representative can inspect the records before the other parties, in order to determine whether a privilege claim can be made to limit further access to the documents.

The question of who may have access, whether a party will have first access, or whether any other special access orders will be made, is often determined on the return date.

The following courts determine access issues in particular ways.

<u>District Court – civil claims</u>

The issuing party in a District Court civil matter is required to include a 'proposed access order" on the subpoena. This is an order for access that the issuing party thinks is appropriate. For example, the proposed access order may be "plaintiff to have first access to the documents for 7 days". This type of access order may be appropriate if the plaintiff was the patient whose records had been produced, as it would allow the plaintiff/patient's solicitor to view the records and determine whether any claims for privilege should be made, prior to the other parties accessing the records.

If the PHO wishes to object to the proposed access order (for example, if a privilege is being claimed), the PHO should first notify the issuing party to attempt to negotiate an agreement as to what the proposed access order should be. If an agreement cannot be reached, a representative of the PHO, or the PHO's legal representative will be required to appear at Court on the return date and argue the question before the presiding registrar.

In any District Court civil case where there is no appearance at the return date, the proposed access order will be made automatically by default.

Supreme Court

If a general access order allowing all parties access to the subpoenaed documents at the same time is not objected to, the Supreme Court will automatically make a default order for general access to the documents at the return date.

If PHO wishes to object to a general access order being made (for example, by claiming a privilege), it should notify the party that issued the subpoena and attend court, or arrange for a lawyer to attend court, on the return date and inform the Registrar of its position.

8.2 What if I receive a request for permission to 'uplift' documents?

Courts have photocopying facilities available on site; however, occasionally parties to litigation seek permission from the court to uplift, or temporarily remove the documents from the court to arrange for them to be copied externally, or reviewed in a more convenient setting. A party may request to uplift x-rays or scans which have been provided to the Court in order to obtain a copy to provide to a medical expert for an opinion. The documents are then returned to the court.

As the documents still belong to the subpoenaed party while they are at the court, some courts seek the consent of the subpoenaed party before they will allow the documents to be uplifted.

If a PHO is asked to consent to a party uplifting records, it is recommended that:

- If original documents have been produced, consent to uplift should generally be refused;
- If copies have been produced, consent can be granted on the basis that the documents do not leave the custody of the parties' legal representatives and/or the medical or other professional expert whom the parties' legal representatives have engaged to provide an expert opinion and the document/s are returned to the court in the same condition.

If a court allows documents to be uplifted, it will normally require the legal representative uplifting them to sign a receipt, accepting responsibility for the records whilst they are in the legal representative's possession.

8.3 Are subpoenaed documents returned?

Original documents should always be returned to the PHO.

Subpoenaed documents that are copies should be returned by the court at the conclusion of the matter, unless the PHO has informed the court that the documents may be shredded. If you have any queries contact the Clerk or Registrar of the court.

9. REQUESTS FOR INFORMATION UNDER CHAPTER 16A OF THE CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT

Chapter 16A of the Children and Young Persons (Care and Protection) Act provides a mechanism for NSW Health staff exchange information with other human services and justice agencies, to ensure the safety, welfare and wellbeing of children and young people in NSW.

These changes have been introduced under *Keep Them Safe - A shared approach to child wellbeing 2009 - 2014*, the NSW Government's response to the Report of the Special Commission of the Inquiry into Child Protection Services in NSW. The legislation introduced as part of *Keep Them Safe* is intended to free up information exchange between certain human service and justice agencies including NSW Health, to facilitate improved interagency collaboration.

Please refer to NSW Health PD2013_007 Child Protection and Wellbeing – Information Exchange hyperlink where NSW Health's policy on child protection information exchange is set out in full.
http://www.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

10. REQUESTS FOR INFORMATION FROM COMMUNITY SERVICES

Pursuant to s248 of the Children & Young Persons (Care and Protection) Act, PHOs may be required to provide information to Community Services. Section 248 is designed to allow an exchange of information about the safety, welfare and wellbeing of children and young people between an agency and Community Services.

Information can only be provided in response to a s248 request if it relates to the safety, welfare and well being of a particular child or young person.

Once records have been provided to Community Services in answer to a s248 request, Community Services may use them as evidence in legal proceedings. If records are to be used in legal proceedings, they are usually annexed to an affidavit (a sworn statement) prepared by Community Services staff in accordance with arrangements agreed upon between NSW Health and Community Services. Community Services staff are not to attach confidential information provided in response to a s248 requests to affidavits without the consent of the person who provided the information.

If the document that Community Services wish to attach to their affidavit is particularly sensitive, the PHO should refuse to consent, (unless the patient's guardian does not object) and ask Community Services to issue a subpoena seeking a copy of the document instead. Once a subpoena has been served, the PHO may consider whether production can be opposed, or whether any type of privilege can be claimed in respect of the document.

For more information regarding responding to S248 requests refer to NSW Health PD2013_007 Child Protection and Wellbeing – Information Exchange hyperlink
http://www.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

11. PRIVACY

Compliance with a subpoena is required by law. Complying with a subpoena will not breach the PHOs obligations under the Health Records Information Privacy Act 2002. For further information about privacy obligations, see NSW Health Privacy Manual.

PART B - SUBPOENAS TO GIVE EVIDENCE

1. A subpoena to give evidence is addressed to a specific individual. It will indicate the time and place the person will be required to give evidence as a witness.

2. A person who receives a subpoena should report that fact to his/her administrator/supervisor as soon as practicable.

3. A person who has been subpoenaed should contact the solicitor who requested the issue of the subpoena to:
   a. confirm that their attendance is still required;
   b. to obtain some better guidance as to when he or she might be required to give evidence; and
   c. confirm that if the solicitor who has issued the subpoena requires the witness to remain on 'standby' rather than come to Court, sufficient notice will be provided if the witness is to be called to Court so that alternative work arrangements can be made.

4. If a solicitor indicates that a person's attendance is not required, this should be confirmed in writing.

5. Witnesses are entitled to receive conduct money and reasonable expenses from the solicitor or person who has issued the subpoena. Conduct money means a sum of money, or its equivalent, such as pre paid travel, sufficient to meet the reasonable expenses incurred by the subpoenaed party in attending court as required by the subpoena, and returning from court after attending.

   For medical officers, the AMA has published guidelines relating to reasonable expenses.

Appendix A

Sexual Assault Communications Privilege

The Sexual Assault Communications Privilege is set out in the Criminal Procedure Act 1986. This privilege allows courts, to exclude evidence which would disclose confidential communications made in the course of a professional or sexual assault counselling, relationship. "Professional" is not defined in the Act but would include a health care worker, social worker, counsellor or youth worker.

The Act not only restricts the use of material as evidence in court, it also places restrictions on who can have access to documents which have been requested under a subpoena. The onus is on the person requesting the documents to show why they should have access to the victim's counselling notes.

The privilege does not apply to federal courts, for example the Family Court.

1. What is a protected confidence for the purpose of claiming sexual assault communications privilege?

A protected confidence means a counselling communication that is made by, a victim or alleged victim of a sexual assault offence.

A counselling communication is a protected confidence even if:

(a) it was made before the relevant sexual assault offence occurred, or is alleged to have occurred, or
(b) was not made in connection with a sexual assault offence or alleged sexual assault offence.

This means that the privilege could apply to any counselling communications, and not just to counselling following a sexual assault. (For example, the privilege could apply to drug and alcohol counselling provided prior to the sexual assault taking place.)

A counselling communication may be made in confidence even if it was made in the presence of a third party if the third party was present to facilitate communication or to otherwise further the counselling process. For example a counselling communication will be protected by the privilege in cases where a parent, carer or other supportive person was present during the counselling process to facilitate communication between the counselled person and the counsellor.

A person counsel's another person if the person has undertaken training or study or has experience that is relevant to the process of counselling persons who have suffered harm and the person

- listens to and gives verbal or other support or encouragement to the other person, or
- advises, gives therapy to or treats the other person

whether or not for fee or reward.

2. Can the sexual assault communications privilege be claimed in all types of court proceedings?

The sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs).

The sexual assault communications privilege can also be claimed in NSW civil proceedings, but only if:

(a) substantially the same acts are in issue in the civil proceedings as were in issue in relation to previous criminal proceedings; and
(b) the evidence was found to be privileged in the previous criminal proceedings.

The privilege cannot be claimed in federal courts, such as the Family Court.

3. Principles applying to sexual assault subpoenas

(a) PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

(b) This obligation is most critical where the patient is a child, or where the disclosure is sought in relation to criminal proceedings and the victim of the assault does not have legal representation. In these cases, the PHO may consider obtaining legal representation to challenge the production of material in response to the subpoena.

(c) In cases where there is a high risk of serious harm such as, for example, a high likelihood of suicide or self harm, to the patient if the records are disclosed, the PHO should consider obtaining legal representation to challenge the production of material in response to the subpoena. Harm can be actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

(d) In proceedings where the patient is represented, the PHO may meet its obligation by referring the matter to the patient's legal representative.

(e) If the patient has legal capacity and chooses to waive the privilege, the PHO must respect that decision.

4. How does sexual assault communications privilege operate?

Preliminary Criminal Proceedings

Preliminary criminal proceedings are committal or bail proceedings (whether or not they relate to a sexual assault offence).

A person cannot be required (by subpoena or otherwise) to produce a document recording a protected confidence in connection with any preliminary criminal proceedings. Evidence that would disclose a protected confidence, of the contents of a document recording a protected confidence cannot be used in any preliminary criminal proceedings.

Criminal Proceedings

Evidence is not be used in any criminal proceeding if the court decides that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

Before a court can make a decision about the documents, they must be produced to court, with an objection to their production noted, so the court can rule on the objection. This means that the PHO

must produce the documents to the court in a sealed envelope marked "sexual assault communications privilege claimed". The court will inspect the documents in order to determine whether the claim for privilege will be upheld. Some courts will not uphold a claim for privilege without hearing legal argument from the issuing party and the subpoenaed party. PHOs should recognise that producing the documents marked privilege may not be sufficient for a claim for privilege to be successful. Legal argument may be necessary.

The court will not allow evidence about a protected confidence or the contents of a document recording a protected confidence to be used unless the court is satisfied that:

(a) the evidence could affect the assessment of a fact in issue in the proceedings; and
(b) other evidence of the protected confidence or the contents of the document recording the protected confidence is not available; and
(c) the public interest in preserving the confidentiality of protected confidences and protecting the confider from harm is substantially outweighed by the public interest in admitting into evidence information or the contents of a document that will affect the assessment of a fact in issue.

The person seeking to adduce the evidence (the issuing party) must provide the patient with notice that they are seeking to adduce the protected confidence, and inform the patient that they may, with the leave of the court, appear in the proceedings.

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard 'in camera' (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence, or the identity of the confider. The court may also make orders limiting who may inspect documents produced.

Appendix B

Professional Confidential Relationship Privilege

1. What is a protected confidence for the purpose of claiming professional confidential relationship privilege?

A protected confidence is a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

The aim of the privilege is to protect marginalised groups (other than victims of sexual assault in relation to whom the sexual assault communications privilege may apply) such as mental health patients and HIV positive patients, who may not seek medical treatment if they are concerned that professional confidentiality will not be maintained.

The rationale for the privilege is that some relationships between health professionals and patients will be severed, if trust and confidentiality are not maintained. This rationale may not apply to a patient's relationship with a Hospital or PHO, where the patient is treated by a team, and may not form a special relationship with a particular health professional.

2. Can the professional confidential relationship privilege be claimed in all types of court proceedings?

No - the privilege cannot be claimed in federal courts, such as the Family Court.

3. How does professional confidential relationship privilege operate?

The court may direct that evidence not be used in proceedings, if the court finds that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

The court can come to this decision on its own initiative, or on an application from the protected confider (the patient) or the confidant (the health professional).

The court must decide not to use evidence about a protected confidence if, it is likely that harm would be caused to the protected confider (the patient) if the evidence is used and if the nature and extent of the harm outweighs the desirability of the evidence being given. It is generally desirable, however, for the evidence to be given. The more important the evidence is, particularly if it is not available from an alternative source, the more desirable it is.

Harm includes actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard 'in camera' (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence.

The privilege can be waived if the confider consents.

4. What will the court take into account when deciding whether the privilege applies?

The court will consider a range of factors, including the following:

1. the extent to which the evidence could affect the assessment of a fact in issue in the proceedings;

2. the importance of the evidence in the proceeding;

3. the nature and seriousness of the relevant offence, cause of action or defence and the nature of the subject matter of the proceeding,

4. the availability of any other evidence concerning the matters to which the protected confidence or protected identity information relates,

5. the likely effect of using evidence of the protected confidence, including the likelihood of harm, and the nature and extent of harm that would be caused to the patient,

6. the means available to the court to limit the harm or extent of the harm that is likely to be caused if evidence of the protected confidence or the protected identity information is disclosed,

7. if the proceeding is a criminal proceeding - whether the issuing party is a defendant or the prosecutor, and

8. whether the substance of the protected confidence or the protected identity information has already been disclosed by the patient or any other person.

Appendix C

Common Courts and Tribunals

The Family Court of Australia

The Family Court resolves and determines family disputes, including disputes about the care, custody and maintenance of children.

The Family Court also provides consent for special medical treatment (such as sterilisation, surgical gender reassignment & the harvest of bone marrow blood cells from a disabled child for transplantation into a relative) to be carried out on minors.

The Supreme Court of New South Wales

The highest court in the State is the Supreme Court of NSW. It has unlimited civil jurisdiction and handles the most serious criminal matters.

The Court of Appeal and Court of Criminal Appeal hear appeals from decisions made in most of the Courts of New South Wales and from decisions made by a single judge of the Supreme Court.

District Court

The District Court is the intermediate Court in New South Wales and deals with criminal and civil cases. The District Court has jurisdiction to hear:

- all indictable criminal offences (except murder, treason and piracy); and
- civil matters with a monetary value up to $750,000, - or greater with the consent of the parties. The Court also has an unlimited jurisdiction in respect of motor accident cases.

The Court can also deal with applications under the De Facto Relationships Act 1984, and the Family Provision Act 1982, that involve property worth up to $250,000. The Court's judges hear appeals from the Local Court and also preside over a range of administrative and disciplinary tribunals.

Local Courts

The Local Courts are the courts of general access in New South Wales. There are 157 Local Courts in NSW. They have jurisdiction to deal with:

- the vast majority of criminal and summary prosecutions;
- civil matters with a monetary value of up to $60,000;
- committal hearings;
- family law matters;
- child care proceedings;
- juvenile prosecutions and care matters; and
- coronial inquiries.

In the Local Court, Magistrates hear criminal cases that do not need a judge and jury. There are called summary offences and include traffic matters, minor stealing, offensive behaviour, and some types of assault. Magistrates also hear applications for apprehended violence orders where one person is seeking a restraining order against another.

A magistrate conducts committal proceedings to decide if there is enough evidence for a serious matter, such as armed robbery, or attempted murder, to go before the District Court or the Supreme Court.

Children's Courts deal with criminal matters involving children who are younger than 18 and with children who are in need of care or protection.

Administrative Appeals Tribunal

The main role of the Administrative Appeals Tribunal is to review administrative decisions of New South Wales government agencies, including freedom of information decisions. The Tribunal also has original decision-making jurisdiction in:

- disciplinary proceedings relating to certain professions;
- equal opportunity complaints under the Anti-Discrimination Act 1977; and
- retail lease claims.

Workers Compensation Commission

The Workers Compensation Commission deals with workers compensation disputes arising out of work related injury or disease suffered by a worker in New South Wales. In addition, the Commission administers medical panels which assess a worker's condition or fitness for employment in circumstances specified in legislation.

Coroners Court

Coroners are situated around New South Wales in Local Courts. They inquire into the circumstances surrounding deaths that are reported to them.

The State Coroner's role is to ensure that all deaths, suspected deaths, fires and explosions which are under the Coroner's jurisdiction are properly investigated, and where the law requires an inquest to be held, or in cases whether the Coroner believes an inquest is necessary, a full inquest is undertaken.

Drug Court

The Local or District Court in the defined catchment area must refer offenders who appear to meet the Drug Court obligatory criteria, to the Drug Court.

The aim of the Drug Court is to protect the public by ensuring drug dependent offenders engage in longer term treatment. The Court works in collaboration with a number of other organisations. These include the Department of Corrective Services, including the Probation and Parole Service, and the Department of Health.

Dust Diseases Tribunal

The Dust Diseases Tribunal hears and determines claims for dust related diseases suffered as a result of exposure to dust. Dust diseases include mesothelioma, asbestosis, silicosis and certain types of lung cancer. The Dust Diseases Tribunal follows the procedural rules of the Supreme Court of New South Wales.

RADIATION ONCOLOGY EQUIPMENT – HEALTH PROGRAM GRANTS (PD20210_025)

Made obsolete – see IB2014_005.

POLICY FOR MANAGEMENT OF AD HOC REQUESTS FOR FUNDING FROM ORGANISATIONS EXTERNAL TO NSW HEALTH (PD2005_507)

Background

A review was recently conducted of NSW Health's management of ad hoc requests for funding. The review found that there are a number of areas in which our procedures require amendment to ensure due process is followed. These issues relate to:

- Delegations
- Transparency
- Contracts and Exit/Termination Arrangements
- Monitoring of grantee performance
- Accountability
- Conflict of Interest
- Probity

Key objectives

The key objectives of this section are to protect the public interest, to ensure effective accountability, to ensure that health funds are used for purposes that advance the mission of the NSW health system and to ensure that the community receives value for money in any grant made.

What requests does this section apply to?

The NSW health system receives requests for funding support from a wide range of groups and organisations including Commonwealth, State and local government bodies, Universities and other educational institutions, community groups, clubs and individuals for a wide variety of purposes including operating costs, equipment purchases, rental assistance, engagement of staff, sponsorship, education/training expenses and the underwriting of events/conferences. It is not possible to rigidly define the term "ad hoc".

A formal process exists for funding of non government organisations by the NSW health system and it is recommended that this process should be followed for grant requests from non government organisations. Copies of the guidelines and procedures for NGO grants under this process can be obtained from Health Services Policy Branch on 02 9391 9479.

Grants made under a formal written agreement between the Department/Area/Service and the legal body corporate of a Commonwealth or State Government Department/Agency, a University or TAFE, a Local Government Council generally have built in accountability mechanisms and are signed by a senior executive of both bodies (eg Director General, Area CEO, Council General Manager, Vice Chancellor or Faculty Dean).

To provide an appropriate balance between the protection of the public interest and local flexibility, the revised procedures outlined in this Circular will now apply to all funding requests received by and/or grants proposed to be made by the NSW public sector health system (Department, Areas, Ambulance Service, Corrections Health, Second and Third Schedule organisations) to groups, organisations and individuals external to NSW Health **other than:**

- grants made following a publicly advertised tender in accordance with Departmental tender policies;
- grants to non government organisations where the request/grant is processed under the NGO funding guidelines and process administered by the Department; and
- grants to another Commonwealth or State Government Department, University, TAFE or Local Council under a formal written agreement between the legal entities and signed by a senior executive of each incorporated body.

What are the revised procedures that must now be followed?

Delegations

Authority to approve ad hoc requests for funding from persons/organisations external to the NSW public sector health system covered by this Circular will now be held by the Minister, Director General and Deputy Directors General for the NSW health system and, in relation to the expenditure of their respective organisations, by Area Chief Executive Officers, CEO Ambulance Service, CEO Corrections Health and CEO New Children's Hospital. This power may NOT be delegated to a lower level within the organisation. The Department Delegations Manual and Accounts and Audit Determination will be amended to restrict the power to allocate one-off grants to the above positions.

The power which Service Co-ordinators within Area Health Services may have previously exercised to grant ad hoc funding to organisations is withdrawn. This delegation will be exercised at Area Chief Executive Officer level.

In exercising such delegations, the delegation will require that prior to approval the delegated officer is satisfied that:

- the grant is in accordance with the mission of the NSW health system
- the person, organisation or group is reputable, accountable and able to provide the service being funded
- there is no conflict of interest
- the funds required are available.

Prior referral to the Minister for Health's Office

While there is no upper limit on the $ value of grants able to be made from available funds, the Minister's office must be informed in advance of proposed one-off grants of **$10,000 or more.** This will provide the Minister's office an opportunity to provide comment and/or accept the opportunity to announce the initiative if the Minister wishes.

The Minister's Chief of Staff is to receive advice via facsimile on the one page form (sample attached) **at least three weeks before** the grant is to be made.

Area/Service Chief Executive Officers or relevant departmental personnel will be advised by the Minister's Chief of Staff if the Minister does not support the proposal or wishes to take up the opportunity to announce the initiative. The time-frame will enable appropriate arrangements to be made. If no advice has been received from the Minister's office after 10 working days, the grant may proceed at the Departmental or Area/Service level.

Transparency

Grants may be approved by the Minister or by other officers holding the delegation outlined above. The following requirements must be met in submissions to the approving officer and/or Minister:

Requests referred directly to the Minister

Recommendations to the Minister regarding ad hoc funding requests by external organisations must include reference to the following matters:

- Likelihood of grant being made under NGO guidelines
- Adherence to Government, Ministerial, Departmental or Area service priorities
- Arrangements for announcement or presentation by Minister or other political representatives
- Proposed performance agreement and contract
- Any commitment to recurrent funding and source of such funding
- Exit strategy
- Probity conditions met

Grants to be approved by Director General, Deputy Directors General or Chief Executive Officers

(A) Less Than $10,000

- Governed by a formal written agreement
- Purpose of grant accords with corporate/business plan priorities of NSW health system
- Exit strategy developed and included in written agreement
- Probity conditions met

(B) Grants of $10,000 or above

- Performance agreement/contract in place
- Purpose of grant accords with corporate/business plan priorities of NSW health system
- Any commitment to recurrent funding and source of such funding
- Exit/termination strategy
- Adopt NGO guidelines to the full extent possible within the circumstances and time-frame available
- Probity conditions met

Contracts and Exit Strategy

All organisations receiving ad hoc grants are required to enter into a written agreement/ contract. A sample base document is attached. The agreement must provide that recipients will return any unspent funds and that repayment will be made of expenditure found not to be in accordance with the agreement. The agreement should outline what is to happen with any revenue generated by the grant. All grants are made subject to a contractual agreement being reached between the parties regarding the amount of money and duration, goals and targets to be reached, a properly acquitted financial statement for monies received, and an undertaking given to repay monies if appropriate.

When modifying the standard Departmental contract to reflect the requirements of a particular funding situation, an exit/termination arrangement in the form of criteria to be met is to be agreed between the parties before the grant is made. The written agreement must explicitly state that the agreement will be terminated should the organisation fail to comply with the agreement.

Unless a specific funded commitment of recurrent funding has been approved by the Minister or the delegated officer approving the grant, the agreement must explicitly state that no further funding is to be provided and this must be acknowledged in writing by the organisation receiving the grant.

If for any reason the amount of the initial ad hoc grant requires increase, full justification must be resubmitted to the delegated approving officer for approval setting out the reasons. Under no circumstances are any additional payments to be made until formal approval is received.

Performance Management and Monitoring

The funding body (Central Office Branch, Area or Service) is required to review the quarterly and annual reports provided as a condition of the grant, to initiate dialogue regarding reports and make any revisions necessary to ensure the achievement of the goals and targets identified in the funding agreement.

This process is mandatory irrespective of the way in which the grant was obtained, ie formal NGO process, ad hoc grant approved at Area or Deputy Director-General level, or allocated following various representations.

All NSW Health employees required to report on their individual performance agreement annually must report on having reviewed the performance of NGO grants within their area of responsibility, discussed the findings of the performance review with the relevant organisation and made any necessary amendments to ensure goals and targets are met, including corrective/remedial action.

Reasons for termination of grants must be explicitly communicated in writing to the organisation, group or individual.

Accountability

Area Health Service CEs and Royal Alexandra Hospital for Children are to determine with an appropriate format and timetable for regular reporting of all ad hoc and routinely provided grants to external bodies. The CEs are to note the allocations and seek further information if required.

Reports should contain:

- name and address of organisation

- amount of money sought and actual amount allocated
- commitments given by organisation regarding goals and targets
- achievement of goals and targets to date.

Ministerially determined grants and allocations greater than $10,000 will continue to be recorded in Area and Departmental Annual Reports.

Wherever possible, ad hoc grants are to be provided retrospectively upon receipt of documentation verifying actual expenses incurred.

Conflict of Interest

Health employees are not prohibited from occupying positions on governing bodies of external groups. It is recognised that in some circumstances it is beneficial to furthering health goals in communities for experienced health personnel to make a contribution to the activities of external bodies within their area of expertise. Nevertheless, there are several measures required to ensure that no conflict of interest exists during such participation in external body activities.

Any health employee who is an office bearer, director or management committee member of an organisation receiving funding or applying for funding from NSW Health must advise their Chief Executive or the Deputy Director-General of their proposed appointment and seek approval for the appointment to proceed.

Any NSW Health employee presently holding office in any NGO or organisation which supplies services to the Department or Area, receives funding from the Department or Area or services clients from an Area Health Service is to refrain from participation in discussion about, application for and involvement in the process of applying for any Government grants. Clearly, NSW Health employees cannot make recommendations about, authorise or approve the allocation of Government funds to any organisation with which they have an association.

NSW Health employees are to refer their potential conflict of interest matter to their Branch Head or Area CEO in writing and not seek to determine if an actual conflict exists themselves. The matter will be determined by the Area Chief Executive Officer or Deputy Director-General.

Probity

Probity requires that the recipient of Government funding, whether an individual or an organisation, is of good standing in the community, will apply the funds for the purpose sought and intended and will use the funds to further the public interest.

Assessing the probity of applicants is a sensitive matter. A graded system of enquires will apply to enable the probity of applicants to be assessed:

All grants

When an individual or an organisation, not known to the delegated officer authorised to approve the funding request, applies for ad hoc funding they are to provide, in addition to the other information in their application, two references with one from the CEO or equivalent of a well respected organisation, known to the Department or Area/Service, with expertise in the subject area in which the grant is sought and the other being a character reference from one of the categories specified by the Commonwealth when attesting to the integrity of a passport applicant (eg solicitor, medical practitioner, bank manager).

Grants $10,000 and Above

Given that the amount of money in this category is significant and the fact that the Minister may be involved in the presentation of grants of $10,000 and above it is essential that the Minister and the Department are confident of the standing of individuals and organisations receiving funding in this circumstance. Accordingly the following additional requirements must be met:

- Evidence must be provided in the application of the existence of management systems and processes within the organisation to ensure review and scrutiny of the behaviour of persons involved in grant implementation.

Criminal Record Checks

All applicants are to be advised that the requirements of PD2013_028 – "Employment Checks – Criminal Record Checks and Working with Children Checks", which specifies that criminal record checks are necessary for all persons working in any capacity in the NSW Health system, may be invoked.

The person authorised to approve funding requests/grants is responsible for determining whether a criminal record check is required and where indicated, this check MUST be completed prior to funds being approved and allocated.

Where the request/grant involves **organisations or individuals providing or seeking to provide services to children or minors**, applicants in this category are to be advised that criminal record checks **WILL** be undertaken before any funds are allocated.

Review of Circular implementation

Implementation of this policy will be reviewed in twelve months time. Your comment and feedback on its application will be appreciated. Comments should be forwarded to Dr Tim Smyth, Deputy Director-General, Policy.

To : MINISTER's CHIEF OF STAFF

From : Area Health Service/ _____ Departmental Division

Name of Organisation/Individual Proposed to Receive Grant:

_____

Amount: $_____ of proposed grant.

Purpose of Proposed Grant:

_____

_____

_____

Date of Suggested Allocation or Announcement:

_____

Significant Community Interests (e.g. Organisations or individuals who it would be appropriate to involve in any presentation or announcement, advice regarding any likely community concern at the allocation of this grant; and assessment of local media interest):

_____

_____

_____

Signature: _____

Position: _____

Date: _____

NSW HEALTH SYSTEM FEES AND CHARGES - IMPACT OF THE GOODS AND SERVICES TAX (GST)

In regard to the impact of the GST on the NSW Health System Fees and Charges the following is advised:

- **Fees and charges determined/reviewed by the NSW Health Department**
- A schedule of the fees/charges determined/reviewed by the Department, which are not subject to GST is at **Attachment l**.
- The fees/charges set by NSW Health that are taxable supplies or that Health Services are to consider for GST implications are as follows:
- **Charges for Health Records and Medical Reports** (PD2006_050)

Where revenue derived from the preparation of Medical Reports is in the context of the Medical Officers Rights of Private Practice the service is to be regarded as a taxable supply.

Where the income derived is treated as public hospital revenue, consideration is to be given as to whether it satisfies GST-free status under section 38-250 of the *A New Tax System (Goods and Services Tax) Act 1999*" (GST Act).

ie. Supplies are GST-free if:

- the charge is less than 50% of the GST inclusive market value of the supply; or
- the charge is less than 75% of the cost to the supplier of providing the supply.

NB. Further details are contained in section 3.3 (pages 22 to 24) of the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" which is available on the NSW Health Intranet.

All health services need to ensure that documentation/systems exist to compare the costs (including overheads) of providing health records and medical reports, and being able to assess the GST status as detailed above.

Where the Service is determined as being GST-free the rates at column A (below) apply.

or

Where the GST free test is not satisfied the service is therefore a taxable supply and the GST inclusive rates at column B (below) apply.

	A Current Fee $	B From Feb 2002 (including GST) $
Medical Reports		
- no further examination of the patient	220	241
- re-examination of the patient is required	314	345
- new medical practitioner/examination is required	566	622
- health professional other than a medical practitioner	220	241
Clinical Notes/Summary of Inquiries/Search Fee	30	32
Heath Records required to be produced by Subpoena		
- at least 5 working days' notice	50	
- less than 5 working days' notice	75	
- Plus a photocopying charge of $0.25 per page		
Photocopying charge (per page) (number of pages being charged multiplied by 27 cents with total rounded down to nearest 5 cents)	0.25	0.27

- **Public Hospital Accommodation Charges**

Public Hospital Accommodation Charges are GST-free under section 38-20 of the GST Act except for taxable services eg cosmetic surgery not covered by Medicare (refer section 38-7 of the GST Act).

Where public hospital accommodation is provided for a taxable supply there is to be no grossing up of the approved bed day charge, however $1/11^{th}$ is payable as GST.

- **Accommodation and Meal charges for Parents, Relatives or Friends of Patients** (PD2015_022)

Accommodation fees are GST-free if: (section 38-250 of the GST Act refers) ie.

- the charge is less than 75% of the GST inclusive market value of the supply; or
- the charge is less than 75% of the cost to the supplier of providing the accommodation.

Supplies (eg **Meals**) are GST-free if: (section 38-250 of the GST Act refers) ie.

- the charge is less than 50% of the GST inclusive market value of the supply; or
- the charge is less than 75% of the cost to the supplier of providing the meal.

NB. Further details are contained in section 3.3 (pages 22 to 24) of the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" which is available on the NSW Health Intranet.

Based upon the benchmark values contained in DEWRSB (Department of Employment, Workplace Relations and Small Business) advice No 1999/7, current Accommodation and Meal charges above are deemed to be GST free ie

	Current Fee $
Accommodation Only (excluding meals)	
- self contained units	30
- other	15
Meals (maximum per meal per person)	5

- **Fees and charges set/reviewed by Area Health Services/Hospitals**

- Treasury Circular No. 00/06, advises the NSW Government's policy on adjusting the prices of government goods and services to reflect the impact of the GST, has issued to Area Health Services (copy attached). Area Health Services are to ensure compliance with the contents of this circular in regard to the fees and charges set/reviewed locally.

- In determining the taxable status of Meals on Wheels the following needs to be considered.

1. Supply of meals **to an individual**.

   The Commonwealth Minister for Aged Care has made a determination under section 38-30(4) (Community Care) of the GST Act that charges for the supply of meals are GST-free.

1. Supply of meals **to a "Meals on Wheels" organisation**. (See also page 3.52)

   Supply of Meals on Wheels is GST free if:

   - the provisions of section 38-250 (nominal consideration etc.) of the GST Act are satisfied.

ie.
- the charge is less than 50% of the GST inclusive market value of the supply; or
- the charge is less than 75% of the cost to the supplier of providing the meal.

NB. Further details are contained in section 3.3 (pages 22 to 24) of the "NSW Health - Finance and Commercial Services - Tax Reform - GST Manual" which is available on the NSW Health Intranet.

If section 38-250 is not satisfied then the provision of meals to a Meals on Wheels Organisation is a taxable supply.

Area Health Services are to review the current rates of charge for Meals on Wheels in accordance with the above advice and the Treasury circular.

- **Ambulance Services** are GST free under section 38-10 of the GST Act in all cases where a person is transported as part of their treatment eg primary responses and inter hospital transports.

  Provision of an Ambulance Service presence at events conducted by organisations (eg sporting events) are a taxable supply and current rates should be grossed up in accordance with the Treasury Circular. Where it is necessary to transport a person as part of their treatment at such an event) the transport is GST free.

Freedom of Information (FOI) requests

It is now confirmed that a Division 81 Determination has been approved in relation to FOI requests which renders fees/charges for these reports 'out of scope' of the GST. Accordingly the Department's advice of 10 July 2000 not to gross up FOI rates for GST or provide 1/11th of FOI payments to the ATO is confirmed.

Health Records required to be produced by Subpoena

The Attorney General's Department has been granted a Division 81 Determination in respect of documents required to be produced by subpoena which renders these fees 'out of scope' of the GST. Accordingly the rates at column A (GST exclusive) of the Department's letter of 10 July 2000 are to apply in relation to Health Records required to be produced by Subpoena retrospectively from l July 2000.

Should you have any enquiries concerning this matter they may be directed to Trevor Smith on (02) 9391 9158.

Attachment 1

DEPARTMENT OF HEALTH FEES AND CHARGES as at 30 JUNE 2000

TITLE	Current Fee /Charge	Effective date of last increase /review	Notification Circular No.	Notification Govt. Gazette No.	Goods and Services Tax Status
PUBLIC HEALTH ACT 1997 - REGULATION					Out of Scope - Division 81 Determination
CREMATION CERTIFICATES	$60.00	01-Jan-97	97/3 13/01/97		
CREMATORY EQUIPMENT					
56(A)(1)	$455.00	01-Sep-99	99/77	GG 100	
56(A)(2)	$230.00	01-Sep-99	10/09/99	27/08/99	
EXHUMATION FEES	$250.00	01-Sep-99	ditto	ditto	
57(2)(c)					
WARM WATER SYSTEM INSTALLATION FEE	$118.00	01-Sep-99	ditto	ditto	
62(2)					
REGULATED SYSTEM OPER./MAINT. MANUAL FEE	$115.00	01-Sep-99	ditto	ditto	
64(5)					
WARM WATER/WATER COOLING SYSTEM DISINFECTION PROCESS FEE	$1,168.00	01-Sep-99	ditto	ditto	
66(2)					
WATER COOLING SYSTEM MAINTENANCE FEE	$115.00	01-Sep-99	ditto	ditto	
76(2)					
POISONS AND THERAPEUTIC GOODS ACT 1966 -					Out of Scope - Division 81Determination
13(7)(a); 14)	$90.00	30-Sep-97			
14(2)(a); 14A(1)(a)	$45.00	30-Sep-97			
14(2)(b); 14A(1)(b)	$406.00	30-Sep-97	N/A	GG 101	
14(4)(a); 14B(2)(a)	$10.00	30-Sep-97		17/09/97	
14(4)(b); 14B(2)(b)	$200.00	30-Sep-97			
14(4)(c); 14B(2)(c)	$48.00	30-Sep-97			
14(4)(d); 14B(2)(d)	$45.00	30-Sep-97			
14 A(3)(a); 14 5(a)	$300.00	30-Sep-97			
14 A(3)(b); 14 5(b)					
PUBLIC HOSPITAL ACCOMMODATION CHARGES					
PRIVATE PATIENTS	Various	07-Jul-99	99/66 of 19/7/99	GG. 78 7/07/99	GST-free (section 38-32) except for taxable services eg. Cosmetic surgery not covered by Medicare.
INELIGIBLE PATIENTS	Various	07-Jul-99	ditto	ditto	
[illegible]	Various	01-Jul-99	ditto	ditto	
COMPENSIBLE PATIENTS					
Other Compensable	Various	07-Jul-99	ditto	ditto	
Motor Accident (Bulk Billing)	Various	01-Jul-99			
Workers Compensation	Various	01-Jul-99	ditto	W/C Act	
PHARMACEUTICAL SCRIPT CHARGES	Various	01-Jan-00	2000/4 24/01/00	GG. 32 3/03/00	GST-free (section 38-10)
PENSION BASED FEES					GST-free (section 38-30, 38-35)
NURSING HOME TYPE PATIENTS					
Hospital Doctor	$28.05	20-Mar-00	2000/28	Narrative	
Doctor of choice	$104.38	20-Mar-00	27/03/00	Form	
STATE GOVERNMENT RESIDENTIAL AGED CARE SERVICES					
ie. State Nursing Homes					
Standard pensioner contribution	$23.84	20-Mar-00	2000/28	Narrative	
Standard non-pensioner contribution	$38.21	20-Mar-00	27/03/00	Form	
RESIDENTIAL SERVICES NOT SUBJECT TO AGED CARE ACT					
eg. CADE Units					
Standard pensioner contribution	$28.05	20-Mar-00	2000/28	Narrative	
Standard non-pensioner contribution	$28.05	20-Mar-00	27/03/00	Form	
PSYCHIATRIC INSTITUTIONS					
Standard Rate	$24.05	20-Mar-00	2000/28	Narrative	
Partnered Rate	$30.78	20-Mar-00	27/03/00	Form	
FEES - VISITING OPTHALMOLOGISTS					GST-free (section 38-30)
Cataract/Implant Operations	$818.00	01-Oct-99	99/106 23/12/99	N/A	
CADAVER DONOR NEPHRECTOMY	$693.00	01-Nov-99	Individual letters		GST-free (section 38-30)
AMBULANCE - TRANSPORT FEES - HELICOPTERS	Various	13-Jul-98		107-13/7/98 114-29/7/98	GST-free (section 38-10) NB except for provision of Ambulance Service at events conducted by organisations

CLINICAL TRAINING GRANTS FOR POSTGRADUATE YEAR ONE AND TWO MEDICAL OFFICERS (PD2005_259)

PDThe purpose of the Circular is to advise Area Health Services, public hospitals receiving Clinical Training Grants and Directors of Clinical Services of changes in funding and reporting arrangements for clinical training grants for postgraduate year one and two medical officers. The following changes become effective with the issuing of this Circular.

1. NSW Health Department provides identified funding on an annual basis for the education, training and supervision of Postgraduate Year 1 and 2 Medical Officers within the primary allocation and secondment networks in NSW.
2. The Postgraduate Medical Council of NSW is responsible for overseeing the distribution of grants to the Directors of Clinical Training in eligible network hospitals.
3. Clinical grant funding is a subsidy only and it is expected that hospitals with Postgraduate Year 1 and 2 doctors will contribute funding (direct and in kind) to support Directors of Clinical Training in the education of and advocacy for junior doctors at their hospital.
4. The distribution of clinical grants is based on the following principles:
   - The funding formula will fit the budget
   - Each eligible hospital will receive a minimum amount for fixed costs
   - There will be no differentiation between rural and metropolitan hospitals for the purposes of funding
   - Primary allocation centres will receive a minimum loading
   - A weighted formula will be based on number of postgraduate year 1 and 2 doctors per hospital in the following groupings:

     Five or less
     Six to fifteen
     Sixteen to twenty five
     Twenty-six to thirty
     More than thirty
5. Grants are to be used predominantly to enable Directors of Clinical Training to promote education and supervision of JMOs within their hospital, rather than salary supplementation. This may include (but is not limited to): conducting educational activities; establishing or improving educational resources and activities; and establishing or improving educational resources for clinical teachers.
6. Funding may also be used to support the DCT in co-ordinating these activities. This may include (but is not limited to) secretarial support for the DCT. The funding must not be used for general secretarial or administrative support, or for duties normally provided or undertaken by Medical Administration.
7. It is expected that Area Health Services will contribute to a salary loading or backfilling for the Director of Clinical Training commensurate with the average number of hours that it takes to perform the role.
8. The Clinical Training Grant will be paid annually at or near the beginning of the clinical year. The monies allocated by the Postgraduate Medical Council of NSW will be paid to the Director of Clinical Training's Area Health Service or Hospital.
9. The Area or Hospital finance department will hold the funds in a general fund reserve account entitled "Director of Clinical Training Grants". A specified cost centre is to be established that limits use of the funds to cover the expenses specified by the Director of Clinical Training. The Director of Clinical Training will be appointed cost centre manager.

10. Approval and payment of expenditure is to be consistent with the Area/Hospital's finance department policy and procedure. Area Health Services or hospitals will ensure delegations include provision for Directors of Clinical Training to expend clinical grant funding.

11. Where there is a dispute between the Director of Clinical Training and hospital administration in relation to the expenditure of the grant, the matter should be referred to the Area Health Service and to the Executive of the Postgraduate Medical Council.

12. The Director of Clinical Training will provide Council with an annual Expenditure Report based on the previous financial year by the end of September. The manager of the finance department of the Area/hospital is required to sign the completed Report. The Report must include a copy of the cost centre summary reports.

13. The Postgraduate Medical Council is to report on Clinical Grant expenditure to NSW Health by December of the same year.

14. The Area Health Service/hospital must carry forward unexpended funds from year to year.

15. Directors of Clinical Training are to provide expenditure proposals to the Area Health Service/hospital and Council if funds are to be rolled over for more than one financial year. Failure to provide this proposal may result in suspension of funding.

For detail on clinical grants allocation and reporting, please contact:

Executive Officer
Postgraduate Medical Council of NSW
Phone: 02 8877 0111
Fax: 02 9816 0250
Email: pmc@doh.health.nsw.gov.au

HEALTH OWNED ACCOMMODATION – REQUESTS FROM EXTERNAL ORGANISATIONS – CONSIDERATION OF RENTAL/MARKET RENTAL ASSISTANCE GRANT (PD2010_038)

PURPOSE

Government policy requires that market values be realised on the sale or lease (rental) of government assets. This means that if a non-controlled NSW Health entity is using a NSW Health building it must be charged market rent for that building. This policy allows for Non Government Organisation's (NGO's) a transitional arrangement. Previously Treasury approval was required if less than market value was to be charged. Where appropriate, NSW Health may consider making accommodation available for use by community/non government organisations or private entities where their services contribute to the provision of health services and programs consistent with the Government's public health priorities.

This policy directive must be read in conjunction with Policy Directive PD2009_061 and includes reference to market rental assistance grants and the issues/steps to be addressed if external organisations need assistance in paying market rental for Health owned accommodation.

MANDATORY REQUIREMENTS

Approaches or applications from non government organisation (NGO) and not for profit (NFP) charitable or philanthropic organisations for Health accommodation assistance should be considered in terms of the Department's Policy Directive PD2009_061 – Accommodation – Health Owned – Requests from External Organisations.

All Health accommodation is to be provided at market rental, in accordance with government policy, with parallel consideration as to the merit of a market rental assistance grant or rental offset due to capital improvements carried out (or proposed) to the original asset, by the organisation.

NGO's and other charitable or philanthropic organisations (providing not for profit health services) occupying or proposing to occupy Health properties, may be eligible for market rental assistance grants and this addendum sets out the issues that should be addressed, approvals that are required, and details the transactions that are necessary to implement these grants.

IMPLEMENTATION

Eligibility for a market rental assistance grant is to be judged on the merit of the services provided by the organisation to NSW Health and the overall contribution to Health outcomes. Any grant to an organisation would be limited to the difference between the rent afforded by the organisation (as negotiated between the parties) and the market rent.

All requests for market rental assistance grants are to be referred to the Chief Procurement Officer for evaluation from a property perspective, and to recommend/coordinate the approval for the grant.

Where the NGO or NFP charitable or philanthropic organisations are considered to be eligible for a market rental assistance grant, the recommendation for the grant will be referred to the Chief Financial Officer for approval under Delegation 7.27 or, if the organisation is ineligible for a grant the matter may be referred to the Treasurer or the Minister (depending on the circumstances for each case) for consideration and approval.

Market rental assistance grant transactions are to be implemented by a physical transfer of cash, facilitated by a reciprocal clause inserted into both the lease agreement and the funding agreement.

BACKGROUND

About this document

This document should be read and considered in conjunction with Policy Directive PD2009_061 titled "Accommodation – Health Owned – Requests from External Organisations". The Health Minister has provided delegation for market rental assistance grants to be provided by NSW Health in limited circumstances to assist non government organisations and not for profit charitable or philanthropic organisations to pay market rental.

This document includes reference to market rental assistance grants and the issues/steps to be addressed if external organisations need assistance in paying market rental for Health owned accommodation.

Reference

- Treasurer's Directive 469.01
- Delegation F105 Page 7.27 of the Department of Health Combined Administrative Financial Staff Delegations Manual
- Web link - Policy Directive PD2009_061 *Accommodation - Health Owned - Requests from External Organisations* *http://www.health.nsw.gov.au/policies/pd/2009/PD2009_061.html*

KEY ISSUES

1. Approaches or applications from non government organisation (NGO) and not for profit (NFP) charitable or philanthropic organisations for Health accommodation assistance should be considered in terms of the Department's Policy Directive PD2009_061 – Accommodation – Health Owned – Requests from External Organisations.

2. All Health accommodation is to be provided at market rental, in accordance with government policy, with parallel consideration as to the merit of a market rental assistance grant or rental offset due to capital improvements carried out (or proposed) to the original asset, by the organisation.

3. All proposals to lease out Health accommodation to organisations at less than market rental must be referred to the Chief Procurement Officer (CPO), Strategic Procurement & Business Development for approval and/or coordination of any other relevant approvals. Also, any proposal to enter into or extend a lease beyond an initial three year period with a three year option i.e. six years total period, should be referred to the CPO for approval.

4. If an organisation does not have the financial capacity to pay full market rental and is considered to be eligible for a market rental assistance grant, negotiations should be undertaken with the organisation to reach an agreement in principle that they pay a rent that they can afford to pay plus annual rent increases such as CPI for each year of the lease, subject to approval being given to a market rental assistance grant to cover the difference between the rent afforded and the market rent (to be assessed by a valuer or licensed real estate agent).

5. Eligibility for a market rental assistance grant is to be judged on the merit of the services provided by the organisation to NSW Health and the overall contribution to Health outcomes. All requests for market rental assistance grants are to be referred to the CPO for evaluation from a property perspective, and to recommend/coordinate the approval for the grant.

6. Where the NGO or NFP charitable or philanthropic organisations are considered eligible for a market rental assistance grant, the grant will then be referred to the Chief Financial Officer for approval under Delegation 7.27.

7. Where the NGO/NFP organisations are ineligible for a market rental assistance grant, the matter may be referred to the Treasurer or the Minister (depending on the circumstances for each case) for consideration and approval.

MARKET RENTAL ASSISTANCE GRANT TRANSACTIONS

1. The Area's/Department's financial records are to recognise the full value of the grant as a grant expense.

2. Rental received is to be recognised as revenue.

3. The grant offered should be offset fully by the rental to be paid by the NGO/NFP charitable organisation

4. Transactions should be accompanied by a physical transfer of cash. Compliance with the transactional requirement could be facilitated by a reciprocal clause inserted into both the lease agreement (for the lease of the land/premises) and the funding agreement (for the market rental assistance grant).

5. The payment of the rent assistance grant and collection of the rent should be arranged as soon as practicable after 1 July each year and prior to the date the annual rent falls due under the lease (as rent is payable in advance). Arrangements should be made for an exchange of funds on the same day. Where part of the rent is to be paid from the Lessee's own funds, the proposed exchange date should be arranged by giving the Lessee at least 14 days notice.

6. If the annual rent is subject to review during the year and cannot be determined as at 1 July e.g. CPI review during the year, the annual rent should be the existing rent as at 1 July and any increase from such rent review should be adjusted in the following years annual rental.

SECTION FOUR

ACCOUNTING FOR PURCHASES AND PAYMENTS

AUTHORITY TO INCUR EXPENDITURE

PROCUREMENT POLICY

ORDERING PROCEDURES

PREPARATION OF ACCOUNTS FOR PAYMENT

AUTHORITY TO PAY ACCOUNTS

PAYMENT OF MONEYS

CHEQUE OPENING

CHEQUE SIGNING MACHINES

DIRECT LODGEMENT OF SALARIES/WAGES

ACCOUNTING FOR EXPENDITURE

FRANKING MACHINES AND POSTAGE STAMPS

SES AND OTHER OFFICERS - VARIOUS ENTITLEMENTS

PAYMENT OF INCOME TAX DEDUCTIONS

FRINGE BENEFITS TAX

TAXATION ALLOWANCES

PRESCRIBED PAYMENTS SCHEME

CREDIT/PROCUREMENT CARDS AND BANK GUARANTEES

PAYMENTS TO VISITING MEDICAL OFFICERS

GST TREATMENT OF RIGHTS OF PRIVATE PRACTICE

TREATMENT OF SALARIED MEDICAL PRACTITIONERS IN PRIVATE PRACTICE GROUPS WHO ARE NOT IN PARTNERSHIP

CIRCULAR TO PUBLIC HEALTH ORGANISATIONS ON APPROVED LEVEL OF ACTUAL ACCOUNTING COSTS FOR LEVEL 2-5 SMP PARTNERSHIPS

SALARIED SENIOR PRACTITIONERS' (SMPS) PRIVATE PRACTICE ARRANGEMENTS: REIMBURSEMENT FROM PRIVATE PATIENT REVENUE OF MEDICAL INDEMNITY INSURANCE PAYMENTS MADE BY LEVEL 2 TO 5 SMPS FOR FINANCIAL YEAR 2003-2004

NATIONAL BLOOD AUTHORITY – ACCOUNTABILITY FOR BLOOD AND BLOOD PRODUCTS IN NSW

BUSINESS ACTIVITY STATEMENT PROCEDURES – NSW HEALTH STANDARDS

VISITING MEDICAL OFFICER TAXATION & SUPERANNUATION ADMINISTRATION

AUTHORITY TO INCUR EXPENDITURE

The Board of a public health organisation or Chief Executive of an area health service or Royal Alexandra Hospital for Children or such other senior staff as the Chief Executive may designate authority to:

(i) engage staff; and
(ii) acquire goods and services and equipment,

for the conduct of the affairs of the health organisation.

Expenditure shall only be committed or incurred by any person, within the limits of a delegation in writing conferred on that person by the Board or Chief Executive of an area health service/Royal Alexandra Hospital for Children.

A person who commits or incurs expenditure shall be responsible to exercise due economy and to ensure that funds are available for the purpose of that expenditure before any commitment is incurred.

A health organisation shall maintain a Manual of Delegations to record details of delegations of responsibility and authority. All delegation approvals are to be recorded in the Board meeting minutes with a separate file being maintained for approvals.

As a general rule an officer/employee is not to approve a matter that is self-related, e.g. travel, expenses, overtime, petty cash etc. or to have an officer/employee who is subordinate to them approve such self-related matters. An officer/employee who exercises a delegation of authority should not approve a matter that is for an officer/employee for whom the delegated officer/employee has no responsibility.

The Chief Executive of a health organisation shall ensure that the Manual of Delegations is kept up-to-date and that each delegate is adequately informed of the respective delegation.

Expenditure for the purchase of land or buildings or the erection of new buildings shall not be incurred unless the proposal for expenditure is submitted for the prior written approval of the Minister for Health or his delegate.

Overseas Travel

Expenditure from the General Fund relevant to visits overseas by staff or a member of the Board of a health organisation shall not be incurred without the prior written approval of the Minister through the Director-General. Expenditure from the General Fund may be approved by the Chief Executive Officer of a health service where a Staff/Senior Staff Specialist travels overseas for TESL purposes in accordance with the Determination. (PD2015_019)

Where expenditure is from a Special Purposes and Trust Fund, or only official travel is requested or travel is part of a sponsorship, overseas travel can be approved by the Director-General, the Deputy Directors-General, the General Manager of Corporate Services, or the Chief Executive Officers of Health Services and the Ambulance Service of NSW, or the Chief Executive Officers of the Royal Alexandra Hospital for Children and the Corrections Health Service. Where expenditure is via a sponsorship authorising officers should ensure that no conflict of interest exists. (PD2015_019)

Expenditure in this context shall include travelling and living expenses and registration fees. Official visits shall include conferences and seminars of professional bodies.

An applicant seeking approval for official overseas or domestic travel is to declare/disclose all private funding, whether provided before or after a claim is made on the health organisation, which may affect any claim on the health organisation for salaries and wages, leave, subsistence or travel costs.

PROCUREMENT POLICY

Goods and services other than those of a minor nature shall be obtained at the lowest possible price, consistent with quality, provided that:

(a) items available under contracts arranged by the State Contracts Control Board shall be obtained through those sources. The prior written approval of the Director-General, Department of Health, NSW, shall be obtained for a departure from this policy. (See provisions in the Purchasing & Supply Manual for country hospitals purchasing items under $1,000 from other than contractors.)

(b) items obtained from sources other than those mentioned in (a) above shall be obtained at the best possible prices and in accordance with the provisions in respect of "out of contract" items incorporated in the Purchasing and Supply Manual issued by the Department of Health, NSW.

(c) nothing contained in (a) or (b) above shall preclude the acquisition of goods or services required urgently to meet a specific emergency from the nearest available source.

(d) non-current assets shall only be acquired by a public health organisation, irrespective of the source of funding involved, with the express approval of the Board (or delegate) or Chief Executive of an area health service/Royal Alexandra Hospital for Children (or delegate) who shall, in making the decision to purchase, take into account amongst other things, the effect on future operating costs and the availability of funding. See specific requirements re procurement of equipment from SP&T funds on page 6.11.

NOTE: For the purposes of this clause, purchases of a minor nature (e.g. petty cash purchases) shall comprise items where the smallness of quantity and differences in price do not justify purchase as in (a) and (b) above.

A health organisation shall comply with the provisions of the Purchasing and Supply Manual (including those relating to the purchase, use and disposal of motor vehicles, and with the Premier's Passenger Motor Vehicle Conditions) and the Government Purchasing Policy and the provisions of the Building and Equipment Manual, issued by the Department of Health, NSW.

A health organisation shall engage the services of a consultant on the basis of the terms and conditions laid down by the Director-General and incorporated in the Purchasing & Supply Manual issued by the Department of Health.

ORDERING GOODS, SERVICES AND OTHER ITEMS

Goods and services for a health organisation shall be:

(1) ordered on its official order form;
(2) authorised by the Chief Executive (or delegate); and
(3) correctly recorded in the Commitments Register.

Orders for drugs of addiction specified under the ***Poisons and Therapeutic Goods Act 1966***, and its regulations shall be authorised only by a person authorised in terms of that Act. In the case of a health organisation this would be a pharmacist. Orders for drugs of addiction are to be countersigned by the Director of Pharmacy or his or her nominee in health organisations with a number of pharmacists and by the Director of Medical Services in small public health organisations without a pharmacy department.

In computer generated order systems or where hard copy orders are not generated, e.g. EDI, controls are to be in place to safeguard the integrity of all orders raised and that all orders are properly authorised.

In respect of periodic service payments, e.g. gas, electricity etc. where individual orders are not raised, a standing order or register of payments is to be maintained as a control against double payment.

A Chief Executive Officer shall ensure that all order forms are properly controlled and safeguarded, available only to persons authorised to have access to them and used only for the purchase of goods and services for the health organisation.

Commitments registers are to be maintained in respect of all goods or services to ensure that costs incurred as a result of the placement of an official order are accounted for.

Other than for items purchased through petty cash goods and services shall only be requisitioned on an official order and appropriate entries shall be made in the Commitments Register (refer Section One of this Manual).

PREPARATION OF ACCOUNTS FOR PAYMENT

(a) Claims for Payment

An account payable from either Fund shall be so recorded that it is readily identifiable with an entry in the accounting records of a health organisation.

The delegate of a CE shall the check and authorise functions for accounts payable to appropriate officers of the health organisation.

A claim for payment shall be checked against the official order and attached to the payment copy of that order (or a copy where an order is supplied in part), supported by appropriate documentation (including a copy of quotations or schedule of quotes, invoices etc.) and checked by an appropriate checking officer who shall confirm in writing the correctness of the claim in respect of:

(i) the performance of service (including copy of delivery dockets where available);
(ii) the consistency in quality, quantity and price with the official order;
(iii) the calculations shown on the supplier's claim;
(iv) that available discounts have been taken and Sales Tax is not being paid; and
(v) the claim is not a double payment.

A record should be made on the order which is supplied in part, to indicate the goods supplied and clearly show what goods are yet to be supplied.

There are to be no general creditors over 45 days as at the end of any month.

An authorising officer shall not authorise an account for payment unless the expenditure has been approved by an officer authorised to commit or incur expenditure.

An authorising officer who is senior to the checking officer shall ensure that all prescribed checks have been made in respect of each account payable before it is authorised for payment.

Except where it is not possible in a small health organisation, checking and authorising officers should be employees whose duties do not involve purchasing, certifying receipt of goods and services and mailing of cheques in respect of accounts payable.

Each invoice presented with the claim for payment shall be clearly marked PAID to ensure that it is not presented for payment again and adequate checks should be made to ensure that the claim has not been previously paid.

Periodic payments for electricity, gas, rates etc., should be supported by an official order or covered by an adequate control to ensure that such payments are only paid once.

(b) Salaries and Wages

A health organisation shall maintain appropriate records showing:

(a) the name of each employee, date of appointment, classification, conditions of employment, tax file number, wage rate and any variations, together with the authority for each of these, and an adequately verified previous work record;

(b) earnings, any authorised deductions, and net payments in respect of each employee;

(c) superannuation payments made on behalf of an employee and any amounts recovered in respect of those payments.

Time sheets or other suitable records shall be maintained in respect of each employee in accordance with the requirements of the ***Industrial Relations Act 1991***.

Wages sheets for a manual payroll system or computer input documents for a computerised payroll system shall be compiled, checked and signed as correct by a responsible officer.

The delegate of a Chief Executive (not below the position of Chief Clerk and independent of the actual preparation of the payroll) shall scrutinise the wages sheets for a manual system, or the payroll journal and the edit report for a computerised system, to ensure that payment is in order; and certify that these records are correct.

All wages sheets/computerised payroll journals shall be numbered, filed consecutively or otherwise appropriately identified, and so filed so that they are readily identifiable with the relevant entries in the accounting and wages records.

(c) Leave Records

A health organisation shall maintain an up-to-date record in respect of each employee showing annual, sick and other leave entitlements, including amounts taken and the untaken balances.

AUTHORITY TO PAY ACCOUNTS

At the end of each accounting cycle **a health organisation having an internal auditor** shall prepare, for submission to the Finance Committee, a report in respect of the financial operations for that cycle as required by the Accounts & Audit Determination.

The Director of Finance (or equivalent) shall include with that report a schedule showing separate figures for:

- total payments for the General Fund;
- total expenditure for the Special Purposes and Trust Fund;

and shall provide a certificate on the schedule in the following terms:

"I certify that the payments and expenditure on this schedule have been checked and are fully supported by vouchers and invoices which have been duly certified as to receipt of goods and rendition of services and as to prices, rates, computations and additions and the amounts as shown thereon have been correctly paid by the health organisation."

The Finance Committee may request the provision of the vouchers and invoices, or a sample of them, for review.

At each meeting of the Finance Committee the authorisation of the total payments on the schedule shall be confirmed by the Committee.

PAYMENT OF MONEYS

A Chief Executive shall ensure that appropriate procedures apply in respect of the control and use of stationery, cheques and other facilities used for the payment of the funds of the health organisation.

Where practicable, the cheque signing officer should be independent of officers involved in voucher preparation, voucher authorisation and cheque preparation.

Each cheque drawn on the funds of a health organisation shall be signed by two signatories who shall not be in a position below the level of a chief clerk, in compliance with the directions of an authority granted by the CE for area health service and Royal Alexandra Hospital for Children, only after the signatory (or the person applying an authorised impression of a signature) has established:

(i) that the amount of the cheque agrees with the amount payable in accordance with its supporting documentation; and

(ii) that it is properly drawn to the payee nominated on the cheque; and

(iii) that the cheque number is adequately recorded on the supporting documentation or can be readily obtained in respect of each invoice paid by accessing the processing system of the health organisation.

In the event that an authorised signatory is not available, the Chief Executive Officer shall arrange authority for members of the Board to sign a cheque in lieu of the usual authorised signatory.

A health organisation shall ensure that cheques are despatched to payees independently of officers involved in preparation and processing of accounts for payment. In small health organisations where this is not practicable, appropriate controls based on a maximum segregation of duties should be applied.

A health organisation shall obtain an acquittance for any disbursement made other than by a "not negotiable" cheque and the acquittance shall be retained for audit purposes for at least six years after the date of payment.

A petty cash limit for any purchase shall not exceed $250 (A&AD clause 7.36), all petty cash claims are to be supported by receipts where possible. All other payments other than approved electronic funds transfers shall be made by cheque. Adequate controls shall be applied in respect of electronic funds transfers to ensure that each transfer is correctly authorised and paid to the correct payee.

A health organisation shall arrange that its supplies of cheque forms are printed with the crossing "not negotiable".

Cheques produced by typewriters shall not be altered using typewriter correctable carbon film ribbon of the type used in conjunction with the adhesive lift-off tape erasure system. Handwritten cheques shall not be prepared or signed using erasable ink type pens.

All alterations on cheques must bear the full signature of the cheque signatories. Where alterations are required to both amounts shown on a cheque, a new cheque should be issued and the old cheque cancelled.

Where cheques with one printed or impressed and one handwritten signature are used, the following controls shall be observed:

- The cheque signing officer shall not have custody of the blank cheque forms.
- The cheque signing officer shall be denied access to the blank cheque forms.
- The facsimile signature plate used in impressing signatures on cheques, shall at all times be held securely by the designated custodian.

Any proposal to dispense with manuscript signature on cheques (e.g. when using printed (lithograph) signature only, impressed signatures only or both printed and impressed signatures) shall be submitted to the Chief Executive Officer as appropriate, for approval before such a proposal is implemented.

Cheques bearing the printed signature of an officer who has ceased duty with the public health organisation or associated organisation shall be withdrawn from use promptly.

A health organisation having a pending resignation, retirement, transfer etc., of an officer whose printed signature appears on a cheque form, should make urgent arrangements with the printer for the blocking-out of the officer's printed signature on the unused cheque forms and for over-printing of a new signature.

A quantity of cheque forms sufficient for use during the period required by the printer for completion of the work of overprinting shall be retained.

Any changes in cheque signatures, including printed or lithograph signatures shall be referred promptly to the branch of the bank where the account is operated.

Where death or some other occurrence precludes advance arrangements being made for overprinting, and the number of cheques issued is considered to be too great for a temporary reversion to manual signatures, the matter shall be referred to the bank promptly.

CHEQUE OPENING

A cheque shall not be opened (i.e. made payable to the bearer in cash) except in exceptional circumstances and only at the request of the payee who has established his/her identity and has first endorsed the cheque. The reason for opening a cheque shall be entered in a Register of Cheques Opened and be signed by the cheque signatories who opened the cheque. An acquittance shall be obtained from the payee for all such payments.

CHEQUE SIGNING MACHINES

The use of cheque signing machines must be approved by the Chief Executive Officer and are subject to the following general conditions:

- A cheque signing machine must be of a make and model approved by the Board of Directors (or the Department in the case of a hospital not under the control of an area health service).

- When a batch of cheques is to be imprinted, the delegated officer shall note the Control Register (see sample folio Appendix A to this section) with the cheque numbers of the first and last cheque within the batch, and the number of spoiled cheques in the batch. These entries are to be verified by the machine operator. The net number of cheques issued and the number shown on the machine meter are then to be noted in the register.

- The machine operator on completion of the batch, completes the relevant entries within the register. In the event of any discrepancy in the totals shown, an explanation is entered in the "Details" column and any spoiled cheques temporarily enclosed within the register.

- After completion of all operations the signature plates and the keys are returned for safekeeping to their respective custodians.

- The register is returned for safekeeping to the delegated officer who verifies the meter reading and any discrepancies and then initials the register and retains any spoiled cheques for audit purposes.

- The internal auditor shall include a check of observance of the abovementioned conditions in the audit of the health organisation.

- The machine's facsimile signature plates may only be engraved with the names of the hospital's authorised cheque signatories.

- When not being used by the machine operator, the signature plate compartment key and the facsimile signature plates must be secured in the custody of a delegated officer, not below the level of Chief Clerk.

- When not being used by the machine operator, the master key (used to restore power in the event of a jammed mechanism) and the operator's key (which activates the machine) must be in the secured custody of some other delegated officer, not below the level of Chief Clerk.

- The duplicate set of keys supplied with the machine is to be held by the Chief Executive Officer, or the hospital's bankers for safe keeping.

- Blank cheque forms must be adequately safeguarded by an officer other than the machine operator.

- Except where it is impracticable, due to the small number of employees in a health organisation, the machine operator should not be involved in the preparation and approval of vouchers, or be a cheque signatory.

LODGEMENTS OF SALARY AND WAGES PAYMENTS INTO EMPLOYEES' BANK ACCOUNTS

In making lodgements to the credit of employees' bank accounts the following procedure shall be followed:

- Cheques covering a single credit shall be crossed "Not Negotiable" and be drawn in favour of the bank for credit of a specific account or order, i.e. "Pay ..... Bank for credit of John Smith or order".

- Cheques covering a number of credits shall be drawn in favour of the bank or order, crossed "Not Negotiable" and accompanied by a schedule (and if necessary, deposit slips) showing the name and amount of each credit (for computerised systems, magnetic tape medium may also be used for this purpose). The schedule shall be signed by the cheque signing and countersigning officers.

ACCOUNTING FOR EXPENDITURE

General Ledger

The Accounts & Audit Determination requires that a general ledger in an appropriate form be kept in respect of each Fund, based on the Chart of Accounts.

Ledgers are to be maintained on a full accrual basis.

Subsidiary ledgers are maintained, where appropriate, with a control account which is reconciled with the General Ledger account.

A trial balance shall be extracted and proved at the end of each month, and retained until the external audit for the year has been completed.

Subsidiary Ledgers

Where a manual system is employed the following subsidiary ledgers should be maintained:

- Debtors for Patients' Fees by Classification.
- Employees' Earnings.
- Capital Works
- Creditors

Patients' Fees

A control account is maintained in respect of each subsidiary ledger and the subsidiary accounts should be listed periodically and balanced with the control account.

Debtors for Patients' Fees should be balanced monthly. The control accounts should be agreed with the corresponding accounts in the general ledger.

Postings to the control accounts in the subsidiary ledger are made from the Patients' Fees Invoices/Fees Journals for Inpatient Fees and for Non-inpatient fees, and from the Cash Receipts Journals.

Separate subsidiary ledgers must be maintained for:

- Inpatients by Classification.
- Non-inpatients.
- Diagnostic Fees.

Employees' Earnings

Where a payroll is prepared manually or on a mechanised system, an earning sheet is prepared in respect of each employee. The earnings sheets comprise the subsidiary ledger.

Separate subsidiary ledgers may be maintained in respect of each payroll classification to facilitate balancing.

A control account is maintained in each subsidiary ledger and should agree in balance with the corresponding Control Account in the general ledger. The earnings sheets should agree in total with the subsidiary ledger control account.

Postings are made to the subsidiary ledger control account from the Payroll Summaries. Employees earnings sheets should be balanced at least quarterly.

Where a hospital is using the HOSPAY system, a subsidiary ledger is not maintained. HOSPAY will produce, on request, an Employee Quarterly Earnings Report, detailing each employee's earnings pay by pay for the previous quarter plus the YTD earnings up to the end of the previous quarter.

The gross totals on the payroll journals should be reconciled with the control accounts in the general ledger.

Superannuation Repayments by Employees

The following accounting arrangements are to be observed for superannuation:

- Areas/Hospitals are to open a ledger account in the General Fund ledger for the payment of employee contributions for superannuation to the SSIMC. This account is to be reconciled with the invoice issued by the SSIMC each

month and any adjustment for appointment, resignation or transfers must be notified to the SSIMC on the appropriate form, where an appropriate adjustment will be made to a future invoice. The invoice is then to be paid in full unless approved by the SSIMC. Such action will involve the recognition of creditors to the extent of any amounts expensed but not yet billed or, alternatively, where accounts are rendered in excess of deductions it may be necessary to register a prepayment until superannuation accounts are subsequently adjusted.

FRANKING MACHINES AND POSTAGE STAMPS FOR OFFICIAL PURPOSES

Postage Stamps

Postage stamps are to be purchased direct from local post offices at sufficiently frequent intervals to keep stocks of stamps on hand at the lowest practical levels.

Effective internal controls with respect to the purchase and usage of postage stamps should ensure that:

- stamps purchased by cheque or on advance from petty cash are actually received and details entered in the standard postage stamp account book;

- an adequate record of stamp usage is completed.

Franking Machines

Effective internal controls must exist in respect of the use of these machines to ensure that all usage is accounted for correctly.

On each occasion that the machine is recharged and after the Post Office clerk has entered the relevant details in the meter card, the meter card together with the receipt should be presented to the Accountant for checking and the meter card initialled by the Accountant when all is agreed.

SES AND OTHER OFFICERS - VARIOUS ENTITLEMENTS

Telephone Expenses (Pr. Mem. 94/17)

All Area Chief Executive Officers and the Deputies will be entitled to be reimbursed for connection fees, full annual base rental, full cost of all official ISD and STD calls as detailed on the telephone bill in view of their requirement to:

(a) give decisions, supply information or provide emergency services; and/or

(b) be available for reasons of safety or security for contact by the public, outside normal office hours.

In respect of the percentage of local costs of calls, the above officers, if they wish to make a claim under this provision, should make a submission for consideration by the Director-General.

In respect of all other officers, delegation is given to Chief Executive Officers, Deputy Chief Executive Officers of Areas to approve of connection fees, full annual base rental, **official** ISD and STD calls as detailed on the telephone bill and a percentage of the cost of local calls nominated as official by the officer and approved by the delegate from those officers who are of the view that their official duties require the installation of a telephone in their private place of residence to:

(a) give decisions, supply information or provide emergency services; and/or

(b) be available for reasons of safety or security for contact by the public, outside normal office hours.

The telephone should be located in the officer's principal place of residence and its telephone number communicated to all persons entitled to have out of hours contact with the officer concerned.

All such approvals granted in this delegation are to be maintained in a register by the Area Health Service which is to be subject to both internal and external audit. The register should be reviewed on an annual basis by a senior officer of the Area to ensure that the register is amended as a consequence of staff movements and variations.

Out-of-Pocket Expenses (PD2005_540)

Where an officer is paid a salary and an identified expense allowance or is paid a remuneration package based on a "Total Cost to Employer" (as is the case for the Senior Executive Service) he or she is expected to cover expenditure of a minor nature associated with work and normal representational responsibilities, such as an occasional round of drinks, confectionery etc (the initial TCE levels had this factored into the rates).

The Director-General, Deputy Directors-General and General Managers in the Department and the Chief Executive Officer of an Area Health Service may approve in particular circumstances certain out-of-pocket expenses by senior officers forming a charge against the funds of the Organisation if such expenses are directly related to the performance of an officer's official duties and the costs are reasonable. Such officers are not to approve of their own expenses, with Chief Executive Officers to have any out of pocket expenses approved by DoH Chief Financial Officer or Deputy Director-General, Health System Support to approve for CEs of area health services and Royal Alexandra Hospital for Children.

Examples of out of pocket expenses include costs incurred on senior representational duties and major hospitality duties (such as entertaining a group of interstate/overseas visitors or representatives of private organisations) where there is a definite business relationship with the health Organisation and a business purpose for the expenditure. All officers are reminded of the ICAC report titled "No Free Lunches" and the policy regarding "Acceptance of Gifts or Benefits" stated in the NSW Public Health System Code of Conduct issued by the Department, and are to exercise caution in accepting any implied benefit.

Where an officer is in receipt of only a cash salary, expenses of an irregular and/or minor nature associated with work and normal representational duties may be charged against the health Organisation. **Other than in exceptional cases, such officers are required to obtain the prior approval in writing of one of the delegated officers in Part 2 above for any out of pocket expenditure of this nature.**

For out of pocket expenses incurred by officers to be acceptable as a charge against the health organisation, the following apply:

i) The event to which the charge is related must have a direct business relationship with the officer's duties.

ii) Internal working meals (including morning tea, afternoon tea and lunch) are not to be regular occurrences and would normally have relatively low charges per head and involve participation of persons from outside the organisation or with officers from across the health system. The provision of the meal must be substantiated by the scheduled times of the meeting. Expenditure on alcoholic beverages for internal working meals is not allowed. (NB Where internal working meals are paid by petty cash, NSW Health cheque or journal, the purpose of the provision of the meal is to be stipulated.)

iii) The expenditure incurred is not to provide a predominantly personal benefit to the officers, members of their family or friends or officers of organisations coming under their responsibility e.g. Christmas and Easter functions or other social functions for staff. Wreaths or flowers may be purchased for the purpose of a floral tribute to immediate families.

iv) Tips are not permissible and are a personal expense.

v) Expenditure on minor gifts of protocol or public relations are not acceptable.

vi) Receipts are to be obtained for such expenditure for substantiation. Full documentation, including the details by name of the persons present and the purpose of the expense is required.

vii) Expenditure by the health Organisation for approved out-of-pocket expenses is to be a charge against the health Organisation (i.e. General Fund).

viii) Officers may choose to use their own credit/charge card and claim reimbursement. Individual receipts under (vi) are still required and any expenses to operate the credit/charge card are not claimable.

ix) Provision of certain facilities for work purposes at home which would, under normal circumstances, be provided by the officer for personal use, may not be claimed as a legitimate expense, e.g. payment for a TV antenna which may be installed to enable officers to receive transmissions to be aware of matters raised by the media, as part of their normal duties. (Prem Circ 97-28)

In respect of out of pocket expenses only involving NSW Health employees and officers (i.e. Departmental, Area, Hospital, Ambulance Service staff and Board members), no entertainment expenses are to be charged to the health organisation but rather the cost of such is to be determined and paid by those involved. Clause 5(ii) applies for internal working meals.

Where a NSW Health employee or officer attends an official farewell or function by personal choice, the cost is to be borne by the officer. Where the attendance of the officer is at the direction of a delegated officer in Clause 2 for official purposes, the cost can be charged to the Health Organisation (NB Delegated officers cannot approve their own attendance).

Attendance at seminars and conferences is an appropriate charge to the Health Organisation providing:

- the seminar etc has benefit and relationship to the officers attending and the health system; and

- that controls are in place to ensure that the number of persons attending is not excessive recognising that public monies are involved and officers in the work environment can report back on the conference etc.

Where a NSW Health employee or official intends to entertain another NSW government official they must seek prior approval from a delegated officer in 2 that the cost can be funded by the health Organisation. In seeking approval, benefits of the meeting are to be identified and clauses 5 (iv), and (vi) are to be observed. (NB Delegated officers cannot self approve expense.)

PAYMENT OF INCOME TAX DEDUCTIONS TO THE COMMISSIONER OF TAXATION (TD 526)

In order to ensure that remittances to the Australian Taxation Office agree in total with the total of income tax deductions shown on group certificates issued by them, areas shall undertake a reconciliation, at least monthly to balance the amounts remitted to the Australian Taxation Office, with the total deducted from employees' salaries and wages in that period, as reflected in the earnings records from which the group certificates are produced.

Any discrepancy between the total of the Group Certificates and the amounts remitted to the Australian Taxation Office, which cannot be located in reasonable time without undue effort and expense, shall be adjusted in the following manner after agreement with the Australian Taxation Office as to the amount involved:

(1) Where the total of income tax deductions as per group certificates exceeds the total of the amounts paid to the Australian Taxation Office for the year in question, the difference is to be paid to the Australian Taxation Office and the amount involved charged against the appropriate salaries, wages and allowances item of the area's budget.

(2) Where the total of the amounts paid to the Australian Taxation Office for the year exceeds the total of income tax deductions as shown by group certificates, the amount of the difference is to be claimed from the Australian Taxation Office and credited to the Consolidated Fund revenue item "Repayments to Credit of Consolidated Fund Votes - Previous Years" or, where Consolidated Fund is not involved, to an appropriate area/district account.

Whilst adjustments are to be effected in the above manner, all reasonable steps shall be taken subsequently to locate and adjust discrepancies.

The attention of areas is drawn to the Australian Taxation Office's general requirement as set out in the leaflet ....."Group Instalment Deduction Procedure - Notes for Guidance of Employers".

In particular, attention is invited to the notes under the headings. Preparation of Group Certificates; Issue of Group Certificates; Group Certificate issued for an amount in excess of Instalment Deductions Made; and Reconciliation Statement.

PAYE, PPS, RPS Taxation Deductions

What Changes Apply to Large Remitters

The essential features of the rationalised payments arrangements are:

- the new arrangements apply to any amount withheld after 30 June 1998;
- each client's payment frequency will be determined by their total annual withholding liability across all PAYE, PPS and RPS roles;
- large remitters will be required to make payment of tax withheld within an average of seven days of withholding amounts from payments; and
- make payments to the Commissioner by electronic funds transfer.

Who Is a Large Remitter?

A large remitter is defined as one with a total withholding obligation of PAYE, PPS and RPS combined of over $1 million in the 1996/97 year or any later financial year. The obligations of companied within a group are combined to determine the level of remittance.

Amounts deducted from PAYE, PPS and RPS payments made on Saturday, Sunday, Monday or Tuesday are to be *paid to the ATO* by the following Monday. Amounts deducted from payments made on Wednesday, Thursday or Friday to be *paid to the ATO* by the following Thursday. Refer to table below.

Timing of Payments

Deductions Made On:	**Payment is Due on:**
Saturday, Sunday, Monday, Tuesday	Monday of next week
Wednesday, Thursday, Friday	Thursday of next week

In addition it is a requirement for payments to be made by electronic funds transfer (EFT), which will bring payment arrangements for large business more into line with modern commercial practice.

The new arrangements provide for two payments dates per week depending upon the timing of the withholding and would in most circumstances allow employers to manage their affairs so that withholding from salary and wages, for example, would fall on one regular day following their normal pay period whether weekly, fortnightly or monthly.

Public health organisations should obtain full details about taxation deductions and remittance from their local ATO.

USE OF PROCUREMENT CARDS (PCARDS) WITHIN NSW HEALTH (PD2016_005)

PD2016_005 rescinds PD2014_035

PURPOSE

This Policy Directive sets out the requirements for the use of Procurement Cards (PCards) within NSW Health. PCards are a type of credit card with features that facilitate expenditure control and are a cost effective way of purchasing high volume, low value goods and services. PCards replace the need to create purchase orders for these types of transactions.

This Policy and the attached Procedure applies to all NSW Health agencies, including the NSW Ministry of Health, and recognises that under the NSW Government Banking Contract, NSW Health agencies may determine to utilise procurement cards to facilitate efficient and effective purchasing of goods and services.

MANDATORY REQUIREMENTS

In accordance with NSW Government policy, NSW Health agencies including the NSW Ministry of Health, are to adopt the use of PCards where practicable, for purchases of goods and services that are $5,000 or less. Chief Executives have the discretion to increase this threshold for particular purchases where appropriate risk management and internal controls are in place.

NSW Health entities are not permitted to utilise or operate any PCard type arrangement other than those provided under the current NSW Government Banking Contract.
The use of PCards will improve the efficiency of the business processes associated with the procurement of goods and services including:

- Reducing the number of purchase orders generated
- Reducing the number of invoices received
- Reducing the number of cheques processed
- Reducing delays in goods delivery
- Improving the timeliness for paying suppliers for goods and services purchased.

PCards are only to be used for business related expenses and in accordance with the NSW Health Code of Conduct. All purchases of goods and services must comply with NSW Government procurement policy, NSW Health policies, procedures and manuals, Treasurer's Directions and statutory requirements, especially as they apply to purchasing goods and services under Government contract, as detailed at section 1.1 of the attached procedure.

PCards are not to be used to split purchases, negate credit limits as set out at section 2.4 of the attached procedure, or to circumvent the requirement to obtain quotes to procure goods and services in line with NSW Government procurement policy.

All NSW Health agencies must have confidence that robust purchasing guidelines and practices are in place within their agency and that an annual audit program of PCards is developed in accordance with section 1.6.4 of the attached procedure.

IMPLEMENTATION

Healthshare NSW is responsible for managing the PCard policy on behalf of NSW Health. The attached procedures outline the business rules and processes for the use of PCards in NSW Health. These procedures are to be adhered to by all NSW Health agencies.

Chief Executives are responsible for:

- Ensuring that robust purchasing guidelines and procedures are in place to support implementation of PCards within their agency and are consistent with this policy and procedure statement
- Determining which roles / employees within their agency can be issued with a PCard and ensuring that these roles / employees hold appropriate delegation and undertake relevant tasks to hold a PCard and procure goods and services on behalf of the agency
- Ensuring PCards are used in accordance with all of the conditions and requirements of this policy and procedure statement
- Developing an annual audit program of PCards in accordance with section 1.6.4 of the attached procedure.

The Chief Executive can delegate the approval to issue PCards to the agency's senior financial officer providing this officer has appropriate delegations to perform this function.

PCard holders:

- Are personally responsible and accountable for the safe keeping of the PCard
- Must not disclose the PIN to any other party
- Must not allow any other person to use the PCard
- Must take care to ensure that goods and services are procured from reputable merchants
- Must use the PCard in accordance with all statutory and policy requirements as detailed at section 1.1 of the attached procedure
- Be aware of their expenditure delegation and ensure that the PCard is used in accordance with all of the conditions and requirements of this policy and procedure statement.

1 BACKGROUND

1.1 About this document

Historically credit cards have been issued to senior NSW Health staff and used primarily for travel and expenses purposes. Procurement Cards (PCards) are designed for purchasing high volume, low value goods and services.

This document provides instructions on the use of PCards within NSW Health that is considered best practice and includes detailed information relating to the use of PCards, and the processing and reconciliation of PCard transactions via the Expense Management System (EMS).

This document is to be used in conjunction with the:

- NSW Health Policy Directive – Use of Procurement Cards within NSW Health
- NSW Health Policy Directive – Goods and Services Procurement Policy
- NSW Health Code of Conduct
- NSW Treasury Circular 11/15 and Treasurer's Directions
- NSW Procurement Board Goods and Services Procurement Policy Framework
- Section 12 of the Public Finance and Audit Act 1983.

The HealthShare NSW PCard Team manages PCards at the direction of the Director of Finance or their approved nominee for each Health Agency.

1.2 What is a PCard?

The NSW Health PCard is a Visa card issued by Westpac Banking Corporation to allow approved Health Agency employees to procure low value goods and/or services directly from suppliers and/or the payment of business related emergency travel expenses on behalf of the Health Agency to which they are employed.

All purchases must be procured in accordance with current financial delegation of authority and be 100% for business related purposes. Prior to an employee being issued with a PCard the employee must sign the Card Holder Agreement which details the card holder's responsibilities.

A virtual PCard is a Visa card issued by Westpac Banking Corporation to allow a specific vendor to charge against the virtual PCard upon receiving a request for goods and /or services from a Health Agency employee. A virtual PCard is issued to a specific Health Agency (not to a Health Agency employee), and is usually assigned to a specific vendor only.

This User Guide applies to both personal and virtual PCards.

1.3 What is an Expense Management System?

The EMS is a sophisticated expense and transaction management platform that is accessible via a specific Internet address.

Westpac automatically feeds all transactional data into the EMS via a nightly feed. The transactions are then available in the EMS the following day for acquittal and documentation by the PCard Holder and Authorising Officers.

1.4 Procurement Card Enquiries

HealthShare NSW will provide a service for resolution of card enquiries. The nature of the enquiry will depend on the level of escalation. If the query is relating to a card issue or an EMS issue, staff are to contact the PCard Support team via email:

HSNSW-PCardSupportTeam@health.nsw.gov.au or phone: 1300 883 965.

If the query relates to spending approval or budgetary concerns, employees should contact their immediate supervisor or the internal point of contact of the Health Agency.

1.5 PCard usage conditions

The NSW Health PCard can be used to purchase goods and or services that meet the criteria set out in Section 4 Acceptable Purchase Criteria.

All card transactions must be supported by a tax invoice and must be reconciled in the EMS within the period specified. Please refer to Section 1.6 Roles and Responsibilities, of this policy for conditions.

Should misuse of a PCard occur the Health Agency is responsible for the immediate suspension or cancellation of the card, and where appropriate, take disciplinary action in accordance with NSW Health's Code of Conduct and the conditions of use outlined in the Card Holder Agreement.

1.6 Roles and Responsibilities

1.6.1 PCard Holder

A PCard Holder is a NSW Health employee who has been issued with a PCard. Their name will appear on the card and they will hold an expenditure delegation conferred by the Health Agency's delegations manual.

Their responsibilities include:

- Purchase of goods and or services using their PCard, complying with the set purchasing criteria outlined in Section 4 of this document
- Recording purchases via the EMS and submission of scanned receipts/tax invoices to their direct line manager for approval within five (5) days of the transaction date
- Advising HealthShare if they have nominated a Coder to code transactions on their behalf.

1.6.2 Coder

This is a person nominated by the PCard Holder to record transactions in the EMS on their behalf. More than one card holder can be allocated to their profile.

Their responsibilities include:

- Coding and submitting scanned receipts/tax invoices to certify and validate transactions
- Submit transactions for authorisation on behalf of the designated PCard Holder
- Recording purchases via the EMS and submitting scanned receipts/tax invoices to their direct line manager for approval within five (5) days of the transaction date.

1.6.3 Authorising Officer

A Health Agency employee who is specifically appointed by the Executive of the Health Agency to independently review and approve PCard transactions within the limits of authority delegated to them. Typically, this is the card holder's direct line manager.

Their responsibilities include:

- Ensuring transactions have been properly procured in accordance with approved purchases as outlined in Section 4 of this policy
- Ensuring all transactions awaiting their authorisation are processed within five (5) days of being allocated to them for approval
- Ensuring all transactions are completely authorised before period end date - the statement cycle end date is the 25th day of each month
- Conducting periodic reviews of staff expenditure patterns and eligibility for the PCard.

1.6.4 Internal Auditor

The Health Agency's internal auditor is required to develop a system based audit of annual transactions by random selection of high and low volume of PCard users and this is to be included in the annual internal audit program. Findings of misuse, if any, are to be reported immediately to the Chief Executive of the Health Agency.

1.7 Infraction

The HealthShare PCard Support Team as part of their responsibilities will monitor and report on spend habits, coding, approval activity and frequency. Regular reports will be provided to Health Agencies.

PCard Holders, Coders and Authorising Officers have the responsibilities set out in Section 1.6 of this policy. Employees have a prescribed time frame in which they will need to complete their portion of the transaction cycle. Should they not complete their task within the time frame, an Aged Transaction report will be provided to Health Agencies by HealthShare showing the overdue tasks by staff member for their Agency. The report will be circulated to the Director of Finance, or equivalent, for review and immediate action. Due to the tight time frames for end of month reconciliation it is important that good EMS practices are embedded within Health Agencies as quickly as possible.

PCard Holders will need to comply with the Acceptable Purchase Criteria as outlined in Section 4 of this guideline. Should a staff member be identified as purchasing items outlined in the Prohibited Purchases – (Section 4.4) the Director of Finance, or equivalent, should review and ensure appropriate action taken.

Whether or not to remove a PCard from an employee is the responsibility of the Health Agency. It is expected that Health Agencies will not allow an employee to hold a PCard if they have not consistently complied with the Card Holder Agreement and business rules.

1.8 PCard Team Structure

1.8.1 PCard Services Manager

A HealthShare NSW employee who is responsible for the overall operation and maintenance of the PCard program. The position is to ensure best practices are engaged and optimum service levels are reached and maintained.

The responsibilities include:

- Coordination of the overall PCard program and delivery of the PCard Training Program to ensure efficient and effective delivery of card services
- Monitoring the compliance of the PCard program and initiating periodic reviews of card usage on behalf of the Health Agency
- Acting upon instruction of Health Agency Directors of Finance or equivalent to revoke PCard privileges where inappropriate use has been proven or the PCard is no longer justified
- Single point of contact for all escalated PCard matters for all Health Agencies
- Liaison with Westpac regarding card administration, card activity and compliance assurance
- Responsibility for the system administration of the operational EMS and for the issuance and maintenance of PCards to approved card holders on behalf of the Health Agency
- Auditing - distribution of reports on behalf of each Health Agency to assist with the maintenance and integrity of the program
- Audit reporting to assist with the enforcement of the Infraction policy
- Ensuring all related documentation is maintained and all PCard details are securely stored.

1.8.2 PCard Support Team Member

A HealthShare NSW employee who is responsible for providing support to the PCard Services Manager in the maintenance of the EMS and card holder activities.

Their responsibilities include:

- Providing assistance to the PCard Services Manager in the system administration of the EMS
- Completing tasks set out in the PCard team procedures as outlined by the PCard Services Manager.

2 CARD ADMINISTRATION

2.1 Eligibility to have a PCard

A PCard may be issued to a Health Agency employee who:

- Is responsible for purchasing low value goods and or services from suppliers on behalf of the Health Agency
- Is a permanent employee of a Health Agency
- Travels (international or domestic) on behalf of NSW Health for business related purposes directly associated to their role.

2.2 Ineligibility to have a PCard

A PCard may not be issued to staff when they are:

- Agency contractors
- External consultants
- Temporary exempt contracted staff
- PCard administrator/s (PCard Support Team Members)

2.3 How to apply for a PCard

The PCard Services Manager coordinates the issuing of PCards. The procedure to receive a PCard is as follows:

- Complete the Application for PCard form available on the HealthShare NSW intranet - http://intranet.hss.health.nsw.gov.au/procurementlogistics/procurement-pcard-card
- Seek your direct line manager's approval
- Seek approval from your Health Agency Director of Finance
- Submit your application to: HSNSW-PCardSupportTeam@health.nsw.gov.au.

Once approved, the PCard Support Team will coordinate training directly with the Health Agency.

Upon successful completion of the PCard Training Program, the employee must read, sign and return the Card Holder Agreement to the PCard Support Team. This agreement contains card holder responsibilities.

Upon receipt of the signed agreement the PCard Support Team will issue the PCard. The employee must then immediately sign the back of the PCard.

PCards that cannot be issued in person will be forwarded to the recipient by Registered Mail and the employee must acknowledge receipt of the PCard. The PCard Support Team will then organise activation of the PCard with the bank. The PCard Support Team will notify the card holder when the PCard has been activated.

2.4 Expenditure Limits

A PCard is issued to an individual employee and is not transferrable.

Each card holder is to ensure they are aware of their expenditure delegation as stated by the Delegation manual and outlined on the Card Holder Agreement. They are to make purchases limited to that authority. This limitation will mirror financial delegation in accordance with other NSW Health accounting systems.

Each PCard transaction is limited to $5,000.00 AUD (except where the Chief Executive of the Health Agency has approved a higher limit). Purchases must not be split to circumvent the limit. There are five (5) credit limit categories as outlined below:

- $500 per transaction, $5,000 per month
- $1,000 per transaction, $10,000 per month
- $3,000 per transaction, $30,000 per month
- $5,000 per transaction, $50,000 per month
- Per transaction, per month limit to be agreed in special circumstances with approval from the Chief Executive of the Health Agency.

The card holder's personal limit will be outlined on the Card Holder Agreement. Card holders will be delegated the card limit that best suits their business needs and objectives as determined by the Health Agency Director of Finance or equivalent.

Should the need arise for a limit increase or decrease; the card holder must initially contact their direct manager who will review the request. Upon approval, a PCard Maintenance Form must be completed and sent to the PCard Support Team who will begin action with the bank. The PCard Maintenance Form is available on the HealthShareNSW intranet.

A virtual PCard issued to a specific Health Agency and assigned to a specific vendor, will usually have a higher expenditure limit than PCards issued to individual staff. This higher limit would be dictated by the amount likely to be spent by the Health Agency on the specific vendor. In any case, the higher limit will require approval from the Chief Executive of the Health Agency.

2.5 Training

Training in the use of the Westpac Visa PCard and the EMS will be compulsory for all PCard Holders, Coders and Authorising Officers.

A card holder may only be issued with their PCard once they and their nominated Authorising Officer have successfully completed training, have passed their assessment & provided both assessment and PCard User Agreements to the PCard Support Team. Training will be coordinated directly with the Health Agency and will be facilitated in a face-to-face or on-line environment which will deliver the same content and outcome. Completing either of these training environments will allow employees to successfully complete the mandatory training component.

2.6 Administration of card and card holder details

PCard Holder details are retained within the EMS by the PCard Support Team. These details need to be amended when the card holder:

- Changes name, status or contact details
- Changes or transfers position (refer to Section 2.6.2)
- Has a change in their delegated authority limit
- Changes cost centre
- Has approved leave for more than one (1) month (refer to Section 2.6.3)
- Ceases employment with a Health Agency
- No longer requires a PCard
- Changes Coders or Authorising Officer or other representative.

All changes to card holder accounts must be accompanied with the appropriate form completed in full. The completed form must then be sent to the PCard Support Team:

HSNSW-PCardSupportTeam@health.nsw.gov.au from the card holder's email address.

2.6.1 Procurement Card Forms

Card holders wishing to make a change to their account must advise the PCard Support Team by completing and submitting in full the applicable form.

All forms relating to PCards are available on the HealthShare NSW intranet:
http://intranet.hss.health.nsw.gov.au/procurementlogistics/procurement-pcard-card

Supporting documentation will be requested for certain changes and if needed, the applicable form will outline the specific supporting documentation required.

2.6.2 Transferring to a new position

When a PCard Holder transfers to a new position in a different cost centre, the card holder must:

- Ensure that all transactions from the previous position are coded and submitted for authorisation within the monthly statement cycle
- All transactions have supporting Tax Invoices attached in the EMS
- Submit the completed Return Advice form to the PCard Support team.

Responsibilities in the new position

Once in the new position, the card holder must:

- If a PCard is required, the card holder and the new line manager must review the card holder's delegation limit, Coder, Authorising Officer and cost centres attached to the card
- To update changes, the Maintenance Form must be completed and submitted to the PCard Support Team
- If a PCard is not required in the new position, the card holder must complete the Return Advice form to the PCard Support team.

Transactions pending from previous position

If a PCard Holder has transactions pending from a previous position, they will need to advise the PCard Support Team that they require multiple cost centres and responsibilities for a period of time.

Once all transactions from the previous role have been coded, submitted and authorised the card holder will need to notify the PCard Support Team to remove the cost centre(s) no longer required via the Maintenance Form located on the intranet.

When a PCard Holder takes leave of more than one (1) month, their PCard will need to be suspended for the period of absence.

PCard Holders cannot allow peers or colleagues to use their PCard in their absence.

Current transactions will need to be coded and submitted for authorisation before the PCard Holder departs for leave. The PCard Holder's Coder will process any remaining transactions after the PCard Holder's departure.

The PCard Holder must:

- Submit the appropriate form to the PCard Support Team to have the card suspended for a period of time
- Process all outstanding transactions by coding, scanning supporting tax invoices and submitting for approval
- Ensure they have nominated a Coder to process any transactions remaining after their departure on leave
- Provide their nominated Coder with all supporting tax invoices (and other documentation required to support evidence of supply) for any remaining transactions that will need to be coded and submitted for approval whilst they are on leave.

2.6.4 PCard Holders no longer requiring a PCard

When a PCard Holder leaves NSW Health's employment or no longer requires a PCard, the card holder must:

- Destroy the card by cutting it into numerous pieces, in front of a witness, and return it to the PCard Support Team, located at the Service Centre Parramatta, with the Return Advice form located on the intranet
- Ensure all current transactions are coded, certified and submitted for authorisation
- Ensure there is a Coder to process any remaining transactions after their departure
- Provide their nominated representative with all supporting tax invoices for any remaining transactions that will need to be coded and submitted for approval.

2.6.5 Automatic replacement of expiring cards

When a card nears its expiry date, Westpac will automatically issue a new card. PCard Holders must ensure their contact details are accurate and up to date within the EMS.

When the card holder receives a new card they must sign the back of the card immediately and destroy the expired card.

2.6.6 Replacing a damaged card

If a PCard is damaged and a replacement card is required, card holders must submit the Lost-Stolen Form to the PCard Support Team HSNSW-PCardSupportTeam@health.nsw.gov.au.

Westpac will re-issue a replacement card with the same card number and expiry date.

2.6.7 Lost or stolen cards within Australia

In the event of loss or theft of a PCard in Australia, the card holder must:

- Immediately, regardless of time and day, notify Westpac's lost or stolen card hotline on 1300 650 107 (available 24/7) or go into any Westpac branch
- Complete the Lost Stolen Card Form available on the HealthShare intranet and submit to the PCard Support Team advising of Westpac's lodgement reference number.

Westpac, upon notification, will:

- Provide the card holder with a log reference number
- Cancel the card to prevent further use
- Issue a new PCard (with a new card number and expiry date).

2.6.8 Lost or stolen cards outside Australia

In the event of loss or theft of a PCard outside Australia, the PCard Holder must:

- Immediately notify Westpac's Lost or stolen card hotline on +61 2 9374 7082 (available 24/7)
- Westpac, via VISA International, will arrange for a temporary replacement card to be delivered within 72 hours to an address nominated by the card holder. This will be a manual card only, with no functioning magnetic strip or NSW Government design
- Upon return to Australia, the card holder must complete the applicable form and return it to the PCard Support Team at HSNSW-PCardSupportTeam@health.nsw.gov.au where a new card will be arranged for issue.

2.6.9 Account/Cost Centre Maintenance

Should the need arise to add or delete an existing Oracle account or cost centre in the EMS, you must:

- Seek formal approval from your immediate supervisor
- Submit the appropriate form (PCard Maintenance Form) to the PCard Support Team at:

  HSNSW-PCardSupportTeam@health.nsw.gov.au

The card holder will be notified by the PCard Support Team when the account or cost centre is set up and ready for use in The EMS.

CARD USAGE

3.1 Overview

PCards are issued subject to the Card Holder Application and Card Holder Agreement which is formally signed by the PCard Holder.

Any failure to comply with the conditions of this policy may result in cancellation of the card and any fraudulent activity may subsequently render the PCard Holder liable to disciplinary or legal action in accordance with the NSW Health Code of Conduct.

NSW Health bears the liability for all PCard transactions. Personal credit ratings do not apply.

3.2 PCard Security

PCard Holders are responsible for the safe keeping and proper use of their PCard and associated security information. PCards are to be secured in the same way as personal credit cards in order to prevent fraudulent use by unauthorised persons.

PCard Holders must:

- Immediately sign the back of the PCard when received.
- Not allow another person to use the card under any circumstances.
- Card details are not to be shared with any other NSW Health employee or any other person.

3.3 Acceptable PCard payment methods

The PCard can be used:

- To purchase goods and/or services to a total value of < $3,000 (or agreed value as approved by the Chief Executive).
- To purchase goods and/or services over the counter, over the telephone, by fax, by email, by post or over the internet. International internet purchases require prior arrangement with the PCard Support Team.

4 Acceptable Purchase Criteria

4.1 Acceptable purchase criteria

PCards can be used to purchase goods and/or services that meet the following criteria only:

- Must be 100% business related expense and
- Are a total value of < $5,000 (or agreed value as approved by the Chief Executive).

PCards can be used for transactions that:

- Are an emergency purchase (refer to Section 4.1.2)
- Relate to emergency travel and accommodation (refer to Section 4.5.1).

4.2 Emergency purchase definition

An emergency purchase is defined as a purchase required to:

- Protect life and property and prevent injury or harm
- Prevent substantial economic loss
- Prevent the interruption of essential services
- An unusual deadline that cannot be resolved by using the designated procurement system and process.

Failure to anticipate a purchasing need, or a lack of planning, is not considered a valid reason for an emergency purchase. Emergency purchases are not to be used to circumvent the procurement system and processes.

4.3 Circumstances where PCards cannot be used

PCards cannot be used for any transactions where:

- The cost of the transaction exceeds the card holders financial delegation
- The transaction is a prohibited purchase (refer to Section 4.4)
- The supplier does not have an ABN and is an Australian supplier
- The transaction is of a personal nature.

4.4 Prohibited purchases

PCards must not be used to purchase any of the following:

- Personal expenditure – expenses of a personal nature that benefits the PCard Account Holder and is not of a business nature
- Alcohol (except in accordance with Policy Directive PD2005_540 -c Out of Pocket Expenses)
- Supplier has no ABN (except for overseas purchases)
- Cash advances
- NSW Health fleet motor vehicle expenses – including fuel, oil, repairs, spare parts (other than in emergency situation)
- Infringements and fines (including motor vehicle infringements incurred by the driver of a NSW Health vehicle)
- Expenditure in excess of the PCard Holder’s financial delegation
- Expenditure in excess of cost centre or budget
- Personal rewards or benefits – implicit at point of purchase including frequent flyer programs, bonus point schemes or gifts designed as benefit for utilising the card
- Gratuities and/or tips – of any nature, both domestic and international
- Workers compensation payments
- On-line Advertising – including Business Directory Listings.

4.5 Travel

4.5.1 Domestic Travel Approval

All NSW Health employees must use public transport such as train, bus, ferry or light rail wherever practicable for domestic business travel. PCards can be used for this purpose.

All domestic travel bookings are to be made with CWT – Domestic Travel – telephone no. 1300 307 852 or 02 8666 1751; Facsimile no. 02 8905 9631;

PCards can be used for unplanned or emergency domestic travel including accommodation but requires the employee to obtain their direct line manager's written approval and in accordance with the NSW Health Policy Directive PD 2009_016.

4.5.2 Overseas Travel

All international travel bookings are to be made with CWT – International travel – telephone no. 1300 657 378 or 02 8666 1703, Facsimile no 02 8905 9646.

Overnight accommodation for employees travelling on official business should be of the middle of the standard range. All accommodation arrangements are to be in accordance with the NSW Health Policy Directive PD 2009_016.

PCards can be used for unplanned or emergency overseas travel including accommodation but requires the employees to obtain their direct line manager's written approval and in accordance with the NSW Health Policy Directive PD 2009_016.

4.5.3 Meals and Subsistence

The Online Travel Booking Company can organise meals as part of the staff travel booking request.

A PCard can be used where no prior arrangement was made for meals, or deemed necessary. Relevant documentation must be obtained to substantiate the transaction in the EMS and the value of a meal is not to exceed the prescribed NSW Government meal allowance rate.

5 PCARD OPERATIONAL GUIDELINES

5.1 Approving transactions

Approval is permission to incur or commit expenditure of behalf of the Health Agency. Approval can only be given by those specifically delegated.

In the case of PCard transactions, expenditure is formally approved when the card holder authorises a vendor to make an over-the-counter, telephone, fax, email, mail or internet purchase i.e. at time of purchase.

5.2 Acquitting transactions

Acquitting a transaction is confirmation that an approved payment is correct.

PCard transactions (i.e. individual payments) are acquitted when the PCard Holder (or their nominated Coder) codes the correct account, cost centre and entity and attaches supporting documentation to the online transactions in the EMS.

The PCard Holder or their nominated Coder acquits each transaction by formally making the following declaration:

I certify this purchase/payment is correct:

- Correct performance of service (except where a deposit or advance payment is unavoidable)
- Correct rates of charge
- Approval having been given
- Available discounts having been taken
- It being due and unpaid
- Correct account code(s) charged
- Availability of budgeted funds
- Correct tax liabilities are acknowledged and
- All required supporting documentation available.

Certification Process

The certification process is the coding of PCard transactions to a General Ledger account.

The EMS enables the online certification of PCard transactions by:

- Importing transactions from Visa on a nightly basis
- Allowing online coding, certification and authorisation
- Attachment of relevant tax invoices (if the card holder has not received a tax invoice for a specific transaction, the item must be left as uncoded - do not code to disputed item)
- Should the value of the purchase be below $75.00 plus GST, the supplier has no obligation to provide a tax invoice and therefore the employee may only receive a receipt which needs to be attached to the transaction
- Submit to selected workflow approver for authorisation.

PCard Holders should refer to the PCard User Guide for the complete guide on how to action these steps in the EMS, available on the HealthShare NSW intranet.

5.3 Authorising Transactions

Authorising a transaction in the EMS is the endorsement process. This is an independent review to permit the release of a payment that has been endorsed by a delegated officer and certified as to its correctness.

Payments can only be endorsed by a PCard Holder's direct line manager under financial delegation.

Endorsement Process

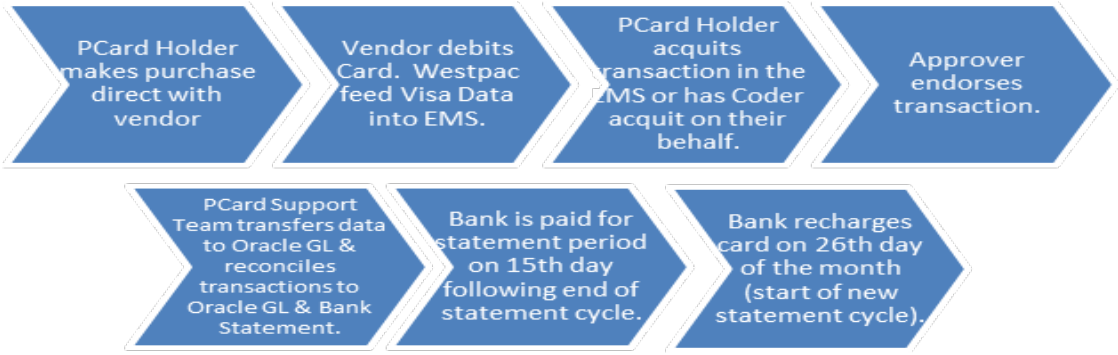
The Authorising Officer endorsing the transaction will review each PCard transaction and endorse/challenge online. Should a transaction be challenged, the Authorising Officer is able to attach comments and submit back to the PCard Holder for review/re-submission.

The Authorising Officer may request that the PCard Holder produce hard copy supporting documentation/receipts at any time.

PCard Authorising Officers should refer to the PCard User Guide for the complete guide on how to action these steps in the EMS. Guide can be found on the intranet:

http://intranet.hss.health.nsw.gov.au/procurementlogistics/procurement-PCard-card

The Expense Management System Transaction Process



Health Agencies should be aware of the cash flow implications: that is, one payment will come direct from their nominated account fifteen days following the end of the Statement Period, being the 25th day of each month, and this should be taken into consideration for cash flow forecasting.

5.4 Repayment of Unauthorised Transactions

Should a transaction be made in error, repayment by the card holder is mandated. Following consultation with their supervisor and the PCard Services Manager, the card holder will mark the transaction as a dispute and refund the funds directly to the Card Account by attending a Westpac Branch and depositing the outstanding amount directly to the Card Account. The following working day they shall acquit the EMS by matching the deposit to the disputed transaction and attaching a copy of the original Tax Invoice for the transaction and the Deposit Receipt Slip provided by the bank to the EMS Transaction. This will allow for direct matching of the subject transaction.

Any transaction made in error is defined as a purchase made by the card holder incorrectly with a NSW Health PCard, where a personal card was to be used. In this instance, the card holder has mistakenly used the NSW Health PCard.

5.5 Disputed Transactions

A disputed transaction is an unknown transaction amount appearing on the PCard Holder's on-line account.

The PCard Holder has 30 days to investigate disputed transactions by contacting the supplier (if known) to ascertain and resolve the problem. After 30 days, unresolved transactions are borne by NSW Health.

In the instance of unknown transactions and those that are unable to be resolved, the PCard Holder must:

- Allocate the transaction to the Dispute queue in the EMS
- Complete the Dispute Form produced out of the EMS
- Inform their supervisor of the transaction(s)
- Forward the Dispute Forms to the PCard Support Team and Westpac.
- The PCard Support Team will follow the dispute through to resolution.

All staff are responsible for promptly trying to resolve any disputed transactions to avoid unknown charges being processed through the Health Agencies bank account.

5.6 Discrepancy Transactions

A Discrepancy transaction is when a portion of the transaction is incorrect. For example, the invoice amount is greater/less than the charge, over/under delivery of purchased goods.

The diagram as shown at **Annexure A** outlines the process of a Discrepancy transaction.

5.7 Credits/Refunds

Should the PCard Holder account be entitled to a credit/refund, under no circumstance is the credit/refund to be received in cash. The transaction is to be processed back to the original card and reflected in the EMS. It will then follow the normal coding/authorisation process.

In the case where goods are returned or the supplier issues a credit for unsatisfactory supply, the credit note must be provided in hard copy and contain:

- The supplier name and ABN;
- The date and the invoice number that the original debit refers to
- A brief description of the goods and or services returned and
- The GST amount and the total amount refunded.

This must be included in the supporting documentation attached to the line item when the transaction is recorded online.

5.8 Credit Card Surcharge

A credit card surcharge is an extra fee charged by some suppliers when paying with a credit card to recover the cost of the merchant interchange fees. The surcharge is clearly marked on the Tax Invoice and is set by the vendor. In the event that a charge does apply card holders will be trained in how to code to allow monitoring using the appropriate account code.

5.9 System Checks Against Unusual Transactions

The following system checks relate to the Satori Continuous Control Monitoring tests which are run daily. Identified exceptions are received by the PCard Team and will be referred to the Health Agency for investigation:

- Identification of excessive adjustments, credits or disputes
- Identification of transactions made on Sundays
- Identification of possible split transactions within PCards
- Identification of duplicate transactions: same invoice number, invoice amount and invoice date for different vendor name
- Identification of duplicate transactions: same vendor name, invoice amount and invoice number for different invoice date
- Identification of duplicate transactions: same vendor name, invoice amount and invoice date for different invoice number
- Identification of employees whose credit cards are dormant for more than 30 days
- Identification of transactions with suspicious key words.

In addition, the following list is an example of the ProMaster Reports available for use by the Health Agency:

- Accounts Credit Limit
- Admin Audit Report
- Card Statement Report
- Expense Detail Report
- Multiple Transactions Report
- Prohibited Merchant Usage
- Unverified Transactions Summary Report
- Merchant Analysis Report

5.10 Idle Cards

Where an issued PCard has not incurred at least one transaction during a 6 month period, the PCard Holder is to be informed that the PCard will be cancelled within 14 days of notice unless the Chief Executive of the Health Agency provides a written request for the continuation of the PCard.

6 Goods and Services Tax

GST is a broad-based consumption tax of 10% levied on the supply of most goods and services consumed in Australia since 1 July 2000.

A tax invoice is a document containing information about a taxable supply that must be provided by the supplier to the purchaser. It is the supplier's responsibility that they are charging for the correct GST if applicable.

When purchasing from an Australian supplier, the card holder must:

- Obtain original or endorsed fax/copy tax invoices as evidence of approval for each PCard transaction and to enable the health service to claim back any GST and
- Ensure all invoices have an ABN.

7 Accounting Treatment

The Accrual Accounting Method will be used to manage PCard transactions within the EMS.

7.1 Month End Reconciliation

At month end all transactions will be reflected in the Oracle General Ledger) and any items not yet verified will then be accrued to allow for future verification.

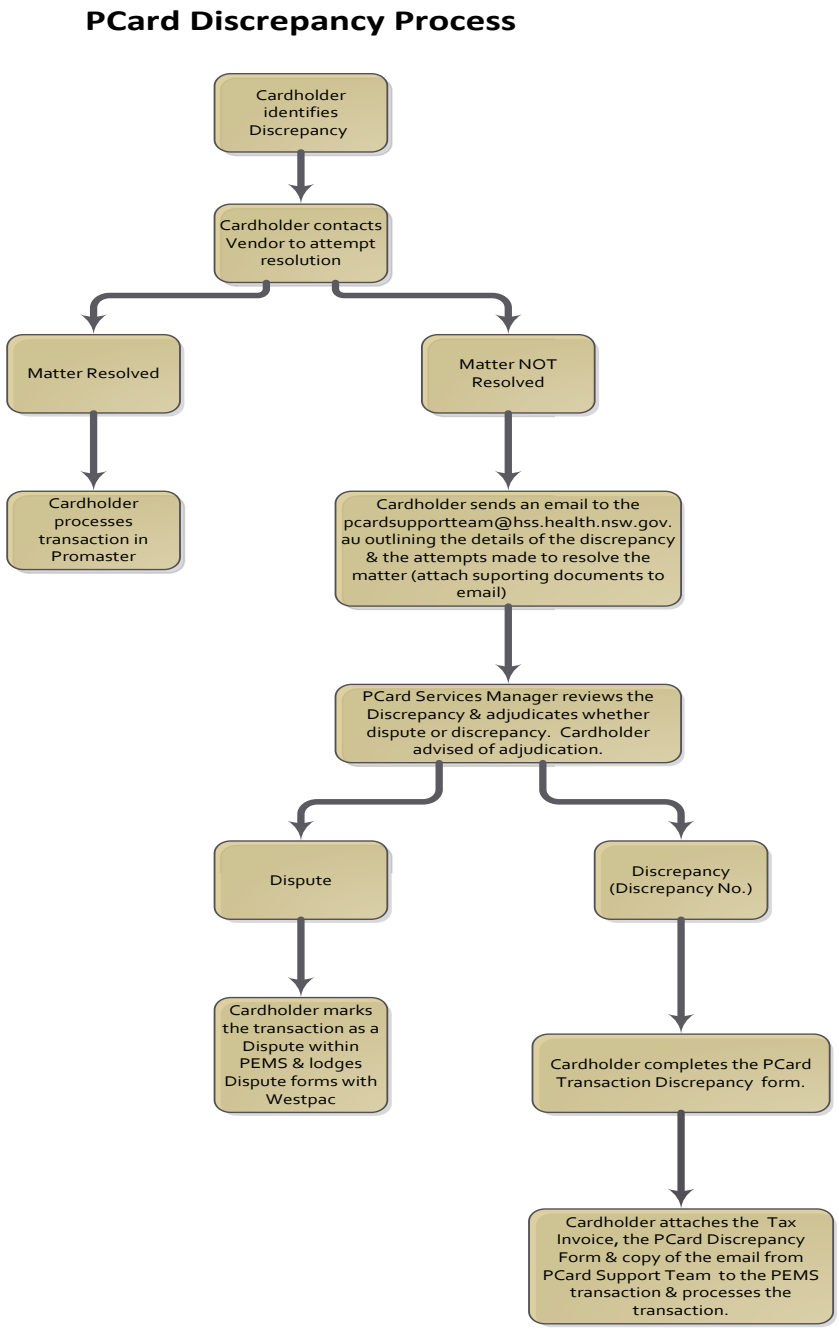
All transactions will be reconciled from the EMS GL Reconciliation Detail report to the General Ledger Module of the Oracle eBusiness Suite (EBS) and the Westpac Monthly statement.

Any transaction that appears in the EMS after the statement cycle date (25th day of the month) and before the actual calendar month end will be taken up in the General Ledger module of Oracle as an accrual and will be identified on the PCard reconciliation as a reconciling item to be cleared the following month.

8 LIST OF ATTACHMENTS

1. PCard Discrepancy Process

ANNEXURE A


PCard Discrepancy Process
Cardholder identifies Discrepancy
Cardholder contacts Vendor to attempt resolution
Matter Resolved
Matter NOT Resolved
Cardholder processes transaction in Promaster
Cardholder sends an email to the pcardsupportteam@hss.health.nsw.gov.au outlining the details of the discrepancy & the attempts made to resolve the matter (attach suporting documents to email)
PCard Services Manager reviews the Discrepancy & adjudicates whether dispute or discrepancy. Cardholder advised of adjudication.
Dispute
Discrepancy (Discrepancy No.)
Cardholder marks the transaction as a Dispute within PEMS & lodges Dispute forms with Westpac
Cardholder completes the PCard Transaction Discrepancy form.
Cardholder attaches the Tax Invoice, the PCard Discrepancy Form & copy of the email from PCard Support Team to the PEMS transaction & processes the transaction.

PAYMENT TO VISITING MEDICAL OFFICERS (76/317 as amended)

It has been brought to the attention of the Department that in some cases where doctors providing services to public patients are practising in partnership, or there is a relationship between such doctors of employer and employee, accounts for the services of all doctors are being issued in the name of one doctor or the partnership concerned.

Areas/hospitals should require and obtain a separate statement of account from each appointee in respect of the services personally rendered by the appointee. (See more hereunder.)

This does not preclude the area/hospital obtaining from a doctor an appropriate direction for payment where the terms of his/her contractual arrangements with another or others preclude payment to him/her personally. That is, a doctor may give a written authority that any moneys due by the hospital be paid to another person or other persons. The authority may either have effect for a particular month's accounts or be for an indefinite period.

The following policy should be adhered to by all areas/hospitals:

- Every doctor, **who is not** a salaried member of the medical staff of the hospital, who provides medical care to public patients shall be individually appointed as a Visiting Medical Officer by the CE, or delegate, of the area health service and Royal Alexandra Hospital for Children under a written service contract unless section 85 as listed hereunder is applied in respect to the service contract.

- Such appointments shall be made by resolution of the Board and be recorded in the minutes of the meeting at which the resolutions were passed.

- Each Visiting Medical Officer will render accounts individually.

The method of payment has been so determined because the contract is between the practitioner and the relevant area health service/public hospital.

Note: Under section 85 ***Health Services Act 1997*** "a medical practitioner who a public health organisation wishes to appoint as a visiting medical officer may elect to be appointed under a service contract entered into between the organisation and the medical practitioner's practice company". No such election may be made unless the medical practitioner's practice company carries public liability and medical indemnity insurance to a level approved by the Department from time to time.

APPENDIX A

FOLIO NO.....

CHEQUE SIGNING MACHINE
CONTROL REGISTER

	DATE	CHEQUE NUMBERS ISSUED		SPOILAGE	NET CHEQUES ISSUED	MACHINE METER		TOTAL IMPRINTED	BANK ACCOUNT	DETAILS	INITIALS
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GST TREATMENT OF RIGHTS OF PRIVATE PRACTICE (PD2005_598)

This Circular follows previous instructions on this subject, issued 27 July 2000 and 1 August 2000, which outlined interim procedures to be adopted for GST treatment of rights of private practice. It should also be noted that the Salaried Senior Medical Practitioner Determination has been amended to reflect the contents of this circular and its attachments.

Following consideration of potential alternative arrangements by the NSW Department of Health (the Department) and the Australian Salaried Medical Officer Federation (NSW) (ASMOF), it has been determined to continue, at this time, with the existing arrangements subject to appropriate adjustments to take account of the new tax system's impact. However, a number of issues and strategies are still being considered and some arrangements may be changed to more streamlined procedures in the future.

Attachment 1 is the revised version of the determination by the Health Administration Corporation incorporating the variations to the existing employment conditions under which rights of private practice may be exercised to take account of the new tax system's impact.

The GST treatment of the arrangements, the procedures for payment of GST inclusive infrastructure charges (incorporating the payment previously known as facility fees) together with the rights and obligations of Senior Medical Practitioners (SMPs) and Public Health Organisations (PHOs) , are the subject of this Circular.

The arrangements that have been agreed to, which are detailed in Schedule 3 to the Determination (see Attachment 2): Procedures for Public Health Organisations on GST Treatment of Rights of Private Practice (the Procedures document), have been designed to ensure that:

1 SMPs do not suffer any unnecessary cash flow disadvantage as a result of the impact of GST on the private practice arrangements;
2 Potential cash flow disadvantages for PHOs have been minimised as far as possible;
3 The GST administration effects on all parties have been reduced to the minimum possible under the new tax laws. This is particularly the case where groups of SMPs choose to register as a legal entity with multiple SMPs as members.

SMPs have been divided into four groups for the purposes of these arrangements. These are:

1 Level 1 SMPs;
2 Level 2-5 SMPs who are **not** in a private practice partnership and whose infrastructure charge is less than 90% of cash received;
3 Level 2-5 SMPs who **are** in a private practice partnership and whose infrastructure charge is less than 90% of cash received; and
4 Level 2-5 SMPs whose infrastructure charge is 90% or more of cash received. (Note, where the infrastructure charge is over 90%, the arrangements will be the same regardless of whether the SMP is an individual or a private practice partnership.)

Please note that, for Level 2-5 SMPs, three sets of arrangements have been outlined. The first set deals with the infrastructure charges for the first four months of the GST (i.e. July to October). The second set provides information on the ongoing arrangements, after the initial period for the monthly component of the infrastructure charge. The third arrangement details treatment of the annual component of the infrastructure charge. These arrangements have been further refined to allow for PHOs who invoice their infrastructure charge in the same month as billings are processed and for those who invoice in the month after billings are processed. Additionally, GST information for Level 1 SMPs has been set out separately in the procedures document.

Level 1 SMPs

The Department and ASMOF, together with their advisers, are still examining a number of issues and options which will most effectively deal with the impact of the GST and the New Tax System for Level 1 SMPs. This is being approached on the basis of minimising tax compliance requirements on Level 1 SMPs. Accordingly, on an interim basis, PHOs should continue to exclude any Level 1 private practice income from BAS reporting.

Level 2-5 SMPs Basic Structure of Arrangements and GST Effects from 1 July 2000

References to SMPs in the points below are to be read, except where specified, to include SMPs either acting as individuals, partnerships or other legal entities. Note, other legal entities are expected to include corporates, however, at this time, any group of SMPs who wish to register otherwise than as an individual or a partnership, for example as a corporate entity, must consult the Department and ASMOF for prior approval.

- Gross billing revenue from rights of private practice activity will continue to be administered by PHOs with receipts being paid into a separately identifiable account (No 1 Account) under the administrative control of the PHO, or another organisation as agreed;

- PHOs supply SMPs with a range of services funded by the monthly and annual components of the infrastructure charge. The services include billing services, facilities and other infrastructure to support their private practices (including some plant and equipment, research support and financial support for professional development activities). Note, this paragraph is not intended to change the scope of the services from that which are already provided;

- Current arrangements for the approval of expenditure from accounts holding annual components of the infrastructure charge (including, where applicable, the account commonly referred to as the No 2 Account), are to be maintained, pending agreement between the Department and ASMOF on "model" arrangements. See page 4.28.1;

- At this time, nothing in this Circular is to be construed as affecting in any way the operation of any formal charitable trust in relation to the expenditure of moneys received from the rights of private practice activity conducted in the period to 30 June 2000.

- PHOs will bill SMPs an infrastructure charge for the above supplies, with instalment amounts being paid monthly and on an annual basis by SMPs;

- The monthly and annual instalments of the infrastructure charge are payment for a taxable supply for GST purposes. The current facility fee (now to be incorporated as part of the infrastructure charge) is to have 10% added to cover GST. PHOs will not receive the additional 10% until SMPs are eligible to receive a credit for this amount from the ATO as an input tax credit, unless sufficient funds are available in the No 1 Account (i.e. the additional 10% may be drawn at any time after the raising of a tax invoice provided that the No 1 Account has sufficient funds to pay that amount after payment of that month's drawings). The combination of revised drawings arrangements plus GST credits means that SMPs will receive the same amount in cash terms as they received as drawings prior to GST. In this way, the arrangements will ensure that the introduction of GST does not impact negatively on the cash flow position of SMPs;

- SMPs will generally be registered for GST and lodge periodic Business Activity Statements (BASs) accounting for GST included in gross billings, if any, and claiming an input tax credit for GST included in infrastructure charges. This will ensure that SMPs do not suffer any unnecessary negative financial effects from the introduction of GST. (Note: An SMP with an annual turnover of less than $50,000 may choose not to register for GST, however, regardless of this fact the procedures will still apply. SMPs who choose not to be registered should be aware that they will suffer a loss of income due to the need to refund an amount equivalent to net GST credits to the No 1 Account irrespective of the fact that these amounts have not been received as an input tax credit from the ATO);

- In respect of the monthly component of the infrastructure charge, for SMPs with an infrastructure charge of less than 90% who are not in a private practice partnership, PHOs will deduct each quarter from the next drawings payment after the date on which a quarterly BAS is required to be lodged, and subsequent months as necessary, an amount equivalent to the net GST credit (calculated on an accruals basis) receivable from private practice activity, for retention in the No 1 Account. This amount will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full $11/11^{th}$ of the infrastructure charge;

- In respect of the monthly component of the infrastructure charge, SMPs who are in a private practice partnership where the infrastructure charge is less than 90% of the gross receipts of the partnership will be required each quarter to have that partnership pay into the No 1 Account an amount equivalent to the partnership's net GST credit (calculated on an accruals basis) from private practice activities received from the ATO. This payment will be required by the 21^{st} day of the month in which a quarterly BAS is required to be lodged. This amount will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full $11/11^{th}$ of the infrastructure charge. In the event that the net GST credit is not received into the No 1 Account as required, the PHO may deduct an amount equivalent to the net GST credit from the drawings paid to the SMPs in the partnership on a prorated basis;

- In respect of the monthly component of the infrastructure charge, SMPs with an infrastructure charge of 90% or more will be required to pay into the No 1 Account an amount equivalent to their net GST credit (calculated on an accruals basis) from private practice activities within 21 days following the end of the period for which the charge is levied. If this amount is not received, then it will be deducted from drawings. This amount

will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge;

- In respect of the monthly component of the infrastructure charge, SMPs who are in a private practice partnership where the infrastructure charge is 90% or more of the total gross receipts of the partnership will be required to have that partnership pay into the No 1 Account an amount equivalent to their net GST credit (calculated on an accruals basis) from private practice activities within 21 days following the end of the period for which the charge is levied. If this amount is not received, it will be deducted from the drawings of the partners on a pro rata basis. This amount will then be transferred to the PHO General Account in the event that the PHO has not already withdrawn the full 11/11th of the infrastructure charge.

- In respect of annual components of the infrastructure charge, SMPs (or the partnership of which they are members) will be required to pay into the No 1 Account an amount equal to 1/11th of the GST inclusive value of the charge within 21 days following the end of the period in which the charge is levied and a tax invoice raised. If this amount is not received, then it will be deducted from drawings;

- The first 1/11th of the annual component of the infrastructure charge (commonly described as the residual) will be paid from the No 1 account to the PHOs General Fund, in accordance with the Procedures document at Attachment 1. The remaining 10/11th of the annual component of the infrastructure charge is to be transferred from the No 1 Account into a separate account of the PHO (the No 2 Account) as directed by the PHO in two instalments (9/11th and 1/11th respectively), as funds are available. PHOs will use this component of the infrastructure charge to pay for SMP professional development, certain facilities, other infrastructure and research activity. Note, the conditions under which this direction takes place will depend on the results of negotiations between ASMOF and the Department.

Fully worked basic examples showing a full work through of one years payments from July 2000 to June 2001 have been included as part of the Procedures document.

Further enquiries on the contents of the Procedures document should be directed to Ken Barker on (02) 9391 9178.

Please ensure that all SMPs are provided with a copy of this circular as soon as possible. They should direct their enquiries to a nominated employee of your Public Health Organisation or to ASMOF.

ATTACHMENT 1

SALARIED SENIOR MEDICAL PRACTITIONERS

DETERMINATION (REVISED VERSION)

INDEX

1 DEFINITIONS

a) The Definitions which appear in Clause 2 of the Salaried Senior Medical Practitioners (State) Award also apply to this Determination.

b) In addition to the definitions referred to in sub-clause (a), the following definitions also apply to this Determination.

"Account" means the financial institution account in the name of the individual Senior Medical Practitioner or in the name of an agreed group of Senior Medical Practitioners.

"annual component of the infrastructure charge" means the amount paid from the amount remaining to the credit of the account in the name of the Senior Medical Practitioner or agreed group of Senior Medical Practitioners in the Private Practice Trust Fund at the end of the financial year after deduction of the monthly charges for the Public Health Organisation and drawings to the Senior Medical Practitioner or agreed group of Senior Medical Practitioners with the addition of 10% to cover GST which the Public Health Organisation is required to include in its GST calculation;

"Arrangement" means a right of private practice arrangement.

"General Fund" means the operating budget of the Public Health Organisation.

"GST" means the goods and services tax imposed under Commonwealth legislation including ***A New Tax System (Goods and Services Tax) Act 1999***;

"Facility charge", "facility fee" and "monthly charge" mean the monthly component of the infrastructure charge;

"infrastructure charge" means the monthly component of the infrastructure charge (however called) and the annual component of the infrastructure charge;

"Private Practice Trust Fund" means the fund in existence immediately prior to the commencement of this Determination or it's equivalent from time to time and which contains accounts in the name of an individual Senior Medical Practitioner or group of Senior Medical Practitioners.

"Public health organisation" is as defined in section 7 of the *Health Services Act 1997*.

"Second Trust Fund" means the fund into which the balance of the Private Practice Trust Funds are transferred at the end of each financial year.

2 PRIVATE PRACTICE ARRANGEMENTS (excluding Postgraduate Fellows)

a) General Provisions

(a) Upon commencement of employment, a Senior Medical Practitioner shall elect to participate in a level arrangement ie either a Level 1, 2, 3, 4 or 5. Senior Medical Practitioners employed at the date of this Determination will make an election pursuant to this sub-clause

immediately after the commencement of this Determination. A Senior Medical Practitioner may then, if he/she so chooses, elect prior to 30 June each year to change his/her level arrangement (drawing rights) to commence on 1 July of the following financial year. This election cannot be changed during the year unless by the mutual agreement of the Senior Medical Practitioner and the Public Health Organisation. A Senior Medical Practitioner is under no compulsion to alter the level arrangement under which he/she works. A summary table of the private practice arrangements is provided in Schedule 1 of this Determination.

Current Scheme "D" Senior Medical Practitioners may only make an election in accordance with the provisions of subclause (d) below.

ii) The salaries referred to in Schedule 2, Column 2 of this Determination, as varied from time to time to reflect the Award, shall be paid to Senior Medical Practitioners subject to the level arrangement elected. The salaries shall be paid during paid absences on approved leave and shall be paid where the monetary value of leave is paid on termination of employment. These salaries include the Award salary and the special allowance (17.4% of Award salary). PAYE deductions are to be made from these payments.

iii) The allowances referred to in Schedule 2, Column 3 of this Determination shall be paid during paid absences on approved leave, where the monetary value of leave is paid on termination of employment and for superannuation and voluntary redundancy purposes. PAYE deductions are to be made from these payments.

iv) Subject to subclause (v) below, the drawing rights referred to for Levels 2 to 5 (refer Schedule 2, Column 4) shall be payable during paid absences on workers' compensation (subject to a maximum of six months), approved annual, sick, long service, parental and training education and study leave but shall not be paid where the monetary value of leave is paid out on termination of employment. The drawing rights **shall not** be taken into account for the calculation of any entitlements or public sector superannuation purposes. PAYE deductions **are not** to be made from these payments.

v) Senior Medical Practitioners working pursuant to part-time agreements or taking long service leave or maternity leave at half pay are entitled to drawing rights on a pro rata basis. Senior Medical Practitioners on leave without pay (including maternity/paternity leave) are not entitled to drawing rights.

vi) Senior Medical Practitioners who elect either Level 2, 3, 4 or 5 will contribute to the same Private Practice Trust Fund or sub-ledger in accordance with subclause (viii) below.

vii) An agreed group can elect to share all benefits of the Private Practice Trust Fund (subject to the Trustees' agreement) to the limit of their entitlement amongst the agreed group, irrespective of the length of service of any member of the agreed group.

viii) An agreed group for the purpose of this clause means a group of Senior Medical Practitioners (whether an individual, in partnership or other approved legal entity) who elect to form a group for the purpose of a sub-ledger of the Private Practice Trust Fund.

ix) All accounts for services rendered to private patients by a Senior Medical Practitioner working under Levels 1-5 are to be issued by the Public Health Organisation acting as the agent for the Senior Medical Practitioner.

x) The Public Health Organisation must obtain, in writing, authority from each Senior Medical Practitioner to issue accounts in his/her name.

xi) A Senior Medical Practitioner shall exercise his/her right of private practice subject to:

(1) the provisions of Clause 8 of the Award; and

(2) the private practice occurring within the agreed facilities; and

(3) the income arising from the exercise of such right of private practice (including the income generated whilst engaged in practice in accordance with Clause 8 of the Award) being paid into the Private Practice Trust Fund.

The provisions of this clause do not apply to "Outside Practice" pursuant to Clause 9 of the Award.

xii) Payment of drawing rights up to the maximum prescribed (refer Schedule 2, Column 4) averaged over the year to date is to be made calendar monthly, subject to there being sufficient trust funds available.

(b) Level Arrangements

(i) Level 1

(1) A Senior Medical Practitioner who elects a Level 1 arrangement pursuant to this Clause, will be paid the salary referred to in Schedule 2, Column 2 of this Determination.

(2) A Senior Medical Practitioner who elects Level 1 shall be entitled to an allowance of 20% of salary (refer Schedule 2, Column 3) in return for the assignment of the billings from the Senior Medical Practitioner's private practice to the Public Health Organisation.

(ii) Level 2

(1) A Senior Medical Practitioner who elects a Level 2 arrangement pursuant to this Clause will be entitled to salary referred to in Schedule 2, Column 2 of this Determination.

(2) A Senior Medical Practitioner who elects Level 2 shall be entitled to an allowance of 14% of salary (refer Schedule 2, Column 3).

(3) A Senior Medical Practitioner who elects a Level 2 arrangement will have drawing rights (to be made calendar monthly) up to a maximum of 24% of the full time salary applicable for a Level 4 arrangement for a Senior Medical Practitioner as referred to in Schedule 2, Column 2 of this Determination. Drawing rights are subject to sufficient individual or agreed group contributions being available in the Private Practice Trust Fund.

(4) (A) For a Senior Medical Practitioner who has elected Level 2, where individual or agreed group contributions are not sufficient to permit drawings of up to 11% of salary (as provided in Schedule 2, Column 2) averaged over the year to date, supplementation equalling the difference between the drawings and 11% of salary will be made monthly by the Public Health Organisation from that proportion of the charges which would otherwise have been appropriated as facility charges paid to the Public Health Organisation by Senior Medical Practitioners.

(B) Where an individual Senior Medical Practitioner has elected a Level 2 arrangement and individual or agreed group contributions are sufficient to permit drawings of 11% of salary (as provided in Schedule 2, Column 2) averaged over the year to date but not sufficient to permit drawings of 18% of salary averaged over the year to date, supplementation equalling the difference between the drawings and 18% of salary will be made by the Public Health Organisation monthly. The Public Health Organisation supplementation is therefore up to 7% of salary, where this subclause applies.

Level 3

(1) A Senior Medical Practitioner who elects a Level 3 arrangement pursuant to this Clause will be entitled to salary referred to in Schedule 2, Column 2 of this Determination.

(2) A Senior Medical Practitioner who elects Level 3 shall be entitled to an allowance of 8% of salary (refer Schedule 2, Column 3).

(3) A Senior Medical Practitioner who elects a Level 3 arrangement will have drawing rights (to be made calendar monthly) up to a maximum of 36% of the full time salary applicable for a Level 4 arrangement for a Senior Medical Practitioner as referred to in Schedule 2, Column 2 of this Determination. Drawing rights are subject to sufficient individual or agreed group contributions being available in the Private Practice Trust Fund.

(4) For a Senior Medical Practitioner who has elected Level 3, where individual or agreed group contributions are not sufficient to permit drawings of up to 17% of salary (as provided in Schedule 2, Column 2) averaged over the year to date, supplementation equalling the difference between the drawings and 17% of salary will be made monthly by the Public Health Organisation from that proportion of the charges which would otherwise have been appropriated as facility charges paid to the Public Health Organisation by Senior Medical Practitioners.

(iv) Level 4

(1) A Senior Medical Practitioner who elects a Level 4 arrangement pursuant to this Clause will be entitled to salary referred to in Schedule 2, Column 2 of this Determination.

(2) A Senior Medical Practitioner who elects a Level 4 arrangement will have drawing rights (to be made calendar monthly) up to a maximum of 50% of the full time salary applicable for a Level 4 arrangement for a Senior Medical Practitioner as referred to in Schedule 2, Column 2 of this Determination. Drawing rights are subject to sufficient individual or agreed group contributions being available in the Private Practice Trust Fund.

(3) For a Senior Medical Practitioner who has elected Level 4, where individual or agreed group contributions are not sufficient to permit drawings of up to 25% of salary (as provided in Schedule 2, Column 2) averaged over the year to date, supplementation equalling the difference between the drawings and 25% of salary will be made monthly by the Public Health Organisation from that proportion of the charges which would otherwise have been appropriated as facility charges paid to the Public Health Organisation by Senior Medical Practitioners.

(v) Level 5

(1) A Senior Medical Practitioner who elects a Level 5 arrangement pursuant to this Clause will be entitled to salary which represents 75% of the rate applicable for a Level 4 arrangement for a Senior Medical Practitioner (refer Schedule 2, Column 2 of this Determination).

(2) A Senior Medical Practitioner who elects a Level 5 arrangement will have drawing rights (to be made calendar monthly) to a maximum of 100 % of the full time salary applicable for a Level 4 arrangement for a Senior Medical Practitioner as referred to in Schedule 2, Column 2 of this Determination. Drawing rights are subject to sufficient individual or agreed group contributions being available in the Private Practice Trust Fund.

(3) The 75% of salary referred to in subclause (1) above reflects the fact that leave without pay is permitted for 25% of the full-time commitment in that speciality. No private practice is to be undertaken during the 75% of time for which a salary is payable (this relates to aggregated time and means that participating specialist must not spend more than an average of 25% of his/her total working time in the treatment of private patients).

(c) Postgraduate Fellow

A Senior Medical Practitioner appointed as a Postgraduate Fellow pursuant to Clause 10 of the Award has no entitlement to any Private Practice Arrangement.

(d) Preserved Arrangement - Scheme D

(1) A Senior Medical Practitioner who participated in Scheme D immediately prior to the commencement of this Determination, will be entitled to 50% of the award salary plus the 17.4% special allowance, as varied from time to time. PAYE taxation deductions **are** to be made in respect of these payments.

The general terms and conditions will be those applying under Scheme D immediately prior to the commencement date of this Determination.

(2) Where a Senior Medical Practitioner's current arrangement is Scheme D then:

(A) the Senior Medical Practitioner can only move to another Level (ie Private Practice Arrangement) by agreement with the Public Health Organisation; and

(B) upon moving to another private practice arrangement the Senior Medical Practitioner cannot move back to Scheme D.

(3) The Scheme D arrangement is not available to any Senior Medical Practitioner who is not employed under Scheme D as at the date of this Determination.

(e) Outside Practice (ie not as an employee of the Public Health Organisation)

(1) Income generated by a Senior Medical Practitioner while engaged in practice pursuant to Clause 9 of the Award, will be retained exclusively by the Senior Medical Practitioner. The Senior Medical Practitioner is under no obligation to provide records regarding the income generated pursuant to Clause 9 of the Award. The Senior Medical Practitioner will be liable for all expenses incurred while engaged in practice including professional indemnity insurance, administration, facility costs and any other expenses arising from the conduct of such practice.

(2) A breach of the agreement referred to in Clause 9 of the Award will be dealt with pursuant to Clause 3 of the Award.

(3) A referral to a Senior Medical Practitioner for the work prescribed in Clause 9 of the Award must be in accordance with the provisions of the Health Insurance Act or its equivalent from time to time.

(4) The use of any of the Public Health Organisation's employees, equipment or other resources in conducting outside practice is not permitted unless approved by the Chief Executive Officer.

(f) Privately Referred Non-inpatients

(1) The charging arrangements for privately referred non-inpatients to all staff specialists who have been granted rights of private practice by the Public Health Organisation remain unaltered.

(2) The charging arrangements will not affect those patients who are inpatients or registered non-inpatients of a recognised hospital but will apply to privately referred non-inpatients who satisfy the following conditions.

(A) The referral must be to the doctor by name and not to the hospital or the outpatient department.

(B) The referral must be made by a doctor in private practice (including a staff specialist or visiting medical officer exercising a right of private practice); it must not be made by an intern, resident medical officer, career medical officer, registrar or medical superintendent.

(C) No patient who presents at the emergency department or an out-patient clinic is to be privately referred for treatment of, or examination relating to, the episode of illness which caused him/her to present at the emergency department or the outpatient clinic.

(D) At the time the appointment is being made, patients are to be advised that they will not be treated as registered non-inpatients of the hospital, and that they will be charged by the attending Senior Medical Practitioner/s as well as for diagnostic services ordered by that Senior Medical Practitioner.

(E) Referrals are to be genuine referrals made at "arm's length", ie the referral letter should be completed before the patient's first appointment is made for an examination, treatment or consultation.

3 INFRASTRUCTURE CHARGES

(1) All fees received from the rendering of accounts to private patients seen by Senior Medical Practitioners employed in a Level 2, 3, 4 or 5 arrangement pursuant to Clause 2, Private Practice Arrangements of this Determination shall be paid into the Private Practice Trust Fund.

(aa) From the fees paid into the Private Practice Trust Fund, infrastructure charges are to be paid in accordance with Schedule 3 of the Determination.

(2) From the fees paid into the Private Practice Trust Fund, facility fees (to compensate for the provision of services and the use of facilities used in generating such private practice fees), as a percentage of the gross fees received, shall be paid to the Public Health Organisation as a first charge against the Private Practice Trust Fund.

(3) The facility fees paid in accordance with authorised arrangements as at the date of this Determination shall continue to apply without variation until the review outlined in subclause (d) below is completed. For the purposes of this clause, "authorised arrangements" shall mean or schedules of fees attached to enterprise agreements approved by the Director-General, or any specific variations to facility fees approved by the Director-General.

(4) The parties agree that a review of facility fees will be completed within 12 months of the making of this Determination. Upon completion and implementation of the review the facility fees identified in the review will apply to all Senior Medical Practitioners.

(5) The annual component of the infrastructure charge is to be paid into the Second Trust Fund.

3A IMPLEMENTATION OF GST

(a) Clauses 1, 2, 3 and 5 of this Determination are to be read subject to this clause. In the event of any inconsistency between this clause and any other provision of the Determination this clause is to prevail.

(b) The Public Health Organisation and Senior Medical Practitioners are to comply with the Procedures Document at Schedule 3 of the Determination, as varied from time to time by further determination.

(c) The monthly component of the infrastructure charge under Clause 3 is varied from 1 July 2000 to have 10% added to cover GST which the Public Health Organisation is required to include in its GST calculation.

(d) Any amounts required to be calculated in accordance with this Determination are to take account of the respective GST liabilities and rights to GST input tax credits of the Public Health Organisation and Senior Medical Practitioners.

Senior Medical Practitioners Levels 2- 5

(e) Drawings for Senior Medical Practitioners Levels 2, 3, 4 and 5 under Clause 2 are to be varied in accordance with following subclauses:

Senior Medical Practitioners not in a Private Practice Partnership with a monthly charge of less than 90%

(i) The above Senior Medical Practitioners' drawings are to be reduced by an amount equal to their net GST credits referable to private practice activities (exclusive of annual infrastructure GST effects) in accordance with the procedures set out at Schedule 3.

Senior Medical Practitioners in a Private Practice partnership with a monthly charge of less than 90%

(ii) The partnership, on behalf of the above Senior Medical Practitioners, is to pay into the Private Practice Trust Fund an amount equivalent to its net GST credits referable to private practice activity (exclusive of annual infrastructure GST effects) in accordance with the procedures set out at Schedule 3.

(iii) The partnership will pay these amounts into the Private Practice Trust Fund, on a quarterly basis, by the date required by and in accordance with the Procedures at Schedule 3. If the partnership has not paid such amounts then drawings of the Senior Medical Practitioner members of the partnership, on a pro-rated basis, are to be reduced by such amounts in that month and successive months as required, in accordance with the Procedures set out at Schedule 3.

Senior Medical Practitioners (whether individually or in partnership) with a monthly charge of 90% or more

(iv) The above Senior Medical Practitioners are to pay into the Private Practice Trust Fund an amount equivalent to their net GST credits referable to private practice activity (exclusive of annual infrastructure GST effects) in accordance with the procedures set out at Schedule 3.

(v) If such a Senior Medical Practitioner does not pay such amount to the Private Practice Trust Fund by the date required by and in accordance with the Procedures set out at Schedule 3, then the Senior Medical Practitioner's drawings are to be reduced by such amount in that month and successive months as required, in accordance with the Procedures set out at Schedule 3.

Annual Component of the Infrastructure Charge

(vi) Senior Medical Practitioners or a Senior Medical Practitioner partnership on behalf of its members are to pay to the Private Practice Trust Fund an amount equivalent to $1/11^{th}$ of the annual component of the infrastructure charge by the date required by and in accordance with the Procedures at Schedule 3.

(vii) If a Senior Medical Practitioner, or a Senior Medical Practitioner partnership on behalf of its members does not pay to the Private Practice Trust Fund an amount equivalent to $1/11^{th}$ of the annual component of the infrastructure charge by the date required by and in accordance with the Procedures set out at Schedule 3, then the Senior Medical Practitioner's drawings are to be reduced by such amount in that month and successive months as required, in accordance with the Procedures set out at Schedule 3.

Senior Medical Practitioners changing to Level 1

(f) The right, under Clause 2, to a change of election to Level 1 is conditional upon a Senior Medical Practitioner paying to the Private Practice Trust Fund all outstanding amounts relating to infrastructure charges for the period prior to changing to Level 1. A change of election to Level 1 may only be effected where the relevant Senior Medical Practitioner has paid the requisite amount to the Private Practice Trust Fund or provided the Public Health Organisation with an irrevocable written authority to deduct from his/her drawings and/or salary the requisite amount and pay it into the Private Practice Trust Fund. The Public Health Organisation is to give a Senior Medical Practitioner seven days notice of its intention to deduct in accordance with this authority.

Termination of employment

(g) Senior Medical Practitioners are to provide to the Public Health Organisation an irrevocable written authority for the Public Health Organisation to deduct from termination payments (including annual leave and long service leave payouts) an amount to meet all outstanding liabilities they may have in relation to infrastructure charges arising from the exercise of their rights of private practice. The Public Health Organisation is to give a Senior Medical Practitioner seven days notice, where practicable, of its intention to deduct in accordance with this authority in the event that payments are not made in accordance with the Procedures Document at Schedule 3.

(h) Senior Medical Practitioners employed as at 1 July 2000 are to provide the Public Health Organisation with such written authorisation as soon as practicable.

(i) Senior Medical Practitioners commencing employment are to provide such written authorisation to the Public Health Organisation on commencement of employment.

4 ABNORMAL WORKING HOURS AND RECALL

(a) It is acknowledged and recognised that Senior Medical Practitioners are required to be available for reasonable on call and recall outside of their Normal Duties and that there is a component within the salary which reflects this.

(b) The parties agree that some Senior Medical Practitioners may be required to work in excess of Normal Duties and reasonable on call/recall to provide direct patient care.

(c) Where a Senior Medical Practitioner is required to work in excess of Normal Duties and reasonable on call/recall to provide direct patient care, the Public Health Organisation, in conjunction with the affected Senior Medical Practitioner, will review the work pattern of the Senior Medical Practitioner to reduce the number of hours. The review will attempt to reduce the number of hours worked by the Senior Medical Practitioner to conform with sub-clause (a) and the reduction may be achieved by means of time in lieu or other variations in Normal Duties as agreed between the Senior Medical Practitioner and the Public Health Organisation.

(d) In the first instance every effort should be made to reduce the number of hours. However, in those exceptional circumstances where the hours worked by the Senior Medical Practitioner cannot be reduced in accordance with sub-clause (c) and this work:

- is required by the Public Health Organisation, and
- relates to direct patient care, and
- occurs in accordance with subclause (e) below,

the hours may be determined to be abnormal and an additional payment may be authorised by the Chief Executive Officer.

(e) Subclause (d) above only applies when a Senior Medical Practitioner is regularly required by the Public Health Organisation to work abnormal hours over a six month period. In these circumstances, a payment of up to 5% of the rate applicable to a Senior Medical Practitioner under a Level 1 arrangement (including the Special Allowance and allowance for the assignment of Private Practice earnings), as provided for in Clause 2 of this Determination, may be authorised. Any such payment will be subject to review every six months. The review should again attempt to reduce the number of hours worked by the Senior Medical Practitioner to conform with subclause (a).

Following approval by the Chief Executive Officer, payments may commence at the commencement of this Determination where a review of the hours worked in the 6 months immediately preceding this Determination revealed that the Senior Medical Practitioner worked abnormal hours in accordance with subclause (d).

(f) Where the six monthly review identifies an exceptionally high level of abnormal hours which cannot be reduced, the Chief Executive Officer may submit all relevant details of that individual case to the Director-General. The submission should include evidence of how the

allowance can be demonstrated to be cost neutral in accordance with Department of Health guidelines, as amended from time to time. In such cases, the Chief Executive Officer may recommend payment of up to 10% of the rate applicable to a Senior Medical Practitioner under a Level 1 arrangement (including the Special Allowance and allowance for the assignment of Private Practice earnings), as provided for in Clause 2 of this Determination.

Upon commencement of this Determination the Chief Executive Officer may immediately make application to the Director-General for approval to pay the allowance to a Senior Medical Practitioner where a review of the hours worked by the Senior Medical Practitioner in the 6 months immediately preceding the date of making this Determination revealed that an exceptionally high level of abnormal hours were worked by the Senior Medical Practitioner.

In making the application the Chief Executive Officer may recommend that payment of the allowance should commence from a time agreed between the Senior Medical Practitioner and the Chief Executive Officer, but in any case the payment shall not commence earlier than the date of ratification of the Award.

This recommendation must include details of the cost neutral basis of such a payment. This payment would be made instead of, not in addition to, the payment described in subclause (e) above.

(g) The payments provided under (e) and (f) above shall not be paid to more than 10% of the Senior Medical Practitioners employed by the Public Health Organisation at any one time without the written approval of the Director-General. Chief Executive Officers who believe that the 10% figure is inappropriate because they employ only a small number of Senior Medical Practitioners should make a written submission to the Director-General about appropriate parameters for the payment of the allowance.

(h) The payments provided under (e) and (f) above shall not count as salary for the purposes of calculating any entitlement.

5 TRAINING, EDUCATION AND STUDY LEAVE (excluding Postgraduate Fellows).

(a) The Parties agree that the Health System has a responsibility to ensure that all Senior Medical Practitioners employed in the Health System have appropriate and equitable access to Training, Education and Study Leave that is relevant to both the Senior Medical Practitioner and the Area.

(b) Leave Entitlement - The parties agree that Senior Medical Practitioners are entitled to 25 calendar days of Training, Education and Study Leave each year.

(c) Funding entitlement -

(i) The parties agree that Senior Medical Practitioners are entitled to funding for the purpose of Training, Education and Study Leave. Such entitlement shall accumulate to a maximum of the dollar value of two years of entitlement unless otherwise approved by the Chief Executive Officer.

(ii) Based on the approved travel and leave arrangements, funds will be paid to the Senior Medical Practitioner on application.

(iii) The entitlement for Level 1 Senior Medical Practitioners is outlined in (l) below. The entitlement for Senior Medical Practitioners employed under Levels 2 to 5 is a matter for the trustees of the appropriate Trust Fund to determine having regard to the payment made to Senior Medical Practitioners under Level 1.

(iv) Funding will be based on a dollar value to be determined by a committee representative of the parties. The committee will use the formula contained in subclause (l). It is agreed that the amount identified in the Central Sydney Area Health Service Staff Specialists Wages Agreement in respect to the annual sum shall apply to all Senior Medical Practitioners until the committee has reached agreement.

(d) Senior Medical Practitioners (Fractional Appointments)

(i) The entitlement to leave and funding for Senior Medical Practitioners who are working pursuant to a Part Time Agreement is pro rata based on the full-time rate.

(ii) Senior Medical Practitioners working pursuant to a Part Time Agreement may accumulate the same maximum dollar value as a full-time Senior Medical Practitioner ie accrue two years full time equivalent entitlement as provided for in subclause (c).

(iii) The Chief Executive Officer may require a Senior Medical Practitioner who is working pursuant to a Part Time Agreement to take Training, Education and Study Leave at the full-time equivalent daily rate. Alternatively, by agreement with the Chief Executive Officer, a Senior Medical Practitioner who is working pursuant to a Part Time Agreement may take Training, Education and Study Leave at the same part-time daily rate of pay, provided that his/her leave entitlement is not exceeded. Agreement will not be unreasonably withheld. Full-time Senior Medical Practitioners shall take Training, Education and Study Leave, however accrued, at the full-time equivalent daily rate.

(iv) Payment of the perdiem element of the available funding should match the rate at which Training, Education and Study Leave is taken, eg. a part-time Senior Medical Practitioner who takes Training, Education and Study Leave at the full-time daily rate of pay should also be paid the perdiem funding at the full-time daily rates, provided that his/her entitlement is not exceeded.

(e) Source of Funding

(i) The funding provided for in c) above, will be funded by:

1) the General Fund for Senior Medical Practitioners employed pursuant to Level 1.

2) the appropriate Trust Fund for Senior Medical Practitioners employed pursuant to Levels 2 to 5. The quantum of the funding is a matter for the trustees of the appropriate Trust Fund to determine having due regard to the payment made to Senior Medical Practitioners under Level 1. Such allocation is to be limited to the ability of the appropriate Trust Fund to meet the allocation.

The funding provided for in c) above is a minimum entitlement. Additional drawings for Senior Medical Practitioners employed pursuant to Levels 2 to 5 will be dependent on the monies available in the appropriate trust Fund.

Note: Any questions about the "appropriate Trust Fund" should be directed to the Workforce Relations Branch of the Department of Health.

(ii) Where a Senior Medical Practitioner has accrued a right to Training, Education and Study Leave with the same Public Health Organisation partly under Level 1 and partly under Level 2, 3, 4 or 5, he/she shall be entitled to access from the Public Health Organisation's general fund 1/12th of the annual funding entitlement pursuant to subclause (c) above for each completed month of service under Level 1 (subject to subclause (c) (i) of this Determination), less any funding entitlement already taken. In the cases of Levels 2 to 5, approval must be obtained from the trustees or the body authorised by the trustees, in order for that portion of the funding entitlement accrued under Level 2, 3, 4, or 5 to be accessed.

(f) Approval of Leave

Training, Education and Study Leave can be taken for purposes relevant to both the Senior Medical Practitioner and the Public Health Organisation, at the discretion of the Senior Medical Practitioner, within or outside Australia, subject to approval by the Chief Executive Officer or his/her nominee:

Approval should not be unreasonably withheld.

(g) If a dispute occurs as to the interpretation of this Clause, the matter will be dealt with in accordance with the Issues Resolution, Clause 6 of this Determination.

(h) The Parties agree that leave entitlements to Conference and Study Leave , accrued prior to the commencement of this Determination pursuant or any Enterprise Agreement, will be transferred in full, to the entitlements accrued pursuant to this Clause.

In respect to leave accrued for study leave purposes a Senior Medical Practitioner who has been employed for less than 5 years will be entitled to a proportionate amount of leave based on his/her length of service less any study leave taken.

(i) Transfer of leave entitlement - a senior medical practitioner who transfers:

(i) between levels pursuant to Clause 2 of this Determination; or,
(ii) between Public Health Organisations in accordance with the provisions of the ***Transferred Officers Extended Leave Act****:*

will have his/her leave entitlement pursuant to subclause (b) of this clause transferred at the same time on the basis of 25/12 days for each completed month of service, less any leave already taken.

(j) A Senior Medical Practitioner will not be entitled to any entitlement pursuant to this Clause upon retirement, resignation (except as outlined in subclause (i) above), redundancy or dismissal.

(k) This Clause shall not apply to Senior Medical Practitioners participating in Scheme D (current scheme), who shall receive Conference and Study Leave in accordance with circular number 90/39 issued by the Department of Health on 23 May 1990.

(l) Pursuant to Subclause (c) (iv) the funding entitlement will be determined by the committee based on the following:

i) Airfare

1. Total each year based on:

   a) 3/5 of a Qantas round the world business class airfare (including departure tax); and

   b) 1 Qantas Sydney-Perth business class airfare.

1. This money may be used to purchase any number of airfares for the Senior Medical Practitioner provided the total value is not exceeded.

3. On 30 June each year any residual will be indexed by using the average of the airfares on that date divided by the average of the airfares for 30 June of the preceding year.

ii) Perdiem

1. Total each year based on:

   a) Overseas: Based on sample of hotel rates and published government incidentals allowances for representative capital cities for 18 days. This should be calculated at June 30 of each year. The calculation should be based on the 10 cities most commonly visited and the 3 hotel chains most commonly used by Senior Medical Practitioners.

   b) Local: Based on government capital city rates for 7 days available at 30 June.

2. These amounts are totalled each year and may be used in any combination of overseas or local travel.

3. If insufficient funds exist to pay for registration, airfares, or other allowable expenses then all or some of the perdiem may be used for this purpose.

4. On 30 June each year any residual of the funding entitlement will be indexed by multiplying the residual by the total of the assigned value for overseas and Australian perdiems divided by the previous year's total.

iii) Registration

1. Based each year on:

   a) 1 overseas conference
   b) 1 Australian conference
   c) 2 local continuing education meetings.

2. This money may be applied to any number of registrations provided the total entitlement is not exceeded.

3. On 30 June each year any residual will be indexed by using the assigned value for conference registration divided by the assigned value for the previous year.

(m) Specialist Medical Administrators

A Specialist Medical Administrator employed in accordance with Clause 18 of the Award may make a once-only election for the term of the Award to either:

(i) accrue the Training, Education and Study Leave funding entitlement pursuant to this clause; or

(ii) use a motor vehicle consistent with Senior Executive Service guidelines and charges.

The election must be made within one month of the date of commencement of the Award, or the commencement of employment.

If a Specialist Medical Administrator elects option (ii) above, he/she will be entitled to access an amount of Training, Education and Study Leave annual funding entitlement which represents the difference in value between (i) and (ii) above. With regard to the accumulation of the funding entitlement, a Specialist Medical Administrator who elects option (ii) above may accumulate the same dollar value as a Specialist Medical Administrator who elects option (i) above. The number of days of Training, Education and Study Leave available shall be reduced by the same proportion as the annual funding entitlement is reduced.

This provision shall not apply to Senior Medical Practitioners who are not Specialist Medical Administrators employed in accordance with Clause 18 of the Award.

6 ISSUE RESOLUTION

Any disagreement in relation to matters contained within this Determination will be resolved in accordance with the Issue Resolution procedure provided for in Clause 3 of the Award.

ATTACHMENT 2

SCHEDULE 3

PROCEDURES FOR PUBLIC HEALTH ORGANISATIONS ON GST TREATMENT OF RIGHTS OF PRIVATE PRACTICE

Basic Structure of Arrangements

Senior Medical Practitioners (SMPs) have been divided into four groups for the purposes of these arrangements. These are:

1. Level 1 SMPs;

2. Level 2-5 SMPs who are **not** in a private practice partnership and whose infrastructure charge is less than 90% of cash received;

3. Level 2-5 SMPs who **are** in a private practice partnership and whose infrastructure charge is less than 90% of cash received; and

4. Level 2-5 SMPs whose infrastructure charge is 90% or more of cash received. (Note, where the infrastructure charge is over 90%, the arrangements will be the same regardless of whether the SMP is an individual or a private practice partnership.)

For reasons of simplicity, this procedure has been set out the tasks associated with the rights and obligations arising for the SMPs and Public Health Organisations (PHOs) for each of these four categories. For this reason, some information may be repeated in more than one section.

For SMPs other than Level 1, the procedural requirements have been clearly set out, and then included into a timeline. The arrangements for processing of infrastructure charges have been set out for three separate periods. These are:

1. The initial period of 1 July to 31 October;
2. Ongoing arrangements from 1 November; and
3. The annual component of the infrastructure charge.

These arrangements have been further refined to allow for PHOs who invoice their infrastructure charge in the same month as billings are processed and for those who invoice in the month after billings are processed.

Definition of terms

A number of common terms have been used throughout this document. To ensure that there is no confusion between different PHOs and SMPs who may use different terms, these terms have been defined below:

PHOs	PHOs can include area health services, statutory health organisations or an affiliated health organisation in respect of its establishments and services recognised in the NSW Health Services Act.

SMPs	SMPs should be read as pertaining to the SMPs individually, in private practice partnership or as a member of an appropriately registered legal entity. Note, other legal entities are expected to include corporates, however, at this time, any group of SMPs who wish to register other than as an individual or a private practice partnership, for example as a corporate entity, must consult the NSW Department of Health (the Department) and Australian Salaried Medical Officers' Federation (NSW) (ASMOF) for prior approval.
No 1 Account	An account administered by the PHOs, or such other organisation as agreed, into which all rights of private practice receipts are deposited, and from which drawings and infrastructure charges are paid.
No 2 Account	A separately identifiable PHO Account into which annual components of the infrastructure charge that have been withdrawn from the No 1 Account are deposited as directed by PHOs.
Infrastructure charge	The infrastructure charge is made up of two components. The first is a monthly component (previously known as a facility fee) which is a monthly percentage of receipts which is drawn into the PHO General Account. The second is an annual component (previously known as the residual) which is paid into the No 2 Account from funds remaining in the No 1 account at the end of each financial year.
Net GST credit	The amount of GST credit available to an SMP from rights of private practice activities. The amount is calculated by deducting any GST payable on taxable supplies from the input tax credit available on the infrastructure charge. Unless otherwise stated, this amount is to be calculated assuming that GST has been accounted for on an accruals basis, regardless of the accounting method used by the SMP.
Private Practice Partnership	SMPs who have entered into a private practice partnership agreement and have registered that partnership for GST purposes.
Infrastructure Charge of 90% or more	SMPs whose infrastructure charge is calculated as being an amount of 90% or more of receipts. Note where the SMP is a partnership, this would be calculated as being the percentage of total infrastructure charge levied on the partnership against the partnerships total receipts.
Infrastructure Charge of less than 90%	SMPs whose infrastructure charge is calculated as being an amount of less than 90% of receipts.

Accounting Procedures

A further circular will be forwarded to finance officers to give details of the accounting transactions required to be completed to give effect to the arrangements, including adjustment event procedures associated as necessary with drawings supplementation. This circular will detail how to take up the interim transactions processed into the arrangements for the period 1 July to 31 October, 2000, as well as the arrangement going forward.

Annexed to this Procedures document are model tax invoices for Level 2-5 SMPs. Included with each model tax invoice is an information schedule, which provides all necessary financial information to be provided to Level 2-5 SMPs by PHO. **These models are to be used by all PHOs unless prior approval has been obtained from the Department.** Note that no financial information is to be issued to Level 1 SMPs at this point in time.

It should be noted that neither the Department nor any PHO can undertake to assist SMPs in business activity statement (BAS) preparation. However, the financial information provided to SMPs (as shown on the model tax invoice annexed to this Procedures document) will be sufficient to ensure that SMPs will be able to complete any rights of private practice component of their BAS. This is regardless of whether they account on a cash or accruals basis. Additionally, this information will assist SMPs to make any calculations of net income necessary for instalment activity statements.

Level 1 SMPs

Practical Procedures & Obligations

In order to minimise or remove, if possible, the impact of GST (and the New Tax System generally) on Level 1 SMPs, as well as to reduce the administrative burden on the PHOs, the Department and ASMOF are still in the process of exploring with their advisers and the ATO certain options under the GST Act and other tax legislation. For this reason, the following interim procedures have been put in place specifically for Level 1 rights of private practice.

GST-free Billings

- The PHO should not include any private practice income in their BAS until further notice;
- The PHO will not be required to issue a statement of income to Level 1 SMPs for the period 1 July to 31 October, at this time.

GST Taxable Billings

- The PHO should not include any GST taxable private practice income, such as those medico-legal reports billed under rights of private practice, in their BAS until further notice;
- PHOs should nevertheless continue to regard all potentially GST taxable activity as in fact GST taxable activity for pricing and billing purposes;
- Level 1 SMPs should advise PHOs if they are registered for GST, and provide details of ABNs, billing addresses and method of GST accounting;

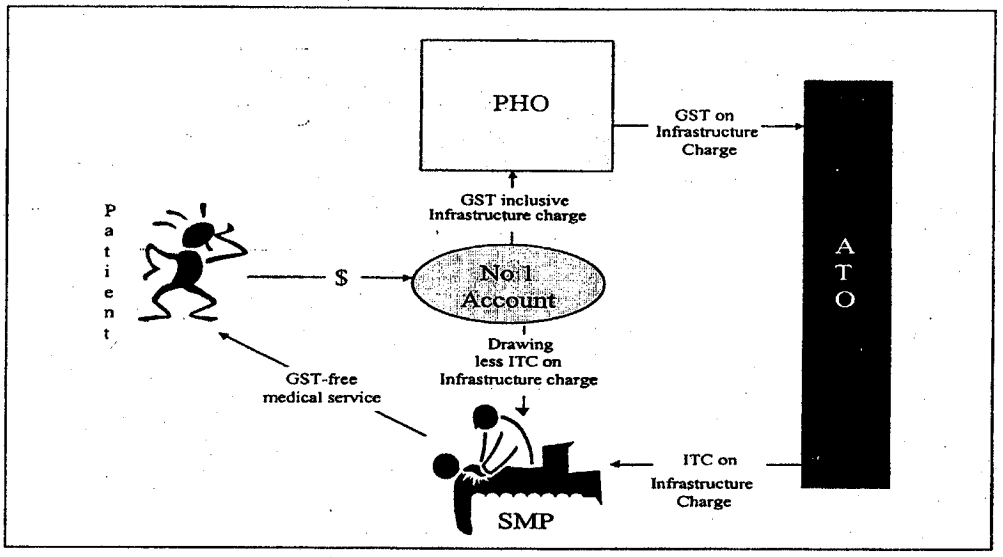
- PHOs should ascertain, which, if any potentially GST taxable private practice activities have been billed as being taxable supplies from a Level 1 SMP who is not registered for GST.

At this stage, no further actions, other than those outlined above, should be taken in relation to Level 1 SMP GST/New Tax System issues. It is expected that the issues still being resolved will be finalised by the end of November, 2000. At that time, a further procedural document for Level 1 SMPs will be circulated.

Levels 2-5 SMPs

GST Treatment Explained

A diagram of how a typical SMP private practice transaction is treated for GST appears below.



Patient Billings: Where the bill is for the supply of a medical service covered by Medicare or is recognised as being required for the treatment of the patient, the supply will be a GST-free supply by the SMP.

Supplies that are not for the treatment of the patient, e.g. the provision of medico/legal reports to insurers, will be a GST taxable supply by the SMP.

Supplies which are of medical services provided for purely cosmetic reasons and for which no Medicare benefit is payable will be a GST taxable supply by the SMP.

Infrastructure charges: *Monthly:* The monthly component of the infrastructure charge will be for a GST taxable supply made by the PHO, however the SMP will be eligible to recover an input tax credit for the GST included in the charge.

Annual: The additional annual component of the infrastructure charge paid from the balance of the No 1 Account will also be for a GST taxable supply made by the PHO, with SMPs again eligible to recover an input tax credit for the GST.

Note: As infrastructure charges can meet the requirements of a progressive or periodic supply, GST will only be payable by the PHO to the ATO on each amount of consideration (i.e. the payment of the infrastructure charge) being received.

Drawings: Drawings will not attract GST, as there is no supply and they are transfers within the same registered entity (i.e. the SMP). That is, it is only the movement of an SMPs funds between two bank accounts.

Level 2-5 SMPs who are NOT in a private practice partnership with an Infrastructure charge of less than 90%

Practical Procedures & Obligations

Note that references in this procedural document to SMPs should be read as pertaining to the SMPs appropriately registered legal entity of which he/she is a member (other than a private practice partnership) or, in the event that such a structure is not in existence, to the SMP individually.

SMPs with an annual turnover of less than $50,000 may choose not to be registered for GST, however, regardless of this fact these procedures will still apply. SMPs who choose not to be registered should be aware that they will suffer a loss of income due to the need to refund an amount equivalent to net GST credits to the No 1 Account irrespective of the fact that these amounts have not been received from the ATO.PHO Obligations

PHOs are obliged to do the following:

- Invoice patients (or other recipients of the supply) on a SMPs behalf. However, the PHO will only issue a tax invoice on behalf of the SMP (quoting the ABN of the PHO, as agent) in the event that a supply is GST taxable and the patient or other recipient requests one. Copies of such tax invoices for any taxable supplies are to be provided to the relevant SMP.

- Ensure that payments for services rendered by SMPs are deposited in a separately identifiable account administered by the PHO (this account is referred to as the No 1 Account throughout this document);

- Issue a compliant tax invoice for the monthly component of the infrastructure charge to SMPs following close of books for that month;

- Issue cash statements of transactions on the No 1 Account to all SMPs (not only those who account for GST on a cash basis), following close of books for that month (refer sample tax invoice and financial information annexed to this Procedures document);

- Issue a statement of gross billings to all SMPs immediately following the close of books for that month. Except in the circumstances detailed in the following dot points, where SMPs are members of a group (e.g. approved pathology provider arrangements), PHOs will undertake to issue patient invoices and provide gross billing statement information on an individual SMP basis. Where this is currently not possible, PHOs will generally undertake to make arrangements to move to a system capable of tracking this information, in the event that such information can be tracked.

- Notwithstanding the above, in the following circumstances, PHOs should provide gross billing information on individual allocation of gross billings based on the proportion of individual drawings to total group drawings. These circumstances are:

    - where individual billing information is not available; or
    - as an interim measure for PHOs moving to individual billings information;

- Issue consolidated gross billing statements covering all SMP members of a legal entity where the SMP is a member of a wider, GST registered legal entity for the purposes of rights of private practice;

- Not draw any amount of the infrastructure charge from the No.1 Account prior to the issue of the tax invoice where the PHO closes their books prior to the end of a month. Where the PHO closes their books at the end of month (1st month) and does not impose an infrastructure charge until the following month (2nd month), the infrastructure charge may be drawn prior to the issue of a tax invoice, provided that the tax invoice, with accompanying billing information for the 2nd month is presented to the SMP no later than two (2) days after the end of the month in which the charge was raised (i.e. in the 3rd month). (Note as the infrastructure charge has been paid in the 2nd month, provided the tax invoice is received prior to lodgment of a BAS in the 3rd month the SMP can include infrastructure charges raised in the 2nd month in their BAS which may be lodged in the 3rd month);

- The first 1/11th of the annual component of the infrastructure charge will be paid from the No 1 account to the PHOs General Fund. The remaining 10/11th of the annual component of the infrastructure charge is to be paid into a separately identifiable PHO account (referred to through this procedural document as the No 2 Account) in two instalments (9/11th and 1/11th respectively), in accordance with the timeline dates outlined later in this procedures document and subject to availability of funds in the No 1 Account. These amounts will not be paid into any other accounts;

- In relation to annual components of the infrastructure charge, if an SMP does not pay an amount equivalent to 1/11th of the annual component by the 21st day of the month following the month in which a tax invoice was issued for the annual component, or such other day as is agreed in accordance with the timeline dates outlined later in this procedures document, then subsequent drawings payments will be reduced, as required, to return this amount to the No 1 Account.

- Issue a compliant tax invoice dated 30 June, for the annual component of the infrastructure charge to SMPs following the close of books at the end of the financial year;

- Only draw out of the No 1 Account, an amount equal to $10/11^{th}$ of the GST inclusive infrastructure charge (whether on a monthly or annual basis) on the day the tax invoice is raised, or the day on which the charge is calculated for PHOs who raise an infrastructure charge after the end of a month (subject to the provisions outlined in the timelines, which appear later in this document, for the annual component of the charge). The additional $1/11^{th}$ will be drawn on the last day of the month in which a quarterly BAS was due for lodgment. However, where sufficient funds are available, the additional $1/11^{th}$ may be drawn prior to the last day of the month in which a quarterly BAS was due for lodgment (i.e. on any day on or after the day on which the $10/11^{th}$ of the infrastructure charge is drawn provided that the No 1 Account has sufficient funds to pay that amount);

- In relation to SMP drawings, the following procedures will operate. For the first drawings payment made after the date on which a quarterly BAS is required to be lodged, and subsequent months as necessary, the SMPs drawings will be reduced by an amount equal to their net GST position (exclusive of annual infrastructure GST effects) for that quarter, from the rights of private practice activities. An amount equivalent to the reduction amount will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full $11/11^{th}$ of the infrastructure charge;

- Meet any approved SMP Professional Development expenditure (TESL). Other than in those circumstances where allowances are paid to SMPs (including per diems), TESL is the hospital's expenditure, for which the PHO may be entitled to an input tax credit. TESL will only ever be paid from the No 2 Account. Where the SMP receiving an allowance (including per diems) is registered for GST, the SMP may be entitled to an input tax credit for any GST taxable expenses met from their allowances. Note, this paragraph is not intended to change the scope of TESL from that which is already provided;

- Ensure payment of drawings to SMPs who have elected Levels 2, 3 or 4 at an agreed minimum level per month. This practice is known as supplementation. If receipts do not allow for this level of drawings, the PHO will reduce infrastructure charges for that month, and previous months if necessary, to provide drawings to the SMP to that level. Where this results in an "adjustment event" for GST purposes, the PHO will raise an adjustment note and provide it to the SMP as required, either on a monthly or an annual basis. (Note, changes to infrastructure charge levels in the same month do not give rise to an adjustment event, therefore, where only the current month's infrastructure charge is adjusted, no adjustment note is required unless a tax invoice for the full infrastructure charge has been provided to the SMP). Note, the operation of this paragraph is not intended to change the scope of supplementation from that which currently exists.

SMP Obligations

SMPs are obliged to do the following:

- Advise PHO whether, with effect from 1 July, 2000 or any other effective date, they are registered, or have applied to be registered, for GST, as an individual or whether they are a member of a legal entity (e.g. partnership) which has so applied. Also, to advise if, at any time they cease to hold that registration during such time as they conduct rights of private practice in a NSW PHO. (Note: where SMPs are members of a partnership for rights of

private practice purposes, this will reduce considerably the administrative burden on all parties);

- Advise the PHO of the details of the individual SMP or the legal entity of which they are a member. Such details are as follows: the ABN (where available), the name and address for inclusion on tax invoices, and their chosen method of GST accounting (i.e. accrual or cash). In the event of any change to the ABN, the SMP will advise the PHO of that change within seven (7) days of that change occurring or advice from the ATO being received that the change has occurred;

- In relation to SMP drawings, to allow for an amount equivalent to any net GST credit, referable to private practice activity (GST on taxable medical services less input tax credits on infrastructure charges) to be retained in the No 1 Account. The PHO will recover these amounts on a quarterly basis. This will be achieved through a reduction of the first drawings payment made after the date on which a quarterly BAS is required to be lodged, and subsequent months as necessary by an amount equal to the net GST position, for that quarter, from the rights of private practice activities. This procedure applies regardless of whether the SMP is lodging on a monthly or quarterly basis. Note, where the SMP has advised the PHO that they account for GST on the cash accounting method but will be moving to accruals from the quarter commencing 1 October, then for the **first quarter only**, the GST net amount will be calculated as being the cash accounting net amount, where the PHO has not drawn the full $11/11^{th}$ of the infrastructure charges raised during the months of July to September. Where this is the case, drawings will only be reduced by the cash amount with the remainder of the accruals based net amount being recovered from January drawings;

- In relation to annual components of the infrastructure charge, the SMP is required to pay into the No 1 Account an amount equivalent to $1/11^{th}$ of the annual component by the 21^{st} day of the month following the month in which a tax invoice was issued for the annual component of the infrastructure charge, or such other date as is nominated by the PHO in the event that the annual component is invoiced but not paid by 30 June. If the payment is not received by the 21^{st} day of the month, then subsequent drawings will be reduced, as required, to return this amount to the No 1 Account. These amounts will then be transferred to the No 2 Account, in the event that the PHO has not already drawn the full $11/11^{th}$ of the infrastructure charge;

- In the event that a SMP changes their private practice election to Level 1, the SMP will ensure that all GST net amounts have been fully funded in the No 1 Account, or make arrangements for payment of any outstanding amounts by the 21^{st} day of the month in which a quarterly BAS is due for lodgment for the period in which the final tax invoice is received. If payment is not received, the PHO will be entitled to recover the outstanding amount through reduction of salary amounts owed to the SMP by the PHO until such time as the amount is paid. The SMP will provide the PHO with a written authority at the time of changing their private practice election to Level 1 to cover this entitlement. Note, the PHO must provide the SMP with seven (7) days notice of their intention to reduce amounts owed to the SMP in accordance with the written authority;

- Provide the PHO with a written authority upon commencement of employment or, if currently employed, as soon as practicable to use any termination payments (including annual leave and long service leave payouts) to offset any remaining liability of the SMP in relation to the infrastructure charge. Note, the PHO must provide the SMP with seven (7) days notice of their intention to reduce these amounts.

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the Billing Month

This part of the procedure should be used by PHOs who close their books on or before the last day of a month and who calculate, invoice and withdraw infrastructure charges on or before the last day of the billing month

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, fully worked examples where an SMP is accounting for GST on accruals basis (example 1a) or a cash basis (example 1b) are provided.

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur.

Assumptions

- SMPs are registered, either individually or as part of a legal entity, from, or with effect from 1 July.
- PHO will raise a tax invoice for the infrastructure charge for the period July to September and then move to monthly tax invoices from October.
- The monthly component of the infrastructure charge is calculated, invoiced and paid in the month it occurs.
- Quarterly BAS period dates are assumed to end on each of 30 September, 31 December, 31 March, 30 June.
- The PHO is assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department.
- Where drawings in November are not sufficient to cover the net GST recoverable from rights of private practice for the period 1 July to 30 September, it has been agreed that the shortfall will be met from the No 1 Account and drawings in the month of December will be reduced to recover these funds.

1 July: SMPs registered for GST (or registrations to be effective from 1 July);

30 September: PHO to withdraw $10/11^{th}$ of GST inclusive infrastructure charge for September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September 2000;

31 October: All SMPs to have notified PHO of either individual or legal entity GST registration details including ABN (where available), name and address for billing purposes and their GST accounting method;

PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of October from No 1 Account;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 30 September 2000;

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the period 1 July to 30 September 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of October;

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September and the month of October.

11 November: SMP to have lodged their BAS for the quarter ended 30 September (note, this is generally the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents);

30 November: PHO to deduct the GST net amount from rights of private practice activities from drawings for the period 1 July to 30 September, 2000 for SMPs with a level of infrastructure charge of less than 90%;

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) for the period 1 July to 30 September. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds).

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month: PHO to raise a tax invoice for an infrastructure charge for the month.

	PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the month.
	PHO to withdraw 10/11th of GST inclusive infrastructure charge.
7th day of following month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the infrastructure charge raised for that month.
Last day of month following end of a quarterly BAS period:	PHO to deduct the GST net amount for the previous quarter from rights of private practice activities from drawings.

Annual infrastructure charge arrangements

Note: where the annual infrastructure charge is not to be raised prior to, or on the last day of the financial year, then the PHO should refer to the arrangements outlined for PHOs who close their books on or after the end of the financial year.

Last day of financial year:	PHO to raise a tax invoice for the annual infrastructure charge;
	PHO to provide the tax invoice to the SMP;
	PHO to withdraw 10/11th of GST inclusive annual infrastructure charge;
7th day of following month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the annual infrastructure charge.
21st day of following month:	SMPs to have paid into the No 1 Account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;
	PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;
	PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts). (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

Example 1 (a)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the same month as the billing period:
- monthly 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
- annual Balance of No 1 account plus GST

Drawings: 70% of Receipts
SMP Accounting Basis: **Accrual & Quarterly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
31/7/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		
	PHO payment of July drawings to SMP	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				
31/8/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to SMP	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
30/9/00	PHO calculation of September Receipts	100.00	120.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to SMP	(70.00)	30.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 30 September.	0		0	
31/10/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Raise a tax invoice for the month of October. Draw 10/11th of total. Raise a tax invoice for the infrastructure charges calculated between 1 July and 30 September, 2000.	(20.00)	110.00		
	PHO payment of drawings to SMP with no deduction.	(70.00)	40.00		
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 30 September and for the month of October.	8.00		(8.00)	
11/11/00	SMP BAS lodgment for Sept quarter including ITC on infrastructure charge for period July to Sept.	(6.00)			6.00
30/11/00	PHO calculation of November Receipts	100.00	140.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of November infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	120.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for the period 1 July to 30 September.	(64.00)	56.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to September.	(6.00)	50.00	(2.00)	
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
31/12/00	PHO calculation of December Receipts	100.00	150.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		
	PHO payment of drawings to SMP	(70.00)	60.00		
7/1/01	SMP BAS lodgment including ITC on infrastructure charge for December quarter.	(6.00)			12.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
31/1/01	PHO calculation of January Receipts	100.00	160.00		
	PHO calculation of January infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	140.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for December quarter	(64.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for December	(6.00)	70.00	0	
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
28/2/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to SMP	(70.00)	80.00		
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
31/3/01	PHO calculation of March Receipts	100.00	180.00		
	PHO calculation of March infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	160.00		
	PHO payment of drawings to SMP	(70.00)	90.00		
7/4/01	SMP BAS lodgment including ITC on infrastructure charge for March quarter.	(6.00)			18.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
30/4/01	PHO calculation of April Receipts	100.00	190.00		
	PHO calculation of April infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	170.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for March quarter	(64.00)	106.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for March quarter	(6.00)	100.00	0	
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
31/5/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to SMP	(70.00)	110.00		
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
30/6/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to SMP	(70.00)	120.00		
	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. Raise a tax invoice. Draw 10/11th of total	(120.00)	0.00		
7/7/01	SMP BAS lodgment including ITC on infrastructure charges for June quarter and year end.	(18.00)			36.00
	PHO BAS lodgment including GST paid on infrastructure charge.	14.00		(18.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
21/7/01	SMP pays an amount equivalent to the ITC on annual infrastructure charge into No 1 Account	12.00	12.00		
31/7/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June quarter	6.00	18.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June quarter and annual component.	(18.00)	0	0	

Example 1 (b)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the same month as the billing period:
- monthly 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
- annual Balance of No 1 account plus GST

Drawings: 70% of Receipts
SMP Accounting Basis: **Cash & Quarterly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
31/7/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO payment of July drawings to SMP	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				
31/8/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to SMP	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
30/9/00	PHO calculation of September Receipts	100.00	120.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to SMP	(70.00)	30.00		
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 30 September.	0		0	
31/10/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Raise a tax invoice for the month of October. Draw 10/11th of total. Raise a tax invoice for the Infrastructure charges calculated between 1 July and 30 September, 2000.	(20.00)	110.00		
	PHO payment of drawings to SMP with no deduction.	(70.00)	40.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 30 September and for the month of October.	8.00		(8.00)	
11/11/00	SMP BAS lodgment for Sept quarter including ITC on infrastructure charge for period July to Sept. (note as only 10/11th of charge paid only 10/11th of ITC is available)	(5.45)			5.45
30/11/00	PHO calculation of November Receipts	100.00	140.00		
	PHO calculation of November infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	120.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for the period 1 July to 30 September	(64.00)	56.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to September	(6.00)	50.00	(2.00)	
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
31/12/00	PHO calculation of December Receipts	100.00	150.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		
	PHO payment of drawings to SMP	(70.00)	60.00		
7/1/01	SMP BAS lodgment including ITC on infrastructure charge for December. (note includes 1/11th of the final 1/11th payment of infrastructure charges for July to September made to December)	(6.00)			11.45
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
31/1/01	PHO calculation of January Receipts	100.00	160.00		
	PHO calculation of January infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for December quarter	(64.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for December quarter	(6.00)	70.00	0	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
28/2/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to SMP	(70.00)	80.00		
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
31/3/01	PHO calculation of March Receipts	100.00	180.00		
	PHO calculation of March infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	160.00		
	PHO payment of drawings to SMP	(70.00)	90.00		
7/4/01	SMP BAS lodgment including ITC on infrastructure charge for February. (note includes 1/11th of the final 1/11th payment of infrastructure charges for October to December made to end of March)	(6.00)			17.45
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
30/4/01	PHO calculation of April Receipts	100.00	190.00		
	PHO calculation of April infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	170.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for March quarter	(64.00)	106.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for March quarter	(6.00)	100.00	0	
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
31/5/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to SMP	(70.00)	110.00		
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
30/6/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to SMP	(70.00)	120.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. Raise a tax invoice. Draw 10/11th of total	(120.00)	0.00		
7/7/01	SMP BAS lodgment including ITC on infrastructure charges for June and year end. (note includes 1/11th of the final 1/11th payment of infrastructure charges for January to March made to June)	(16.91)			34.36
	PHO BAS lodgment including GST paid on infrastructure charge.	14.00		(14.00)	
21/7/01	SMP pays an amount equivalent to the ITC on annual infrastructure charge into No1 Account	12.00	12.00		
31/7/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June quarter	2.00	14.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June quarter and annual component.	(14.00)	0	0	
7/10/01	SMP BAS lodgment including ITC of 1/11th of the final 1/11th payment of infrastructure charges for April to June and annual component made in July B not claimable in previous BAS under cash accounting rules)	(1.64)			36.00

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the month after the Billing Month

This part of the procedure should be used by PHOs who close their books on or after the last day of a month and who calculate, invoice and withdraw infrastructure charges in the month following the billing month

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, fully worked examples where an SMP is accounting for GST on accruals basis (example 1c) or on a cash basis (example 1d) are provided.

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur. The second day of the following month has been used as the date for payment of the infrastructure charge only for ease of understanding as this is the day on which a tax invoice and financial information is provided. This does not necessarily reflect the date on which this amount is actually paid.

Assumptions

- SMPs are registered, either individually or as part of a legal entity, from, or with effect from 1 July.
- PHO will raise a tax invoice for the infrastructure charge for the period July to August and then move to monthly tax invoices from September.
- The monthly component of the infrastructure charge is calculated, invoiced and paid in the month after the billing month (with the exception of the month of June, where the invoice should be dated 30 June).
- Quarterly BAS period dates are assumed to end on each of 30 September, 31 December, 31 March, 30 June.
- The PHO is assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department.
- Where drawings for November (drawn in December) are not sufficient to cover the net GST recoverable from rights of private practice for the period 1 July to 31 August, it has been agreed that the shortfall will be met from the No 1 Account and drawings paid in January for December will be reduced to recover these funds.

1 July: SMPs registered for GST (or registrations to be effective from 1 July);

2 July: PHO to withdraw the June infrastructure charge with no GST applicable;

2 August: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of July from No 1 Account;

2 September: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of August from No 1 Account;

2 October: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charges raised for the period 1 July to 31 August, 2000;

31 October: All SMPs to have notified PHO of either individual or legal entity GST registration details including ABN (where available), name and address for billing purposes and their GST accounting method;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 31 August, 2000 (Note there is a requirement for the PHO to provide transaction information to 30 September while the tax invoice is only to 31 August);

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the period 1 July to 30 September, 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of September (Note there is a requirement for the PHO to provide transaction information for October while the tax invoice is for September);

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 31 August and the month of September.

11 November: SMP to have lodged their BAS for the quarter ended 30 September (note, this is generally the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents). This BAS should include infrastructure charges raised for July and August, and billing information for the period 1 July to 30 September;

2 December: PHO to deduct the GST net amount from rights of private practice activities from drawings for the period 1 July to 31 August, 2000 for SMPs with a level of infrastructure charge of less than 90%;

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to $1/11^{th}$ of the invoiced amounts) for the period 1 July to 31 August. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds).

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month: PHO to close off month in ledgers.

2^{nd} day of following month: (i.e. the 2^{nd} month) PHO to withdraw $10/11^{th}$ of GST inclusive infrastructure charge calculated for the billing month.

2^{nd} day of 3^{rd} month: PHO to issue a tax invoice for the infrastructure charge levied during the 2^{nd} month. PHOs should note that there is a requirement for the PHO to provide transaction information for the 2^{nd} month while the tax invoice is only for any infrastructure charges levied during the 2^{nd} month (ie the charge calculated on the billing month on the 2^{nd} day of the 2^{nd} month). As the infrastructure charge has been paid in the 2^{nd} month, provided the tax invoice is received prior to lodgment of a BAS in the 3^{rd} month the SMP can include the infrastructure

	charges levied in the 2nd month in their BAS for the 2nd month, lodged in the 3rd month; PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies during the 2nd month.
7th day of 3rd month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on any infrastructure charge levied during the 2nd month.
Drawings payment following lodgment of a quarterly BAS:	PHO to deduct the GST net amount for the previous quarter from rights of private practice activities from drawings.

To align payments of the monthly infrastructure charge with those of the annual charge, and thereby ensuring that no income tax misalignment of fees collected and infrastructure charges arises for SMPs, PHOs should ensure that invoices raised for the month of June are dated 30 June.

Annual infrastructure charge arrangements

This timeline requires that the tax invoice being dated 30 June is observed. PHOs may use their discretion to vary the date in July that payment by an SMP, who accounts for GST using the accruals method, is required. This discretion is dependant on the date that they provide the tax invoice to the SMP, allowing sufficient time for BAS preparation and a fourteen day return of any refund from the ATO.

Assumption:	The annual component of the infrastructure charge is invoiced but not paid prior to the end of the financial year (i.e. 30 June)
30th June:	PHO to close off books for the financial year. PHO to raise a tax invoice for the annual infrastructure charge. **This invoice must be raised with a date of 30 June**;
2 July:	PHO to provide the tax invoice to the SMP; PHO to withdraw 10/11th of GST inclusive annual infrastructure charge and pay to 1/11th to the General Fund and 9/11th to the No 2 account;
7th July:	PHO expected to have lodged their BAS for June incorporating an amount of 1/11th GST on the annual infrastructure charge. SMPs expected to have lodged their BAS for June quarter. If accounting on an accruals basis, then the SMP should include the annual infrastructure charge on that BAS.

21st July: SMPs accounting on the accruals method for GST to have paid into the No 1 account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;

PHO to raise a debtor against an SMPs drawings, who were required to pay by 21st July, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;

21st October: SMPs accounting on the cash method for GST to have paid into the No 1 Account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;

PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;

PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) and pay to the credit of the No 2 Account. (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

PHOs should note that the these arrangements have been made to ensure that neither the PHO nor the SMP are adversely affected in cash flow terms by the imposition of the GST. The 30 June date on the tax invoice is imperative to the workings of these procedures. The different repayment date for SMPs who are still accounting for GST on the cash method is to reflect their inability to claim an input tax credit for the infrastructure charge at an earlier date.

Example 1 (c)

Assumptions:
- Gross Billing: $100/month (no GST taxable activities)
- Infrastructure charge raised in the month after the billing period:
  - monthly: 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
  - annual: Balance of No 1 account plus GST
- Drawings: 70% of Receipts
- SMP Accounting Basis: **Accrual & Quarterly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
2/8/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		
	PHO payment of July drawings to SMP	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				
2/9/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to SMP	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
2/10/00	PHO calculation of September Receipts	100.00	120.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to SMP	(70.00)	30.00		
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 31 August which was paid in August and September.	0		0	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
2/11/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	110.00		
	PHO payment of drawings to SMP with no deduction.	(70.00)	40.00		
3/11/00	Raise tax invoice for the infrastructure charges calculated between 1 July and 31 August, 2000 and an additional tax invoice for the month of September. Provide billing information for the period 1 July to 30 September and for the month of October				
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 31 August and for the month of September.	6.00		(6.00)	
11/11/00	SMP BAS lodgment for Sept quarter including ITC on infrastructure charge raised in September quarter for period July to August.	(4.00)			4.00
2/12/00	PHO calculation of November Receipts	100.00	140.00		
	PHO calculation of November infrastructure charge plus GST. Draw 10/11th of total	(20.00)	120.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for the period 1 July to 31 August.	(66.00)	54.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to August.	(4.00)	50.00	(2.00)	
	Raise a tax invoice for the infrastructure charge for the month of October (raised in November) and provide billing information for November.				
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/1/00	PHO calculation of December Receipts	100.00	150.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO payment of drawings to SMP	(70.00)	60.00		
	Raise a tax invoice for the infrastructure charge for the month of November (raised in December) and provide billing information for December.				
7/1/01	SMP BAS lodgment including ITC on infrastructure charges raised in the December quarter (ie September-November).	(6.00)			10.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
2/2/01	PHO calculation of January Receipts	100.00	160.00		
	PHO calculation of January infrastructure charge plus GST. Draw 10/11th of total	(20.00)	140.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for December quarter	(64.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge raised in the December quarter (i.e. charges for September-November)	(6.00)	70.00	0	
	Raise a tax invoice for the infrastructure charge for the month of December (raised in January) and provide billing information for January.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/3/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to SMP	(70.00)	80.00		
	Raise a tax invoice for the infrastructure charge for the month of January (raised in February) and provide billing information for February.				
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/4/01	PHO calculation of March Receipts	100.00	180.00		
	PHO calculation of March infrastructure charge plus GST. Draw 10/11th of total	(20.00)	160.00		
	PHO payment of drawings to SMP	(70.00)	90.00		
	Raise a tax invoice for the infrastructure charge for the month of February (raised in March) and provide billing information for March.				
7/4/01	SMP BAS lodgment including ITC on infrastructure charge for March quarter.	(6.00)			16.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
2/5/01	PHO calculation of April Receipts	100.00	190.00		
	PHO calculation of April infrastructure charge plus GST. Draw 10/11th of total	(20.00)	170.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for March quarter	(64.00)	106.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charges raised during the March quarter	(6.00)	100.00	0	
	Raise a tax invoice for the infrastructure charge for the month of March (raised in April) and provide billing information for April.				
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/6/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to SMP	(70.00)	110.00		
	Raise a tax invoice for the infrastructure charge for the month of April (raised in May) and provide billing information for May.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
30/6/01	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. PHO raises a tax invoice dated 30 June.				
2/7/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to SMP	(70.00)	120.00		
	Raise a tax invoice for the infrastructure charge for the month of May (raised in June) and provide billing information for June.				
	PHO withdraws annual infrastructure charge from No 1 Account and pays in accordance with procedures. PHO provides a copy of the tax invoice to the SMP	120.00	0	8.00	
7/7/01	SMP BAS lodgment including ITC on infrastructure charges raised during the June quarter and for the annual infrastructure charge.	(18.00)			34.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO BAS lodgment including GST paid on monthly and annual components of the infrastructure charge.	14.00		(6.00)	
21/7/01	SMP accounting for GST on accruals method pays an amount equivalent to the ITC on annual infrastructure charge into No 1 Account	12.00	12.00		22.00
	PHO draws remaining 1/11th of annual component of infrastructure charge (paid to No 2 account)	(12.00)	0		
2/8/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June quarter	6.00	6.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge raised during the June quarter.	(6.00)	0	0	
7/8/01	PHO BAS lodgment including GST paid on monthly components of the infrastructure charge.	2.00		(2.00)	
7/10/01	SMP BAS lodgment including ITC for June infrastructure charges raised in July	2.00			24.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
2/11/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June	2.00	2.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June raised in July.	(2.00)	0	0	

Example 1 (d)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the month after the billing period:
- monthly 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
- annual Balance of No 1 account plus GST

Drawings: 70% of Receipts
SMP Accounting Basis: **Cash & Quarterly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
2/8/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		
	PHO payment of July drawings to SMP	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
2/9/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to SMP	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
2/10/00	PHO calculation of September Receipts	100.00	120.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to SMP	(70.00)	30.00		
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 31 August which was paid in August and September.	0		0	
2/11/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	110.00		
	PHO payment of drawings to SMP with no deduction.	(70.00)	40.00		
3/11/00	Raise tax invoice for the infrastructure charges calculated between 1 July and 31 August, 2000 and an additional tax invoice for the month of September. Provide billing information for the period 1 July to 30 September and for the month of October				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 31 August and for the month of September.	6.00		(6.00)	
11/11/00	SMP BAS lodgment for Sept quarter including ITC on infrastructure charge raised in September quarter for period July to August.(note as only 10/11th of the charge has been paid, only 10/11th of the ITC is available)	(3.64)			3.64
2/12/00	PHO calculation of November Receipts	100.00	140.00		
	PHO calculation of November infrastructure charge plus GST. Draw 10/11th of total	(20.00)	120.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for the period 1 July to 31 August.	(66.00)	54.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to August.	(4.00)	50.00	(2.00)	
	Raise a tax invoice for the infrastructure charge for the month of October (raised in November) and provide billing information for November.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/1/00	PHO calculation of December Receipts	100.00	150.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		
	PHO payment of drawings to SMP	(70.00)	60.00		
	Raise a tax invoice for the infrastructure charge for the month of November (raised in December) and provide billing information for December.				
7/1/01	SMP BAS lodgment including ITC on infrastructure charges raised in the December quarter (ie September-November)(note includes 1/11th of the final 1/11th payment of infrastructure charges for July and August but does include the final 1/11th for the December quarter).	(5.82)			9.46
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
2/2/01	PHO calculation of January Receipts	100.00	160.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of January infrastructure charge plus GST. Draw 10/11th of total	(20.00)	140.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for December quarter	(64.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge raised in the December quarter (i.e. charges for September-November)	(6.00)	70.00	0	
	Raise a tax invoice for the infrastructure charge for the month of December (raised in January) and provide billing information for January.				
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/3/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to SMP	(70.00)	80.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	Raise a tax invoice for the infrastructure charge for the month of January (raised in February) and provide billing information for February.				
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/4/01	PHO calculation of March Receipts	100.00	180.00		
	PHO calculation of March infrastructure charge plus GST. Draw $10/11^{th}$ of total	(20.00)	160.00		
	PHO payment of drawings to SMP	(70.00)	90.00		
	Raise a tax invoice for the infrastructure charge for the month of February (raised in March) and provide billing information for March.				
7/4/01	SMP BAS lodgment including ITC on infrastructure charge for March quarter (note includes $1/11^{th}$ of the final $1/11^{th}$ payment of infrastructure charges for December quarter but does not include the final $1/11^{th}$ payment for the March quarter).	(6.00)			15.46
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
2/5/01	PHO calculation of April Receipts	100.00	190.00		
	PHO calculation of April infrastructure charge plus GST. Draw 10/11th of total	(20.00)	170.00		
	PHO payment of drawings to SMP less net GST refund from rights of private practice activities for March quarter	(64.00)	106.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charges raised during the March quarter	(6.00)	100.00	0	
	Raise a tax invoice for the infrastructure charge for the month of March (raised in April) and provide billing information for April.				
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/6/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to SMP	(70.00)	110.00		
	Raise a tax invoice for the infrastructure charge for the month of April (raised in May) and provide billing information for May.				
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
30/6/01	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. PHO raises a tax invoice dated 30 June.				
2/7/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to SMP	(70.00)	120.00		
	Raise a tax invoice for the infrastructure charge for the month of May (raised in June) and provide billing information for June.				
	PHO withdraws annual infrastructure charge from No 1 Account and pays in accordance with procedures. PHO provides a copy of the tax invoice to the SMP	120.00	0	8.00	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/7/01	SMP BAS lodgment including ITC on infrastructure charges raised during the June quarter (note includes $1/11^{th}$ of the final $1/11^{th}$ payment of infrastructure charges for March quarter but does not include the final $1/11^{th}$ payment for the June quarter).	(6.00)			21.46
	PHO BAS lodgment including GST paid on monthly and annual components of the infrastructure charge.	14.00		(6.00)	
2/8/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June quarter	6.00	126.00		
	PHO draws an amount from No 1 Account to pay debtor of $1/11^{th}$ of infrastructure charge raised during the June quarter.	(6.00)	120.00	0	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/8/01	PHO BAS lodgment including GST paid on monthly components of the infrastructure charge.	2.00		(2.00)	
7/10/01	SMP BAS lodgment including ITC for annual component of infrastructure charge and June infrastructure charges raised/paid in July (note includes 1/11th of the final 1/11th payment of infrastructure charges for June quarter but does not include the final 1/11th payment for the month of June or the annual component).	13.27			34.73
21/10/01	SMP pays an amount equivalent to the ITC on annual infrastructure charge into No 1 Account	12.00	12.00		22.73
21/10/01	PHO draws remaining 1/11th of annual component of infrastructure charge and pays to No 2 Account	(12.00)	0	(2.00)	
2/11/01	PHO deduction from SMP of net GST refund from rights of private practice activities for June	2.00	2.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June raised in July.	(2.00)	0	0	
7/1/02	SMP BAS lodgment including ITC of 1/11th of the final 1/11th payment of the infrastructure charges for June and annual component made in July B not claimable in previous BAS under cash accounting rules	1.27			24.00

Level 2-5 SMPs who ARE in a private practice partnership with an infrastructure charge of less than 90%

Practical Procedures & Obligations

Note that, references in this procedural document to SMPs should be read as pertaining to the SMPs appropriately registered private practice partnership.

PHO Obligations

PHOs are obliged to do the following:-

- Invoice patients (or other recipients of the supply) on an SMPs behalf. However, the PHO will only issue a tax invoice on behalf of the SMP (quoting the ABN of the PHO, as agent) in the event that a supply is GST taxable and the patient or other recipient requests one. Copies of such tax invoices for any taxable supplies are to be provided to the relevant SMP;

- Ensure that payments for services rendered by SMPs are deposited in a separately identifiable account administered by the PHO (this account is referred to as the No 1 Account throughout this document);

- Issue a compliant tax invoice for the monthly component of the infrastructure charge to SMPs following close of books for that month;

- Issue cash statements of transactions on the No 1 Account to all SMPs (not only those who account for GST on a cash basis) following close of books for that month (refer to the sample tax invoice and supporting financial information annexed to this Procedures Document);

- Issue a statement of gross billings to the SMP private practice partnership following close of books for that month. Where SMPs are members of a group (e.g. approved pathology provider arrangements), PHO will undertake to issue patient invoices and provide gross billing statement information for any partnership which is a member of this group (Note such groups will not necessarily comprise the same membership as a particular private practice partnership). Where this is currently not possible, PHO will generally undertake to make arrangements to move to a system capable of tracking this information, in the event that such information can be tracked.

- Notwithstanding the above, in the following circumstances, PHOs should provide gross billing information on partnership allocation of gross billings based on the proportion of private practice partnership drawings to total group drawings. These circumstances are:

    - where individual billing information is not available; or
    - as an interim measure for PHOs moving to individual billings information;

- Not draw the infrastructure charge from the No.1 Account prior to the issue of the tax invoice where the PHO closes their books prior to the end of a month. Where the PHO closes their books at the end of month (1st month) and does not impose an infrastructure charge until the following month (2nd month), the infrastructure charge may be drawn prior to the issue of a tax invoice, provided that the tax invoice, with accompanying billing information for the 2nd month is presented to the SMP no later than two (2) days after the end of the month in which the charge was raised (i.e. in the 3rd month). (Note as the infrastructure charge has been paid in the 2nd month, provided the tax invoice is received prior to lodgment of a BAS in the 3rd month the SMP can include infrastructure charges raised in the 2nd month in their BAS which may be lodged in the 3rd month);

- The first 1/11th of the annual component of the infrastructure charge will be paid from the No 1 account to the PHOs General Fund. The remaining 10/11th of the annual component of the infrastructure charge is to be paid into a separately identifiable PHO account (referred to through this procedural document as the No 2 Account) in two instalments (9/11th and 1/11th respectively), in accordance with the timeline dates outlined later in this procedures document and subject to availability of funds in the No 1 Account. These amounts will not be paid into any other accounts;

- In relation to annual components of the infrastructure charge, if a SMP does not pay an amount equivalent to 1/11th of the annual component by the 21st day of the month following the month in which a tax invoice was issued for the annual component, or such other day as is agreed in accordance with the timeline dates outlined later in this procedures document, then subsequent drawings payments may be reduced, as required, to return this amount to the No 1 Account.

- Issue a compliant tax invoice dated 30 June, for the annual component of the infrastructure charge to SMPs following the close of books at the end of the financial year;

- Only draw out of the No 1 Account, an amount equal to 10/11th of the GST inclusive infrastructure charge (whether on a monthly or annual basis) on the day the tax invoice is raised, or the day on which the charge is calculated for PHOs who raise an infrastructure

charge after the end of month (subject to the provisions outlined in the timelines, which appear later in this document, for the annual component of the charge). The additional 1/11th will be drawn on the last day of the month in which a quarterly BAS was due for lodgment. However, where sufficient funds are available, the additional 1/11th may be drawn prior to the last day of the month in which a quarterly BAS was due for lodgment (i.e. on any day on or after the day on which the 10/11th of the infrastructure charge is drawn provided that the No 1 Account has sufficient funds to pay that amount);

- In relation to monthly components of the infrastructure charge, if the private practice partnership has not paid an amount equal to their net GST credit from rights of private practice activity into the No 1 Account by the 21st day of the month in which a quarterly BAS is required to be lodged then subsequent drawings payments made to the SMP members of the partnership, on a pro-rated basis, may be reduced as required to return this amount to the No 1 Account. This amount will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge;

- In the event that partners drawings have been reduced and the GST net amount is paid into the No 1 Account at a later date, the PHO will increase the next drawings payment to the partners by the amounts deducted.

- Meet any approved SMP Professional Development expenditure (TESL). Other than in those circumstances where allowances are paid to SMPs (including per diems), TESL is the hospital's expenditure, for which the PHO may be entitled to an input tax credit. TESL will only ever be paid from the No 2 Account. The private practice partnership may be entitled to an input tax credit for any GST taxable expenses met by member SMPs from the allowances received. Note, this paragraph is not intended to change the scope of TESL from that which is already provided;

- Ensure payment of drawings to SMPs who have elected Levels 2, 3 or 4 at an agreed minimum level per month. This practice is known as supplementation. If receipts do not allow for this level of drawings, the PHO will reduce infrastructure charges for that month, and previous months if necessary, to provide drawings to the SMP to that level. Where this results in an "adjustment event" for GST purposes, the PHO will raise an adjustment note and provide it to the SMP as required, either on a monthly or an annual basis. (Note, changes to infrastructure charge levels in the same month do not give rise to an adjustment event, therefore, where only the current month's infrastructure charge is adjusted, no adjustment note is required unless a tax invoice for the full infrastructure charge has been provided to the SMP.) Note, the operation of this paragraph is not intended to change the scope of supplementation from that which currently exists.

- Where a partnership deposits an amount greater than the calculated GST net credit. The additional amount will be refunded to the partners in addition to the next drawings payment made, provided that seven (7) days notice has been provided to the PHO of the distribution details of the amount. Where seven days notice is not provided, then the choice of repayment with current drawings or deferment of refund to following drawings payment will be discretionary on the PHO.

SMP Obligations

SMPs are obliged to do the following:

- Advise the PHO, with effect from 1 July, 2000 or any other effective date, that they are registered, or have applied to be registered, for GST as a private practice partnership. Also, to advise if, at any time they cease to hold that registration during such time as they conduct rights of private practice in a NSW PHO;

- Advise the PHO of the details of the private practice partnership of which they are a member. Such details are as follows: the ABN (where available), the name and address for inclusion on tax invoices, the members of the private practice partnership, and their chosen method of GST accounting (i.e. accrual or cash). In the event of any change to the ABN, the SMP will advise the PHO of that change within seven (7) days of that change occurring or advice from the ATO being received that the change has occurred;

- Repay an amount equivalent to any net GST credit, referable to private practice activity (GST on taxable medical services less input tax credits on infrastructure charges) into the No 1 Account . To effect this, the partnership will repay these amounts, on a quarterly basis, by the 21st day of the month in which a quarterly BAS is required to be lodged. This date applies regardless of whether the partnership is lodging on a monthly or quarterly basis. If this amount is not received by the 21st day of the month then subsequent drawings payments may be reduced as required, to return this amount to the No 1 Account. These amounts will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge. Note, where the SMP has advised the PHO that they account for GST on the cash accounting method but will be moving to accruals from the quarter commencing 1 October, then for the **first quarter only**, the GST net amount will be calculated as being the cash accounting net amount, where the PHO has not drawn the full 11/11th of the infrastructure charges raised during the months of July to September. Where this is the case, drawings will only be reduced by the cash amount with the remainder of the accruals based net amount being recovered from January drawings. Additionally, for the **first quarter only,** where PHOs have sufficient funds to draw the final 1/11th of the infrastructure charge, where a partnership has not been able to obtain their GST registration and complete BAS lodgment prior to the 11 November deadline, drawings will not be reduced until one month after they would otherwise have been reduced under this obligation;

- In relation to annual components of the infrastructure charge, the SMP will pay into the No 1 Account an amount equivalent to 1/11th of the annual component by the 21st day of the month following the month in which a tax invoice was issued for the annual component of the infrastructure charge or such other date as is nominated by the PHO in the event that the annual component is invoiced but not paid in June. If the payment is not received by the 21st day of the month, then subsequent drawings of the members of the private practice partnership will be reduced, on a pro-rated basis, in that month and successive months, as required, to return this amount to the No 1 Account. These amounts will then be transferred to the No 2 Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge;

- Where the partnership has included creditable acquisitions on its BAS other than those used to calculate the net GST credit for the purposes of this procedure, the partnership may deposit an amount greater than that owed to the No 1 Account. Where this is the case, the Partnership must provide details of the additional payment to the PHO together with details of the distribution of repayment of these funds to the partners seven (7) days prior to a drawings distribution. Where seven days notice is not provided, then the choice of repayment with current drawings or deferment of refund to following drawings payment will be discretionary on the PHO.

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the Billing Month

This part of the procedure should be used by PHOs who close their books on or before the last day of a month and who calculate, invoice and withdraw infrastructure charges on or before the last day of the billing month.

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, a fully worked example where the partnership is accounting for GST on accruals basis is provided at example 2a.

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur.

Assumptions

- The private practice partnership is registered from, or with effect from, 1 July.
- PHO will raise a tax invoice for the infrastructure charge for the period July to September and then move to monthly tax invoices from October.
- The monthly component of the infrastructure charge is calculated, invoiced and paid in the month it occurs.
- Quarterly BAS period dates are assumed to end on each of 30 September, 31 December, 31 March, 30 June.

PHO assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department.

1 July: Private practice partnership registered for GST (or registrations to be effective from 1 July);

30 September: PHO to withdraw $10/11^{th}$ of GST inclusive infrastructure charge for September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September, 2000;

31 October: All SMPs to have notified PHO of private practice partnership GST registration details including ABN (where available), name and address for billing purposes, membership of the partnership, and their GST accounting method;

PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of October from No 1 Account;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 30 September, 2000;

PHO to provide the tax invoice to the partnership together with copies of any tax invoices issued on the partnership's behalf, for taxable supplies for the period 1 July to 30 September, 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of October;

PHO to provide the tax invoice to the partnership together with copies of any tax invoices issued on the partnerships behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September and the month of October.

11 November: Private practice partnership to have lodged their BAS for the quarter ended 30 September (note this is the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents);

27 November: SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity for the quarter ended 30 September, into the No 1 Account.

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) for the period 1 July to 30 September. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds).

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month: PHO to raise a tax invoice for an infrastructure charge for the month.

	PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the month.
	PHO to withdraw 10/11th of GST inclusive infrastructure charge.
7th day of following month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the infrastructure charge raised for that month.
7th day of month following end of a quarterly BAS period:	Partnership expected to have lodged their BAS for the previous quarter. (Note this is the last day for lodgment if the partnership is to have the refund back prior to the date of repayment into the No 1 Account.)
21st day of month following end of a quarterly BAS period:	Partnership to have paid an amount equivalent to the GST net amount for the previous quarter from rights of private practice activities from refunds received from the ATO.

Annual infrastructure charge arrangements

Note: where the annual infrastructure charge is not to be raised prior to, or on the last day of the financial year, then the PHO should refer to the arrangements outlined for PHOs who close their books on or after the end of the financial year.

Last day of financial year:	PHO to raise a tax invoice for the annual infrastructure charge;
	PHO to provide the tax invoice to the partnership;
	PHO to withdraw 10/11th of GST inclusive annual infrastructure charge;
7th day of following month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the annual infrastructure charge.
21st day of following month:	Partnership to have paid into the No 1 Account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;
	PHO to raise a debtor against an Partner's drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;
	PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts). (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

Example 2(a)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the same month as the billing period:
- monthly 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
- annual Balance of No 1 account plus GST

Drawings: 70% of Receipts
SMP Accounting Basis: **Accrual & Quarterly BAS lodgment**

Note: Private practice partnerships should not have an effect from taxation matters outside the GST, therefore, their credit from the ATO should equal the amount owed to the No 1 Account for rights of private practice activity.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
31/7/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		
	PHO payment of July drawings to Partnership	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				
31/8/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to Partnership	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
30/9/00	PHO calculation of September Receipts	100.00	120.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to Partnership	(70.00)	30.00		
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 30 September.	0		0	
31/10/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Raise a tax invoice for the month of October. Draw 10/11th of total. Raise a tax invoice for the infrastructure charges calculated between 1 July and 30 September, 2000.	(20.00)	110.00		
	PHO payment of drawings to Partnership	(70.00)	40.00		
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 30 September and for the month of October.	8.00		(8.00)	
11/11/00	Partnership BAS lodgment for Sept quarter including ITC on infrastructure charge for period July to Sept.	(6.00)			6.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
27/11/00	Partnership payment of GST net credit for September quarter to No 1 Account	6.00	46.00		0
30/11/00	PHO calculation of November Receipts	100.00	146.00		
	PHO calculation of November infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	126.00		
	PHO payment of drawings to Partnership	(70.00)	56.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to September.	(6.00)	50.00	(2.00)	
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
31/12/00	PHO calculation of December Receipts	100.00	150.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		
	PHO payment of drawings to Partnership	(70.00)	60.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/1/01	Partnership BAS lodgment including ITC on infrastructure charge for December quarter.	(6.00)			6.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
21/1/01	Partnership payment of GST net credit for December quarter to No 1 Account	6.00	66.00		0
31/1/01	PHO calculation of January Receipts	100.00	166.00		
	PHO calculation of January infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	146.00		
	PHO payment of drawings to partnership	(70.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for December	(6.00)	70.00	0	
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
28/2/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to Partnership	(70.00)	80.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
31/3/01	PHO calculation of March Receipts	100.00	180.00		
	PHO calculation of March infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	160.00		
	PHO payment of drawings to Partnership	(70.00)	90.00		
7/4/01	Partnership BAS lodgment including ITC on infrastructure charge for March quarter.	(6.00)			6.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
21/4/01	Partnership payment of GST net credit for the quarter ended April to No 1 Account	6.00	96.00		0
30/4/01	PHO calculation of April Receipts	100.00	196.00		
	PHO calculation of April infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	176.00		
	PHO payment of drawings to Partnership	(70.00)	106.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for March quarter	(6.00)	100.00	0	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
31/5/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to Partnership	(70.00)	110.00		
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
30/6/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to Partnership	(70.00)	120.00		
	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. Raise a tax invoice. Draw 10/11th of total	(120.00)	0.00		
7/7/01	Partnership BAS lodgment including ITC on infrastructure charges for June quarter and year end.	(18.00)			18.00
	PHO BAS lodgment including GST paid on infrastructure charge.	14.00		(18.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
21/7/01	Partnership pays an amount equivalent to the ITC on annual infrastructure charge into No 1 Account	12.00	12.00		6.00
	Partnership payment of GST net credit for the June quarter to No 1 Account	6.00	18.00		0
31/7/01	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June quarter and annual component.	(18.00)	0	0	

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the month after the Billing Month

This part of the procedure should be used by PHOs who close their books on or after the last day of a month and who calculate, invoice and withdraw infrastructure charges in the month following the billing month

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, a fully worked example where the private practice partnership is accounting for GST on accruals basis (example 2b) is provided.

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur. The second day of the following month has been used as the date for payment of the infrastructure charge only for ease of understanding as this is the day on which a tax invoice and financial information is provided. This does not necessarily reflect the date on which this amount is actually paid.

Assumptions

- The private practice partnership is registered from, or with effect from, 1 July.

- PHO will raise a tax invoice for the infrastructure charge for the period July to August and then move to monthly tax invoices from September.
- The monthly component of the infrastructure charge is invoiced and paid in the month after the billing month (with the exception of the month of June, where the invoice should be dated 30 June).
- Quarterly BAS period dates are assumed to end on each of 30 September, 31 December, 31 March, 30 June.
- The PHO is assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department.

1 July: Private practice partnership registered for GST (or registrations to be effective from 1 July);

2 July: PHO to withdraw the June infrastructure charge with no GST applicable;

2 August: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of July from No 1 Account;

2 September: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of August from No 1 Account;

2 October: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charges raised for the period 1 July to 31 August, 2000;

31 October: All SMPs to have notified PHO of private practice partnership GST registration details including ABN (where available), name and address for billing purposes, membership of the partnership, and their GST accounting method;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 31 August, 2000 (Note there is a requirement for the PHO to provide transaction information to 30 September while the tax invoice is only to 31 August);

PHO to provide the tax invoice to the partnership together with copies of any tax invoices issued on the partnership's behalf, for taxable supplies for the period 1 July to 30 September, 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of September (Note there is a requirement for the PHO to provide transaction information for October while the tax invoice is for September);

PHO to provide the tax invoice to the partnership together with copies of any tax invoices issued on the partnership's behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 31 August and the month of September.

11 November: Private practice partnerships to have lodged their BAS for the quarter ended 30 September (note, this is generally the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents). This BAS should include infrastructure charges raised for July and August and billing information for the period 1 July to 30 September;

27 November: SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity for the quarter ended 30 September, into the No 1 Account.

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to $1/11^{th}$ of the invoiced amounts) for the period 1 July to 31 August. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds).

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month: PHO to close off month in ledgers.

2^{nd} day of following month: (i.e. the 2^{nd} month) PHO to withdraw $10/11^{th}$ of GST inclusive infrastructure charge calculated for the billing month.

2^{nd} day of 3^{rd} month: PHO to raise a tax invoice for the infrastructure charge raised during the 2^{nd} month. PHOs should note that there is a requirement for the PHO to provide transaction information for the 2^{nd} month while the tax invoice is only for any infrastructure charges levied during the 2^{nd} month (ie the charge calculated o the billing month on the 2^{nd} day of the 2^{nd} month). As the infrastructure charge has been paid in the 2^{nd} month, provided the tax invoice is received prior to lodgment of a BAS in the 3^{rd} month the partnership can include the infrastructure charges levied in the 2^{nd} month in their BAS for the 2^{nd} month, lodged in the 3^{rd} month;

PHO to provide the tax invoice to the partnership together with copies of any tax invoices issued on the partnership's behalf, for taxable supplies during the 2^{nd} month.

7^{th} day of the 3^{rd} month: PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on any infrastructure charge levied during the 2^{nd} month.

7th day of month following end of a quarterly BAS period:	Partnership expected to have lodged their BAS for the previous quarter. (Note this is the last day for lodgment if the partnership is to have the refund back prior to the date of repayment into the No 1 Account).
21st day of month following end of a quarterly BAS period:	Partnership to have paid an amount equivalent to the GST net amount for the previous quarter from rights of private practice activities from refunds received from the ATO. PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts). (Note this may be withdrawn earlier or later at the PHOs discretion, subject to availability of funds.)

To align payments of the monthly infrastructure charge with those of the annual charge, and thereby ensuring that no income tax misalignment of fees collected and infrastructure charges arises for SMPs, PHOs should ensure that invoices raised for the month of June are dated 30 June.

Annual infrastructure charge arrangements

This timeline requires that the tax invoice being dated 30 June is observed. PHOs may use their discretion to vary the date in July that payment by an SMP, who accounts for GST using the accruals method, is required. This discretion is dependant on the date that they provide the tax invoice to the SMP, allowing sufficient time for BAS preparation and a fourteen day return of any refund from the ATO.

Assumption:	The annual component of the infrastructure charge is invoiced but not paid prior to the end of the financial year (i.e. 30 June)
30th June:	PHO to close off books for the financial year. PHO to raise a tax invoice for the annual infrastructure charge. **This invoice must be raised with a date of 30 June**;
2 July:	PHO to provide the tax invoice to the SMP; PHO to withdraw 10/11th of GST inclusive annual infrastructure charge and pay 1/11th to the General Fund and 9/11th to the No 2 account;
7th July:	PHO expected to have lodged their BAS for June incorporating an amount of 1/11th GST on the annual infrastructure charge. Partnership expected to have lodged its BAS for June quarter. If accounting on an accruals basis, then the SMP should include the annual infrastructure charge on that BAS.

21st July SMPs accounting on the accruals method for GST to have paid into the No 1 account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;

PHO to raise a debtor against an SMPs drawings, who were required to pay by 21st July, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;

21st October: SMPs accounting on the cash method for GST to have paid into the No 1 Account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;

PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;

PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) and pay to the credit of the No 2 Account. (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

PHOs should note that the these arrangements have been made to ensure that neither the PHO nor the SMP are adversely affected in cash flow terms by the imposition of the GST. The 30 June date on the tax invoice is imperative to the workings of these procedures. The different repayment date for SMPs who are still accounting for GST on the cash method is to reflect their inability to claim an input tax credit for the infrastructure charge at an earlier date.

Example 2(b)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the month after the billing period:
- monthly 20% of Gross Billing plus GST (i.e. does not cover SMPs with a infrastructure charge level of 90% or more)
- annual Balance of No 1 account plus GST

Drawings: 70% of Receipts

SMP Accounting Basis: **Accrual & Quarterly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
2/8/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(20.00)	80.00		
	PHO payment of July drawings to partnership	(70.00)	10.00		
7/8/00	PHO BAS lodgment.				
2/9/00	PHO calculation of August Receipts	100.00	110.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(20.00)	90.00		
	PHO payment of August drawings to partnership	(70.00)	20.00		
7/9/00	PHO BAS lodgment.				
2/10/00	PHO calculation of September Receipts	100.00	120.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	100.00		
	PHO payment of drawings to partnership	(70.00)	30.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the period 1 July to 31 August which was paid in August and September.	0		0	
2/11/00	PHO calculation of October Receipts	100.00	130.00		
	PHO calculation of October infrastructure charge plus GST. Draw 10/11th of total.	(20.00)	110.00		
	PHO payment of drawings to partnership.	(70.00)	40.00		
3/11/00	Raise tax invoice for the infrastructure charges calculated between 1 July and 31 August, 2000 and an additional tax invoice for the month of September. Provide billing information for the period 1 July to 30 September and for the month of October				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 31 August and for the month of September.	6.00		(6.00)	
11/11/00	Partnership BAS lodgment for Sept quarter including ITC on infrastructure charge raised in September quarter for period July to August.	(4.00)			4.00
27/11/00	Partnership payment of GST net credit for September quarter to No 1 Account	4.00	44.00		0
2/12/00	PHO calculation of November Receipts	100.00	144.00		
	PHO calculation of November infrastructure charge plus GST. Draw 10/11th of total	(20.00)	124.00		
	PHO payment of drawings to partnership.	(70.00)	54.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for the period July to August.	(4.00)	50.00	(2.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	Raise a tax invoice for the infrastructure charge for the month of October (raised in November) and provide billing information for November.				
Second Arrangement Begins					
7/12/00	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/1/00	PHO calculation of December Receipts	100.00	150.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(20.00)	130.00		
	PHO payment of drawings to partnership	(70.00)	60.00		
	Raise a tax invoice for the infrastructure charge for the month of November (raised in December) and provide billing information for December.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/1/01	Partnership BAS lodgment including ITC on infrastructure charges raised in the December quarter (ie September-November).	(6.00)			6.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
21/1/01	Partnership payment of GST net credit for December quarter to No 1 Account	6.00	66.00		0
2/2/01	PHO calculation of January Receipts	100.00	166.00		
	PHO calculation of January infrastructure charge plus GST. Draw 10/11th of total	(20.00)	146.00		
	PHO payment of drawings to partnership	(70.00)	76.00		
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge raised in the December quarter (i.e. charges for September-November)	(6.00)	70.00	0	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	Raise a tax invoice for the infrastructure charge for the month of December (raised in January) and provide billing information for January.				
7/2/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/3/01	PHO calculation of February Receipts	100.00	170.00		
	PHO calculation of February infrastructure charge plus GST. Draw 10/11th of total	(20.00)	150.00		
	PHO payment of drawings to partnership	(70.00)	80.00		
	Raise a tax invoice for the infrastructure charge for the month of January (raised in February) and provide billing information for February.				
7/3/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
2/4/01	PHO calculation of March Receipts	100.00	180.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of March infrastructure charge plus GST. Draw 10/11th of total	(20.00)	160.00		
	PHO payment of drawings to partnership	(70.00)	90.00		
	Raise a tax invoice for the infrastructure charge for the month of February (raised in March) and provide billing information for March.				
7/4/01	Partnership BAS lodgment including ITC on infrastructure charge for March quarter.	(6.00)			6.00
	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(6.00)	
21/4/00	Partnership payment of GST net credit for March quarter to No 1 Account	6.00	96.00		0
2/5/01	PHO calculation of April Receipts	100.00	196.00		
	PHO calculation of April infrastructure charge plus GST. Draw 10/11th of total	(20.00)	176.00		
	PHO payment of drawings to partnership	(70.00)	106.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charges raised during the March quarter	(6.00)	100.00	0	
	Raise a tax invoice for the infrastructure charge for the month of March (raised in April) and provide billing information for April.				
7/5/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(2.00)	
2/6/01	PHO calculation of May Receipts	100.00	200.00		
	PHO calculation of May infrastructure charge plus GST. Draw 10/11th of total	(20.00)	180.00		
	PHO payment of drawings to partnership	(70.00)	110.00		
	Raise a tax invoice for the infrastructure charge for the month of April (raised in May) and provide billing information for May.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/6/01	PHO BAS lodgment including GST paid on infrastructure charge.	2.00		(4.00)	
30/6/01	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. PHO raises a tax invoice dated 30 June.				
2/7/01	PHO calculation of June Receipts	100.00	210.00		
	PHO calculation of June infrastructure charge plus GST. Draw 10/11th of total	(20.00)	190.00		
	PHO payment of drawings to partnership	(70.00)	120.00		
	Raise a tax invoice for the infrastructure charge for the month of May (raised in June) and provide billing information for June.				
	PHO withdraws annual infrastructure charge from No 1 Account and pays in accordance with procedures. PHO provides a copy of the tax invoice to the SMP	120.00	0	8.00	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/7/01	Partnership BAS lodgment including ITC on infrastructure charges raised during the June quarter and annual component.	(18.00)			18.00
	PHO BAS lodgment including GST paid on monthly and annual components of the infrastructure charge.	14.00		(6.00)	
21/7/01	Partnership payment of GST net credit for June quarter and annual charge to No 1 Account	18.00	18.00		0
	PHO draws remaining 1/11th of annual component of infrastructure charge (paid to No 2 account)	(12.00)	6.00		
2/8/01	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge raised during the June quarter.	(6.00)	0	0	
7/8/01	PHO BAS lodgment including GST paid on monthly components of the infrastructure charge.	2.00		(2.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/10/01	Partnership BAS lodgment including ITC for June infrastructure charges raised in July	2.00			2.00
21/10/01	Partnership pays an amount equivalent to the ITC on infrastructure charges incurred in the September quarter (i.e. June) into No 1 Account	2.00	2.00		0
2/11/01	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for June raised in July.	(2.00)	0	0	

Level 2-5 SMPs with an Infrastructure charge of 90% or more

Practical Procedures & Obligations

Where an SMPs infrastructure charge is 90% or more, the arrangements will be the same regardless of whether the SMP is an individual, a private practice partnership or any other legal entity.

Note, references in this procedural document to SMPs should be read as pertaining to the SMPs appropriately registered legal entity of which he/she is a member (partnership or otherwise) or, in the event that such a structure is not in existence then, to the SMP individually.

SMPs with an annual turnover of less than $50,000 may choose not to be registered for GST, however, regardless of this fact these procedures will still apply. SMPs who choose not to be registered should be aware that they will suffer a loss of income due to the need to refund an amount equivalent to net GST credits to the No 1 Account irrespective of the fact that these amounts have not been received from the ATO

PHO Obligations

PHOs are obliged to do the following:

- Invoice patients (or other recipients of the supply) on an SMPs behalf. However, the PHO will only issue a tax invoice on behalf of the SMP (quoting the ABN of the PHO as agent) in the event that the patient or other recipient requests one. Copies of such tax invoices for taxable supplies are to be provided to the relevant SMP;

- Ensure that payments for services rendered by SMPs are deposited in a separately identifiable account administered by the PHO (this account is referred to as the No 1 Account throughout this document);

- Issue a compliant tax invoice, for the monthly component of the infrastructure charge, to SMPs following close of books for that month;

- Issue cash statements of transactions on the No 1 Account, to all SMPs (not only those who account for GST on a cash basis) following close of books for that month (refer to the sample tax invoice and financial information provided annexed to this Procedures document);

- Except as detailed in the following dot points, issue a statement of gross billings to all SMPs following close of books for that month. Where SMPs are members of a group (e.g. approved pathology provider arrangements), the PHO will undertake to issue patient invoices and provide gross billing statement information on an individual SMP basis. Where this is currently not possible, the PHO will generally undertake to make arrangements to move to a system capable of tracking this information, in the event that such information can be tracked.

- Notwithstanding the above, in the following circumstances, the PHO should provide gross billing information on individual allocation of gross billings based on the proportion of individual drawings to total group drawings. These circumstances are:

    - where individual billing information is not available; or
    - as an interim measure for the PHO moving to individual billings information;

- Issue consolidated gross billing statements covering all SMP members of a legal entity where the SMP is a member of a wider, GST registered legal entity (e.g. partnership) for the purposes of rights of private practice;

- Not draw the infrastructure charge from the No.1 Account prior to the issue of the tax invoice where the PHO closes their books prior to the end of a month. Where the PHO closes their books at the end of month (1st month) and does not impose an infrastructure charge until the following month (2nd month), the infrastructure charge may be drawn prior to the issue of a tax invoice, provided that the tax invoice, with accompanying billing information for the 2nd month is presented to the SMP no later than two (2) days after the end of the month in which the charge was raised (i.e. in the 3rd month). (Note as the infrastructure charge has been paid in the 2nd month, provided the tax invoice is received prior to lodgment of a BAS in the 3rd month the SMP can include infrastructure charges raised in the 2nd month in their BAS which may be lodged in the 3rd month);

- The first 1/11th of the annual component of the infrastructure charge will be paid from the No 1 account to the PHOs General Fund. The remaining 10/11th of the annual component of the

infrastructure charge is to be paid into a separately identifiable PHO account (referred to through this procedural document as the No 2 Account) in two instalments (9/11th and 1/11th respectively), in accordance with the timeline dates outlined later in this procedures document and subject to availability of funds in the No 1 Account. These amounts will not be paid into any other accounts.

- In relation to annual components of the infrastructure charge, if a SMP does not pay an amount equivalent to 1/11th of the annual component by the 21st day of the month following the month in which a tax invoice was issued for the annual component, or such other time as is agreed in accordance with the timeline dates outlined later in this procedures document, then subsequent drawings will be reduced as required, to return this amount to the No 1 Account.

- Issue a compliant tax invoice, for the annual component of the infrastructure charge, to SMPs following the close of books at the end of the financial year;

- Only draw out of the No 1 Account, an amount equal to 10/11th of the GST inclusive infrastructure charge (whether on a monthly or annual basis) on the day the tax invoice is raised or the day on which the charge is calculated for PHOs who raise an infrastructure charge after the end of a month (subject to the provisions outlined in the timelines, which appear later in this document, for the annual component of the charge). The additional 1/11th will be drawn on the last day of the month in which a quarterly BAS was due for lodgment. However, where sufficient funds are available, the additional 1/11th may be drawn prior to the last day of the month in which a quarterly BAS was due for lodgment (i.e., on any day on or after the day on which the 10/11th of the infrastructure charge is drawn provided that the No 1 Account has sufficient funds.

- In relation to monthly components of the infrastructure charge, if a SMP does not pay an amount equivalent to their net GST amount by the 21st day of the month following the month in which a tax invoice was issued, or the charge was withdrawn (in the event that the tax invoice is issue within two days of the end of the month in which the charge was withdrawn), for the monthly charge, then subsequent drawings will be reduced as required, in order to retain such amounts in the No 1 Account. Where the SMP have advised that they will be in a private practice partnership, for the **first quarter only,** if PHOs have sufficient funds to draw the final 1/11th of the infrastructure charge and the partnership has not been able to obtain their GST registration and complete BAS lodgment prior to the 11 November deadline, drawings will not be reduced until one month after they would otherwise have been reduced under this obligation;

- Meet any approved SMP Professional Development expenditure (TESL). Other than in those circumstances where allowances are paid to SMPs (including per diems), TESL is the hospital's expenditure, for which the PHO may be entitled to an input tax credit. TESL will only ever be paid from the No 2 Account. Where the SMP (or private practice partnership etc) receiving an allowance (including per diems) is registered for GST, the SMP may be entitled to an input tax credit for any GST taxable expenses met from the allowance received. Note, this paragraph is not intended to change the scope of TESL from that which is already provided;

- Ensure payment of drawings to SMPs who have elected Levels 2, 3 or 4 at an agreed minimum level per month. This practice is known as supplementation. If receipts do not allow for this level of drawings, the PHO will reduce infrastructure charges for that month, and previous months if necessary, to provide drawings to the SMP to that level. Where this results in an "adjustment event" for GST purposes, the PHO will raise an adjustment note and provide it to the SMP as required, either on a monthly or an annual basis. (Note, changes in infrastructure charge levels in the same month do not give rise to an adjustment event, therefore, where only the current month's infrastructure charge is adjusted, no adjustment note is required unless a tax invoice for the full amount of the infrastructure charge has been provided to the SMP.) Note, the operation of this paragraph is not intended to change the scope of supplementation from that which currently exists.

- Where a partnership deposits an amount greater than the calculated GST net credit. The additional amount will be refunded to the partners in addition to the next drawings payment made, provided that seven (7) days notice has been provided to the PHO of the distribution details of the amount. Where seven days notice is not provided, then the choice of repayment with current drawings or deferment of refund to following drawings payment will be discretionary on the PHO.

SMP Obligations

SMPs are obliged to do the following:

- Advise the PHO whether, with effect from 1 July, 2000 or any other effective date, they are registered, or have applied to be registered, for GST, as an individual or whether they are a member of a legal entity (e.g. partnership) which has so applied. Also, to advise if, at any time they cease to hold that registration during such time as they conduct rights of private practice in a NSW PHO. (Note: where SMPs are members of a legal entity for rights of private practice purposes, this will reduce considerably the administrative burden on all parties);

- Advise the PHO of the details of the individual SMP or the legal entity of which they are a member. Such details are as follows: the ABN (where available), the name and address for inclusion on tax invoices, membership of any partnership, and their chosen method of GST accounting (i.e. accrual or cash). In the event of any change to the ABN, the SMP will advise the PHO of that change within seven (7) days of that change occurring or advice from the ATO being received that the change has occurred;

- In relation to monthly components of the infrastructure charge, the SMP will pay an amount equivalent to their net GST credit from rights of private practice by the 21st day of the month following the month in which a tax invoice was issued, or the charge was withdrawn (in the event that the tax invoice is issued within two days of the end of the month in which the charge was withdrawn), for the monthly charge. If the payment is not received by the 21st day of the month, then subsequent drawings will be reduced as required, to return this amount to the No 1 Account. These amounts will then be transferred to the PHO General Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge. Note, where the SMP has advised the PHO that they account for GST on the cash accounting method but will be moving to accruals from the quarter commencing 1 October,

then for the **first quarter only**, the GST net amount will be calculated as being the cash accounting net amount, where the PHO has not drawn the full 11/11th of the infrastructure charges raised during the months of July to September. Where this is the case, drawings will only be reduced by the cash amount with the remainder of the accruals based net amount being recovered from January drawings. Additionally, where the SMP has advised that they will be in a private practice partnership, for the **first quarter only,** if PHOs have sufficient funds to draw the final 1/11th of the infrastructure charge and the partnership has not been able to obtain their GST registration and complete BAS lodgment prior to the 11 November deadline, drawings will not be reduced until one month after they would otherwise have been reduced under this obligation;

- In relation to annual components of the infrastructure charge, the SMP will pay into the No 1 Account an amount equivalent to 1/11th of the annual component by the 21st day of the month following the month in which a tax invoice was issued for the annual component of the infrastructure charge, or such other date as is nominated by the PHO in the event that the annual component is invoiced but not paid in June. If the payment is not received by the 21st day of the month, then subsequent drawings payments will be reduced as required, to return this amount to the No 1 Account. These amounts will then be transferred to the No 2 Account, in the event that the PHO has not already drawn the full 11/11th of the infrastructure charge;

- In the event that a SMP changes their private practice election to Level 1, the SMP will ensure that all GST net amounts have been fully funded in the No 1 Account, or make arrangements for payment of any outstanding amounts by the 21st day of the month in which a quarterly BAS is due for lodgment for the period in which the final tax invoice is received. If payment is not received, the PHO will be entitled to recover the outstanding amount through reduction of salary amounts owed to the SMP by the PHO until such time as the amount is paid. The SMP will provide the PHO with a written authority at the time of changing their private practice election to Level 1 to recover this entitlement. Note the PHO must provide the SMP with seven (7) days notice of their intention to reduce amounts owed to the SMP in accordance with the written authority;

- Provide the PHO with a written authority upon commencement of employment or, if currently employed, as soon as practicable, to use any termination payments (including annual leave and long service leave payouts) to offset any remaining liability of the SMP in relation to the infrastructure charge. Note the PHO must provide the SMP with seven (7) days notice of their intention to reduce these amounts.

- Where the partnership has included creditable acquisitions on its BAS other than those used to calculate the net GST credit for the purposes of this procedure, the partnership may deposit an amount greater than that owed to the No 1 Account. Where this is the case, the Partnership must provide details of the additional payment to the PHO together with details of the distribution of repayment of these funds to the partners seven (7) days prior to the next drawings distribution. Where seven days notice is not provided, then the choice of repayment with current drawings or deferment of refund to following drawings payment will be discretionary on the PHO.

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the Billing Month

This part of the procedure should be used by PHOs who close their books on or before the last day of a month and who calculate, invoice and withdraw infrastructure charges on or before the last day of the billing month.

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, a fully worked example where SMPs are accounting for GST on accruals basis is provided as example 3.

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur.

Assumptions

- SMPs are registered, either individually or as part of a legal entity, from, or with effect from 1 July.
- The PHO will raise a tax invoice for the infrastructure charge for the period July to September and then move to monthly tax invoices from October.
- The monthly component of the infrastructure charge is calculated, invoiced and paid in the month it occurs.
- The PHO is assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department.

1 July: SMPs registered for GST (or registrations to be effective from 1 July);

30 September: PHO to withdraw 10/11th of GST inclusive infrastructure charge for September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September, 2000;

31 October: All SMPs to have notified PHO of either individual or legal entity GST registration details including ABN (where available), name and address for billing purposes, membership of any partnership, and their GST accounting method;

PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of October from No 1 Account;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 30 September, 2000;

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the period 1 July to 30 September, 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of October;

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 30 September and the month of October.

11 November: SMP to have lodged their BAS for the quarter ended 30 September (note this is the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents) and the month of October;

27 November: SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity, into the No 1 Account for the period 1 July to 30 September and for the month of October.

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to $1/11^{th}$ of the invoiced amounts) for the period 1 July to 30 September and for the month of October. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds).

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month: PHO to raise a tax invoice for an infrastructure charge for the month;

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the month;

PHO to withdraw $10/11^{th}$ of GST inclusive infrastructure charge;

7^{th} day of following month: PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the infrastructure charge raised for that month.

21^{st} day of following month: SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity, into the No 1 Account and provide documentary evidence of this payment to the PHO.

	PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;
Last day of following month:	PHO to withdraw the outstanding amounts of infrastructure charges (equal to $1/11^{th}$ of the invoiced amounts). Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds.

Annual infrastructure charge arrangements

Note: where the annual infrastructure charge is not to be raised prior to, or on the last day of the financial year, then the PHO should refer to the arrangements outlined for PHOs who close their books on or after the end of the financial year.

Last day of financial year:	PHO to raise a tax invoice for the annual infrastructure charge; PHO to provide the tax invoice to the SMP; PHO to withdraw $10/11^{th}$ of GST inclusive annual infrastructure charge;
7^{th} day of following month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on the annual infrastructure charge.
21^{st} day of following month:	SMPs to have paid into the No 1 Account an amount equivalent to $1/11^{th}$ of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO; PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made; PHO to withdraw the outstanding amounts of infrastructure charges (equal to $1/11^{th}$ of the invoiced amounts). (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

Example 3(a)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the same month as the billing period:
- monthly 90% of Gross Billing plus GST
- annual Balance of No 1 account plus GST (assume drawn annually)

Drawings: 5% of Receipts

SMP Accounting Basis: **Accrual & Monthly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs, or the registered entity of which they form a part, will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
31/7/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(90.00)	10.00		
	PHO payment of July drawings to SMP	(5.00)	5.00		
7/8/00	PHO BAS lodgment.				
31/8/00	PHO calculation of August Receipts	100.00	105.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(90.00)	15.00		
	PHO payment of August drawings to SMP	(5.00)	10.00		
7/9/00	PHO BAS lodgment.				
30/9/00	PHO calculation of September Receipts	100.00	110.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total. Raise a tax invoice for the infrastructure charges calculated between 1 July and 30 September, 2000.	(90.00)	20.00		
	PHO payment of drawings to SMP	(5.00)	15.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the quarter ended 30 September.	0		0	
31/10/00	PHO calculation of October Receipts	100.00	115.00		
	PHO calculation of October infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	25.00		
	PHO payment of drawings to SMP	(5.00)	20.00		
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 30 September and for the month of October.	36.00		(36.00)	
11/11/00	SMP BAS lodgment included ITC on infrastructure charge for Sept quarter.	(27.00)			27.00
	SMP BAS lodgment included ITC on infrastructure charge for October.	(9.00)			36.00
27/11/00	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	36.00	56.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for Sept quarter and October	(36.00)	20.00	0	
Second Arrangement Begins					
30/11/00	PHO calculation of November Receipts	100.00	120.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of November infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	30.00		
	PHO payment of drawings to SMP	(5.00)	25.00		
7/12/00	SMP BAS lodgment included ITC on infrastructure charge for November.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/12/00	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	34.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for November	(9.00)	25.00	0	
31/12/00	PHO calculation of December Receipts	100.00	125.00		
	PHO calculation of December infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	35.00		
	PHO payment of drawings to SMP	(5.00)	30.00		
7/1/01	SMP BAS lodgment included ITC on infrastructure charge for December.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
21/1/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	39.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for December	(9.00)	30.00	0	
31/1/01	PHO calculation of January Receipts	100.00	130.00		
	PHO calculation of January infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	40.00		
	PHO payment of drawings to SMP	(5.00)	35.00		
7/2/01	SMP BAS lodgment included ITC on infrastructure charge for January.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/2/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	44.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for January	(9.00)	35.00	0	
28/2/01	PHO calculation of February Receipts	100.00	135.00		
	PHO calculation of February infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	45.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO payment of drawings to SMP	(5.00)	40.00		
7/3/01	SMP BAS lodgment included ITC on infrastructure charge for February.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/3/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	49.00		0
	PHO draws an amount from No 1 Account to pay debtor of $1/11^{th}$ of infrastructure charge for February	(9.00)	40.00	0	
31/3/01	PHO calculation of March Receipts	100.00	140.00		
	PHO calculation of March infrastructure charge plus GST. Raise a tax invoice. Draw $10/11^{th}$ of total	(90.00)	50.00		
	PHO payment of drawings to SMP	(5.00)	45.00		
7/4/01	SMP BAS lodgment included ITC on infrastructure charge for March.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/4/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	54.00		0

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for March	(9.00)	45.00	0	
30/4/01	PHO calculation of April Receipts	100.00	145.00		
	PHO calculation of April infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	55.00		
	PHO payment of drawings to SMP	(5.00)	50.00		
7/5/01	SMP BAS lodgment included ITC on infrastructure charge for April.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/5/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	59.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for April	(9.00)	50.00	0	
31/5/01	PHO calculation of May Receipts	100.00	150.00		
	PHO calculation of May infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	60.00		
	PHO payment of drawings to SMP	(5.00)	55.00		
7/6/01	SMP BAS lodgment included ITC on infrastructure charge for May.	(9.00)			9.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/6/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	64.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for May	(9.00)	55.00	0	
30/6/01	PHO calculation of June Receipts	100.00	155.00		
	PHO calculation of June infrastructure charge plus GST. Raise a tax invoice. Draw 10/11th of total	(90.00)	65.00		
	PHO payment of drawings to SMP	(5.00)	60.00		
	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. Raise a tax invoice. Draw 10/11th of total	(60.00)	0		
7/7/01	SMP BAS lodgment included ITC on infrastructure charges for June and year end.	(15.00)			15.00
	PHO BAS lodgment including GST paid on infrastructure charge.	15.00		(15.00)	
21/7/01	SMP payment of an amount equivalent to their GST net Amount to No.1 Account	15.00	15.00		0

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No1 Account to pay debtor of 1/11th of infrastructure charge for June	(15.00)	0	0	

Practical Implementation of GST for PHOs who Levy the Infrastructure Charge in the month after the Billing Month

This part of the procedure should be used by PHOs who close their books on or after the last day of a month and who calculate, invoice and withdraw infrastructure charges in the month following the billing month

GST has been in place since 1 July so it is necessary to institute an initial set of procedures (described as the First Arrangement below) as well as ongoing procedures to apply going forward (described as the Second Arrangement below).

These arrangements are described below in timeline format. In addition, a fully worked example where SMPs are accounting for GST on accruals basis is provided as example 3(b).

First Arrangement (July, 2000 B October, 2000)

For ease of understanding, tasks have been set out in a timeline. Note the dates included are the latest possible date for each action/transaction to occur. The second day of the following month has been used as the date for payment of the infrastructure charge only for ease of understanding as this is the day on which a tax invoice and financial information is provided. This does not necessarily reflect the date on which this amount is actually paid.

Assumptions

- SMPs are registered, either individually or as part of a legal entity, from, or with effect from 1 July.
- The PHO will raise a tax invoice for the infrastructure charge for the period July to August and then move to monthly tax invoices from September.
- The monthly component of the infrastructure charge is calculated, invoiced and paid in the month after the billing month (with the exception of the month of June, where the invoice should be dated 30 June).
- The PHO is assumed to be following the interim procedures set out in 27 July and 1 August instructions from the Department of Health.

1 July: SMPs registered for GST (or registrations to be effective from 1 July);

2 July: PHO to withdraw the June infrastructure charge with no GST applicable;

2 August: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of July from No 1 Account;

2 September: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of August from No 1 Account;

2 October: PHO to withdraw 10/11th of GST inclusive infrastructure charge for the month of September from No 1 Account;

7 October: PHO to have lodged their September BAS without incorporating an amount of GST on the infrastructure charges raised for the period 1 July to 31 August, 2000;

31 October: All SMPs to have notified PHO of either individual or legal entity GST registration details including ABN (where available), name and address for billing purposes, partner details if in partnership, and their GST accounting method;

3 November: PHO to raise a tax invoice for an infrastructure charge for the period 1 July to 31 August, 2000 (Note there is a requirement for the PHO to provide transaction information to 30 September while the tax invoice is only to 31 August);

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies for the period 1 July to 30 September, 2000;

PHO to raise a tax invoice for the infrastructure charge for the month of September (Note there is a requirement for the PHO to provide transaction information for October while the tax invoice is for September);

PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies in the month of October;

7 November: PHO to have lodged their October BAS incorporating an amount of GST on the infrastructure charge raised for the period 1 July to 31 August and the month of September.

11 November: SMP to have lodged their BAS for the quarter ended 30 September (note, this is generally the last possible date for lodgment unless a specific extension has been received from the Australian Taxation Office e.g. through tax agents) This BAS should include infrastructure charges raised for July and August and billing information for the period 1 July to 30 September. SMP also to have lodged their BAS for the month of October;

27 November: SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity, into the No 1 Account for the period 1 July to 30 September and for the month of October.

PHO to withdraw from the No 1 Account the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) for the period 1 July to 31 August and for the month of September. (Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds.)

Second Arrangement (ongoing from November 2000 billings)

Note, the days nominated are expected to be the last day on which a task would be carried out and may happen earlier.

Last day of billing month:	PHO to close off month in ledgers.
2nd day of following month: (i.e. the 2nd month)	PHO to withdraw 10/11th of GST inclusive infrastructure charge calculated for the billing month.
2nd day of 3rd month:	PHO to raise a tax invoice for the infrastructure charge raised during the 2nd month. PHOs should note that there is a requirement for the PHO to provide transaction information for the 2nd month while the tax invoice is only for any infrastructure charges levied during the 2nd month (ie the charge calculated on the billing month on the 2nd day of the 2nd month). As the infrastructure charge has been paid in the 2nd month, provided the tax invoice is received prior to lodgment of a BAS in the 3rd month, the SMP can include the infrastructure charges levied in the 2nd month in their BAS for the 2nd month, lodged in the 3rd month; PHO to provide the tax invoice to the SMP together with copies of any tax invoices issued on the SMPs behalf, for taxable supplies during the 2nd month.
7th day of 3rd month:	PHO expected to have lodged their BAS for the previous month incorporating an amount of GST on any infrastructure charge levied during the 2nd month.
21st day of 3rd month:	SMPs to have paid an amount, equal to the net GST credit from rights of private practice activity for the 2nd month (includes the infrastructure charge calculated on the billing month but levied in the 2nd month) into the No 1 Account and provide documentary evidence of this payment to the PHO. PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts). Note this may be withdrawn earlier, at the PHOs discretion, subject to availability of funds. PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;

To align payments of the monthly infrastructure charge with those of the annual charge, and thereby ensuring that no income tax misalignment of fees collected and infrastructure charges arises for SMPs, PHOs should seek to ensure that invoices raised for the month of June are dated 30 June.

Annual infrastructure charge arrangements

This timeline requires that the tax invoice being dated 30 June is observed. PHOs may use their discretion to vary the date in July that payment by an SMP, who accounts for GST using the accruals method, is required. This discretion is dependant on the date that they provide the tax invoice to the SMP, allowing sufficient time for BAS preparation and a fourteen day return of any refund from the ATO.

Assumption:	The annual component of the infrastructure charge is invoiced but not **paid** prior to the end of the financial year (i.e. 30 June)
30th June:	PHO to close off books for the financial year.
	PHO to raise a tax invoice for the annual infrastructure charge. **This invoice must be raised with a date of 30 June**;
2 July:	PHO to provide the tax invoice to the SMP;
	PHO to withdraw 10/11th of GST inclusive annual infrastructure charge and pay 1/11th to the General Fund and 9/11th to the No 2 account;
7th July:	PHO expected to have lodged their BAS for June incorporating an amount of 1/11th GST on the annual infrastructure charge.
	SMPs expected to have lodged their BAS for June. If accounting on an accruals basis, then the SMP should include the annual infrastructure charge on that BAS.
21st July:	SMPs accounting on the accruals method for GST to have paid into the No 1 account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;
	PHO to raise a debtor against an SMPs drawings, who were required to pay by 21st July, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;
21st August:	SMPs accounting on the cash method for GST to have paid into the No 1 Account an amount equivalent to 1/11th of the GST inclusive annual infrastructure charge and provide documentary evidence of this payment to the PHO;
	PHO to raise a debtor against an SMPs drawings, where no payment has been received. These amounts to be withdrawn from the next, and if necessary, subsequent drawings payments made;
	PHO to withdraw the outstanding amounts of infrastructure charges (equal to 1/11th of the invoiced amounts) and pay to the credit of the No 2 Account. (Note this may be withdrawn earlier or later, at the PHOs discretion, subject to availability of funds);

PHOs should note that the these arrangements have been made to ensure that neither the PHO nor the SMP is adversely affected in cash flow terms by the imposition of the GST. The 30 June date on the tax invoice is imperative to the workings of these procedures. The different repayment date for SMPs who are still accounting for GST on the cash method is to reflect their inability to claim an input tax credit for the infrastructure charge at an earlier date.

Example 3(b)

Assumptions: Gross Billing: $100/month (no GST taxable activities)
Infrastructure charge raised in the month after the billing period:
- monthly 90% of Gross Billing plus GST
- annual Balance of No 1 account plus GST (assume drawn annually)

Drawings: 5% of Receipts
SMP Accounting Basis: **Accrual & Monthly BAS lodgment**

Note: In working this example, due to complexities of adding in other taxation matters, no regard has been paid to PAYG or other GST liabilities outside rights of private practice. In reality, it is likely that every quarter, SMPs, or the registered entity of which they form a part, will receive their net GST credit by way of an offset to other tax liabilities, not a cash refund.

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
First Arrangement Begins					
2/8/00	PHO calculation of July Receipts	100.00	100.00		
	PHO calculation of July infrastructure charge plus GST. Draw 10/11th of total	(90.00)	10.00		
	PHO payment of July drawings to SMP	(5.00)	5.00		
7/8/00	PHO BAS lodgment.				
2/9/00	PHO calculation of August Receipts	100.00	105.00		
	PHO calculation of August infrastructure charge plus GST. Draw 10/11th of total	(90.00)	15.00		
	PHO payment of August drawings to SMP	(5.00)	10.00		
7/9/00	PHO BAS lodgment.				
2/10/00	PHO calculation of September Receipts	100.00	110.00		
	PHO calculation of September infrastructure charge plus GST. Draw 10/11th of total.	(90.00)	20.00		
	PHO payment of drawings to SMP	(5.00)	15.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/10/00	PHO BAS lodgment without including GST paid on infrastructure charge for the quarter ended 30 September.	0		0	
2/11/00	PHO calculation of October Receipts	100.00	115.00		
	PHO calculation of October infrastructure charge plus GST. Draw 10/11th of total	(90.00)	25.00		
	PHO payment of drawings to SMP	(5.00)	20.00		
3/11/00	Raise tax invoice for the infrastructure charges calculated between 1 July and 31 August, 2000 and an additional tax invoice for the month of September. Provide billing information for the period 1 July to 30 September and for the month of October				
7/11/00	PHO BAS lodgment including GST paid on infrastructure charge for the period 1 July to 31 August and for the month of September.	27.00		(27.00)	
11/11/00	SMP BAS lodgment included ITC on infrastructure charges raised during the Sept quarter (i.e. July and August).	(18.00)			18.00
	SMP BAS lodgment included ITC on infrastructure charge for September.	(9.00)			27.00
27/11/00	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	27.00	47.00		0

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for Sept quarter and October	(27.00)	20.00	0	
Second Arrangement Begins					
2/12/00	PHO calculation of November Receipts	100.00	120.00		
	PHO calculation of November infrastructure charge plus GST. Draw 10/11th of total	(90.00)	30.00		
	PHO payment of drawings to SMP	(5.00)	25.00		
	Raise a tax invoice for the infrastructure charge for the month of October (raised in November) and provide billing information for November.				
7/12/00	SMP BAS lodgment included ITC on infrastructure charge for October.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/12/00	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	34.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for October	(9.00)	25.00	0	
2/1/01	PHO calculation of December Receipts	100.00	125.00		
	PHO calculation of December infrastructure charge plus GST. Draw 10/11th of total	(90.00)	35.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO payment of drawings to SMP	(5.00)	30.00		
	Raise a tax invoice for the infrastructure charge for the month of November (raised in December) and provide billing information for December.				
7/1/01	SMP BAS lodgment included ITC on infrastructure charge for December.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/1/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	39.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for December	(9.00)	30.00	0	
2/2/01	PHO calculation of January Receipts	100.00	130.00		
	PHO calculation of January infrastructure charge plus GST. Draw 10/11th of total	(90.00)	40.00		
	PHO payment of drawings to SMP	(5.00)	35.00		
	Raise a tax invoice for the infrastructure charge for the month of December (raised in January) and provide billing information for January.				
7/2/01	SMP BAS lodgment included ITC on infrastructure charge for December, raised in January.	(9.00)			9.00

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/2/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	44.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for January	(9.00)	35.00	0	
2/3/01	PHO calculation of February Receipts	100.00	135.00		
	PHO calculation of February infrastructure charge plus GST. Draw 10/11th of total	(90.00)	45.00		
	PHO payment of drawings to SMP	(5.00)	40.00		
	Raise a tax invoice for the infrastructure charge for the month of January (raised in February) and provide billing information for February.				
7/3/01	SMP BAS lodgment included ITC on infrastructure charge for January raised in February.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/3/01	SMP payment of an amount equivalent to their GST Net amount to No 1 Account	9.00	49.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for February	(9.00)	40.00	0	
2/4/01	PHO calculation of March Receipts	100.00	140.00		

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO calculation of March infrastructure charge plus GST. Draw 10/11th of total	(90.00)	50.00		
	PHO payment of drawings to SMP	(5.00)	45.00		
	Raise a tax invoice for the infrastructure charge for the month of February (raised in March) and provide billing information for March.				
7/4/01	SMP BAS lodgment included ITC on infrastructure charge for February, raised in March.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/4/01	SMP payment of an amount equivalent to their GST net amount to No 1 Account	9.00	54.00		0
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for March	(9.00)	45.00	0	
2/5/01	PHO calculation of April Receipts	100.00	145.00		
	PHO calculation of April infrastructure charge plus GST. Draw 10/11th of total	(90.00)	55.00		
	PHO payment of drawings to SMP	(5.00)	50.00		
	Raise a tax invoice for the infrastructure charge for the month of March (raised in April) and provide billing information for April.				

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
7/5/01	SMP BAS lodgment included ITC on infrastructure charge for March raised in April.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/5/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	59.00		0
	PHO draws an amount from No 1 Account to pay debtor of $1/11^{th}$ of infrastructure charge for April	(9.00)	50.00	0	
2/6/01	PHO calculation of May Receipts	100.00	150.00		
	PHO calculation of May infrastructure charge plus GST. Raise a tax invoice. Draw $10/11^{th}$ of total	(90.00)	60.00		
	PHO payment of drawings to SMP	(5.00)	55.00		
	Raise a tax invoice for the infrastructure charge for the month of April (raised in May) and provide billing information for May.				
7/6/01	SMP BAS lodgment included ITC on infrastructure charge for April raised in May.	(9.00)			9.00
	PHO BAS lodgment including GST paid on infrastructure charge.	9.00		(9.00)	
21/6/01	SMP payment of an amount equivalent to their GST Net Amount to No 1 Account	9.00	64.00		0

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
	PHO draws an amount from No 1 Account to pay debtor of 1/11th of infrastructure charge for May	(9.00)	55.00	0	
30/6/00	PHO calculation of remainder of infrastructure charge (i.e. balance of No 1 Account) plus GST. **Raise a tax invoice**.				
2/7/01	PHO calculation of June Receipts	100.00	155.00		
	PHO calculation of June infrastructure charge plus GST. Draw 10/11th of total	(90.00)	65.00		
	PHO payment of drawings to SMP	(5.00)	60.00		
	PHO withdraws annual infrastructure charge from No 1 Account and pays in accordance with procedures. PHO provides a copy of the tax invoice to the SMP	(60.00)	0	6.00	
	Raise a tax invoice for the infrastructure charge for the month of May (raised in June) and provide billing information for June.				
7/7/01	SMP BAS lodgment included ITC on infrastructure charges for May raised in June and annual infrastructure charge.	(15.00)			15.00
	PHO BAS lodgment including GST paid on monthly and annual components of infrastructure charge.	15.00		(9.00)	

Date	Transaction	Amount	No 1 A/c Balance	PHO Account GST Balance	SMP Account GST Balance
21/7/01	SMP payment of an amount equivalent to their GST Net Credit for monthly and annual components of infrastructure charge to No.1 Account	15.00	15.00		0
	PHO draws an amount from No1 Account to pay debtor of 1/11th of infrastructure charge for June and for annual component. The annual component is paid to No 2 Account.	(15.00)	0	0	
2/8/01	Raise a tax invoice for the infrastructure charge for the month of June (raised in July)				
7/8/01	SMP BAS lodgment included ITC on infrastructure charges for June raised in July.	(9.00)			9.00
	PHO BAS lodgment including GST paid on June.	9.00		(9.00)	
21/8/01	SMP payment of an amount equivalent to their GST Net Credit to No.1 Account for June and annual infrastructure charges	9.00	9.00		0
	PHO draws an amount from No1 Account to pay debtor of 1/11th of infrastructure charge for June	(9.00)	0	0	

Annexure 1: Sample Tax Invoices

Sample Tax Invoice for the First Arrangement

XXXX HEALTH SERVICE
ABN: 12 345 678 910
Revenue Dept., Locked Bag xxxx, Sydney, NSW 2170 AUSTRALIA
Telephone: (02) xxxx xxxx $ Fax: (02) xxxx xxxx

TAX INVOICE NO: 090002 / SS ***DATE: 31-Oct-00***

TO: Dr. XXXX
(Address of Dr as advised)

For the Period : 01/07/00 to 30/09/00	**Amount**
Infrastructure Charge for the Period	2,300.00
Goods and Services Tax on Infrastructure Charge	230.00
Total Infrastructure Charge for Period:	**$2,530.00**

To be provided to the SMP on a separate sheet to the tax invoice above

Supporting Information for Business Activity Statement

1. Accrual Information:

1.1	**Gross Patient Fees Raised for the Period (GST-free Supply)**	11,000.00
1.2	**Bad Debts Written Off**	-(100.00)
1.3	**Interest Earned on No 1 Account (Input Taxed Supply)**	600.00
1.4	**Fees Raised for Medical Reports Prepared (Taxable Supply)**	1,100.00
(Note : GST Payable on these Fees = 100.00 **)**		
Total Revenue for Accrual Purposes = 1.1+1.2+1.3+1.4		12,600.00

2. Cash Information:

(a) Cash Received

2.1	**Gross Patient Fees Received in the Period (including bad debts recovered)(GST-free Supply)** (exclude any amounts for services rendered prior to 1 July, 2000)	10,500.00
2.2	**Interest Received on No 1 Account in the period (Input Taxed Supply)**	500.00

2.3 Fees Received in the period for Medical Reports Prepared (including bad debts recovered) (Taxable Supply)
(exclude any amounts for services rendered prior to 1 July, 2000) 1,100.00
(Note : GST Payable on these Fees = 100.00**)**

Total Receipts for Cash Purposes = 2.1+2.2+2.3 12,100.00

(b) Cash paid

2.4 Amounts withdrawn in the period from No 1 Account for Monthly Infrastructure Charges (includes GST) 2,530.00

3. Other Information

3.1 Notional Annual Infrastructure Charge for the period
(for PAYG instalment information only) 2,132.00

3.2 Drawings paid to you in the Period 7,438.00
(Note this equals Total Cash Receipts less 2.4 & 3.1)

4. Amount to be deducted from your future drawings 130.00

Assumptions/Notes

General assumptions

This example is based on information for a Senior Medical Practitioner (SMP) with the following circumstances:

- the SMP is an individual who is not in Private Practice Partnership
- the infrastructure charge is less than 90% of cash received
- the information in the tax invoice and supporting information is for the first quarter following the introduction of GST i.e. 01/07/00 B 30/09/00
- the infrastructure charge is 20%
- the infrastructure charge is calculated on cash received in the period for gross patient fees, medical report fees (on a GST-exclusive basis) and bad debts recovered
- the drawings calculation is based on the Determination and Level election of SMP (in this example, $7,438).

Item 2.4 Amounts withdrawn from No 1 Account for monthly infrastructure charges

In this example, total cash paid by the SMP to the AHS in the period includes the full amount of the 3 months' worth of monthly infrastructure charges (11/11ths).

In other circumstances, the cash paid may only be 10/11ths of the infrastructure charge and, potentially, additional amounts owing from prior months.

Item 4: Amount to be deducted from your future drawings

In the circumstances of a Private Practice partnership with an infrastructure charge of less than 90% or SMPs with an infrastructure charge of 90% or greater (regardless of whether they are in a

partnership), this amount will be the amount to be paid by the partnership or the individual SMP into the No 1 account rather than a reduction in drawings.

The wording at Item 4 of the supporting information will need to be changed from the example where this is the case.

In this example, the drawings deduction amount of $130 is derived as the difference between the SMP input tax credit of $230 (that is, the same amount as the goods and services tax payable by the AHS in respect of the infrastructure charge shown on the tax invoice) and the SMP GST payable on medical reports of $100 (shown at Item 2.3).

Invoice for the Second Arrangement (i.e. ongoing)

XXXX HEALTH SERVICE
ABN: 12 345 678 910
Revenue Dept., Locked Bag xxxx, Sydney, NSW 2170 AUSTRALIA
Telephone: (02) xxxx xxxx $ Fax: (02) xxxx xxxx

TAX INVOICE NO: 090002 / SS ***DATE: 31-Dec-00***

TO: Dr. XXXX
(Address of Dr as advised)

For the Period : 01/12/00 to 31/12/00		**Amount**
Infrastructure Charge for the Period		210.00
Goods and Services Tax on Infrastructure Charge	21.00	
Total Infrastructure Charge for Period:		**$231.00**

To be provided to the SMP on a separate sheet to the tax invoice above

Supporting Information for Business Activity Statement
(Information for the Month of December)

1 Accrual Information:

1.1 Gross Patient Fees Raised for the Period (GST-free Supply) 1000.00

1.2 Bad Debts Written Off (10.00)

1.3 Interest Earned on No 1 Account (Input Taxed Supply) 10.00

1.4 Fees Raised for Medical Reports Prepared (Taxable Supply) 110.00
(Note : GST Payable on these Fees = 10.00 **)**

Total Revenue for Accrual Purposes = 1.1+1.2+1.3+1.4 1,110.00

2. Cash Information:

(a) Cash Received

2.1 Gross Patient Fees Received in the Period (including bad debts recovered)(GST-free Supply) (exclude any amounts for services rendered prior to 1 July, 2000) 950.00

2.2 Interest Received on No 1 Account in the period (Input Taxed Supply) 10.00

2.3 Fees Received in the period for Medical Reports Prepared (including bad debts recovered) (Taxable Supply)
(exclude any amounts for services rendered prior to 1 July, 2000) 110.00
(Note : GST Payable on these Fees = 10.00**)**

Total Receipts for Cash Purposes = 2.1+2.2+2.3 1,070.00

(b) Cash paid

2.4 Amounts withdrawn in the period from No 1 Account for Monthly Infrastructure Charges 240.00

3. Other Information (for PAYG instalment information only)

3.1 Notional Annual Infrastructure Charge to date
2,132.00

3.2 Drawings paid to you in the Period 600.00

4. Amount to be deducted from your future drawings 51.00

Assumptions/Notes

General assumptions:

This example is based on information for a Senior Medical Practitioner (SMP) with the following circumstances:

- the SMP is an individual who is not in Private Practice Partnership
- all calculations are performed on cash received during the month rather than billings raised
- the infrastructure charge is 20%, i.e. less than 90% of cash received

Notes:

- the infrastructure charge is calculated on cash received in December for gross patient fees, medical report fees (on a GST-exclusive basis) and bad debts recovered. Amounts of GST and interest should not be included in the calculation of the infrastructure charge

- the drawings calculation is based on the Determination and Level election of SMP less any amounts deductible from previous months.

- where an invoice is for a private practice partnership, the invoice and the supporting information will be provided as a consolidation of all amounts pertaining to the partners (based on the partner information provided by the partnership to the PHO). That is only one tax invoice and schedule needs to be prepared consolidating the information for the individual SMPs making up the partnership;

- where an invoice relates to an infrastructure charge that was calculated and paid after month end, the tax invoice will contain information which has been calculated on the billing month (the 1st month), but will indicate that it has been raised and billed in the following month (the 2nd month). All supporting information will pertain to the 2nd month B not the 1st month. This invoice and supporting information will be provided within two (2) days of the end of the 2nd month (i.e. in the 3rd month).

Other points have been referenced to their item number on the supporting information schedule:

1. Accrual information is provided for the benefit of SMPs who account for GST on an accruals basis. No information on cash amounts paid out is provided for accruals purposes, as SMPs who account for GST on an accruals basis claim an input tax credit on the entire amount of the infrastructure charge as it appears on the tax invoice;

2. Cash information is provided for the benefit of SMPs who account for GST on a cash basis;

2.1 As patient fees received can include amounts invoiced prior to the commencement of GST (i.e. 1 July, 2000), these amounts must be excluded from the information reported. However, these amounts should still be incorporated into the calculation of the infrastructure charge;

2.2 As fees received for medical reports can include amounts invoiced prior to the commencement of GST (i.e. 1 July, 2000), these amounts must be excluded from the information reported. However, these amounts should still be incorporated into the calculation of the infrastructure charge. As stated previously, the amount of GST included in these fees must be excluded from the calculation of the infrastructure charge;

2.3 This sample invoice assumes that only 10/11th of the infrastructure charge for December ($210.00) and the final 1/11th of the November infrastructure charge ($30.00) were recovered during December. In some cases, a PHO will be able to recover the full 11/11th of an infrastructure charge in one month as well as an amount carried forward from previous months. Therefore, this amount may appear to be higher than the amount of the infrastructure charge that appears on the tax invoice. This item and its amount will need to be adjusted to reflect the payment of the annual component of the infrastructure charge in the periods when they occur.

3. This information is provided to assist SMPs in their calculation of their net income for the purposes of determining any income tax instalments. It has no GST relevance.

3.1 The notional annual infrastructure charge to date should be the current balance of funds "belonging" to an SMP the No 1 Account after accounting for monthly infrastructure charges, drawings and any amounts outstanding. Note where these funds have been used for supplementation and the amount is a negative, this should be recorded as "0" until such time as the funds come back into credit.

3.2 This amount represents the amount of drawings paid to an SMP during the period. It should be calculated as being the drawings payable based on the percentage relevant to their Level less any amounts of net GST credits outstanding and currently recoverable (i.e. due for payment by the SMP) to the No 1 Account.

4. In this example, the December information is based on the amounts outstanding for the entire quarter (i.e. October-December) the drawings deduction amount of $51 is derived as the difference between SMP input tax credits for the quarter of, say, $71 (that is, the total of amounts of the GST payable by the AHS in respect of the infrastructure charge shown on this tax invoice [$21] plus the amounts shown on the previous two tax invoices [say $50]) and the SMP GST payable on medical reports of $10 (shown at Item 2.3) plus say $10 GST payable on medical reports from statements from the previous two months which go to making up the quarter.

In the circumstances of a Private Practice partnership with an infrastructure charge of less than 90% or SMPs with an infrastructure charge of 90% or greater (regardless of whether they are in a partnership), this amount will be the amount to be paid by the partnership or the individual SMP into the No 1 account rather than a reduction in drawings. Where this is the case, the wording at Item 4 of the supporting information will need to be changed from the example to reflect that this amount is payable to the No 1 Account by the SMP.

It is possible, that where amounts have not been paid into the No 1 Account by their due date, the supporting information may need to reflect both drawings recovery and amounts payable.

Treatment of Salaried Medical Practitioners in Private Practice Groups who are not in a Partnership (PD2005_532)

The Circular is to be read in conjunction with and as a variation to PD2005_598, which outlines the GST Treatment of Rights of Private Practice.

The purpose of this Circular is to provide guidelines for Public Health Organisations (PHOs) on the method of dealing with payments between Salaried Medical Practitioners (SMPs) group members (who do not elect to be part of a partnership). The Circular details the most administratively viable guidelines in a way which does not affect the current tax treatment of payments to SMPs.

It is not the purpose of this circular to address whether there is a partnership at law for those members who remain in groups but do not formally wish to be in a partnership as this is a matter for consideration by the SMPs and their advisers.

It is understood that the major reason for certain SMPs not participating in a private practice partnership is that certain SMPs have some issues with the legal aspects of partnerships, particularly joint and several liability.

Procedures

The following procedure has been developed with the agreement of the Australian Salaried Medical Officers Federation (NSW) (ASMOF).

Where a private practice group exists and distributes income earned by individuals in the group on a shared basis, it is necessary to ensure, for the correct tax treatment of such arrangements, that supporting documentation clearly represent the transactions involved.

The transactions involved are:

1. Individuals in the group earn income from private practice billings;

2. Lower billing individuals in the group support the higher billing group members in a variety of capacities, for example research and administration. These individuals receive payment from a PHO for those activities through agreed levels of a distribution of group income as drawings in addition to those amounts required for payment under the SMP Determination (ie they draw more than they have invoiced);

3. The PHO levies an additional infrastructure charge on the higher billing group members. The charge raised is in addition to the scheduled infrastructure charge rates, in order to recompense the PHO for additional infrastructure related expenditure associated with relevant support activities. These support activities include the provision of services by other group members.

In order to reflect these transactions clearly, it is necessary for PHOs to ensure they include in their monthly private practice transactions (raised under PD2005_598) an invoice for additional charges levied on the group members who earn higher billings through obtaining access to the support services provided by other group members. This should occur by either adjustment to the tax invoice raised for the scheduled infrastructure charge or through an additional tax invoice. PHOs should also ensure that, for group members who receive additional drawings (refer to transaction 2 above), that these additional drawings are clearly reflected in their monthly private practice information schedules.

Note, where any additional infrastructure charges incurred in this manner would place a group member in the position of incurring an overall infrastructure charge in excess of 90% of billings, then this group member will be regarded, for the purposes of PD2005_598, as incurring an infrastructure charge based on their scheduled infrastructure charge rate. That is, where the scheduled charge is less than 90%, the group member will be subject to the recovery procedures outlined for SMPs with an infrastructure charge of less than 90%.

Further enquiries on the contents of this Circular should be directed to Ken Barker on (02) 9391 9178.

Where an SMP will be subject to the procedures outlined in this Circular, they should be provided with a copy of the Circular. Any queries they have should be directed to a nominated employee of your PHO or to ASMOF.

STAFF SPECIALIST RIGHTS OF PRIVATE PRACTICE ARRANGEMENTS (PD2016_042)

PD2016_042 rescinds PD2014_048

PURPOSE

This Policy Directive addresses the rights of private practice arrangements for Staff Specialists in respect of fees that can be charged where medical gap cover insurance is held, the availability of medical indemnity, and the disbursement of funds from the No 1 Account. The Policy Directive does not introduce any changes to existing practices, but extends the period in which Staff Specialists can be reimbursed medical indemnity costs from 30 June 2016 to 30 June 2017.

MANDATORY REQUIREMENTS

All Public Health Organisations (PHOs) are required to comply with the attached arrangements.

IMPLEMENTATION

Chief Executives are responsible for ensuring that this policy directive is brought to the attention of Staff Specialists and staff who are involved with Staff Specialist private practice billing arrangements.

Staff Specialists are responsible for ensuring that their billing procedures are in conformity with the provisions of this policy directive.

1. BACKGROUND

1.1 About this document

This Policy Directive deals with the rights of private practice arrangements for Staff Specialists, as established by section 2 of the *Staff Specialists Determination,* in respect of fees that can be charged where medical gap cover insurance is held, the availability of medical indemnity, and the disbursement of funds from the No 1 Account. (This Policy Directive does not introduce any changes to existing practices.)

2. FEES THAT CAN BE CHARGED WHERE MEDICAL GAP COVER INSURANCE IS HELD

1. Eligible persons treated as private (chargeable) patients by Staff Specialists when exercising rights of private practice, are able to be charged above the Medical Benefits Scheme (MBS) fee in the following circumstances:

i. The patient has medical gap cover insurance from a health fund, so that the fund will cover the "gap" between the MBS fee and the fee charged by a hospital on behalf of the Staff Specialists and
ii. The patient will not have any out of pocket expenses in relation to the particular service involved.

2. The approval to charge eligible patients above the MBS fee is subject to the following provisions:

   i. The arrangements can apply to all episodes of treatment and attendance in respect of which hospitals issue bills on behalf of Staff Specialists and

   ii. The relevant Public Health Organisation (PHO) must have given prior approval to a Staff Specialist's participation in the arrangements.

3. There is no obligation on a PHO or a Staff Specialist to become involved in these arrangements. Where a PHO does elect to become involved, they will need to arrange for procedures to be put in place so that when a patient indicates an election to be treated as a private patient, information is sought on where that patient has available health fund gap cover insurance with a health fund, in order that the necessary billing arrangements can be implemented by the hospital on behalf of the Staff Specialist.

4. The need to operate a more complex billing system may involve further administrative work, possible software revision, and possible additional extra costs. Where such additional costs can be clearly demonstrated, arrangements can be made to recoup them on a cost recovery basis. The costs so recovered:

   i. Should be the first charge on the monies received where patients have been charged above the MBS fee

   ii. Are to be in addition to infrastructure fees levied and

   iii. Are to be accounted for in the same manner as infrastructure fees received in respect of private practice revenue.

In assessing whether additional charges are to be made, regard should be had to any additional revenue from infrastructure fees that would be received as a result of the high charges that would be involved.

3. APPROVED LEVEL OF ACTUAL ACCOUNTING COSTS FOR PARTNERSHIPS

Approval for the payment from the relevant sub-ledger of the No. 1 Account of actual accounting costs associated with establishing and operating partnerships for Staff Specialists who have elected a Level 2 to 5 right of private practice arrangement are up to the following amounts:

- $2,420 for established costs
- $5,500 p.a. for ongoing costs

These amounts will be reviewed from time to time as appropriate.

4. PROVISION OF MEDICAL INDEMNITY

The provision of all Treasury Managed Fund (TMF) indemnity cover is subject to certain qualifications including:

1. The conduct constituting the tort to be indemnified was not criminal and did not involve serious and wilful misconduct.

2. The conduct giving rise to the liability claim occurred in the course of, or arose out of, the treatment of a private (i.e. chargeable) patient for which the employing PHO was entitled to raise an account in the name Staff Specialist.

3. The Staff Specialist agreeing that the management and conduct of the claim passes entirely to the PHO and the TMF.

4. Any decision as to whether a claim is to be settled or defended rests with the TMF.

5. TMF indemnity does not provide cover for coronial inquests, inquiries of the Health Care Complaints Commission (HCCC) or other disciplinary matters. (Staff Specialists should consider making alternative arrangements to provide indemnity cover for these types of matters.)

Staff Specialists Level 1

Staff Specialists employed by PHOs who have elected a Level 1 private practice arrangement, are indemnified through the TMF against liability for claims arising during the course of treating both public and private (i.e. chargeable) patients in public hospitals or as part of other services provided by the PHO.

Staff Specialists Level 2 to 5

Staff Specialists employed by PHOs who have elected a Level 2 to 5 private practice arrangement, are indemnified through the TMF against liability for claims arising during the course of treating public patients in public hospitals or as part of other services provided by the PHO.

Where a Staff Specialist who has elected a Level 2 to 5 private practice arrangement has entered into a contract of liability coverage for the indemnity under the TMF, indemnity is also provided in respect of services provided as part of the exercise of rights of private practice to private rural and / or paediatric patients in or at public hospitals or as part of other services provided by the PHO. Staff Specialists with a contract of liability coverage should refer to their contract for specific details of the applicable terms and conditions of cover.

1. The conduct giving rise to the liability claim occurred in the course of, or arose out of, the treatment of a private (i.e. chargeable) patient for which the employing public health organisation was entitled to raise an account in the name of the Staff Specialist.

2. The Level 1 Staff Specialist acknowledges that the management and conduct of the claim passes entirely to the public health organisation and the Treasury Managed Fund.

3. Any decision as to whether a claim is to be settled or defended rests with the Treasury Managed Fund.

4. Treasury Managed Fund indemnity does not provide cover for coronial inquests, inquiries of the Health Care Complaints Commission (HCCC) or other disciplinary matters. Staff Specialists should consider making alternative arrangements to provide indemnity cover for these types of matters.

5. REIMBURSEMENT OF MEDICAL INDEMNITY COSTS

The scheme by which medical indemnity costs incurred by Staff Specialists who have elected a Level 2 to 5 private practice arrangement can be reimbursed, will remain in place until 30 June 2017.

1. Staff Specialists who have elected a Level 2 to 5 private practice arrangements are authorised to receive reimbursement from the relevant sub-ledger of the No. 1 Account of amounts paid in order to obtain medical indemnity cover relating to the exercise of their rights of practice which is not covered by TMF indemnity. This includes all amounts paid in relation to membership of medical indemnity provider organisations and insurance (excluding those costs incurred in respect of outside private practice as specified below at section 5(4)).

2. In circumstances where an agreed group of partnership pools private practice billings, it is a matter for the members of the agreed group of partnership to determine the manner in which claims for reimbursement are to be made, having regard to the possibility that there may be insufficient funds to meet all costs. Each agreed group or partnership will need to advise their PHO of the approach they wish to take in respect of reimbursement prior to reimbursement being paid.

3. Reimbursement is only payable where originals or certificated copies of renewal forms, receives or other documents provided by the medical insurer have been provided, which show the amount of the membership subscription or premium payable, and the amount paid.

4. The amount that can be reimbursed will reflect only the costs relating to obtaining indemnity cover in respect of a Staff Specialist's private practice billings in the public hospital system (not relating to any outside private practice component). Staff Specialists can obtain reimbursement only for that part of their indemnity costs that would have been paid exclusive of any outside practice billings. Any additional premium or membership costs that arise from or are due to outside practice will not be reimbursed.

5. The costs for which reimbursement can be made also include payments made during a financial year to purchase run off cover where a Level 2 to 5 Staff Specialist proposes to acquire TMF cover in respect of all patients treated as private patients under the private practice arrangements, and as a consequence purchases run off cover from a medical defence organisation. For such reimbursement to be made, it will be necessary for a Staff Specialist to provide evidence that is acceptable to the relevant PHO that an election to Level 1 private practice arrangements has been made of that a contract of liability cover for the treatment of private rural and / or paediatric patients has been signed, and that the reimbursement is only of costs incurred in purchasing run off cover and does not involve any other costs (such as obtaining medical indemnity cover for patients treated outside the public health system as part of outside practice).

6. PHOs are to reimburse only the GST - exclusive amount of the medical indemnity costs. It is a matter for the individual Staff Specialist or the Staff Specialist partnership, as appropriate, to claim input tax credits in relation to the GST paid on these costs.

7. Where a Staff Specialist ceases employment in the New South Wales public health system, having obtained reimbursement for indemnity costs which relate to a full year of practice, before the conclusion of that year, a pro rata repayment of that extent of the reimbursed costs which corresponds to that proportion of the year of practice which remain following the cessation of the employment should be recovered from the Staff Specialist. Where a Staff Specialist increases the proportion of outside practice so as to reduce the amount of indemnity insurance costs payable that relate to public hospital private practice, the amount of any reimbursed indemnity costs that no longer relates to private practice billings should also be removed with effect from that time.

6 DISBURSEMENT OF FUNDS FROM THE NO 1 ACCOUNT

1. The following charges are to be made on a monthly basis against the relevant sub-ledgers of the No. 1 Accounts, in the order given and only to the extent that funds are available:

   a. Monthly infrastructure charges.

   b. Approved costs for Levels 2 to 5 Staff Specialists, which are accounting costs for partnerships as provided for at section 3 above and reimbursement of medical indemnity insurance costs as provided for at section 5 (1) above.

2. Where a Staff Specialist is entitled under the Determination to a guaranteed level of drawings under Level 2, 3 or 4 rights of private practice arrangements, supplementation shall take into account and be reduced by any amounts paid to the Staff Specialist for approved costs (i.e. under section 5 (1) above). (Therefore supplementation in these circumstances would be the amount of the guaranteed supplementation, minus amounts already paid or payable as approved costs under section 6 (1) (b) above and drawing rights under section 6 (1) (c) above.)

3. Approved costs and drawing rights are only to be paid to the limit of funds that are available in the No. 1 Account during the financial year. If there are insufficient funds to pay fully for approved costs, a partial reimbursement is payable, to the extent that funds are available. (There would be no entitlement to drawing rights in these circumstances.) At the end of the financial year, PHOs are to raise a tax invoice for the residual funds in the No. 1 Account (called the annual infrastructure charge) and transfer the appropriate residual funds to the No. 2 Account.

31(29/9/16)

BUSINESS ACTIVITY STATEMENT PROCEDURES - NSW HEALTH STANDARDS
(GL2010_012)

PURPOSE

There are currently a number of different methods being used for preparation of monthly Business Activity Statements (BAS) across NSW Health.

The purpose of this guideline is to provide Health Services with a standard BAS preparation procedure which is compliant with the ATO best practice guide for the management of GST.

The implementation of a standard process will enhance the quality of returns to the ATO and therefore reduce compliance risk relating to GST on a State-wide basis.

The standardised procedures have been reviewed and endorsed as compliant with ATO GST Best Practice Guidelines by the Department's external advisors PriceWaterhouseCoopers.

KEY PRINCIPLES

The key tools to complete the BAS are the NSW Health Standardised BAS Procedures and the excel Standard BAS Template Workbook. Both are available on-line.

The NSW Health Standardised BAS Procedures provides:

- General information relating to BAS preparation including lodgement, timeframes and what information is required to complete the BAS is detailed in pages 1-9.
- The logic of the process, prerequisites, and a step by step method of how to run the necessary reports and extract the required data are outlined in pages 10-16. The logic is also shown as a flow chart attached to the end of the document.
- Instructions on how to complete the Supplies, Acquisitions, General Journal and Capital sections of the BAS are detailed in pages 17-71, and include instructions on pivot table formats, completion of the comprehensive BAS excel worksheets, and reconciliations back to the general ledger GST control accounts.
- A number of checks are included in the above processes.
- Manual adjustments and accounting entries to account for errors or amendments noted in the worksheets are provided in pages 72-76.
- Quality assurances tests highlight any errors by review and testing on page 77.
- A soft copy of the excel Standard BAS Template workbook will be available on the NSW Health intranet and a detailed description of the information required is found at page 78-80.

29(02/03/15)

- A checklist template is provided to guide preparers including all of the necessary monthly tasks, responsibilities and completion dates at page 81.

USE OF THE GUIDELINE

The NSW Health Standardised BAS Procedures should be used in the following manner:

- The checklist should be copied each month and used to guide the BAS preparation process

The Health Service should check that person completing the BAS and the Health Service have all of the prerequisites listed in the guidelines

- The monthly process including running the reports, pivot tables, completing the data entry into the workbook and checking the worksheets reconcile to the reports should be completed each month in accordance with the guidelines
- The BAS should be checked for reasonableness and the QA testing completed
- Sign off and approval of the final BAS must be as per the delegations (usually Director Financial Operations)
- Lodgement must be done electronically and all working papers and files should be kept electronically
- Any necessary accounting entries/corrections or journals arising from the BAS process should be completed

The following documents are available from the Department of Health's intranet site http://internal.health.nsw.gov.au/finance/taxissues.html

1. NSW Health Standardised BAS Procedures
2. Standard BAS Workbook template

VISITING MEDICAL OFFICER TAXATION & SUPERANNUATION ADMINISTRATION (IB2011_041)

PURPOSE

The purpose of this bulletin is to inform Health Services of the taxation and superannuation administration requirements in relation to Visiting Medical Officer (VMO) contracts.

KEY INFORMATION

There are two types of standard VMO contracts (i) fee-for-service contracts; and (ii) sessional contracts.

A sessional contract is one in which a VMO is contracted on a regular hourly basis, and fee for service contract is one in which the VMO is paid a fee for each service.

There are six model VMO contracts:

1. Model sessional service contract
2. Model sessional service contract - practice company
3. Model fee-for-service service contract
4. Model fee-for-service service contract - practice company
5. Fee-For-Service VMO Practice Company - Rural Doctors Package Hospitals
6. Fee-For-Service - Rural Doctors Package Hospitals

ABN and Recipient Created Tax Invoices

- Under Division 184 of the *Goods and Services Tax Act 1999* (the GST Act) a person can act in a number of capacities and each is considered a separate entity for Australian Business Number (ABN) purposes.
- Health Services are required to check the ABN and GST registration of VMOs to ensure compliance with the GST Act in relation to the issue of recipient created tax invoices (RCTI) and RCTI Agreements. It is important that ABN details identify the contracted party (the supplier). The Australian Business Register can be found at www.abr.gov.au
- Where a VMO contracts as an individual e.g. Dr P Smith the ABN should identify the individual (sole trader) e.g. Dr P Smith.
- Where a VMO chooses to use a Sole Practice Company the ABN should identify the sole practice company e.g. Dr P Smith Pty Ltd.

ABN Withholding

- ABN withholding tax applies where the VMO has not quoted an ABN. The rate of withholding is 46.5%.

Superannuation

In accordance with the *Superannuation Guarantee Administration Act 1992*, a person who works under a contract that is wholly or principally for the labour of the person is deemed an employee under an extended definition for purposes of the Act.

- Where a VMO enters into a sessional contract in their individual capacity, 9% superannuation must be paid into their nominated complying superannuation fund.
- Where a VMO enters into a fee-for-service contract or chooses to contract as a sole practice company no superannuation is paid.
- Where an individual performs work for another party through an entity such as a company, there is no employer-employee relationship between the individual and the other party for the purposes of the SGAA, either at common law or under the extended definition of employee. This is because the company (not the individual) has entered into an agreement rather than the individual.

VMO Payments

- VMO payments should be made into the bank account of the VMO's choice. There is no requirement for the bank account to be in the name of the contracted party.

VMO – V Money set up forms (Sessional and Fee-for-Service)

STAFF SPECIALISTS RIGHTS OF PRIVATE PRACTICE DISBURSEMENT OF FUNDS NO 2 ACCOUNTS (PD2015_009)

PD2015_009 rescinds PD2005_324.

PURPOSE

The purpose of this Policy Directive is to set out the procedures for disbursement of the funds in the No 2 Account ledgers in the SP&T account of each public health organisation.

MANDATORY REQUIREMENTS

All public health organisations are required to comply with this Policy Directive.

IMPLEMENTATION

Chief Executives
Chief Executives must ensure that the arrangements set out in this Policy Directive are communicated to all Staff Specialists levels 2 to 5 and other relevant medical administration and HR staff.

Directors of Medical Services
Directors of Medical Services must ensure and verify that there is full compliance with the terms and conditions of this Policy Directive.

Staff Specialist
Staff Specialists must ensure that they co-operate with public health organisation management in implementing the arrangements set out in this Policy Directive.

1. BACKGROUND

1.1 About this document

The purpose of this Policy Directive is to set out the procedures for disbursement of the funds accrued in the No 2 Accounts which all public health organisations are required to establish as sub-ledgers in their Special Purpose and Trust Account.

1.2 Key definitions

Chief Executive: means the Chief Executive of the public health organisation or a person delegated to perform certain functions of the Chief Executive.

Number 2 Account: separate account in the Special Purpose and Trust Account (SP&T) bank account which contains separate sub-ledgers in the name of facilities, business units, agreed groups or individual Staff Specialists.

Public Health Organisation (PHO): Public Health Organisation is defined in s7 of the *Health Services Act 1997*. For the purposes of this document, PHO will include the Ambulance Services of NSW and other agencies as set out in PD2013_021 (Application of Policies - Newly Established NSW Health Agencies).

1.3 Policy framework

- NSW Health Policy Directive IB (Staff Specialists Training, Education & Study Leave (TESL) New Funding Entitlement (changed yearly)
- NSW Health Policy Directive IB (Staff Specialists Training, Education & Study Leave (TESL)
- NSW Government Travel User Guide December 2006 (outlines the arrangements with current Government contractor for travel
- Staff Specialists (State) Award
- Staff Specialist Determination
- Australian Taxation Office – Tax Determinations released each financial year for Reasonable Travel & Meals Allowances

2. POWER OF DECISION-MAKING AND APPROVAL

2.1 The Chief Executive of each public health organisation is responsible for the approval of the expenditure of funds from the relevant No 2 Account. This function can be delegated to a designated member of staff of the public health organisation subject to such conditions as may be imposed.

2.2 Each public health organisation (defined in this document, consistent with PD2013_021, to include any NSW Health entity at which Staff Specialists who have elected a Level 2 to 5 Rights of Private Practice arrangement are employed) is to establish a Management Committee to oversee the administration of funds in the No 2 Account which will make recommendations to the Chief Executive or nominated delegate for the expenditure of those funds.

2.3 In some public health organisations separate sub-ledgers are created within the No. 2 Account for facilities, business units, agreed groups or individual staff specialists. Individual sub-ledgers may have their own Management Committees to oversee the administration of funds from each sub-ledger, even though this may lead to multiple Management Committees operating within a public health organisation. Each Management Committee should have a membership of at least 5, with a majority of staff specialists, and also including the Director of Finance of the public health organisation or his or her nominee. The staff specialist members of each Management Committee are to be elected from and by staff specialists who have elected a Level 2 to 5 private practice arrangement (within the meaning of clause 2 of the *Staff Specialist Determination)*. In the case of Management Committees for sub-ledgers, the staff specialist membership should be elected from and by staff specialists who work in the relevant facility, business unit or agreed group ('relevant staff specialists'). Where there are not enough relevant staff specialists to constitute a majority of a 5 member Management Committee, the relevant staff specialist may seek approval from the Chief Executive for a reduced membership Management Committee. Such a reduced membership Management Committee must have a majority of relevant staff specialists.

2.4 No expenditure from the No 2 Account of a public health organisation is to occur which has not been properly submitted and approved in accordance with the above three sub-clauses.

2.5 Where sub-ledgers are established or already exist, they should only be closed with the agreement of a majority of the relevant staff specialists or of the relevant individual staff specialist. Where such sub-ledgers already exist within a public health organisation or facility, the capacity to operate a separate sub-ledger should be made available to any new business units or agreed groups which may be established, or to any new individual staff specialist who may be appointed, in the interests of maintaining consistency with existing arrangements within the public health organisation or facility.

2.6 Where in such circumstances there is more than one Management Committee operating within a public health organisation, the additional Management Committees can only be disestablished with the agreement of a majority of the relevant staff specialists. Management Committees should have administrative support, including accounting support, provided by the public health organisation, subject to section 3 below.

2.7 Where sub-ledgers are in place within the No 2 Account, a recommendation of a Management Committee for the disbursement of funds from a sub-ledger must be made with the support of at least two staff specialists contributing the relevant sub-ledger (except where there is only one contributor) who must ensure that such expenditures have the support of the majority of the contributors to that sub-ledger. The Management Committee at its discretion may seek confirmation that the majority of Staff Specialists who contribute to that sub-ledger support the recommended disbursement.

2.8 Each Management Committee should meet at least once per year, but must meet more frequently when specific matters are awaiting consideration. The Management Committee may appoint a subcommittee or senior officer to perform the functions of the Committee with respect to proposals for the expenditure of funds below a designated amount, subject to such conditions as may be imposed. Matters dealt with under such delegated authority must be reported to the next meeting of the Management Committee.

3. DISBURSEMENT OF FUNDS FROM THE NO 2 ACCOUNTS – AREAS OF ALLOWABLE EXPENDITURE

3.1 The first priority for expenditure from the No 2 Account is for Training, Education and Study Leave (TESL) for Level 2 to 5 SMPs as described in the *Staff Specialists Determination.* The individual funding entitlement should be determined having regard to the current funding entitlement applying to Level 1 staff specialists, which is determined annually and notified by the Ministry through a Policy Directive. Staff specialists who have elected a Level 2 to 5 private practice arrangement may agree to accept a lower maximum funding entitlement in order that more funds are available in the No 2 Accounts for other purposes.

3.2 The second charge on the No 2 Account is the annual audit and accounting costs for the Account. Expenditure for such purposes does not require consideration by Management Committees. Costs attributable to individual sub-ledgers should be met from that sub-ledger.

3.3 The expenditure of funds in excess of those required for TESL and audit costs should be for purposes that will benefit the public health organisation and the level of clinical services provided by it. These purposes are primarily the purchase of equipment, education and research.

3.4 Examples of appropriate expenditure which in all cases require the recommendation of the Management Committee and the approval of the Chief Executive or delegate, consistent with the requirements and processes contained in sections 2.4, 2.8 and 3.5 of this Policy Directive, include:

(i) A priority area for expenditure is the purchase and/or lease of equipment (including software) which will support and/or augment the provision of clinical services by the public health organisation. (Any such purchased equipment remains the property of the public health organisation.)

(ii) Other examples are:

a. Research funding, including equipment, scholarships or fixed term project funding. (Applications for research grants or equipment grants shall be accompanied by a detailed description of the planned project together with a statement outlining the need for such project or equipment, a detailed costing in Australian dollars and whether additional staff

or equipment will be needed to support the project, and demonstrating whether the expenditure will benefit the public health organisation and the level of clinical services provided by it. (Any purchased equipment remains the property of the public health organisation.)

b. Travel/study grants for persons employed within the public health organisation. (Applications for travel grants for conference attendance or other study purposes must be accompanied by adequate detail of travel and study itineraries to enable the Management Committee to determine the level of funding to be recommended for approval, and also material which demonstrates how the expenditure will advance the public health organisation and the level of clinical services provided by it.)
c. Donations to research organisations affiliated with the public health organisation where the provision of such funding would be consistent with the principles set out in sub-paragraph 3.3 above.
d. Support for visiting experts who may provide lectures or demonstrations to staff.
e. Books, journals, and electronic information sources (which remain the property of the public health organisation).
f. The payment of costs associated with the generation of income through the exercise of the rights of private practice arrangements which apply to the contributing staff specialists.
g. Postgraduate course fees for courses undertaken by level 2 to 5 staff specialists who contribute to the relevant sub-ledger that are directly relevant to the staff specialist's area of specialty.
h. Membership of organisations which support research and professional development.

3.5 The relevant Management Committee should exercise care in putting forward recommendations that involve recurrent/ongoing expenditure for future financial years, such as the engagement of staff or ongoing leases, due to possible fluctuations in income flowing to the No 2 Accounts. The Chief Executive or delegate in considering recommendations that have recurrent cost implications should obtain independent advice from the relevant Director of Finance. This advice should include a financial assessment of the risks of such proposals, including a schedule of other forward year commitments and a funding strategy if funds in the No 2 Account in forward years are insufficient to meet the expenditure involved. Where it is proposed that the employment of any staff be funded through the No 2 Account, that employment must be in accordance with NSW Health policies regarding the recruitment and selection of staff.

3.6 Where the disbursement of funds to reimburse expenditure under clause 3 is proposed, tax invoices, receipts or credit card statements must be presented by the staff specialist putting forward the claim and approved by his or her supervisor. Other than payment of perdiems or reimbursement of expenses incurred, there are to be no payments made directly to the level 2 to 5 staff specialists who contribute to the relevant sub-ledger, including by way of managerial or other forms of allowances. (This provision does not preclude staff specialist positions from being funded by the No 2 Accounts pursuant to sub-clause 3.5 above, but the remuneration must comply with the relevant industrial instruments.)

4. DISPUTE RESOLUTION

Any disagreement in relation to the matters set out in this Policy Directive between public health organisations and staff specialists can be referred to the Secretary of the NSW Ministry of Health for resolution. In this case, a statement is to be submitted to the Secretary which sets out the respective views of both parties to the dispute. This paragraph does not restrict the capacity of any party to have a dispute arising with regard to the matters dealt with in this Policy Directive dealt with in accordance with the issue resolution clause of the *Determination*.

5. ENQUIRIES

Enquiries concerning the above information should be directed to the relevant human resources/finance staff in Public Health Organisations. Only human resources/finance staff from Public Health Organisations are to contact the NSW Ministry of Health.

SECTION FIVE

FINANCIAL AND STATISTICAL REPORTS

REFERENCE SHEET

FINANCIAL REPORTING REQUIREMENTS FOR AREAS AND OTHER CONTROLLED ENTITIES CAN BE FOUND AT THE DEPARTMENT'S INTRANET SITE AT THE FOLLOWING ADDRESS:
http://internal.health.nsw.gov.au/fcsd/reprequi.htm

NSW DoH REPORTING SYSTEM - DOHRS GLOSSARY - SEE DoH DATA MANAGEMENT UNIT NSW HEALTH NET SITE:
http://internal.health.nsw.gov.au/

SECTION SIX

ACCOUNTING PROCEDURES FOR

SPECIAL PURPOSES AND TRUST FUND

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THE No. 1 ACCOUNT

THE No. 2 ACCOUNT

GENERAL

The Accounts & Audit Determination:

(a) directs that each health organisation shall establish a SPECIAL PURPOSES AND TRUST FUND which shall be separate and distinct from the GENERAL FUND and shall have its own separate bank account and set of accounting records; and

(b) prescribes the various categories of income which are required to be credited to the Special Purposes and Trust Fund. Broadly, these comprise donations, legacies and bequests other than those designated as General Fund; Proceeds of fundraising activities; Trust Funds held on behalf of third parties, i.e. hospital auxiliaries and patients (and for which the patient's written consent for banking has been received); Private practice trust funds; Other items as scheduled by the Director-General of Health; Income earned on the above, apportioned and credited to the applicable account.

OBJECTS OF THE SPECIAL PURPOSES AND TRUST FUND

There are three primary objects of the Special Purposes and Trust Fund:

- To separate from General Fund, all moneys not available for general operating purposes.

- To segregate into a separate Fund all moneys and transactions relating to expenditure and dealings in trust moneys which have no bearing on the health organisation's financial position in respect to general funds.

- To ensure that the General Fund itself will at all times disclose the true operating and financial position of that Fund.

ACCOUNTING REQUIREMENTS

The Special Purposes and Trust Fund shall be kept on an accrual accounting basis. The following conditions apply:

- The accounts of the Fund shall be kept quite separate and distinct from those of the General Fund, involving a separate banking account, and a complete and separate set of books, that is, separate receipt book, cash book, cheque book, ledger and journal. Nonetheless for the purposes of the externally audited annual financial statements the Special Purposes and Trust Fund is to be combined with the General fund to report each entity's consolidated results.

- Except in isolated and exceptional circumstances, all transactions affecting the Special Purposes and Trust Fund should be recorded only through the Fund.

- Invoices for payments shall be filed quite separately from those of the General Fund.
- Expenditure from the Fund should only be made if funds are available for the purpose.
- There is no limit on the number of banking accounts which may be opened, although one is usually sufficient.
- Funds in the General Fund shall not be used to finance Special Purposes & Trust Fund payments or expenditure. Where computerised creditors and cheque payments systems exist it is permissible to draw cheques for payment from the General Fund for payment of SP&T accounts provided that reimbursement is made to the General Fund Bank Account from the SP&T on the same day.

TRANSACTIONS TO BE RECORDED IN THE FUND

The actual transactions to be recorded within the Fund are clearly defined by the Accounts & Audit Determination.

The Special Purposes and Trust Fund shall be credited with:

- Trust funds held on behalf of third parties, i.e. patients and hospital auxiliaries.
- Donations, legacies and bequests other than those designated as General Fund.
- Proceeds of fundraising activities.
- Private practice trust funds.
- Any unconditional donation/bequest provided that the monetary value of such an item shall be credited to an account with the title "Public Contributions Trust Account".
- Other items as scheduled by the Director-General of Health.
- The income earned on any asset of the Fund other than those assets acquired with conditions requiring that such income should be paid into the General Fund.

Interest earned from the investment of Special Purposes and Trust Fund assets shall be apportioned to each respective account in a timely and equitable manner but not later than 30 June in each financial year.

Income subject to the ***Trustee Act 1925*** which is earned on the Special Purposes and Trust Fund assets but not received in cash shall be brought to account at least by the end of each financial year.

The assets of the Special Purposes and Trust Fund shall be applied only in accordance with the purposes for which they have been received and the trust conditions attached to them.

An appropriately named special purpose or trust ledger account shall be opened within the Special Purposes and Trust Fund to record all transactions in respect of each purpose or trust on account of which the assets of the Fund are held. Each such account shall be credited with all revenue and debited with all expense in respect of the specific purpose or trust to which it relates, so that the credit balance on each account will represent at all times the amount held for each specific purpose or trust whilst the cash and other assets accounts of the Fund will show the form in which those balances are held.

The cost of any asset purchased or the value of any asset otherwise acquired through the Special Purposes and Trust Fund shall be debited to the appropriate asset account and credited to the Accumulations Account in the General Fund by journal entry. Depreciation should then be expensed no later than the month following the month of acquisition.

Most moneys credited to the Fund are subject to some condition, either specific or general, and until they are applied in accordance with the Accounts & Audit Determination to the purpose for which they have been received, the health organisation has a responsibility to state/observe the nature of the restrictions. Accordingly, the system of accounts should clearly show at all times the exact purposes for which all moneys in the Fund are held, and how they have been applied.

To achieve this objective, a separate ledger "sub-equity" account should be opened for each special purpose for which money is received. Monies held in trust, e.g. Patient Trust Accounts will be specifically identified in Creditor Accounts. Revenue and Expense accounts will be maintained for each Specific Purpose and aggregated for the purpose of financial statements.

At any time the Opening Equity advised in the sub-equity account plus the net effect of revenue/expense will represent the amount available for the particular purpose. The equity will generally be matched by cash/investments.

Example 1

Moneys are received from various persons who have imposed restrictions upon their application as below:

$1,000 to endow a bed in perpetuity.
$ 750 towards equipping a newly established maternity unit.
$ 650 to purchase additional equipment generally.
$ 100 lodged by a patient for safe custody.

Receipts having been issued and the amounts debited in the cash book in the normal way, the double entry is completed by posting to the credit of special purpose or trust ledger accounts opened as illustrated in figure 1A.

Figure 1A

PERPETUAL ENDOWMENT OF BED ACCOUNT (Revenue)

| By Cash $1,000

NEW MATERNITY UNIT EQUIPMENT ACCOUNT (Revenue)

| By Cash $750

NEW EQUIPMENT GENERAL ACCOUNT (Revenue)

| By Cash $16,500

PATIENT MONEYS TRUST ACCOUNT (Creditor)

| J. Smith $100

It will be noted that the accounts have been given headings which in themselves indicates the purpose to which the money may be applied. Should it not be possible for an account to be given a name which clearly indicates its purpose, a brief note should be inserted underneath the name of the account giving the necessary details.

When the above accounts have been opened, any further moneys received on account of those particular purposes or trust are, of course, also credited to those accounts in the usual way.

Perpetual endowment moneys are required to be invested in trustee investments such as Commonwealth Stock or Bonds. Assuming this was done in the example quoted above, the accounting entries would be:

	$	$
Dr. Commonwealth Stock Investment Account	1,000	
Cr. Cash Account		1,000

Similarly, other moneys in the fund if not required for immediate expenditure should also be invested until required. For example, assuming that $1,250 of the remaining cash will not be required for another year and it is decided to invest it at fixed deposit, the bookkeeping entry to record the transaction would be:

		$	$
	Dr. Fixed Deposit Account	1,250	
	Cr. Cash Account		1,250

Assuming that shortly afterwards, an additional steriliser costing $10,000 is purchased from the New Equipment Account, the transaction would be recorded by the following entry:

		$	$
(a)	Dr. Non Current Asset - General Fund	10,000	
	Cr. General Fund Equity Account		10,000
(b)	Dr. New Equipment General Account (Equity)	10,000	
	Cr. Cash		10,000

The Fund Cash Account would then appear as follows:

CASH ACCOUNT

To Perp. Endow. of Beds	$1,000	By Commonwealth Stock	$1,000
To New MU Equipment	750	By Fixed Deposit	1,250
To New Equipment Generally	16,500	By Equipment Generally Steriliser	10,000
To Patients' Moneys Trust A/c	100	By Balance c/d	6,100
$18,350			$18,350
To Balance b/d	6,100		

By a collection of balances of the various accounts, the Combined General Fund/Special Purposes Statement of Financial Position would then comprise the following balances:

Equity

Perpetual Equity Endowment of Beds Account	$1,000
New Maternity Unit Equipment Account	750
New Equipment General Account	6,500
General Fund Equity	10,000
$18,250	

Assets

Commonwealth Stock	$1,000
Fixed Deposits	1,250
Cash at Bank	6,100
Sterilizer	10,000
	$18,350

Liabilities

Patients Money Trust Account	100
$18,350	

It will be seen that the Equity Accounts show the actual amount held for each purpose while the asset accounts show the form in which those balances are held.

Points to note are:

- Where cash is invested, it reflects a transfer from one asset account to another and has no effect whatsoever on the Special Purpose or Trust ledger accounts.

- The purchase of the steriliser was debited to the New Equipment General Equity Account, with a corresponding increase in General Fund Equity. This action serves to record that only $6,500 remains in this equity account which is subject to donor restrictions.

Adjusting entries of this nature must be made for every asset purchased through the Special Purposes and Trust Fund. Journal entries are to be made progressively throughout the year as and when each purchase is made with due depreciation charges then raised against the assets acquired.

FINANCIAL STATEMENTS

When all transactions and adjusting entries for the year have been made, a trial balance should be extracted. If correct, all ledger accounts should be ruled off, the balances carried down and the final accounts of the Fund presented in the form of the Operating Statement and the Statement of Financial Position. Note that the Consolidated Statement of Financial Position is the aggregate of the General Fund and Special Purposes and Trust Fund.

The nature of any donor restrictions are to be disclosed (with monetary values) in the notes to the financial statements.

Distinction must be made between moneys which are available for expenditure or use on some health organisation purpose and those which are held in trust for the time being and repayable to the party on whose account they are held.

The former are regarded as special purpose moneys and the latter as trust moneys, hence the description: special purpose accounts or trust accounts.

All true trust accounts are to have the word “trust” incorporated in the account title. Any accounts without the word “trust” in the title would be special purpose accounts so there is no need to incorporate the words “special purpose” in the account title.

PUBLIC CONTRIBUTIONS TRUST ACCOUNT

Any individual donation or legacy received without any conditions being imposed by the donor as to its use, shall be credited to a special purpose revenue account styled Public Contributions Trust Account within the Special Purposes and Trust Fund.

It is important that the account be credited only with unconditional donations and legacies etc. This policy applies even though a donor has given a substantial amount, imposing only that it be used for capital expenditure generally. In this case the donation should not be credited to Public Contribution Trust Account but to a separate account styled "General Capital Purposes Account".

For bookkeeping purposes, **transactions on the Public Contributions Trust Account are recorded in the same way as those on any special purpose account**.

Moneys in the Public Contributions Trust Account shall be applied to any of the following:

(a) the acquisition and improvement of land;

(b) the construction of or additions to or renovations of buildings;

The prior written approval of the Department of Health shall be obtained before incurring expenditure on (a) or (b) where it involves the purchase of land or buildings or the erection of new buildings or the extension of buildings.

(c) the purchase of plant and equipment; and

The approval of the Board (or delegate) or Chief Executive (or delegate) of an area health service and Royal Alexandra Hospital for Children shall be obtained before incurring expenditure on (c). The Board (or delegate) or Chief Executive (or delegate) of an area health service and Royal Alexandra Hospital for Children is to be provided with a statement detailing the estimated annual operating costs associated with the use of the equipment or plant.

(d) any other health related purpose approved by the Director-General of the Department of Health, NSW.

TRUST LEDGER (LIABILITY) ACCOUNTS

As in the case of special purpose moneys, ledger accounts must be opened within the Fund to record the receipt and payment of moneys held in trust for various persons from time to time. These comprise mainly moneys lodged by patients for safe custody and moneys received for transmission to pensioner patients. It is only necessary to open one trust ledger account for each particular type of trust on account of which money is held (for example, one ledger account would be opened for patients' money held in safe custody and another for refunds to pensioners). However, should the number of transactions be numerous, it may be necessary to maintain a subsidiary record showing the amounts received and paid in respect of each person, with the unpaid balances being agreed periodically with the balance of the trust ledger account which would, in effect, become a control for the subsidiary record.

APPLICATION OF MONEYS ACCORDING TO THE CONDITIONS ATTACHING TO THEM

If a person or body gives or bequeaths money to a health organisation for a specific purpose, it is legally bound to apply those moneys to that specific purpose unless:

- It obtains the consent of the donor to apply the money to some other purpose, or

- If the purpose cannot be complied with, the approval of the Master-in-Equity or Commissioner of Dormant Funds, as the case may be, must be obtained before any decision is made to spend that money, or any part of it, on some other purpose. Pursuant to the ***Charitable Trusts Act 1993*** the Attorney General may vary the application of a gift without the need to go to the Supreme Court (ie. the Master-in-Equity) if the sum in question is under $500,000.

The Board of a health organisation cannot itself impose conditions upon a donation more restrictive than those imposed by the donor. For example, if a person gives a donation subject only to the condition that it be used for capital expenditure, the Board is not entitled to impose a further restriction that it be credited to, say, a new X-ray Account or new Maternity Wing Account. The money should be credited to a General Capital Purposes Revenue Account to indicate that it is available for any capital expenditure which, of course, would include using any money in that account to supplement moneys collected specifically for a new X-ray, new maternity wing or any item of capital expenditure as and when it might be incurred.

Apart from not being entitled to impose greater restrictions than those imposed by the donor, it is not in a Board's interest to do so. The greater the number of donations it can obtain for general capital purposes, the greater the scope available to the Board to determine itself how the money might be spent on behalf of the health organisation. When the time arrives to obtain a particular item in question, and the amount in the Specific Special Purposes Account is insufficient, it can be supplemented from the General Purposes Account, or with Departmental approval, even from the Public Contributions Trust Account.

The chief executive officer and the board of directors of a health organisation shall exercise due care in regard to observing the trusts or purposes of a fund within the Special Purposes & Trust Fund. They may be held accountable by the Attorney-General if they breach their trustee obligations.

DONATIONS OR GIFTS-IN-KIND

Occasions arise where a health organisation may receive a donation or gift of a specific item of capital equipment as distinct from a donation of money. It is important to bring the value of all such capital donations to account although such action would generally be via the General Fund unless specific restrictions are imposed.

In the event that a non-current asset is acquired the accounting entry involves debit to the asset account and a credit to revenue. Should the asset not warrant the assignment of a value in terms of the Department's accrual accounting policy a debit to expense should be raised provided the value can be reliably measured.

INVESTMENT OF FUNDS (See Investment provisions contained in Section 3 for detailed procedures)

BEQUESTS/GIFTS OF SHARES

In relation to bequests or gifts of shares which are not authorised for investment by the ***Trustee Act*** and subsequent increase in share investments when a health organisation seeks to take up an entitlement to a new issue of shares, accept an entitlement to bonus shares or meet payments that fall due on shares on call, the Crown Solicitor has advised that the Board of an Area Health Service/Public Hospital:

- could not be compelled to convert gifts of shares to authorised investments (i.e. investments in accordance with the ***Trustee Amendment (Discretionary Investments) Act 1997*** but it is possible that the Board could be liable for losses which might occur if it failed to make such a conversion;

- may only purchase shares for investment purposes if such purchase is an authorised investment;

- could accept bonus shares, assuming no payments were required, but the Board could again be liable for any loss which might occur if it failed to convert those shares to an authorised investment;

- could not take up an entitlement to new shares, and probably could not make payments that fall due on shares on call unless such action was an authorised investment.

Moneys in the Perpetual Endowment of Beds Accounts are required to be invested in perpetuity and the income paid to the General Fund. It is therefore advisable to record their investment in investment accounts separate from those relating to the investments of other moneys in the fund. This enables all investments and income applicable to perpetual endowments to be readily identifiable at all times. Income from perpetual endowments should be paid directly into the General Fund as and when received.

In investing Special Purposes and Trust Fund moneys it is not necessary to relate the actual investments made to any particular special purpose account, unless there are special conditions applicable. An investment should be determined having regard to the total cash balance of the Fund and the likely demands upon it for expenditure over the period of the proposed investment.

This means that investments are made on behalf of all special purpose accounts and that each is entitled to share in the income earned in proportion to the sum contributed. Because apportionment of income received on an exact basis could involve considerable calculation it would be sufficient to apportion it on the basis of the monthly or quarterly balance of each special purpose account involved.

Having determined the apportionment, the bookkeeping entry debits the Cash Account for the total income received, and credits each special purpose revenue ledger account with the amount apportioned to it. However, if funds have been made available with appropriate

Departmental authorisation from a temporary surplus in the General Fund, interest received will be recorded as a receipt item in the General Fund.

SAMARITAN FUND

Section 133 of the ***Health Services Act 1997***, requires that all money and personal effects which are left in the custody of the hospital by a patient, and which are not claimed by the person lawfully entitled to them within twelve months after the death or discharge of the patient, are to be realised and paid into a distinct and separate fund to be called the Samaritan Fund.

The Samaritan Fund, whether or not a separate bank account is used, forms part of the Special Purposes and Trust Fund. Disbursement may be made as prescribed for the benefit of necessitous inpatients and patients being discharged.

Section 133 reads:

(1) The following money and personal effects are taken to be the property of a public health organisation:

(a) all money and personal effects (being choses in possession) that are:

(i) left in its custody by any patient who dies in one of its hospitals or health institutions, and

(ii) not claimed by the person lawfully entitled to them within a period of 12 months after the patient's death, and

(b) all money and personal effects (being choses in possession) that are:

(i) left in its custody by any patient discharged from one of its hospitals or health institutions, and

(ii) not claimed by the patient or other person lawfully entitled to them within a period of 12 months after the date of discharge.

(2) All such money, and the proceeds of the realisation of any such personal effects, are to form a distinct and separate fund of the public health organisation to be called a Samaritan Fund.

(3) A Samaritan Fund is to be managed and disposed of in such manner as may be prescribed by the regulations for the benefit of patients or outgoing patients who are needy.

(4) An area health service or statutory health corporation may establish a separate fund for each hospital or health institution, or a single fund for all public hospitals or health institutions, under its control.

(5) A reference in this section to a public health organisation includes a reference to the Crown in relation to any public hospital controlled by the Crown (including the Minister or the Health Administration Corporation).

Part 4 - Miscellaneous

Clause 38 - Health Services Regulation 1998 - Samaritan Funds

(1) The Samaritan Fund of a public health organisation is to be kept as a separate account in its Special Purposes and Trust Fund.

(2) The Minister may determine the manner in which the accounts for a Samaritan Fund are to be kept and the circumstances in which those accounts are to be audited.

(3) Money is not to be withdrawn from the Samaritan Fund of a public health organisation except by, or with the written approval of, the chief executive officer (or person authorised in writing by the chief executive officer) of the public health organisation.

(4) Money is not to be withdrawn from the Samaritan Fund of a public health organisation except for payment to, or for the purchase of items for, a necessitous patient or necessitous outgoing patient. The payment or purchase may be made only if it is essential to the well-being of the patient.

(5) In this clause:

Samaritan Fund of a public health Organisation means the Samaritan Fund of the Organisation referred to in section 133 (2) of the Act.

Special Purposes and Trust Fund, in relation to a public health organisation, means the fund of that name established by the public health organisation.

Whilst it is the public health organisations responsibility to determine appropriate payments from the Samaritan Fund listed hereunder are examples of the types of payments that can be made in respect to **a necessitous patient or necessitous outgoing patient**:

- fares for patients to return to their residence
- clothes, food and goods for out of hospital use
- surgical/treatment supplies e.g. bandages, ostomy supplies, sterilising fluids etc for out of hospital use - if the public health organisation considers that suppliers are required for the discharged patients immediate health/treatment needs.
- Aids, appliances and equipment eg. Wigs, crutches, walking frames for discharged patient where the item will enable the patient to be ambulating and/or improve the patients well being and quality of life.
- Non PBS listed drugs for out of hospital use (DoH)

PURCHASE OF EQUIPMENT

The decision to purchase items of equipment from funds held in health organisation's No.2 Account and other accounts in the Special Purposes and Trust Fund should be made by the CE for area health services and Royal Alexandra Hospital for Children but limited to who can be delegated, e.g. Director, Corporate Services of the health organisation irrespective of the source of funds except:

(i) in the case of pathology, diagnostic and radiology equipment purchases where the approval of the Department of Health, NSW may be required for purchases as outlined in the Building and Equipment Manual, viz. health technology; and

In arriving at a decision the CE, or delegate, should arrange for a statement to be prepared and submitted with the proposal to purchase, detailing the estimated annual operating costs associated with use of the equipment. The CE, or delegate, should consider the proposal having regard to:

- the availability of funds to meet the costs of operating and maintaining the equipment; and

- the desirability of continuing a service that is either uneconomical in terms of utilisation and maintenance or is no longer an approved service in accordance with the health organisation's determined role.

The minutes of the Board Meeting recording the decision to purchase the equipment are to indicate that the Statement of Operating Costs had been considered. If a purchase is approved by a delegate the details of the purchase including the Statement of Operating Costs are to be notified to the CE.

THE NO.1 ACCOUNT

Health organisations that grant their full-time salaried medical specialists right of private practice should maintain accounting records relating to the collection of fees on behalf of clinicians.

Accounting Documents Required

- tax invoices, in triplicate sets,
- receipts forms in triplicate and serially numbered,

- cash books,
- ledger cards,
- bank deposit books which provide for duplicate copies of deposits.

Accounts to be Opened

Subject to the decision of the CE, or delegate, for area health services and Royal Alexandra Hospital for Children and the full-time salaried clinicians as to whether there shall be only one pool of funds to be shared among the participants or whether there shall be a separate pool for each clinical group, i.e. surgical, medical, the following trust accounts shall be opened:

(1) No. 1 Account (for each pool),
(2) No. 2 Account (also for each pool).

Both trust accounts are to be operated independently of the other Special Purposes and Trust Accounts of the hospital but form part of the Special Purposes & Trust Fund Bank Account. Both accounts are to be recognised as liability accounts.

All fees received on behalf of doctors are to be accounted for through the No. 1 Account. Where appropriate, each account should have its own cash book, cheque book, bank deposit record and, as appropriate, ledger accounts.

Issue of Tax Invoices

A health organisation, acting as agent for the salaried clinical specialists, shall issue individual tax invoices in the name of the particular specialist who has earned a fee under his/her right of private practice. The original of each tax invoice should be issued to the patient, the duplicate to the specialist for his/her personal file and the triplicate retained for record purposes and the follow-up of unpaid fees.

A health organisation shall file separately (a) the triplicate copies on which payment has been received (appropriately endorsed that the account has been paid) and (b) those which are awaiting payment.

Fees Collected

A health organisation, acting as agent for the salaried clinical specialists, shall issue a receipt in the name of the participating doctor. The original receipt will be issued to the patient and the duplicate copy retained as a posting medium for the cash book and the ledger accounts. The triplicate copy should be forwarded to the specialist for his/her file.

Details of the receipts should be posted to the cash book opened for the No. 1 Account and to the ledger cards used to record the collections made on behalf of the individual doctors.

Bank deposits shall be made up and entered on the bank deposit forms and balanced with the amounts due to be banked, as disclosed by the entries in the cash book.

The fees collected are to be banked regularly to the No. 1 Account for each pool.

Accounting to Doctors

At the end of every month a disbursement of funds from the No. 1 Account shall be made, based upon the respective balances payable.

Transfer of Excess Fees, etc.

Any funds remaining in the No. 1 Account after the final distribution for the year has been made, and payments made for the procurement of equipment, research and travel, shall be paid into a separate related trust account to be styled; The No. 2 Account in the Special Purpose and Trust Fund Account following the issue of the final tax invoice for the "Balance of Infrastructure Charge" refer PD2005_598.

Signatories to Cheques

All cheques drawn on the Number One Account are to be signed by two authorised officers.

THE No. 2 ACCOUNT

A health organisation may maintain a bank account for the No. 2 Account separate from the Private Practice Trust Fund Account bank account.

Funds shall be administered by nominees of the participating specialists and the CE, or delegate, for area health services and Royal Alexandra Hospital for Children with the participating specialists having majority of voting rights.

The payment of grants for post-graduate study travel (salary whilst on conference or study leave is **not** included in such grants) shall be a first charge on the No. 2 Account. Other purposes for which these Funds may be used are:

(1) research; and

(2) the purchase of special equipment for the health organisation where the clinicians are practising. Equipment purchased from the No. 1 Account becomes the property of the Area Health Service and the income from the sale/disposal of equipment is to be lodged in the General Fund.

Bank Reconciliation

Bank statements posted with transactions to the close of business on the last bank trading day in each month must be obtained from the banking institution in respect of the No. 1 Account and, if applicable, the No. 2 Account banking accounts.

A bank reconciliation statement shall be prepared for each of the accounts, and be checked and certified as correct by a responsible accounting officer of the health organisation.

Audit

Although the collection of fees and the accounting for the earnings of participating salaried clinicians under their rights of private practice is a service rendered by the health organisation, the participating doctors should, in their own interests as a group, appoint and remunerate an auditor to audit the records of the No. 1 Account and the No. 2 Account.

The health organisation shall not be called upon to remunerate the auditor for this service. The cost of the audit should be met from the balance of funds available immediately before the distribution is made as at the end of June or before a transfer is made to the No. 2 Account.

Each Financial Year to Stand Alone

The results of each financial year are to stand alone. No adjustment is to be made subsequently if in a later year the participating doctors earn less than their proportional entitlements.

Part-time Officers

The accounting provisions shall apply also to those specialists who elect to be remunerated on a part-time basis provided that the whole of the balance of fees collected after the health organisation has deducted the charge for the use of health organisation infrastructure and a proportionate contribution to the audit fee is to be paid to the specialists without any contribution to the No. 2 Account.

SECTION SEVEN

INTERNAL CONTROL AND INTERNAL AUDIT

INTRODUCTION

CASH HANDLING CHECKLISTS

MICROFILMING OF ACCOUNTING RECORDS

INTERNAL CONTROL FOR MANUAL SYSTEMS

INTERNAL CONTROL FOR COMPUTER BASED SYSTEMS

INTRODUCTION

Internal control is the whole system of controls, financial and otherwise, established by management in order to carry on the operations of the health organisation in an economical, efficient, effective and orderly manner, ensure adherence to management policies, safeguard its assets and secure as far as possible the accuracy and reliability of its records.

The primary objectives of internal control are to ensure:

- the reliability and integrity of information;
- compliance with policies, plans, procedures, laws and regulations;
- the safeguarding of assets;
- the economical and efficient use of resources; and
- the accomplishment of established objectives and goals for operations or programs.

Section 7.1 of the Accounts & Audit Determination identifies the major components required to be incorporated in the system of internal control maintained by a health organisation.

Every system of internal control should have these broad characteristics but the manner in which this is accomplished will vary from one health organisation to another. In designing internal control systems health organisations should comply with the procedures set out in the following pages of this Manual, the requirements of the Accounts & Audit Determination, Sections 7.1 to 7.38 and the standards and guidelines issued by the professional accounting bodies.

Health organisations should regularly review their internal control systems in accordance with Section 7.2 of the Accounts & Audit Determination. The need for review remains even in situations where a separate internal audit organisation has not been established.

Modern internal auditing is a comprehensive review function. It is an independent appraisal of the diverse operations and controls within an organisation to determine whether:

- acceptable policies and procedures are followed;
- established standards are met;
- resources are used economically and efficiently; and
- the organisation's objectives are achieved.

INTERNAL CONTROLS FOR COMPUTER BASED FINANCIAL SYSTEMS

Definitions of Terms

Project Sponsor - Officer responsible for the project development. Normally this officer is responsible for the user department/program/branch for which the project is being developed, e.g. Chief Executive Officer, Executive Officer, Director of Administration or Finance.

User Manager - Department/Program/Branch manager of user operations.

System Administrator - Officer responsible for daily maintenance of system. In large installations this may be the Computer Services Manager or nominated delegate, while in micro systems a System Administrator's tasks may be part of a clerical officer's duties.

Project Manager - Officer responsible for the day to day work of the project development team.

Internal Control

Within each area health service/hospital the Project Sponsor, the User Manager and the System Administrator, as appropriate, shall be responsible through appropriate management channels, for the application of the following controls. Where the data processing function is not wholly within the ambit of that person's responsibility, the officer shall be satisfied by enquiry and periodical review, that these controls are applied.

These controls apply to all computerised systems including mainframe, mini, micro and visual record computers and service bureaux operations.

Where use is made of the resources of a consultant or a bureau, reference should be made to the standards, guidelines and notices published by those organisations for assistance in determining requirements in regard to user specifications, programming, documentation, data input and output, file design and data retention.

Internal controls on computer based financial systems shall be described under the following headings:

1. Organisational
2. Development
3. Operational
4. Processing
5. Documentation
6. Micro-computer

1. **Organisational Controls**

Segregation of Duties

Effective organisational controls shall be exercised through appropriate segregation of duties:

Personnel **outside** the EDP Section shall be allocated responsibility for:

(a) Initiation and authorisation of transactions.

(b) Necessary action in response to output reports.

(c) Control or accounting for critical items such as unused cheques and signature plates. In this respect, when signature plates are used, a user representative shall have custody of the plates and supervise the issue, printing, signing, reconciliation and distribution of cheques prepared by the computer.

Also the following duties shall be segregated as indicated:

(a) The functions of -

(i) systems design and application programming,

(ii) computer operations,

(iii) data base administration, and

(iv) where practical software maintenance; shall be separated.

(b) A control group or function, wherever practicable independent of the other computer operating functions and independent of officers who generate or authorise transactions, shall be established to review and balance computer input and output.

(c) Amendments to production programs shall be authorised and implemented independently from the programming team.

2. **Development Controls**

Development of Systems and Programs

Health organisations must use an appropriate methodology such as "Spectrum" to control systems development. Through the use of such methodology the Project Sponsor shall ensure either directly or through appropriate enquiry that accounting and internal control requirements are met in regard to the specifications of systems

and subsequent amendments and that computer programs and the data converted to machine readable form are adequately checked and tested for correctness. The following procedures shall be included in any methodology adopted:

(a) Standards shall be established, documented and enforced for the specification of systems.

(b) Programming and computer systems design standards shall be established, documented and enforced by appropriate systems and programming staff. Where appropriate, confirmation should be obtained by the Project Sponsor that reference has been made to industry standards for coding conventions.

(c) Authorisation and approval in writing shall be obtained at each major phase of development as given below:

- User specifications for each system shall be reviewed and approved by the Project Sponsor prior to the commencement of computer systems design and programming.

- Acceptance of test results and final approval shall be obtained from the Project Sponsor prior to implementation and operation of a new system.

(d) Systems and programs shall be sufficiently tested under the supervision of the Project Manager in order to ensure reliability in accordance with original specifications -

- Co-operation should exist between the User Manager and the Project Manager in testing of systems. As a minimum, test data shall include transactions specifically designed to violate control procedures incorporated in the program as well as all combinations of valid transactions in order to test their acceptance and proper processing. This should be an ongoing control function.

- Final tests shall include all phases of the system including manual and computer, i.e. procedures used by computer operators, data control groups, source and user branches as well as the programs to be used.

(e) Effective control shall be maintained over the conversion of data from the old record systems to the new master files and the initial operations up to and including final testing in order to prevent unauthorised changes and to ensure accurate and complete results.

As a control procedure, wherever practicable, accounting records converted to machine-sensible form should be balanced to those contained in the old system by a person independent of the conversion process. In some cases it

may be necessary to print the master file or any fields recalculated or converted and manually check data.

(f) Internal and external auditors as appropriate shall be consulted during systems design including preparation of specifications, computer systems design, testing and documentation to ensure that control requirements are satisfied. This consultancy should extend to any amendments made to systems and/or programs.

(g) Consideration should be given to the archive storage of public records which are or may become permanently valuable to the State. The Archives Office should be consulted on this aspect during the system design phase.

(h) Changes to systems and programs shall be subjected to the same controls as for new systems, i.e.:

- Authorisation shall be obtained in writing before a change is initiated.

- Acceptance of tests results and final approval of changes shall be obtained in writing from the Project Sponsor.

- Computer operations staff shall not be authorised to make changes however minor these changes may be.

- The computer operations sections shall accept only properly approved changes. All changes shall be documented.

All staff involved in the development of a system shall be given appropriate training in their respective duties.

All staff shall be given at least an overview of the methodology adopted for the development.

3. **Operational Controls**

Computer operating standards shall be established, documented and enforced (usually) by computer operations staff (or in the case of micro computers, the user staff) after due regard has been given to user requirements with respect to controls for the systems.

The System Administrator and all computer operations staff shall be given appropriate training to ensure that the operating standards are carried out.

The User Manager shall periodically review computer operations to establish that physical security of files and integrity of data is maintained during computer operations. To achieve this objective the User Manager shall ensure either directly or

through appropriate management channels that the following procedures are observed to the extent indicated:

(a) There shall be some method to check that correct files are used and output files are properly allocated, as indicated below:

- Computer files shall be labelled internally and externally to assist the operator in using the correct file for a run. (Note: It is the user's responsibility to specify the file to be used.)

- The version number of files maintained on disk should be verified before use and relabelled afterwards.

- In the absence of an automatic cataloguing system all computer files shall be controlled by the:

  (i) maintenance of a properly indexed library,

  (ii) issue of files, including master files and programs, only upon an authorised request or according to schedule,

  (iii) maintenance of a library register of usage for all files which should be checked to ensure that unauthorised access has not occurred.

- Operators' manuals shall be used as the basis for all required actions by computer operators.

- The computer operating system (or programs) should be used to the extent possible to determine the validity of the files being used, e.g. validity of version numbers checked before use.

- If files specified by the user are not available the job should not be run and the user shall be advised accordingly.

(b) Where possible, computer operators should be denied access to program and systems documentation in order to guard against the possibility of manipulation of operating programs.

(c) Computer equipment and facilities shall be effectively supervised to prevent unauthorised use. Access to the computer room shall be restricted to authorised personnel.

(d) Where appropriate there should be a planned program of rotation of operators and joint operation on sensitive applications.

(e) Where practicable, machine utilisation logs and console print-outs should be reviewed periodically, if possible, by a person independent of operators, to determine if standard operations procedures have been followed.

(f) A password security system must be used to limit access to all files.

(g) Knowledge of passwords shall be restricted to a practical minimum number of officers who shall be made aware of the need for secrecy in this respect. Where practicable passwords should be committed to memory and should not be written down by operators. Passwords shall be changed frequently and at irregular intervals.

(h) A master list of passwords shall be securely stored.

(i) There should be procedures to ensure that only authorised jobs are processed and to prevent unauthorised changes to jobs being made.

(j) The custody and distribution of all negotiable and accountable documents, license forms, etc. used in computer processing should be formally controlled. Areas to be considered include:

- secure storage locations,
- registers of usage, and
- post production and issue reconciliations.

(k) There should be established procedures for the disposal of EDP output and that these procedures take into account the sensitivity of the information contained thereon.

Consider:

- when decollating sensitive documents, ensure that interleaved carbon paper is disposed of in a secure manner.

- spoiled documents may require secure disposal, and

- classified or sensitive printout should not be released to unauthorised outside organisations.

(l) There should be adequate control over the use of terminals. Possible techniques include:

- physical locking of terminals,

- housing terminals in lockable rooms,

- restriction of terminal use to specific periods, functions, persons, locations, etc.,
- centrally initiated connect/disconnect,
- misuse of terminals automatically reported to the main computer site, and
- a secure power supply should be provided to terminals particularly in open office environments.

Security of Records and Equipment

There shall be some method to readily and economically reconstruct files after minor processing errors or minor destruction of records.

Procedures shall be established to detect errors as early as possible.

Explicit operator instructions on error and halt conditions shall be prepared.

A back-up cycle for all master and transaction files shall be maintained.

In the event of the necessity to re-create a file, the System Administrator shall specify by way of standing instructions the files to be used. User branches shall be advised of any such action if practicable in advance.

Checkpoint and restart procedures should be included with each program, where appropriate.

Equipment and file duplication should be used on critical systems where practicable.

Detailed and explicit file redundancy procedures shall be maintained to avoid loss of critical data and to achieve economical use of storage mediums.

There should be physical safeguards. Access to the computer room should be appropriately restricted and equipment which is considered 'at risk' should be protected against theft. (See Security Manual - chapter 30.)

Disaster Recovery Plan

There shall be a disaster recovery plan approved by the health organisation for each computer installation. The plan should address the threats to and the protection of the computerised information, the detection and containment of disasters and the recovery from disasters. If appropriate specialist external advice should be obtained.

The plan for prevention of disaster shall include:

- Procedures for the back-up and off-site storage of:

  master files and transaction files,
  transaction logs,
  software, and
  copies of files updated on-line.

- A risk analysis identifying and quantifying the risk the health organisation faces under each potential threat.

- Security strategies for protection against all significant anticipated threats to the data, hardware and environment, including:

  (i) complete loss of all on-site data,

  (ii) long term failure of main processor unit, and

  (iii) fire, flood, power surges or failure, air conditioning fluctuations or failure.

The plan for recovery from disaster shall include:

- The procedures for mobilising resources to continue the information processing while maintaining integrity of data,

- The emergency response to mitigate the damage being caused,

- An alternate processing arrangement including hardware, software, and stationery in an appropriate environment to permit recovery, and

- Procedures to restore back-up copies of the system to its status before disaster.

After quantifying all risks and preparing a plan for prevention and recovery, each health organisation shall identifying and quantify any remaining loss of revenue during the disaster and the recovery which cannot be prevented.

The disaster recovery plan shall as far as possible be tested regularly and must be reviewed at least bi-annually to ensure it is current and accurate.

Security of On-Line Systems

Transaction or processing messages for security or high level maintenance from all terminals shall be included on a machine log. Messages should be serially numbered (where necessary and practicable) and include terminal identification, operator time and details of transactions or processing.

Where practicable, the log should be regularly reviewed to ensure only authorised use has occurred.

Where practicable, physical access to a terminal should be restricted - locks and keys should be provided for each terminal which should not be left unattended without being locked off.

There must be a system of password security to limit access to data.

Knowledge of passwords shall be restricted to a practical minimum number of officers who shall be made aware of the need for secrecy. Where practical passwords should be committed to memory and should not be written down by operators. Passwords should be changed frequently and at irregular intervals. A master list of passwords shall be security stored.

Where appropriate, a software time lock should be placed on the system to prevent use outside permitted hours.

4. **Processing Controls**

The System Administrator and User Manager must ensure that there are internal controls within a system which provide for completeness and accuracy of processing and the early detection of invalid or improbable situations caused by such factors as errors, fraud or unusual activity.

Adequate training and supervision shall be given to all people associated with preparation of data for subsequent computer processing.

(a) **Input Controls**

Controls shall be established to:

- Ensure that all input has been properly checked and authorised.

- Where practicable, record input data in a control register as it is received together with the control totals which are to be used for subsequent balancing.

- Control errors rejected by the computer through the maintenance of a register which can be used to ensure that all errors are corrected by the proper source and that the corrections are re-entered into the system.

- Where practicable, ensure that output reports are available on time, that they balance with input controls and that they are properly distributed to users.

- Ensure there is evidence of correct processing. Output reports, especially error and control reports, should be reviewed as soon as available. Discrepancies, errors, other unusual features which are detected should be reported immediately to appropriate staff so that corrective action may be taken while intermediate and/or print files are still available.

- Where the processing consists of several stages, controls should be established to ensure correct processing of each stage before proceeding to the next stage.

  There shall be some method of ensuring that all data is initially recorded, identified and verified.

- Where practicable, each transaction which materially alters master file records should be recorded initially on a specially designed for which should bear a processing identification code and be filed in such a manner that subsequent reference can be made to it. These transaction advices should be prepared by a designated officer and should be checked by an authorising officer and both officers should sign or initial the form accordingly. Unused portions of these forms should be ruled off and once authorised, they should be kept under security prior to data entry in order to guard against unauthorised alterations and the introduction of unauthorised transactions.

- Where the accounting systems incorporate program generated transactions (e.g. debit raising on debtors accounts) there shall be a management trail to indicate the transactions automatically generated.

- Where records are deleted from files or where fields are automatically "zeroised" (e.g. after production of group certificates, deletion from file of employees whose employment was terminated during the year and the return to zero of the year to date totals for continuing employees) appropriate output reports shall be produced fully documenting the changes made.

- Where possible, the computer should be able to detect missing input.

  Control shall be established as close as possible to the source of the transaction to guard against the loss of data.

- Where practicable, input data should be batched close to the point of preparation and batch control totals taken.

- Where applicable, data preparation equipment should be programmed to verify and enable correction of batch totals as well as any other edit functions which should be incorporated.

- Ensure that overrides to programmed edit functions are reported and approved by designated personnel independent of data entry and operations.

- Where real time updates are effected a transaction log identifying the originating officer should be provided.

(b) **Edit Controls**

Controls, including the following, should be used wherever appropriate to edit the input data for accuracy:

- Check digit verification.
- Limit and range checks.
- Sequence checks.
- Format checks.
- Completeness checks.
- Data reasonableness checks.
- Logical relationship checks.
- Record count.
- Alphabetic checks.
- Numeric checks.
- Signed numeric checks.
- Batch checks.

Manual editing (checking) should be used wherever appropriate, to edit or scrutinise data for accuracy. Manual checking procedures would include:

(i) Review of output reports by users for reasonableness.

(ii) Periodical review of print-outs, complete or selective, of key master files.

Where appropriate, editing functions of data preparation equipment should be fully utilised. This enable errors to be detected while the source document is in hand. These editing functions should be in addition to, and not in replacement of, comprehensive editing procedures during actual processing by the computer.

Where practicable, keyed data input should be verified by a second keying operation except where otherwise controlled, for example, by use of control or hash totals.

Where practicable, information on input documents should be pre-printed or pre-coded with maximum field size stated, thereby reducing the risk of errors in transcription. If practicable, data should be coded simultaneously with the recording of the original transaction for example, by using cash registers with a magnetic tape cassette facility to capture data.

There shall be procedures to ensure that all required output reports are delivered to the correct users.

All reports must be headed with description and nature of report, they must be dated and wherever possible include the system time.

All pages must be numbered.

All reports must have an end of report indicator.

A "NIL" report should be produced, if appropriate.

The user should anticipate the production of output and immediately follow-up output not received.

Proper receipting procedures must be established, documented and enforced for the delivery and receipt of computer input and output.

Where practicable, output must be reconciled to input:

- Output control totals must be reconciled to batch control totals by a control group or where no such group exists, by an officer other than the computer operator.

- As an alternative output control totals should be reconciled to input control totals by computer through entering initial batch control totals as computer input.

- In the case of either of the above, input and output control totals must be printed out for manual verification and later reference.

- Changes to the master file must be verified by reconciliation of manually prepared control totals to computer generated totals.

- All discrepancies, errors or other unusual features detected by reference to individual records must be immediately reported for corrective action. Subsequent action should be documented and noted on the relevant output report.

- Where practicable, management reporting systems should be used to detect incorrect (accidental or fraudulent) transactions. For example, disbursement entries should be reported directly to appropriate levels of management in sufficient detail and clarity to enable identification of unauthorised expenditures.

(c) **Management Trails**

There shall be some method of identifying and locating the component file records and input/output documents involved in the processing of a given transaction or in the accumulation of a given total.

Each document and computer file record shall have a unique identification.

Each document and computer file record shall be filed in a planned sequence to facilitate its accessibility.

Methods of tracing specific items of data backwards and forwards through the processing cycle shall be an integral part of the systems design.

Procedures must be established, documented and enforced for the secure storage of documents for an appropriate length of time after computer processing.

(d) **Completeness and Accuracy of Input and Processing in an On-Line Environment**

The communications software shall provide for messages in both directions between computer and the terminal to acknowledge that transmission has been received.

Where data is not transmitted in batch format all messages should be included on a transaction file, where practicable.

The transaction file should be printed and reviewed to ensure accuracy and completeness, where practicable.

Whenever possible edit functions should be performed at the data entry point before transactions are applied to the master file.

Where possible, the data transmitted for a certain period, e.g. a day, should be reconciled to predetermined manual figures.

5. Documentation Controls

Adequate Documentation

Adequate documentation shall be prepared in accordance with predetermined standards developed by appropriate staff, reviewed under a quality review process and approved by the Project Sponsor in regard to the following:

- User requirement specifications.
- Computer systems design.
- Program source listings and narrative descriptions.
- Computer and peripheral equipment operations.
- Library procedures.
- Data preparation and data entry.
- Computer input - output controls.
- User procedures and staff training manuals.
- Amendments and testing procedures.
- Back-up and recovery procedures.
- Management overview of system.

6. Micro-Computer Controls

Micro-computers are widely used in health organisations to achieve distributed processing of data. This approach often introduces unique management problems to ensure that Organisational, Development, Operational, Processing and Documentation Controls are implemented. The following procedures are to apply to Micro-computer or Personal Computer systems **in addition** to those set out in the preceding pages relating to computer based systems generally.

Each workstation (personal computer) or cluster of workstations shall be assigned a system administrator who shall be responsible for compliance with the operational controls in section 3.

The System Administrator must ensure that users are aware of the standard back-up cycle and that written procedures are issued to users who are responsible for back-up of their own application data files.

All back-up medium such as tapes and diskettes must be stored in a secure area and environment free from the effects of sun, heat, dust and other damaging factors.

Security of application and operating systems software on micro-computers is usually achieved by passwords. System Administrators shall ensure that passwords are:

- Known to as few senior officers as possible who should commit the password to memory;

- Written down and stored in a sealed envelope in a safe; and

- Changed at regular intervals, when staff changes occur or if compromised.

The User Manager shall ensure that:

- Appropriate staff are fully trained in the operation of the application systems and sufficient areas of the operating system to provide continuity of operation; and

- Adequate and current procedure manuals exist for all applications in addition to the operating system manuals and application training guides.

INTERNAL CONTROL - GENERAL

Organisation

The smooth functioning of a health organisation depends largely on a good organisation of departments, staff, and duties.

(i) A clear and well-planned organisational chart should be displayed in all departments to disclose the formal allocation of functions, responsibility and accountability.

(ii) A Manual detailing the delegation and limitations of authority to specified officers should be maintained.

(iii) An employees' duties should be:

(a) clearly stated in a statement of duties or a job description to ensure that the employee knows what is expected of him/her. The statement should be explained to the employee, signed by the employee and a copy provided to the employee.

(b) organised with a maximum separation of duties consistent with available human resources to ensure that no part of the accounting function is under the absolute and independent control of any one person.

(iv) The Accounting Department function should be completely separated from:

(a) Admissions Department,
(b) Purchasing,
(c) Cash Disbursements,
(d) Cash Receipts,
(e) Discharge Department.

(v) Where possible, accounting employees duties should be rotated to guard against defalcations.

(vi) Employees whose main duty is the handling of cash or securities should be required to take annual leave at least once each year for a minimum period of two (2) consecutive weeks and their duties should be assumed by other employees.

(vii) Internal audit programs where used should be reviewed by the external auditor.

(viii) The internal auditor should be responsible directly to the Chief Executive Officer.

Accounting Records and Controls

(i) Copies of the Accounting Manual (including Accrual Accounting Standards and Procedures Section), Accounts & Audit Determination, Purchasing and Supply Manual, Leave Manual, Occupational Health and Safety Manual, Building and Equipment Manual and others as they are compiled should be located in departments where relevant to the function.

(ii) Internal check procedures should exist to ensure the procedures in the Manuals are being followed.

(iii) Changes in systems and procedures should be approved by the Chief Executive Officer and recorded for the notice of the internal auditor and external auditor.

(iv) Accounting and other records should:

(a) explain the transactions clearly,

(b) comply with statutory and Departmental requirements,

(c) be kept up-to-date,

(d) balanced monthly,

(e) be maintained in a neat, legible and comprehensive fashion.

(v) The retention period of accounting, financial and statistical records is shown as Appendix 1 to this section.

Property, Plant and Equipment

(i) A motor vehicle register must be maintained, as described in Purchasing and Supply Manual.

(ii) Log books and running sheets should be maintained in respect of each vehicle.

(iii) Assets should be capitalised at the time of purchase.

(iv) A preventive maintenance program should be in operation.

(v) Adequate internal disaster plans should be prepared and rehearsed periodically to safeguard the buildings and equipment.

Investments

(i) A Register showing all relevant details should be maintained and periodically checked with documentation and with the financial accounts.

(ii) All income should be accounted for in the year it is earned.

(iii) Dealings in investments should be authorised by the CE for area health services and Royal Alexandra Hospital for Children with all documents being filed for audit purposes.

Stocks

(i) Perpetual stock records should be maintained where possible.

(ii) Stores records should not be handled by persons responsible for physical handling of stock in the store.

(iii) Reports should be prepared periodically on stock which is:

(a) slow moving,
(b) obsolete,
(c) outside maximum or minimum requirements,
(d) dam aged.

Stocktaking

(i) All classes of stock should be counted at least once a year.

(ii) Written instructions for the conduct of the stocktake should be prepared for the guidance of employees.

(iii) Where perpetual stock records are maintained, periodic test counts should be made on a cyclic basis.

(iv) All counts should be double-checked.

(v) Adjustments to stock records should be investigated and properly authorised.

Handling of Monies (ALSO SEE CASH HANDLING CHECKLIST IN THIS SECTION.)

Each location or function in the health organisation where cash is received for an official purpose should be identified.

i) An official receipt of the health organisation should be written for all monies received.

ii) At the close of business each day all monies received shall be balanced and agreed with the total of receipts issued on that day.

iii) Cheques must not be cashed from takings or change given in respect of cheques.

iv) All inward mail shall be opened in the presence of 2 officers.

v) Postal remittances other than cash shall be crossed "Not Negotiable" and entered in a suitable remittance by mail register.

vi) Bank lodgements shall be made daily where the total amount of monies exceeds $400, but in no circumstances shall bankings be made less frequently than once each week.

vii) Payment of accounts against the health organisation shall not be paid until their payment has been authorised.

viii) Supplies of cheque forms should be printed as payable "to order" and crossed "not negotiable".

ix) Blank cheque forms shall be kept under lock and key. If practical the custody of the cheques should be the responsibility of a person not involved in the process of disbursing money.

x) Cheques should be issued in sequence.

Payroll and Personnel

(i) Requests for new personnel should be originated only by department heads or properly authorised persons.

(ii) Applicant's background, former employers and references should be investigated. Qualifications should be verified.

(iii) Initial rates of pay and subsequent changes should be authorised by an appropriate officer.

(iv) Adequate personnel files should be maintained.

(v) Employee Base Data input forms used to create new employees on the computer file or to amend information should be prepared by persons not involved in the preparation of the payroll.

(vi) Where practicable entries on a time sheet should be made daily under the supervision of departmental head.

(vii) The use of time clocks should be supervised.

(viii) Time records should be checked and approved by departmental head.

(ix) Employees preparing payroll should not be involved in:

(a) engagement of staff;
(b) rate authorisation;
(c) time and attendance records;
(d) cashing pay cheque;
(e) distribution of pay.

(x) Payroll staff should check:

(a) computation of payroll hours;
(b) overtime for approval;
(c) overtime hours computations;
(d) that alterations or erasures are approved.

(xi) All clerical payroll calculations should be double checked before payment is made.

(xii) Payroll sheets should be authorised by the appropriate officer.

(xiii) Where HOSPAY is used, pay variation advices should be batched. A header form should be prepared and control totals entered in batch register.

(xiv) Where employees are paid in cash:

(a) payroll cheque cashed by employee not involved in preparing payroll or timekeeping;

(b) cash should be enveloped by persons who do not prepare the envelopes or the payroll.

(xv) If employees are paid by bank transfer, employees should receive advice as to:

(a) gross amount;
(b) deductions;
(c) net pay.

(xvi) Pay cheques/envelopes should be distributed by someone independent of all payroll functions or envelopes.

(xvii) Employees should be identified before given pay.

(xviii) A record should be made of all unclaimed wages.

(xix) The custodian of unclaimed wages should check wages against payroll and the record and should be an authorised officer independent of the payroll office.

(xx) Group certificates for the year should be reconciled to general ledger and payroll totals.

(xxi) Returned and unclaimed Group Certificates should be investigated by other than payroll and timekeeping personnel.

HOSPAY/COMPUTERISED SALARY SYSTEM

Where the hospital payroll is processed by HOSPAY or other computerised payroll system the following additional rules should be adhered to:

(a) A system of batch control should exist to verify that all data forwarded to HOSPAY is processed and returned.

(b) All input data prepared should be verified independently.

(c) All time sheets etc. should be certified by the departmental head.

(d) The paymaster should add some comment or reference to each variation highlighted on the Consolidated Edit Report and Audit Trail and the report referred to a senior officer, i.e. the Accountant, for certification.

(e) Where possible and practicable, paymasters should bring to the attention of departmental heads any discrepancies found in the time sheet/bundy card.

(f) Alterations to payrates should be properly authorised.

(g) Bundy Cards, Time Sheets, Input Forms, etc. should be retained for two (2) years after examination by audit.

COMMUNICATIONS

Lines of communication and a system for the promulgation of policy/procedural information should be defined so that employees are made aware of current requirements in a timely manner.

CASH HANDLING CHECKLIST

Internal Audit Units are to conduct audits to determine compliance with the checklist as part of their annual audit plans. Audit Committees in area health services and public hospitals are to ensure that :

i) auditing of cash handling functions is performed by their Internal Audit Units to determine the degree of compliance with the undermentioned checklists; and

ii) corrective action is taken to correct any instances of non-compliance.

Hospitals Under 100 Adjusted Daily Average

1. Each hospital should have reviewed its cash services with a view to rationalisation. (Q.A1)

2. One officer should be responsible for processing storing cash. (Q.B3)

3. Officer responsible for cash should not be situated in an openly accessible position. (Q.B4)

4. Cash and valuables should be stored in a safe which is located in a closed off office. The safe as a minimum is to have a single lock with the key being the responsibility of the officer responsible for the cash. (Q.B9, 10, 11, 14)

5. Each hospital is to maintain a register of all keys in the hospital. (B.18a)

6. Each hospital is to maintain a record of all locations where staff handle cash. If a hospital has only one (1) cash collection point the record is not required. (B.19a)

7. Hospitals are to ensure that: (C.1)

   i) receipt procedures are checked
   ii) supervisors check all cash handling duties
   iii) receipts and revenue are reconciled daily
   iv) cash handling staff are trained in their duties and responsibilities
   v) staff rotation is introduced where practicable.

8. There is to be a central cash depositing facility. (D.6a)

9. A receipt (either manual or cash register entry) is to be issued on every occasion cash or property is received. (D.9a)

10. Each receipt is to be accountable and prenumbered. (E.22)

11. Each receipt is to incorporate provision for: (D.11 & D.13)

    - the date
    - name of issuing officer and location if cash receipting outpost
    - the amount
    - payment type, e.g. cash, cheque
    - what receipt is for

12. Cash is to be banked at least weekly and more frequently if monies received total $400 or more. (E.5)

13. All deposits are to be reconciled between the total of receipts and the bank deposit advices. (E.7)

14. If the hospital has coin operated machines the undermentioned functions are to be undertaken: (E.8)

    - machines where possible are to have two key access
    - two or more officers are to clear machines
    - staff who collect cash are to reconcile the total amount of cash collected with the amount of cash deposited by using a daily balance sheet and signed receipts
    - amounts collected and receipted from coin machines are to be checked against accounts, meter readings or stock records. Where meters exist a book is to be maintained recording meter readings when cash is collected and said book is to be reconciled against amounts receipted on a regular basis by a supervisor.

15. Two officers are to transport cash within the hospital and to the bank. (E.19) Officers transporting cash are to vary times and routes where and when possible.

16. Each hospital is to have an Accountable Books Register: (E.23)

    - all accountable books and documents, e.g. receipts, are to be numbered with all documents being recorded in the register
    - distribution is to be recorded, viz. date, name, section
    - completed documents are to be returned, with said return being recorded.

17. Each hospital is to have a formal (written) procedure for taking action and reporting thefts and or any other possible fraud. The procedure is to have as key elements the requirement to report to the Board and Police. (E.24)

18. Each hospital is to conduct a surprise audit of cash handling procedures at least annually. (E.28)

Hospitals Over 100 Adjusted Daily Average

1. Each hospital should have reviewed its cash services with a view to rationalisation. (Q.A1) A review of the cash services should be performed at least annually to determine appropriateness of services, procedures being complied with, suitable staff employed etc.

2. One officer should be responsible for processing and storing cash. (Q.B3)

3. Officer responsible for cash should not be situated in an openly accessible position. (Q.B4)

4. Cash and valuables should be stored in a safe which is located in a closed off office. The safe as a minimum is to have a single lock with the key being the responsibility of the officer responsible for the cash. (Q.B9, 10, 11, 14)

   A system is to be in place so that if several officers have access to safes and/or cash storage facilities, responsibility for shortages can be identified to one officer at any particular time by means of access records etc.

5. Each hospital is to maintain a register of all keys in the hospital. (B.18a)

6. Each hospital is to maintain a record of all locations where staff handle cash. If a hospital has only one (1) cash collection point the record is not required. (B.19a)

7. Each hospital is to introduce standard procedures for all cash collection outposts, e.g. receipting, lodgement at cashiers, banking, reconciliation etc.

8. Hospitals are to ensure that: (C.1)

   i) receipt procedures are checked
   ii) supervisors check all cash handling duties
   iii) receipts and revenue are reconciled daily
   iv) cash handling staff are trained in their duties and responsibilities
   v) staff rotation is introduced where practicable.

9. There is to be a central cash depositing facility. (D.6a)

10. The central cashier is to issue a covering receipt for all monies received from cash services or cash collection outposts.

11. A receipt (either manual or cash register entry) is to be issued on every occasion cash or property is received. (D.9a)

12. Each receipt is to be accountable and prenumbered. (E.22)

13. Each receipt is to incorporate provision for: (D.11 & D.13)

    - the date
    - name of issuing officer and location if cash receipting outpost
    - the amount
    - payment type, e.g. cash, cheque
    - what receipt is for

14. Cash is to be banked at least weekly and more frequently if monies received total $400 or more. (E.5)

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    - amounts collected and receipted from coin machines are to be checked against accounts, meter readings or stock records. Where meters exist a book is to be maintained recording meter readings when cash is collected and said book is to be reconciled against amounts receipted on a regular basis by a supervisor.

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    - distribution is to be recorded, viz. date, name, section
    - completed documents are to be returned, with said return being recorded.

19. Each hospital is to have a formal (written) procedure for taking action and reporting thefts and or any other possible fraud. The procedure is to have as key elements the requirement to report to the Board and Police. (E.24)

20. Each hospital is to conduct a surprise audit of cash handling procedures at least annually. (E.28)

MICROFILMING OF ACCOUNTING RECORDS

Accounting records may be retained either in their original form or in microform. Where health organisations intend to microfilm accounting records the following guidelines should be observed:

- original documents must be retained for a minimum period of three (3) years before microfilming;

- all microfilming should be prepared in accordance with the relevant sections of the ***Evidence (Reproductions) Act 1967***;

- proper controls should be instituted to ensure the safe keeping of such records for the prescribed period.

AUDIT COMMITTEE

A health organisation shall constitute an Audit Committee as a standing committee of the Board of Directors. The Audit Committee shall comprise at least three (3) members of the Board of Directors and the Committee shall meet to perform its functions at least quarterly.

Chairpersons of Audit Committees are to be Board Directors but not Area Chief Executive Officers or employees of the entity.

The Chairperson of the Audit Committee is not to be the Chairperson of the Finance Committee (or a similar Committee).

The Audit Committee is to comprise the full Board or a separate Sub Committee of the Board providing all conditions of this document are observed concerning chairpersons and the roles of employees.

Area Chief Executive Officers or employees of the entity may be invited to attend Audit Committee Meetings (at Chairpersons' discretion) but must not be allowed to move resolutions, second resolutions or vote on any issue.

Internal Audit officers are to have direct access to the Audit Committee but operationally, will continue to report to the Area Chief Executive Officer.

SECTION 8

ACCRUAL ACCOUNTING STANDARDS AND PROCEDURES

ACKNOWLEDGMENT

In preparing this document the Department has benefited from comments and suggestions provided by the following parties:

- The Treasury of New South Wales
- The Auditor-General's Office, New South Wales
- Participants in Accrual Accounting Implementation Committee for the NSW Health Department

REFERENCES

- NSW Treasury

  "Public Sector Policy Guidelines for Valuation of Physical Non-Current Assets in NSW Public Sector"

  "Financial Reporting Code on Accrual Accounting for Inner Budget Sector Entities"

  "Financial Management for Inner Budget Sector Entities"

- Australian Society of CPA's.

  Members Handbook which Incorporates "The Australian Accounting Standards" and Statements of Accounting Concepts.

  Institute of Chartered Accountants in Australia.

CONTENTS

PART ONE

DISCUSSION OF

ACCOUNTING ISSUES

AND

ASSOCIATED REQUIREMENTS

1.0 BACKGROUND AND TIMETABLE FOR THE INTRODUCTION TO ACCRUAL ACCOUNTING

Following the release of the "Report on the State's Finances" (mid 1988) by the Commission of Audit there has been a continual evaluation by the representatives from the Treasury, the Auditor-General's Office, and the Office of Public Management, relating to suggestions concerning the introduction of the accrual accounting concept in the budget sector. The Committee formed from these sources examined the issues and problems associated with the implementation target of 3-5 years.

In the same year the Minister for Health indicated his commitment to introduction of global budgeting and associated management systems including accrual accounting as a strategy for improved health service management for the Department generally. Furthermore the Auditor-General wrote to the Department endorsing the commitment and offering to participate in the development of accrual accounting methods for the Area Health Services and public hospitals.

Subsequently it was agreed that a number of Area Health Services/public hospitals would pilot the implementation of a **"modified"** accrual accounting (see definition) system from 1st July 1990 with appropriate assistance from the Treasury, the Office of the Auditor-General and the NSW Health Department.

Following nominations for the pilot program at the Senior Executive Council Meeting of 16th August 1989, Western Sydney, Southern Sydney, Northern Sydney and Illawarra Area Health Services and Goulburn Health Service (South Eastern Region) were selected to participate in this exercise.

It was agreed that the change to accrual method of accounting is to impact all of the State's subsidised hospitals and is to encompass all the relevant operating funds. For public hospitals, this includes the General Fund and the Special Purposes and Trust Fund Accounts.

The implementation timetable observed for the introduction of accrual accounting within the NSW Health System is as follows:

1990/91 Modified Accrual	1991/92 Modified Accrual	1992/93 Modified Accrual
Piloted Area Health Services and Goulburn Base Hospital	All Area Health Services and selected country hospitals	Department's Central Office, **all** Area Health Services/Regions/NSW Ambulance Services/other hospitals and Dept. Services

Full accrual accounting requirements applied from July 1993.

Definitions:

"Full" accrual accounting: a **monthly** accrual will be required to be calculated and reported in respect to "operating" income/expenditure and asset/liability items.

"modified" accrual accounting: **Accruals** will be calculated and reported in respect to "operating" income/expenditure and asset/liability items ie. on 30th June for each year.

2.0 THE PURPOSE OF ACCRUAL ACCOUNTING

Before the introduction of accrual accounting the NSW Government accounting and reporting practices as reflected through departmental organisational structures including the NSW public hospital system, were unable to accurately identify to the users of their financial statements the full cost of their operations and the extent of their asset holdings.

Therefore it can be argued that in many instances the cash basis accounting did not present accurately the financial affairs of our public hospitals and the health system generally.

Difficulties are experienced by entities which are expected to effectively use a budget as a control mechanism without being on an accrual basis. This is because under a cash concept, payments and receipts may lag for a long time after incurring the obligation. The accrual basis of accounting becomes the more appropriate basis when an entity has substantial unpaid bills or uncollected income at the end of each period and these amounts vary from period to period. Therefore entities that must carefully budget their activities will find accrual basis accounting advantageous.

Apart from criticisms which may be levelled at entities which do not account for their financial transactions in accordance with this accepted accounting standard, there are other problems arising from such non-compliance which may reduce the effectiveness of an entity and its management. These include:

- Not knowing what resources are available and therefore, an inability for them to plan for and exert adequate controls over asset utilisation/ maintenance in the manner expected of managers in the private sector.

- Not being aware of the replacement value, which is the most important criterion in assessing the operating capability in policy terms, including pricing decisions and public fund raising.

- Making policy decisions on insurance, transfers between public bodies, and acquisition and disposal of assets, on incomplete information.

By the adoption of accrual accounting across the board it is now possible for users of financial statements to obtain:

- A complete picture of the financial position, including all the resources available.
- An accurate picture of the size and current value of an entity.
- A complete measure of the annual cost of the services.
- A measure of cost that is useful for analysis of trends and for comparison with measures of output or benefit.
- A measure of annual deficit that reflects the consumption of resources to finance current operations.

3.0 DEFINITION OF ACCRUAL ACCOUNTING

The accrual accounting concept means:

- **That revenues should be recorded in the period in which the service is given,** although payment is received in a prior or subsequent period, and

- **That expenditures should be recorded in the period in which the benefit is received,** although payment is made in a prior or subsequent period.

An important aspect of accrual accounting is accounting for and recording of fixed (non-current) assets and liabilities. The generally accepted accounting principle in this regard is the capitalisation approach, where the full cost of the asset is capitalised and recorded in the Statement of Financial Position. The entity can then follow depreciation and revaluation accounting techniques.

4.0 PRINCIPAL EFFECT OF THE CHANGE TO ACCRUAL ACCOUNTING

Prior to 1st July 1990 Area Health Services/public hospitals prepared their accounts on a cash basis and in accordance with requirements outlined through the Accounts and Audit Determination.

The Area Health Services/public hospitals are to continue to be required to comply with financial and reporting standards specified by the Accounts and Audit Determination made under the ***Public Hospitals Act*** rather than the ***Public Finance and Audit and Annual Reports Acts*** which govern public service (category A) organisations. The Accounts and Audit Determination makes reference to the accrual accounting standards and associated financial procedures which have been developed for Area Health Services/public hospitals for the purpose of the introduction and maintenance of accrual accounting concepts. Such standards/procedures have been made consistent with the mentioned legislation in order to ensure uniformity within all entities in the inner budget Government sector.

Budgets for Area Health Services/public hospitals are to continue to be approved by the Minister for Health within the context of the overall Health budget allocated by the Treasurer.

The principal effects of changes to accrual accounting for Area Health Services/public hospitals are as follows:

- **Accrual basis of accounting was introduced** by selected Area Health Services/public hospitals from 1st July 1990 with full introduction throughout the health system in 1992/93.

- **Fixed (non-current) assets acquired are capitalised** instead of being expensed in the year of acquisition.

- **All Area Health Services/public hospitals keep a fixed (non-current) assets ledger** and maintain an appropriate **fixed (non-current) asset register.**

- **Fixed (non-current) assets are depreciated except where otherwise stated** and appropriate accounting records maintained for this purpose.

- **The full amount of current assets and liabilities incurred through operations and including the amount of expense in respect of employers superannuation and leave entitlement are brought to account** in a manner appropriate to accrual accounting methodology.

Note: These changes are designed to encompass all the operational funds ie. for Area Health Services/public hospitals this includes the General Fund, Group Services and the Special Purposes and Trust Fund Accounts.

5.0 PRELIMINARY

5.1 Financial Reporting Directives

This document comprises financial reporting directives.

This document shall be cited as the Accrual Accounting Standards and Procedures Manual for Area Health Services, the NSW Ambulance Service and Public Hospitals in New South Wales.

5.2 Purpose

The purpose of this Manual is to establish financial reporting directives to govern the form and content of Area Health Service/Hospital (Entities) financial reports. The objective of such financial reports is to provide information which is useful to users for making and evaluating decisions on the allocation of scarce resources. Financial reports prepared to achieve this objective will assist Area Health Service/Public Hospitals in meeting their financial accountability obligations.

Note: For the purposes of this Manual the Area Health Services and public hospitals shall be termed as "entity".

5.3 Authority of Financial Reporting Directives

The financial reporting directives in this Manual are issued under the Accounts and Audit Determination. The directives are consistent with those issued under Section 9 of the ***Public Finance and Audit Act 1983***. Compliance by the Area Health Service and Public Hospitals with the financial reporting directives is mandatory.

Note: Area Health Services and Public Hospitals are to continue to be required to comply with financial and reporting standards specified by the Accounts and Audit Determination made under the *Public Hospitals Act* rather than the *Public Finance and Audit and Annual Reports Acts.* The terms/standards specified by the Accounts and Audit Determination are consistent with the latter legislation in order to ensure that all entities within the inner budget general government sector are subject to uniform directives.

5.4 Application of Australian Statements of Accounting Concepts and Australian Accounting Standards.

Financial reports shall be prepared in accordance with Australian Statements of Accounting Concepts (SACs) and applicable Australian Accounting Standards (AASs) unless directed otherwise by the Department or where the financial reporting directives of this Manual differ from the requirements of those SACS or AASs.

5.5 Application of the Manual and Operative Date

The financial reporting directives in this Manual apply to all financial reports prepared by an entity commencing in the financial period in which an entity first adopts accrual accounting.

5.6 Application of Materiality

The financial reporting directives set out in this Manual shall, in accordance with AAS 5 "Materiality in Financial Statements", only apply to financial reports where such application is of material consequence.

5.7 Language and Monetary Amounts

Financial reports shall be expressed in the English language.

Financial statements shall be presented in Australian currency and any amounts stated therein shall be rounded to the nearest one thousand Australian dollars.

Where the amount of any item shown in a financial statement is desegregated or further explained in the notes to the financial statements, a cross reference to that note shall be included in the financial statement against that item.

5.8 Definitions

For the purposes of this Manual:

> "Abnormal items" means items of revenue and expense included in the operating result for the financial period, which are considered abnormal by reason of their size and effect on the operating result for the financial period.
>
> "Addition" means, in the context of property, plant and equipment, an increase in the future economic benefits or service potential of an item of plant and equipment such as may result from acquisitions, extensions, improvements, betterments and major replacements.
>
> "Assets" means service potential or future economic benefits controlled by the reporting entity as a result of past transactions or other past events.
>
> "Budget sector entity" means an administrative unit which relies predominantly on the budget for funding. By predominantly is meant that 50 per cent or more of the total recurrent funding for the unit is appropriated by Parliament.

"Carrying amount" means:

(a) in relation to an asset, the amount at which the asset is recorded in the accounting records at a particular date after deducting any related accumulated depreciation or amortisation, and

(b) in relation to a class of assets, the sum of the carrying amounts of the assets in that class.

"Class of assets" means a category of assets having a similar nature in the activities of the entity which category, for the purpose of disclosure in the financial statements of the entity is shown as a single item without supplementary dissection.

"Current assets" means the assets of the entity that would, in the ordinary course of that entity providing goods or services, be consumed or converted into cash within twelve months of the end of the current financial period.

"Current liabilities" means the liabilities of the entity that would, in the ordinary course of that entity providing goods or services, be due and payable within twelve months after the end of the current financial period.

"Equity" is the residual interest in the assets of an entity after deduction of its liabilities.

"Expenses" means consumptions or losses of economic benefits or service potential in the form of reductions in assets or increases in liabilities of the reporting entity, other than those relating to distributions to equity contributors, which result in a decrease in equity during the reporting period.

"Extraordinary items" means items of revenue and expense which are attributable to events or transactions of a type that are outside the ordinary operations of the entity and are not of a recurring nature.

"Fair value" means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length exchange.

"Financial Period" means, in relation to an Area Health Service/Hospital, a period as determined by the NSW Health Department.

"Financial report" means a general purpose financial report which includes financial statements, notes to the financial statements and any supplementary information attached to or intended to be read in conjunction with those financial statements.

"Financing activities" means, for the purposes of the statement of cash flows, those activities which result in changes in the size and composition of the financial structure of the entity, both equity and borrowings, not falling within the definition of "government funding activities".

"Flows of Funds" means the movement of funds into or out of the entity resulting from transactions with parties external to the entity.

"Funds" means cash and cash equivalents (credit or barter).

"Gain (loss) on disposal" means, in relation to property, plant and equipment, investments or intangibles, the gross proceeds of sale less the carrying amount of the asset at the time of disposal and expenses directly incurred in disposing of that asset.

"Government funding activities" means, for the purposes of the statement of cash flows, those activities which result from transactions between the entity and the Crown, including the receipt of NSW Health Department Cash Payments and capital allocations.

"Grants" means voluntary, non reciprocal transfers of resources between the entity and another entity.

"Inflows of funds from financing" means those increases in liabilities which involve a flow of funds during the financial period.

"Inflows of funds from investing" means those decreases in assets which involve a flow of funds during the financial period.

"Inflows of funds from operations" means those items of revenue, included in the net cost of services, which involve a flow of funds during the financial period.

"Inventories" means goods, other property and services:

(a) held for sale or consumption in the ordinary course of service delivery.

(b) in the process of production for such sale or consumption, or

(c) to be used up in the production of goods, other property or services for sale or consumption including consumable stores and supplies, but does not include depreciable assets as defined in AAS 4 "Depreciation of Non-Current Assets".

"Investing activities" means, for the purposes of the statement of cash flows, those activities relating to the acquisition and disposal of non-current assets,

including property, plant and equipment, and other productive assets, and of investments, such as securities, not falling within the definition of government funding activities.

"Investments" means assets held by an entity primarily for the accretion of wealth through receipt of distributions (such as interest, royalties, dividends and rentals) or for capital appreciation, and includes items of property, plant and equipment held for resale other than in the ordinary course of the entity's operations.

"Liabilities" means the future dispositions of economic benefits that an entity is presently obliged to make to other entities as a result of past transactions or other past events.

"Net market value" means the amount which could be expected to be received from the disposal of an asset in an orderly market after deducting costs expected to be incurred in realising the proceeds of such a disposal.

"Non-current assets" means all assets other than current assets.

"Non-current liabilities" means all liabilities other than current liabilities.

"Operating activities" means, for the purposes of the statement of cash flows, the activities involved in producing and delivering goods and services, and includes all transactions and other events that are not investing, financing, or government funding activities.

"Outflows of funds from financing" means those decreases in liabilities which involve a flow of funds during the financial period.

"Outflows of funds from investing" means those increases in assets which involve a flow of funds during the financial period.

"Outflows of funds from operations" means those items of expense, included in the net cost of services, which involve a flow of funds during the financial period.

"Property, plant and equipment" means assets that:

(a) are held by the entity for use in the production or supply of goods and services, for rental to others, or for administrative purposes and may include items held for the maintenance, construction or repair of such assets.

(b) have been acquired, obtained or constructed with the intention of being used on a continuing basis, and

(c) are not intended for sale in the ordinary course of business or service delivery.

"Recognition" means the process of reporting or incorporating an item in the financial statements other than by way of note.

"Recoverable amount", in relation to an asset, means the net amount that is expected to be recovered:

(a) from the total cash inflows less the relevant cash outflows arising from its continued use and through its subsequent disposal, or

(b) through its sale

"Revaluation" means the act of establishing a revised carrying amount (other than for the purposes of recognising a change in accumulated depreciation or amortisation or any permanent impairment in service potential) for a non-current asset.

"Revaluation increment" means the amount by which the revalued carrying amount of a non-current asset as at the date of revaluation exceeds its previous carrying amount.

"Revaluation decrement" means the amount by which the revised carrying amount of a non-current asset at the date of revaluation is less than its carrying amount before revaluation.

"Revenues" are inflows or other enhancements or savings in outflows of economic benefits or service potential in the form of increases in assets or reductions in liabilities, other than those relating to contributions by owners, that result in an increase in equity during the reporting period.

"Taxes, fines and regulatory fees" means compulsory levies which are not directly related to the specific provision of goods or services provided by The entity. Such compulsory levies are not to be recognised as revenues of the entity.

"User charges" means revenues of the entity which result from the voluntary acquisition by the purchaser of particular goods or services of direct benefit to the purchaser.

"Written down net market buying value", in relation to an asset, means its net market buying values less, where applicable, accumulated depreciation calculated on the same basis of its net market buying value to reflect the already consumed or expired service potential of the asset.

PART TWO

ASSETS AND LIABILITIES

6.0 ACCOUNTING FOR ASSETS - OVERVIEW

6.1 Objectives

The need for an adequate report on the assets of an entity stems from the objective of financial reporting, which is to give information that is useful for making decisions about the allocation of scarce resources. An overview of the types of information disclosed is provided in Section 4 of this document.

The financial report of an entity should disclose the following types of information about its assets (Section 13 specifies detailed requirements):

- nature and amounts of assets on hand.
- additions to its stock of assets.
- depreciation and other consumption of assets, and
- disposals of assets.

6.2 Definition of Assets

An item is classified as an asset if:

- it has service potential or future economic benefits.
- an entity controls the service potential or future economic benefits, and
- the transaction or other event giving rise to an entity's control over the service potential or future economic benefits has occurred.

Any item having these characteristics is to be classified as an entity (Area/District Health Service/public hospital) asset irrespective of whether it was acquired by the entity, (eg. Area/District Health Service or Hospital ownership) gifted or bequeathed to the entity (trust property), provided to the entity by the NSW Government, (Crown or Health Administration Corporation "ownership") or otherwise obtained by the entity. Whether or not the item is monetary (a claim to a fixed number of dollars such as cash and receivables) or non-monetary (inventories and property, plant and equipment) in nature is also irrelevant for determining whether an item is an asset.

It may occasionally be difficult to evaluate whether an entity controls a specific asset, or alternatively:

- whether an entity is merely providing a service, for example, by maintaining an asset which is controlled by another entity or the Government, or
- whether that asset is jointly controlled by an entity and another entity such as a Government department, a local council or private sector entity.

6.3 Maintenance Agreements

The distinction between a maintenance agreement and control over an asset is normally clear-cut, e.g. an agreement to paint a bridge does not amount to control over the bridge. Similarly an agent in possession of goods or monies for transfer to a third party on behalf of a principal does not have control over the service potential implicit in those goods. This distinction is less clear, however, when there is no formal specification for:

- the ability of the entity to deny or regulate the access of others to those service potentials, or
- the primary responsibility of the entity for ensuring the continued provision or a certain quantity and quality of service potential.

In these circumstances it is likely that weight would be placed on widely accepted public sector practices, norms and customs concerning "which entity is responsible for what". The NSW Treasury, the Department Head/and or Minister may need to be consulted to clarify such matters.

6.4 Joint Control

In general, where the entity has primary responsibility for providing certain services to the community it will have the control necessary to provide those services effectively. A hypothetical example of a jointly controlled asset could be where the NSW Health Department via a public hospital provides funds for the building of a recreational facility in conjunction with the local community, on say a $1 for $1 basis. In determining whether the public hospital controls, jointly controls or does not control the facility's service potential it is necessary to have regard to whether the public hospital has the ability to restrict access to the facility or whether, for example, such decisions are shared with a local council, or whether the public hospital has no such ability.

6.5 Recording and Recognition of Assets

An asset of an entity shall be recognised in the statement of financial position when, and only when,

- it is probable that the service potential or future economic benefits embodied in the asset will eventuate, and
- the asset possesses a cost or other value that can be measured reliably.

6.6 Acquisition of Assets

Acquisitions of assets shall be accounted for in accordance with AAS21 "Accounting for the Acquisition of Assets (including Business Entities)".

Assets donated or otherwise provided to the Area/District Health Services/public hospitals shall be recognised at fair value.

6.7 Main Functional Categories of Physical Non-Current Assets

6.7.1 Infrastructure Assets

The term "infrastructure" includes all non-current assets comprising the public facilities that provide essential services and enhance the productive capacity of the economy eg. includes such public sector assets as roads, bridges, sewerage systems, water supply systems, power generation plants, hospitals and other Government buildings.

In the normal course of operations, infrastructure assets are expected to be replaced.

6.7.2 Restricted Use Assets

All physical assets including infrastructure assets, whether held by the private or the public sector are subject to natural and legal restrictions on their use. These restrictions may arise out of:

- limits inherent in the asset itself
- limits imposed by other Government entities
- limits imposed by a donor or grantor; and
- self-imposed limits

The general practice is to record physical assets at market values that reflect all restrictions in effect at the time the assets were acquired. Any restrictions placed on the use of an asset after acquisition which resulted in a reduction in market value may require a write-down in the value of assets.

6.7.3 Heritage Assets

The expression "heritage assets" refers to those assets that an entity intends to preserve indefinitely because of their unique historical, cultural or environmental attributes. A common feature of heritage assets is that they cannot be replaced (eg. monuments, historic museum collections, wilderness preserves and historic buildings).

There are a number of physical assets which have been designated heritage assets in the sense that a conservation order has been placed on them. However, a conservation order does not necessarily restrict the pre-existing use of those assets, for instance as commercial premises. Consequently there would be no need for a valuation write-down in such circumstances.

6.8 Broad Classification of Physical Non-Current Assets

Based on their potential availability for alternative use, including disposal, physical non-current assets can be divided into three broad categories:

(A) assets which may, under present legal and policy provisions, be redeployed or disposed of.

(B) assets which are not currently available for redeployment or disposal by reason of legal or policy constraints, but

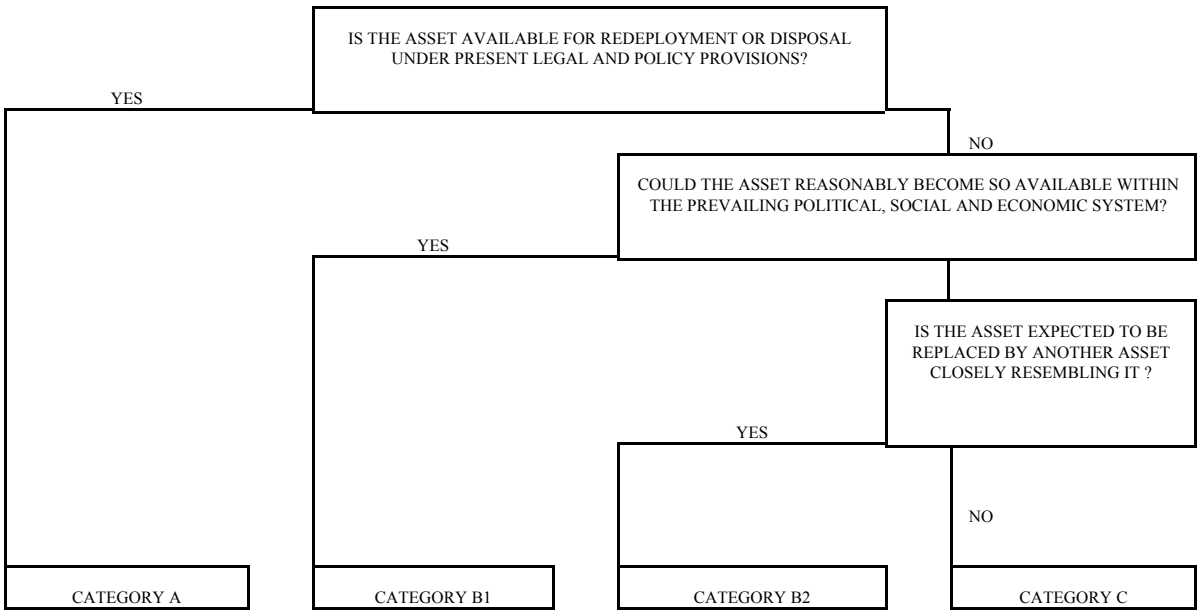
1. which could reasonably become so available, within the context of the prevailing political, social and economic system, or

2. which need to be maintained with the expectation that they would be replaced by assets closely resembling them.

(C) assets which are not currently available for redeployment or disposal and for which there is no reasonable expectation of change.

6.9 Valuation of Physical Non-Current Assets

FLOWCHART FOR SELECTION OF METHOD OF VALUATION.



CURRENT MARKET VALUE (INCLUDING NET REALISABLE VALUE, EXPERT APPRAISAL)	CURRENT MARKET VALUE (WITH FOOTNOTE REFERENCE)	WRITTEN DOWN REPLACEMENT COST (FOR PHYSICAL ASSETS OTHER THAN LAND) OR EXISTING USE VALUATION SUBJECT TO ANY RESTRICTIONS OR ENHANCEMENTS SINCE ACQUISITION (FOR LAND)	NO VALUATION, FOR RECORD ONLY

6.9.1 Category (A) Assets

If the reporting entity has control over its assets and alternative use is a real possibility, ie. the asset is readily available in the market place, then market valuation (including expert appraisal) is to be used. Valuation will depend on the nature of control over the asset and the options available for alternative use. Category (A) assets where redeployment or disposal is an available option would include the following:

- **Surplus Land** - market valuation based on adjacent usage valuation and orderly disposable land near roads, railways and transmission lines may be valued at farm land or residential land valuations.

- **Buildings** - market valuation based on existing or alternative usage valuations and orderly disposal.

- **Works of Art** - market valuation based on expert appraisal and orderly disposal eg. paintings and art collections may be valued by experts.

- **Other examples** - a less tangible asset associated with public sector assets relates to the air space rights over land occupied by certain entities. The point in time when it would be reasonable to assign a market value to such air space rights is dependent on several factors. Firstly, there must have been genuine expressions of interest to utilise air space. Secondly, reliable measures of valuation must be available. Any capitalisation of the air space rights would have to be determined on a case-by-case basis and must also have regard to the terms of agreement for the acquisition of the air space rights.

6.9.2 Category (B1) and (B2) Assets

Where Estimated Market Value is Available - Category (B1)

For category (B1) assets, **estimated market value where available is to be used,** but with the proviso that a footnote reference be placed against each item or a group of items. The footnote should specify that the valuation is based on a market value which **assumes the absence of constraints on alternative use or disposal,** although the prevailing situation may prevent or limit any such action.

Category (B1) assets would include hospitals which have been earmarked by Government for disposal. Where at the date of valuation, if in fact alternative nearby facilities such as another hospital is being constructed, then such an existing asset should be included in Category (A). In that instance market valuation is to be used. The only difference arising from moving a Category (B1) asset to Category (A) is that it would not be necessary to provide a footnote reference against such items.

Where Market Value May not be Available - Category (B2)

In most other cases, where the service potential of infrastructure assets is to be maintained and continued then those assets should be valued at **Written Down Replacement Cost** for physical assets other than land, **or existing use valuation** subject to any restrictions or enhancements since acquisition in the case of land.

Written Down Replacement Cost is particularly relevant because there is a reasonable expectation that if the existing asset was disposed of, it would be replaced by another asset closely resembling it.

Assets Having Excess Productive Capacity

Certain infrastructure assets of the larger reporting entities might have been constructed using a set of assumptions and demand forecasts which no longer apply. In line with the general principle of using Written Down Replacement Cost for Category (B2) assets other than land, a downwards revaluation should be undertaken to reflect any excess productive capacity. Such an approach is not inconsistent with Australian Accounting Standards AAS10 (Accounting for the Revaluation of Non-Current Assets) paragraph 23:

"A downwards revaluation of a non-current asset should be undertaken only where the carrying amount is greater than the amount that is expected to be recovered from the continued use and, where applicable, disposal of that asset; that is, its recoverable amount. In this situation the asset should be revalued to its recoverable amount.

6.9.3 Category (C) Assets

For Category (C) assets, it is unreasonable to assign any value, since the asset has neither market value nor prospect of alternative use. A non-numeric symbol or a $1 nominal value, also explained in a footnote, is to be inserted in the money column of the asset register to indicate an asset whose value is not reasonably measurable.

Further, if assets are subject to natural and legal restrictions on their use such that the reporting entity has little or no control over alternative use or disposal of those assets, then they should be shown as record only within appropriate notes to the financial statements. In other words, it seems reasonable to write down the recorded historic value of physical assets in order to reflect any impairment in value that arises from the restrictions placed on them.

Specific Examples of Category (C) Assets

(i) Parks

If the Valuer-General were requested to value a portion of a public hospital site classified as natural parkland, the first question he would ask is likely to be: What assumptions regarding its use should be made? Existing use, commercial rezoning, or perhaps residential development?

Under existing use assumption, there can be no taker even if it were offered for free to a private operator, since it is a loss-making operation. It may need a number of staff all year round just to keep the area in question in good order, let alone other maintenance costs. (In this regard the reporting entity's notes to the accounts should clearly indicate costs of operating and maintaining the asset.)

Until such time that a decision has been made by the Government to look at alternative uses for such areas, neither historic cost nor any purported market valuation can be meaningful. Therefore, such assets should be shown as a note only.

(ii) Historic Houses/Heritage Assets

Over time Historic Houses/Heritage Assets have acquired attributes which are valued by the community by virtue of their representing an architectural style or a past era, their use by persons of note, or their historical significance. Constraints on their existing use would preclude any meaningful valuation unless an alternative use becomes a distinct possibility.

(iii) Certain Museums, Archival and Other Collections

Particular museum, archival and other artefacts may be designated not available for disposal by virtue of their unique historical and cultural attributes. Where they are merely representative of a collection which is available or found elsewhere, and is therefore less than unique, they should be valued where practicable.

Copies of archival collections, though valuable in their own right, do not attain the status of the originals. Since they are not unique, they should be valued where feasible.

(iv) Memorials

While historic houses do not begin to be regarded as having historical and cultural attributes until a considerable passage of time, memorials by their very nature are akin to "instant" historic houses.

Notes to the financial statements are to include an approximate description (where information is readily available) for such Category C items eg:

- the monument (or historic house) cost $x in 19xx and was financed by a grant from the xxxxxxxxxxxxxxxxxxxxxxxx. The value of an equivalent grant or contribution required to construct (or to acquire) it today is of the order of $y.

Hospitals which have not previously prepared balance sheets should adopt these procedures. Where Area Health Services/hospitals have previously prepared balance sheets and have included original purchase cost (even say 50 years ago), and the Auditor-General's Office expresses reservations on nominal valuation of $1, original purchase cost may, for the time being, continue to be used.

Note: Schedule of Category (C) Assets
Where Area and District Health Services/Hospitals are of the view that certain of the assets under their control warrant inclusion in the Schedule of Category C assets, they should consult with the NSW Health Department in the first instance.

6.10 Valuation of Land

In both the private and public sectors, valuation of land should reflect any restrictions or enhancements arising from development activities since its acquisition in order to give a more meaningful indication of its worth.

Land value is generally dependent on the range of use or potential use that applies to the land. For land that has other physical structures placed on it, its value must necessarily be related to the benefits that these physical structures themselves generate. In terms of its relationship with the range of use and physical structures that it accommodates, land may fall into one of the following categories:

Type of Land	Asset Category
• Surplus Land	
• Land on which commercial buildings are erected	(A)
• Land on which other commercial and non-commercial structures are erected, eg. sewerage and water supply systems, power plants, schools and ambulance stations (not earmarked for closure)	(B2)
• Land on which other commercial and non-commercial structures are erected and the structures have been designated for closure	(B1)
• Land which has become an inherent part of an infrastructure eg. roads, railways	(B2)
• Land on which heritage assets are located eg. memorials, historic houses (other than those which strictly serve commercial purposes)	(C)
• Land which by itself is essentially a heritage asset in that it is not available for redevelopment or disposal and for which there is no reasonable expectation of change	(C)
• Forest land on which commercial crops are grown	(A)
• Land being used for waste disposal purposes	(B2)
• Developed Crown land	(A)
• Undeveloped Crown land for which no specific purpose has been identified	(C)

Valuation of Land in Category (A), (B1) and (B2)

Where feasible land and the physical structures placed on it should be valued separately. In the case of Category (B2) assets, written down replacement cost would generally apply to the physical structures. For the land component, existing use valuation subject to any restrictions or enhancements since acquisition is to be adopted. In this regard, zoning restrictions will usually result in the land being valued relative to adjacent land usage.

Surplus land having no physical structures placed on it would have a market value which is largely dependent on adjacent land usage and the range of potential uses allowed within the zoning restrictions. An important difference between land valuation in Category (A) or (B1) and Category (B2) may be contrasted as follows:

Category	Land Valuation
(A), (B1)	Market value based on potential uses as well as existing use.
(B2)	Existing use valuation subject to any restrictions or enhancements since acquisition.

6.11 Sources of Valuation

Having selected the method of valuation, it is of course necessary to determine how it can be obtained in the most cost effective manner. In many cases there is sufficient expertise within a hospital to undertake asset valuation.

The following valuation sources might be used:

Land to be valued by the Valuer-General or another registered valuer.

Assets Other Than Land, including plant and equipment are to be valued by either:

- Experts (such as engineers and curators) within the hospital, or
- Other Available Expertise (eg. staff or another public sector organisation).

The notes to the financial statements should clearly indicate the source of the valuation, year of valuation and valuation method adopted.

6.12 Accounting for Revaluations

Where a class of non-current assets is revalued, the revaluation increment or decrement shall be accounted for as follows:

(a) an increment shall be credited directly to an asset revaluation reserve - except that, to the extent such an increment reverses a revaluation decrement previously charged to the operating statement in respect of that same class, it shall be credited to the operating statement for the period; and

(b) a decrement shall be debited to the operating statement - except that, to the extent such a decrement reverses a revaluation increment previously credited to, and still included in the balance of, an asset revaluation reserve in respect of that same class, it shall be debited directly to the revaluation reserve.

Increments and decrements on revaluation of individual assets shall not be offset against one another, except within a class of assets.

Where it is proposed to revalue a class of depreciable assets upwards or downwards, any accumulated depreciation existing in respect of that class, at the date of revaluation, shall be credited against the asset account to which it relates. The asset account shall then be increased or decreased to the amount of the revaluation.

The gain or loss on disposal of a previously revalued non-current asset shall be determined as the difference between the carrying amount of the revalued asset at the time of sale and the proceeds of disposal, and shall be recognised in determining the net cost of services for the period in which disposal of the asset occurs.

Any amount remaining to the credit of the asset revaluation account in relation to that asset shall be transferred directly to accumulated surplus/deficit.

6.13 Timing of Revaluations

Revaluations shall be recognised at intervals of five financial periods. Revaluations shall be performed in a systematic and consistent manner.

Where an enhancement to the original physical structure has been added, the asset should be revalued taking into account that particular enhancement.

Where assets have a relatively short useful life, say five years, no asset revaluation would generally be necessary. This is particularly applicable to assets such as computer equipment where the rate of change in technological advances tends to outpace the rate of inflation. In more extreme cases, of course, it may still be appropriate to write down or write off an asset entirely.

6.14 Acquisition Costs and "Fair Value" Concept

Determining the cost of a completed asset, say an item of property, plant or equipment purchased for cash is reasonably straightforward. The entity need only consider whether or not there are any costs incidental to the acquisition which need to be capitalised as part of the cost of the item or property, plant or equipment. Costs incidental to an acquisition may include:

- site preparation
- delivery and handling costs
- installation costs, and
- professional fees.

Where an asset is acquired in exchange, or in part exchange, for a non-monetary purchase consideration, the entity will need to assess the fair value of the non-monetary purchase consideration given-up. The cost of acquisition will therefore comprise:

- the amount of any cash purchase consideration
- the fair value of any non-monetary purchase consideration, and
- any costs incidental to the acquisition.

6.15 Donated Assets and Capital Grants

Area Health Services/public hospitals may receive assets in the nature of property, plant and equipment in the form of capital grants made by governments and as a result of donations and other contributions made by individuals. Items obtained by entities in these circumstances represent assets and are to be recorded accordingly. Furthermore it would be inconsistent with the objectives of reporting on assets to deny recognition of the service potential of such items. Accordingly such items are to be recognised at their fair value with the credit reflected in revenue for the period.

Assuming the donation is in the form of cash for a future capital purchase the initial entry is:

Dr Cash
Cr Industry Contributions/Donations - Increased Service Potential

If no use is made of the cash for the year, the effect at year end on Accumulations is a direct increase by the value of the donation. If the cash is used to acquire a physical asset the entry involved is

Dr Asset
Cr Cash

Industry contributions/donations provided in the form of a "free" asset or by way of funding for the construction/acquisition of a non-current physical asset or to effectively increase the operating capacity of an existing asset are to be recorded as "Industry Contributions/Donations - Increased Service Potential". The entry must be made prior to the appropriation section of the Operating Statement.

Industry contributions/donations which are received with the expectation that they will be applied to meet operating expenses are to continue to be recorded as revenues within the body of the Operating Statement.

In this matter it is recognised that due to the generality of some donations it may not be possible to readily establish how revenues will be applied. In these cases it is considered that the revenues should be reported as "Industry Contributions/ Donations - Increased Service Potential."

The second accounting entry referenced above does not reduce the impact on Accumulations of the first entry and still enables proper Statement of Financial Position disclosure.

Such entries take the place of the previous practice in which the asset and accumulation account entries were effected on acquisition only.

Note that control over contributed assets normally arises upon their receipt or upon prior notification that a contribution has been secured. The fact that there may be conditions imposed on the use of the contributed asset does not give rise to a "liability" as there does not exist "a present obligation to make future dispositions of economic benefits to a particular external party".

In those instances where conditions are attached to monetary contributions, it will be necessary to include the following disclosures in the notes to the financial statements:

(a) The aggregate of contributions recognised as revenues during the financial year in respect of which expenditure had yet to be made as at balance date in the manner specified by contributors;

(b) The aggregate of contributions recognised as revenues during the financial year which were provided specifically for expenditure over a future period;

(c) The aggregate of contributions recognised as revenues in a previous financial year which were obtained for expenditure in respect of the current financial year;

(d) The nature of the material components of the amounts referred to in (a), (b) and (c) above and, in respect of (b) the periods to which they related; and

(e) Total amounts of contributions (classified by major categories) which were unexpended at balance date (including those received in prior years) together with brief details of externally imposed conditions.

The notes to the financial statements shall also disclose details of any restrictions placed on non-monetary assets together with the amount of restricted assets, in aggregate and by class of assets.

6.16 Classification of Assets

Section 4 of this document specifies the minimum classes into which assets should be classified.

6.17 Investments

Section 4 (paragraph 12.2(c)) identifies the asset class, investments, as including investment properties. It may also include heritage collections of historical artworks. Where it has been formally decided by the government to sell service facilities and other items of property, plant and equipment such items should be reclassified as investment properties. This classification is considered appropriate because:

- the item no longer meets the definition of property, plant and equipment as it is intended for sale, and

- the item is not inventory as the sale of such items is outside the ordinary course of the service-delivery activities performed by the entity.

6.18 Natural Resources

Natural resources are economic resources in their natural undeveloped state. They can be categorised as renewable or depletable. **Renewable resources** are those natural resources that can be developed and managed to produce a sustained yield for an indefinitely long period while **depletable resources** are such known natural resources that will diminish to the point of exhaustion over the period of their production.

6.19 Public Lands

A hospital may own a part of the State's land area consisting of Crown Lands, roadways, parklands, building sites, etc. Crown Lands are part of the natural resources controlled by the hospital. **Lands acquired for future**

development which are expected to provide cash inflows as a result of their marketability should be accounted for not as fixed (non-current) assets, but as inventories for sale.

6.20 Restructuring of Assets

The asset base of the Area Health Services/public hospitals will periodically be restructured so as to ensure that resources are being utilised efficiently and effectively. These activities may result in the redeployment of items of property, plant and equipment which are no longer required by the entity in their present capacity. For example hospital facilities may be closed or restructured. The appropriate accounting to be followed in accounting for such items, post-closure/restructure, or when substantially all of the conditions need to achieve closure/restructure are satisfied, will depend on the intended use of the asset. The following guidance would generally be applicable:

- where an asset is closed for demolition, the service potential of the asset, excluding the land component, would be permanently impaired and should be written off as required by paragraph 7.9. So long as the intention is for the land component to be retained and, for example, used as a site for development of a new building to provide services, then the land should be classified as property, plant and equipment and accounted for accordingly.

- if an asset, for example a building presently occupied by an entity is vacated or leased to third parties under a finance lease arrangement, the entity as lessor, would classify the lease as a receivable and account for the lease in accordance with AAS17 "Accounting for Leases", and

- in the event that an asset is closed and held for sale, it should be accounted for as an investment.

6.21 Depreciation

Area Health Services/public hospitals shall recognise depreciation charges in relation to all depreciable assets, including property, plant and equipment, and identifiable intangible assets, in accordance with the requirements and guidance contained in AAS4 "Depreciation of Non-Current Assets".

Definition

Depreciation describes the accounting process by which the using up or loss of the service potential of depreciable assets is progressively brought to account by means of periodic charges. **It is a process of cost allocation and does not have as its primary objective the accumulation of funds for asset replacement.**

6.22 Calculation of Depreciation Charges

The manner in which depreciation charges are calculated for any asset is dependent upon four major factors:

- the basis for determining asset values;
- the basis for assessing the useful life of the asset;
- the estimate of the useful life of the asset; and
- the estimate of the net amount recoverable on ultimate disposal of the asset.

Category (A), (B1) and (B2) assets should be depreciated, where applicable, on the basis of their expected life, where this is below the accepted threshold period (200 years has been proposed as the threshold). For Category (C) assets, for which no valuation is required, no depreciation charge is applicable.

6.23 Method of Choice

When applied to specific assets, one method of depreciation might provide more appropriately for one asset than for another. However, from a total view of public sector assets, a simplified approach is again to be preferred. Given the very large asset base, the range of asset lives, the degree of estimation or approximation applicable to any one accounting period, and the cost and effort involved in adopting different methods for different assets, **the method which is to be used by Area Health Services/public hospitals for depreciation of assets generally is the "Straight-line Remaining Life Method".**

Definitions

Straight-line Remaining Life Method: allocates the balance of the depreciable amount equal instalments over the remaining useful life.

Therefore the residual values have to be established for fixed (non-current) assets and taken into consideration on the calculation of depreciation charge eg.

An asset has a total useful life of 10 years, 6 years of residual life, a cost (or revalued amount) of $100,000 and a nil net recoverable amount. Depreciation for year 5 would be:

$$\frac{\$100,000 - \$40,000}{6} \times \frac{1}{} = \$10,000$$

6.24 Depreciation Rates and Effective Lives

The following table of depreciation rates and effective lives address the major categories of fixed assets which are normally maintained by Area Health

Services/public hospitals. It is appreciated that some entities may have specific assets which require the use of other more appropriate criteria. **Areas/hospitals must seek a ruling/approval from the NSW Health Department before implementing a local variation to this standard.**

	Useful Life **Expectancy** (Years)	Prime Cost Depreciation **Rate** (Percentage)
Buildings	40	2.5
Electro-Medical Equipment (costing < $200,000)	10	10.0
Electro-Medical Equipment (costing more than or equal to $200,000)	8	12.5
Computer Equipment	5	20.0
Office Equipment	10	10.0
Furniture, Fittings & Furnishings	20	5.0
Plant and Machinery	10	10.0
Motor Vehicles - Trucks, Vans etc.	5	20.0
Motor Vehicles - Sedans etc.	N/A	N/A
Sundry Equipment	10	10.0
Linen Stocks, Group Services	5	20.0

6.25 Materiality

When applying the mentioned rates, the initiative will be with the individual entities to determine the materiality aspects of depreciation ie:

- Attractive or high risk **assets costing $5,000 or more with an expected useful life of 2 years or more are to be depreciated.**

- **Items of less than $5,000 in value are not to be depreciated.** Such items are to be expensed in the year of acquisition and would include:

    - Computers and Ancillary Equipment
    - Typewriters
    - Electronic Calculators (costing more than $200)
    - Audio Equipment, Cameras and Recording Equipment
    - Works of Art
    - Donations in kind with a value of less than $5,000

- Any other items which are considered by the Supply Service Managers to be at no risk of loss or misappropriation.

Such items should be recorded in an asset register for safe-keeping purposes.

Depreciation charges are to commence not later than the month following the month of acquisition; Depreciation charges are to be raised at least up to the end of the month prior to disposal.

Office furniture should generally be expensed in the year of acquisition.

6.26 Electronic Equipment in a Network

For the purpose of determining the cut-off dollar value (currently at $5000) for which depreciation should apply, electronic equipment which forms part of a network is to be aggregated. Stand-alone cash registers, computers and other electronic equipment less than $5,000 per item are to be expensed in the year of acquisition. It may still be appropriate however to record such items in an asset register for safe-keeping purposes.

Computer software should be capitalised where costs exceed $50,000.

6.27 Motor Vehicles (Sedans etc)

The following method is to be applied for the annual valuation of Motor Vehicle Sedans:

- Each Area Health Service/public hospital is to maintain a Schedule of Motor Vehicles by Hospital Unit showing make and model, registration number, engine number, purchase date, historical cost, and the dealer's name.

- The schedule can be established in word processing or spreadsheet format to facilitate updates.

- Details of sale or trade-in price and dates of disposal are also to be maintained for internal control/audit purposes.

- At the end of the financial year, the total cost (ie. historical basis) of all motor vehicles recorded on the schedule should be brought to ledger and account.

- If an increase in value is shown then the asset is capitalised as follows:

Debit	Fixed Assets - Motor Vehicles
Credit	Operating Expense

- If there is an actual decrease in value, the reverse of this entry would apply.

In view of the cost advantage obtained from the sales tax exemption, the method above is considered the most efficient way of accounting for the large fleets of motor vehicles that exist in each of the Area Health Services/public hospitals. The notes to the accounts need not refer to the non-depreciation of motor vehicles due to the immateriality of the transactions involved.

Motor vehicles other than sedans should be depreciated in accordance with the percentage specified in Paragraph 5.24

6.28 Assets with Very Long Lives

For practical purposes, **public sector assets with a life expectancy of over 200 years need not be depreciated.**

7.0 ACCOUNTING FOR ASSETS - SPECIFIC ISSUES

7.1 Expenditures Carried Forward

Expenditure carried forward arises when expenditure is incurred, the benefit of which will extend to future accounting periods. The nature of the asset arising from such expenditures will depend on its characteristics.

For example, prepaid expenses arise when payments are made, for example of rents, rates or insurance, which refer wholly or partly to a succeeding period. Prepaid expenses are normally relatively immaterial and will normally be disclosed as current assets "other". Promotional expenditure (such as the costs of advertising, market surveys and of display material) is not usually carried forward. This is due to difficulties in reliably establishing that future benefits will probably eventuate, or the amount of such benefits.

7.2 Research and Development Costs

Research and development costs shall be accounted for in accordance with AAS13 "Accounting for Research and Development Costs".

7.3 Holding Costs

The entity may incur holding costs in the nature of leasing costs, interest costs and/or depreciation costs with respect to assets in use or idle assets ready for such use. Such costs shall not be capitalised.

7.4 Receivables

There shall be separate disclosure of:

(a) the amount of bad and doubtful debts, by class of assets, charged to the operating statement, and

(b) the amount of any provision for doubtful debts shown as a deduction from the related class of assets.

The term receivables includes trade debtors, bills of exchange and other debtors resulting from the sale of property, plant and equipment and other assets. **Receivables are to be recognised when the hospital's goods or services have been accepted by the customer and performance by the hospital of its obligations has occurred.** It is important to review the carrying amounts of receivables for bad and doubtful debts and write-off bad debts and to provide for doubtful debts, where appropriate. Similar provisions should be made with respect to sales of investments.

7.5 Inventories

Inventories shall be accounted for in accordance with requirements of AAS2 "Valuation and Presentation of Inventories in the Context of the Historical Cost System", except for paragraph 8 of AAS2 in the case of inventories not held for sale or in the process of production or use for such sale. Such inventories, which include stocks of materials, consumable stores and supplies, shall be carried at weighted average cost subject to adjustments for loss of service potential (such as by obsolescence).

The Area Health Service/public hospital are to have a consistent method of valuing stores. **Costs should be assigned to particular items of inventory using the "weighted average cost" method.** This method assigns weighted average costs arrived at by means of a continuous calculation, a periodic calculation or a moving periodic calculation.

It is important to segregate items held in stores which are held for resale, and those held for consumption by the hospitals.

In an unlikely situation **where a hospital has inventory stores which are held for resale, these should be accounted for in accordance with AAS2** "Valuation and Presentation of Inventories in the Context of the Historical Cost System".

Items in stores held for the hospitals own consumption should be valued at weighted average cost in accordance with AAS2 and AAS9 "Expenditure Carried Forward to Subsequent Accounting Periods". These should be expensed as consumed, rather than when purchased. **Obsolete items will be written off or**

reduced in value in accordance with the "prudence" concept in AAS6 "Accounting Policies: Determination, Application and Disclosure".

Inventories as identified are not subject to depreciation. As a matter of principle, when valuing inventories, each item included in the inventory should be dealt with separately, however, if this is impracticable, similar items should be dealt with as a group.

7.6 Leases

An entity may lease certain plant, equipment, and/or land & buildings and should account for such in accordance with the accepted accounting standards AAS17.

Finance leases, which effectively transfer to an entity substantially all of the risks and benefits incident to ownership of the leased item, **are to be capitalised at the present value of the minimum lease payments, disclosed as leased fixed assets and liabilities, and amortised over the period the hospital is expected to benefit from the use of the leased assets.**

Payments in respect of operating leases where the lessors effectively retain substantially all the risks and benefits of ownership of the leased items, **are to be included in the determination of the result of operations in equal instalments over the lease term.**

7.7 Investments

Where an investment is classified as a current asset it shall be revalued to net market selling value. Each current investment shall be dealt with separately. Revaluation increments and decrements arising on current investments shall be credited/(debited) to the operating statement.

Where a class of investments is classified as non-current then all investments within that class shall be revalued annually to their net market value in accordance with AAS10. Each class of non-current investments shall be dealt with separately.

Where investments are of a fixed term and attract a fixed rate of return it is considered appropriate that the investment be stated at cost and it need not be revalued.

7.8 Property, Plant and Equipment

- **Construction**

The cost of an item of property, plant and equipment under construction shall comprise those costs that:

(i) relate directly to the specific item
(ii) are attributable to construction activity in general and which can reasonably be allocated to that specific item, and
(iii) are necessarily incurred in obtaining the service potential embodied in the asset.

Cost inefficiencies caused, for example, by significant periods of inactivity due to industrial disputes, and other holding costs shall not be included as part of the cost of an item of property, plant and equipment.

Administration and other general overhead expenses shall not be included in the cost of acquisition of any item of property, plant or equipment, unless they can be specifically related to the acquisition of the asset.

Start-up and related pre-production costs shall not comprise part of the cost of an item of property, plant and equipment unless they are necessarily incurred in order to ready the item for its intended use. Depreciation charges are to commence in the month after the asset becomes available for use.

7.9 Additions including Extensions, Improvements, Betterments and Major Replacements

Any addition to an existing item of property, plant and equipment which becomes an integral part of that item shall comprise part of the carrying amount of that item. Where an addition to an existing item of property, plant and equipment retains its separate identity and will be capable of being used after that item is disposed of, the addition shall be recognised as a separate item of property, plant and equipment.

- **Permanent Impairments in Service Potential**

Where the service potential or future economic benefits embodied in an item of property, plant and equipment is permanently impaired, for example, by damage, technological obsolescence or exhaustion, the carrying amount of that item shall be written down to its recoverable amount. The amount of the write down shall be charged to the operating statement immediately except that, to the extent such an impairment reverses a revaluation increment previously credited to, and still included in the balance of, an asset revaluation reserve in respect of that specific asset, it shall be debited directly to that revaluation reserve. In relation to a depreciable asset, the write down in its carrying amount shall normally be achieved by increasing its accumulated depreciation.

- **Basis of Measurement**

Each item of property, plant and equipment within a class of non-current assets shall be measured in accordance with Paragraph 6.9, "Valuation of Physical Non Current Assets". (Refer also to Paragraph 6.12).

- **Disclosures**

In respect of each class of property, plant and equipment, the following disclosures shall be made:

(a) a reconciliation of the opening and closing carrying amounts, showing separately:

(i) additions
(ii) disposals
(iii) accumulated depreciation
(iv) write downs for permanent diminutions in value, and
(v) revaluations

(b) the basis or bases of valuation, and
(c) the party or parties which performed the valuations.

AAS21 does not provide direct guidance on the nature and extent to which expenditures may be capitalised in relation to property, plant and equipment presently under construction either by a contractor ("construction contracts" or by the entity itself ("self constructed assets"). AAS9 "Expenditure Carried Forward to Subsequent Accounting Periods" provides general guidance. For construction contracts, the accounting policy followed should be comparable to the standards of accounting set out in the AAS11 "Accounting for Construction Contracts".

8.0 ACCOUNTING FOR LIABILITIES

8.1 Recognition of Liabilities

A liability of the entity shall be recognised in the statement of financial position when, and only when:

(a) it is probable that settlement of the liability will be required, and

(b) the amount of such settlement can be measured reliably.

Discussion

The criteria for the recognition and classification of liabilities are intended to provide information in the financial report of the entity as to the amount and timing of any future dispositions of economic benefits an entity is presently obliged to make and is to enable users of the financial reports to assess the financial flexibility of an entity regarding its ability to meet future obligations as they fall due.

Liabilities which fail to meet either of the probability or measurement criteria should be accounted for as contingent liabilities i.e. in accordance with Section 12.8.7.

PART THREE

REVENUES AND EXPENSES

9.0 REVENUES AND EXPENSES

9.1 Recognition of Revenues and Expenses

All revenues and expenses of an entity that can be measured reliably shall be recognised in the operating statement.

9.2 User Charges

The proceeds of the sale of goods and services shall be recognised as revenue in accordance with paragraph 9.1 above.

9.3 Sales of Assets

Where an entity is obligated to remit either all or a portion of the proceeds of sale of assets to the Government, or the Department such amounts shall be shown separately. (The application of this clause will depend upon Departmental policy).

The NSW Health Department has no such obligation.

9.4 Industry Contributions and Grants by Other Agencies of the Crown

Industry contributions and grants by other agencies of the crown of both monetary and non-monetary resources shall be recognised in the financial statements as assets and by crediting revenue, classified as appropriate. Non-monetary industry contributions and grants by other agencies of the crown shall be recognised at fair value.

In relation to each of the programs, there shall be separate disclosure of a brief description of the kind of services provided by volunteers, where such services can be quantified, the nature and fair value of physical resources granted, and the nature and amount of any significant amounts of resources provided to an entity at less than full cost.

In certain instances, third parties may pledge to grant resources to an entity in the future. In general, because pledges are voluntary rather than contractual in nature, an entity should not accrue pledges until they are received.

9.5 Entitlement and Discretionary Grants

There are many payments which are made by an entity on behalf of the Government, for example, payments to welfare beneficiaries in respect of which an entity is simply performing an administrative task, ie. it has no control over the benefits implicit in the resources being transferred to the beneficiary.

However where a grant or subsidy is paid to a body outside the NSW public sector the entity would normally be presumed to be able to determine or have a significant influence over who receives the amount and how much the grantee receives. Where such an influence is evident any revenues/expenses associated with "Entitlement and Discretionary Grants" are to be included in the Operating Statement.

9.6 Revenue and Capital

A satisfactory distinction between revenue and capital has long been recognised as a fundamental of accounting. The term "capital" is used in two main senses. Firstly, "capital" can refer to debt and contributed capital; the latter represents the sum of contributions by owners (less withdrawals by owners) to the entity's equity. Secondly, "capital" can refer to assets of an entity. Clear concepts of capital, in both senses, are necessary in order to distinguish revenue from capital.

9.7 Distinguishing Revenue and Contributions by Owners

Revenues are essentially increases in assets or decreases in liabilities, other than those relating to contributions by owners, that result in an increase in equity. Note also that:

> **"contributions by owners"** means those resources that have been contributed to a reporting entity by parties external to the entity, other than those which result in liabilities of the entity, that establish a financial interest in the net assets of the entity which:
>
> (a) conveys entitlement both to distributions of resources by the entity during its life, such distributions being at the discretion of owners or their representatives, and to distributions of any excess of assets over liabilities in the event of the entity being wound up, and/or
>
> (b) can be sold, transferred or redeemed (refer ED51A).

9.8 Distinguishing Between Revenue, Capital and Capital Maintenance

The importance of distinguishing between revenue, capital and capital maintenance is dealt with in ED51B and the "Framework for the Preparation and Presentation of Financial Statements" issued by the Board of the International Accounting Standards Committee.

In brief, the concepts of capital and capital maintenance are concerned with how a reporting entity defines the capital that it seeks to maintain. Profit is the excess over the amount necessary to maintain capital. The capital of an entity, that is its stock of assets or net assets, is a measure of the operating capability and service delivery capacity in financial terms. In this context, the operating result of an entity should indicate whether the operating capability and service delivery capacity of the entity has been maintained.

Theoretically, a nil operating result should indicate, for example, that the entity's operating capability and service delivery capability has been maintained.

9.9 Employee Related Expenses

An entity should recognise the cost of employee entitlements in respect of services provided to the entity up to the financial reporting date. Employee entitlements include wages and salaries, annual leave, long service leave and superannuation entitlements.

Employees' entitlements could be described as rights or benefits of employees which accrue over a period of service. From the hospital's point of view they are an unavoidable cost throughout an employment period.

For each of these employee entitlements, **it is important to distinguish between those entitlements which are an absolute entitlement and those entitlements which are more of a contingent nature. Absolute entitlements such as annual leave, are those entitlements that the organisation is liable for, irrespective of any future event. A contingent entitlement, on the other hand, is an entitlement that is contingent upon a certain event happening,** eg. the payment of untaken sick leave may well be contingent upon an employee having a long period of illness.

Where a liability is contingent upon a particular event happening, then no book entry should be made. Hospitals must however fully account for all absolute employee entitlements.

9.10 Long Service Leave

The entity shall recognise the normal cost of providing long service leave benefits to its employees calculated having regard to their period of past service.

Where the State has agreed to assume the entity's liability for long service leave, an entity shall recognise non-monetary revenue entitled "acceptance by State of Area/District Health Service liability" equal to the accrued cost of employee entitlements for the current financial period. (This currently applies to the Department's Central Administration only.)

The normal accrual accounting procedures for recording long service leave would be for an entity to recognise its liability to employees for their service in prior financial years, add the current year expense and deduct cash payments made. The liability is to be calculated for all employees with over five years' service.

Under these procedures the entity's net cost of services would not be affected in future financial periods when the long service leave entitlement is paid to the employee.

9.11 Employee Superannuation Entitlements

The cost of superannuation benefits shall be determined, using appropriate and compatible assumptions, by consistently using an accrued benefit valuation method.

The cost of providing superannuation benefits for the financial period, as a consequence **of services provided during the financial period, shall be recognised as an expense in that financial period. This action has been taken since the 1992/93 year i.e. the first year in which accrual accounting was adopted by all Health organisations.**

Where the State has agreed to assume the entity's liability for superannuation, the entity shall recognise non-monetary revenue entitled "Acceptance by State of Area/District Health Service" equal to the accrued cost of employee entitlements for the current financial period.

The entity shall disclose the accounting policies adopted for superannuation benefit plan costs.

9.12 Visiting Medical Officers

Some health services are experiencing control difficulties over periodic commitments to VMOs and this will have a substantial impact on the accuracy of the accruals raised for this purpose. Where health services find their current systems do not allow for an accurate calculation of monthly accrual, an estimate should be calculated and based on the historical trend of payments.

9.13 Doubtful/Bad Debts

The allowance method of accounting for uncollectible accounts is to be used by health organisations. Estimated amounts for doubtful accounts will be credited to a doubtful debts provision. When the account is eventually judged to be uncollectible, the balance will be written off as a bad debt.

The doubtful debts/bad debts will at times, therefore represent a period loss on credit sales of services by the health organisation.

The quantum of doubtful debts can be established using either the percentage of revenue method or the ageing of receivables method.

PART FOUR

FINANCIAL REPORTING

10.0 CONSOLIDATION

10.1 Instructions for Preparing Annual Financial Statements

The consolidation process consists of re-casting the completed annual financial statements of the Department's Area and District Health Services/Hospitals into a single uniform format which can be aggregated to form a full view of the State Public Health Sector's Operating Statement and Statement of Financial Position.

The results for Group Services are to be included in Area/District Health Service Consolidated audited statements ensuring that all elimination entries are effected, i.e. eliminate the "Goods and Services" expense recorded by hospital units and the corresponding revenue reported by the Group Services. Receivables and Payables are to be similarly adjusted.

Combined financial statements are to be produced incorporating both the General Fund and Special Purposes and Trust Fund Accounts. In respect of the Special Purposes and Trust Fund Account, moneys held in trust are to be reported in the Statement of Financial Position as creditors.

Capital grants from the NSW Health Department are to be reflected in the General Fund Operating Statement.

An Area or District Health Service which has budget setting and monitoring responsibility for Third Schedule Hospitals is to comply with the following policy. The requirements not specifically applying to Third Schedule Hospitals should also be observed by remaining health organisations.

Operating Statements

Accrual figures to be included are to cover Second Schedule Hospitals only. Third Schedule Hospitals are only to be included to the extent of cash transactions that have been effected by the respective Area/District. A note to the Statement is to cover the net results for Third Schedule hospitals by location.

Statement of Financial Position

Third Schedules are to be excluded from the Statements.

Accumulated deficit/surplus balances are only to reflect Second Schedule hospital activities.

Special Purposes and Trust Fund Account balances of Third Schedule hospitals are not to be included.

In the first year of completing the required returns the opening Statement of Financial Position figures are to be included for comparative purposes. In subsequent years comparisons will be made between financial years ended 30 June.

10.2 Supporting Information for Consolidation

The notes to the accounts are designed to provide the NSW Treasury with information that will assist in the consolidation of the Department's results with all other New South Wales Government Departments and Statutory Bodies. In this regard it should be noted that Area/District Health Services/Hospitals are presently required to identify transactions within Departmental areas and Budget Sector Government Trading Enterprises and Other Government Enterprises and non budget sector entities so that these transactions can be eliminated upon the consolidation of state consolidated financial statements. Accounting arrangements should be in place to capture details of such transactions.

A list of Budget, Government Trading Enterprises and Non Budget Sector Agencies is included in Section Eight.

10.3 Consolidated Financial Statements

Area/District Health Services/Hospitals as a Reporting Entity

In order to qualify as a reporting entity, a health organisation should have the capacity to deploy scarce resources in order to achieve objectives.

In terms of this definition Area and District Health Services/Hospitals are considered to be reporting entities.

The essence of the reporting entity concept is the need to hold a particular entity financially accountable.

The Parent and Economic Entity Concepts

AAS 24 defines an economic entity as a group of entities comprising a parent entity and each of the entities controlled by that parent entity. Controlled entities are referred to as subsidiaries.

A reporting entity is to prepare a consolidated set of financial statements for all controlled entities under its control (refer Paragraph 10.1). Where the entity has control over commercial activities in order to achieve its objectives then a consolidated set of financial statements should be prepared. Further guidance is provided on this topic in AAS 24.

For the purposes of preparing financial reports under this Manual, Treasury special deposit accounts will be treated as part of the reporting entity which controls the

special deposit account. Similarly trust and endowment funds would be included in the entity financial report where the entity controls such funds.

Note: The sub-classification of activities within a government service organisation into commercial and government service activities is the subject of NSW Treasury paper published in March 1990 titled "The Classification and Control of User Charges Activities within Budget Sector Agencies". It required that each government service organisation classify its activities between: government service activities, semi commercial activities, commercial service activities, and commercial enterprise activities.

11.0 FINANCIAL STATEMENTS, FORM AND CONTENT

11.1 Financial Statements

The financial report of an entity, in respect of a financial period, shall include a statement of financial position, an operating statement, a statement of cash flows and notes to the financial statements.

Decisions as regards the information to be displayed within the financial statements and the extent to which that information should be amplified in the notes of the financial statements significantly affect the understandability of financial reports to users. This section of the Manual identifies the minimum set of information to be displayed in the financial statements, subject to the application of the AAS 5 "Materiality in Financial Statements", so as to ensure their usefulness in achieving their objectives.

11.2 Format of Statement of Financial Position

Objectives

The statement of financial position should be presented so as to reveal the following aspects of the entity's financial position:

- to provide information about the financial structure of an entity, its obligations, its equity and the types of the resources available to it;

- to provide information about the capacity of an entity to adapt to changes in its operating environment, for example, by sub-classifying assets, liabilities and equity; and

- to provide information about the financial flexibility of an entity, for example, by separately disclosing its current assets and current liabilities.

Presentation

The statement of financial position shall disclose the assets, liabilities and equity of an entity as at the end of the financial period.

The statement of financial position shall be presented, together with relevant amounts, as shown in the pro-forma provided in Section 13.

The amounts of assets and liabilities shall be set-off in the presentation of the statements of financial position only when there is a right of set-off relating to those assets and liabilities and in accordance with the requirements of AAS 23 "Set-off and Extinguishment of debt".

Assets shall be classified into current assets and non-current assets. Each asset category, as specified in the statement of financial position format, shall comprise the classes of assets identified in paragraph 12.2, unless further dissection is made, in which case it is the sub-category which would constitute the class.

Liabilities shall be classified into current liabilities and non-current liabilities. Each liability category, as specified in the statement of financial position format, shall comprise the classes of liabilities identified in paragraph 12.2 unless further dissection is made, in which case it is the sub-category which would constitute the class.

The opening equity of the entity shall initially be measured as the opening amount of net assets, being the difference between the amounts assigned to its assets and liabilities, at the commencement of the first financial period in which accrual accounting is implemented. The amounts of opening equity, accumulated surplus/(deficit) and reserves shall not be set-off or otherwise combined except where the Treasurer has approved such an action.

A statement of financial position presented in accordance with the format prescribed above would contain, in a single column, a self-balancing set of amounts. This approach recognises the basic accounting identity that assets equal liabilities plus equity.

It is clear that the NSW Government has the capacity to exercise control over entities, to cause resources to be re-allocated across entities, to redefine the objectives of entities and to divest the assets of entities. It is therefore reasonable to regard the NSW Government as having "equity" in an entity and similarly, to refer to an entity as having "equity". Equity" is equal to the difference between the assets and liabilities of an entity; its net assets.

The equity of an entity comprises opening equity, the accumulated surplus/(deficit) and reserves. The opening amount of equity on the implementation of accrual accounting will equal the difference between the amounts attributed to assets and liabilities at that time.

The description of the "wash-up" of items as opening equity is considered appropriate because it recognises that the financial accountability of an entity has been re-established on a new footing under accrual accounting.

11.3 Format of Operating Statement

Objectives

The operating statement of an entity should be presented to reveal the following aspects of its performance:

- to report in aggregate and by their nature the expenses incurred by an entity during the financial period
- to disclose in aggregate and by their nature the operating revenues earned by an entity during the period and, separately, the gains/losses on the disposal of certain assets.
- to highlight the net cost of services provided by an entity, and
- to show the extent to which the net cost of services has been met by consolidated fund allocations.

The net cost of services for a financial period shall, subject to paragraphs (a) and (b), take into account all items of operating revenue and expense arising in that period:

- irrespective of whether they are attributable to the ordinary operations of an entity during the financial period, or to events or transactions outside those operations, and

- even though they may relate to prior financial periods.

The operating result for a financial period shall, subject to paragraphs (a) and (b) take into account the net cost of services, the consolidated fund recurrent allocation and the acceptance by the crown of the entity's liabilities.

(a) When a reporting entity changes an accounting policy in order to comply with an Australian Accounting Standard or a statutory requirement which specifically requires the making of an initial accounting entry to give retroactive effect to the changed accounting policy, any resulting revenue or expense shall be adjusted directly against opening accumulated surplus/(deficit) at the beginning of the reporting period in which the change is made.

(b) The operating statement shall disclose, after the operating result, the aggregate amount of any extraordinary items. The consolidated fund capital allocation and any returns of funds to the crown resulting from the sale of assets shall be disclosed after the operating result or, where applicable, the operating result after extraordinary items.

11.4 Statement of Cash Flows

Objectives

The information provided in a statement of cash flows, used together with the other disclosures in the financial report, should help users to:

(a) assess the nature and amount of financial support that the entity receives from the Crown, and

(b) assess the nature and amount of cash inflows and outflows from operating, investing and financing activities.

Presentation

The statement of cash flows shall disclose the net cash flows provided or used for the period classified between operating, investing, financing and government funding activities and so as to reconcile cash at the beginning and end of the financial period.

Subject to the paragraph directly following, the major cash inflows and outflows shall be disclosed separately.

The net cash flows from operating activities shall be determined using the direct method by adjusting items reported in the Operating Statement for non cash items and items which do not relate to operating activities.

Discussion

The Manual requires the presentation of a statement of cash flows. Area Health Services/Districts/Hospitals are no longer required to present a statement of sources and applications of funds. The main reason for requiring the presentation of a cash, rather than a funds, based statement is that knowledge of cash and cash flows, classified as required under this Manual, is useful for understanding the effects of each entity's activities on the overall cash financing requirements of the budget sector. It is generally considered that a statement of cash flows provides this information with greater clarity and simplicity than would a statement of sources and applications of funds.

In the departmental context perhaps the most significant issue concerns the classification of cash receipts and payments (ie. cash flows) between operating, investing, financing and government funding activities.

Cash Flows from Government Funding Activities

Government funding activities includes those activities which result in transactions between the Area Health Service/District/Hospital and the State. Cash inflows from government funding activities include:

(a) NSW Health Department Cash Payments
(b) NSW Health Department Capital Appropriations

Cash outflows from government funding activities include the sharing of revenue generated from commercial activities.

Cash Flows from Investing Activities

Investing activities are concerned with the investment and divestment of cash in non-current assets such as property, plant and equipment, investments and identifiable intangible assets. Cash inflows (outflows) from investing activities include:

(a) receipts (disbursements) of cash from sales (purchases) of property, plant and equipment and

(b) receipts (disbursements) of cash from sales (purchases) of debt and equity investments.

Cash Flows from Financing Activities

An entity's financing activities relate to the size and composition of its financial structure as defined by reference to its equity and borrowings, but excluding such items where they are transacted with the State. Indeed most finance is likely to be received from the State in the form of advances, if at all and as such would be classified with government funding activities.

Cash Flows from Operating Activities

The main types of cash inflows from operating activities includes receipts from user charges activities such as Patients' Fees.

Cash flows from operating activities include cash payments relating to:

(a) employees' services
(b) Visiting Medical Officers
(c) Goods and Services

12.0 MINIMUM CONTENT OF NOTES TO THE FINANCIAL STATEMENTS

12.1 Accounting Policies

A summary of accounting policies shall be disclosed in accordance with AAS 6 "Accounting Policies: Determination, Application and Disclosure". The determination, application and disclosure of accounting policies shall be governed by the requirements of AAS 6 and SAC 3 "Qualitative Characteristics of Financial Information".

12.2 Notes to the Statement of Financial Position

The disclosures in the notes to the statement of financial position shall include, as a minimum, the following classes of assets, with any non-current portion of a class being separately disclosed:

(a) Cash includes the following classes:

(i) cash, including moneys held at call with a financial institution, petty cash, change floats and advance accounts, and
(ii) balances remitted to the NSW Health Department and held in special deposit accounts.

(b) Receivables includes the following classes:

(i) trade debtors - The estimated doubtful debt content and the amounts of bad debts written off should be reported.
(ii) amounts receivable from the NSW Government
(iii) bills of exchange and promissory notes, and
(iv) other non-trade debtors.

(c) Investments includes the following classes:

(i) government and semi-government stocks and bonds
(ii) debentures
(iii) shares
(iv) options in respect of shares, and
(v) investment properties.

(d) Inventories includes the following classes:

(i) raw materials
(ii) work in progress, and
(iii) finished goods.

The notes to the accounts should provide details of stock on hand for all significant components, eg. drugs, medical/surgical supplies, food.

(e) Property, plant and equipment includes the following classes:

(i) land
(ii) buildings, and
(iii) plant and equipment.

A list of all land holdings which are valued at $500,000 and over together with a description of current or planned use described and ranked according to the potential for alternative use is to be included. Land valued at under $500,000 is to be advised by way of schedule indicating the number of properties and aggregate value.

(f) Intangibles includes the following classes:

(i) identifiable intangible assets, and
(ii) goodwill.

The notes to the statement of financial position shall include, as a minimum, disclosure of the following classes of liabilities with the non-current portion of a class being separately disclosed:

(a) Borrowings includes the following classes:
(i) bank overdrafts
(ii) bank loans
(iii) loans from State Government entities
(iv) other loans
(v) lease liabilities, and

(b) Creditors and Advances includes the following classes:
(i) trade creditors
(ii) other creditors and
(iii) advances from the Crown

(c) Provisions includes the following classes:
(i) provisions for employee entitlements (eg. annual leave), and
(ii) provisions in respect of legal claims.
(iii) provision in respect of major deferred maintenance

As a minimum, the nature and amounts of the following classes of equity shall be shown separately.

(a) accumulated surplus/(deficit), inclusive of contributed capital.
(b) asset revaluation reserves

12.3 Notes to the Operating Statement

12.3.1 The notes to the operating statement shall include disclosure of each of the following items recognised in determining employee related expenses:

(a) long service leave and annual leave
(b) superannuation entitlements, and
(c) other employee entitlements

The nature and amount of each grant and subsidy expense shall be disclosed.

Grants received directly from governments other than the NSW Government shall be disclosed separately by source.

Industry contributions shall be disclosed separately by source.

12.3.2 The amount of emoluments or other benefits paid, or due and payable, directly or indirectly to members or directors (however described) of the health organisation, but not including amounts paid by way of salary to full time members or directors of the health organisation.

12.3.3 Consultancy fees are to be included in the body of the Annual Report. For consultancies costing $30,000 or more details should be provided of the consultant's name, the nature of the consultancy and the amount paid. For engagements costing less than $30,000 the total number of engagements and total cost is required.

Payments to Clinical and Medical Consultants (including VMO's) are to be excluded.

12.4 Notes to the Statement of Cash Flows

Information about all investing and financing activities of the entity during the financial period that affect assets and liabilities which have been recognised but that do not result in cash flows during the financial period shall be disclosed in the notes to the financial statements.

The notes to the financial statements should also include a "Reconciliation of Net Cash Used in Operating Activities to Operating Result".

12.5 Abnormal and Extraordinary Items

Where the operating result has been affected by any abnormal items, such item or items shall be disclosed in the notes to the operating statement together with an explanation of the nature, reason and amount of each abnormal item. The nature, reason and amount of each extraordinary item shall be disclosed.

Where any abnormal or extraordinary item relates directly to one or more prior financial periods, such financial periods shall be specified.

Examples of items which may fall within the definition of abnormal items in particular circumstances include:

- bad debt write-offs
- inventory write-downs
- write-offs of research and development costs
- depreciation adjustments upon re-assessment of the estimated useful lives of non-current assets
- differences between carrying amounts and proceeds from the sale of investments whether or not acquired for resale
- differences arising on investments denominated in foreign currencies

It is expected that only on rare occasions will items fall within the definition of extraordinary items. Examples of such items include the condemnation, expropriation or unintended destruction of property.

12.6 Provisions in Respect of Asset

Where, at the end of the financial period, there exists accumulated amortisation, depreciation or diminution in value in respect of any class of assets, the amount of that accumulation shall be shown separately as a deduction from the gross amount recorded for the asset.

12.7 Changes in Equity

A reconciliation of the opening and closing balances of equity shall be disclosed.

12.8 Supplementary Financial Information

12.8.1 Program Statements

In respect of each major program of an entity, the entity shall disclose as supplementary financial information:

(a) a brief description of the nature and objectives of that program
(b) the revenues and expenses which are attributable to that program including separate disclosure of grants and subsidies
(c) the net cost of the program services, and
(d) the operating result after Departmental funding and
(e) the carrying amount of non-current assets which are directly attributable to that program.

Note that:

a particular program shall be presumed to be major and to warrant separate disclosure where its net cost of services is 10% or more of the entity's net cost of services:

it is acceptable to attribute assets and depreciation to programs notionally, by application of a reasonable cost allocation method, for the purposes of satisfying the requirements in paragraphs (b), (c), (d) and (e) above.

Program statements are presented so as to reveal the following aspects of the entity's performance and financial position:

- the costs of providing major program services to the community and the extent to which they are recovered by revenues, and

- the amount of resources invested in major programs.

Program statements shall be presented in the financial report on an accruals basis consistent with the operating statement and the statement of financial position.

Program Statements facilitate the reporting of two essential types of information, namely a break down of the net cost of services for the entity by program and, similarly, a desegregation of the assets of an entity.

However, there are some limitations in the usefulness of program statements, for measuring the efficiency and effectiveness of the entity's activities. These are briefly summarised as follows:

- program statements are only a measure of the costs for the financial period classified on an output basis. They do not measure other dimensions of an entity's outputs (services) such as the quantity of services provided. It is therefore important to develop non-financial measures of the outputs of an entity so as to facilitate the reporting of reliable efficiency measures which relate the volume and cost of inputs to the outputs produced, and

- program statements do not measure the outcome for the community of providing a particular set of services. Other types of information will be required in order to evaluate the social costs and benefits of providing a particular service to the community.

12.8.2 Comparative Amounts

In respect of the amount of each item disclosed in the financial report for the current financial period the corresponding amount of that item for the immediately preceding financial period shall be disclosed except that, in respect of the financial period in

which accrual accounting is first implemented by the entity, such corresponding amounts need only be disclosed where they are available.

Where an item was disclosed in the financial report for the preceding financial period and the amount of that item is immaterial in the current financial period, both the immaterial amount for the current financial period and the amount of the item for the immediately preceding financial period shall be shown in the current financial report.

The duration of the current financial period shall be disclosed and where different the immediately preceding financial period shall be disclosed with an explanation for any difference in duration.

12.8.3 Budgetary Amounts

In respect of the actual amount of each item disclosed in the financial statements for the current financial period, the corresponding budgeted amount of that item for the current financial period shall be disclosed where accrual budgets have been advised by the Department.

The budgetary amounts disclosed in accordance with the preceding paragraph shall be drawn from the entity's budget as approved and agreed between the entity and the department/government, inclusive of S24 and S26 allocations as allowed under the Accounts and Audit Determination i.e. which reflects the requirements of the ***Public Finance and Audit Act 1983***.

The reasons for material differences between budget and actual amounts for the net cost of services shall be briefly summarised in the financial report.

The provision of comparative budgetary and actual information is required so as to provide benchmarks against which the performance of an entity can be assessed.

12.8.4 Restricted Assets

The entity shall disclose, the nature of any externally imposed financial restrictions operable in respect of its assets together with the amount of restricted assets, in aggregate and by class of assets.

Restricted assets of those assets of an entity whose use is limited by externally imposed restrictions, including those that may expire by passage of time, or which can be fulfilled and removed by actions of the entity pursuant to those restrictions, e.g. resources which are donated to an entity under a tacit agreement that those resources will be applied to a particular purpose or in other circumstances the donor may specify in detail the purpose and controls to be applied in order to ensure that the resources donated will be used appropriately, and such restrictions may require that the Entity report separately to the donor on the uses of those particular resources.

Paragraph 6.15 further refers.

12.8.5 Significant Assets to Which No Value is Attributed in the Statement of Financial Position

An entity shall disclose a summary of significant assets employed or held by them to which no or only nominal values have been attributed. The following information shall be disclosed about such assets either separately or by class:

(a) the nature and function of the assets, including references to their size, quantity and quality, and
(b) the amount of expense incurred in the current financial period in maintaining the assets.

There is a significant range of assets in the public sector which are often not recognised in the entity's statement of financial position other than at a nominal value of $1. The measurement of assets which are not currently available for redeployment or disposal and for which there is no reasonable expectation of change are discussed in Section Two (6.7) of this manual.

The Guidelines (6.9.3) indicate that for practical reasons certain Category C assets may be recognised at the nominal value of $1. It is nevertheless important that summarised information is disclosed about such assets as they are a strong focus of community interest in general and for those interested in the service delivery objectives of an entity.

12.8.6 Commitments for Capital Expenditure

In respect of commitments for capital expenditure not recognised as liabilities in the statement of financial position, there shall be disclosed in the notes to the financial statements the nature and amount of each type of commitment for expenditure, both in total and according to whether they are payable:

(a) not later than one year
(b) later than one year and not later than two years
(c) later than two years and not later than five years, and
(d) later than five years after the end of the financial period.

12.8.7 Contingent Liabilities

Where they are not recognised as liabilities in the statement of financial position, the financial report shall disclose the amount and description of contingent liabilities.

For the purposes of the preceding paragraph, the amount and description of contingent liabilities shall be expressed in aggregate and, if applicable, by class where discrete contingent liabilities are material in nature.

12.9 State Consolidation

To assist the Department in preparing the State Consolidation it is considered necessary to adopt, as far as practicable, a standard set of notes to the accounts.

Such notes are included in the specimen financial statement in Paragraph 13.

13.0 FINANCIAL STATEMENTS

13.1 Schedules

The various financial statements and notes to the accounts should be allocated Schedule Numbers as follows:

Schedule I Operating Statement

Schedule II Statement of Financial Position

Schedule III Statement of Cash Flows

Schedule IV Notes to Financial Statements

13.2 Certification of Accounts

The Chief Executive Officer of a health organisation shall ensure that the financial statements required are presented to the auditor for audit within six weeks of the financial year. A statement signed by the person primarily responsible for their preparation and the Chief Executive Officer should be consistent with the following:

> Pursuant to Section 45F(1B) of the ***Public Finance and Audit Act 1983***, we declare on behalf of the Board of the ..... Health Service that:
>
> (i) the financial statements of the ..... Health Service for the year ended 30 June 19.... have been prepared in accordance with the requirements of Australian accounting standards, the ***Public Finance and Audit Act 1983*** and its regulations, and the ***Public Hospitals Act 1929*** and its regulations.
>
> (ii) the financial statements present fairly the financial position and transactions of the ..... Health Service; and
>
> (iii) there are no circumstances which would render any particulars in the accounts to be misleading or inaccurate.

Chairman
(Date)

Chief Executive Officer
(Date)

13.3 Audit Statement

In regard to the Annual Financial Statements required by the Department, the auditor shall include a certified audit report, in similar form to that specified below. The report shall, unless otherwise qualified, contain words to the effect:

To Members of the New South Wales Parliament and Members of the Board

Scope

I have audited the accounts of the ..... for the year ended 30 June 19.... The preparation and presentation of the financial statements, consisting of the statement of financial position, operating statement and statement of cash flows, together with the notes thereto, and the information contained therein is the responsibility of the Board of the ..... Health Service. My responsibility is to express an opinion on these statements to Members of the New South Wales Parliament and Members of the Board based on my audit as required by Sections 34 and 45F(1) of the ***Public Finance and Audit Act 1983***. My responsibility does not extend here to an assessment of the assumptions used in formulating budget figures disclosed in the financial statements.

My audit has been conducted in accordance with the provisions of the Act and Australian Auditing Standards to provide reasonable assurance as to whether the financial statements are free of material misstatement. My procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, 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 the requirements of the ***Public Finance and Audit Act 1983*** and Australian accounting standards, so as to present a view which is consistent with my understanding of the ..... Health Service's financial position, the results of its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

Audit Opinion

In my opinion, the financial statements of the ..... Health Service comply with Section 45E of the Act and present fairly in accordance with applicable Accounting Standards the financial position of the Service as at 30 June 19.... and the results of its operations and its cash flows the year then ended.

Assistant Auditor-General

(duly authorised by the Auditor-General of New South Wales under Section 45F(1A) of the Act)

Sydney
(Date)

.....

The auditor should state in the report, particulars of any deficiency, failure or shortcoming in respect of any matters referred to above.

In regard to the Annual Report of a Health organisation, the auditor shall supply for inclusion in the Annual Report, a certified audit report on the financial statements and information required in an Annual Report by this manual.

The auditor shall give the audit report to the CE for area health services and Royal Alexandra Hospital for Children. Copy to DoH where there is no Board.

13.4 Statement of Financial Position as at 30/6/9X

	Notes	Actual 30/6/9X $000	Budget 30/6/9X $000	Actual 30/6/9Y $ 000
Current Assets				
Cash	13			
Investments	14			
Receivables	15			
Inventories	16			
Other		---	---	---
Total Current Assets		---	---	---
Non-Current Assets				
Investments	14			
Property, plant and equipment	17			
Intangibles				
Other				
		---	---	---
Total Non-Current Assets				
		---	---	---
Total Assets				
		---	---	---
Current Liabilities				
Creditors and Advances	18			
Borrowings	19			
Provisions	20			
Other				
Total Current Liabilities		---	---	---
Non-Current Liabilities				
Creditors and Advances	18			
Borrowings	19			
Provisions	20			
Other				
Total Non-Current Liabilities		---	---	---
Total Liabilities				
		---	---	---
Net Assets				
		======	======	=====
=				
Equity				
Accumulated surplus/(deficit)	21			
Asset Revaluation Reserve	21			
Total Equity				
		======	======	

======

The above format applies equally to Royal Alexandra Hospital for Children, the Ambulance Service and the Sydney Home Nursing Service.

13.5 Operating Statement for the year ended 30/6/9X

	Notes	Actual 30/6/9X $000	Budget 30/6/9X $000	Actual 30/6/9Y $000
Expenses				
Employee related	3			
Other Operating Expenses	4			
Maintenance	2(e), 5			
Depreciation	2(f), 16			
Grants & Subsidies	6			
Interest				
Total Expenses				
Revenues				
User Charges	7			
Donations & Industry Contributions	8			
Other Income	9			
Total Revenues				
Net Cost of Services for Year before Abnormal Revenue/(Expense)	10 & 29			
Abnormal Revenue/(Expense)	11(a)			
Net Cost of Services after Abnormal Revenue/(Expense)	10 & 29			
Add Government Contributions				
NSW Health Department Cash Payments	2(i)			
NSW Health Department Capital Appropriation	2(l)			
State Acceptance of Departmental Liability	2(a) & 2(b)			
Add				
Industry Contributions/Donations - Increased Service Potential				
Net Revenues from Disposal of Non Current Assets	10			
Surplus/Deficit for Year before Extraordinary Revenue				
Extraordinary Revenue	11(b)			
Surplus/(Deficit) after Extraordinary Revenue				
Accumulated Surplus, 1 July 199X				
Administrative Restructure				
Accumulated Surplus, 30 June 199X				

The accompanying notes form part of these Financial Statements

13.6 Statement of Cash Flows
for year ended 30/6/9X

		Consolidated		
	Actual Notes	199X	Budget 199X	Actual 199Y
		$000	$000	$000
Cashflows From Operating Activities				
Payments				
Employee Related				
Suppliers and Other Services				
Interest				
Grants and Subsidies				
Other Payments				
		< >	< >	< >
Receipts				
User Charges				
Donations & Industry Contributions				
Interest				
Other Income				
		< >	< >	< >
Net Cash Used on Operating Activities				
Cashflows From Investing Activities				
Purchases of property plant & equipment				
Proceeds from the sale of property, plant & equipment		< >	< >	< >
Advances received from other organisations				
Advances paid to other organisations				
Purchase of investments				
Proceeds from sale of investments		< >	< >	< >
Net Cash Used on Investing Activities				
Net Cash Outflows From Operating and Investing Activities				
Government Funding				
Consolidated Fund Recurrent Appropriation				
Consolidated Fund Capital Appropriation				
Repayment of Borrowings		< >	< >	< >
Proceeds from borrowings				
Net Cash Provided by Government				
Net Increase/(Decrease) in Cash				
Opening Balance				
Closing Cash Balance				
Cash and its Equivalents Have Been Included in the Statement of Financial Position As Follows:	24(a)			
Cash				
Bank Overdraft				
Current Investments				
Closing Cash Balance (Cash and Cash Equivalents as above)				

The accompanying notes form part of these Financial Statements

Notes to and forming part of the Financial Statements
30 June 19XX

1. The Area/Hospital Reporting Entity

The ..... Area Health Service/Hospital comprises all the operating activities of the Hospital facilities and the Community Health Centres under the control of the Area/District/Hospital. It also encompasses the Special Purposes & Trust Funds which, while containing assets which are restricted for specified uses by the grantor or donor, are nevertheless controlled by the Area/District/Hospital.

2. Summary of Significant Accounting Policies

The Area's/District's/Hospital's Financial Statements have been prepared in accordance with applicable Australian Accounting Standards, the requirements of the ***Public Finance and Audit Act 1983*** and its regulations and the requirements of the ***Public Hospitals Act 1929*** and its regulations.

The Operating Statement and Statement of Financial Position have been prepared on an accrual basis and, except where stated, under the historical cost convention. An exemption has been obtained from Treasury to vary the format of the Operating Statement. The revised format provides additional disclosure of Operating Statement components. The Statement of Cash Flows is prepared on a cash basis using the direct method.

Budgets are on an accrual basis and these figures have been included for comparative purposes in the financial statements presented.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

Other significant accounting policies used in the preparation of these financial statements are as follows:

(a) Employee Entitlements

These include estimated amounts expected to be paid to employees for their prorata entitlement to long service and annual leave (including Annual Leave Loading) and are accrued annually at current pay rates having regard to the period of service. These amounts have been dissected between current and non-current portions based on past experience and, in respect of the non current values, have been recognised in the financial statements at present discounted value of the estimated future cash outflows as required by AAS30, “Accounting for Employee Entitlements”.

In determining the present value of future cash outflows the interest rates attaching to Government Guaranteed Securities, which have terms to maturity approximating the terms of the related liability, are used.

(b) Superannuation Benefits

The cost of superannuation is included as an operating expense. However, as the ... Area Health Service/District/Hospital's liabilities for Superannuation are assumed by the State, the Area Health Service/District/Hospital accounts for the liability as having been extinguished resulting in non-monetary revenue described as "State Acceptance of Superannuation liability".

(c) Use of Outside Facilities

The Area/District/Hospital uses a number of facilities owned and maintained mainly by the local authorities in the area to deliver community health services; no charges are raised by the authorities. (SHOULD CIRCUMSTANCES VARY THE NOTE SHOULD BE AMENDED ACCORDINGLY.)

(d) Acquisition of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is determined as the fair value of assets given up at the date of acquisition plus costs incidental to the acquisition.

(e) Repairs & Maintenance

Repairs & Maintenance costs and minor renewals (items less than $5,000) are expensed as incurred. Maintenance costs include expenses on periodic overhaul of major items of plant, machinery and equipment.

(f) Depreciation

Depreciation is provided on a straight line basis against all depreciable assets so as to write off the depreciable amount of each depreciable asset as it is consumed over its useful life.

Details of depreciation rates for major asset categories are as follows:

Buildings	2.5%
Electro Medical Equipment	
- Costing <$200,000>	10%
- Costing more than or equal to $200,000	12.5%
Computer Equipment	20%

Office Equipment	10%
Plant and Machinery	10%
Linen	20%
Furniture, Fittings and Furnishings	5%

(g) Patient Fees

Patient fees are derived from chargeable inpatients and non-inpatients on the basis of rates specified by the NSW Health Department from time to time.

(h) Use of Hospital Facilities

Specialist doctors with rights of private practice are charged a facility fee for the use of hospital facilities at rates determined by the NSW Health Department and are based on fees collected.

(i) NSW Health Department Cash Payments

Cash Payments are made by the NSW Health Department on the basis of the net allocation for the Area/District/Hospital as adjusted for approved supplementations mostly for employee enterprise agreements and approved enhancement projects. This allocation is included in the Operating Statement before arriving at the operating result on the basis that the allocation is earned in return for the health services provided in 19XX/XY on behalf of the Department.

General operating expenses/revenues of ... (Third Schedule Hospitals) have only been included in the Operating Statements prepared to the extent of the net cash payments made to the Hospitals concerned. The Area is not deemed to own or control the various assets/liabilities of the aforementioned hospitals and such amounts have been excluded from the Statement of Financial Position. Any exceptions are specifically listed in the notes that follow.

(j) Inventories

All inventories have been valued at the lower of cost and net-realisable value, and have been classified as current assets based on expected use. Costs are assigned to individual items of stock mainly on the basis of weighted average costs.

Obsolete items are disposed of in accordance with instructions issued by the NSW Health Department.

(k) Property, Plant & Equipment

(i) Land and Buildings are valued by independent valuers at 5 yearly intervals. Generally, land is valued on the basis of existing use and buildings on the basis of depreciated replacement cost.

(ii) Land & buildings which are owned by the Health Administration Corporation or the State and administered by the Area/District/Hospital are deemed to be owned by the Area/District/Hospital and are reflected as such in these financial statements.

(iii) Physical assets costing less than $5,000 in value are expensed in the year of acquisition.

(iv) Donated physical assets are capitalised and brought into account at fair market value if such value is $5,000 or more [see (iii) above].

(v) The recoverable amount test required under AAS10, Accounting for the Revaluation of Non Current Assets is deemed by the NSW Health Department to be inappropriate as the service potential of assets is generally not dependent on their ability to generate net cash inflows.

(l) NSW Health Department Capital Allocations

Capital Allocations made in the 19XX/XY year have been treated as revenue in these financial statements being brought to account after the Operating Result.

(m) Research & Development Costs

Research and development costs are charged to expense in the year in which they are incurred.

(n) General Fund Revenues

The NSW Health Department has implemented a policy of net appropriation with all revenues earned being retained at an Area/District/Hospital level and, with NSW Health Department Cash Payments, applied to offset the expenses incurred.

(o) Accumulated Leave Provisions

Under the Leave Mobility provisions applicable in the Government Sector from May 1993, the Area/District/Hospital receives moneys equivalent to the value of employee leave transferred. Note 20 reflects the values involved.

(p) Leases

i) The NSW Health Department has entered into a number of operating lease agreements for buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Operating Statement over the lease term as this is representative of the pattern of benefits to be derived from the leased property.

ii) The Department's rights and obligations under finance leases, which are leases that effectively transfer to the Department substantially all of the risks and benefits incident to ownership of the leased items, are initially recognised as assets and liabilities equal in amount to the present value of the minimum lease payments. The assets are disclosed as property, plant and equipment under lease, and are amortised to the operating statement over the period during which the Department is expected to benefit from the use of the leased assets. Minimum lease payments are allocated between interest expense and reduction of the lease liability, according to the interest rate implicit in the lease.

3. **Employee Related Expenses**

Employee related expenses comprise the following:

	199X $000	199Y $000
Salaries & Wages		
Enterprise Agreements/Awards		
Long Service Leave [see note 2(a)]		
Annual Leave [see note 2(a)]		
Redundancies		
Nursing Agency Payments		
Workers Compensation Insurance		
Superannuation (See note 2(b))	_____	_____
	=====	=====

4. Goods & Services

		199X	199Y
(a)	Expenses on Goods & Services comprise the following:		
	Food Supplies		
	Drug Supplies		
	Medical & Surgical Supplies		
	Special Service Departments		
	Fuel, Light & Power		
	Domestic Charges		
	Administrative Expenses	-------	------
		====	====

(b) Administrative expenses include:

- Consultancies
- Operating Activities
- Capital Works
- External Audit Fees
- Audit Work
- Other Services
- Travelling-Overseas Fares
- Interest
- Staff Training & Development
- Provision for Bad & Doubtful Debts
- Rental of Premises
- Operating Lease Expense

Fees/other benefits paid to Area/District/Hospital Board members excluding payments made in the nature of normal employee salary or payments made in accordance with conditions applied to Visiting Medical Officers in general are disclosed hereunder.

5. Replacements, Maintenance & Repairs

	199X $000	199Y $000
Expenses on replacements, maintenance and repairs comprise the following:		
Renovations & Additional Works		
Replacements & Additional Equipment less than $5,000		
Repairs & Maintenance		

6. Grants and Subsidies

	199X $000	199Y $000
Major categories (to be listed)		
Other		

7. Payments to Third Schedule Hospitals and Other Contracted Hospitals

a) Operating
List each hospital and amount paid

b) Capital
List each hospital and amount paid

8. User Charges

	199X $000	199Y $000
(a) User charges comprise the following:		
Patient Fees [see note 2(g)]		
Staff-Meals & Accommodation		
Services provided to Other Hospitals		
Use of Hospital Facilities [see note 2(h)]		
Other		

9. Donations and Industry Contributions

University Commission grants		
Grants		
Other -		
Agriculture, Forestry and Fishing		
Mining		
Manufacturing		
Electricity, Gas and Water		
Construction		
Wholesale and Retail Trade		
Transport and Storage		
Communication		
Finance, Property & Business Services		
Public Administration and Defence		
Community Services		
Recreation, Personal & Other Services		
(DELETE NON APPLICABLE ITEMS)	_____	_____
	=======	=======

10. Other Income

Other Income comprises the following:

Interest Revenue		
Sundry Revenue	_____	_____
	=======	=======

11. Disposal of Assets

Property, Plant & Equipment		
Other Assets		
Cost or value		
Less Accumulated Depreciation	_____	_____
Written Down Value		
Less Proceeds from Sale		
Net Revenues from Disposal of	=======	=======
Non-Current Assets	_____	_____
	=======	=======

12. Abnormal Items

Components are to be clearly documented and quantified, inclusive of advice concerning the accounting period to which they relate.

13. Current Assets-Cash

Cash on Hand		
Cash at Bank	_____	_____
	=======	=======

14. Investments

	199X	199Y
Listed as Current Assets		
Treasury Corporation		
Other (Specify)		
Debentures		
Shares		
Surplus Land & Buildings		
Listed as Non Current Assets		
Treasury Corporation		
Other (Specify)		
Debentures		
Shares		
Surplus Land & Buildings		
	_____	_____
	=====	=====

The vast majority of investments are held as cash deposits which would suffer no capital losses if they were redeemed before maturity. The need does not therefore arise to restate them at net market selling values.

Surplus Land & Buildings is described as follows:

15. Current Assets-Receivables	**199X $000**	**199Y $000**
(a) Patient Fees-Compensables		
- Other		
Less Provision for Bad and Doubtful Debts		
Sub-Total		
Prepayments		
Other		

(b) Bad debts written off are as follows:

16. Current Assets-Inventories	**199X**	**199Y**
Drugs		
Medical & Surgical Supplies		
Food & Hotel Supplies		
Engineering Supplies		
Other including goods in transit		

17. (a) Property, Plant & Equipment

	Land $000	Buildings $000	Construction In Progress $000	Plant & Equipment $000	Other	Total
Cost or Valuation Balance 1 July 199Y Revaluation Adjust. [see note 2(k)(i)] Capital Expenditure/ Donations [see note 2(k)(ii) & (iii)] Disposals Reclassifications Valuation Increments Valuation Decrements Assets Brought to Account for first time						
Balance 30 June 199X						
Depreciation Balance 1 July 199Y Charge for the year [see note 2(f)] Write back on disposal Reclassifications Transfer on Revaluation						
Balance 30 June 199X						
Carrying Amount 30 June 199X						

Above categories and transaction type should be deleted if not applicable.

(i) Land & Buildings include land owned by the NSW Health Department and administered by the Area/District/Hospital [see note 2(k)(ii)]

(ii) Land & Buildings were valued by XXXXXXXX (relevant qualifications to be entered) on XXXXX 19XX [see note 2(k)(i)]..... is/is not an employee of the Area/District/Hospital.

(iii) Plant & Equipment, other than motor vehicles, were valued by the Area/District/Hospital on ..... on the basis of depreciated replacement cost [see note 2(k)(i)]

(iv) Property, Plant & Equipment have been depreciated from not later than the month following acquisition.

(v) Discussions have been held with organisations as necessary and agreement has been reached in terms of reporting assets in the appropriate entity's statement of financial position.

(b) Details of Inter Government agency transfers are as follows:

Land Buildings	**Constructions**	**Plant & Equipment**

(c) Land & Buildings which have been excluded from the Statement of Financial Position are as follows:

Details of Asset	**Location**

(d) The cost of maintaining historic buildings/parks to which no value has been attributed in the Statement of Financial Position was $..... for the year now reported.

18. Creditors

		199X **$000**	**199Y** **$000**
(a)	Bank Overdrafts		
	Refundable Deposits		
	Patient Trust Accounts		
	Trade Creditors		
	Private Practice Trust Funds		
	Capital Works		
	Other Creditors		
		=====	=====

Delete non applicable or non material items.

19. Borrowings

a) **Current**
Dept Loan Against Recurrent Allocation
Dept Capital Loan

Non Current
Dept Loan Against Recurrent Allocation
Dept Capital Loan

Agreement with the Department involves interest of ....% per annum (Capital Loans - Interest Payable only). Final Repayment is scheduled for .....

20. Provisions

	Opening Balance 1/7/9Y	Provision for the year	Entitlements Transferred In	Payments during the year	Closing Balance 30/6/9X
Employee Annual Leave [see note (a)]					
Employee Sick Leave (if required under award conditions/legislation)					
Employee Long Service Leave					
Other					
Total					
(a) Current					
(b) Non-current					

21. Equity

	Accumulated Funds		Asset Revaluation	
	199X $000	199Y $000	199X $000	199Y $000
Balance at beginning of year				
Surplus/(Deficit) for the year				
Surplus on revaluation of non-current assets				
Transfers to/(from) Revaluation Reserves				
Total				

22. Contingent Liabilities

(a) Loans negotiated in previous years under Section 37 of the ***Public Hospitals Act 1929*** are:

Loan Sum $000	Period Years	Interest pa %	Commenced Year Ended

The balance outstanding at 30 June 199X on these loans was $.

Whilst loans are guaranteed by the State Government and repayable by the NSW Health Department, the ..... Area/District Health Service/Hospital, as additional security, has been required to institute mortgages over its income, other than Trust income, for the period of the loans.

(b) Claims on Managed Fund

Since 1 July 1989, the Area/District Health Service/Hospital has been a member of the NSW Treasury Managed Fund. The Fund will pay to or on behalf of the health service all sums which it shall become legally liable to pay by way of compensation or legal liability if sued except for employment related, discrimination and harassment claims that do not have statewide implications. The costs relating to such exceptions are to be absorbed internally. As such, since 1 July 1989, apart from the exceptions noted above no contingent liabilities exist in respect of liability claims against the Area/District Health Service/Hospital. A Solvency Fund (now called Pre-Managed Fund Reserve) was established to deal with the insurance matters incurred before 1 July 1989 that were above the limit of insurance held or for matters that were incurred prior to 1 July 1989 that would have become verdicts against the State. That Solvency Fund will likewise respond to all claims against the Area/District Health Service/Hospital.

(c) Sessional and Fees for Service Remunerated Visiting Medical Officers Superannuation

The Department's position is that no superannuation charge liability exists in respect of NSW Health entities for any Visiting Medical Officer since 1 July 1992, other than payments made in respect of Sessional Visiting Medical Officers consistent with:

- an agreement with the Australian Medical Association for the period 1 July 1993 to 31 January 1994
- an Industrial Relations Commission Determination of 25 March 1994 for payment from 1 February 1994.

The Department is now pursuing a judicial determination on the matter.

(d) Third/Fourth Schedule Organisation

Based on the definition of control in Australian Accounting Standard AAS24, Health Organisations listed in the Third and Fourth Schedules of the ***Public Hospitals Act 1929*** are only recognised in the Department's consolidated Financial Statements to the extent of cash payments made.

However, it is accepted that a contingent liability exists which may be realised in the event of cessation of health service activities by any Third/Fourth Schedule Organisation. In this event the determination of assets and liabilities would be dependent on any contractual relationship which may exist or be formulated between the administering bodies of the organisation and the Department.

23. Capital Works in Progress

	199X $000	199Y $000
(a) Capital Commitments		
Aggregate capital expenditure contracted for at balance date but not provided for in the accounts:		
Not later than one year		
Between one and two years		
Between two and five years		
Later than five years		
Total Capital Expenditure Commitment		
Of the above amount reported for 199X, it is expected that $.... will be met from locally generated moneys.		
(b) Lease Commitments		
Aggregate lease expenditure contracted for at balance date but not provided for in the accounts, payable:		
Not later than one year		
Between one and two years		
Between two and five years		
Later than five years		
Total Operating Lease Commitments		
(c) Finance Lease Commitments		
Not later than one year		
Between one and two years		
Between two and five years		
Later than five years		
Total Finance Lease Commitments		
Less: Future Financing Charges		
Finance Lease Liabilities		

24. Consolidated Program Statement

	Total Operating *1 Expenses	Revenue	Net Cost of Services after Abnormal Items	Net Revenues from Disposal of Non-Current Assets	Government Cash Payments	Capital Allocation	Operating Result after Government Allocation	Total Non-Current Assets
Program 1.1 $000								
Program 2.1 $000								
Program 2.2 $000								
Program 2.3 $000								
Program 3.1 $000								
Program 3.2 $000								
Program 3.3 $'000								
Program 4.1 $000								
Program 5.1 $000								
Program 6.1 $000								
Total 30.6.x2 $000								
Total 30.6.x1 $000								

*1Provision of the above details is only required where the net cost of a program is 10% or more of the entity's net cost of services. Programs which are individually less than 10% are to be aggregated and reported as “Other Programs”.

Program Descriptions

Program 1.1 **Population Health Services**
Objective: To promote health and reduce the incidence of preventable disease and disability by improving access to opportunities and prerequisites for good health.

Program 2.1 **Primary and Community Based Services**
Objective: To improve, maintain or restore health, through health promotion, early intervention, assessment, therapy and treatment services for clients in a home or community setting.

Program 2.2 **Aboriginal Health Service**
Objective: To raise the health status of Aborigines and to promote a healthy life cycle.

Program 2.3 **Outpatient Services**
Objective: To improve, maintain or restore health through diagnosis, therapy, education and treatment services for ambulant patients in hospital setting.

Program 3.1 **Emergency Services**
Objective: To reduce the risk of premature death and disability for people suffering injury or acute illness by providing timely emergency diagnostic, treatment and transport services.

Program 3.2 **Overnight Acute Inpatient Services**
Objective: To restore or improve health and manage risks of illness, injury or child birth through diagnosis and treatment for people intended to be admitted to hospital on an overnight basis.

Program 3.3 **Same Day Acute Inpatient Services**
Objective: To restore or improve health and manage risks of illness injury and child birth through diagnosis and treatment for people intended to be admitted to hospital on a same day basis.

Program 4.1 **Mental Health Services**
Objective: To improve the health, well being and social functioning of people with disabling mental disorders and to reduce the incidence of suicide, mental health problems and mental disorders in the community.

Program 5.1 **Rehabilitation and Extended Services**
Objective: To improve or maintain the well being and independent functioning of people with disabilities or chronic conditions, the frail aged and the terminally ill.

Program 6.1 **Teaching and Research**
Objective: To develop the skills and knowledge of the health workforce to support patient care and population health.

25. Note to Cash Flow Statement

	Consolidated	
	199X	**199Y**
	$000	**$000**
RECONCILIATION OF NET COST OF SERVICES TO NET CASH USED ON OPERATING ACTIVITIES		
Net Cost of Services after Abnormal Revenue	<_____>	<_____>
Industry Contribution/Donations - increased Service Potential (cash component only)		
Adjustments for Items not involving cash		
Depreciation	_____	_____
Other Provisions and Accruals	_____	_____
Acceptance by State of Superannuation Liability	_____	_____
(Increase)/Decrease in Receivables	_____	_____
(Increase)/Decrease in Inventories	_____	_____
Increase/(Decrease) in Creditors	_____	_____
(Increase)/Decrease in Other Assets	_____	_____
Increase/(Decrease) in Other Liabilities	_____	_____
Total Net Cash Used On Operating Activities	======	======

26. Voluntary Services

It is not possible to quantify the monetary value of voluntary services provided to the Area Health Service/Hospital. Services provided include:

27. Restricted Assets

The Area Health Service/Hospital's financial statements include the following assets which are restricted by externally imposed conditions, e.g. donor requirements.

The assets are only available for application in accordance with the terms of the donor restrictions. Further details appear in the appendices to the Annual Report.

Major Category	**$**	**Brief Details of Externally Imposed Conditions**

28. Charitable Fundraising Activities

Fundraising Activities
The consolidation of fundraising activities by health services under Departmental control is shown below.

Income received and the cost of raising income for specific fundraising, has been audited and all revenue and expenses have been recognised in the financial statements of the individual health services.

Fundraising activities are dissected as follows:

	INCOME RAISED $000	DIRECT EXPENDITURE* $000	INDIRECT EXPENDITURE+ $000	NET PROCEEDS $000
Appeals (Consultants)	993	217	26	749
Appeals (In House)	13,671	779	1,308	11,584
Fetes	331	69	22	240
Raffles	226	32	4	191
Functions	578	70	15	493
	15,800	1,167	1,376	13,258
Percentage of Income	100%	7.39%	8.71%	83.90%

* Direct Expenditure includes printing, postage, raffle prizes, consulting fees, etc.
\+ Indirect Expenditure includes overheads such as office staff administrative costs, cost apportionment of light, power and other overheads.

The net proceeds were used for the following purposes:	$000
Purchase of Equipment	8,635
Purchase of Land & Buildings	517
Research	8
Held in Special Purpose and Trust Fund Pending Purchase	4,098
	13,258

The provision of the ***Charitable Fundraising Act 1991*** and the regulations under that Act have been complied with and internal controls exercised "by health services under Departmental control" are considered appropriate and effective in accounting for all the income received in all material respects.

29. Unclaimed Moneys

Unclaimed salaries and wages are paid to the credit of the Department of Industrial Relations and Employment in accordance with the provisions of the ***Industrial Arbitration Act 1940***, as amended.

All money and personal effects of patients which are left in the custody of Health Services by any patient who is discharged or dies in the hospital and which are not claimed by the person lawfully entitled thereto within a period of twelve months are recognised as the property of health services.

All such money and the proceeds of the realisation of any personal effects are lodged to the credit of the Samaritan Fund which is used specifically for the benefit of necessitous patients or necessitous outgoing patients.

30. Net Cost of Services Result

The Net Cost of Services after abnormal expenses result varies from the budget by $440.486 million. The variance is principally attributed to the additional expenditure sourced from Commonwealth funds provided after the initial framing of budgets and the abnormal expense associated with the revaluation of property, plant and equipment at the Northern Sydney Area Health Service. Note 11(a) also refers.

31. Post Balance Date Events

- The Department effected a merger of Eastern Sydney and Southern Sydney Area Health Services on 1 August 1995 to form South Eastern Sydney Area Health Service. However, the merger, although significant within Health will not impact on the consolidated financial statements presented.

- On 14 July 1995 the South Eastern Sydney Area Health Service completed the sale of land which is to be utilised as a private hospital, medical centre and car park.

  Full ownership of the complex was transferred to the purchaser in return for the payment of $4,185,108.

- On 21 December 1994 the Wentworth Area Health Service entered into a Services Agreement for the design, construction and operation of a public hospital in Windsor.

  The hospital is expected to be commissioned in 1996 from which time the Wentworth Area Health Service becomes responsible for the payment of an availability charge which, under the terms of the agreement, is to be based on the number of public patients occupying beds relative to total patients, and is not to fall below 70%.

Under the terms of the agreement Wentworth Area Health Service will also make payments for the provision of hospital services to public patients (service charges).

At the end of twenty years the health facility will revert to Wentworth Area Health Service although options do exist to extend the term for two years at the Area's option or five years at the option of the private sector provider.

End of Audited Financial Statements.

PART FIVE

ACCOUNTS AND AUDIT

DETERMINATION DIRECTIVES

14.0 ACCOUNTS AND AUDIT DETERMINATION

The Area Health Services/Districts and public hospitals are to continue to be required to comply with financial and reporting standards specified by the Accounts and Audit Determination made under the ***Public Hospitals Act*** rather than the ***Public Finance and Audit and Annual Reports Acts***. The terms/standards specified by the Accounts and Audit Determination are consistent with the latter legislation in order to ensure that all entities within the budget general government sector are subject to uniform directives.

Relevant changes to the Accounts and Audit Determination have been prepared in order to accommodate the introduction of Accrual Accounting and formulation of the "Accrual Accounting Standards and Procedures" Manual for Area Health Services/ Districts/public hospitals.

PART SIX

REFERENCE MATERIAL

Sample 1

BUDGET SECTOR AGENCIES,

STATE GOVERNMENT TRADING ENTERPRISES

AND OTHER

GENERAL GOVERNMENT AGENCIES

BUDGET SECTOR AGENCIES

Aboriginal Affairs, Office of
Agriculture, Dept
Archives Authority of NSW (The)
Art Gallery of NSW Trust
Arts, Ministry for the
Attorney-General's Department
Australian Museum Trust
Bush Fire Services, Dept of
Business & Regional Development, Dept
Cabinet Office
Capital Works Financing Corporation (NSW)
Casino Control Authority
Chief Secretary's Dept (incl Liquor Admin Bd)
Coal Compensation Board (NSW)
Community Services, Department of
Community Services Commission
Conservation & Land Mgt, Dept of
Consumer Affairs, Dept of
Corrective Services, Dept of
Courts Admin, Dept of
Crime Commission (NSW)
Crown (Transactions) the Consolidated Fund Entity
Educn & Youth Affairs, Office of
Energy, Office of (inc. Energy Corp)
Environment Protection Authority
Ethnic Affairs Comm.
Film & TV Office (NSW)
Fire Brigades (NSW)
Fisheries, Office of (NSW)
Govt Pricing Tribunal
Health, Department of
including:
- All Area Health Services
- Ambulance Services (NSW)
- Healthquest (Medical Examn Centre)
- All Public Hospitals (NB EXCEPT FOR 3rd Schedule Hospitals)

Health Care Complaints Commission
Historic Houses Trust
Home Care Services-NSW
Homebush Base Devt Corpn
Homefund Commissioner's Office

Independent Comm'n Against Corrptn
Indus Relations & Employ (DIRETFE)
Judicial Commission - NSW
Juvenile Justice, Dept of
Legal Aid Commission, NSW
Legislature, The
Local Government & Co-operatives, Dept of
Mineral Resources, Dept of
Museum of Applied Arts & Sciences
National Parks & Wildlife Service (including NPWS State Recreation Areas)
Office Chief Secretary & Minister for Admin. Services
Office of the Min. for Public Works & Ports
Ombudsman's Office
Parliamentary Counsel's Office
Planning-Community Service Obligations under the control of the Minister
Planning, Dept of
Police Service-NSW
Police & Emergency Services-Ministry for
Premier's Dept
Public Prosecns, Office of the Director for
Roads and Traffic Authority
Royal Botanical Garden & Domain Trust
Rural Assistance Authority
School Education, Dept of
Social Policy Directorate
Sport Rec & Racing, Dept of
State Electoral Office
State Emergency Services
State Library-NSW
Status and Advancement of Women, Ministry for
Suitors Fund
TAFE Commission, The NSW
Tourism Commission-NSW
Transport, Dept of
Treasury
Urban Parks Agency
Victims Compensation Fund
Water Resources, Department of

OTHER GENERAL GOVERNMENT AGENCIES

Aboriginal Land Council - NSW
Adult Migrant English Service
Agriculture Scientific Collection Trust
Air Transport Council
Anzac Memorial Building Trustees
Art Gallery of NSW Foundation
Audit Office (NSW)
Australia Day Council
Building Services Corporation
Cancer Council (NSW)
CB Alexander Foundation
Chipping Norton Lake Authority
City West Devt Corpn
Commercial Services Group (CSG)
including:
- Govt Information & Advertising
- Govt Printing
- State Fleet M/V Leasing
- NSW Supply
- Q Stores
- State Mail Services
- Telecommunications

Crown Commercial Activities
Dairy Corporation (NSW)
Dams Safety Committee
Darling Harbour Authority
Drug Offensive Foundation
Eastern Creek Raceway
Education and Training Foundation
Election Funding Authority-NSW
Electricity Council of NSW
Entertainment Industry Interim Cncl
Environmental Education Trust
Environmental Research Trust
Environmental Restoration and Rehab Trust
Environ Planning & Assessment Act
Erudition Authority
Farrer Memorial Research S'hip Fund
Financial Institutions Commn NSW
Fisheries Administration Ministerial Corpn
Forestry Commission (State Forests, NSW)
Gas Council of NSW
Geological and Mining Museum Trust
Government Actuaries Office
Government Agencies (Combined) - State Bank
Government Records Repository - Archives
Greyhound Racing Control Board
Harness Racing Authority
Health Foundation of NSW
Heritage Act-Corpn Sole
Home Purchase Assist Fund
Home Purchase Assistance Authority
Honeysuckle Devt Corp
Housing Planning & Urban Affairs, Ministry
HPAA/FANMAC Combined Trust (DORMANT-via HPAF)
Hunter Catchment Mgt Trust
IMC - Insurance Ministerial Corpn NSW
Industrial Ballots & Local Govt Electns
Internal Audit Bureau
Lake Illawarra Authority
Land and Housing Corporation (NSW)
also known as Dept of Housing
Lands Title Office
Library Council of NSW
Lord Howe Island Board
Meat Industry Authority (NSW)
Mine Subsidence Board
Mines Rescue Board
Ministerial Development Corpn
Ministerial Holding Corpn (Hunter Water Corp)
Motor Accidents Authority
Protective Commissioner
Psychiatry Institute NSW
Public Trustee (Office Admin A/C only)
Public Works NSW
Real Estate Services Office (inc Rental Bond Brd)
Registrar of Encumbered Vehicles
Registry of Births, Deaths & Marriages
School Furniture Complex
Science & Technology Council-NSW
Soil Business (CALM)
Somersby Park Ltd
Sporting Injuries Committee
State Compensation Court
State Sports Centre Trust
Sydney Cove Redevelopment Authority
Sydney Organising C'tee-Olympic Games
Technical Education Trust Fund
Telco (Govt Telecommn Authority)
Treasury Corpn-NSW
Upper Parramatta Catchment Trust
Valuer General's Office
Vocational Education & Training Accredn Board
Workcover Authority
Workers' Comp (Broken Hill) Act
Workers' Comp (Dust Dis) Bd

STATE GOVERNMENT TRADING ENTERPRISES

Electricity Distribution Authorities
- Central West Electricity
- Illawarra Electricity
- Monaro Electricity
- Murray River Electricity
- Murrumbidgee Electricity
- Namoi Valley Electricity
- New England Electricity
- NorthPower (Oxley Elect)
- North West Electricity
- Northern Riverina Electricity
- Northern Rivers Electricity
- Ophir Electricity
- Peel Cunningham Electricity
- Prospect Electricity
- Shortland Electricity
- South West Slopes Electricity
- Southern Mitchell Electricity
- Southern Riverina Electricity
- Southern Tablelands Electricity
- Sydney Electricity
- Tumut River Electricity
- Ulan Electricity
- Western Power - Macquarie

Broken Hill Water Board

Cobar Water Board

Fish River Water Supp

Hunter Water Corpn

Irrign Area-Coleambally

Irrign Area-Murrumbidgee Region & Districts

Jenolan Caves Reserves Trust

Lotteries NSW

Maritime Services Board

Newcastle Internatl Sports Centre

Newcastle Showground Exhbn Centre Trust

Pacific Power (Elcom)

Parramatta Stadium Trust

Property Services Group

State Rail Authority

State Transit Authority

Sth-Wst Tab'lands Wtr Supp

Sydney Cricket & Sports Ground Trust

Sydney Market Authority

Sydney Opera House Trust

Sydney Water (prev Water Board)

Teacher Housing Authority

Totalizator Agency Brd (TAB)

Waste Recycling & Processing Services

Wollongong Sports Ground Trust

Zoological Parks Bd of NSW

EXCLUDED PUBLIC SECTOR AGENCIES

Architects Board of NSW
Banana Industry Committee
Barristers Admission Bd
Bldg & Cons Ind Ls Pay Corp
Coal & Oil Shale Mine Workers Super Trib
Coal Mining Industry LSL Trust
Coastal Council NSW
Dairy Industry Conference
Dental Board
Dried Fruits Board NSW
Dumaresq-Barwon Border Rvrs Comn
ICAC Superannuation Fund
Joint Coal Board
Lotto Act - Prize Fund
Medical Board - NSW
Mktg Board - Central Coast Citrus
Mktg Board - NSW Grains
Mktg Board - Rice
Mktg Board - Tobacco Leaf
Mktg Board - Wine Grapes
Mktg Comm - Kiwifruit
Mktg Comm - MIA Citrus Fruit
Mktg Comm - Processing Tomato
Motor Vehicle Repair Industry
NSW Commercial Fishing Advisory Council
Optical Dispensers Licg Board
Parliamentary Contribution Super Scheme
Pathology Labs Accreditation Board
Pharmacy Board - NSW
Public Sector Executive Super Board
Public Sector Executive Super Plan
Public Trustee (Trust monies)
Regn Board - Chiropractors & Osteopaths
Regn Board - Dental Technicians
Regn Board - Nurses
Regn Board - Optometrical
Regn Board - Physiotherapists
Regn Board - Podiatrists
Regn Board - Psychologists
Solicitors' Admission Board
State Authorities Super Board
Surveyors Board NSW
Tow Truck Industry Council
University Council - Macquarie
University Council - New England
University Council - Newcastle
University Council - NSW
University Council - Technology
University Council - Wollongong
University of Western Sydney
University Senate - Sydney
University Senate - Charles Sturt
Veterinary Surgeons (Board of)
Wild Dog Destruction Bd

* **ASSETS – VALUATION OF PHYSICAL NON-CURRENT ASSETS AT FAIR VALUE** (PD2008_013)

The Valuations of Assets policy has been tailored to NSW Health needs with reference being made to the Department's 3 yearly revaluation policy, the need to engage external valuations, the recognition of heritage assets at "written down replacement" of a modern equivalent asset, the exclusion of Plant & Equipment from revaluation requirements, the expectation that there are no investment properties. The updated policy should not require any change in accounting treatment with NSW Health and the prime benefit of its issue is to consolidate various instructions issued and extend the guidance available.

The Policy can be accessed at http://www.health.nsw.gov.au/policies/pd/2008/PD2008_013.html

SECTION NINE

GROUP SERVICES/COMMERCIALISATIONS

INTRODUCTION

ACCOUNTING AND REPORTING FOR BUSINESS UNITS

PRINCIPLES FOR FUNDING OF NSW PUBLIC HEALTH SECTOR PATHOLOGY SERVICES

SPONSORSHIPS

SPONSORSHIP PRINCIPLES INDEPENDENT COMMISSION AGAINST CORRUPTION DOCUMENT

INTRODUCTION:

(See section on pathology and linen service Business Units hereunder in this section.)

In 1984 and 1985 the Department issued advice concerning the establishment of Group Services which, in summary, required:

- Head Office approval prior to establishment
- accounts to be maintained on an accrual basis
- rates/charges to be set at a breakeven level after providing for employee and equipment reserves
- cash reserves for employee and equipment items to be remitted to the Department for deposit to Treasury holding accounts
- the funding of services from the charges raised with no separate injection of Government funding to supplement charges.

Following the issue of these instructions a number of new services have been established as group services (e.g. laundry, pathology) and "commercialised" services (e.g. accommodation).

During this period the Department's financial reporting/management policies have also been subject to substantial change due to Government and Departmental initiatives with such policies impacting directly and indirectly the situation as it existed in 1985. (Further reforms will occur in 1993/94 with monthly accrual and GFS reporting.)

During the course of the 1991 accounting controls review, it also became apparent that, whilst the majority of group services/commercial activities did have Head Office approvals, some did not. As well some "commercial" activities had a mix of income/expenditure between the Special Purpose Fund and the General Fund.

REVISED POLICY, BUDGET SECTOR ENTITIES

1. It is expected that services will be accounted for as On Budget activities unless exceptional circumstances exist.

   On Budget activities relate to services which rely on over 50% of income from the NSW Health system and/or the activities of the service are not self contained or separate from the core activities of the organisation (e.g. charges/services provided to public hospitals, areas, ambulance, etc.)

In categorising services, it needs to be recognised that scope may exist for the more efficient provision of services by the private sector and, therefore, contracting out opportunities must be identified (e.g. review of the provision of laundry services may highlight this fact in certain cases).

2. From 1 July 1992, the "Other Revenue" line item has operated on a 100% incentive scheme, therefore, enabling retention of excess collections over budget.

3. Unless it can be satisfactorily demonstrated that a venture is primarily concerned with the generation of revenues from outside the Health system it is the Department's expectation that each service will operate "on budget" to avoid the passing on of non budget sector charges to the public health sector e.g. payroll tax, sales tax, superannuation and dividend returns.

4. All of the NSW Health system will be required to produce accrual based annual financial statements from 1992/93.

   In respect of Group Services/Commercialisations, it is held that, at the latest, accounts should have been maintained on an accrual basis from 1 July 1992 and will form part of the **monthly** GFS reporting system to the Department from 1 July 1993. (Previously reports were produced by many sites on a four weekly cyclical basis only).

5. Retention of cash, equivalent to employee provisions, the level of linen stock depreciation and the depreciation on equipment with further allowance for technological improvements may continue for all group services recognised by the Department in, or prior to, the 1992/93 year. At this point no approval exists to establish reserves for new services.

   The cash equivalent is to be managed by Group Services in General Fund accounts with action taken to ensure that:

   - the cash equivalent is to be separately identified and interest thereon is to be calculated and applied to keep rates/charges low.

   - the level of cash maintained is consistent with replacement needs. No cash is to be specifically provided for expansion purposes unless the express approval of the Department is obtained prior to the initiation of such accumulations.

   - cash "reserve" funds may only be used for the purpose for which they are set aside - borrowing from such moneys or their use in any other manner is not permitted.

   - authority to expend funds from discrete cash reserves is restricted to the Chief Executive Officer/Board.

6. Group Service Accounts are to be kept which provide for separate expenditure and revenue budgets. Within the Group Service Accounts there should be no recredit to expenditure of other Health organisation revenues. Elimination to be effected for the purpose of the Consolidated Accounts should only take place at the Area or District level.

   In accordance with the Department's revenue policy which specifies the adoption of a revised formula for Government Cash Payments based on Net Appropriations revenues are to be retained locally to provide the cash needed to meet expenses. However in the case of Group Services or services established to efficiently provide centralised services to hospitals and health units the revenue may only be used to meet the expenses of the Group Service. **On no account must the operation of a Group Service which provides services principally to other sectors of the Health Service in a captive market situation use pricing above costs to secure funds for transfer to other activities.**

7. Group Service staff should be included in staff profiles to ensure that funding for award increases is provided in the normal manner. Group Service employees should also be included in Area/District staffing statistics.

8. Concerns expressed at the possible loss of "corporate/management identity" through absorption of services by Area Health Services and Hospitals may be allayed by the recognition of Group Services as budget units on DOHRS with accounting treatment as detailed in 6. above.

9. As a principle Group Services must operate on a cost neutral basis. Where a Group Service operating in an open competitive market generates a profit after all costs, and provisions are expensed the following options will exist to local management to use such accumulated profit.

   - it may be applied against over-expenditures or channelled towards identified area priorities including Capital projects

   - it may be carried forward as savings to the next year and used to benefit the users of the Service (which may extend to other Areas/Districts) through the adoption of reduced charges for that year.

   However, where a Service caters for a captive market where alternative sources are clearly not available or not permitted by the Department, the only avenues available are to utilise the surplus towards service improvements within the Group Service activity or, alternatively reduce the charges subsequently raised on hospital users.

10. Where an area wishes to establish a new service, Departmental approval must be obtained through the submission of a business case which identifies the benefits as opposed to the separate contracting of services.

11. The financial statements of Group Services will form part of the annual consolidated financial statement process as stipulated in the Accounts and Audit Determination. The Annual Reports of Areas and Districts should include coverage of group service activities including specific comment on cash held to cover leave liability and equipment/lines replacement.

12. Eliminations are to be effected within parent Areas/Districts for Group Service transactions which relate to that particular Area/District. Details of Other Intra Health transactions are to be identified in monthly/annual reports to the Department for further elimination actions.

REVISED POLICY, NON BUDGET SECTOR ENTITIES

1. Only in exceptional circumstances will the Department authorise Group Services/ Commercialisations to operate off budget.

2. Prior to any approval being given it would be necessary to demonstrate that the activities have strong commercial potential or are currently engaged in active competition with the private sector.

3. Those services established as commercial in addition to satisfying the income criteria will also need to be able to operate on a level playing field. In this respect they will, in all likelihood, be required to pay payroll tax, sales tax, and dividend returns to Treasury (to provide a return on equity invested by the State) in addition to superannuation liability.

4. In respect of superannuation liability all commercial services are now expected to assume the unfunded employer liability in their financial statements and take action to extinguish that liability with the superannuation authority.

5. It should be noted that the services operated previously were quasi commercial at best and it is understood that in some instances the level playing field charges were deliberately avoided by practices such as meeting all employee costs from Area/ District payrolls on a recoup basis to ensure that superannuation accounts were not separately rendered. These actions cannot be countenanced and, if it is maintained that a service should continue to operate off budget all such costs must be absorbed by the service without adversely impacting the cost charged to NSW public hospitals.

6. The Department will maintain a register for all such services and will require the receipt of annual financial statements including a specific statement on cash reserves for those services accepted as non-budget activities.

ACCOUNTING AND REPORTING FOR BUSINESS UNITS IN NSW HEALTH (by DoH Letter 16/4/97)

The guidelines hereunder are to be adopted for business units from 1 July 1997 in respect of pathology and linen. (NB: Food Services are presently under consideration and may also be subject to the guidelines from 1 July 1997.)

Should your Health Service have pathology and linen Business Units which you consider should not be subject to the guidelines, an exemption should be sought outlining the reasons why the Unit should be exempted.

PRINCIPLES AND GUIDELINES

The objective of these principles and guidelines is to upgrade the accounting and reporting systems of the NSW health system to cover the business units providing patient care related and support services to hospitals. The aim is to establish best practice accounting and reporting standards and benchmarks for a range of patient care related and support services and products including costs and prices.

Business units are to be established for public service providers such as pathology, linen, radiology, nuclear medicine, food, engineering, maintenance, and pharmacy. The business units will need to establish accounting and reporting systems that will facilitate the production of financial reports prepared in accordance with Australian Accounting Standards and the Department's Accounting Manual. An on line DOHRS reporting structure will be set up to facilitate business units reporting on a regular and consistent basis. This will assist the development and the publication of benchmark data. The generation of costing information through this process will be brought together with other systemwide activities and initiatives in the development and publication of benchmark information.

The purpose of issuing these guidelines on accounting arrangements is to ensure that there are uniform principles in allocating and calculating costs for each individual business unit on a statewide basis. This will allow comparison between units on a consistent basis in full knowledge that a standard accounting and costing structure is in place.

The following are broad principles to guide accounting and reporting practices of business units:

BROAD PRINCIPLES

- **Definition of Business Unit**

A business unit is a discrete entity that provides services in support of patient care in hospitals and other health facilities in the Area Health Services. The services provided include the following: pathology, linen, food, engineering, maintenance, radiology, nuclear medicine,

pharmacy, other services considered by the Health Economic Reform Committee - Networking Committee, and any other units as may be specified from time to time by the Director General of NSW Health. **Attachment A** provides a list of existing units in pathology and linen services. Other Business Units to be included in standardisation and benchmarking will be determined and advised in the subsequent issues of these guidelines.

The business unit is a financial entity but not a separate legal entity and forms part of management accountability of the Area Health Service. Business units have total responsibility for service efficiency, quality and customer service for their particular service. Departmental approval is required prior to establishment of new Business Units.

- **Assignment of Costs to Appropriate Cost Centres**

All direct and indirect costs associated with the production of the goods or the delivery of services in business units should be allocated to the Business Unit.

The costs should include the following:

- all direct material costs;
- all indirect material costs;
- all direct labour costs;
- all indirect labour costs including insurance, superannuation, workers compensation and leave provisions;
- all utility charges including electricity, water and telephone;
- corporate overheads including information services, human resources, payroll services, financial services, audit and executive management;
- any costs incurred centrally, eg, provision of meals to staff provided free or on a subsidised basis;
- depreciation costs and other costs of capital;
- transport costs.

The above list is not exhaustive and there may be other costs that should be included. Should there be any cost items other than the above, these should to be identified and reported on.

Cost centres will need to be established within Business Units to allow costs to be appropriately accounted for. The NSW Costing Standards Manual, Version I provides more detailed description of these costs. Appendix D of the Manual provides cost allocation options and statistics and service weights for various cost components and cost centres.

Example:

Business Unit	Cost Centre	Cost Allocation Options	
		Preferred	Default
Pathology	General Pathology	usage per patent * actual costs	clinical laboratory service weight per separation
	Anatomical	usage per patient * actual costs	hispathology service weight per separation
	Microbiology	usage per patient * actual costs	microbiology service weight per separation
	Haematology	usage per patient * actual costs	haematology service weight per separation

- **Program Structure**

There is no Program Budget Structure that deals specifically with support services. Currently, program information is recorded against the patient's episode in the hospital's patient administration system. Patient administration systems store information on the financial program relevant to each patient episode of care. This information would have to be referred to in order to facilitate the split up of the cost output by program.

To the extent possible, direct patient cost data should be dissected by program. e.g., Population Health Services, Primary and Community Based Services, Outpatient Services, Emergency Services, Overnight Acute Inpatient Services, Same Day Acute Inpatient Services, Teaching and Research, Mental Health Services and Rehabilitation and Extended Care. (Refer to the document *"Reform of the Program Structure for NSW Health"* issued in June 1995 for definition of programs, inclusions and exclusions and treatment of boundary issues.)

Accordingly as the principle of a business unit is to charge for services without being allocated a cost centre budget, it will be necessary that existing support services budgets (where they exist) be desegregated to direct patient care areas and hence programs. This will enable transfer pricing to occur in exchange for business unit services.

- **Employee Entitlements**

  Salaries and Wages, Annual Leave, Sick Leave and On-costs

  Liabilities for salaries and wages, annual leave and vesting sick leave are recognised and measured as the amount unpaid at the reporting date at current pay rates in respect of employees' services up to that date.

  Unused non-vesting sick leave does not give rise to liability as it is not considered probable that sick leave taken in the future will be greater than the entitlements accrued in the future.

  The outstanding amounts of workers' compensation, insurance premiums and fringe benefit tax, which are consequential to employment, are recognised as liabilities and expenses where the employee entitlements to which they relate have been recognised.

  Superannuation

  Existing funding arrangements for employer's superannuation will continue under the proposed arrangement, i.e., the liability will be met by the Treasury.

  The superannuation expense will, however, need to be included in the full costs of the Business Units and is to be determined by using the formula specified in the Treasurer's Directions. The expense for certain superannuation schemes (ie., Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie., State Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

  Long Service Leave

  Long service leave measurement is based on the remuneration rates at year end for all employees with five or more years of service. It is considered that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

- **Revenues**

For the purpose of promoting responsibility and accountability, all monies received, including grants and donations, are recognised as revenues. Grants and donations are considered revenues when the business units obtains control over the asset. Control over the asset is normally obtained upon receipt of cash.

All revenues generated by the units are to be retained by the units. This is to include any interest earned on cash reserves.

- **Charge Out Rate**

The determination of charge out rate is an independent business unit decision. Whatever method of calculation the business unit deems appropriate, eg; user pay "fee for service", use of sliding scale or marginal pricing, or any other form of pricing contract, the principle that revenues should cover all direct and indirect costs of providing the service should apply.

In determining charge out rates, costs are to be discounted for block funding grants needed to cover Statewide type services (e.g., forensic pathology).

Excluding block grant offsets and assumed Crown liabilities, all costs incurred in providing the service, inclusive of all overhead costs, must be accounted for and considered in determining the charge out rates.

The business units will determine a list of prices on different products with prices approved by the CE, or delegate, as appropriate. It is not the intention for units to produce a comprehensive price list for all products or services nor one single price for all its products. However, it is expected that units will establish a pricing range for its products.

Charge out rates for non NSW Health activities are to include a component to cover assumed Crown liabilities.

- **Block Grants**

Some business units due to historical reasons have provided a statewide service for which a pricing allocation is inappropriate. In such cases the host Area is to continue to provide a block grant to cover costs.

Any block grants are to be reviewed to ensure devolvement is not possible. Annual financial statements are to include by way of Note the purpose and value of any block grant. Block grants are to be treated as income although for purposes of determining the charge rate, a corresponding cost offset is required.

- **Financial Statements**

Financial statements are to be prepared for each unit in accordance with Australian Accounting Standards on a monthly accrual basis. Each unit is to prepare a set of annual financial statements certified or audited as determined by the Department for that category of business unit.

Financial statements should include:

- Operating Statement;
- Statement of Financial Position

The business units' financial statements are to present the true and fair view of its financial position and results of operations. Where appropriate, business units are to include additional information (accompanying notes) and explanations to ensure that the financial statements are not misleading.

- **Capital Funding**

When requiring capital funds in excess of $5000, each unit must:

- put forward a business case for the funds, outlining how the funds are to be used and how the project is to be sourced;

- include an economic appraisal of the project outlining a cost benefit analysis. For comparison purposes, appropriate discount rates must be used as determined by NSW Treasury for the evaluation of capital projects. The project must have a positive net present value;

- the proposal must comply with any Capital Charging Policy of the Department and include a repayment schedule including interest on principal of any loan funds required.

- **Acquisition of Assets**

The cost method of accounting should be used for the initial recording of all acquisitions of assets controlled by the business units. Cost is determined as the fair value of the assets given as consideration plus the cost incidental to the acquisition.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition. Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction.

- **Plant and Equipment**

Plant and equipment costing $5000 and above individually are capitalised.

- **Depreciation of Non Current Physical Assets**

Depreciation should be provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life. Land is not a depreciable asset.

- **Leased Assets**

A distinction should be made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits.

Where a non current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the inception of the lease. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the operating statement in the period in which they are incurred.

It should be noted that Health Services have no authority to enter into new finance leases.

- **Inventories**

Inventories are to be stated at the lower of cost and net realisable value. The cost is calculated using the average cost or "first in first out" method.

- **Profit/Loss**

As a business unit, the accounting principle of a "going concern" is appropriate and therefore profit/losses are anticipated due to changes in volumes or costs over estimates. Profits can be used to minimise subsequent years' price increases. Losses will require a reduction in costs and/or an increase in prices.

The business units need to balance price increases against financial benchmark indicators determined for that particular service.

- **Accumulated Surplus**

The Department will monitor accumulated surpluses and profit/loss results. Generally, surpluses should be used for the relevant business unit. Where an Area wishes to use a surplus for an unrelated activity to the business unit, Department approval is required.

- **Reporting**

All Business Units are to be incorporated within the General Fund. The business units are required to forward reports of activity and financial operations in DOHRS, ORACLE and SunSystems on an annual basis. Such facility will be set up in the reporting system by August

1997 and business unit reporting will commence in June 1998 for the financial year 1997/98 report. The input and report formats will be issued to the Areas/business units separately.

- **Bank Accounts**

Business Units are not to operate separate bank accounts. The overall General Fund Bank Account should incorporate the activities of all Business Units within the health service.

- **Benchmarking**

The networking implementation committees will agree upon appropriate benchmarks for all units to allow for meaningful comparison between units, such benchmarks to be a combination of financial and non-financial. All financial indicators must be capable of extraction from the standard accounting systems. Benchmarking information will be provided quarterly to the Department and fed back to all entities and published by similar business units.

- **Timetable**

New costing and pricing structures are expected to be implemented from 1 July 1997 with benchmarking to commence from that date. The DOHRS, ORACLE and SunSystems will be updated for business units by August 1997.

ATTACHMENT A

LINEN SERVICE BUSINESS UNITS

LINEN SERVICE	ADDRESS	PHONE/FAX
Western Riverina	PO Box 1013 GRIFFITH NSW 2680	tel (02) 6962 1266 fax (02) 6964 1587
New England	PO Box 83 TAMWORTH NSW 2340	tel (02) 6766 5655 fax (02) 6766 1215
Northern Rivers Hospital	PO Box 145 LISMORE HEIGHTS NSW 2480	tel (02) 6624 3899 fax (02) 6625 1138
Parkes	PO Box 103 PARKES NSW 2870	tel (02) 6862 1611 fax (02) 6862 3921
South West Hospitals	PO Box 159 WAGGA WAGGA NSW 2650	tel (02) 6931 4801 fax (02) 6931 4802
Central Coast	PO Box 361 GOSFORD, NSW 2250	tel (02) 4320 2111 (02) 4320 3261 fax (02) 4325 0566 (02) 43203 244
Concord	Hospital Road CONCORD, NSW 2139	tel 9736 7911 fax 9736 6991
Eastern Suburbs	Prince Henry Hospital Anzac Pde LITTLE BAY, NSW 2036	tel 9694 5815 fax 9311 4393
Lower Hunter Hospitals	PO Box 154 CESSNOCK NSW 2325	tel (02) 4990 1166 fax (02) 4991 3291
Royal North Shore Hospital	RNS Hospital Pacific Highway ST LEONARDS NSW 2065	tel 9438 7523 fax 9438 7779
Illawarra	PO Box 131 PORT KEMBLA, NSW 2505	tel (02) 42761 991 fax (02) 42761 993
Parramatta	PO Box 2062 NORTH PARRAMATTA, NSW 2151	tel 9683 3066 fax 9683 6731

Bega District Hospital	PO Box 173 BEGA, NSW 2550	tel (02) 6492 9111 fax (02) 6492 3274
Broken Hill Base Hospital	PO Box 457 BROKEN HILL, NSW 2880	tel (080) 880 465 fax (080) 871 295
Central West	PO Box 257 ORANGE NSW 2800	tel (02) 6362 4488 fax (02) 6363 5692
Dubbo Base Hospital	Dubbo Base Hospital Linen Service DUBBO NSW 2830	tel (02) 6885 8621 fax (02) 6882 9034
Goulburn	PO Locked Bag No 11, GOULBURN NSW 2580	tel (02) 4827 3399 fax (02) 4827 3471
Macleay Valley	River Street KEMPSEY WEST NSW 2440	tel (02) 6562 6155 fax (02) 6563 1557

ATTACHMENT A

PATHOLOGY BUSINESS UNITS

BUSINESS UNIT	ADDRESS	PHONE/FAX
CENTRAL COAST AREA	PO Box 361	tel (02) 4320 3375
CENTRAL SYDNEY AREA HEALTH SERVICE	Director of Laboratory Services Royal Prince Alfred Hospital Level 6 Renal Laboratory Missenden Road Camperdown NSW 2050	tel (02) 9515 6600 fax (02) 9515 6250
FAR WEST HEALTH SERVICE	Laboratory Manager Gribbles Pathology C/- Broken Hill Hospital Thomas Street Broken Hill NSW 2880	tel (080) 880 2063 fax (080) 880 7769
GREATER MURRAY HEALTH SERVICE	General Manager C/- Southwest Pathology PO Box 159 Wagga Wagga NSW 2650	tel (02) 69386686
HUNTER AREA HEALTH SERVICE	Director of Laboratory Services Hunter Area Pathology Services Locked Bag 1 Hunter Regional Mail Centre Newcastle NSW 2316	tel (02) 4921 4444 fax (02) 4921 4440
ILLAWARRA AREA HEALTH SERVICE	Department of Anatomical Pathology Level 6 Wollongong Hospital Illawarra Path Centre Level 5 Wollongong Hospital Crown St, Wollongong NSW 2500	tel (02) 4227 3797 fax (02) 4220 1401 tel (02) 4220 1528
MACQUARIE AREA HEALTH SERVICE	Director of Pathology Orana Pathology Service PO Box 739 Dubbo NSW 2830	tel (02) 6885 8747

MID NORTH COAST HEALTH SERVICE	Director of Clinical Services PO Box 126 Port Macquarie NSW 2444 Director of Laboratory Services Mid Nth Coast Pathology Service 30-38 York Street Taree NSW 2430	tel (02) 6583 0721
MID WESTERN HEALTH SERVICE	Head of Pathology PO Box 319 Orange NSW 2800	tel (02) 6360 5295
NEW CHILDREN'S HOSPITAL SERVICE OF NSW	Head of Pathology Royal Alexandra Hospital for Children PO Box 3515 Parramatta NSW 2124	tel (02) 9845 3295 fax (02) 9845 3332
NEW ENGLAND HEALTH SERVICE	Laboratory Manager Johnston St, Armidale NSW 2350 C/- ICPMR att: Laboratory Manager Mr Murray Austin Armidale Hospital ARMIDALE NSW 2350 & SYDPATH at MOREE NSW 2400	
NORTHERN RIVERS HEALTH SERVICE	Director of Laboratory Services PO Box 419 Lismore NSW 2480	tel (02) 6620 2907
NORTHERN SYDNEY AREA HEALTH SERVICE	General Manager (acting) Pacific Laboratory Medicine Services PALMS, Royal North Shore Hospital Pacific Highway ST LEONARDS NSW 2065	tel (02) 9926 8086 fax (02) 9926 6395
SOUTH EASTERN SYDNEY AREA HEALTH SERVICE	Executive Director South Eastern Area Laboratory Services (SEALS) Prince of Wales Hospital High Street, Randwick NSW 2031 St Georges Hospital Pathology Department	tel (02) 9382 9054 fax (02) 9382 9098

SOUTH WESTERN SYDNEY AREA HEALTH SERVICE	Director South Western Area Pathology Service (SWAPS) Locked Bag 90 Liverpool NSW 2170	tel (02) 9828 5001 fax (02) 9828 5015
SOUTHERN AREA HEALTH SERVICE	Director, Medical and Clinical Services Locked Mail Bag 11 Goulburn NSW 2580 Sen Scientist Pathology Queanbeyan Hospital PO Box 729 Queanbeyan NSW 2620	tel (02) 4827 3802 tel (02) 629 89211
WENTWORTH AREA HEALTH SERVICE	Director of Pathology Nepean Hospital Great Western Highway Penrith, NSW 2750 Director of Haematology Nepean Hospital	tel (02) 4724 2000
WESTERN SYDNEY AREA HEALTH SERVICE	Director of Laboratory Services ICPMR C/- Westmead Hospital Cnr Hawkesbury & Darcy Rds Westmead NSW 2145	tel (02) 9845 6188 fax (02) 9891 6908

PRINCIPLES FOR FUNDING OF NSW PUBLIC HEALTH SECTOR PATHOLOGY SERVICES (PD2005_533)

1 INTRODUCTION:

1.1 All health services are required to operate their pathology services (one per health service) as a Business Unit.

1.2 The accounting and reporting guidelines for business units are prescribed in Section 9 of the Area Health Service and Public Hospitals Accounting Manual. Revenues collected will include all facility fees and research monies (exclude Special Purpose & Trust Account (SP&T) funds) and expenses will include all direct and indirect costs.

1.3 The Accounting Guidelines require a determination of charge out rates (or Prices) on different products with prices to be approved by the CE, or delegate, as appropriate. Charge out rates for non-NSW Health activities are to include a component to cover assessed Crown Liabilities.

1.4 The Peak Pathology Council has considered the matter of charge out rates for Pathology Services to establish a standard methodology across all services but at the same time recognising the right of Area Boards or Area Networking Boards to make the final decision on prices.

1.5 When a conflict in policy exist, the contents of this circular takes precedence over existing NSW Department of Health policy in regards to NSW Public Health Sector Pathology charging.

2 PATHOLOGY CHARGE OUT PRICING PRINCIPLES:

2.1 All pathology services will have available for distribution to users a schedule of rates and prices for provided services such a schedule to be predominantly based upon the Pathology Service Table (PST) (See Clause 3 below for further explanations). Only one charge can be raised for any one test, such a charge is to cover both the performance and interpretation.

2.2 Where the NSW Department of Health issues any direction on pathology fees that direction will be observed and take precedence over Principle 2.1 above.

2.3 All services provided by pathology services will be charged in accordance with clauses 2.1 and 2.2 above unless:

- a separate arrangement exists between the services and user (including Networking Agreements);
- a health service provides a block grant to cover services not normally associated with the PST (eg forensic pathology, HIV confirmation).

2.4 Where a reasonable number of tests are being referred out from a pathology service in one health service to another health service, the referring Area Pathology Service may periodically undertake a "contestability" study to determine if it would be more effective or efficient to do such tests in its own laboratories, such studies to be fully documented by a business case with the final decisions to be made locally. It is emphasised that the selection of providers external to the Area should remain subject to any agreements existing concerning "networking" of pathology services.

2.5 Pathology services have a responsibility to ensure timely provision of invoices and other information to enable a journalisation of internal revenues or claims to be issued to other health services and users.

2.6 Health services will process internal journals upon receipt from their pathology service. Payments by one health service to a pathology service in another health service for services provided will be within normal trading terms (ie within 45 days of receipt of invoices).

2.7 Where a dispute over payment exists within a health service, that dispute will be resolved in accordance with instructions issued by the Chief Executive Officer. Where a dispute over payment exists between two health services that will be resolved in accordance with advice issued by the NSW Department of Health or where a dispute over payment exists with a non NSW Health user, normal debt recovery procedures are to be followed.

3 Guidelines for Determination of Pathology Charges:

3.1 Where the services are of a type described in the PST of the Medicare Benefits Schedule (MBS) the following should apply:

3.1.1 Unless otherwise agreed and stated explicitly by the provider, the service will be provided in accordance with the description of the item in the PST.

3.1.2 The episode cap ("grand cone") should not to apply for any episode to a public hospital inpatient or non-inpatient

Note:
This is consistent with intention of the Health Insurance Act B all of these services are for "referred" patients.
The episode cap only applies to pathology episodes arising from unreferred attendances)

3.2 Where the provider and user are within the same health service the arrangements fundamentally are for mutual agreement and subject to the approval of the CE, or delegate. It is recommended that these arrangements be detailed in a Service Level Agreement, which should be in accordance with the following guidelines:

3.2.1 Where the fee is expressed as a percentage of the current MBS fee that percentage should be determined after due process to determine what is required for adequate total cost recovery and not arbitrarily. This should include not only direct costs but also an appropriate moiety for equipment replacement and other infrastructure costs as specified in the "Accounting and Reporting Guidelines for Business Units"

3.2.2 When charging internally an "episode fee" should be used in addition to the test fee(s) the Medicare Benefits Schedule (e.g. "coning rules" and "inbuilt multiple services rule") should not apply automatically but the issues which these present should be addressed explicitly in the policy document approved by the relevant Area Health Service.

3.3 Where the provider and user are in different health services and the services are eligible for a medicare rebate the requester (user) shall take all reasonable measures to ensure that the request conforms with the requirements of the Health Insurance Act and its Regulations and that the provider will render the service strictly in accordance of the provisions of that Act.

3.4 Where the provider and user are in different health services and the person is ineligible for a Medicare rebate (and no NSW Department of Health policy directive applies.)

3.4.1 An agreement in advance involving the requestor, provider and funder of the service is essential, and

3.4.2 Irrespective of the identity of the original requestor a copy of the results of such tests shall be provided to the Area Pathology Service responsible for the geographic area in which the request was originated unless prohibited by law or an administrative decision or by agreement.

3.4.3 The Area Pathology Service performing the test(s) shall invoice the Area Pathology Service responsible for the geographic area in which the request was originated for payment so that the Area Pathology Service performing the tests can recover the full cost of the referred test. This as a rule would only be the charge from the referral laboratory but in some situations a "handling charge" would also apply. The referring Area Pathology Service needs to identify a source of local funds (consistent with local policy) to cover the cost of referred tests.

3.5 Where the service is of a type, which though not listed in the PST can be described in a form similar to such an item, the following should apply both within and between health services:

3.5.1 The description of the service will be agreed explicitly and in writing by the provider and user(s) of that service (unless determined otherwise by a NSW Department of Health Policy)

Notes:

(1) Reference may be made to the item descriptions in the Centre for Clinical Epidemiology and Biostatistics (CCEB)/The Royal College of Pathologist of Australasia (RCPA) benchmarking survey to assist with service definition

(b) Non-PST "Class A" tests delineated by the Genetics Services should be included in this category.

3.5.2 The fee will be agreed in advance in writing between the provider(s) and user(s) of the service (unless determined otherwise by a NSW Department of Health Policy).

3.5.3 In arriving at a fee in this clause the charge shall be fair, competitively neutral and have regard to indirect and overhead costs.

3.6 Where it has been determined that some activities provided by Area pathology Services are to be funded other than using the PST approach:

3.6.1 The arrangements should be set out explicitly by either a specific NSW Department of Health Policy or by a published Memorandum of Understanding between all relevant parties.

3.6.2 The Services covered by this clause may include:

- provision of clinical services eg clinical haematology
- teaching
- infection control
- surgical audit
- mortuary services including conduct of autopsies and relevant laboratory testing of autopsy material
- public health testing and advisory activities
- advanced "limited use" tests, eg Non-PST "Class B" tests

3.7 This documentation should include

- an adequate description of the activity/activities (see clause 14.2 for examples)
- the organisation(s) funded to provide them
- the dollar amount of funding allocated and the number of services to be provided for this funding.
- the identity of the person(s) or bodies corporate who may access these services without attracting a "user charge" as specified in clauses 3.5 and 3.6 above.
- the duration for which the arrangement remains in force and the circumstances which would result in re-negotiation between the funder and the provider.

4 Transitional Arrangements for clauses 3.5 and 3.6:

4.1 Where parts of Clauses 3.5 and 3.6 impact upon more than one health service, a service level agreement must exist between the provider health service and the user.

4.2 Provider and referring health services are not to take unilateral action that will adversely affect the other.

4.3 Where agreement cannot be reached (including a meeting of relevant Chief Executive Officers) the matter is to be referred to Finance & Commercial Services of the Department for consideration of resolutions.

4.4 Departmental health policies exists as at 1 July 2000 for the following services:

- Genetics (Specialised Testing for Genetic Disorders)
- HIV Testing (in accordance with the formula in "A Guide to Aids program for Area Health Services and Districts 1993/94" as varied from time to time by changes to Department policy).

Further enquires are to be referred to Finance Branch (02) 9391 9047 or (02) 9391 9178 of the Department who, if appropriate, will seek expert advice from the Peak Pathology Council.

5 Charging of Pathology Services

5.1 The attached schedule outlines the NSW Department of Health's charging policy as reflected in the Fees Manual for Public Hospitals, Departmental Circulars and letters issued by the Department's Finance Branch.

Charging Policy for Pathology Services

Non Admitted Patients

Patient Classifications	Notes	Charging Policy
Public (Including Prisoners) and all no charge patients eg reciprocals	**(4)**	***Within Health Service*** Rates by mutual agreement approved by AHS Board *External to Health Service* Charge facility MBS rate
Privately Referred Non-Inpatients		Charge patient up to the MBS rate
Veterans' Affairs		***Within Health Service*** **Rates by mutual agreement approved by AHS Board** ***External to Health Service*** **Charge facility MBS rate**
Ineligible/Overseas	**(2)**	**Charge patient cost recovery**
Compensable **3rd Party (NSW)** **(Bulk Agreement)**	**(4)**	***Within Health Service*** **Rates by mutual agreement approved by AHS Board** ***External to Health Service*** **Charge facility cost recovery rate**
3rd Party **External NSW**	**(2)**	Charge insurer cost recovery rate
Workers Comp.	**(1)**	**Charge insurer occasions of service rate**
Other	**(2)**	**Charge insurer cost recovery rate**

Admitted Patients

Patient Classifications	Notes	Charging Policy
Private Patients		**Charge patient MBS rate**
Public (Including Prisoners) and other non chargeables eg reciprocals	**(4)**	***Within Health Service*** **Rates by mutual agreement approved by AHS Board** ***External to Health Service*** **Charge facility MBS rate**
Veterans' Affairs		**Charge Veterans' Affairs MBS rate**
Ineligible/Overseas	**(2)**	**Charge patient cost recovery**
Compensable **3rd Party (NSW)** **3rd Party (External NSW)** **Workers Comp.** **Other**	**(4)** **(3)** **(3)**	***Within Health Service*** **Rates by mutual agreement approved by AHS Board** ***External to Health Service*** **Charge facility cost recovery rate**

All Patients

Service is of a type not listed in the PST (but similar)
Agreed in advance with the user of the service.

Public Health, infection control etc (Clause 14)
Memorandum of Understanding between all relevant parties.

Notes:

(1) By legislation only the occasion of service (OOS) rate can be charged which is tied to the type of hospital eg metropolitan referral, metropolitan non-referral.

An alternative to having the Group Pathology Service (GPS) charge the insurer would be to have the GPS charge:

Within Health Service
- Charge facility rates by mutual agreement approved by the AHS Board

External to Health Service
- Charge facility cost recovery rate

with the facility charging the insurer the OOS rate appropriate to the facility.

In respect to all compensable patients direction is required if GPS charge facility cost recovery which is the present policy or insurers at OOS cost recovery rate whichever is the higher.

(2) The Department of Health in its allocation letter 97/98 indicated that staff specialists could set own fees in respect of services they provide to ineligible and compensable patients or the OOS rate whichever is the higher.

(3) The accommodation rates set by the Department of Health incorporate all diagnostic services. Charges have to be raised against facility.

(4) Present policy indicates that charge is to be cost recovery rate

CHARGING POLICY FOR CLINICALLY REQUIRED SPECIALISED GENETICS TESTS WHICH ARE NON MEDICARE BENEFITS SCHEDULE ITEMS (PD2005_335)

1. Introduction

In accordance with the recommendations of *Specialised Testing for Genetic Disorders*, NSW Health, May 2000, **http://www.health.nsw.gov.au/health-public-affairs/publications/gentest/** charging may be introduced for all specialised genetics tests which are non-Medicare Benefits Schedule items, with the exception of newborn screening and some biochemical genetic tests which are funded separately.

Area Health Services are to meet the cost of testing from within their global budget allocation, for clinically/medically required specialised genetic testing for non-Medicare Benefits Schedule items for:

- admitted public patients
- non-admitted public patients, and,
- privately referred non-inpatients referred to a public sector specialist clinic

Except where indicated, arrangements are to be consistent with "Pathology Services - Principles of Funding of NSW Public Health Sector" PD2005_533
http://www.health.nsw.gov.au/policies/pd/2005/PD2005_533.html

1.1 **Specialised tests for genetic disorders** refers to tests which are non Medicare Benefits Schedule items performed by public hospital laboratories and funded by the NSW Health System. The costs of tests are generally in the range of $100 to $2000 per test, and more in rare instances.

These tests are used to:

- diagnose a genetic disorder, including a prenatal diagnosis
- determine if a person is a mutation carrier for a disorder, or
- detect an inherited predisposition to a genetic disorder.

using the following techniques or processes:

- molecular genetic testing, including PCR based methods
- molecular cytogenetics testing procedures such as FISH testing
- biochemical genetic testing, including functional studies, but excluding first-line urine metabolic screening tests
- microsatellite instability and immunohistochemistry of tumours in cancer genetics testing

1.2 It is to be noted that the scope of this definition does not include tests for non-inherited disorders which may use the same testing techniques, for example the diagnosis of bacterial, viral or malignant conditions for therapeutic purposes, or testing for multifactorial disorders, which are the result of an interaction of multiple genes with environmental factors.

1.3 As specialised genetic testing is generally complex with low throughput, it is appropriate that most testing for the State's population is provided by a limited number of laboratories. It should be noted that the complexity of some testing might create a lengthy period to achieve a result. Some tests may need to be sent overseas and may incur transport costs. The exact cost of a test may not be known at the time of the request.

2. Charging policy within the public sector

2.1 Funding of testing
The following funding policy takes precedence over PD2005_533 "Pathology Services - Principles of Funding of NSW Public Health Sector"
http://www.health.nsw.gov.au/policies/pd/2005/PD2005_533.html

Area Health Services are to meet the cost of testing from within their global budget allocation, for clinically/medically required specialised genetic testing for non-Medicare Benefits Schedule items for:

- admitted public patients
- non-admitted public patients, and,
- privately referred non-inpatients referred to a public sector specialist clinic

The rationale for this variation to include privately referred non-inpatients of a public sector specialist clinic is that the lack of Medicare Benefits rebates and the lack of public patient clinics would unfairly discriminate against patients with, or at risk of, genetic conditions by imposing test costs on them. A public sector specialist clinic is a clinic managed and controlled by a Public Health Organisation as defined under ***the Health Services Act 1997*** (NSW).

2.2 Cost recovery processes

Other arrangements are to be consistent with "Pathology Services - Principles of Funding of NSW
http://www.health.nsw.gov.au/policies/pd/2005/PD2005_533.html

The laboratory performing the test shall invoice the facility/Area Health Service requesting the test so that the laboratory can recover the full cost of the test. Facility is defined as an Area Health Service, or its delegated authority, eg hospital, pathology ser vice or clinical unit. The facility/Area Health Service requesting the test needs to identify a source of local funds to cover the cost of the tests. The majority of tests are requested by a limited number of tertiary facilities for patients residing both within and outside the facility's geographic area. Where a facility/Area Health Service requests tests for patients residing outside its geographic area, the facility/Area Health Service requesting the test may make agreements with patients' Area Health Services of residence to recoup test costs in accordance with Section 3.4 of PD2005_533.

2.3 Responsibility for authorising tests

Testing is available to patients, in accordance with Genetic Testing, PD2007_066
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_066.html

Local arrangements are to be negotiated concerning clinical responsibility for authorising testing as well as budget responsibilities for approving test requests. This would most appropriately rest with the head of a clinical genetics unit or delegated staff member. Referral to public sector genetics services will provide the patient with clinical geneticist expertise not generally available in the private sector. It will not guarantee testing, as it will need to be assessed and prioritised according to clinical necessity.

In some instances, the specialty of genetics overlaps with other specialties for example, oncology, gastroenterology or neurology. Where this occurs it may be appropriate for responsibilities to rest also with such units.

2.4 Public patients where public sector services are not available

In circumstances where patients elect to be public patients but public hospital clinical or pathology collection services are not available, the Area Health Service may agree to meet the cost of testing by arrangement with requesting physicians or private pathology collection services. Written authority must accompany test requests so that the testing laboratory can bill the authorising Area Health Service, otherwise the patient is assumed to be private and would be billed accordingly (see Section 3 below). Services may not be available or accessible due to geographical or other circumstances, eg

- where public clinics, eg neurology or paediatrics are not provided in some rural areas
- where public pathology collection services are not available eg Port Macquarie and private pathology collection services are used
- Where private pathology collection services are used due to difficulties with access to public pathology collection eg referrals from disability services

2.5 DNA predictive testing for serious adult onset disorders which may reduce normal life expectancy

DNA predictive testing for serious adult onset disorders undertaken by NSW Health public hospital laboratories may be subject to special requirements, ie shall only be undertaken when requested by clinical geneticists or other specialists with expertise in the genetics of the specific disorder.

Generally these would be Class B tests (Appendix 1) as classified by the National Pathology Advisory Accreditation Council's document *Laboratory Accreditation Standards and Guidelines for Nucleic Acid Detection* http://www.health.gov.au/npaac/pdf/naagenetictest.pdf , ie

- diagnostic tests for which complex genetic analysis is required to identify mutations and for which negative test results also require detailed genetic counselling (e.g. hereditary cancer syndromes)
- predictive tests for untreatable adult onset conditions (e.g. Huntington's disease).

The rationale is that this type of testing raises complex genetic and psychosocial issues for the patient and is best provided through a multidisciplinary clinical and laboratory service to ensure appropriate clinical care and interpretation of the results and their implications.

2.6 Cost recovery processes and patient privacy and confidentiality

The above-mentioned Class B tests, carry with them special privacy considerations. Optimal patient care requires formal written consent and confidentiality procedures. On completion of testing the molecular genetics laboratory is to send the result report to the referring practitioner. The referring laboratory is to be advised for their records that testing has been completed and that the report has been issued to the referring practitioner. The advice to the referring laboratory will not include test results for reasons of privacy and confidentiality. The patient's name and address details may also be withheld, provided there is a sufficient audit trail including: laboratory episode number, broad test category, date of service, name of requesting clinician and test cost. The patient's postcode must be included.

3. Charging for Patients in the Private Sector

3.1 Private patients are defined as patients who consult with and have tests requested by general practitioners or specialists in private rooms outside public hospitals.

3.2 **Charging private patients -** Where public hospital laboratories provide specialised genetic/DNA tests which are non Medicare Benefits Schedule items to private patients, the patients will be responsible for their own test costs. The special requirements in 2.5 above are to be noted concerning requests for predictive testing through clinical geneticists and other specialists with expertise in the genetics of the specific disorder.

3.3 **Consent to testing -** Patients should consent to testing on an informed basis, in regard to their financial obligations as well as to the test and its implications. Before commencing testing, public hospital laboratories require all the information indicated on the template **Request Form** (Appendix 2) including an acknowledgement that the patient has been advised of the test cost and agreed to meet the cost. The laboratory may also require a copy of the clinical consent form to indicate appropriate test and specimen management.

3.4 **Provision of information about costs to the patient -** Concerning financial consent, the patient should be informed about the following:

- the test cost
- there is no Medicare rebate, and
- there is an alternative for testing without cost to the patient through the public sector genetics services (Appendix 3). It should be noted that the intent of this point is *not* to dissuade private practitioners or private laboratories from collecting and forwarding specimens to public hospital laboratories, but simply as part of the process of ensuring informed financial and clinical consent.
- referral to a public sector genetics service will not guarantee testing as it will need to be assessed and prioritised according to clinical necessity.

3.5 **Tests forwarded by public pathology collection centres** on behalf of private patients will be billed directly to the patient. The referring laboratory must clearly indicate that the patient is private or the Area Health Service will be billed.

3.6 Tests forwarded by private pathology collection centres are to be treated as private patient referrals, (unless special arrangements have been made - see 2.4 above). The account is to be sent to the patient. If patient details are not provided the account is to be forwarded to referring pathology laboratory.

3.7 Privacy and confidentiality of test results – see 2.6.

The NSW public health system will meet the cost of specialised genetic testing for non-Medical Benefits Schedule items for admitted public patients, non-admitted public patients and privately referred non-inpatients referred to a public sector specialist clinic, ie a specialist clinic managed and controlled by a Public Health Organisation as defined under the Health Services ACT 1997 (NSW).

Private patients are responsible for their own test costs.

Testing is available to patients for whom it is relevant for strictly clinical/medical reasons in accordance with Genetic Testing, PD2007_066
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_066.html

Patient Classification	Pathology Collection	Costs to be met by:
Eligible patients • admitted public patients • non-admitted public patients, and, • **privately referred non-inpatients referred to a public sector specialist clinic**	**Public hospital pathology collection service**	***Area Health Service/public facility requesting the test***
	Private pathology collection service (only where initial referral is from a public sector specialist clinic)	***Area Health Service/public facility requesting the test*** provided there is written authorisation indicating its agreement to meet the test cost. Otherwise patient to be considered private and billed accordingly.
Non-Eligible Patients Patients who consult with and have tests requested by general practitioners or specialists in private rooms outside public hospitals. Note: some tests provided by public sector laboratories shall only be undertaken when requested by clinical geneticists or other specialists with expertise in the genetics of the specific disorder.	**Public hospital pathology collection service**	***Private patient*** **- bill** the patient direct. • Obtain informed financial consent prior to testing. • Clearly indicate private patient's contact details for billing, otherwise the bill will be sent to the *referring laboratory*
	Private pathology collection service	***Private patient*** As above

NPAAC ADVISORY DOCUMENT

INFORMATION FOR CLASSES OF GENETIC TESTING

The NPAAC document *Laboratory Accreditation Standards and Guidelines for Nucleic Acid Detection Techniques* recognises that many human genetic tests simply require the patient's verbal consent after the provision of appropriate information by a qualified practitioner. There are however other human genetic tests where pre- and post-test genetic counselling as well as formal consent and confidentiality procedures are appropriate parts of the testing process and are required for optimal patient care. The current definitions of testing classes are as follows.

Class A: Diagnostic Genetic Tests

Tests in this class are conducted largely on symptomatic patients with the aim of making a diagnosis for the purpose of treatment, patient management or else are supported as routine public health measures by a State or Territory Department of Health (e.g. newborn screening tests). The tests in this class require verbal consent of the individual being tested (or legal guardian) and do not require specific pre-test counselling for genetic disease. Tests in this class are appropriate for access by the health professionals providing patient care. This class of tests is expected to represent the substantial majority of nucleic acid based tests conducted by multidisciplinary laboratories.

Class B: Predictive, Carrier and Prenatal Genetic Tests

This class of tests would typically be the province of a specialist laboratory working in close association with clinical genetics units or a number of specialist referrers. The tests in this category are largely conducted on samples from non-symptomatic patients, for the purpose of determining carrier status or predictive testing, or for prenatal diagnosis. They require formal consent, pre- and post-test counselling, confidentiality procedures, and close dialogue between laboratory and clinical services.

In order to encourage uniformity of practice in human molecular genetics laboratories NPAAC requested that stakeholders* provide guidelines as to which molecular genetic tests should be categorised as 'Class A' or 'Class B' tests.

There was consensus that the following four indications could be undertaken as Class A tests:

- Diagnostic tests for which a simple definitive test exists (e.g. Fragile XA)
- Predictive tests for conditions where a simple treatment exists (e.g. Haemochromatosis)
- Screening tests supported as a public health measure by a State or Territory Dept of Health (e.g. Newborn Screening Tests)
- Some carrier tests for autosomal recessive or X-linked conditions (e.g. Tay Sachs disease).

There was consensus that the following indications should be undertaken as Class B tests:

- Diagnostic tests for which complex genetic analysis is required to identify mutations and for which negative test results also require detailed genetic counselling (e.g. hereditary cancer syndromes)
- Predictive tests for untreatable adult onset conditions (e.g. Huntington's disease)
- Prenatal diagnostic tests
- Some carrier tests for autosomal recessive or X-linked conditions (e.g. Duchenne Muscular Dystrophy).

The major discriminator between whether a test falls into Class A or Class B is the reason for the performance of the test rather than the test itself. For example a Fragile XA test could be a Class A or Class B test depending on whether it is offered for diagnosis in a developmentally delayed child or undertaken on a sample from a known carrier for prenatal diagnosis.

Further information relating to the ethics of laboratory genetic testing is available in the NHMRC publication: Ethical Aspects of Human Genetic Testing: an Information Paper (2000).

*Responses were received from: the Human Genetics Society of Australasia, Royal College of Pathologists of Australasia, Australasian Association of Clinical Geneticists, Australian Society of Genetic Counsellors, Genetic Services Advisory Committee of the New South Wales Department of Health, Victorian Clinical Genetics Service, Queensland Clinical Genetics Service.

Appendix 2

Request Form for Specialised Molecular Genetic/DNA Testing for Genetic Disorders

- Must be used for **non-Medical Benefits Schedule items**
- Before testing is commenced, the laboratory may require the following details (see ***Guidelines for Specialised DNA Testing for Genetic Disorders*** www.health.nsw.gov.au/health-public-affairs/publications/gentest/)

Send by courier/express post to:

Send samples at room temperature
Same day OR overnight

Patient ID MRN

Last name .....

First name .....

Address .....

..... Postcode .....

Date of birth ...../...../..... (dd/mm/yyyy) Sex M F

Sample Date Drawn ...../...../..... (dd/mm/yyyy)

Blood

☐ EDTA ..... mL (room temp)

☐ Lithium heparin..... mL (room temp)

Prenatal

☐ amniotic fluid ..... mL (room temp)

☐ cultured amniocytes xT25 Flask(s) (room temp)

☐ CVS sample ..... mg ☐ on ice ☐ cleaned ☐ uncleaned

Other

☐ DNA .....µg

Other, specify:

Test requested

PLEASE ATTACH FAMILY/PEDIGREE INFORMATION

Purpose of test

☐ Confirm clinical diagnosis
☐ Predictive/presymptomatic testing
☐ Carrier Status
☐ Prenatal Diagnosis - complete box below
☐ Determine feasibility of prenatal Dx
☐ Family study (no report for this individual)
☐ For research (no report for this individual)
☐ Bank DNA until further notice
☐ Other.....

Pregnancy Information (if applicable)

Is this individual or the partner of this individual currently pregnant

L.M.P. (dd/mm/yyyy) .....

Amnio (dd/mm/yyyy) .....

CVS (dd/mm/yyyy) .....

Family Information

Have samples from this family been sent to a DNA lab before? ☐ Yes ☐ No

If Yes, specify .....

Date of birth or age .....

Ethnic background .....

Genetic Counselling

Has the individual been offered counselling consistent with ***Specialised/DNA Testing for Genetic Disorders***? www.health.nsw.gov.au/health-public-affairs/publications/gentest/

☐ Yes ☐ No ☐ Refused

Consent to Testing

Has a ***Consent Form for Specialised/DNA Testing*** been completed?

☐ Yes ☐ No

Consent to payment

☐ **Public patient, or**

☐ **Privately referred non-inpatient**

Payment to be made by Area Health Service by arrangement

Authorised by.....

☐ **Private patient** - Payment to be made by patient

Consent to payment .....

Send Account to:

Name .....

Address .....

..... Postcode .....

Test requested by:

Name ..... Initials .....

Address .....

..... Postcode .....

Telephone No .....

Signature..... Date .....

Specialty /Appointment.....

Copy of report to:

Name Initials .....

Address .....

..... Postcode .....

Telephone No .....

Appendix 3

Clinical and Genetic Counselling Service Locations

Camperdown
Department of Molecular and Clinical Genetics
Royal Prince Alfred Hospital
Missenden Road
CAMPERDOWN NSW 2050
Tel. 9515 5080
Fax. 9515 7595

Liverpool
Dept of Clinical Genetics
Health Services Building
Cnr Campbell & Goulburn Sts
LIVERPOOL NSW 2170
Tel. 9828 4665
Fax. 9828 4650

Penrith
Nepean Hospital
Summerset Street
PENRITH NSW 2750
Tel. 4734 3362
Fax. 4734 2567

Randwick
Dept of Medical Genetics
Sydney Children's Hospital
High Street
RANDWICK NSW 2031
Tel. 9382 1708
Fax. 9382 1711

Westmead
Dept of Clinical Genetics
The New Children's Hospital
Hawkesbury Road
WESTMEAD NSW 2145
Tel. 9845 3273
Fax. 9845 3204

Newcastle
Hunter Genetics
Cnr Turton & Tinonee Streets
WARATAH NSW 2298
Tel. 4985 3100
Fax. 4985 3105

Genetic Counselling Services in conjunction with visiting clinical genetics services

Kogarah
Women's & Children's Health
2nd Floor Prichard Wing
St George Hospital
Gray Street
KOGARAH NSW 2217
Tel. 9350 2315
Fax. 9350 3901

St Leonards
Fetal Medicine Unit
Royal North Shore Hospital
Pacific Highway
ST LEONARDS NSW 2065
Tel. 9926 6478
Fax. 9906 1872

Bathurst
Community Health Centre
158 William Street
BATHURST NSW 2795
Tel. 6331 5533
Fax. 6332 2039

Broken Hill
Community Health Centre
BROKEN HILL NSW 2880
Tel. (08) 8080 1556
Fax. (08) 8080 1611

Canberra
The Antenatal Clinic
The Canberra Hospital
Gilmore Crescent
CANBERRA ACT 2605
Tel. 6244 4042
Fax. 6244 3422

Coffs Harbour
Coffs Harbour Health Campus
Pacific Highway
COFFS HARBOUR 2450
Tel. 6656 7806
Fax. 6656 7817

Gosford
Child Health Centre
297 Henry Parry Drive
WYOMING NSW 2250
Tel. 4337 0207
Fax. 4337 0217

Goulburn
Child Development Unit
Cnr Albert and Clifford Streets
GOULBURN NSW 2580
Tel. 4827 3951
Fax. 4827 3958

Lismore
Child & Family Health Centre
37 Oliver Avenue
GOONELLABAH NSW 2480
Tel. 6625 0111
Fax. 6625 0102

Mudgee/Dubbo
Mudgee Community
Health Centre
MUDGEE NSW 2850
Tel. 6372 6455
Fax. 6372 7341

Muswellbrook
Community Health Centre
Brentwood Street
MUSWELLBROOK NSW 2332
Tel. 6542 2083
Fax. 6542 2005

Port Macquarie
Hastings Macleay
Community Health
Morton Street
PORT MACQUARIE 2444
Tel. 6588 2882
Fax. 6588 2800

Tamworth
Community Health Centre
Cnr Dean and Johnson Streets
TAMWORTH NSW 2340
Tel. 6766 2555
Fax. 6766 3967

Taree/Forster
Community Health Centre
64 Putney Street
TAREE NSW 2430
Tel. 6592 9315
Fax. 6592 9607

Wagga Wagga
Wagga Base Hospital
Edward Street
WAGGA WAGGA NSW 2650
Tel. 6938 6393
Fax. 6921 5632

Randwick
Prenatal Diagnosis
Royal Hospital for Women
Barker Street
RANDWICK NSW 2031
Tel. 9382 6098
Fax. 9382 6706

Cancer Genetics Specialised Services

Darlinghurst
Family Cancer Clinic
Dept of Medical Oncology
St Vincent's Hospital
Victoria Street
DARLINGHURST NSW 2010
Tel. 8382 3395
Fax. 8382 3386

Wollongong
Maternal and Paediatric Services
Wollongong Hospital
Crown Street
WOLLONGONG NSW 2500
Tel. 4222 5216
Fax. 4222 5477

Penrith
Fetal Medicine Unit
Nepean Hospital
Summerset Street
PENRITH NSW 2750
Tel. 4734 3163
Fax. 4734 3206

Kogarah
Cancer Care Centre
St George Hospital
Belgrave Street
KOGARAH NSW 2217
Tel. 9350 3815
Fax. 9350 3958

MotherSafe
Statewide Medications in Pregnancy and Lactation Advisory Service

Royal Hospital for Women
Barker Street
RANDWICK NSW 2031
Tel. 9382 6539 (Sydney calls)
Tel. 1800 647 848 (Other calls)

St Leonards
Fetal Medicine Unit
Royal North Shore Hospital
Pacific Highway
ST LEONARDS NSW 2065
Tel. 9926 7280
Fax. 9906 1872

Liverpool
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel. 9828 4665
Fax. 9828 4650

Prenatal Diagnosis & Counselling Services

Camperdown
Fetal Medicine Unit
King George V Hospital
Missenden Road
CAMPERDOWN NSW 2050
Tel. 9515 8258
Fax. 9515 6579

Westmead
Fetal Medicine Unit
Westmead Centre
Hawkesbury Road
WESTMEAD NSW 2145
Tel. 9845 6802
Fax. 9845 7793

Randwick
Hereditary Cancer Clinic
Prince of Wales Hospital
High Street
RANDWICK NSW 2031
Tel. 9382 2587
Fax. 9382 2588

Liverpool
Fetal Medicine Unit
Liverpool Hospital
Elizabeth Drive
LIVERPOOL NSW 2170
Tel. 9828 4145
Fax. 9828 4146

Newcastle
Prenatal Diagnosis Unit
John Hunter Hospital
NEWCASTLE NSW 2310
Tel. 4921 4694
Fax. 4921 3133

Westmead
Familial Cancer Services
Westmead Hospital
Hawkesbury Road
WESTMEAD NSW 2145
Tel. 9845 5079
Fax. 9687 2331

Newcastle
Hunter Genetics
Cnr Turton & Tinonee Streets
WARATAH NSW 2298
Tel. 4985 3100
Fax. 4985 3105
AGSA

Association of Genetic Support of Australasia Inc.

66 Albion Street
SURRY HILLS NSW 2010
Tel. 9211 1462
Fax. 9211 8077
Email. agsa@ozemail.com.au
Web. www.agsa-geneticsupport.org.au

Further Information On services in other areas and newly developed services:

NSW Genetic Education Program
PO Box 317
ST LEONARDS NSW 2065
Tel. 9926 7324
Fax. 9906 7529
Web. www.genetics.com.au

SPONSORSHIP PRINCIPLES INDEPENDENT COMMISSION AGAINST CORRUPTION DOCUMENT

The undermentioned principles are to be followed by area health services, district health services, hospitals and other units of the Department of Health when considering entering into any type of "sponsorship" arrangement.

INTRODUCTION

For present purposes, "sponsorship" means a contribution in money or kind, generally by the corporate sector or private individuals, in support of a public sector activity. It does not include the selling of advertising space, joint ventures, consultancies and gifts or donations where the reciprocal benefit provided by the government agency does not extend beyond some modest acknowledgement.

Many government departments and agencies are turning increasingly to sponsorship for financial and other kinds of support for their general activities or for particular programs. The trend is likely to continue and expand owing to increasing pressures on public funding and the requirement for public sector agencies to raise some of the funds for their activities.

Sponsorship often excites opposing views, particularly about the appropriateness of particular sponsors to some aspects of government activity.

Despite the increasing importance of sponsorship, there are few public agencies with well-developed polices and procedures relating to it. Many agencies have asked the Commission for specific advice and have expressed the need for general guidance. For these reasons, the Commission has produced the accompanying principles after wide consultation with both public and private sector organisations.

The principles are framed in general terms and are designed to assist each agency to formulate guidelines which are specific to its particular needs and structure. They encompass two major objectives - good management and minimisation of opportunities for corruption.

The Commission suggests that each public sector agency interested in sponsorship develops policies and procedures relating to the topic. These could be published in the agency's Annual Report and sections - for example, those referring to personal benefits - could be included in the agency's Code of Conduct. They should be reviewed on a regular basis.

In November 1993, the Independent Commission Against Corruption (ICAC) published ten principles to be used as a guide by public sector agencies in establishing and managing private sector sponsorship. The following definition of sponsorship and principles are from the Commission's publication "And Now a Word from Our Sponsor ..... Review of the ICAC Sponsorship Principles" published in September 1995 and is a revision of the 1993 guidelines. Health organisations involved in sponsorships should obtain a copy of this document for guidance.

We hope that the principles which follow will make this task easier and help public sector agencies to utilise sponsorship effectively and with probity.

(i) A sponsorship arrangement should not impose or imply conditions that would limit, or appear to limit, a public sector agency's ability to carry out its functions fully and impartially.

This principle needs to be clearly understood by sponsors. The sponsorship agreement should state positively that the agency's functions will continue to be carried out fully and impartially, notwithstanding the existence of a sponsorship arrangement

Clear guidelines should describe the process and possible consequences of any sponsorship related impacts on a public sector agency's responsibilities (for example, a statement to the effect that any attempted influence of the sponsored agency's functions will result in an automatic review and/or termination of the sponsorship arrangement).

(ii) There should be no real or apparent conflict between the objectives and mission of the sponsored agency and those of the sponsor.

Sponsorship agreements should be monitored. Provision should be made for contingencies such as a change in the sponsor's corporate mission or objective.

Be aware of the possibility that the objectives and mission of a sponsor's parent company or subsidiaries might be in conflict with those of the agency.

(iii) A public sector agency with regulatory or inspectorial responsibilities should neither seek nor accept sponsorship from persons or bodies which are, or are likely to be, subject to regulation or inspection by the agency during the life of the sponsorship.

Accepting sponsorship in such circumstances is a delicate business and one where the manager must exercise some judgement as to who should or should not be an exception to the general rule.

For those exceptional cases where a decision is taken to accept sponsorship in such an environment, all parties should be in no doubt that the sponsorship relationship has absolutely no bearing on the sponsored agency's exercise of regulatory or inspectorial functions. This should be made clear in all negotiations and documentation, not only for the benefit of those who are parties to the agreement but also to ensure public confidence in the integrity of the agreement.

Always ensure that a method for dealing with any exercise of the regulatory or inspectorial function is in place and clearly spelt out in the specific sponsorship agreement.

It is just as important that the principles which will be used to manage such contingencies are published in generally available documentation of the agency's sponsorship policy.

In the case of local government, consideration should be given to establishing a means for dealing with sponsors who become involved in a regulatory or inspectorial activity. Possible solutions might include referring the matter to another council or private organisation that can carry out the functions impartially and provide an independent report, and/or suspending/terminating the sponsorship arrangement.

(iv) Sponsorship of a public sector agency or activity should not involve explicit endorsement of the sponsor or the sponsor's products.

Care also needs to be taken to avoid strong implicit endorsement of a sponsor's products. Sponsorship agreements should set out the range of uses to which the sponsor can put the relationship (for example, in advertising copy) and perhaps give the agency an opportunity to review specific uses prior to release.

(v) Where sponsorship takes the form of provision of a sponsor's product, the product should still be evaluated for its fitness for purpose against objective operational criteria which are relevant to the agency's needs.

Agencies should be careful not to accept a sponsor's products simply because they are offered free of charge. There could be an implicit agency endorsement of a sub-standard product.

(vi) It is inappropriate for any employee of a public sector agency to receive a personal benefit from a sponsorship.

This principle should be included in the appropriate section of the agency's code of conduct.

Where a benefit is provided by a sponsor on a corporate basis (for example, meeting the cost of hospitality at a conference), it is important to ensure there is no perception of a personal benefit being given to a public official as an individual.

Depending on conditions of engagement, contractors and consultants could be regarded as employees of public sector agencies and should be considered when assessing the status of personal benefits in a sponsorship agreement.

(vii) In most circumstances, the public interest is best served by making sponsorship opportunities widely known. To this end, sponsorships should be sought by calling expressions of interest or using other broadly based mechanisms not limited solely to invited sponsors.

When and in what form a broadly-based process should be used depends on the nature of the market. If there is vigorous interest in sponsorship, the process should be competitive. Alternatively, if interest is restricted to potential sponsors with highly specialised characteristics, then more direct methods would be unlikely to offend. In any case, agencies should make their general willingness to accept sponsorship as widely known as possible. The response could indicate how competitive the race for a specific sponsorship might be.

Where a decision is taken not to offer sponsorship opportunities widely, the reasons for doing so should be clearly documented.

The reasoning behind this principle can be found in the ICAC's Report on Investigation into the Silverwater Filling Operation (1990, pp 26-27). The 'Silverwater Principles' as they have become known, recommended that:

(1) Public property must be utilised so as to maximise public benefit.

(2) All should have equal opportunities relative to public property.

(3) Accordingly, tenders should be called whenever large benefits will pass to or costs be incurred by either the State, or a party contracting with the State, in relation to public property.

(4) If that general rule is departed from, the reasons for so doing should be recorded.

The New South Wales Government Procurement and Disposal Guidelines (1995) also recommend (at point 2.8) that "competition be considered even where no apparent public expense is to be incurred, for example where a firm offers payment or services in exchange for an intangible benefit such as publicity as a sponsor...".

(viii) Government agencies should assess sponsorship proposals against predetermined criteria which have been published in advance or which are circulated to organisations which submit an expression of interest.

The assessment should be done by persons who have relevant qualifications and can act, and be seen to act, impartially.

Proposals must be assessed consistently, using predetermined criteria available to all potential sponsors. The criteria should be established and documented prior to culling for expressions of interest. For the process to be fair, the criteria should not be changed midstream unless all potential sponsors are given an equal opportunity to revise their proposals.

The assessment process and reasons for decisions should be fully documented.

A more detailed discussion on managing the tendering process can be found in the ICAC publication Contracting for Services: The Probity Perspective (1995).

(ix) A sponsorship arrangement is a contract and should be described in a written agreement.

The written agreement (an exchange of letters could suffice) should clearly set out.

- the benefits, including economic benefits, available to the sponsored agency and to the sponsor,

- **any personal benefits available to the sponsor's employees and their relatives;**

- the form or forms of sponsorship acknowledgment which will be available;

- **the scope of uses which the sponsor can make of the sponsorship arrangement;**

- the term of the sponsorship and any conditions regarding renewal,

- consequences of changes which may occur over time (for example, a shift in the relationship, new policies, new corporate missions or objectives);

- financial accountability requirements,

- **provisions for termination or suspension of the agreement;**

- any special conditions which apply.

Agencies should be mindful that sponsorship agreements constitute contracts and should be administered by people who are appropriately trained. This training should include basic contract administration and commercial dealings with the private sector.

(x) All sponsorship arrangements should be approved by the CEO or another designated senior officer of the agency and described in the agency's annual report, in a form commensurate with the significance of the sponsorship.

Highly dispersed agencies should ensure regional managers have appropriate delegations to deal with sponsorship on a local level and that a reporting system is in place to enable data collection for the agency's annual report.

Where boards or volunteer committees are convened by public sector agencies, it is important to provide such people with the support necessary to effectively administer sponsorship arrangements.

(xi) A sponsored agency must ensure that sufficient resources are available to enable the promised sponsor benefits to be delivered. The sponsored agency should provide sufficient information for the sponsor to evaluate the outcomes of the sponsorship.

The benefits which are provided should be commensurate with the level of sponsorship and consistent with the sponsorship arrangements.

NSW HEALTH SPONSORSHIP POLICY (PD2005_415)

Sponsorship is a useful and potentially beneficial mechanism that reinforces and enhances NSW Health business activities. Across the health system cash and in-kind sponsorships have been used for some time to support a range of activities that are inline with NSW Health strategic directions.

The NSW Health Sponsorship Policy has been developed to ensure that NSW Health organisations respond in a consistent and ethical way to seeking and granting sponsorships. It recommends that each organisation methodically approach sponsorships by identifying potential opportunities, preparing sponsorship plans, seeking approval dependent on level of commitment, formally confirming arrangements and monitoring and evaluating partnerships to maximise benefits and protect public confidence.

This policy was developed by the NSW Health Sponsorship Committee, in consultation with all Area Health Services, ICAC and the Audit Office of NSW.

CONTENTS

NSW HEALTH SPONSORSHIP POLICY

1. CONTEXT

Over the past two decades there has been a national and international trend for government agencies to develop community partnerships and to seek sponsorship from the private sector. Through such arrangements and as a result of additional funds, many government agencies have been able to develop new services and receive regular income from sponsorship. The public health system, particularly through individual hospital and community facilities, is often a beneficiary of sponsorship arrangements.

As well as the benefits, there are risks associated with sponsorship. Sponsorship agreements require careful review to ensure they fit within an ethical framework that complies with accountability and transparency requirements set out for the public sector and are in the public interest. Additionally, there is a responsibility to ensure that a sponsorship agreement provides good value, that the conditions of agreement are fair and transparent and that the arrangement is appropriately documented and monitored and will not create any conflicts of interest for the sponsorship agency.

This policy provides a framework to ensure compliance with basic principles established by the *Independent Commission Against Corruption (ICAC)* to assess sponsorship proposals. The policy is applicable to all NSW Health public health organisations and contains a process for assessment, approval and implementation of sponsorships, a checklist and a draft contract.

2. WHAT IS SPONSORSHIP?

2.1 Definition of Sponsorship

The ICAC defines sponsorship as:

> 'a contribution in money or kind, generally by the corporate sector or private individuals, in support of a public sector activity. It does not include the selling of advertising space, joint ventures, consultancies and gifts or donations when the reciprocal benefit provided by the government agency does not extend beyond some modest acknowledgment.'[1]

This definition is adopted for the purpose of this NSW Health policy.

Often external organisations might provide modest contributions, for example free meals, attendance at events or promotional products on such a regular basis that such contributions cannot be deemed modest. Health organisations are required to determine whether such contributions are in fact "sponsorships" or "donations" – the only determining factors in deciding such is the level of acknowledgement that is required for example a letter of thanks as against signage, promotional opportunities to the external organisation, and whether it could be perceived that the external organisation and/or external organisation product is being endorsed.

Health organisations should also consider whether the contributions have a "personal benefit" to particular staff etc of the health organisation and not to the health organisation as an entity and should be treated as a possible conflict of interest. An example of this is where a company regularly pays for the lunches of a health organisation's committee, work/review group wherein it could be perceived that a "conflict of interest" could exist and that in fact staff members should pay for own meals – such arrangements are not acceptable.

1 "And now a word from our Sponsor: *Review of the ICAC Sponsorship principles*." NSW 1995

2.2 Examples of Sponsorship

In reviewing sponsorship guidelines, the Commonwealth Australian National Audit Office (ANAO)[2] listed the following benefits an agency can receive from private sector sponsorship:

- An injection of resources, either a cash or in-kind sponsorship. This may reduce the cost of performing a particular activity or allow for enhanced program delivery or expansion.
- Providing funding for publications, conferences or other special activities that promote the program or the agencies.
- Providing the program or agency with an opportunity to develop better working relationships with stakeholders.
- Promoting the public profile of a program or agency to a wider than normal audience. This may include increasing community awareness of a program or agency and its activities.
- Free advertising/promotion from television (free and pay), radio, newspaper or other media companies.

2.2 Benefits of Sponsorship

There are a number of benefits for both sponsor and recipient in a sponsorship arrangement. The potential benefits for a sponsor are generally greater exposure and a positive association with an agency's products or services.

These may include:
- Opportunities to demonstrate the company's business principles.
- Increased staff morale and pride through association with a 'worthwhile' activity or service.
- Naming opportunities, for example, for conferences, publications or facilities.
- Participation of agency staff at sponsor events, such as training courses.
- Public relations benefits, including invitations to events.
- General corporate image/profile-raising through philanthropic activity.
- Signage and plaque placement[3].

For a Government agency, receiving sponsorship may enable a range of activities, projects and services that may not have been possible without additional funding.

2.3 Risks of Sponsorship

While receiving sponsorship offers significant benefits to government agencies, it also potentially exposes them to risk. A key risk is the potential for a sponsorship arrangement to compromise due process and influence how an agency may conduct its business, for example, its purchasing and other contractual arrangements. A more serious example would be where an agency's policy objectives were to be somehow altered or affected by a sponsorship arrangement.

There is also a further, more intangible risk for government agencies: how a sponsorship arrangement between an agency or department and a particular sponsor is perceived by the general community.

Public confidence can quickly be eroded if there is a perception that, by way of a sponsorship arrangement, a government agency is no longer neutral, or is implicitly promoting or endorsing a particular sponsor's products or services.

2 ANAO audit report of the *Management of Corporate Sponsorships* (1997)
3 *NSW HEALTH BUILDING GUIDELINE 2000 PLAQUE PROTOCOL* Circular No 2000/11

The test is whether the arrangement will withstand full public scrutiny and not undermine public confidence in the neutrality and integrity of the agency. While ultimately, this is based on a subjective set of judgments, risks can be minimised by ensuring that sponsorship arrangements are properly assessed, developed, documented, managed, monitored and evaluated.

2.5 Application of Policy

This policy applies to all sponsorships except those exceptions listed hereunder. In regard to low value sponsorships of under $10,000 this policy still applies however, there are less stringent requirements specified for formal agreements. Smaller sponsorships should be assessed against the same guidelines as far as they are relevant.

2.5.1 Policy does not apply where benefit is only 'modest acknowledgement'

This policy does not apply to donations and gifts where the reciprocal benefit does not extend beyond some form of 'modest acknowledgment'. Examples of 'modest acknowledgement' include a letter of thanks, discreet signage such as a small plaque on a wall, media release or mention in a newsletter or conference material.

2.5.2 Guidelines do not apply to clinical trials and research grants

These guidelines exclude clinical trials and research projects. *A separate policy will be developed to cover these categories.*

3. PRINCIPLES OF SPONSORSHIP

In its role of assisting NSW public sector agencies to maintain a high standard of public accountability and ethical practice, the ICAC has developed a set of sponsorship principles as a guide for public sector agencies to modify and adopt. These are adapted to NSW Health's requirements as follows:

Principle 1. A sponsorship arrangement should not impose or imply conditions that would limit, or appear to limit, NSW Health's ability to carry out its functions fully and impartially.

The ICAC suggests that a sponsorship agreement should foreshadow 'the possible consequences of any sponsorship related impacts on a public sector agency's responsibilities. A sponsorship contract should have a statement included to the effect 'that any attempted influence of the sponsored agency's functions will result in an automatic review and/or termination of the sponsorship arrangement.'[4] This has been included in the draft contract at the back of this document (Appendix 3 – Clause 4 Termination).

Additionally public health organisations must ensure that where a sponsor is involved in lodging a quote or tender, all relevant processes detailed in the *NSW Health Purchasing Manual* are to be strictly followed. Decisions for awarding the tender should be clearly and explicitly documented to avoid any perception that a sponsor may receive favourable treatment.

Principle 2. There should be no real or apparent conflict between the mission and objectives of NSW Health and those of the sponsor.

The proposed sponsorship needs to be consistent with the mission, goals and priorities of NSW Health, as outlined in the NSW Health 'Strategic Directions' document and Corporate Plan. See the NSW Health website at http://health.nsw.gov.au/pubs/c/pdf/corporateplan_03.pdf or attachment.

4 ICAC. *Review of the ICAC Sponsorship principles*, NSW 1995

The proposed sponsor's activities and corporate values should be consistent with the values of NSW Health and the general community.[5]

Prohibited sponsorship and conflicts

Tobacco products
NSW Health specifically prohibits any sponsorship with a company that owns, controls or is involved with the manufacture and production or promotion of tobacco-related products, which includes cigarettes, cigars and pipes.

All NSW Health sponsors are required to certify they are not involved with the production, manufacture or promotion of tobacco and tobacco related products, including cigarettes and cigars

Other conflicts
Other potential conflicts may arise between the mission and goals of NSW Health and a sponsor.

For example a sponsor may:
- produce products or services that could damage health; or
- does not practice good corporate governance (eg does not observe proper Occupational Health and Safety requirements, regulatory compliance, financial accountability requirements, etc).

Note: Sponsorship of staff to attend conferences or to view equipment where sponsorship comes from the company is not desirable and should be avoided wherever possible due to the conflict of interest.

What happens if there is a change in a sponsor's 'reputation'?
A sponsor's corporate objectives or reputation may change over time. All sponsorship agreements need to be able to monitor such changes and include a termination clause that is fair to both parties.

A sponsorship arrangement should be carefully monitored to ensure that the association does not damage or undermine the reputation of the public health organisation.[6]

All sponsors should be requested to confirm in writing that they operate under a current code of ethics, have a good corporate governance record, stable financial position, appropriate employment and marketing practices.

Principle 3. NSW Health should neither seek nor accept sponsorship from persons or bodies that are, or are likely to be, subject to regulation or inspection by NSW Health during the life of the sponsorship.

NSW Health has a regulatory role in areas such as environmental health, marketing of tobacco to minors, mental health, private hospitals, aged care and pharmaceutical services. Individuals, organisations or the corporate sector that provide sponsorship may also be the subject of regulation or inspection.

Experience suggests that corporate sponsors will most likely include some persons or companies who are subject to NSW Health regulation, and special arrangements must be put in place to ensure that sponsorships are undertaken completely independent and at arms length from our regulatory role. Where this occurs, the matter requires careful consideration at senior executive level.

5 *A Guide to Managing Sponsorship in the Public Sector*, p.13
6 ibid, p.13

If a decision is taken to accept sponsorship in an area that NSW Health regulates, sponsors are to be advised that the relationship will be completely independent from NSW Health's exercise of regulatory or inspectorial functions. **This must be specifically documented by the parties to the agreement to ensure the integrity of the arrangement.** This principle applies even where it is another part of NSW Health that has the regulatory responsibility.

Principle 4. Sponsorship of NSW Health activities or events should not involve explicit or implicit endorsement of the Sponsor or the Sponsor's products or services.

Care needs to be taken to ensure that the sponsor or their sponsor's products/services are not explicitly or implicitly endorsed or promoted by NSW Health. For example, the public may regard the naming of an event or a facility after a specific product or organisation, or using named products or services as an endorsement of that sponsor.

All sponsorship agreements should set out an agreed range of options to which sponsorship may apply. These may include, for example, signage, advertising copy, media release acknowledgement and conference promotional material. Area Health Service Media Liaison Officers or Departmental Corporate Communications staff should be consulted prior to release of any material and should also review all sponsored products.

Principle 5. Where sponsorship takes the form of provision of a sponsor's product, the product should still be evaluated for its fitness for purpose against objective operational criteria, which are relevant to the organisation's needs.

Organisations should be careful not to accept a sponsor's products simply because they are offered free of charge. This could result in an implicit health organisation endorsement of a sub-standard product and could have implications under the Occupational Health and Safety Act.

Principle 6. It is inappropriate for any employee of NSW Health to receive a personal benefit from a Sponsorship.

It is inappropriate for NSW Health staff (or relatives and friends) to receive either directly or indirectly any personal benefits arising out of sponsorship arrangements. The only circumstances in which an employee is able to accept a benefit is when required to do so as part of his/her representational or official duties e.g. making a presentation, doing an assessment of the sponsorship or undertaking a training course that is relevant and timely for the role held. Such representational duties are to be approved by the employees manager and must be appropriately recorded. The *NSW Health Code of Conduct* policy indicates that receipt of **non-token** gifts and benefits by employees is **not appropriate** and this requirement also applies in respect to sponsorships (Refer to *NSW Health Code of Conduct* and the ICAC *Gifts, benefits or just plain bribes? Guidelines for public sector agencies and officials* for further information). Employees/staff in the context of this principle include Visiting Medical Officers (VMOs), contractors and Board Members.

Principle 7. In most circumstances, the public interest is best served by making sponsorship opportunities widely known, that is, by calling for expressions of interest or using other broadly based mechanisms.

While individual approaches to potential sponsors are a valid and effective method of attracting sponsorships, the ICAC points out that it could exclude potential sponsors. To ensure a fair and transparent process, general sponsorship opportunities should be made widely known to all potential sponsors. This will be done through an annual advertisement seeking expressions of interest that will be placed by the Department.

An annual notice will ensure that all potential sponsors get the opportunity to show interest in sponsoring NSW Health services or activities. The tendering policy in the '*NSW Health Purchasing/Supply Manuals'* should be observed in receiving, evaluating, approving and disclosing any outcomes. See the NSW Health website at http://internal.health.nsw.gov.au/audit/manuals/purch_supply.pdf

If calls for expressions of interest for sponsorship opportunities do not result in appropriate sponsorship offers, then individual public health organisations and NSW Health entities are not precluded from considering sponsorship offers made through other means, or from canvassing potential sponsors.

Where a company or person directly approaches the health organisation, subsequent to and outside the EOI process, wishing to sponsor the health organisation or a particular event etc of the health organisation such approaches can be accepted however it is critical that they are assessed in accordance with the principles and procedures of this policy with a view to ensuring transparency of process.

Principle 8. Sponsorship proposals should be assessed against transparent criteria that are publicly available.

Proposals must be assessed consistently, using the same selection criteria against all potential sponsor applications. The criteria should be established and documented prior to calling for expressions of interest.

The selection criteria should include:

- the benefit NSW Health is seeking and/or the benefit the sponsor is offering;
- degree of acknowledgement and recognition expected by the sponsor of NSW Health activities;
- context of the arrangement within NSW Health's overall strategic directions; and
- potential to build positive alliances or public/private partnerships, which provide additional benefit to the public.

A detailed checklist has been developed to assist public health organisations in assessing the above criteria. See Appendix 2.

Principle 9. All Sponsorships should be documented in a written agreement.

Every sponsorship arrangement requires a **written agreement** which outlines the terms and conditions of the sponsorship relationship between NSW Health and the sponsor.

For sponsorships under $10,000 the written agreement can constitute an exchange of letters signed by the Chief Executive or delegated officer at 4.3.1.

For sponsorships over $10,000, a formal contract is required. An example appears at Appendix 3.

Principle 10. All Sponsorships are to be approved by the Chief Executive or another delegated senior officer of the relevant Public Health Organisation.

Where a sponsorship proposal is assessed as having the benefits that outweigh the potential risks and costs, and satisfies the selection criteria and checklist, it should be formally submitted for approval to the Chief Executive or another delegated senior officer of the relevant Public Health Organisation or (in relation to the Department) the Director-General.

A completed checklist (as appears at Appendix 2) must accompany the sponsorship proposal.

Principle 11. All Sponsorships are to be reported annually in the relevant Annual Report.

Information on the nature and extent of all sponsorships should be made publicly available in the *Annual Report*. Sponsored benefits for individual employees, that are part of representational or official duties are to be reported to the relevant Public Health Organisation Chief Executive (Public Health Organisation employees), or the Director-General (Departmental employees).

Principle 12. Sponsored projects need to be supported by sufficient resources.

Sponsorships (particularly of an ongoing nature) may need to be supported by appropriate resources. If this is relevant, the potential cost to NSW Health of supporting a particular project is a factor, which should be estimated and evaluated during the assessment and approval process and included in the sponsor's agreement.

Principle 13. All Sponsorships are to be monitored and their outcomes evaluated[7].

All sponsorship projects need to be continually monitored and their outcomes assessed against the written agreement. By evaluating these, the benefits to NSW Health can be clearly identified and future arrangements improved. Monitoring and evaluation procedures are under Section 4.4.

4. IMPLEMENTATION OF SPONSORSHIP PRINCIPLES INTO SPONSORSHIP POLICY

The above ICAC principles outline a framework for ensuring that sponsorship principles are fairly and transparently applied across NSW Health activities. Applications of these principles in relation to NSW Health relates to four areas which are dealt with below in more detail:

- *development* of sponsorship opportunities;
- *assessment* of sponsorship proposals;
- *approva*l of the recommended sponsorship proposals; and
- *resourcing*, monitoring, evaluating and reporting.

4.1 Development of sponsorship opportunities

In summary, sponsorship opportunities can be developed by identifying existing or proposed programs and services which:

- could be enhanced by an injection of private funds;

7 ICAC, *And Now a Word from our Sponsor, Review of the ICAC Sponsorship Principles.*

- would not be compromised by appropriate private sector involvement;
- provide a useful or additional service to the community; and
- have corresponding promotional or other benefits for a potential sponsor.

Many sponsorships have traditionally involved direct approaches from potential sponsors to public health organisations, or vice versa. In order to comply with the ICAC Principle 7, and to ensure that opportunities are provided for potential sponsors in a fair and transparent way, the Department will co-ordinate and publish an annual notice calling for expressions of interest for private sponsors to support nominated events, activities or facilities across the health system. This notice will coordinate information and individual contact details for each public health organisation so that potential sponsors can direct their inquiries to the relevant area. The notice will give details of:

- relevant projects by public health organisations or at a NSW Health level for which sponsorship is sought; and
- how sponsorship proposals are assessed and processed within NSW Health, and
- an explanation of the assessment process.

4.2 Assessment of Sponsorship Proposals

In assessing all sponsorship proposals, the benefits, risks and costs of the sponsorship must all be evaluated. The benefits and risks need to be defined, both for NSW Health and the sponsor, and if appropriate, a risk management strategy established. The costs associated with implementation of a sponsored project (or dollar value of the resources involved in ongoing support of the sponsorship) also need to be evaluated. For larger sponsorship this may require a cost-benefit analysis. Sponsorship proposals are to be assessed in a transparent and accountable way.

4.3 Approval of the recommended Sponsorship Proposals

All sponsorship proposals should be evaluated against the checklist at Appendix 2, which should be included within any recommendation.

For sponsorships ***under $10,000*** the written agreement can constitute an exchange of letters signed by the Chief Executive or delegated officer.

Every sponsorship arrangement ***over $10,000*** requires a formal contract between NSW Health and the Sponsor as per Principle 9. See the draft contract at Appendix 3.

4.3.1 Public Health Organisation Approvals/Delegations

Sponsorship proposals need to be submitted to the Chief Executive or delegated senior officer for approval.

The Chief Executive may delegate this power to no more than two other Public Health Organisation executives, both of whom must be SES or Senior Officer equivalent and neither of whom is directly responsible for the operation of a public hospital or other health care service (ie public hospital general managers are excluded). Such delegations are to be minuted and be reflected in the relevant Public Health Organisation's Delegation Manual.

'In-kind' sponsorship is to be valued as far as is realistic and practicable at normal commercial rates, eg, free advertising promotion by a television company is to be valued at what it would have cost the Health Service to produce the advertisement and run it on the television station, or if a company was to provide a free service, it should be valued at the normal cost in a competitive situation.

As a general rule the period of a sponsorship is to be limited to a period of two (2) years and only in exceptional circumstances, approved by the Chief Executive, are periods to be in excess of two (2) years. The two (2) year total period is inclusive of any "renew" options incorporated in contracts/agreements viz if original contract is for 1 year the "renew" clause in the contract is only to be for a period of 1 year unless Chief Executive approval is obtained. Contracts are not to have opened ended renewals.

4.3.2 NSW Department of Health Approvals Irrespective of Value
In relation to Departmental sponsorship activities, the proposed sponsorship agreement should be sent to the Manager, Corporate Communications or equivalent for assessment and referral to the Director-General for approval.

4.4 Supporting, Monitoring and Evaluation of the Sponsorship

Adequate support and resources need to be assigned to ensure the sponsorship can be effectively implemented. The sponsor should be provided with regular progress reports and efforts should be made to maintain a positive professional relationship.

Sponsorship funds received by NSW Health must be allocated to an account or cost code that allows for the expenditure of the funds to be monitored. A regular financial income and expenditure statement for the account or cost code should be available to the employee responsible for monitoring the implementation of the sponsored project.

Implementation of the written agreement must be monitored to ensure that as a minimum all contractual obligations are met, including the agreed resource commitment of NSW Health. It is important to ensure that both parties are receiving the expected benefits and risks are being managed appropriately.

All sponsored projects should be evaluated to assess the outcomes of the project for NSW Health.

If a sponsor conducts an external evaluation of a project, the Department or Public Health Organisation involved with the sponsorship should request a copy of the report or findings.

Evaluation information from all projects should be analysed with a view to improving future sponsorship arrangements.

All evaluation reports are to be reported to the approving authority;

ie	Public Health Organisations	-	Chief Executive
Departm	ent	-	Director-General

Chief Executives are to ensure a senior officer is responsible for obtaining an evaluation report of approved projects.

With respect to the Department, the Manager, Corporate Communications or equivalent will be responsible for Departmental coordination of approvals.

5 REPORTING OF SPONSORSHIPS

All sponsorships are to be listed in the relevant annual report by name, project and the value of the sponsorship. The total amount of all sponsorship revenue (including employee benefits) should be identified as a distinct revenue item in the General Fund of the Public Health Organisation. The *Accounting Manual* and Notes to the *Annual Financial Statement* will be amended to reflect this requirement.

6 FURTHER ENQUIRIES

Issues surrounding advertising tendering agreements, negotiations, monitoring, evaluation, and referral of proposals to the Director-General are to be raised with the Manager, Corporate Communications or equivalent, and financial issues with the Chief Financial Officer or equivalent of the Department.

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APPENDIX 1

DEFINITIONS

Area Health Service

An Area Health Service is a statutory corporation established to provide and manage public health services within a geographical area. There are 8 Area Health Services in the State of NSW, listed in Schedule 1 of the Health Services Act 1997.

NSW Health

NSW Health refers to all bodies or organisations under the control and direction of the Minister for Health, and includes the Department of Health, the Health Administration Corporation, Area Health Services, Justice Health, The Children's Hospital at Westmead and the Ambulance Service of NSW.

Public Health Organisation

Public Health Organisation refers to an Area Health Service, a statutory health corporation, or an affiliated health organisation in respect of its recognised establishments and recognised services.

Statutory Health Corporation

Current statutory health corporations are Justice Health, The Children's Hospital at Westmead, The Stewart House Preventorium, Curl Curl, Institute for Clinical Excellence, The Cancer Institute and HealthQuest. In contrast with Area Health Services, existing statutory health corporations provide health services other than on the basis of defined areas.

Affiliated Health Organisation

Affiliated Health Organisations (AHOs) are non-profit religious, charitable or other non-government organisations or institutions providing certain health services or health support services that contribute significantly to the operation of the public health system. However, an AHO is not an AHO in relation to all its services and institutions. It is only an AHO in relation to the recognised establishments and recognised services listed in column 2 of Schedule 3 of the Health Services Act next to its name. St Vincent's Hospital, Darlinghurst and the Newcastle Mater Misericordiae Hospital are examples of recognised AHOs.

The Department

The Department refers to the NSW Department of Health.

2004 Sponsorship Committee

- Mr Ken Barker, Chief Financial Officer, NSW Health
- Professor Bill Bellew, Director Chronic Disease Prevention and Health Advancement, NSW Health
- Ms Marion Downey, Director Public Affairs, Central Sydney Area Health Service
- Ms Nidia Marneros, A/Strategic Communications Officer, NSW Health
- Professor Kim Oates, CEO, The Children's Hospital at Westmead
- Professor Ron Penny, Senior Clinical Advisor, NSW Health
- Ms Victoria Walker, Director Audit, NSW Health
- Ms Michelle Wensley, A/Manager Corporate Communications, NSW Health

APPENDIX 2

NSW HEALTH SPONSORSHIP CHECKLIST

The following is a checklist against which to assess potential sponsorship proposals. This list is intended to be a guide in assisting staff to evaluate whether a sponsorship is appropriate for a NSW Health project, service or activity and is to be included with any recommendation

1. What are the value and terms of the sponsorship proposal?

- How much will the sponsorship cost the sponsor, in cash value and in-kind?
- How long should it run (eg annual)?
- Are options to renew the arrangement appropriate?
- Has Chief Executive approval been obtained if total contract period (including renew option) is in excess of 2 years?
- What are the rights and terms of the arrangement for both parties?
- How might the agreement be terminated if needed?
- If the sponsorship is 'in-kind' is it valued at commercial and/or competitive rates?

2. Are the objectives of the sponsor/sponsorship proposal compatible with those of NSW Health?

- Do the potential sponsor's values and objectives complement those of NSW Health?
- Has the sponsor indicated that they do not own, control or are involved directly in the product and manufacture of tobacco and tobacco related products including cigarettes and cigars?
- Is the potential sponsor part of an industry that produces products or services that may damage physical health or mental well-being of the community?
- Does the potential sponsor have an acceptable past sponsorship record?
- Is the reputation/public perception of the sponsor and its products appropriate for NSW Health to be associated with?
- Does the potential sponsor operate under a current code of ethics, have a good corporate governance record, stable financial position and appropriate employment and marketing practices?

3. What are the benefits of the sponsorship to NSW Health?

- Describe the benefits of the sponsorship to NSW Health (eg, enhance an existing service, fund a new service, support an event, meet costs of publication, fund additional training).

4. How did the sponsorship proposal come about?

- Was the sponsor selected through the annual advertisement seeking expressions of interest placed by the Department?
- Was a competitive selection process used?
- If not by EOI process, reasons why?
- If the process was not competitive
    1. Would the likelihood of other sponsors being able to participate mean that benefit to NSW Health could be greater?
    2. Could NSW Health be subject to criticism by not offering the sponsorship opportunity by EOI process?

5. Are there benefits to NSW Health individual employees?

- Describe benefits to individual employees (eg sponsored travel, accommodation, conference fees, etc).
- Can the individual benefits be justified in professional terms?

6. What are the benefits to the sponsor?

- List sponsor benefits (eg form of acknowledgment such as use of sponsor's logos, signage, product displays, public relations outcomes, etc).
- If naming rights have been requested, provide details.

7. What are the risks to NSW Health?

- Will public trust in NSW Health be maintained?
- Will the sponsorship withstand public scrutiny?
- Are there any risks to NSW Health's independence and impartiality?
- Is the sponsor likely to be inspected by NSW Health?
- Could the sponsorship arrangement be seen as an endorsement of the sponsor or its products and services?
- Can the risks be satisfactorily managed?

8. What are the costs to NSW Health?

- Provide details of resources required to support the sponsorship (eg staff time, equipment use, materials, infrastructure resources, insurance, etc).Costing in dollars to be completed.
- Is this the best use of these resources?
- Are these resources required after the sponsorship ceases? If so, how could they be funded?

9. Any other relevant factors?

- What is the cost/benefit to NSW Health and is this a reasonable return for effort?

APPENDIX 3

SPONSORSHIP CONTRACTS

All agreements should include the following general statement:
The sponsored organisation's functions will continue to be carried out fully and impartially, notwithstanding the existence of the sponsorship agreement and any attempt by the sponsor to influence the sponsored organisation's functions will result in an automatic review or termination of the agreement.

The sponsored organisation reserves the right to terminate the agreement:
- in the event of the sponsor being found to have been involved in the provision or promotion of a product or service that could damage the physical or mental health of members of the public; or
- where, at the sole discretion of the sponsored organisation, termination is warranted in the public interest.

The agreement should include the following information:
- the parties to the agreement;
- an outline of the benefits (funds, goods and services) to be delivered by the Sponsor to NSW Health and/or its employees and the delivery timeline;
- an outline of the benefits to be delivered by NSW Health to the Sponsor and the delivery timeline including an outline of the way/s in which the Sponsor will be publicly acknowledged;
- requirement concerning the provision of funding and other obligations (eg products under the contract, cost and GST) to be clearly stated;
- a prohibition on the use by the Sponsor of NSW Health's name and logo without prior approval;
- the term of the Sponsorship and any conditions regarding renewal (renewal period to be specified);
- contingency arrangements to address changes, eg change to legislation affecting NSW Health;
- that the sponsor does not own, control or is involved directly in the production and manufacture of tobacco and tobacco related products, including cigarettes and cigars;
- termination clause, eg to accommodate change of Sponsor performance or reputation;
- any other special conditions that may apply;
- an accountability mechanism, ie to ensure information about the origin, nature and extent of the Sponsorship is available to the public;
- monitoring responsibilities of either or both parties throughout the life of the project;
- responsibilities of either or both parties to evaluate the outcome of the Sponsorship; and
- any resourcing (staff or funds) required by NSW Health.

A draft contract follows.

NSW HEALTH SPONSORSHIP CONTRACT

THIS AGREEMENT is made the day of 200.

PARTIES

The **HEALTH ADMINISTRATION CORPORATION**, a Corporation solely constituted by section 9 of the Health Administration Act 1982, ABN 45 100 538 161, and having its office at 73 Miller Street, North Sydney [*Sponsored Organisation*].

OR

AREA HEALTH SERVICE, a statutory corporation constituted by section 17 and Schedule 1 of the Health Services Act 1997, ABN [*insert number*] of [*address*] [*Sponsored Organisation*].

OR

[*Name of other Public Health Organisation*], ABN [*insert number*] of [*address*] [*Sponsored Organisation*].

AND

[*Name of Sponsor*], ABN [*insert number*] of [a*ddress*] [*Sponsor*]

The Sponsored Organisation has agreed with the Sponsor to enter into a sponsorship agreement to (*describe terms of Sponsorship arrangement*).

The Sponsor will provide:

(*insert details of Sponsorship arrangement*)

The Sponsored Organisation will provide:

(*Insert details of Sponsorship arrangement*)

The benefits or outcomes to the Sponsored Organisation and the general public as a result of the Sponsorship will be as follows:

(*Insert dot points here*)

TOTAL VALUE AND TERM OF AGREEMENT

(*Insert details*)

OPERATIVE PART

1. OBLIGATIONS OF THE SPONSOR

The Sponsor agrees that it will:

- do all things necessary to the satisfaction of the Sponsored Organisation in accordance with the Sponsorship agreement with the Sponsored Organisation;

- ensure all advertising and promotional material is consistent with the terms of use as agreed to in this agreement including, in particular, the use of the name, logo or other intellectual property of the Sponsored Organisation or a related body or organisation; and
- regularly consult with and take into account any suggestions, which the Sponsored Organisation may make from time to time in relation to the sponsorship arrangement under this agreement.

The Sponsored Organisation agrees that it will:

- comply with the terms of the agreement as outlined above; and
- regularly consult with and take into account any suggestions, which the Sponsor may make from time to time in relation to the Sponsorship agreement.

2. INTELLECTUAL PROPERTY RIGHTS

The Sponsor acknowledges that Sponsored Organisation's name and logo (or those of related bodies or organisations) is the intellectual property of the Sponsored Organisation (or those of related bodies or organisations) and the Sponsor will obtain prior approval for use of these.

The Sponsor acknowledges that by entering into an Agreement, the Sponsored Organisation is not endorsing any product or service of the Sponsor and neither party should imply such endorsement.

3. REPRESENTATIONS AND WARRANTIES

The Sponsor represents and warrants to the Sponsored Organisation:

- that it does not own, control or is involved with the manufacture and production or promotion of tobacco-related products, which includes cigarettes, cigars and pipes;
- that it does not manufacture, provide or promote any products or services that could damage the physical health or mental wellbeing of members of the public;
- the accuracy of all representations and statements made by the Sponsor, or on its behalf, in connection with negotiations held with the Sponsored Organisation prior to entry into this agreement;
- that it has not made or received any payment or other inducement to or from the Sponsored Organisation or its employees, agents or contractors in connection with entry into this agreement; and
- that the use by the Sponsored Organisation pursuant to this agreement of any logos or material provided by the Sponsor for promotional purposes, will not infringe the intellectual property rights of any person.

4. TERMINATION

The Sponsored Organisation's functions will continue to be carried out fully and impartially, notwithstanding the existence of the Sponsorship agreement. Any attempt by the Sponsor to influence the Sponsored Organisation's functions will result in an automatic review or termination of the agreement.

Without limiting any other right or remedy of the Sponsored Organisation, this agreement may be terminated by notice in writing to the Sponsor if:

- the Sponsor is or has been directly involved in the manufacture and production or promotion of tobacco-related products, which includes cigarettes, cigars and pipes;
- the Sponsor is or has been directly involved in the production, manufacture or promotion of any product or service that could damage the physical health or mental wellbeing of the members of the public;
- the Sponsor has made or received any payment or other inducement to or from the Sponsored Organisation or its employees, agents or contractors in connection with entry into this agreement;
- the Sponsor becomes subject to any form of insolvency administration or a receiver, official manager or administrator is appointed over any part of the property of the Sponsor;
- the Sponsor is in breach of any clause of this agreement and such breach is not rectified within 7 days of the Sponsored Organisation providing in writing notice of that breach to the Sponsor; or
- at the sole discretion of the Sponsored Organisation, termination is warranted in the public interest.

5. RIGHT TO RENEW

The Sponsored Organisation reserves the right to offer the Sponsor an option to renew the sponsorship for an additional period of…….years7 based on its satisfaction with the terms, conduct and outcome of the sponsorship arrangement.

6. MONITORING

The Sponsor and the Sponsored Organisation will agree on a mutually satisfactory monitoring process for the life of this agreement.

7. REPORTING

The Sponsor must report to the Sponsored Organisation any such information as the Sponsored Organisation may reasonably require from time to time. The Sponsor must immediately notify the Sponsored Organisation of any change in circumstances or other factor which would or might cause there to be an actual or potential conflict between the Sponsor's objectives and the Sponsored Organisation's or NSW Health's corporate mission, objectives or interests.

Sponsor consents to the Sponsored Organisation incorporating details of the sponsorship in its Annual Report.

8. ACCOUNTABILITY

The Sponsor and the Sponsored Organisation will agree on an appropriate accountability measure to ensure information about the origin, nature and extent of the Sponsorship is available to the public.

9. EVALUATION

The Sponsor and the Sponsored Organisation agree that either or both parties will conduct an evaluation of the Sponsorship outcome.

7 Refer to 4.3.1 for guidelines on sponsorship terms.

10. FORCE MAJEURE

A party is not to be held liable for any failure to observe obligations under this agreement where such failure is wholly or substantially due to any cause beyond control of the party, provided that in any circumstances the party seeking to rely on the benefit of this clause must use its best endeavours to put itself in a position where it is able to meet its obligations under this agreement as quickly as possible.

11. DISPUTE RESOLUTION

The parties must use reasonable efforts to resolve any dispute, which arises between them under this agreement, by mediation or any other recognised methods or alternative dispute resolution before commencing court proceedings to resolve this dispute.

12. CONFIDENTIALITY

This agreement is confidential to the Sponsored Organisation and neither its terms nor any particulars relating to it may be published or disclosed to any person by the Sponsor (except as required by law or to the extent necessary for the purposes of this agreement) without the Sponsored Organisation's written consent.

13. ASSIGNMENT

The Sponsor is not entitled to assign this agreement without prior written approval of the Sponsored Organisation.

14. RELATIONSHIPS BETWEEN PARTIES

Except as specifically provided in this agreement nothing in it is to constitute or be deemed to constitute a partnership among the parties or any party for any other purpose. No party shall have authority to bind another or contract in the name of another in any way or for any purpose.

15. CONTRACT CONTACT OFFICERS

All communications between the Sponsor and Sponsored Organisation shall be directed to:

- **Sponsored Organisation Representative**
  The current details are:
  Name:
  Address:
  Ph:
  Fax:
  Email:

- Sponsor Representative
  The current details are:
  Name:
  Address:
  Ph:
  Fax:
  Email:

EXECUTED for and on behalf of the
HEALTH ADMINISTRATION CORPORATION/
[*Name of Public Health Organisation*]
but not so as to incur personal liability
by:

……..…… ……
(Signature) (Nam e and Position)

……... ……

(Signature of Witness) (Print Name of Witness)

EXECUTED by and on behalf of:

……
(Full name of Sponsor)

…… ……
(Name of individual or authorised representative for company or organisation)

(Signature of individual or authorised representative)

…… ..……
(Signature of Witness) (Print Name of Witness)

APPENDIX 4

NSW HEALTH SPONSORSHIP APPROVAL BRIEF

(Answers needs to satisfy Checklist at Appendix 2)

1. Activity, event or facility attracting sponsorship

Briefly describe the activity, event or facility for which sponsorship is proposed.

2. Sponsorship Offer

Nature and duration of sponsorship offer (describe cash and/or in-kind contributions).

3. Sponsor Information

Sponsor name, contact details and nature of sponsor's business.

4. Ethical Considerations

Has the sponsor clearly indicated that they do not own, control or are involved with the manufacture and production or promotion of tobacco-related products, which includes cigarettes, cigars and pipes. YES/NO

5. Sponsored Organisation's Contacts

Contact details of Sponsored Organisation employee responsible for:

- Developing the sponsorship proposal
- Implementing the sponsorship proposal

6. Assessment of Proposal

Brieflyoutline **major** factors from checklist influencing recommendation decision (attach checklist at Appendix 2 and answer each question).

7. Recom mendation

On balance, does the value of the sponsorship benefits outweigh the risks and costs to the Sponsored Organisation or NSW Health? YES/NO

Should the sponsorship proposal be accepted and approved? YES/NO

8. Written Agreement

Is the contract/letter of agreement attached? YES/NO

9. Approval *(NB. Can only be approved if Q4 is "YES")*

……. ……

Signature – Chief Executive (Date)

or Director-General

10. Referral by Chief Executive

To Area Executive Meeting for second opinion. YES/NO

SECTION TEN

CHART OF ACCOUNTS